Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Department of Health WA – Dr DJ Russell-Weisz, Mr R Anderson
Date: 10 February 2022, Time: 0805 - 0934

KENNEDY, DR: Okay. Thank you.

Thanks very much for your interest in the Inquiry and for your appearance at today's hearing. The purpose of the hearing is to assist in gathering evidence for the Inquiry into Aeromedical Services in Western Australia.

I'll begin by introducing myself. My name's Marcus Kennedy, I've been appointed to - by the Chief Health Officer, to undertake the Inquiry. Beside me is Mr Jonathan Clayson, who is the Inquiry's Project Director.

Please be aware, everybody in the room, that the use of mobile phones and other recording devices is not permitted in this room and please make sure that your phone is 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 a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private.

You've previously been provided with the Inquiry's terms of reference, the Inquiry's current state considerations paper, a focused list of relevant considerations and information on giving evidence for the Inquiry.

Before we begin, do you have any questions about today's hearing?

RUSSELL-WEISZ, DR: No.

KENNEDY, DR: Thanks.

So, for the transcript, could I ask each of you present, as witnesses, to state your name and the capacity in which you are here today?

RUSSELL-WEISZ, DR: Yes, Dr David Russell-Weisz, Director General of Department of Health.

KENNEDY, DR: Thank you.

ANDERSON, MR: Rob Anderson, Assistant Director General of Department of Health.

KENNEDY, DR: Thank you.

You'll now be invited to address the focus considerations list that's been provided to you, and you may speak to these matters for up to approximately 60 minutes. After your address, I will be asking specific questions, and in the remaining time available after that, you may address any other matters of relevance to the Inquiry.

I understand that you may need to alter the use of the time available to allow for other commitments - and I've had some messaging in that regard, so if there is need to that, could we discuss that at this point, so that we can - we'll just plan the timetable?

RUSSELL-WEISZ, DR: I just - there's just media I might need to do, so - - -

KENNEDY, DR: Okay.

RUSSELL-WEISZ, DR: - - - I - the phones on silent, I'll take it - well, I'll just have to stop and take - and step out if - - -

KENNEDY, DR: Okay.

RUSSELL-WEISZ, DR: - - - I need to take any, but I think we'll be fine for the next - - -

KENNEDY, DR: (Indistinct) 8.07.24.

RUSSELL-WEISZ, DR: - - - hour.

KENNEDY, DR: And Mr Anderson, I understand that there was a preference that you give your evidence jointly in this sitting and try and avoid the - having to come back this afternoon. I understand that, and if we can possibly do that, we'll aim to do that. I have a number of questions that I need to ask each of you, but where those are in common, are you happy to answer those singly, or do you want me to ask the questions - - -

RUSSELL-WEISZ, DR: I'm happy to - - -

KENNEDY, DR: Or you - - -

RUSSELL-WEISZ, DR: We - - -

KENNEDY, DR: - - - can answer them jointly - - -

RUSSELL-WEISZ, DR: Jointly - - -

ANDERSON, MR: Yes.

RUSSELL-WEISZ, DR: We - I'm quite - if you're happy, I'll pass to Rob, and he can pass to me.

KENNEDY, DR: Fine. So, we shall consider you as one from the point of view - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - of the - okay. Over to you.

RUSSELL-WEISZ, DR: Thank you very much, Dr Kennedy.

I don't have any particular opening statement, because we provided a - we reported our responses to some of your questions, and I don't think - I think I would probably rather take your questions and use the time to consider some of the things and considerations, which I have looked at.

The one thing I would say, as a start, is we considered this was an Inquiry that was probably, at a bare minimum, two to three years in the making. We - this is - this was not a criticism of the provision of care by the dedicated services in what is a broad aeromedical environment, but more a reflection on the fact that the environment had changed and become more complex.

And as the environment had changed over 20 - probably 20 years, we saw that there were multiple providers in providing aeromedical services. The care of those - the care, generally, was of an extraordinary high standard by the providers - and I - in that, the providers were both - external providers, such as St John's Ambulances and Royal Flying Doctor Service, but also, providers within the State health system, because we provide those services as well. And it's quite a mesh of different services from our neonatal retrieval services that might use the outside providers, but uses our internal staff, to WA Health.

The concerns - and I think the concerns of the developing environment, was that services were potentially going to start up where there was developing potential confusion of governance. And where organisations employ their own staff - and they're primarily health organisations dealing with health tasking, dealing with the provision of services to rural, remote and even - and outer metropolitan areas, it was clear, but what became apparent was, there were multiple organisations either in the provision of the infrastructure to provide those aeromedical services, but also, I think there was a lack of - excuse me, a lack of clarity sometimes in relation who tasked or who was responsible for more the clinical governance of those services.

And I've - we saw this, both Dr Robertson and I saw this as forward looking about planning for the future, how best do we provide the most optimal - primarily, clinical governance, but more broadly, corporate governance, for aeromedical services into the future.

This was not so much about contract management, this was really not focused - and it was never my intent - and I probably was a driving force behind this with Dr Robertson, to focus on contract management of the providers. This is more forward-looking about how do we make sure there are no gaps in clinical governance, even though we have a suite of excellent providers, including the State health system, that we actually have an ecosystem that lasts us for the next 20 years, and that patients get serviced by a system that is well-governed, people - well, the WA health system and government know where it's procuring and it's getting value for money out of the services it provides, but much more importantly, that there is no confusion of governance between either the government agencies or the providers in the field.

So it actually was not a criticism of what was being provided, more foreshadowing that there was some concerns about either providers or different government agencies all having a part of this pie. And when people all have a part of the pie, where there is sometimes confused governance, there is risk. And I think this was about obviating that risk into the future.

KENNEDY, DR: Thank you.

RUSSELL-WEISZ, DR: But I'm happy - I mean, I'm happy to work - if you're happy, Dr Kennedy, do you want me to work through some of these considerations I think are of particular importance?

KENNEDY, DR: Yes, I think the things that you wish to focus on.

RUSSELL-WEISZ, DR: Yes.

Health service - I think the first one is on page 1, so it's number 3, "Health service governance including aeromedical services must be closely monitored and managed by a central coordinating authoritative agency". I think there is - I think we have to really be clear here about what is contract management and what is operational oversight. And I - this is my - having worked in the health system for many, many years, I'm a great believer in that the contract management of external providers should sit as closely as it can to the organisation it provides services for.

I'm not a centralist, and I think if everything comes into the Department of Health, you cannot run everything from 189 Royal Street. It is impossible. So, for example, if the Royal Flying Doctors Service provides services ostensibly to rural and remote regions, they ostensibly are providing - that's not completely, but they're ostensibly providing services to our country health service. And that country health service is not just about the WA health system, it's also about Aboriginal medical services, it's about private practitioners in the regions and it's not just about doctors.

For example, the Joondalup health - and I know we're not talking about PPPs or private-public providers, but if you look at the Joondalup health contract, the Joondalup health contract, it provides services to the North Metropolitan Health Service region. It is therefore best contract managed by the North Metropolitan Health Service.

There can be good coordination between all those contract managers in - who are contract managing, but I don't think it means that all contract management should be centrally governed. I can remember when that happened and that was - and we have moved, since 2016, through a new Health Services Act 2016, which was - which followed a Public Health Act and followed a Mental Health Act. We reformed the governance in the mid last decade and we went to more devolved governance, where we had health service provider boards that have accountability for the clinical services, the safety and quality and the financial management and contract management they oversight. And the Health Department was established as a system manager at that time.

So, I just wanted to split that. I thought that was one of the most important considerations, because we won't go through all of these, but - - -

KENNEDY, DR: No.

RUSSELL-WEISZ, DR: - - - I think that the contract - the system manager acts as - the Department of Health as a regulator, an assurer and a facilitator.

So, if somebody says to me, "What does the Department do as system manager?" It leads, its stewards, but on hard terms, at one minute, it regulates, so it's a hard regulator when it needs to be. And it's an assurer of the system - that is the system as a whole, providing safety and quality, is it providing robust financial management, does it perform its task as the hazard management agency - and for example, with the COVID-19 pandemic. Does it step in, does it intervene with health service provider boards when things are not working well, as we have done over the last six years, and also, does it facilitate - and that support role is probably significant as the Department of Health. So those are the three real key roles for the Department.

So, in relation to the Aeromedical Inquiry and the aeromedical service provision, I do believe there should be central coordination in the operation environment. And we have talked a little bit about - in other discussions, about setting up a State health operations centre, along with police, along with our providers. This is not taking over what the providers do, it is actually having everybody together, so we have a real-time vision of the services that are being provided.

And we have probably - and probably what this will lead to is much better tasking and much better coordination - I'm not saying the tasking is poor at the moment, but actually, what happens is, it doesn't matter whether it's by RFDS, whether it's by St John's, whether it's by our retrieval - you know, with the small retrieval we do, whether it's by helicopters, they all end up in our hospitals. And the one thing we want better coordination of is inter-hospital patient transports. We want better coordination of where patients go, better patient flow.

We also want to work with our providers - not our providers, but with our stakeholders, and that is, the people I've mentioned, but it also is police. And we've had very initial discussions about setting up a State health operation centre with police. They are very supportive, but naturally, things have been slightly diverted by the pandemic, and I still think that's a few months away, because we're in the heart of the COVID-19 response.

So, I think just on that consideration 3 - or number 3, it is a - it's not so much the contract management, much more the central coordination from an operational perspective.

I think that goes to number 4, I think the system is - as one of the other considerations have - and I think I've noted - it was used, the word, "Fragmented", is slightly fragmented, but I would also, on the other hand, say the system has responded to the COVID-19 pandemic in a very organised collegiate fashion. It's - yes, we're in a Public Health State of Emergency, and hopefully, one day, we get out of that, as we are in a State of Emergency, but all health service providers. It doesn't matter whether you are State health, it doesn't whether you're Flying Doctor Service, you're St John's Ambulance, you're a public-private provider, they have come together to work as one.

And that's not written down anywhere, that's just a fact that the system works in WA when there is an existential threat. This is not an existential threat, this is about improving the better coordination of aeromedical services throughout the State, and I think that can be (1) that can be achieved by better governance, both corporate and clinical, but also, on an operational basis, it can be improved by a State health operations approach without any talk of State health providing any of the services that our stakeholders currently do.

Are you happy I just work some of these and then take questions - - -

KENNEDY, DR: Yes - - -

RUSSELL-WEISZ, DR: - - - at the end? Yes.

KENNEDY, DR: - - - the time's yours.

RUSSELL-WEISZ, DR: Okay.

I just want to pick up - I won't - Rob is a better - Rob can talk more about data management systems than I can, but on number 9, "The establishment of a formal board and management structure" - I just wanted to comment on that.

I don't think it needs a health service provider board on its own to provide aeromedical services. We have - we're one of the two States that has St John's Ambulance that provides emergency retrievals, and they provide emergency retrievals, and they're a separate organisation, the Northern Territory are the same. The contract is managed centrally at the moment and the contract for RFDS is managed through WA Country Health Service, and I think that's appropriate for WA Country Health Service. But what I would say, I don't think there is a need to provide another health service provider board for what are external organisations. Again, there is a need to provide better coordination on the ground.

For example, at the moment, as we go into COVID-19, we're establishing, slowly, a, "Patient Flow Command Centre". Health service providers, at the moment, have their own patient flow command centres - or I think, in WA Country, as they're called, is Emergency Operation Centres. They will - and it's not for the Department of Health to tell them where to send their patients within their area, but when you have something like a pandemic, or you have an existential threat or there's an issue such as we had a few years ago, two weeks where all our ICT systems are down, you do need organisations coming together in the patient flow command centre perspective.

We have a State Health Incident Control Centre, and I think what that's shown us during the pandemic is, on a daily basis, we do need an operations centre to coordinate and oversight - not necessarily interfere, but oversight where patients are going and work with our providers to do it. I don't think that needs a board of management, it just needs a much more robust operational structure or State health operations centre, as an example, which has the other organisations within it.

But I wouldn't - because - I mean, if, for example - and this is not - I'm not advocating for this, but if, for example, that the State - and no State health system is providing this, but the State health system was providing all aeromedical services - we were providing them all and we were providing their staff, you might have a health service provider. That's not going to happen and that's not part of this - I don't think this is - that's part of this Inquiry, but I do think it needs better coordination. And it can bring in - the oversight can bring in all the different components from the Department of Health, from those who contract manage the different areas, because it's not just limited to those providers who actually provide aeromedical services, because the - they actually - it's the recipients as well, and the recipients are the hospitals.

I - the - number 11, I mean, this is obviously a consideration. I think we are then stemming into contract management, and again, I would separate contract management from operational oversight. I think, actually, contract - as I said - and I won't say it again, I don't think everything should come into the Department of Health, and I actually don't think that it's appropriate that it should sit there where the actual - it should sit where the services are provided. We talk about care closer to home. If you bring everything centrally, you take care away from home, if providers are providing services to those areas.

Number 13, in relation to the aeromedical rotary wing service, I think, you know, it has served us well that DFES has been - was there from the beginning. They certainly were, in the beginning, I think - and I'm not expert at this, but they were procuring helicopters to - or - you know, other - like, helicopters to provide services for fires and for other types of services in the outer metropolitan and other areas. But we've seen aeromedical retrieval services, quite rightly, expand from fixed wing into rotary wing.

So, I'd say two things there: 1) DFES are - have, in a sense, wet leased some of the rotary wing infrastructure. Now, if you look at Flying Doctor Service, if you look at St John's Ambulance, St John's Ambulance are responsible for providing their ambulances, RFDS are responsible for providing their planes. That's part of their infrastructure, that's part of their governance. I wouldn't want to be responsible for those, they're the experts at that. And, I think, now the system has moved to say to DFES, "Look, whatever the - whoever procures that, there should be some absolute principles that it's either their medical organisation or it's other organisations".

And my concern here is that DFES may be dragged into an aeromedical system where there are other providers potentially providing aeromedical services, who do not have the expertise, such as Flying Doctor Service, St John's Ambulance, are - you know, other providers. So, I think we do need to move to a more health-based, a procurement of infrastructure assets and also, oversight of any leasing or procurement arrangements. It's not a criticism of DFES, it's just there's too many potential players in this regard.

In relation to number 14, I would agree that we - in what you've found, and the themes is that through the aeromedical environment, we do need better State policy and strategic directions. And whilst in the past, there have been patient transport plans and some of those are focused on the PAT scheme or how patients get from rural and remote areas to Perth, there does need to be an improved policy environment. But we also need to know the - what's the future of the ecosystem and the governance to be able to inform that policy environment.

I absolutely agree that in number 15, you said that - and we have a very - the one thing I think WA has done well, we've had a clinical service framework for many years, since probably 2004, that clinical service framework is being - it's just - it's being updated as we speak and has - was updated last year. The clinical service framework lasts till 2024. It tells us what services should be provided at certain hospitals.

Now, it should also, I think, as it matures, bring into account the environment of patient retrieval, and that's not just aeromedical retrieval, because the bulk of patients are retrieved, you know, on four wheels. So, I would argue that that links quite nicely into the policy and strategic direction that you've had - been noted.

And I think also, in relation to number 16, I would agree there is an opportunity to develop a single patient transport strategy, and I think that can then bring in the themes and the really important principles of corporate and clinical governance. It doesn't mean that we are impinging on the control of the responsibility of the organisations who provide care, but we do set down principles.

For example, the two other organisations I've mentioned a bit, but Flying Doctor Service and St John's Ambulance, have to report any of their Severity - SAC 1. So, they have to report them. There are certain things they have to do either through contract or policy. And I think that no more than this, is we do have an opportunity to have a single patient transport strategy that sets the direction for the next 10-20 years, but within that, really improve the corporate and clinical governance oversight of whoever - and it's really whoever.

I've concentrated on those two large organisations, my biggest fear happens to be other organisations who we cannot see today, who might be setting up systems and suddenly, either RFDS or St John's or health services find their staff potentially being asked - and this has happened on occasion, to go on another provider's aeromedical transport, be it - not usually fixed wing, it's usually rotary, and there are limited policy settings around that. And I can think

of occasions in the North West where patients have been retrieved from either oil rigs or you know, what you would not call the normal environment, where clinical staff have assisted, but I think you do need that overarching patient strategy and a patient transport strategy and policy framework.

You know, and that leads into a number of other themes, which I won't necessarily comment on. I think, just on number 20, I think there is a real opportunity there. When I was in the North West as Medical Director many moons ago, we did set up the much better - we set up the WA/Northern Territory cooperation. So, patients were not going from Kununurra always to Perth. And that wasn't just on aeromedical retrievals, that was on - that was actually patients who were going for outpatients' appointments and follow ups and there was - there's now a formal agreement in place in relation to that.

I - and there was a formal agreement - I will check, but there was a formal agreement in how many intensive care unit beds we could use. That should be able to be extended to aeromedical services as well. But I think there is - I would like to just emphasise there, the cooperation over the last 20 years between the two states has improved significantly.

I mentioned, in number 26, the clinical service framework, and I think 28, you're absolutely - you're right about the potential fragmented nature. I'm not convinced that we need an authoritative contract management body, but we do need operational oversight - which would come from the Department of Health, in relation to how the organisations work together. And we've actually seen the benefits at police. If you go to one of their operation centres, they've actually got the Department of Communities there, they've got other departments and they've got St John's Ambulance. That's how I'm seeing it - I'm seeing you bring - at the moment, we have a State Health Incident Control Centre. We have St John's Ambulance sitting there with us, working every day with us, why shouldn't that happen in a business as usual environment?

And I know some of the health service providers have set up their own command centres and that the external providers are cooperating with them. But this is formalising it more to see some of the information police have at their hands, and knowing where you have vulnerable patients from either a communities or a health perspective, you can imagine the better synergies you have with all the health service providers. And I haven't even mentioned mental health yet or community mental health teams.

I'll let others comment in relation to the actual contract management of the providers, but I would say is, all contract management has evolved over the years. I've - from experience, I've been specifically involved in the public-private provider contracts with six years as the Chief Executive of North Metro Health Service. Again, I would strongly advocate that they should be contract managed by those organisations that have the - that actually have - are responsible for the delivery of healthcare. So, I'll ask others to comment on it.

"Aeromedical contracts must be led by" - this is number 38, "a commercial process". I think many of them are, and I think - my worry, actually, was not necessarily by - in this, was about more competitive tendering. I have to say, Dr Kennedy, it was more about the concerns I had with other providers setting up and potentially setting up aeromedical retrieval transfers.

Now, I probably have no issues with a - you know, with an organisation who's got all the policies in place, but at the moment, we know that our two major organisations who provide patient retrieval have to abide by our clinical governance processes, our SAC 1s, our SAC 2s, they have to do investigations, they have to report. I am not sure whether every small

organisation who may or may not do that in future would have to comply. So, an aeromedical policy framework that all organisations would have to comply to would be very useful.

I think that - you know, if I go through, that there are more things here, really, in relation to contract. I think Mr Anderson may want to comment on them, but I think if I pick up number 43, there is absolutely no doubt that - and I think we would have to argue this with Treasury, I think that some of our providers who are observing my comments today would probably - would support me and say, "We do need a slightly more nimble or long-term contract that takes into account infrastructural requirements as well". But I could also say that from - just from a WA health system perspective, our infrastructure requirements are constant.

And you know, we would probably value the more nimble - we've seen how it - from the mere medical perspective, we see how things have changed significantly over the years, from the non-pressurised planes I used to fly in as a Royal Flying Doctors Service doctor, non-pressurised, old Australian aircraft - I think one was called the Nomad, and it moved then to pressurised fixed wings to king airs and now, to PC 12s to the - all the debate about single engine aircrafts and the safety of those and they've been proved a huge success across Australia. And now, the rotary wing and the different providers of that services is, so I just think we - the aeromedical environment is moving quicker than potentially - you know, those who oversight it behind it. And again, it's not a particular criticism, I think it's just part of the environment we're in.

I think number 61 is very, very clear. I think you're right; it's not strategically managed by a central body with whole of State responsibility. And there are a range of (indistinct) 8.35.09 - so this is my - probably my fundamental point about talking to Dr Robertson about holding such a review or an inquiry. I'm not sure that's best served by centralised contract management, but it is best served by centralised mandatory policy.

So, the Department of Health, how it manages, it has - but with a devolved governance, it has service agreements with our health service providers. It has - it can issue directions very rarely. It has mandatory policies. And mandatory policies are what all our health service providers have to follow, and therefore, those people who contract with them have to follow as well. So, I think if we really expanded number 61 here, it's how you do that. I think you're - that the theme is right. A range of services - some of which actually may be contemporary, but we do have platforms, we do have completely different crewing sometimes, distribution, funding or governance.

I think, again, if we can get some policy setting on the operational coordination of these, and - rather than pure contract management - because I think contract management is too binary, I think this is about service to patients and it's about operational service to patients. So I think that goes back to an earlier theme, which, from my view, is the - is part of the Inquiry, is really one of the key areas - number 10 and number 11, but again, I'm not advocating for a single contract management authority.

There are certain comments in relation to some of the regions you've made, and I would support that. We've seen - for example, you've made, in 65, the issues in relation to the South West of WA. Now, in relation to this area, we've seen that whole area grow. Bunbury is going through a major redevelopment at the moment, it's one of our most complex redevelopments and probably, the Chief Executive of the Country Health Service would agree with me, probably one of our most challenging, because we've got to build on-site. But you can imagine, Bunbury, in the future, will be a Joondalup of the future. It will be a major regional hub with the whole of the South West.

Then, you've got Albany and Geraldton, and then, from experience of eight years in the North West, you don't have the large centres like you have in Queensland or New South Wales, you have small centres. You're lucky if you get to 15,000 people in those centres. Did a lot of work on establishing regional resource centres so that, in the past, sometimes the air retrieval organisations would be going to multiple sites, but now, they know they would go to Broome, Port Hedland, Geraldton, Albany.

But I think, if you look at - if your comments about the South West, we do need to decentralise our hubs from Perth and our aeromedical hubs as well. And again, I'm being provider agnostic, I'm saying there needs to be capability at those sites, where you're actually not going to retrieve into Perth, you're actually going to retrieve into those regional resource centres.

I think that the theme in 72 is correct, but I think that's a symptom of why we're here today. I think providers - and not just the main two providers, but actually smaller providers, are able to set up, potentially, aeromedical rotary wing provision with no or minimal feedback to the Department of Health and a mandatory policy framework.

There's a comment - there's a theme in 75 in relation to rotary wing into primary (indistinct) 8.39.04 are actually platforms. I was going to just probably see what was being - it wasn't very clear what was being said there, but I would say is, in our transport contracts, we have tried to be flexible and in - years ago, there was one contract. There'd be - for example, RFDS over here, St John's here, but what we've looked - what we've actually matured with last year is, we've said, actually, we need a dedicated mental health contract, we needed a dedicated inter-hospital transport contract, we needed a dedicated emergency contract, because sometimes, they're conflicting.

And naturally, you're going to go with an emergency before you go with a, say, an inter-hospital patient transport. So, I would say the whole inter-hospital patient transport environment has evolved and evolved, I think, well. I think the - I mean, it needs to be better coordinated and it needs to bring in the aeromedical.

You - 84, I would agree, I think we do need to make sure - and I think this goes to the state-wide - sorry, the - a state health operational approach, and it goes to centralised coordination. And it's not, again, a - necessarily a top down with a central controller, it is about the organisations working together. Because if you're - if you've got better centralised coordination and real-time data and that oversight of what's happening right across the State, 1) you release the aeromedical assets or the inter-hospital transport assets that are going - that are being tasked to certain - to patients or whatever, because you know what the recipient hospital is expecting or can take.

If I can just turn to 113, I think that - I think I've talked enough about that, but I think that sums up - that's one of the absolute themes. There is - but I - what I just wanted to say to that one is the clinical governance, the organisations that provide aeromedical services do have clinical governance framework. We get reports on Severity Assessment Code 1s from the organisations, but there isn't that overarching clinical governance framework to stop, potentially, aeromedical services falling through the gaps, or where you have a patient who is retrieved and you have multiple providers providing that retrieval. It's not saying it shouldn't happen, that might be exactly what should happen, it's just saying there's not a policy framework providing that.

And I think that goes - and I won't necessarily talk about KPIs, there are KPIs in all our State - all our contract management, and there are probably better people to advise in relation to two person clinical teams, three person teams, and how that works.

On 157, "(Indistinct) 8.42.08 have process for central management and scope of practice and credentialing", and I think that's a really important point. I don't think we - I mean, we started with a one State credentialing system in 2004. We actually started it in country, because we had lots of practitioners working from Carnarvon to Albany, and they said, "I've got be credentialed at each site". It was bonkers. So, WA Country Health Service set up a centralised credentialing system and now, you have a much more efficient credentialing system in the metropolitan hospitals.

I don't think you have to put another credentialing system over everybody, but it might be, it would be very useful, I'm sure, if you're Flying Doctors Service, you're St John's, if you're taking health service personnel from the Department, you are absolutely assured they are there to provide the - they have - they've got the credentials to provide the services, be it neonatal retrieval, be it, for example, significant cardiothoracic retrieval.

I know you'll speak to the Child and Adolescent Health Service, and I think one of the things that we're finding is there is now, in the aeromedical environment, not only a policy framework - you need a good policy framework, better clinical governance, better oversight, but there's oversight of what I'm calling some very specialised or boutique services such as neonatal retrieval. And we've seen a huge uptake in, for example, in neonatal retrieval services. I'll be frank, they're competing, sometimes, for retrieval services either through St John's or RFDS, where they are being stretched here and there.

And I think one of the things, if you had an overarching aeromedical approach and coordination, you could see that there was a gap and you could see that the government may need to advocate for funding to provide extra services to always service, for example, neonatal services. If I can say, we have sought additional funding in budgets - and I think we're doing it this year as well in relation to increasing the funding for slightly more reliable - actually, it's not - because the word is not, "Reliable", is probably having more assets on the ground, for example, neonatal retrieval services.

I won't comment on the Commonwealth. And I think though, at 190, there is no single point of government control or responsible coordination of aeromedical funding. There isn't - I'm not sure that will - I'm not sure that we can sort out the Commonwealth/State split in this Inquiry. I think they will always be - yes, that will always be a challenge.

But again, my whole - and I did - and I have to say I did advocate for such a review, again, this was not about getting more command - potentially, command and control of contracts with providers. It was not about saying the health system should actually provide those services, this was about better oversight of what was happening on the ground on a day to day basis and making sure we had the best clinical governance, the best corporate governance, we were able to do risk evaluations, we were able to see today where the gaps are. We wanted to see where the gaps were in relation to aeromedical services, and then, making sure that the providers and the Health Department were working holistically to give the best patient care for the whole State.

So that was where it was coming from. It wasn't probably so much about command and control, even though we are in a very command and control environment at the moment.

And I think I should stop there.

KENNEDY, DR: Thank you very much.

Mr Anderson, did you have anything to add in terms of your area? At this stage, we've got time to hear from you before we move onto questions.

ANDERSON, MR: Well, there's a couple on data, but I think we can probably cover those in questions, if you like? (Indistinct) 8.46.18 the Director General's covered everything fairly well.

KENNEDY, DR: (Indistinct) 8.46.23 okay.

So, I guess my first question relates to contracting and relationships. Where we have contracts between WACHS and RFDS - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - Health and St John's, DFES and the ERHS service, essentially, there are three completely separate contracts whose commonality is the provision of clinical care to patients in different settings. I think, from my perspective, that is problematic, because there's clearly overlap in there.

What's your view on bringing those contracts together and what kind of mechanism may exist for that? What ways could you look at doing that, in particular, in regard to the contract driving service quality and safety at a patient level, and recognising that management of capital payments, fee for service in terms of mileage of flight - and those sorts of things are often quite separate, but what's your feeling about how that could be resolved or rationalised?

RUSSELL-WEISZ, DR: I mean, there are - we have a lot of - and I think to start with, there are a lot of contracts that Health has, and since the devolved governance - and I'm not actually - I'll start by saying I won't talk about RFDS or St John's, but we have smaller contracts that deliver patient services, for example, to our - some patients who require hospital in the home, for example.

And some of those, actually, are run by the Department of Health. And the Department of Health is quite divorced from actually on the ground patient care. Again, it's a regulator, it's an assurer, it's a system manager. And the health service providers said, "We actually know best" - so North Metro, South Metro Health Service, "We know best about what our patients need, and we would like that contract". And that makes - to be honest, Dr Kennedy, I think that makes sense, they're closer to the ground, and I think to centralise everything in the Department of Health, we're a long way from.

We've actually devolved the governance, we've got through - government have gone through a process of devolving governance, very similar to New South Wales and Queensland, not so similar to Victoria, where we have 88 - they have 88 boards - we won't be going there, we've got seven, and I think, yes, there are some areas of improvement, but I think the board structure and the devolved governance has worked well. And with the devolved governance, the contract management has gone with that.

For example, East Metropolitan Health Service contract managed the PPP - the provision of healthcare through Midland - through St John of God Midland with St John of God Healthcare. So, I would advocate that is the best way to go, because it's actually on the ground. I would

then - if you take a corollary of that, then you've got the Royal Flying Doctors Service, who provide services ostensibly to rural remote. They do provide services to the city or to the outer metro as well, I know that, but it is - ostensibly, they are our rural and remote provision of services. And the actual health service providers in charge of that is WA Country Health Service.

So, I'm not an advocator for taking that away. Actually, the - there's been work through - you'd be aware of the Country Ambulance Strategy, which was done - and the work that WA Country Health Service want to see much more - they want to have much more oversight of what not only what RFDS do - because they do have that anyway, but actually, St John's Ambulance.

Your question is about, well, how do you make sure that's not duplication? See, ultimately, if everything came into the Department of Health, what I would have to do then is say - well, actually, I would probably say, "Well, I need a team that's going to look after, say, the RFDS contract, because it's actually the country, and I'd be going with the best to do that would be country, because they're the WA Country Health Service".

Where I think we would do much better is in the commonalities between the contracts. So, one is the policy frameworks, it's the clinical governance oversight, it's the reporting, it's potentially some commonality of KPIs, not taking away the contract management. And I think what would be better is government not being surprised by providers putting in bids for assets, be they ambulances, specialised ambulances, RFDS - you know, planes, upgrading planes.

So I think that's where the Department - the oversight - as the system manager should come in to oversight those parts of the contracts and actually having mandatory policy frameworks that the contract manages - so WA Country Health Service, and the Department, ourselves, when it comes to St John's Ambulance, actually has to put in place. And I think - so I think you can get the best of both worlds.

I think there's some real negatives to bringing everything in to a centralised process when you have a devolved government structure, because what will happen is, your - the people on the ground, who know what's happening, will not be involved in the oversight of the contract. I'm not saying devolve everything - not at all, I would not devolve the St John's Ambulance metropolitan contract to every single metropolitan provider, and I don't think St John's would want me to do that, because - and - but I think we can actually get, potentially, the best of both worlds having better oversight, better - we could have a mandatory policy framework that determines how aeromedical providers actually function, and then, on a day to day basis, better operational oversight working with the providers.

ANDERSON, MR: Yes, I'd have to agree, I think the key here is about integration and service provision amongst the organisations. But then, from a contract management point of view, it's about the consistency of those contracts. And we've worked really hard, I guess, in the last six years and a little bit longer, to develop a whole suite of mandatory policies for the system, which we then flow through to contracts with external providers.

And so I can give you a couple of examples without going into detail, but we have large public-private provider contracts and the work we're doing now with renegotiating those contracts for future terms is to ensure that they are aligned to the mandatory policies, the funding frameworks and so forth that our health service providers are governed - by which they're governed.

So, in doing that, we can then hold - in that case, the private providers to account. We can performance manage them and we can assure the Director General and the Minister and the State of WA that the performance being provided by those private providers is consistent with what we expect of our own health service providers, and that they are aligned back to the strategies and policies of the system manager in the Health Department. And I think that's probably where we've - we need to do a considerable piece of work in this space around contracts

KENNEDY, DR: Yes. So, at the moment, you would see that the way that those contracts are being administered or monitored over time is possibly not where you would like it to be?

ANDERSON, MR: I would say that the contracts are - some of them are largely historical and as is the case with any large organisation, you quite often find that they just continue over time. And they have - there needs to be a similar reset that we're doing with other major contracts, and that includes our partners at St John's and - - -

KENNEDY, DR: Yes.

ANDERSON, MR: - - - so forth to go back and look at, "Well, is this contract fit for purpose in 2022 and beyond?"

KENNEDY, DR: Yes.

ANDERSON, MR: And again, it's aligning it back to those mandatory policies.

RUSSELL-WEISZ, DR: I - just one more - I mean, one more comment, I've been involved in a number of contracts, I mentioned the Joondalup Health Campus - the Ramsay contract with the Joondalup Health Campus, and I also was the Commissioning Chief Executive at Fiona Stanley, we had a contract and still have a contract with Serco. And I think contracts that have myriads of KPIs and then, contracts that have very few.

And there has to be a medium - I think we went - there was a phase where you'd have to have something like 250 KPIs, that you'd be drowning in contract management and you forget the very word that you said initially, Dr Kennedy, which was, "relationships". It is about relationships as well as it's about contract management, and I think we've learnt over the years there is - you have to have the happy medium. It does not - I mean, I remember, as the Chief Executive of North Metro Health Service, my - the ability to work with Ramsay Healthcare in relation to what Joondalup Health Campus could provide - and we did a lot of rebuilding at that stage, and expansion at Joondalup Health Campus, was actually the relationship with the Chief Executive at the time.

Yes, there were times for significant contract management, but it was actually about working with the organisation, and that would be the same for St John's Ambulance, for RFDS, for Serco and so I always - I advocate for a happy medium to make sure you deliver great care.

KENNEDY, DR: I think there is - and this is a question in terms of how you may resolve (indistinct) 8.55.52, in my mind, I see some kind of almost philosophical conflict between the concept of a centralised coordination and governance point, which is developing aeromedical services standards et cetera and applying those across the whole system, overseeing clinical governance and coordinating that as a centralised structure. And then, contracts which are divested to external organisations in terms of them managing the performance of that system.

So, the question is, really, how do you connect those two concepts in a way that works?

RUSSELL-WEISZ, DR: I think that's a great question. I think you can do it - I mean, I think we do it. So, I'll take, for example, we have safety and quality policies. So I mean, I - any organisation, be it a health service provider board, be it RFDS, be it St John's Ambulance, be it any organisation that's delivering clinical care, we'll be saying, 1) safety and quality performance, 2) clinical performance, 3) financial performance - not particularly in that order, but you always start with safety and quality.

The standards are set - we accredit our hospitals. I - we hold hospitals to account for standards that are set through the - through ACHS. And in relation to reporting on significant clinical governance issues, all organisations that have a contract with the Department of Health or with the health service providers and health service providers themselves, have to follow mandatory policies in safety and quality. So, I think that part, that then all organisations that provide aeromedical services should provide the same. It doesn't mean that they're micromanaged, it means that they have to report, and the Department of Health and the contract manager - the contracting oversight organisations have to have visibility of that.

And I think that can work well when contracts are diverted to external organisations. And they're not diverted to small, external organisations, they're large health service providers who are managing multiple contracts. And I can tell you, from WA Country Health Service, WA Country Health Service will be managing contracts in its area in relation to disability, aged care. And those aged care - for example, those aged care services that are not provided by them, they will want to see their safety and quality outcomes. And under a mandatory policy at the moment, certain safety and quality outcomes get reported to the Department of Health.

So, I think you can marry the two, but you've just got to make sure that - what we're lacking in the aeromedical environment is that mandatory policy that brings it all in place. And I think there's a third thing here. So, you've talked about standards, and it's about standards, reporting, oversight. It's also the Department of Health's role to make sure it's a system manager oversighting the health service provider - that oversights the actual contract of an organisation.

I think the other area that I'm probably more concerned about is where there are gaps, because at the moment, the two areas you've just talked about - the two facets about contracts, contract manage - contracts being diverted to external organisations and standards and overseeing the clinical governance, I think those two can be very clear and can be managed very clearly.

The issue is, once those are managed clearly, will it pick up all the gaps, because at the moment, I cannot - can I tell you, today, do I know there's not another organisation setting up in some town in Western Australia with a helicopter, who wants to go and retrieve patients, but is not one of the main patient retrieval services? Do they - does an organisation then have to report, does an organisation have to go to WA Country? We don't have that mandatory policy framework in place. So that's a gap that wouldn't be - if you had the best contract management in place of, say, the Royal Flying Doctors Service, you had the best standards in place, it doesn't point out where the gaps are.

KENNEDY, DR: So how do you see the change to the policy environment that would move to that position, because clearly, it doesn't exist now, where there is a degree of freedom amongst existing contractors to alter services platforms unilaterally?

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: So, is there a proposition in terms of how that could change, so that that level of control is established?

RUSSELL-WEISZ, DR: I think, certainly, for clinical standards and through a mandatory policy framework, and through better operational coordination at a sort of day to day level, we could do that.

I must say, there is one area that I think we would still have a gap with is how - what could the State do - what could, potentially, the State do, to make sure that all aeromedical providers had to actually come through the Department of Health to make sure that if they were setting up aeromedical provision services, they were regulated. And we do that with private hospitals. So, we have a hospital - a 1927 Act, so it's a bit old, it wasn't - and it is due for renewal, but through our licencing and regulation unit in the Department of Health, private hospitals have to - are regulated.

But that's regulated under an Act, and I don't - I'll have to say I don't know, it might be - we might need to seek some advice about whether that could extend to a provision to make sure other providers who come in go through that. And I'm not saying that unit would have to be the unit to go through, it might just be that anyone has to follow a mandatory policy framework and get approvals through the Department of Health. That's the way I would do it.

KENNEDY, DR: The same scenario applies to road ambulance services, obviously, theoretically.

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: You know, there is the same concept sitting there in terms of development of ad hoc ambulance services.

RUSSELL-WEISZ, DR: It does, but any - with road ambulance services, we obviously have contracts with three - - -

KENNEDY, DR: Control (indistinct) 9.02.26 - - -

RUSSELL-WEISZ, DR: - - - and they have to fulfil certain - - -

KENNEDY, DR: To get - - -

RUSSELL-WEISZ, DR: requirements.

KENNEDY, DR: - - - paid, you have to be part of the contract.

ANDERSON, MR: That's right.

RUSSELL-WEISZ, DR: That's absolutely right.

KENNEDY, DR: I will run through some questions, firstly, things that I had in common. They will sound somewhat stilted, I think.

I'll try not to cover things that you have already spoken to - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - but some of them are clarifying positions on certain issues.

So, do you agree with the general premise that the WA Aeromedical Service requires significant organisational restructuring and better integration with the health system?

RUSSELL-WEISZ, DR: Two words there, the, "Significant", and, "Restructuring", I'm not sure it needs restructuring, because I don't think it - it depends on what you mean by, "Restructuring". If you mean restructuring of contracts and that they come in centrally, I wouldn't agree with that for the reasons I've gone through. Does it need better operational day to day oversight and cooperation between the different parties - and also other parties that, again - that I've mentioned, like police, through some - through, for example, a State health operation centre, yes, I do, but that's on a day to day, that's better cooperation.

I always worry about potentially restructuring to get an outcome that we can get through better policy and oversight with the structures - - -

KENNEDY, DR: Yes.

RUSSELL-WEISZ, DR: - - - we have in place.

KENNEDY, DR: Let's change that to, "Reorganisation".

RUSSELL-WEISZ, DR: Yes, it - yes, I wouldn't want to - what I'm saying, I wouldn't want to move - reorganisation. Yes, I think it's - yes, I mean - sorry, I'm - I just want to do - I don't want to advocate for a reorganisation, because we've got a health system that is organised, I don't think that will change. It's got seven boards, it's got a Department of Health, so therefore, am I going to reorganise where - significantly, where St John's Ambulance or RFDS sit? I wouldn't necessarily advocate for that, but would I advocate for better - in your word, was integration, yes. Absolutely, integration, on a day to day planning policy working together, yes, absolutely.

Again, reorganisation, I just worry that says, "Restructuring", and I think people focus on a restructure sometimes if you're going to do one rather than the main game, which is getting better patient care.

KENNEDY, DR: Okay.

RUSSELL-WEISZ, DR: If I can just add to that? I think more stringent policy - absolutely more stringent, mandatory policy framework to cover all organisations in this sphere, yes.

KENNEDY, DR: Sure. From what you've said earlier, I have - I understand that you would agree with the need for the development of a State-wide strategic plan for aeromedical services and related structures, and that in general terms, you support the concept of a transport plan, if you like, a whole of State approach to patient transport?

RUSSELL-WEISZ, DR: That's correct. I think, you know, we originally did have a - I don't know if you'd call it a patient transport strategy - there's been a number of inquiries, but I think we do need a more contemporary patient transport strategy, which would have a component

that is aeromedical services. And I think that's got to be done at a time where we are - where we have got the capacity to do it.

KENNEDY, DR: Okay. The next question is really a contract question, so you may wish to consider this one as well, Mr Anderson.

Do you agree that the government - or health contracts with government and health contracts with aeromedical service suppliers and contractors should reflect contemporary commercial standards and that the contracts ensure that a provider's other commercial activities or obligations create no conflict of interest or potential for operational compromise - - -

ANDERSON, MR: Absolutely.

KENNEDY, DR: - - - and that all aeromedical service contracts must specify clearly and unequivocal aviation and service, i.e. clinical standards?

ANDERSON, MR: Yes, absolutely.

RUSSELL-WEISZ, DR: Yes. And the clinical standards that we're paying - the clinical standards, in many of these cases, will be set by the Department, because that would apply to health service providers who manage these contracts.

KENNEDY, DR: Yes. You have spoken to the question of the EHRS service in terms of its current placement with DFES, do you have a view with regard to the suggested realignment of the EHRS - which is, essentially, an ambulance service, to sit within Health, broadly - I don't mean the Health Department, I mean a part of a health - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - agency, as is the case for aeromedical rotary wing services in all other Australian AMS jurisdictions.

RUSSELL-WEISZ, DR: Yes, I do, but without unduly criticising DFES, it's not - - -

KENNEDY, DR: No, I - - -

RUSSELL-WEISZ, DR: - - - a - - -

KENNEDY, DR: - - - understand - - -

RUSSELL-WEISZ, DR: - - - criticism - - -

KENNEDY, DR: - - - that.

RUSSELL-WEISZ, DR: - - - it's just a - it's just moving history.

KENNEDY, DR: Yes.

Is there a current view on the development of specialist fixed wing contracts to introduce service provider options for health to access and to create stronger commercial atmosphere in WA aeromedical services? Examples of such specialised services may include NETS, mental health, repatriation, interstate transfer, capability for reserve and search.

RUSSELL-WEISZ, DR: Yes, I think - what I would just say to that is NETS, mental health, interstate, we do pretty rarely, I think, and also, that's usually provided, I mean, if we're doing cardiac retrievals - I'm not an expert on who does this, but I think it's done quite rarely and done by other providers. But I think, for all of those, we have to develop the need. So, we have to actually say, what is the need, going forward, of neonatals that - and potentially, then, the need of what is not being met at the moment.

And it might not be met - it's being met, but it might not be met in the time that those providers would like it to be met. And then, I think you can say, either, you - we need to procure that of current aeromedical providers to say, "You need a standby capacity, I'd like that (indistinct) 9.09.48 reserve, so you need to have that, we're going to pay for that and actually, you need, for example, a neonatal retrieval service available at all times", if that's it, but we need to then pay for that; or you - and you could do that two ways, you go to the current provider, or you could go to another provider - I think that needs to be left open.

KENNEDY, DR: Okay.

Is there any view, at the moment, on a proposal to retender all aeromedical services to fixed wing platforms, resetting the system with a newly contracted platform arrangement and potentially separating clinical staffing from platform provision? This is a model, as you would be aware, that is applied in different settings. Does the State, at this stage, have an open view or a closed view, just from a point of view of progressing the Inquiry and its findings?

RUSSELL-WEISZ, DR: Well, can I just say, I haven't discussed that with - that option's not been discussed with government. I certainly wouldn't want to be disruptive to the system at the moment that is going to be dealing with a pandemic for - we just don't know, we thought we'd be out of it by now, but we're not.

I do worry about having two different provisions (indistinct) 9.11.10 this is a personal view. We - when we contracted - as an example, when we went out to market for PPPs - so some of the hospitals, like Joondalup or St John's, we had people put in, saying, "We'll provide you with the infrastructure, we'll build your hospital", and then you get a provider in at the next stage. And it's - I always worry about that, because you don't - they don't have skin in the game, and when we - when you do that, you want providers to be able to build an asset that is actually going to deliver the services that you've got there.

I think splitting aeromedical assets from the people who provide them - and I'm not talking about anybody in particular, would mean that you are then forcing somebody who provides the staff to do the services, potentially on an asset they've had very little involvement in procuring. I think that's potentially not ideal - I'm no expert in it, but I would certainly say we have got no intent to do that at the moment.

In relation to competitively contracting, we were already - for example, for road-based transport, we already split certain services. But also, we are a large State, but we are a small State, and there are certain providers who have got expertise at this, and I think we have to acknowledge that.

So, I think - I don't think there's anything - I do not think there's particularly any appetite to split asset from provision of actually staff, if that's the question? I think it would be - I'm very happy to look at working better with providers to make sure that if we're providing - if we are providing staff for a retrieval - be it helicopter or fixed wing, that we're really clear where the clinical

governance lies, but no, I think that would - again, that would divert - I think it's actually served us quite well.

The fact is, if we take St John's Ambulance and RFDS, they procure their infrastructure, because they know what they need to provide. We say, "You need to provide this". It's a bit like Serco and Fiona Stanley, I don't tell them how many widgets they need to buy to provide their facilities management services, I just want an outcome.

I don't know what you've got.

ANDERSON, MR: No, I agree, we buy a service, we don't buy the inputs, so I don't see there to be any benefit in Health taking on that role.

KENNEDY, DR: Okay.

The understanding that I would have in that regard, then, is that the revised approach that is developed around clinical governance and oversight of the system - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - ensures that the delivery of services by those staff who are not directly your employee meet the standards that your system - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - requires and specifies.

RUSSELL-WEISZ, DR: And we would expect the organisation to provide either a fixed or rotary asset that meets certain standards in the industry.

KENNEDY, DR: Yes, absolutely.

RUSSELL-WEISZ, DR: And it would - then it wouldn't - you know - and that would apply to any provider.

ANDERSON, MR: I think the thing we haven't mentioned - and I - which would apply to all of these things, which - and I can give a real example, is that we performance manage the health service providers on a whole suite of indicators and performance regularly, routinely - monthly, quarterly, we have meetings and so forth.

And the reason I bring that up is if you take North Metro, for example, and you use the Joondalup contract, we don't performance manage directly as a system manager with Joondalup. We performance manage North Metro on the expectations of the services they provide and their performance against the standards and a whole suite of indicators - financial or otherwise. And then, it is North Metro's responsibility to have those contract management meetings with Ramsay's, who run Joondalup. But by having those policies in place, those policy frameworks and those clear standards and guidelines, that flows directly down to the provider and - - -

KENNEDY, DR: Absolutely.

ANDERSON, MR: - - - to go to the Director General (indistinct) 9.15.14 if they need to buy a new multi-million-dollar machine there are processes to come back to the system manager and say, "We need this for us to go to government", but we don't performance manage them on, you know, staff or those machines, but it is inherent in providing those services (indistinct) 9.15.32. If they have to do it a certain way or they want to do it a different way, that's upon them, but they still have to meet minimum standards.

And I think that would be the same for any of these aeromedical contracts. It's a matter of getting those policies and standards and the framework in place, that we can then flow that down to the contract, and then we don't have to worry about centralising contracts and ensuring - I think your previous comment was about the philosophical question about having centralised standards and decentralised contracts, that's how it works now with a whole range of massive contracts that we run.

KENNEDY, DR: Yes.

So, in the aeromedical world, who is the Northern Health Service? So, you've got Health, Northern Health Service, Joondalup?

ANDERSON, MR: Yes.

KENNEDY, DR: In the aeromedical world, you've got Health, vacant, aeromedical services?

ANDERSON, MR: So, the RFDS contract is managed by WACHS. And I think we need to do more - this goes back to our previous conversation; we need to do more about the policies and the indicators that we would use to performance manage WACHS.

They are actually inherent in a lot of the indicators they have to provide now, such as, you know, patient outcomes and so forth, and they may then take that up with RFDS, but - - -

KENNEDY, DR: Can I just observe - and maybe you can respond, to the fact that part of the current issues - part of the current reason for the Inquiry is the fact that that middle zone is not - - -

ANDERSON, MR: Yes.

KENNEDY, DR: - - - as functional as it could or should be? In other words, you've got disparate contracts, different performance, you've got no overarching standards. If we say we're going to have overarching standards for the system at an aviation level and at an aeromedical clinical governance level, are you expecting that those would exist within three different places that currently manage contracts or would they exist in some intermediate organisational structure of some sort that has to develop those things?

RUSSELL-WEISZ, DR: I think the actual - I think Health and Health with WA Country, but - could look at - if we're looking at the middle - and I think you're right, in the middle, in the say - in the metro area, where you've got - or outer - I mean, anything sort of north of Alkimos and a bit further north is - comes under WA Country, but I know that the middle is where, if you provide helicopter services, where does the governance come in - so who is providing that?

Now, if RFDS provide it through their helicopters, I'm very clear where the clinical governance would lie. St John's provide it through their provision - through their road ambulance, I know where the clinical governance would lie. Where other services have potentially been tasked

with potentially our staff - it might be with their paramedics, for example, the trauma helicopter, I want - yes, so the - I would like to know that there's a mandatory policy framework that whichever organisation is staffing them, that they're all adhering to.

And I think that's probably where some of the gaps are. And also, then, there potentially are gaps opening up if other providers start rotary wing in rural areas as well.

So, if you had a mandatory policy framework that says, "Actually, you need all these things in place". So if you were tasking health service staff, for example, you were taking the neonatal specialist, along with the RFDS nurse, along with a St John's Ambulance paramedic, and you're putting them on a helicopter that doesn't belong to RFDS, what - have you followed every mandatory - are you following the mandatory policy and have you got all the clinical governances in - clinical governance standards in place, and have you actually got permission from the Department, or are you - to actually run that service, because you want your staff safe. I actually don't mind if it's three different levels of staff, sometimes you need that for a specialist service.

KENNEDY, DR: Who is asking that question?

RUSSELL-WEISZ, DR: Well, I think we are, through this. I think we're asking that. We would - - -

KENNEDY, DR: On a day to day basis, in terms of administering your system - your future system, who asks that question of the provider or - - -

RUSSELL-WEISZ, DR: Well, I would - well, I think if it's a provider that's in the metro area, we would actually have to task - either it would be the Department of Health, in the metro area, to make sure new - you know, any new provision of services was covered by that mandatory policy. And I think if it's rural or remote areas, then it would be WA Country. But I think there is a - I've mentioned - - -

KENNEDY, DR: So, you have two systems?

RUSSELL-WEISZ, DR: Yes, but I would - it could be that the Department do both, but the Department - but again, we'd have to work with WA Country. My issue is, in the country, are there services being set up that don't revert back to either Flying Doctors Service or St John's Ambulance, that potentially, could slip through the gaps.

Now, if they have to come through the Department for a tick off from the regulator to make sure they've followed all the clinical governance frameworks that were in the Department, you probably would be comfortable, but that's - so I think you've - I think we are going down to now - to the nitty gritty of where the gaps might lie.

KENNEDY, DR: So, the next question I had is a kind of design or structural question. It relates to hub and spoke structures for the development of services. Do you support or have a view, in principle, around expanded hub and spoke structures for core aeromedical functions - so this could include concepts like co-located fixed wing and rotary wing bases, aeromedical staff centres, development of - or increased development of local WACHS operational links with RFDS and other providers, and better integration of those systems, particularly in more remote areas, where you are resource challenged?

RUSSELL-WEISZ, DR: Absolutely. I mean, we have not - just because we have different providers in RFDS, St John's, and we have WA Country Health Service, you find that the people on the ground always work pretty well together, and we've seen a consolidation of bases through RFDS. I think if there's a need to consolidate around the clinical expertise, we would support it.

KENNEDY, DR: Okay. Most aeromedical systems rely, to a degree, on patient flow and patient destination arbitration. So, most times, fortunately, things work through organic relationships and - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - standard flow patterns and things, but there are always, in every system, times where there's a need for arbitration. And that may be about a destination or it may be about a level of care or a type of response.

Do you see space for the development of a system or part of your system that has coordination and oversight of a system's capacity and capability, such that that type of arbitration could be applied in a per case - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - real-time scenario?

RUSSELL-WEISZ, DR: Yes, I do. I think that's probably one of the advantages, that with the organisations working together, there can be, potentially, better flow, better use of all the resources. And I think that comes from listening to police, when they've done it in their operation centre - - -

KENNEDY, DR: Yes.

RUSSELL-WEISZ, DR: - - - listening to them, they say, actually, they find that a lot of the issues where you were dealing remotely, in different areas, trying to sort an issue when you see it, at three or four organisations, all working together, you actually sort it out on the ground.

Now, on an operational basis, you have to sort that out at the time. There are going to - there's - your word, "Arbitration", there might be issues that need to be arbitrated which are longer - which are of a longer nature, and you need a - and I think you would - these things would flow to the surface, and you'd have to say, "That has to be solved, either by policy, funding, new - or a new approach".

KENNEDY, DR: Thank you.

Can I clarify the thinking in terms of the concept of centralising coordination? At the moment, this is largely under the WACHS bailiwick, through the coordination centre, in terms of current service and practice, you've also talked about the concept of a shock centre or service - as I would like to think of it, which, I think, in its early iterations, has been spoken about as being a - within the health space directly - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - so central - very central?

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: How do you see these two things working together? Or do you see an evolution - - -

RUSSELL-WEISZ, DR: Yes, I do. I've just seen it work with the pandemic in the State Health Incident Control Centre. You've had all organisations working pretty well together, so - especially in the early days, and will now, soon, going to be tested over the next few months.

But at the moment, you have, I think - you would (indistinct) 9.25.14 - you'd have to ask RFDS and St John's ambulance, you have their - they've got their control centres, they know what they're doing, but we - they - one doesn't have visibility over the other, and Health doesn't have visibility over the other. And this is not about control, it's about - - -

KENNEDY, DR: No.

RUSSELL-WEISZ, DR: - - - working together - - -

KENNEDY, DR: Absolutely.

RUSSELL-WEISZ, DR: - - - to say how do we best get - what is - for me, it's about patient flow. And if you get good patient flow, you get good care. And at the moment, we don't have that real-time oversight - and I will say oversight, it's not - this is not about contract management oversight and working together.
And I've found that both organisations - and we don't - I don't really want to just concentrate on RFDS or St John's Ambulance, because it's also about what the health service providers are doing.

So you'll have (indistinct) 9.26.00 health service providers come and talk to you about - they don't particularly want a State Health Operations Centre interfering with what they're doing with their patients on wards or between their hospitals, and I don't want anything to do with that as well, but I do want to know what's happening with patients coming - you know, either through - into Perth, how hospitals are either being overloaded or not, making sure the organisations have the ability to look at what each other is doing, and working together. Very much, we have in SHICC, but SHICC is a structure of the - it's an incident control. We want to make this like business as normal - business as usual.

I mean, organisations - it's not about taking over organisations, it's actually about having them in the same room, so you could get better coordination. And it means, at times, things could flow very well, there may be no issues to resolve, but from everything I've seen, when we have established patient - in really - in critical need - not just in critical times, but in times of significant demand, when we've established patient flow command centres and when organisations have worked together, patient flow has improved. And I just think the principles of that mean that all organisations - I think organisations should see what each other is doing.

So, it's very much about the - integration is not integration of organisations, it's integration of service delivery, so you get better delivery for the patient.

KENNEDY, DR: Yes, absolutely, it's that collaboration at a process level, so that knowledge is shared - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - right across the system, that the patient is transiting.

RUSSELL-WEISZ, DR: Yes. Also, I think, as we get more, for example, rotary wing out there, are we sending the right rotary wing to the right place, with the right people on board, because I think people will comment in the Inquiry about, potentially, when we do task rotary wing - and this is not an aspersion on anybody who tasks it, but when it's tasked, sometimes it doesn't come back with any patients. And therefore, one would argue, well, how are we best tasking road transport as opposed to aeromedical, as opposed to own transport.

KENNEDY, DR: I guess the flow on question from that would be, how often does a fire engine go to a non-fire?

RUSSELL-WEISZ, DR: Quite often - - -

KENNEDY, DR: Yes, exactly.

RUSSELL-WEISZ, DR: - - - especially at the Health Department.

KENNEDY, DR: It is an element of emergency service to be a bit more proactive, yes.

RUSSELL-WEISZ, DR: Someone left the toaster again.

KENNEDY, DR: Correct. Do you have any other issues or matters which you wish to bring to the Inquiry or to raise at this point from - - -

RUSSELL-WEISZ, MR: I - - -

KENNEDY, DR: - - - either - - -

RUSSELL-WEISZ, MR: - - - would only ask, Dr Kennedy, that we - out of the Inquiry - and this is only asking, what we seek is, I think, some very clear themes that you find, and I would seek, maybe - I would rather have a few recommendations that are absolutely key with what we need to do. I'm used to, you know, sort of being at the other end of inquiries. If we get 200 recommendations, it becomes a large bath. I'm very keen to get the real - go to the real crux for the benefit of patients, and also, the benefit of the organisations that work together.

And I won't reiterate what I've said. This is not - it's not really a criticism of what we do now, we just want to do things better and we want to do things in a more coordinated manner. So it's how we do that, where we think the gaps are, and I would just seek - I really, near the end of the Inquiry, like to get what you think are the high level priority recommendations, and maybe, the secondary. That's probably what I would only say what I would seek.

KENNEDY, DR: Yes, I appreciate what you're saying. The purpose of the considerations paper, as you will - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - appreciate, is to bring the voice of - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - all of the people that we've consulted - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - with to - the Inquiry. I will suggest that, in terms of where we're heading, there's probably somewhere between 15 and 20 themes - - -

RUSSELL-WEISZ, DR: Yes.

KENNEDY, DR: - - - that are consolidating. And I don't think, in this type of inquiry, that it's possible to get to kind of process level anyway.

RUSSELL-WEISZ, DR: No.
KENNEDY, DR: So, it would be very - it'll be principle based, and hopefully, with a pathway attached to it in terms of the next steps, which is part of the terms of reference.

Did you have any further questions or - - -

ANDERSON, MR: No, one thing I would say is that everything we've discussed with regard to contract management, with regard to indicators and compliance to standards and policy and everything else, is crucial, it's important, but it's also reliant upon good information. And I know we've talked a little bit about, you know, data and so forth, but I think a focus on information sharing and commitment from all parties to improve the quality and consistency of data is crucial, otherwise, all these things we speak of are totally difficult to implement and maintain.

KENNEDY, DR: Yes, I understand exactly what you're saying, and to be honest, one of the challenges that we've had through the Inquiry is obtaining consistent data in a timely fashion and that is - I mean, consistent in terms of even definitions - - -

ANDERSON, MR: Okay.

KENNEDY, DR: - - - between services. So, I think there's a lot of work to be done there. But both at a kind of macro contract and financial - - -

ANDERSON, MR: That's right.

KENNEDY, DR: - - - management level, but also at a clinical level - - -

ANDERSON, MR: That's right.

KENNEDY, DR: - - - in terms of understanding the services and patient outcomes and so on - - -

ANDERSON, MR: Yes.

KENNEDY, DR: - - - I would agree completely.

So, I'll take it that there - that you have no further questions - - -

RUSSELL-WEISZ, DR: No, fine.

KENNEDY, DR: - - - in which case, we will formally move to close this session.

Thank you very much for your attendance at today's hearing.

RUSSELL-WEISZ, DR: Thank you.

KENNEDY, DR: The transcript of the hearing will be sent to you - to both of you, so that you can correct any minor factual errors before it's placed on the public record, and you will need to get that back to us, hopefully, within 10 days. That will be explained in covering emails et cetera.

So, while you can't amend any of the evidence per se, if you'd like to explain particular points in the transcript further, to clarify it for interpretation, we'll consider that also.

So once again, thank you very much for your attendance and for your time, and - - -

RUSSELL-WEISZ, DR: Thank you.

KENNEDY, DR: - - - it's been appreciated. Thank you.