Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: North Metropolitan Health Service – Mr A Dolan, Ms J Zagari, Ms N Hoskins, Mr J Carroll
Date: 10 February 2022, Time: 1230 - 1300

KENNEDY, DR: Thank you very much for coming along this afternoon and for your interest in the Inquiry.

The purpose of this hearing is to establish and to assist me in establishing 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, who is the Inquiry Project Director

I need to remind you to be aware that the use of mobile phones and other recording devices is not permitted in this room and would ask you to please make sure that your phone is on silent or switched off. I'd better make sure that mine is too. That'd be embarrassing.

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.

This is 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, then 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 in the Inquiry.

Before we begin, do you have any questions about the way that we'll run this afternoon? I nearly pressed the distress button by my side. That would've been interesting, wouldn't it? It'll be you they come and (indistinct) 12.31.54.

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

DOLAN, MR: My name is Tony Dolan, Acting Chief Executive for North Metro Health Services.

KENNEDY, DR: Thank you.

ZAGARI, MS: Janet Zagari, Executive Director, Sir Charles Gairdner Osborne Park Health Care Group.

HOSKINS, MS: Nicole Hoskins, Coordinator of Nursing for the Emergency Department.

CARROLL, MR: And John Carroll, General Counsel, North Metropolitan Health Service. And I'm here as an advisor to the witnesses, rather than a witness myself.

KENNEDY, DR: Right. Good. Thank you.

So you will now be invited to address the focused considerations list that's been provided to you, which you may speak to in any way you feel comfortable, and I'm more than happy if we spend, you know, 15 to 20 minutes doing that. I've then got a series of - a short series of questions that I would need to ask you, and after that, if there's any remaining time, we're able to discuss other matters.

So, for this first part, I will hand over to you. I'll try not to interrupt you, unless I don't understand something that you're telling me about, and I will pay attention. So - thank you.

DOLAN, MR: Thank you for the opportunity to discuss some of North Metro viewpoints around the Inquiry. What we've looked at is, obviously, we (indistinct) 12.33.19 the questions that we've grouped together, and we're happy to respond to those individual questions, but if it's okay, I'll start with just a summary of our views from North Metro, and I'll refer to some of my colleagues, who will - can give a very specific.

So, the priorities, which we want to convey this morning, is really the importance and a discussion around clinical governance in this process. And it is (indistinct) 12.33.44 that's one of the top priorities that we probably should be looking at, is to make sure that it is a patient-centred approach, and that there is a very strong focus around the patient outcomes, but more importantly, that ability for clinician to clinician engagement to then care plan, the requirements of that transfer, rather than the process.

Clinicians do hold the most responsibility and the decision-making upfront. So again, back to the importance of clinician to clinician engagement - and I do apologise, I will probably trip myself up, because I'll say that a few times, but clinician to clinician engagement, to us, is really important. And then from there, how then that information of that decision is then filtered through the organisation or the receival site, and obviously, the information back to the site that we're sending the patient forward.

I think the central coordination of the process of the transport options is a clear advantage for everyone involved, and obviously, time critical transfers are really important. So however, we can make that as safe and as quick as possible, should be a priority. And obviously, the clinical treatment that's required within that and the time taken to get the patient to the appropriate place for treatment is also really important.

The second part, looking at North Metro and some of the services that are a little bit differently is around what we call the "Subspecialty patients", that may well come to North Metro, that may not go to any other health service provider across Western Australia.

Some of these are very unique subspecialties, and one of the things that we would like to raise - and there is a couple of clinical specialities around that, but the importance around the vulnerability of specific specialties within that, and I could use mental health as an example, I could use stroke as an example, palliative care is another example around that - and my colleagues might expand on that.

The problem around that is the care coordination. It's the decision-making at the time, whether the patient can stay where they are, can any of those services providing it, and then, the decision around (indistinct) 12.35.55 transport and actually getting the patient down there.

The second part to that is how that individual that is then transported down to us as a health service - which can be (indistinct) 12.36.03 can be a detriment to the patient by the time they get to the appropriate location, and the type of transport that's then used for those subspecialisations around how we get them there, and the ability to actually have clinical support while that patient is transported down.

I might refer to Ms Zagari or Ms Hoskins to add anything to that from a - - -

HOSKINS, MS: Yes, I think - well, because I work in the Emergency Department or oversee the Emergency Department, just expanding on that is, you know, when we are - refer - a patient is referred to the Emergency Department and it's clinician to clinician, but then, we may say that we can't take them or they can stay where they are and then they're still transported to the Emergency Department, they go from one Emergency Department to another, and sit there for hours, it's not in the best interests of the patient. And sometimes, they could have stayed where they were and be treated at that place, and then they come to the Emergency Department, and then, trying to get them back to where they've come is sometimes challenging.

And you know, sometimes we will say, you know, if a patient - a palliative care patient has a health directive not to transport, they are still transported and then that has - causes more issues down the track. So that's just some of the experiences we have.

ZAGARI, MS: I think to add to that - so Sir Charles Gairdner has a large number of State services, which creates significant complexities in terms of managing beds - and I know we're talking about managing patients, but a critical part of that is managing bed capacity, because being able to provide the right care is dependent on the right place, and if we don't have a bed at a given point in time, adding a patient into an overburdened Emergency Department or sending them to the wrong hospital actually doesn't provide a better standard of care for that patient.

And I think that one of the challenges that we see, in particular, is around when providing a State service for stroke, neurosurgery, a number of other specialities where we often have patients sitting in outlying hospitals for beds, that to then be transferred a patient who could receive care at another hospital, and where capacity might be more available and/or ends up in multiple moves around the metropolitan area isn't useful or functional either.

So, clinician acceptance necessarily needs to include a consideration of where bed capacity is in the metropolitan area so the patient receives the best care at the right site, and that is not always the case, currently.

DOLAN, MR: Just to add into that, I think that some of the discussions we've had is around the decision to transfer out, and whether some of those regional centres have the capacity to keep that patient with the right support mechanisms.

So we've got the emergency telehealth service, how much do we use that and how much can the metro services support, with a view that patient can stay, hopefully, in a regional centre and care closer to home, which is what we're all striving to look for as part of assisting with this review, so probably a little bit more around what are the services that are out there, to what level can be provided in the regional centre and have a greater shared understanding around that, rather than the default of patients getting transferred that may well have been able to be cared for in a different location.

KENNEDY, DR: So I guess, from my perspective, that goes to the concept of coordination in the system, and that - is there a point at which a conversation occurs from a referring organisation to somewhere that could assist in the coordination of that, in terms of capacity of hospitals, capability of destinations, and appropriateness of the transfer and potentially, the ability to look at alternatives which may include outreach and support in various forms.

And that, currently, is not systematised is what I think you're saying? And I suspect there's also an issue, in terms of changing and junior staff at either ends and consistency of - - -

HOSKINS, MS: Yes.

KENNEDY, DR: - - - knowledge and awareness and policy currency and - - -

ZAGARI, MS: Yes.

KENNEDY, DR: - - - all the rest of it that confuses that even more?

ZAGARI, MS: If I could just speak to that as well, I guess nervousness or tension around the idea of systematising and ensuring that whatever - if there's a central mechanism, there is still absolute primacy of that clinician acceptance of the patient and us being able to provide appropriate care, but also, a very clear understanding of the set of circumstances that exist at an individual site, because, you know, a tertiary hospital - there's not a tertiary hospital *(Additional notation: Ms Zagari indicates that the intention was to communicate that not all tertiary hospitals are the same; there are nuances to this),* and understanding of what else we're expecting in managing at that time, so there being sufficient information involved in that decision, rather than a - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - isolated decision - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - making.

HOSKINS, MS: And I'll just add, and seeing that from a clinical point of view, within the Emergency Department, and the impact it has. If the right decision has not been made and consideration of beds has not been taken into and the patient comes to a tertiary hospital, just the impact on the patient, the family, it can be quite detrimental to their recovery. So, I - it's really, really important that we get those aspects right.

KENNEDY, DR: So can you just explain to me how your - the receiving clinician with whom this conversation may occur about a transfer, who, you know, as you say, has - there is supremacy, in terms of the decision-making, but - that you expect, how does that person understand all of the other factors involved in the system at that time that may influence the alternatives available to the patient?

ZAGARI, MS: So, for me, I would say that that is the current gap that the clinician that's being spoken to will often have a good understanding of what's happening at their site.

KENNEDY, DR: Correct.

ZAGARI, MS: But not always a view of the broader system. Probably the exception to that is the ICU ED clinicians, who have a really good link.

So - and broadly speaking, our ICUs always know what the state is around the system and can, therefore - will generally have had a conversation about how we're going to manage the next demand.

There are some other subspecialties - again, and in particular, the State ones, where there's also an understanding in relation to those specific subspecialty beds, but not the entire picture. So, whilst clinician A may have a view for vascular surgery, for example, of what Charlie's looks like, they won't know what Royal Perth or Fiona Stanley looks like. And - - -

KENNEDY, DR: Okay.

ZAGARI, MS: - - - currently, there isn't a single view, that is held anywhere, of that, and so it's about ensuring that if that is something that's established, that there is a sufficient understanding and not too superficial.

KENNEDY, DR: Yes, I understand.

DOLAN, MR: You know, I think one of the important steps in this is that there is often, in the first stages, a clinician to clinician conversation and a decision, and it's then that next step to then say that that's a decision to be made, does the operation manager - bed manager or whatever the title might be, in that organisation, and how practical that would be to accept that patient at that time. That's a local - this doesn't look at it from a bigger picture viewpoint.

And part of the discussion we were talking about is that transparency of knowing what type of service can be managed in which location, which will also help with that decision-making and whether that's the right acceptance of that patient or is there another option that's available at that time.

KENNEDY, DR: Yes, I understand. And factoring, obviously, the time pressure of potential interventions et cetera - - -

ZAGARI, MS: Absolutely.

KENNEDY, DR: - - - for some - - -

ZAGARI, MS: Yes.

KENNEDY, DR: - - - patient groups above others and you know, sometimes a corridor in your hospital is actually better than an Emergency Department in a place where they're not going to get neurosurgery.

ZAGARI, MS: Yes.

KENNEDY, DR: I understand. So - yes.

DOLAN, MR: Yes. And there is some - - -

ZAGARI, MS: And absolutely, if - sorry, if we think about mechanical thrombectomy for stroke, for - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - example, there's no - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - question - - -

KENNEDY, DR: No.

ZAGARI, MS: - - - if the patient is determined that they need to come, they come to our corridor - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - and we deal with them.

KENNEDY, DR: Yes.

ZAGARI, MS: Yes.

KENNEDY, DR: Major trauma to - - -

ZAGARI, MS: Absolutely.

KENNEDY, DR: Yes.

HOSKINS, MS: Yes.

ZAGARI, MS: Yes.

KENNEDY, DR: I mean, those things are all - yes. Okay.

DOLAN, MR: And I was just going to add, very similar to - was it around some of the - the importance of some things that clinical to clinical decision and discussion, which will alert Sir Charles Gairdner that a stroke patient is coming in (indistinct) 12.44.51 so you're already planning to get quicker access into that. So, there is a very strong importance around that clinical decision-making, but then the operational outcome from that clinical decision and how far that discussion goes.

KENNEDY, DR: Yes. Okay.

DOLAN, MR: Can I also just - what we were also discussing was around - and I'll use these words (indistinct) 12.45.14 there's a - it's a one-way street. So, we were talking about the repatriation aspect of it.

So the - we talk a lot about the patients that will come from regional into the metro services, but those patients then have to return, so the discussion around the ability that we are always thinking about the repatriation and the timeliness of getting people back to home and back to country, and for us, as an experience, is that that's usually poorly done.

And that's a lot around the willingness to take the patient from a clinical decision to provide clinical care, but when the repatriation comes, it's a much slower process and with a lot more hurdles in the way to get the patient back to where they've come from and the places - how we can manage that, but it doesn't seem to be how we're bringing everyone in.

But this coordinated effort would be about how we also then can have - get people back home as soon as - in a timely manner.

KENNEDY, DR: Yes. It's a very valid consideration that's been raised by a number of people, and - - -

DOLAN, MR: Yes.

KENNEDY, DR: - - - I think the - you know, the impact on wasted bed days is a no brainer argument, in terms of what the system misses out, like people sitting in queues.

DOLAN, MR: Yes.

KENNEDY, DR: So - yes.

ZAGARI, MS: Yes.

DOLAN, MR: That would be our key focus points and priority groups that we've looked at.

KENNEDY, DR: Okay.

DOLAN, MR: Yes.

KENNEDY, DR: So just to continue that - the question around system coordination, would you agree with the suggestion that an overarching service management system or entity or series of processes should exist and that a body or a process like that could potentially adopt a broader system's role than simply aeromedical services?

So, looking at this from outside aeromedical services, there's only one component of patient movement, and the things that you've talked about, in terms of people moving through the system, applies to all those forms of movement. So, would it make sense that you would have a system, which could bring together all of those patient transport functions, as well as the outreach support coordination and governance of that inter-hospital patient working? Do you see an attractiveness in having that kind of centralised and managed across the system?

DOLAN, MR: I think there's a great benefit of having that visibility across the system, and I think it will help with some of the stuff we've talked about around the timeliness of transferring but also the repatriation back and being able to have visibility of where their opportunities are for patients to return to country - - -

KENNEDY, DR: Yes.

DOLAN, MR: - - - and return home. I think for - thinking about what you said, I think the governance aspect - particularly the clinical governance, it would be something that would be a priority to make sure that there is a clinical decision, and it's led by the clinical decision around that and not a decision made by non-clinicians, based on a series of process steps.

KENNEDY, DR: Thank you. And within such a service, can you see a role for an arbitration process where there may be stalemate about the movement of a patient from A to B, C or D, when B, C and D are in a position where they have difficulty in accepting a patient, but the patient needs to move for a next level care - not just move for standard care, but to move - - -

DOLAN, MR: Yes.

KENNEDY, DR: - - - up the chain of care, can you see the value of an arbitration point in that central process?

ZAGARI, MS: So, I can see a value in an arbitration point when it's a decision between different sites and where it is, necessarily, an up escalation of care.

KENNEDY, DR: Yes.

ZAGARI, MS: I think the tension or the consideration in that needs to be that often we are performing relative prioritisation between numbers of patients at - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - multiple outlying sites and that there needs to be consideration of all of those patients in that, in reaching what is - and I'm loathed to use the phrase, but what is the least worst option, so what is the best thing that we can manage with the resources available for all of those patients and with a clear understanding of sites. So, the concern - not with the arbitration, I think that is fair and reasonable, the concern is about completely divorcing that from site, because this is so integral to our operations. I mean, I spend a great deal of time in the weeds and arbitrating actually between our teams and relative prioritisation, so removing that too far from the clinical interface would be worrying.

KENNEDY, DR: Yes. Okay. Thank you.

So the next question relates to aeromedical systems specifically - so it's not something that you have spoken about, but obviously, as a receiver, in particular, of patients that come via aeromedical services, do you agree with the need for the development of a State-wide strategic plan for aeromedical services and systems and their related structure, which defines the service model and the pathways to implementation of that?

DOLAN, MR: (Indistinct) 12.50.31 - - -

HOSKINS, MS: So - sorry, which one was that one? The - - -

KENNEDY, DR: No, it's not on there.

HOSKINS, MS: No? Okay. So - - -

KENNEDY, DR: This is my special - - -

HOSKINS, MS: Yes, so yes, sorry, could you just read - - -

KENNEDY, DR: This is my particular question.

HOSKINS, MS: Yes.

KENNEDY, DR: So basically, this is saying, do you support the concept that the State needs a strategic plan around aeromedical services, because at the moment, there isn't one?

HOSKINS, MS: Yes.

KENNEDY, DR: And so, things like the development of rotary services, the extent and performance of fixed wing services, all of those things are occurring outside of a strategic planning - - -

HOSKINS, MS: Yes.

KENNEDY, DR: - - - context, and the strategic plan needs to be - or would be cognisant of the hospital component of that journey. It's not just about aeromedical services, it's about - - -

HOSKINS, MS: Yes.

KENNEDY, DR: - - - where is someone coming from and where are they going to?

HOSKINS, MS: Yes, I think there needs to be, from my point of view, there needs to be some form of plan of patients, when they come to metro area, what is the plan from start to finish, and it needs to be a clear plan and clear considerations and discharge planning that we can work with. And I don't know if that - who needs to coordinate that, but at the moment, it's just like we said before, a one-way street - - -

KENNEDY, DR: Yes.

HOSKINS, MS: - - - and to try and get them back, there's just no consideration to that end. And you know, what other services can we use, what's best for that patient. It's never quite clear how, from an Emergency Department, how we're going to get the patient back or what the right process is, so - you know - - -

KENNEDY, DR: I appreciate that one, and you know, I think what you're admitting there is that discharge planning starts from the time the patient arrives - - -

HOSKINS, MS: Yes.

KENNEDY, DR: - - - and is in the back - - -

HOSKINS, MS: Yes.

KENNEDY, DR: - - - of your mind all the way through their journey?

HOSKINS, MS: It is, and I think if it's discussed with the patient, if - - -

KENNEDY, DR: Yes.

HOSKINS, MS: - - - reasonable, and the family - - -

KENNEDY, DR: Yes.

HOSKINS, MS: - - - before they leave - wherever they're leaving, and the plan is sent with the patient to the receiving hospital, it just makes it clear and it also - when you're discussing that with the patient - because obviously, we sometimes get patients that come to the Emergency Department with mental health issues or - there are other issues, but I'm just thinking of the mental health, and you know, they're in a new place, they're scared, they're not used to maybe the culture and they're - all they're worried about is, "When I'm getting back, how am I getting back?", and sometimes, we don't know the answer, because there is no planning.

So, to be honest, to have that information and a structured approach would be really beneficial for the clinicians, the patient and - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - the family, who are calling and saying, "What's happening, what's going on? We don't know".

KENNEDY, DR: Sure.

DOLAN, MR: The - I think, to answer your question, I think, from a North Metro - - -

HOSKINS, MS: Yes.

DOLAN, MR: - - - viewpoint, we would be very excited to be part of a strategic plan that brings all that together, as long as it's incorporating everything from the start of their journey to getting - - -

KENNEDY, DR: (Indistinct) 12.53.23 - - -

DOLAN, MR: - - - them back to where they've - you know, they might be returning to.

KENNEDY, DR: Okay.

ZAGARI, MS: Yes, and the benefit of a strategic plan would be that ability to respond to changes in demand patterns and - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - particularly - - -

KENNEDY, DR: And understood ways to deal with those - - -

ZAGARI, MS: Absolutely.

KENNEDY, DR: - - - scenarios, which - - -

ZAGARI, MS: Yes.

KENNEDY, DR: - - - were all agreed well before they happen.

ZAGARI, MS: Yes.

KENNEDY, DR: It's just called a plan.

ZAGARI, MS: Yes.

KENNEDY, DR: Think pandemic plan.

ZAGARI, MS: Yes.

KENNEDY, DR: Having - the other thing I just wanted to touch back on is mental health transfers. In the consultation phase of the Inquiry, we have had enormous input from people with concerns about the aeromedical systems or dealing with mental health transfers, and you know, I think, in terms of the potential for delay or suboptimal management to cause significant morbidity, excess subsequent resource consumption - and sometimes, mortality, you know, I think the efficiency of an aeromedical system actually has got a lot to look at in that space.

Was there something that you - is there anything that you needed to say in that regard, and/or did you have a view about the current processes for triage and the current understanding of the relative urgency of mental health transfer versus - - -

DOLAN, MR: Yes.

KENNEDY, DR: - - - you know, the clearly obvious numerical based organic problems that we're all very aware of?

DOLAN, MR: Yes, I think, having a look at this, it's specifically around mental health, it is clear improvements that should be made around that particular subspecialty group. North Metro do have the forensic service, so there'll be certain mental health patients that would come to that service, but the possibility of missed opportunity to get the patient to where they need to go much quicker. And if I use an example where we are transferring from the region, often those patients are sedated, could be intubated to transfer down.

That then requires them to go to an ED department, who then try to extubate, and sometimes, that's - there's a delay in that and causes other physical issues, whereas ideally, if there was an opportunity to get that patient from where they needed to be straight into the forensic service, would be of much greater benefit to the patient, which then means they can access the care that they need much quicker. So, I think there's a lot of processes around where we could actually look around the importance of the clinical requirements of the patient, rather than the process of how we get them out of one area into the next area.

And I think - and Nicole will tell me if I'm wrong about this, but there is a lot of assumptions that they have to go through an Emergency Department, and I think, at some point, we need to be challenging the need for that to happen, and I think - - -

ZAGARI, MS: Absolutely.

DOLAN, MR: - - - there's a lot of defaulting that happens, that when it becomes - if there's a certain point where it's not manageable, the default then is to send them to another Emergency

Department, which is probably just creating a lot more problems for that patient, particularly if they end up staying in an Emergency Department longer than what they should do.

KENNEDY, DR: So, relooking at processes to understand urgency imperatives - - -

ZAGARI, MS: Yes.

KENNEDY, DR: - - - to understand value added steps in the process, as opposed to duplication and - - -

ZAGARI, MS: Yes.

DOLAN, MR: Yes.

KENNEDY, DR: - - - things that don't add value or cause harm?

DOLAN, MR: Yes.

KENNEDY, DR: Okay. I understand.

HOSKINS, MS: Yes, I would agree.

ZAGARI, MS: And maybe to add to that, that sometimes, we see transfer of patients for mental health reasons, because of a lack of beds in regions when there is no bed in the metro area, so it will be a four - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - day stay in our Emergency Department in five-point restraint, on occasion, where there's not a care requirement that is unable to be met in the WACHS site, it's about bed availability, so they're transferred to another area without beds into an environment which also is not conducive to safe care.

KENNEDY, DR: Yes.

ZAGARI, MS: So, it's that - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - thought process ahead of time.

KENNEDY, DR: So, the assumption should be that an aeromedical transfer occurs to improve the level of - - -

ZAGARI, MS: Correct.

KENNEDY, DR: - - - care that a - - -

ZAGARI, MS: Absolutely.

KENNEDY, DR: - - - patient receives?

ZAGARI, MS: Yes.

KENNEDY, DR: Yes.

DOLAN, MR: That's a good sign.

ZAGARI, MS: But that mental health transfers are as emergent as physical health transfers to that point - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - and that repatriation of those patients in a timely manner is almost more critical - - -

KENNEDY, DR: Yes.

ZAGARI, MS: - - - in terms of deterioration of their well-being when they sit, waiting, in an Emergency Department, to go back as well.

KENNEDY, DR: Yes, absolutely. Okay. Thank you.

Unfortunately, we're pretty much out of time, but thank you for your attendance here at the hearing today.

The transcript of this hearing will be sent to you, so if you can correct any minor factual errors or - before it's placed on the public record, and you'll need to return that transcript to us within 10 days of receiving that, otherwise, we'll assume that it's correct. While you can't amend your evidence, if you would like to explain particular points in more detail or present further information, you can provide this as an addition to your submission to the Inquiry when you return the transcript.

So once again, thanks very much for your evidence and input, and thank you for coming in.

DOLAN, MR: Thank you.

ZAGARI, MS: Thank you.

KENNEDY, DR: Thank you