Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Aspen Medical Pty Ltd – Mr S Nelson,
Date: 15 February 2022, Time: 1205– 1232

KENNEDY, DR: Okay, thank you for your interest in the Inquiry and your appearance at today's hearing.

The purpose of the hearing is to assist me in gathering information and evidence for the inquiry into aeromedical services in Western Australia. My name is Marcus Kennedy. I've been appointed by the Chief Health Officer to undertake the Inquiry. And beside me is Jonathan Clayson. He's the Inquiry project director. You can't see that there are other members in the audience here as well. I need to remind you to be aware that the use of mobile phones or any other recording device during this hearing is not permitted. So please make sure that your phone is silent or switched off as well.

The hearing is a formal procedure convened under Part 15 of the Public Health Act 2016 (WA). And while you're 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's false or misleading. This is a public hearing and a transcript of your evidence will be made for the public record.

So, 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 been provided with the Inquiry's terms of reference and the Inquiry's current state consideration paper and information on giving evidence to the Inquiry. So, before we begin do you have any questions about today's hearing?

NELSON, MR: I don't.

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

NELSON, MR: My name is Steve Nelson and I am the director of retrieval services for Aspen Medical.

KENNEDY, DR: Thank you. You're now invited to address the hearing, the considerations paper specifically and other matters that you may wish to bring before the hearing and we would expect that you could speak - you may speak for 15 or 20 minutes and then we can have some time for discussion and questions at that point. So, I'll hand over to you and try not to interrupt unless there are things that I can't understand in terms of the presentation or things that need clarification as we go with the context. Thank you.

NELSON, MR: No problem, sir. Thank you. All right, well, I would like to say from the outset that Aspen Medical is happy to contribute to the Inquiry, being already an aeromedical service provider, domiciled in Western Australia and have been since 2009. So, my comments on behalf of the organisation will be directed towards the considerations paper and generally commenting on or endorsing some of the observations that are made in that paper.

So, I'll start with the preliminary observations and from the outset we are in total agreement that the aeromedical system and network in Western Australia should be essentially governed, coordinated and clinically focused towards the patient journey and management. Also consider in our view asset locations and the disparate nature of the assets and resources throughout Western Australia which is a large land mass to be covered.

Aspen Medical can provide a depth and experience both in Western Australia and in similar conditions in Queensland and I note that the Inquiry has also taken reference from discussions

and meetings with members of the retrieval services Queensland unit for Queensland Health. And we are contracted to Queensland Health to provide jet air ambulance services specifically to cover large distances which is very similar to what you're facing in Western Australia. So that's I guess our input would be based on that experience and also to agree that Western Australia could go to a more defined and more enhanced aeromedical network system.

We make note of point number 8 on page 7 of the considerations document, at least the draft that I have. It may have developed since then. But the central coordination and governance of aeromedical system is paramount. And I think from what we understand being a private operator for industry that it is not that at the moment and is in need of some improvement.

We also note that there are a number of organisations contributing to the aeromedical network in Western Australia, each of them specialists in their own area and we don't aim to take any view on any particular brand. But we do note that the system - to maintain system integrity, that the operators should remain operators rather than coordinators of the aeromedical network in Western Australia.

In terms of the strategic direction point 16 specifically, the use of geographically remote resource to best manage patient journey and certainly our experience out of Karratha and in Queensland where we're based in Brisbane that the use of jet air ambulance capability with range and speed conducive to the longer distances. Particularly in Queensland jets are typically used for distances of more than 600 kilometres from Brisbane to bring patients back into destination medical facilities in the south-east corner.

So we make note of the fact of that I guess Western Australia is ideally placed to make use of the regional resources that already exist and to leverage those resources and locations to be able to move patients more effectively into Perth-based destination medical facilities. And that conversely, Perth-based operators and resources are ideally suited to what we call step downs in Queensland which is the repatriation cases to make sure that patients who have come into Perth for treatment and have finished their treatment get back to where they came from and importantly unloads the beds for other patients to come into those destination medical facilities.

And in the Queensland context that's exactly what RSQ or Retrieval Services Queensland do, is that coordination function so that patients can be brought in and patients can be moved out to meet the needs of the patient and the healthcare system. And typically, what we found in Queensland over the last couple of years is RSQ looking to optimise any activation of, in particular jet ambulance service, so that we can undertake multi-sector, multi-patient transfers.

And an example of that if there's what they call a trigger case, if there's a patient that needs to come from Cairns for example to Brisbane that they look for an opportunity for us as a service provider to take patients out of Brisbane on a step down or repat back to Cairns or a number of destinations on the way to Cairns to then pick up the patient who is the trigger for that service activation. And also, we see a number of cases where we would pick up a trigger patient and also another patient on the way back. So that our direct routing or indirect routing can see us undertake multiple sectors and deal with multiple patients both in the repat or step down and retrieval capacity. And I think Western Australia is probably ideally suited that sort of model as well.

I talk briefly to the culture and we know that unification also is effective in breeding a network culture. And to do that I think we need to bring the operators together in common forums. And again, we reference our experience in Queensland where there is two kind of forums where

all operators come together to talk both clinically and in terms of their observation and review of the system.

So, the first of those is they're both chaired by Retrieval Services Queensland but the first of those is the State-wide Integrated Governance Quality Assurance Committee or STIGQAC S-T-I-G-Q-A-C for short. And the second is the System Audit Committee. That meets monthly which really has a look at from an operator's point of view as well as the Queensland Health coordination point of view, looks at the system in totality to look for ways of improving it and to hear the operators' voices in terms of how the system might be improved.

We had one of those this week and of particular note within that environment was the issue of ambulance ramping in our state which has a detrimental impact to the retrieval network. So that's a forum where all the operators can come together to share their insights and observations of the aeromedical network. And in our view that breeds a strong culture of (indistinct)12.16.21.

We also make note of the fact that in relation to the occupational health and workplace health and safety systems that the recent CASA rule changes clearly place an onus and a burden upon aeromedical operators and we think positively for clinicians to be also guided by CAO48.1 requirements for fatigue management. And that's - I think it's an endemic problem throughout the health system is the fatigue that clinicians are suffering and often not guided by a rule set. So fortunately, within the aeromedical environment the aviation rules set advises us to ensure that clinicians are on the same standard of fatigue management as those of the pilots. And we see that from an integrated crew point of view to be very positive although it does impact the resourcing model to some degree.

And lastly, look, I just want to make a point again of the geographical considerations and to leverage the capacity and capability that's already within Western Australia. There are a number of operators doing tremendous work and with facilities located in strategic positions, particularly in the Pilbara and the Kimberley. We are one of those. And certainly, we'd be offering our capability to enhance the aeromedical network for both WA Health and WACHS into the future. We operate a fairly large base out of Karratha Airport. We have three jets there.

I think contrary to what was in the considerations paper we now have three jets there and we have capacity to take on more capability there specifically to meet the needs of the WACHS or WA Health. And I think there's probably a number of other operators in the same position that can leverage their already existing footprint to give benefit to the health system and aeromedical network more generally. So that's my input for today. I'm happy to take any questions.

KENNEDY, DR: Thank you very much. I apologise for the error in counting but that's the only one that we've had reported to us. I reckon we did okay.

NELSON, MR: Probably a consequence of historical data, I'd suggest.

KENNEDY, DR: Could be. So just going back to a couple of your points, you said earlier on that operators should remain operators not coordinators of the system. Why? Can you explain that statement and the rationale that you have for that?

NELSON, MR: Well, I think it's simply a case of system integrity.

So in our view similar to the model in Queensland that the states should be running the health network including aeromedical network and that the operators should be providing the capability to that network, but that the governance and coordination of tasking and use of and allocation of resources should be invested in a government coordination rather than an operator coordination thereby lending integrity to the system and also protecting those operators who may be currently involved in self-determination or tasking on behalf of the government, protecting them from negative feedback or sentiment in regard to how they task. And I note there's some comment in the considerations paper about that very matter.

KENNEDY, DR: Yes. Okay, thank you. You talked about STIG which is a very powerful and very effective forum and the Systems Audit Committee for QRS. I guess I've been around long enough to have understood the implementation of those committees. What would you see are the challenges in establishing similar structures to that in an environment that doesn't have them such as WA?

NELSON, MR: I think the challenge with establishing anything really is getting 'buy-in'. So, I think it takes pretty solid terms of reference and terms of reference that aren't too complex and complicated. To make sure that everyone involved, all the stakeholders in those sort of environments and committees are completely aware of the expectations and also to make sure that the culture is one of a just culture so that operators can raise issues even if those issues may be highlighting the fact that their particular service was deficient. And that's certainly the attitude we've taken. It be open and transparent because our view is that without that openness and transparency the patient outcome could be adversely affected. And you know as the considerations paper rightly points out from most if not all operators that's our focal point, is the patient.

So, I think the challenges with those environments is simply it takes a little bit of time to establish that level of trust and openness and particularly when you've got competitors coming together talking about their performance within the system and potential vulnerabilities. I know we had some teething problems with that early in the forums in Queensland. But you know due to I think the right people chairing those forums and the right people from organisations who were invested in patient outcomes rather than brand protection I think we've seen positive outcomes in Queensland which should be able to be achieved. But no doubt there would be some initial challenges with getting those started and getting a level of trust and expectation established.

KENNEDY, DR: Thank you, I think that's a very astute observation about an incredibly powerful component of the Queensland system. So, thank you for raising that. I think at this stage that's probably the main questions that I have for you. I think we're in reasonably - on a similar wavelength in terms of most of the issues and I'm not suggesting for a minute that the considerations paper is a draft report or anything. It is actually quite a you know discussive paper that's come from many different sources. And what's been interesting in it is the degree of repetition which is a good thing. Lots of people thinking and proposing things that are heading in the same direction. So, I guess before we finish, I would just check with you to see whether there's any other matters that you would like to bring to the table today before we finish up?

NELSON, MR: I was probably I'd just like to make one point about system innovation and advancement.

And I think every aeromedical network around the country faces the same issue and it all comes down to budget. But I think there have been some jurisdictions in Australia where

those aeromedical networks have taken bold steps in both their capability outlook and their budget submissions to ensure that the service is developed in a way that's complementary to standardisation and the introduction of innovation.

So I guess if I could give any sort of advice it would be to government to look ahead and into the future particularly when you're well positioned with your budget balancing at a particular point in time to make allowances for standardisation and innovation such that interoperability can be achieved so you don't just have a monopoly of operators in the state because you know as in Western Australia you've got a number of very capable companies who are doing very similar things. And I think interoperability, particularly for patient journey management to ensure that that journey management is optimised as much as possible.

And something we're looking at in Queensland to try and reduce the amount of times a patient is shifted from one stretcher to another because that's an inherent kind of risk within the system. So and I think if there's a lasting legacy that WA could leave is not only to get their systems in place such that the government is running the show and they've got the operators in there that are performing to those standards and expectations but they also cater for innovation and system standardisation.

KENNEDY, DR: Yes, I think that's a very valid point. I mean one of the considerations in that space is if you look at WA there are a lot of potential operators that could be partnered into a whole state system. Standardisation issue, whether it's aviation standards that need to be complied with which are fairly generic or clinical governance and kit out kind of standards that you would want to see across the whole state to guarantee that flexibility and interoperability that you talk about. Is it really a practical consideration to expect you know industry to respond to that because industry has its own business already that it's running and presumably doesn't have lots and lots of spare platforms sitting around although there might be some?

Do you see where I'm heading? That if one of the options is that you go down a whole new system and you buy a whole heap of new helicopters and planes and put them up the coast or the other is that you use what's there in a new and slightly innovative way - well, it's not actually innovative. It's done in lots of places. Which do you think is you know a more practical solution? Can you actually get there by engaging with all of those disparate providers? Would that be achievable?

NELSON, MR: Absolutely. I think so. And again, it comes back to the process of management of change and perhaps you may make a progressive pathway towards the system that you want into the future. So, I think it's future-proofing giving operators clear understanding of where you want to head.

Now, we often talk to the Queensland government about service assurance and service assurance is only underpinned by giving operator certainty. You know, operators can't run at a loss. Always the systems are going to degrade. They're going to start necessarily looking for ways to save money. And one of the issues we face is it's very difficult to bring innovation if there's no budget to support it.

So the point I would make to governments is you know look further ahead, engage with operators before you go to the market and find out what operators are thinking because you know we've often got solutions in mind that are far in advance of those that are in play at the time. It's just the need to underpin the financial impact of getting those into the marketplace and then let the operators tell you what it looks like or tell the government what it looks like

from an optimised point of view. And particularly one thing we focus on is how we improve the patient journey management? And that can pretty easily be done in a lot of cases. And I'm not suggesting that this is the case in WA.

In a lot of cases for instance if the ambulance service is running a standardised stretcher system then let's have a look at the way we can standardise throughout the aeromedical network so that the patient journey is on one stretcher and that those assets are interoperable between any mode of transport. So multi-modality transport of a patient is what we're looking at in terms of innovation. Nothing much changes in terms of the aeroplanes and the helicopters apart from a few upgrades. It's how you deal with the patient on that journey. That's the real issue for us and we think that's where still a lot of risk lies.

So I would personally like to see, having been in the industry for 24 years now, I would personally like to see governments take a more proactive approach to engaging with operators to you know ask them what their wish list looks like and then see how much budget can be afforded to that. And I know it's not a bottomless bucket. Certainly, Western Australia is flush at the moment. It's a good opportunity for them to have a crack.

KENNEDY, DR: Sounds like a good piece of advice to finish with. Thank you for that. It's been a very useful session and well though through submission. So again, thanks for your attendance at the hearing today. A transcript of the hearing will be sent to you so that you can correct any minor factual errors before it's placed on the public record. You need to return the transcript within 10 days of the date of the covering letter or email otherwise it will be deemed to be 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, thank you very much, Steve, for your time and input to the hearing today.

NELSON, MR: It's a pleasure. Thank you, Marcus. Thank you, Jonathan.

KENNEDY, DR: Thank you.