**Aeromedical Services WA Inquiry – Formal Hearing Transcription**
**Inquirer: Dr Marcus Kennedy**
**Organisation: CareFlight Ltd – Mr M O'Shea**
**Date: 15 February 2022, Time: 0915 – 0945**

**KENNEDY, DR:** Good morning, thank you for your interest in the inquiry and for your attendance today.

The purpose of the hearing is to assist me in gathering evidence for the inquiry into Aeromedical Services in Western Australia. And I'll begin by introducing myself, my name's Marcus Kennedy and I've been appointed by the Chief Health Officer to undertake the inquiry. And beside me is Jonathan Clayson who's the Inquiry's Project Director. We need to make you aware that the use of mobile phones and other recording devices is not permitted in this room and could you please ensure that your phone is on silent or switched off.

The hearing is a formal procedure convened under part 15 of the Public Health Act 2016 in 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 which is 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 have previously been provided with the inquiry's terms of reference I believe and the current State considerations paper. Before we begin do you have any questions about the process of the hearing today?

**O'SHEA, MR:** No, I think you've answered them all, yes.

**KENNEDY, DR:** Okay, thank you. For the transcript could I ask you to state your name and the capacity in which you are here today?

**O'SHEA, MR:** Yes, so my name is Matthew O'Shea and I'm here as part of the management team of CareFlight.

**KENNEDY, DR:** Thank you.

You now are invited to address the hearing and that can be in essentially whatever format you wish to and/or drawing on the considerations document, if that's what you wish to speak to. After your address I may ask you specific questions and then we can discuss things after that. And I will attempt not to interrupt you as you're speaking initially unless there's aspects of what you're presenting that I don't understand and it's important at the time. You're welcome to remove your mask, if that's better from the point of view of - - -

**O'SHEA, MR:** Yes.

**KENNEDY, DR:** - - - communication and we'll try and keep ours on at other times. So over to you.

**O'SHEA, MR:** Yes, thank you.

We do have a prepared statement, if that's okay, which - - -

**KENNEDY, DR:** Yes.

**O'SHEA, MR:** - - - addresses all of the terms of reference. So, if it's okay I'll read that and then - it's probably about 10 to 12 minutes.

**KENNEDY, DR:** Yes.

**O'SHEA, MR:** And then I can take questions, if you like - - -

**KENNEDY, DR:** Okay.

**O'SHEA, MR:** - - - after that.

**KENNEDY, DR:** Thank you.

**O'SHEA, MR:** So, good morning, Commissioner. My name is Matthew O'Shea and I have worked at CareFlight for almost three years in Perth, Western Australia. I'm an AHPRA registered paramedic with an MBA and am part of the CareFlight management team. At CareFlight our mission is to save lives, expediate recovery, and serve the community, so our participation in this inquiry is one hundred per cent mission aligned.

Our aim here today is to speak from our collective experiences with the intent to help improve patient outcomes in Western Australia. This is important to us as an organisation. We intend to make a number of observations today in addition to our written submission on 3 December 2021. Those observations pertain to the following areas outlined in the terms of reference, the role of WA Health, the coordination and tasking of assets, contract management, clinical governance, and workforce composition.

I'd first like to take the opportunity to introduce CareFlight and background our credentials for the record. Many people in Western Australia, including some here today, may not know very much about our organisation, so we feel it's important to provide some context to the comments that we're about to make.

CareFlight is an aeromedical for purpose charitable organisation established in 1986 in New South Wales and is rated in the top three most trusted charities in Australia in the Australian Charity Reputation Index for the last four years, rating number 1 in 2019. CareFlight is headquartered in Sydney, New South Wales with major operational centres located at Westmead Hospital, Bankstown Airport, Darwin Airport, and Gove. We currently employ approximately 550 people, operate a fleet of 21 aircraft and 13 patient transport vehicles, and service numerous State and Territory Government contracts.

CareFlight owns and operates a blended fleet, which includes seven helicopters as well as eight turbo prop aeroplanes and two jets, including a brand-new Gulfstream, which came online last year. We also have four additional jets dedicated to CareFlight from other organisations for aeromedical work. This fleet plus our 13 on-road patient transport vehicles makes CareFlight a truly integrated aviation medical provider with a very diverse AOC.

We provide a wide range of Aeromedical Services, including expert advisory services to government and non-government organisations across Australia, the Asia Pacific, and the Middle East. Our rapid response helicopter supporting New South Wales Ambulance can be airborne with an emergency doctor and paramedic within four minutes from time of call making it the fastest response medical helicopter in Australia.

Our top end medical retrieval service to the Northern Territory provides many remote indigenous communities across the top of Australia with 24/7 high acuity Aeromedical Services using King Air, a jet aircraft. Our AW139 provides emergency rescue helicopter services in

the Northern Territory community as well as in support for AMSA and the ADF for search and rescue.

Our new Gulfstream jet provides a long-range aeromedical capability dedicated to the Northern Territory, including NETS services, which are supported by a B400 for shorter missions. And in WA we have been providing specialist paramedical and emergency medical advice to the energy sector since 2013 as well as dedicated aeromedical jets based out of Darwin for offshore clinical support and rotary wing emergency response.

In addition to the domestic market CareFlight has an international experience to draw on as well. Our jet air ambulances based out of Sydney and Darwin provide Aeromedical Services to Australian Embassy staff throughout Southeast Asia as well as Australian civilians ill or injured on holidays overseas. For example, CareFlight was responsible for the medical repatriation of two of the most critical burns patients after the 2019 White Island volcano eruption in New Zealand.

We have also recently loaned the Fijian Health Service a PTV in cooperation with DFAT to help meet their surge requirements for COVID on the island. And we are currently providing advice and aeromedical expertise to a Middle East country in the process of starting its own national aeromedical service. CareFlight is also a highly regarded training institute. We have a long affiliation with the Australian College of Emergency Medicine, the Australian New Zealand College of Anaesthetics, and the Australian College of Rural and Remote Medicine. And CareFlight is accredited by all three colleges and provides secondments to doctors undertaking their respective fellowships.

In addition to our fellowship work with the college we also provide a wide range of educational programs to the community from Sick Kids in the Bush Program where we work with allied healthcare providers in the indigenous communities through to vocational first aid programs under our RTO status. We have high levels of community engagement across the country. In fact, we deliver many courses here in WA building resilience in communities through upskilling emergency responders through our trauma care workshops.

On a personal note I do have some background in Aeromedical Services in WA prior to my work at CareFlight. As a medic with a special air service regiment I undertook the Army's rotary wing aeromedical course in 1997. In 1998 and 1999 whilst posted at the regiment we helped provide AME training to members of the WA Police Air Wing as well as providing them with additional medical equipment for their helicopter. This helicopter held the medical response mission for government at that time.

Until 2003, which is just 19 years ago, that was the extent of Western Australia's emergency helicopter retrieval capability provided by government for WA taxpayers, a police helicopter with police staff responding to medical emergencies. At the same time between '99 and 2003 CareFlight was flying doctor led helicopter retrieval services for New South Wales Ambulance and a dedicated helicopter emergency medical service known as HEMS and the first doctor led service of its kind in Australia, which actually began in 1986. CareFlight has been a global leader and innovator in the design and delivery of rotary wing HEMS ever since.

I make the point about the police helicopter for a reason as it highlights some important issues for this inquiry in line with the terms of reference we mentioned earlier. Firstly, it's interesting that the Western Australian Government has a history of delegating authority and operational responsibility for emergency medical helicopter retrieval to non-health agencies. Initially it was with the police before it moved to the Department of Fire and Emergency Services in 2003

who rolled the task in with various other emergency duties perhaps to justify the expense of a helicopter at the time. But the fundamentals remain. Police handed over responsibility of a medical service to DFES, government agency to government agency, both who do not have intrinsic health structures or contract and performance reporting lines to the Department of Health for patient care.

We note the concurrent Parliamentary committee inquiry into the delivery of ambulance services in Western Australia by St John Ambulance and the concerns raised over response times and ramping. Perhaps there is an opportunity here to collaborate on findings and move towards a single patient movement framework with a whole of government approach. The WA Government is responsible for the single largest geographical space in the world of one single statutory authority and ultimate responsibility and accountability for moving complex patients the equivalent distance of a transcontinental European evacuation.

The ultimate risk we wish to address are adverse outcomes to patients from poorly coordinated movements. By not defining a single State-wide patient transport framework with centralised government tasking patients' outcomes will not be optimised and the cost of individual services will potentially grow far higher than is necessary through duplication of capability and what is a possible stagnation in capacity.

A good example of having no single point of accountability is call management in WA. St John Ambulance have a call centre and operation centre. WA Country Health have a telehealth centre and as of Friday released the new tender calling for a software solution for acute patient transfer coordination solutions. Fiona Stanley now has a telehealth centre for respiratory issues to assist St John Ambulance paramedics. And RFDS runs its own call centre and operations centre. All paid for in one way or another by WA taxpayers, all with system overlap, different aims and duplication of effort in some areas.

We have no doubt that everyone working in these respective organisations are applying their best endeavours, but it is clear there is an opportunity for a streamlined coordinated approach to improve patient outcomes through the centralisation of command and control.

To the point of coordinating and tasking of assets we view Aeromedical Services as part of a health system, a patient care continuum where patient welfare is central to the care plan, including their movement. A system-based approach to patient movement must be considered essential to provide meaningful change to patient care and patient movement in Western Australia. A simple services-based approach managed by multiple government departments does not effectively serve the people of WA. And with that in mind the State should seek to define what type of patient movement system it wants for both high acuity and low acuity patients. This is an important strategic piece of work that this inquiry will help inform.

A single State-wide framework and revised KPIs that include patient related KPIs would also be a more effective way to determine the performance of existing contracts and future contractors all collaborating in a multi-organisational patient transport system. It is possible to have more than one organisation deliver a service within a system. It is important to note that Aeromedical Services do not need to be synonymous with one provider. It is possible to have multiple providers delivering the service, particularly if there is an effective centralised tasking system in place. In that way providers must continue to collaborate, innovate, evolve to best serve the community with organisations bringing their own strengths to the system.

As an example, New South Wales Ambulance have several helicopter providers, various pools of doctors from across the State that come together and partner with New South Wales

Ambulance to deliver the rotary wing aeromedical retrieval service for the New South Wales Government. Additionally, New South Wales Health has multiple providers delivering low acuity patient transport services by PTV and aircraft through a centralised tasking hub, both are very effective systems.

On the point of workforce composition and tasking coordination, if you look at Western Australia's approach to patient movement more broadly you can make another important observation for the inquiry. All aspects of patient movement are outsourced to non-government commercial organisations. All of these organisations are contracted by different agencies with broad divergence of actual responsibility and outcomes but all moving patients primarily in one direction towards Perth and major hospitals. One can't help but wonder if this would be better coordinated and managed by a singular centralised government operations centre especially when the greatest determining factor on patient movement in WA is bed availability in the hospital.

Visibility of this and liaison with hospitals is best performed by a single centralised tasking agency ideally directly controlled by health. One example that could be better coordinated centrally with wider positive outcomes to patient movement across the State is the disruption caused by ramping of St John Ambulance. St John spent 52,000 hours ramped at hospitals in 2021. Whilst an ambulance is ramped at a hospital is not available for other tasks such as transferring patients from aircraft at Jandakot to hospital. It has a direct knock on effect to the safe and efficient movement of patients by aeromedical providers.

This raises an interesting question for the State to consider. Where does the health system start? Based on the current Western Australian model you could argue that the government feels the health system starts at the front door of a hospital when you are admitted.

In almost every other jurisdiction in Australia at least one part of the pre-hospital patient care system is government owned and operated, including the centralised management of 000 calls for health assistance. Centralised control of 000 calls by a government health department instead of a contractor allows for better more informed choices about where a patient might go or if alternate care pathways might be available.

On the point of service coordination tasking of assets and contract management we strongly recommend a centralised government authority who can create a State-wide framework to support a systems-based approach to patient movement. We operate into other Australian jurisdictions where the delivery of the service is shared by more than one organisation and the results for patients and taxpayers are very good.

On the point of contract management, we'd like to comment on the current DFES tender, which is due to be awarded shortly. The tender is for Aviation Services as the medical component is a separate contract. The tender documents described how an Aviation Service will be provided to DFES. It focused on the technical aspect of the helicopter and base operations, which you would expect, but provided no context as to how the service was to fit within a broader aeromedical patient transport strategy for the State, which given the length of the contract would have provided important planning and cost considerations for respondents, if such a framework or strategy existed. In full disclosure CareFlight responded to that tender.

In a separate process CareFlight also submitted a market led proposal for a community led regional helicopter emergency medical service. The intent was to place CareFlight helicopters in Kalgoorlie and Geraldton and offset the cost of running them through our community focused charitable activities, like we do with the Northern Territory Government's AW139. The

market led proposal was a State Government process administered by the Department of Finance, which allows industry to approach government with innovative business ideas they believe provide a service or solution to the State.

Our MLP was assisted by our friends at St John Ambulance who provided excellent 000 data on calls across the State. This data highlighted a clear opportunity for CareFlight to provide services to the communities of Kalgoorlie and Geraldton now. Here is a quote from the written response from the Department of Finance:

> "The preliminary scope and priorities assessment was conducted as per the policy and it was determined that the proposal was to be declined as it does not adequately align with the scope with the MLP policy due to the proposed service being dealt with by an existing government process. Further, the proposal does not align with the WA Country Health Service's current strategy for centralised acute patient transfer services."

There are two key issues we think are important to note around contract management for the inquiry. Firstly, the comment "It does not adequately align with the scope of the MLP policy due to the proposed service being dealt with by an existing government process". During the debrief with the Department of Finance we sought clarification of this, and the process referred to here, that it excludes us from pursuing our MLP for community led HEMS in Kalgoorlie and Geraldton, is the DFES tender process.

The tender document, which is 124 pages long in detail, included one subparagraph on page 46 buried in amongst nine other paragraphs under section 2.23 rescue helicopter base facilities that said:

> "This request will also be used for additional emergency rescue helicopter services located at current or future airport locations dependent on State Government approvals and State funding allocation. Any expansion of services was at the absolute discretion of the contract authority and will be treated as an optional requirement."

The term of the DFES contract is - the term of the contract DFES is about to issue is a two-year initial heads of agreement, then a seven-year initial term with three one year options, that's a total of 12 years. What this seems to suggest is that only DFES and the incumbent can deliver any helicopter medical services in Western Australia for the government over the next 12 years. We feel this limits any type of innovation in the HEMS space in WA to DFES and the incumbent over the next 12 years given the other terms of the contract. We don't feel this is in the best interest of West Australians.

Furthermore, in the written response from the Department of Finance there is the following comment:

> "Further, the proposal does not align with the WA Country Health Service's current strategy for centralised acute patient transfer."

A copy of that strategy document was requested at the debrief and has never been provided. We have also searched the WA Country Health website specifically under strategic plans and as well as policies and cannot find one. There are several strategic plans listed and we have them here but that does not appear as a strategic plan. We absolutely support a WA Country Health led strategy for centralised acute patient transfer services, but it should not just be for

acute patients, it should be for all patients and it should be government led and managed. We do find it interesting that WA Country Health Services recently released a new request for tender for acute patient transfer coordination solutions, which was released on Friday, 18 February whilst this inquiry is still underway and yet to deliver its findings.

In summary, every decision or recommendation should focus first on what is best for the patient. We know from the forums and other respondents in the inquiry that there had been plenty of submissions about fleet choices and the issues with possible grading of aircraft type and its impact, contract KPIs and contract pricing, clinical teams and their makeup whether they be doctors, nurses or paramedics, and the possible impact of union action on senior or service providers and many other observations. These are all valid considerations for the inquiry, but we choose to focus on the patient. If you put the patient at the centre of your decision making algorithm, cut out the white noise from various interest groups, and really ask what is best for the patient, the model will become a little more clear and the KPIs self-evident.

Patient transport is part of the health system. It is not something that happens outside the system. Ask a patient where they believe their care starts, at first contact with a paid care professional or when they get to the hospital. Ask the nurse in the back of the plane or the paramedic in the back of the helicopter if they consider themselves part of the healthcare system. I think they would consider themselves part of a system.

So why is aeromedical transport, in fact, all patient transport in WA not centrally managed by a government system with the right framework in place to allow greater depth of capacity beyond decentralised single service contracts? CareFlight thanks you for allowing us to make these comments today and look forward to providing any further assistance we can.

**KENNEDY, DR:** Thank you for very well prepared and thought through and well delivered submission. Can you just refresh me on the date that the submission that you referenced in regard to Kalgoorlie and Geraldton solution? When was that submission made?

**O'SHEA, MR:** When we submitted the MLP. So that market led proposal was submitted - I'd have to check accurately but it would have been in March 2021. So, it was during the period of time that the tender had come out. And, in fact, the reason we submitted the MLP is we'd already approached DFES and we spoke to the previous Director of Aviation Services and asked him directly if there was any intentions to put helicopters into Geraldton and Kalgoorlie at any time in the future and they had told us "No" at a meeting. And we actually told them at the time "We are proposing an MLP for these two locations" and there was no objection to us putting that forward at the time.

**KENNEDY, DR:** Yes. Which to my understanding is kind of it's a discretionary process.

**O'SHEA, MR:** That's right, yes.

**KENNEDY, DR:** That submission is the government's not calling for it, it doesn't have plans.

**O'SHEA, MR:** That's right, yes.

**KENNEDY, DR:** You can make a submission. Given also, just I mean keeping in mind the other contextual issues around that, would have been the knowledge and commitment to Aeromedical Services review, which was on the cards at that point.

**O'SHEA, MR:** Yes.

**KENNEDY, DR:** So, there was a clear issue of, you know, potentially system redesign and changes to occur. And I guess the other consideration in that time period was the RFDS Act was issued over two rotary platforms that were yet to be commissioned and whose role was yet to be defined but they existed by that time and had been purchased.

**O'SHEA, MR:** But those helicopters, yes, that wasn't public knowledge when we submitted the MLP, that was after we'd submitted the MLP that that was drawing to our attention. And our assessment at the time was that they would utilise those in replacement of fixed wing for areas close to Perth. So, we didn't see that as a particular reason not to go ahead and put the MLP in.

**KENNEDY, DR:** Understood.

Do you have a view in regard to the commissioning of those vehicles and where they sit within the system that you wish to put before the inquiry?

**O'SHEA, MR:** The helicopters you mean? Not a particular view. Our understanding is that those helicopters were going to fit within an existing scope of work within an existing contract and supplement their fleet to provide a more cost-effective method for close range interhospital patient transfers. We hadn't envisaged them using them as a primary aeromedical retrieval helicopter given the DFES tender. So that was our assumption I guess as - - -

**KENNEDY, DR:** Yes.

**O'SHEA, MR:** - - - an organisation.

**KENNEDY, DR:** Yes. We have heard on numerous occasions through this process suggestions around an agreement to the need for overarching coordination, a single point of contact, a point of coordination and authority, if you like, also. And a space from which to ensure standards in terms of both aviation standards and clinical governance standards in the whole aeromedical system - - -

**O'SHEA, MR:** Yes.

**KENNEDY, DR:** - - - space. I'm taking from what you've said that that is something that you would support (indistinct 9.42.24) - - -

**O'SHEA, MR:** Absolutely, yes.

**KENNEDY, DR:** - - - as a key change and development.

I guess that - I mean you have covered really comprehensively a lot of material and I don't have any particular questions in terms of your presentation. I think it will need to be reread and digested, which we will do - - -

**O'SHEA, MR:** Sure.

**KENNEDY, DR:** - - - obviously, as time goes by. But I guess it would be fair to say that CareFlight has an interest in the Western Australian environment from the point of view of potential partnering with the system in some way to provide services within the AMS space.

**O'SHEA, MR:** Yes, that's right. I mean we're absolutely - - -

**KENNEDY, DR:** That's what you're here for.

**O'SHEA, MR:** - - - interested in providing a service. In fact, we already do provide services to WA Country Health in the north and we have provided aeromedical support where RFDS have been unable to move a patient primarily around Kununurra and Derby in the north of the State. We've provided mission support up there for WA Country Health.

**KENNEDY, DR:** So, what's your primary activity in terms of the aeromedical space in Western Australia at the moment? Where are you?

**O'SHEA, MR:** At the moment we have no activity in Western Australia at the moment. Our last operational contract finished here in September 2019 and at the moment most of my responsibilities are with the Darwin team.

**KENNEDY, DR:** Okay.

**O'SHEA, MR:** So, although I'm here in Perth prior to COVID I was in Darwin quite a lot.

**KENNEDY, DR:** Okay.

**O'SHEA, MR:** Yes.

**KENNEDY, DR:** All right, so that's understood. Okay, is there anything else that you wish to raise today?

**O'SHEA, MR:** No, that's it. We just thank you for the opportunity to be able to present our thoughts and views on - - -

**KENNEDY, DR:** Well, it's - - -

**O'SHEA, MR:** - - - the inquiry.

**KENNEDY, DR:** - - - appreciated and you've raised a number of things which, you know, I think highlight the orientation of your organisation, which is laudable, and also have pointed constructively at some issues which need to be clearly addressed, so I thank you for that. So, thank you again for coming today.

A transcript of the hearing will be sent to you, so that you can correct any minor factual errors that may have occurred in the transcript before it's placed on the public record.

**O'SHEA, MR:** Yes.

**KENNEDY, DR:** You will need to return the transcript within 10 working days of the covering letter or email otherwise it will be deemed to be correct. You can't amend your evidence in that response but 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 for your evidence today and for your submissions and contributions prior to today as well. Thank you.

**O'SHEA, MR:** Thank you.

**KENNEDY, DR:** Thanks very much.