EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 31 AUGUST 2009

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

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Hearing commenced at 10.00 am

AHERN, MR TONY
Chief Executive Officer,
St John Ambulance WA,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing, and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Have you completed the "Details of Witness" form?

Mr Ahern: Yes, I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Mr Ahern: Yes, I do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Mr Ahern: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Ahern: No.

The CHAIRMAN: Would you please state the capacity in which you appear before the committee today.

Mr Ahern: I am the chief executive officer at St John Ambulance in Western Australia.

The CHAIRMAN: Thank you very much, Tony, for coming along. Basically, under our terms of reference we are looking to identify any outstanding needs and gaps in health care services both from the metropolitan sector and the WA perspective. I was hoping this morning that you might initially give us an overview of what is happening in both the metropolitan area and the outer metropolitan area. If it is all right with you, as you give that initial overview, committee members will possibly interject with questions they might have. Is that acceptable?

Mr Ahern: I am happy to do that.

The CHAIRMAN: For the record, whilst there is a camera in here, the media has been advised that they can take only visual shots. Anything you say will not be audible to the media, and they will be leaving us fairly soon.

Mr Ahern: I suppose the starting point is that we did not provide a submission for this inquiry. One of the reasons is that this inquiry is happening more or less in conjunction with the ambulance service review that was recently announced by the minister. However, we have done a 150-page submission for that process, which we are happy to make available and submit here. It tends to cover, I guess, the broader picture and I may well refer to it, if that is all right, during this session.

The CHAIRMAN: That would be wonderful. Yes, we would be very happy to accept that as supplementary information.

Mr Ahern: Thanks. In the provision of ambulance services in Western Australia, the St John model is fairly unique in that there are only two jurisdictions in the country that carry non-government services; that is, Western Australia and the Northern Territory. In Western Australia when looking at the provision of ambulance services for the whole state—metropolitan and country—there are some very unique challenges, as there obviously are in a lot of service provision areas. The size of the state and the sparse, small population centres is a significant challenge in providing ambulance services. It is the largest land mass in the world covered by one single ambulance service. In the country, it presents some very unique challenges. That is why, even today in 2009—the twenty-first century—St John Ambulance as an organisation is totally committed to the fact that Western Australia can have a good ambulance service in the country only with a significant volunteer contribution. I am happy to expand on that as we go forward. In terms of the provision of service in the metropolitan area, again, Perth is not dissimilar to any of the other capital cities in that regard. We fundamentally have a fully paid staff paramedic service in the metropolitan area. We still utilise volunteers with paramedics on the fringes—Wundowie, Serpentine, Mandurah.

Mr P.B. WATSON: What percentage is that?

Mr Ahern: Eighty per cent of our state-wide work load is done by metropolitan paramedics. Some of those are working. In Wundowie the percentage is very small—several hundred calls a year. In Mandurah, where we do many thousands of calls, the Mandurah crews are paramedics and volunteers. To give a feel for that total split of workload, about 80 per cent are metropolitan paramedics and about another 12 per cent are regional centres such as Albany, Bunbury, Collie, et cetera. That means that 92 per cent of the total workload is done either by a paramedic crew or a paramedic working with a volunteer crew. The last eight per cent—Mt Barker, Denmark, et cetera—are done by full volunteer crews. There are 101 of those full volunteer centres across the state, some of which operate across multiple towns. They cover about 150 locations. As I say, about 92 per cent of ambulance cases have either a full paramedic crew or paramedic-volunteer crew and eight per cent have a volunteer crew.

Mr P.B. WATSON: Is that the mix that you want?

Mr Ahern: The mix is not far out in terms of percentages, but there is definitely a need for more paramedics in country areas. We have a submission before the government. It has obviously been reinforced through our review process. We submitted a contract negotiation document in January or February 2009, which outlined all the resources. There were a couple of things in relation to country staffing; one of them was that, in the existing regional centres, there tends to be a bit of a mismatch of staffing arrangements. The basis for the number of staff who exist from one place to another is largely historical.

The first part of our submission was a proposal that there be a clear formula for the staffing of country centres. Basically, we want three categories of staffing: category 1 would be any centre that is doing 3 000 ambulance cases or more a year with full staffing. That would be a full paramedic crew with paramedic back-up, et cetera.

The next level, and the centres that will fall into that —

[10.10 am]

The CHAIRMAN: So they are not volunteers?

Mr Ahern: No; just full paramedic. Again, in those centres, we would still try to use volunteers for public first aid events and that sort of thing, but not in terms of ambulance provision. In that category at the moment, Bunbury and Kalgoorlie are the only centres that have that level of workload and again there are a couple that are not too far away from that, but they are the only centres. Category two, the next level of staffing, we said should have full paramedic cover on day shift—that is, two paramedics working together to make up crew—and then on night shift there should be a paramedic still working with a volunteer. I should have said that full staffing of one 24-hour ambulance in the Bunbury-Kalgoorlie category one requires 11 paramedics; category two takes eight paramedics. Category three centres have 1 500 to 2 000 cases and they would always be staffed by one paramedic working with one volunteer. We had proposed those three levels and, as I said, clearly linked them to workload so that everybody—the community, the government and everybody else—understands at what level you put in paramedics.

Mr P.B. WATSON: Tony, did you have to make these categories up due to a lack of funding or is this just the best work practice for it?

Mr Ahern: The answer would be a combination of both. There is pressure on some of the locations. In some locations, the volunteer numbers work really well so there is not really pressure. In other locations we would be struggling when there is a high workload. One statement that I will make about volunteers is that there is a little bit of a myth, both within our organisation and outside it, about there being a lack of volunteers. We operate at about double the number of volunteers that we had in the 1980s. Everybody thinks that 1980s, 70s and 60s people were more inclined to volunteer, but we operate with about double the number that we had then. The challenge with volunteers is the daytime. Also, there are some big challenges about how you manage volunteers—it is completely different from what it was 10 years ago. I guess the pressures for those staff have come on as a combination of a lack of funding and a lack of capability. It is also necessary to look forward and project the level of investment required to sustain this model.

There is one more component to it. Effectively, I have talked about three categories that cover workloads of 1 500 ambulance cases and above. Below that we have about 17 centres that fit into a range of 250 to 1 500 ambulance cases a year. Although we still say that the volunteer model is entirely appropriate in those workloads, we want to supplement or complement the volunteer model with a thing called a community paramedic which is a locally based paramedic with a slightly broader role; that is, they can do other work within the health service. Again, these projects are going on all around the country and, in fact, all around the world where sometimes you may have paramedics doing shifts in emergency departments or you may have them doing some things in the provision of other primary healthcare services. We have two of these in place as a trial in Kununurra and Newman and we will probably be going ahead with Karratha fairly shortly. In the contract negotiations we have put to government, 17 centres require a community paramedic; that is, every centre that has a workload of between 250 and 1 500 cases. As I have said, at 1 500 cases, the paramedic response model kicks in.

The CHAIRMAN: I guess this paramedic response model is to meet a gap that you have identified in those areas.

Mr Ahern: Yes.

The CHAIRMAN: You believe that a fulltime community paramedic hoping to enrol volunteers will fill that gap by training those volunteers.

Mr Ahern: Absolutely.

The CHAIRMAN: Recruitment and training?

Mr Ahern: Yes. The best example that I can give is Kununurra. We think of Kununurra as the jewel in the crown. For many years we had really struggled in Kununurra. We would get just enough volunteers to manage and they would drop away. It was a constant roller coaster in

maintaining the service there. We put in place the community paramedic. Through WA Country Health Services, we told the Department of Health that we would half fund the service for a year and were looking to the department to provide the other half of the funding, which it did. We put a community paramedic in and we went from literally a handful of volunteers to now having about—I think the latest number is 32 volunteers. It is absolutely vibrant. Initially, when the community paramedic goes in, we found that he was getting dragged in to fill gaps on the roster, but that is absolutely not the role of the community paramedic; it is to have a vibrant volunteer model and someone to be there on the ground for mentoring and training. One of our greatest challenges with training volunteers in the country is not the total quantity of training that we are able to provide—that is not bad relative to numbers and need—but having it in the right place at the right time. Again, given the nature of the state, it is never in quite the right place at the right time. When you put a community paramedic on the ground, they can literally customise it. They can be doing the training for one or two new volunteers in the time frames that suit. They could have half a dozen or eight volunteers and they could have two or three different timetables or time frames running with the training. We believe that is a very significant part of or reason for Kununurra and Newman having seen this increase.

The CHAIRMAN: How many centres did you say had between 250 and 1 500 cases?

Mr Ahern: Seventeen centres.

The CHAIRMAN: Seventeen and you have got three of those new —

Mr Ahern: We have got two at the moment; Karratha is in the pipeline. I am not sure whether we have the go-ahead for Karratha, but I do not believe it is too far away.

The CHAIRMAN: So you are seeking 14 additional paramedic officers.

Mr Ahern: Yes, community paramedics.

Ms L.L. BAKER: Tony, can you explain to me a little bit about how the community paramedic compared to the paramedic fits in terms of a career path in your organisation?

Mr Ahern: It is very much in the development phase. I can talk about our concepts and ideas but it is very much an evolving process. The first thing that I can say is that when I got involved with an international group that talks and exchanges information about what is happening with the different pilot projects around the world, interestingly we realised that although this was a new concept for St John in Western Australia, it is actually not a new concept. A number of years ago—15 years or so—we actually stepped into the area of industrial paramedics. We were negotiating with mining companies and putting paramedics on site who had an extended scope of practice. Again, we had not done the modern thing and produced, I guess, a marketing angle to this; we had just been doing it. In fact, we realised that in many ways what we had been doing with industrial paramedics in the private sector was what we now simply needed to take into the public sector. The concept will involve us identifying the additional skills and training needed at the moment. However, the university sector—Edith Cowan University who in partnership with us do the paramedic degree program—is very interested in developing some sort of postgraduate qualification for the community paramedic. Our challenge in that is simply the fact that we want the community paramedic to be very much a flexible thing. We do not think that a community paramedic in Kununurra is going to be doing the same as one working in Esperance. Nevertheless, it is early days.

Ms L.L. BAKER: Do you see it as a postgraduate qualification that would happen on top of a paramedical qualification?

Mr Ahern: Yes, the current degree.

Ms L.L. BAKER: Okay. So there would obviously be budgetary implications for your organisation around that.

Mr Ahern: Yes.

Ms L.L. BAKER: What percentage increase are you going to need on your budget for these guys?

Mr Ahern: I have not got the break-up for just these guys. In a minute I can perhaps give you the whole lot including the metro figures. After that I can tell you the additional costs that we are looking for. I have not got the break-up. The only thing I can say is that obviously, as you would know, the provision of north west services is very expensive because of housing and all the things that go with that. That is possibly what we are finding a little bit of difficulty with at the moment. The department and WA Country Health Services look at the cost of those individual components and say it is a lot. For example, in Kununurra you are talking about costs of around $250 000 for a community paramedic by the time you factor in the additional vehicle, housing, training, maintaining skills et cetera. It is expensive, but against that it is a case of saying that you have a whole vibrant ambulance service for about $250 000 whereas, if the volunteer model in Kununurra fell away and we had to put in a paid model we are talking about 11 paramedics. Yes, the community paramedic is expensive as a standalone role when you look at all the logistical difficulties that go with it, but it is cheap relative to the alternative to providing an ambulance model.

[10.20 am]

The CHAIRMAN: Whilst royalties for regions funding is not to be used to support current full-time positions within the regions, as this is a new approach it might be something that the government would look at in terms of that funding.

Mr Ahern: Absolutely. We are hopeful that it will. Again, we have not worked out percentages, but from the point of view of our needs—the training, mentoring and building the volunteer model—the whole concept of community paramedic is that we would probably need paramedics for 50 to 60 per cent of their time. It would provide a significant resource that could be plugged back into something new or in addition to something for the rest of the community. We hope that it does capture the government's imagination.

The CHAIRMAN: Why are you looking at Edith Cowan University to undertake this course at a postgraduate level? I think that in Victoria, paramedic is a degree course.

Mr Ahern: It is a degree program here. To be quite honest, the current situation with a community paramedic course is that it is Edith Cowan that is chasing us to get something happening. We are more focused on developing the role, knowing what we will do with it and trying to find a funding channel for it. Edith Cowan is there.

I do not know whether you know our existing paramedic degree model. Perhaps it would be worthwhile if I outlined it to the committee. In Western Australia we have a unique model for a paramedic degree. When it became evident a number of years ago that paramedic education would go down the tertiary pathway, we looked at it and thought that as an organisation we would obviously like the benefits that come from a university education, but we did not want some of the downsides that we saw with other programs. I guess that nursing is an example. The two things we were looking at were trying to prevent the disconnect between supply and demand. Our industry is much different, because it is basically one employer, therefore there should be the ability to maintain that link between supply and demand a little better. We were not keen on having students come out with a degree, but with little or no work practice. We wanted to try to get those two things —

The CHAIRMAN: Tony, I am a nurse. Before we go much further along the tracks, I want to put that on the table. I think the courses we have for our nurses are wonderful and, yes, they would like additional practical experience. However, it is a funding problem and that is the reason those universities have not been able to give nurses more practical experience.

Mr Ahern: We believe that it is something we could achieve, because we have one employer in the industry. For nursing and other industries there are other issues involved. We started negotiations with UWA and Edith Cowan and it became obvious that for our circumstances Edith Cowan was a better fit for what we were looking for.

We actually do the selection process, which includes all of what existed with our selection requirements prior to starting this program and obviously making sure that we were also bringing into that the requirements to go to ECU as an undergraduate. We do the selection. We make the decision in October or November each year and the people who are successful go to ECU as a full-time HECS student the following year. They do one year as a full-time student and at the commencement of the following year they come into our system and are on our payroll. They do an induction course that includes the specifics of vehicles and operational procedure et cetera. The remainder of their degree program is done while they are employed and working on the road. In means by the end of their three-year degree program they have been working on the road for two years as well as undertaking their degree component. It is the only model like it in the country. The others are geared towards people getting their degree first. To give a comparison, when our people qualify they will have something like about 4 000 hours of work experience compared with between 100 and 200 hours with the other programs.

The CHAIRMAN: What is the retention rate?

Mr Ahern: The retention rate is very good. Again, it is new territory, because suddenly we have somebody come in with a qualification that is more portable than it was when it was more of an in-house course. We have to expect that people will look within the health service.

Being a paramedic is actually very attractive from a working condition point of view. It is almost one-way traffic from nursing to become a paramedic. Not many go back out. We think it is a nice working environment. One of the positive things about our model is that it is one-way traffic with paramedics coming into Western Australia. Over the past decade we can count on one hand the number of paramedics who have left to work in other state services. The model has its tensions, but it works really well and we think that conceptually it is right model. It will always need tinkering and adjusting.

The CHAIRMAN: At a postgraduate level are you hoping to attract nurses as well?

Mr Ahern: We have a number of nurses switching over—some staff nurses will switch over. Again, in the first year at ECU students are exposed to a broader range of learning. They are not interacting only with other paramedic students; therefore, an exchange goes on.

Ms L.L. BAKER: You mentioned that it is a one-way flow with paramedics coming into the state. Apart from the good training that you have outlined, what are paramedics in WA paid compared with other states?

Mr Ahern: It compares very well. The history behind that is that we had our wage negotiation last year and it was settled just before the end of the year. When the government changed the new minister was subject to a protest as he arrived at his office one morning. As a result of that we had a discussion and he made it clear to us that he was very keen to resolve this and make sure that paramedics were happier than they had been. At that stage we had on the table a 15 per cent increase over three years—five, five and five each year. It was the right number except that we believed, and the government accepted, that there was probably a need for a one-off catch up. It was something in the order of 15 to 20 per cent where we were out of kilter.

Ms L.L. BAKER: With the other states?

Mr Ahern: No, with other professions—compared with police and other professions. Probably there was a need for an adjustment. The upshot was that the increase for paramedics with seven years or more experience went from a 15 per cent to a 28 per cent increase over three years. It put a seven-year paramedic on about $85 000 a year, before overtime. Again, there are location

allowances and other allowances available. On average, paramedics would be earning about $90 000 a year, and that is the best in the country. Before, depending on the timing of wage increases, we would hover in the first, second or third, but the last increase certainly puts us ahead.

Mr P.B. WATSON: What about country areas compared with the other states that would be mostly city based?

Mr Ahern: The paramedics who go into the country areas earn more than that, because they have access to more overtime and obviously zone allowances, and we have an allowance called a proximity allowance. We try to encourage our paramedics to live reasonably close to the centre of town and we pay them more if they do so that they are more accessible to us when we call them back.

The CHAIRMAN: You said that the qualifications are on a par with other states. Are we on a par with other states in the actual practice and administration of health care?

[10.30 am]

Mr Ahern: We believe we are ahead of the other states. This is a significant focus of the current review, but we believe that the service in this state, for a variety of reasons, has the strongest patient-focused, evidence-based approach to what we do in the area of ambulance and paramedicine of any state. In the submission that we have given, there is a whole list of reasons. We do not just make that statement; there is a whole list of things. I guess some of the most telling ones are that in the late 70s early 80s when the concept of paramedic was just starting to really crank up, if you like, the whole thing then was built on the notion that if it is a good thing to do in an emergency department, it must be good to try to stick it in a vehicle and take it out to the patient. Of course, time showed that some things fell into that category and a lot of things did not. We were very fortunate as an organisation to have both a corporate direction and governance and, in particular, a medical director who was very focused on the notion of patient focus and evidence base. To give an example: one of the early things was defibrillation. Where you saw in all of the other services as they were advancing they would create an elite paramedic service—"We will get a group of people. We will train them more highly, and then we will have these sort of intensive-care vehicles", and there are a variety of names for them, "We will have this elite service. We will then develop procedures as to how we turn that out"—our medical director and organisation at that time said, "No, let us look at the things they are talking about letting them do, and let us look at the things that will make the greatest difference." The one at that stage was obviously defibrillation. Western Australia was the first ambulance service in the world that had a defibrillator on every ambulance. It did not have an elite paramedic service. The theory was to put them on every ambulance—there were no paramedics then—and train every ambulance officer to use them and then authorise that. So we did. In New South Wales it obviously became quite famous when Kerry Packer had his incident and then donated a lot of money to New South Wales ambulance service for defibrillators. That was more than a decade after Western Australia had already had them. So there is that approach.

With our education model it is exactly the same principle. We said, "Hang on, let's just not go with the flow. Let's challenge it. Yes, there are advantages, and we want to pull those advantages out, but there are also disadvantages with that way. Let's see if we can minimise those." As a result of that, we have a very patient-focused, evidence-based approach. When you come to the areas specifically then of clinical practice, there is a whole list of things that we do either differently or we do not do where other services do. That has brought us under a lot of criticism in the recent times. The *Four Corners* episode and the public criticism that we have been under in recent months are driven by a fairly strong core of our paramedics who just do not believe in what we are putting forward as clinical practice. We believe very strongly that what we do with clinical practice is the right clinical practice, but it frustrates people, particularly the ones who have come from other services and joined us: "We did this over there and now you are telling us we can't do it here." We

get criticised for it. As I say, that is specifically one of the things being looked at as part of this review.

The CHAIRMAN: Because of the time factor, maybe we should look at needs and gaps in the metropolitan area. We have identified some for the outer metropolitan area. I guess one of the concerns that often come to me as a local member would be patients with private health insurance who are taken into our public hospitals when sometimes they have asked to go to a private hospital.

Mr Ahern: I will answer that first and then give you a broader rundown of that policy. We are going through work practice change in the service, and have been over the past few years. Not that many years ago it was pretty much the decision of the paramedic as to where a patient went. When I say "the decision of the paramedic", in consultation with the patient, but really they were not being given too much directive. They had that flexibility to go where they needed. When the public system started to come under so much pressure, we ended up having a contractual obligation built into our contract with the Department of Health about the way we distribute patients across the range of public hospitals to make sure we get that distribution as evenly as possible. One of the things with that is it started to suddenly mean that paramedics were often being directed to go to a place that was neither where they wanted to go to nor where the patient wanted to go to. That created obvious problems. So this whole issue became a fairly difficult one, and still is. There are still elements of a problem with that. In terms of the decision around public or private, we still have quite a cultural work practice challenge, I guess, in terms of getting paramedics to understand and realise that where arrangements have been made—so a patient in consultation with their doctor or whatever has an arrangement to go somewhere—do not take them somewhere else. Typical ones would be chest-pain patients that maybe could be going to the Mount or somewhere else where they want to go and it has been arranged, and the paramedics are much more comfortable with taking those sorts of patients to Royal Perth or Sir Charles Gairdner —

The CHAIRMAN: Or Fremantle.

Mr Ahern: — or Fremantle, simply because that is the routine that they are in. There is no doubt about it; that is still a challenge for us from a work-practice point of view.

Mr P.B. WATSON: What happens if someone wants to go somewhere and the paramedic takes them somewhere else?

Mr Ahern: Interestingly, I was only dealing with one on Friday, with a paramedic who appealed all the things that he had done right up to me and so had a meeting with me about it on Friday. This was out in the southern area, down Rockingham way. The patient's doctor had made arrangements for this patient to go to Fremantle Hospital. It was a cardiac condition. The paramedic felt that the patient's condition was worse than the doctor was saying, and basically, as soon as the paramedic set out and the doctor was not there, so the paramedic says, "I am carrying the can now", he was not prepared to carry on to Fremantle and went into Rockingham hospital. The doctor seriously challenged that decision. There was a question as to whether the paramedic had the right to make the decision in those circumstances. Again, it is a judgement call, because where we say they absolutely have the right is once they have got the patient and if they believe a patient's wellbeing is now jeopardised as a result of going 10 or 15 kilometres versus five or six kilometres, then we give them the right to make the call and say, "You can make the call but we will hold you accountable. You are going to have to be able to say, 'I did this because I genuinely had a concern about the patient's welfare.'" Those calls are not always right; sometimes they are not made for the right reason.

The CHAIRMAN: Those calls can be made by the patient's doctor. Can they be made by the patient or client? I am not sure how you refer to your —

Mr Ahern: Generally, they are made by the doctor. If there is not either the doctor or an absolutely clear arrangement made for a patient to go somewhere else, the default is always going to be going

to an emergency department. That is what the paramedics will gravitate back towards. We do get patients as well who will have had a fall and they will have a fractured neck of the femur who say, "I want to go to Bethesda" or somewhere they want. That cannot happen unless arrangements have been made. The paramedics are dealing with that sort of thing literally on a day-to-day basis but, as I say, sometimes then their judgement is wrong where the arrangements are in place and the doctor has said that they want the patient to go there, and sometimes they make the call believing that it is in the patient's interest, but sometimes they are not aware of all the facts. We do get those messy situations to try to unravel where we have taken a patient to the wrong place and that has upset a whole lot of things.

Mr P.B. WATSON: Would it not be best to err on the side of caution now?

Mr Ahern: Again, I think you really do have a mixture. I would say that most of the times when the paramedics make that decision they are, but sometimes they are applying a judgement that goes beyond what they should be applying. That is the problem.

The CHAIRMAN: I was just going to ask you the impact that ramping has on the provision of the St John's Ambulance service.

Mr Ahern: I am sorry because I did not answer the broader picture of metro, so I will do that in the context of ramping. The five-year contract that we have just ended with the health department ran from mid-2004 to mid-2009. In the first year of that contract there was ramping.

By the last year of the contract, we had more than 6 500 hours of ramping, so that is 6 500 hours where paramedics are looking after patients at hospitals.

[10.40 am]

The CHAIRMAN: Sorry, was that six —

Mr Ahern: Six and a half thousand hours.

Ms L.L. BAKER: In the full term of the contract, did you say?

Mr Ahern: In a year, so by 2008-09 it was more than 6 500 hours.

The CHAIRMAN: Do you have the statistics for this year to date? Do you do it six-monthly?

Mr Ahern: No, we do it every month. I cannot remember the precise number for July; July this year was higher than July last year, but August looks like it will be lower. August last year was the worst month ever; it was around 1 200 hours for the month, which was huge for us. August this year, we think, will come in at around 900 to 1 000. That is where it was tracking by the middle of last week.

Mr P. ABETZ: That would really affect your ability to respond in a timely manner to calls, would it not?

Mr Ahern: Absolutely. If one thinks about 6 500 hours, an average case in the metropolitan area takes about an hour, so it is the equivalent of about 6 500 extra cases. The problem is that it occurs when we are busiest. It occurs when we have the least capacity to deal with it. Purely from an ambulance response point of view, that is the greatest challenge.

To give the committee a feel for the broader metropolitan area and the issues with that, ramping is a significant complication. In Western Australia, we have less response capability or capacity per capita than any other jurisdiction. I am talking only about the metropolitan area now. It is very hard to measure that across country areas. I will provide some examples. To look at the situation as it is at the moment, we took three snapshots of different times of the day. At 10.00 am in the Perth metropolitan area, there is one ambulance for every 45 000 people. That is the worst end of the scale, nationally. At the other end of the scale nationally, in Brisbane at 10.00 am there is one emergency ambulance for every 28 000 people. The 3.00 pm snapshot is the same: there is one ambulance for every 39 000 people in Perth; in Brisbane, it is one ambulance for every 18 000

people. At 10.00 pm, it is one ambulance for every 57 000 people in Perth, while in Adelaide and Hobart—which are the best in the country—there is one ambulance for every 35 000.

Our response capacity is lower than the other jurisdictions. Our submission to the Department of Health as part of our contract negotiation identified that we need to introduce another 187 paramedics over a five year period to get us back to the level of response time that we believe is needed. The 1995 ministerial review of ambulance services identified that, in order to maintain good response times, there should be no fewer than 52 per cent on standby of the total capacity. In other words, to get good response times, we have to have ambulances sitting around, waiting to respond. If we try to work them all up to a full work capacity, there will be no-one sitting around to respond when a call comes in. The 1995 review recommended that the level should not go below 52 per cent; the current level is down to 40 per cent, so we are a long way below the recommended level. The 187 staff we have proposed for the next five year contract is purely the mathematical calculation, based on the trend of our workload increase, of how many crews it will take to get the 40 per cent standby rate back to 52.5 per cent. We modelled that and we came up with the figure of 187 paramedics necessary for the metropolitan area.

The CHAIRMAN: Does that also look at the number of beds in accident and emergency? Have you worked with the emergency department directors to identify where the greatest needs are?

Mr Ahern: Certainly from the point of view of ramping not existing, I have to say that I have some degree of confidence with what has been proposed with the four-hour rule.

The CHAIRMAN: I am very hopeful that that is going to make a big difference.

Mr Ahern: Absolutely, and it seems to be that we really do now have something on the table that might well either completely take away or at least drastically reduce any concept of ramping. We factored that into that calculation, assuming that that is the case. We also put up a proposal prior to the change of government. The previous minister and the previous director general both agreed in concept to this proposal, which was to actually have paramedics looking after the patients in a different way until they could be handed over. This was certainly not a solution to ramping. From the patient's point of view, the patient was no better off, but from an ambulance response point of view, the proposal would have meant that we could take the impact of ramping away from our response capability. We were not successful in negotiating that industrially, however.

The CHAIRMAN: What services are Western Australian paramedics unable to administer that might help, particularly in that ramping situation?

Mr Ahern: I do not think there are any particular services that they are unable to administer that would help that. The proposal we put at the time was that we would put an extra six or eight paramedics into our system on a daily basis, which instantly gave us six or eight paramedics that we could draw back out of the system. The number was basically to give us the capability to manage patients that were ramped and could not get in, but manage them in a different way. At the moment, an ambulance pulls up at the emergency department and there are two paramedics to look after every patient. These are not at the highest acuity end, because even with ramping, if a patient is a category 1, they will go straight through. They are still sick patients, but they are not at that highest end. We were saying that we could have a paramedic to patient ratio of fewer than two paramedics for one patient. We believed that in some instances, we could have three or four ramped patients being looked after by a paramedic. However, it was not so much a skills or practices issue; it was a physical environment. We were saying, "If we put this in place, we cannot just do it in the corner of the corridor, trying to get into the hospital". The critical part was providing an environment in which the paramedics could manage, because the reality is —

The CHAIRMAN: An additional triage room?

Mr Ahern: Yes. The realities are the challenges of toileting and the really basic care functions, not skills with medication and things like that. That was the challenge.

Mr P. ABETZ: Does the extra 187 staff make allowance for the ageing of the population? As people get older, they tend to make much greater use of medical services and, I assume, ambulance services. Is that factored in, or will it be something that may perhaps catch up with us?

Mr Ahern: It may creep up a little, but that is based on our long-term trending of our growth. It will not be far out, certainly in the five year time frame. However, once we start looking at 10, 15 and 20 year time frames, obviously it will start to impact even more.

Ms L.L. BAKER: I have a question that I have not actually checked out with my colleagues. I have a vested interest in this, because the only reason I am alive is because of St John Ambulance having picked me up off the floor, taken me to hospital and resuscitated me on the way. You can either blame them or thank them for that!

I do not remember any of it, of course, but one of the amazing things I got as a result of that is that I believe they arrived within eight or nine minutes of the call being made. The performance of call centres is therefore very near and dear to my heart. I know you have been under a lot of pressure over the past 12 months, but in relation to service gaps, or things that you would like to see improved, would you be able to comment a bit on the call centre performance?

[10.50 am]

Mr Ahern: Sure. I think the first part about call centre performance is that the single biggest determinant of being able to get response times like the one the member just described is the ambulances. If the operation centre has an ambulance available in reasonably close proximity, there will be a good response time. If it does not, it is playing chess and literally juggling resources all round. That is the single biggest component.

After recent scrutiny, one of the things that we have come under pressure from is the way in which the ambulance operations centre prioritises its calls. All jurisdictions either use or are on a path to using structured call taking. That is a little like the *healthdirect* concept. It is not that product, but it is a little bit like it. The call takers are trained to a lower level than our call takers because, fundamentally, the system drives them. The call takers answer the phone and ask the first question. Depending on the answer to that question, the questions will keep coming up on the screen and the call takers will follow a pathway to get to a priority. We believe that it is better to have more highly trained call takers and to allow them to use their judgement. Obviously, that must occur within fairly strict criteria. We do not just hold that view as a matter of opinion; it is based on the evidence that is available, which we have submitted to the review process. A paper was published on the performance of the call-taking process in Melbourne, based on the data received in 2006. The report looked at how often the structured call taking correctly identified a cardiac arrest case. I might get the numbers slightly wrong, but the call takers in Melbourne were correct approximately 96 per cent of the time. Ian Jacobs from UWA, who manages our cardiac arrest register, looked at the number of cardiac arrests in the metropolitan area in WA and found that we were one per cent higher, which equates to about 20 cases. On just that area alone, the pressure that we are under to do what everybody else is doing would have resulted in 20 cardiac arrest cases being underprioritised. Overall, our operations centre is providing a good service. Just as I described before about being underdone in terms of paramedic numbers, we are underdone in numbers there. Our contract submission to the government identified that we needed another 35 people. That is divided by four because it is spread across 24 hours. That is the single biggest area that we can help.

Just one last point—maybe it is an advertisement —

Ms L.L. BAKER: I hope to not have to use your services again very often!

Mr Ahern: One of the statistics that we know about regarding cardiac arrests is that of all the cardiac arrest cases that our ambulances go to, in only one in four will someone perform CPR. Whatever we do on the ambulance end to take off a few minutes or to give paramedics more tricks up their sleeve, it is only one in four that we can do them with because the other three or four cases

will not survive if they are in cardiac arrest. The first aid training arm to the organisation is very important in that regard.

The CHAIRMAN: We could keep you here all day, Tony. Because we have got through so much so quickly today, I once again remind you that our terms of reference are to identify the needs and gaps and to indicate what might be done to meet these outstanding needs. Could you give us a summary? If we have not asked you about some areas of need that you know about, could you identify those needs for us so that we can follow that up by asking further questions? The intent of this review is to assist the government to ensure that in 2010-11, health-care services will be improved.

Mr Ahern: The first point at the top of the list is the ambulance capacity and the ability to respond. The second point is strategic engagement. We have made a submission to the Department of Health on this. We are both of the same view that we must make it happen, but it has not happened yet to the extent that it should happen. As a service provider, we should not be driving the strategic need in isolation to health. There must be a much stronger engagement with health on the development of the community paramedic concept and of innovative ways to provide service delivery for ambulances, for example. Both of us agree on that; it is a matter of making it happen. The staffing and community paramedics are the key factors relating to the country model. As an organisation, the other matter which sits across all of that and which we believe is lacking in this state is statewide clinical coordination. When patients are moved around within the health system, there is a lack of coordination about how that happens. Different components do different sections of it either very well or not so well. For example, RFDS does clinical coordination around the cases it is involved in, but there is a need for a statewide clinical coordination process for a patient who needs to be moved from Swan District Hospital to wherever, or whether a patient at Three Springs needs to go to Geraldton or Perth, for example. There must be a consistent approach that does not come down to a particular practitioner's preferred way of doing it. We must look at the whole system and determine where the best place is, clinically, for the patient to go. Where that practically impacts on us—I use Three Springs as an example—is it not uncommon for us to have someone at Three Springs check with RFDS about a patient and the nature of the patient's clinical condition means that it is appropriate for the patient to wait eight, 16 or 24 hours to be transferred. However, because of the difficulties with staffing or whatever at Three Springs, they might decide to ring the St John volunteers and tell our volunteers to transfer the patient to Geraldton. The St John volunteers will set off to Geraldton, which is a seven or eight hour round trip, but before they have even left for Geraldton, they will receive a phone call from Geraldton to say that the patient will be flown to Jandakot. It is basically the same distance to fly either from Geraldton to Jandakot or from Three Springs to Jandakot. The patient and our volunteers are then subjected to a lot that they do not need to be subjected to. There are a lot of other parts to statewide clinical coordination, but that is just one example. They are the main things: capacity, strategic engagement and the country model—that includes all the things we have covered relating to the country model—and statewide clinical coordination.

The CHAIRMAN: I thank you very much for the evidence you have given before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, we would be happy to accept a supplementary submission for the committee's consideration when you return your corrected transcript. We have already told you that we would appreciate a copy of the report that you have submitted.

Mr Ahern: The submission, which is 150 pages, refers to a whole lot of attachments. I will not send the attachments but if the committee requires any specific attachments, we will be happy to provide them.

The CHAIRMAN: Than you very much.

Hearing concluded at 11.00 am