COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

HEARING IN RELATION TO COUNTRY AMBULANCE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
THURSDAY, 10 DECEMBER 2009

Members

Ms A.J.G. MacTiernan (Chairman)
Mr A.P. Jacob (Deputy Chairman)
Mr I.M. Britza
Mr A.P. O'Gorman
Mr T.G. Stephens

Hearing commenced at 10.38 am

JOYCE, MR GREG
Chairperson, St John Ambulance Inquiry, examined:

CAMPBELL, MS CATHY
Manager, System Reviews, Department of Health, examined:

The CHAIRMAN: Greg and Cathy, we have with us Hon Tom Stephens, the member for Pilbara, and Ian Britza, the member for Morley. I am sure that Greg is very familiar with this process, but have you both completed the "Details of Witness" form?

Mr Joyce: Yes.

Ms Campbell: Yes.

The CHAIRMAN: You know that you have to tell the truth, the whole truth and nothing but the truth, or you will be taken down into the dungeons of Parliament House and tortured. You realise that this is a committee hearing, which has all the standing of a parliamentary deliberation. You are not required to give evidence under oath, but any deliberate misleading of the committee will be regarded as a contempt of Parliament.

We are disappointed. We had hoped that we would have some relevant health department officials with us. Cathy, I am not quite sure about your area of expertise.

Ms Campbell: My expertise relevant to today is having been the department's executive officer in the recent inquiry into the St John Ambulance service.

The CHAIRMAN: One of the things that we are interested in pursuing, particularly following the inquiry into the provision of St John Ambulance services in the metropolitan area, and that we are keen to look at as part of the committee's brief to examine regional development, is how this might play out and what the issues are in country areas and in regional areas. We were advised that the department had commissioned Greg to do a subsequent report. Is that correct?

Mr Joyce: Chair, it is not a subsequent report; in fact, the minister has expressed that he does not want another report. However, there is now what is called an implementation year across the 12 substantive recommendations, one of which includes looking at the country ambulance service across a range of issues. But also there is a process currently going that cabinet asked for, and that is to prepare a business case for an allocation of funds pursuant to the budget process. That is now being worked through by finance, health and also the Treasury officials. It is hooking into that budgetary process, and the country is a significant part of that application for more funds and more officers across the country. In effect, there are two processes going. One is to do this business case that goes through to the economic and expenditure review committee, if I have that name right; and the second is, during the implementation process, for the team to take a close look at the country ambulance service.

The CHAIRMAN: I am just trying to get this clear in my mind. Are you saying that the report identifies the need to do more work in relation to country services? Is that right?

Mr Joyce: That is right; but bear in mind, Chair, that the inquiry went for only 12 weeks, and when we looked at the country, we felt that we could not do justice to it because of the extent of the issues involved in it, and that we needed to have a closer look at that, and we recommended that.

Mr T.G. STEPHENS: Which recommendation is that?

The CHAIRMAN: It is number six.

Mr Joyce: Yes.

The CHAIRMAN: I am a bit puzzled. How can you be moving to the implementation phase in relation to country ambulance services if you have not done a proper assessment of them?

Mr Joyce: We did do an assessment in the sense that we involved the WA Country Health Service. It made a substantial and very high quality submission to the inquiry. We had a series of meetings with the service. We also had a series of meetings with the paramedics, including visiting country areas. Rather than make definite recommendations on a range of issues, Chair, we felt that we were sufficiently informed to say that we needed to do more work. The areas of work that we have identified include the actual contract between the Department of Health and St John Ambulance, and the call centre. You will appreciate that the recommendations on the call centre are really relevant to the operations of the country system. We have made recommendations about training, which bear particularly on some of the complaints and criticisms that we heard about the volunteer system. We have also suggested that we need to do more work on the tasking of the helicopter. One of the issues that emerged in the inquiry itself was the patient transfer system and how the inter-hospital transfer system clogs up the emergency ambulance service. Finally, probably the most important area is the staff levels in the country and the interface between the volunteer system and the professional system.

The CHAIRMAN: What sorts of areas are you proposing to look at? Which regional areas need further assessment?

Mr Joyce: Would you like me to go through them?

The CHAIRMAN: Yes.

Mr Joyce: The first issue that has been raised very thoroughly by the WA Country Health Service is that of a thorough contractual relationship between St John and the WA Country Health Service—their acronym, I think, is WACHS. They are saying that in the existing contract—bear in mind that it has been an evolutionary process—the country does not get sufficient recognition; that the KPIs are prepossessed and obsessed by the metropolitan area; and that they have no remedy. If you read the fine print in the contract, it just says that St John will use its best endeavours to do certain things. The KPIs all relate to the metropolitan area and not to the country. So the contract itself needs to be rewritten in a more balanced way to give the Country Health Service an opportunity to manage all these issues through the contract itself and to put the Country Health Service on a legal footing with St John's, so that it can manage the contract accordingly. To be fair —

The CHAIRMAN: Sorry, that last sentence, "to put the country health service on the same footing" as —

Mr Joyce: As the metropolitan area and in a legal relationship with St John Ambulance.

The CHAIRMAN: At the moment, is the contract with the Department of Health as a whole?

Mr Joyce: It is. But, to be fair, it is obsessed by the metropolitan area.

The CHAIRMAN: Are we looking at the possibility of there being two separate contracts?

Mr Joyce: That has been suggested, but it has not yet been approved. I think that the heads of Health would rather see it, rather, as one contract, but with a section for country health. I was enamoured by the view of having two separate contracts, but I do not think I will get approval for that. Should I go on, Chair?

The CHAIRMAN: Yes.

Mr Joyce: In fact, if you look at what is called the RCAs, the root cause analyses of the four deaths that were highlighted in the *Four Corners* program, the real issue we discovered in inquiry was the

operations of the call centre. We felt that there needs to be a strategic shift by Johns in the way in which it governs and manages that area—that it has not given the strategic importance to it that it should have over time. It is so crucial that when a person rings that call centre on 000, there needs to be an immediate response. As we looked through it—we went out and had a look at the police call centre, which is a different system that has been well endowed over time and well structured—we could see major deficiencies in the existing call centre. In particular, in respect of the country, criticisms were lodged whereby the tasking was incorrect. I am quick to say that in no way is this meant to be a criticism of the officers involved. They are hard-working, genuine people, who are really at the end of their tether; they are really under stress. In respect of the country, there is a good argument, I think, as the police do, to separate the country out of the metropolitan area, so you get some expertise. We heard evidence of various examples whereby people at the call centre did not know country areas as well as they should. I can understand that. I am from the country. You are probably talking about 3 000 different localities in the country, and you do need expert training in it. So there is a good argument that the tasking is separated within the call centre and that officers are made particularly dedicated to the country areas, so that mistakes are not made when tasking is done. We heard evidence of several cases where people suffered because of improper tasking.

The reform of the call centre St Johns has now accepted as a criticism, and that a lot of work needs to be done. When the government considered the report, they made available an immediate allocation of money to staff the call centre, to get it, both in terms of quality and quantity, trained up. You might appreciate that there is a system in there called Health Direct, in which the centre would employ nurses to go into the call centre to make the system better and to get the prioritisation, the triaging of the calls, at a higher quality.

The CHAIRMAN: Greg, can I just clarify that connection with Health Direct?

Mr Joyce: Over time Health Direct has endeavoured to establish a relationship with Johns, and vice versa. To be fair, I think, they have failed. We heard a lot of evidence from Health Direct that they were very keen to have another go and to get into the call centre, because the argument is that a lot of these cases can be resolved without calling out an ambulance, and that would take the pressure off the call centre. Health Direct in its own right I think takes something like 250 000 calls a year—I know, for instance, my wife has used it with my daughters—whereby they just get some expert advice from a qualified person, and it takes the panic out of the situation. So it was argued that if we could get those sorts of people into the call centre, it would take the pressure off the prioritisation and take the pressure off the officers. A lot of these issues can be talked through and done with visits to GPs or clinics associated with the hospitals. Of course, that does not help the country people too much, but that is one of the issues within it.

In general, Chair, the notion is to dramatically improve the operations of the call centre, both in terms of quantity and quality, and to get a better service coming out of there, because when you look at the four cases highlighted on TV, it is common ground amongst everyone that mistakes were made and that those four cases were mis-prioritised. They should have received priority one, and they received other priorities, and the ambulance did not get there quick enough. So it does need to be improved. The RCAs have made the point that too often the officers within the call centre were making decisions on the basis of operational exigencies rather than the wellbeing of the patient. The whole culture in the call centre needs to change and it just needs to have a substantial lift.

The CHAIRMAN: It is an interesting concept of getting it working with Health Direct. How would you do that?

Mr Joyce: Cathy, did you want to expand on that?

Ms Campbell: Yes. There is a direct phone link, so when communications officers have a call come in that they believe is low priority and could be handled by a qualified nurse rather than sending out an ambulance, they can ask the caller if they would like to speak to a nurse, in which

case they patch them through to the Health Direct switchboard. There is a process set up for that and how that would happen. There is a process by which if an ambulance is required, after assessment by a nurse, they are immediately transferred back. So there is a system that has been developed specifically for this and specifically for specified low-priority cases.

The CHAIRMAN: Are you saying, Greg, that you thought this could be ramped up in some way or this could be intensified?

Mr Joyce: Yes, because it has been tried over time. There has been a fair amount of resistance to it, particularly by St Johns, because they argue that they end up back with the call and that it is an ineffectual system. But after lots of discussion and argument, I think they do now accept the premise that they have got to take those people on and see if they can improve. It depends on who you talk to in this argument. Some people say that it is 20 per cent of the calls—I think that is the paramedics' and the union's view—and people within Johns say only five per cent of the calls, but somewhere in the middle is the truth, and we can improve and take the pressure off the system. Some of the money that has been allocated by government is going to be used to employ nurses in that system to do exactly what we are talking about.

The CHAIRMAN: Let me just get this right. Among the concerns that you have for the regional areas, you are concerned that the contract is inappropriate for the regional areas.

Mr Joyce: Yes.

The CHAIRMAN: You are concerned that it does not take into account the KPIs for the country areas. You are concerned at the call centre, but that is probably a more general issue. The call centre aspect is that what is happening is that the people do not know many of these rural locations, and so, if I have got it right, you are suggesting that they have dedicated officers that know the areas. Is that right?

Mr Joyce: That is right—both in terms of quality and quantity—so that the system is not under pressure and so that they do know what they are doing. It is a very complex area because you are actually asking an officer to task and make decisions on whether to bring a helicopter in or whether to get the Royal Flying Doctor service in sometimes or whether to use road transport. There is a great deal of knowledge needed to be known in those areas so that it is tasked properly.

Mr T.G. STEPHENS: Greg, you mentioned that the police department has two call centres—one dedicated for the metro and one for the country. Is that right?

Mr Joyce: Yes.

Mr T.G. STEPHENS: Are they in different locations?

Mr Joyce: No, they are all in the same building. We went to watch them operate a couple of times. They are all in one building but it has been well resourced over time, and they just have a better, high-quality system. They have a system of self-auditing and a system, whereby if an officer makes wrong decisions, they go through that decision and explain why. If they need more training et cetera, they do that. It is just a very professional system compared with the Johns system.

Mr T.G. STEPHENS: Which does not have a sort of specialised knowledge input —

Mr Joyce: No, it all comes into one point and the officers are expected to know it all, and it is just impossible.

Mr T.G. STEPHENS: Greg, there are a few call centres across a whole range of government departments.

Mr Joyce: I think there are, yes.

Mr T.G. STEPHENS: Is it inappropriate that we have specialised-focus call centres? Can Johns breathe off the resources of the government call centres?

Mr Joyce: It is a good suggestion. One possible view is that they could be come part of the police centre. We looked at that as much as we could, and it should be an issue that we look at in the future. Bear in mind, though, that there is a lot of bulk that goes through it. Johns get 400 000 calls a year, and of those, 150 000 are 000 calls. It is a very bulky business. We would want to be careful, if we did make changes, that we made them properly, because I can see that if we go in there with an iron fist, then we will cause real problems. This has got to be done very carefully and very sensitively, because they are stretched.

The CHAIRMAN: Greg, did any of those cases that you talked about emanate from a lack of understanding of geography? We can see your point that someone is ringing an ambulance and saying, "I'm in Burracoppin" and you do not know where that is, and you might make an inappropriate call. Did you hear of examples of that being given, where the call centre officer completely misunderstood where the area was and then made a bad call?

Mr Joyce: Yes, there were several examples, but they did not include the four cases that *Four Corners* dealt with. One of those was about a call from Gingin and the volunteer system. The one that sticks in my mind is the example given in the union submission whereby Brunswick was tasked to do a call in Harvey to a person who had had a cardiac arrest. However, there was a person and an ambulance available in Harvey that could have gone directly there. The ambulance was tasked to go there and, ultimately, by the time the callout was completed the person was deceased. We did not hear specific evidence on that or ensure that the facts were correct. That was certainly an example given in the union submission. Other examples were given. There was a road trauma at the back of Busselton whereby it was argued by the volunteers that the tasking was done incorrectly. It involved a mix-up between the helicopter and the road service. Those sorts of issues are prevalent within the system.

The CHAIRMAN: This comes out of a complete lack of a detailed understanding of the geography of the country areas.

Mr Joyce: Yes, in my view. Other people argue against me and say the person should be jack-of-all-trades and be able to do everything. There is a need for specialisation in the area.

Mr T.G. STEPHENS: Greg, you mentioned that the Western Australian Country Health Service made a detailed submission to your inquiry. What were the headline points of that submission?

Mr Joyce: The two recommendations to the inquiry were, first, that they establish a decent contractual relationship.

Mr T.G. STEPHENS: That is in their submission?

Mr Joyce: Yes. Secondly, that there be a decent ongoing planning process between Johns and country health and that they continue to talk to each other, which, in effect, is what we will do.

The CHAIRMAN: Related to this is the concern by country health that the KPIs in the contract are all metro driven. Is that because of the volume issue?

Mr Joyce: The figures show that 20 per cent of activities are done in country areas and of that 20 per cent, eight per cent are done by volunteers. Yes, it is a volume issue. The major KPI, for instance the one that all jurisdictions around the world rely upon, is response time. That is only in respect of the metropolitan area at the moment. Johns do keep response times in the country areas. We hear different stories about them. I am advised that they are roughly equivalent to the metropolitan area, but they are not part of the contract at this stage, and they should be.

Mr I.M. BRITZA: Greg, would you confirm whether there is an ageing profile in the WA Country Health Service; and, if so, what effect does that have?

Mr Joyce: Yes, there certainly is an ageing profile, and WACHS' submission acknowledges that. They also indicate that there will be a significant population increase in the country. Both of those,

particularly the ageing profile, will have a significant effect on both the call centre and the demand for the ambulance service.

Mr I.M. BRITZA: What difference is there in the ageing profile between the country and the metropolitan area?

Mr Joyce: I have not been into that.

The CHAIRMAN: Could I clarify that: with the ageing profile, are we talking about the volunteers? There is some suggestion it is the volunteers, but is it also the vehicles?

Mr Joyce: It is both—the volunteers and the patients, because there is an ageing profile out there.

The CHAIRMAN: Are the vehicles in the country ambulance service, by and large, older? Do they get the pensioned-off vehicles from the metropolitan area?

Mr Joyce: I could not answer that. However, certainly in that submission they made the point that the volunteer system is ageing.

Mr I.M. BRITZA: In all aspects?

Mr Joyce: Yes. They gave some instances during the inquiry of people who were no longer competent to drive but were still in the system.

The CHAIRMAN: You made a comment in your report that there was a lack of support for and coordination of the volunteers. Are you confident about the volunteer figures that were given? Do you think that they were reliable? How do you think this volunteer arrangement will survive into the future?

Mr Joyce: It is a point of extreme contention and it depends on who you listen to. If you go to the formal position of Johns, there are 3 500 volunteers in the system, across, I think, 111 sub-centres, and the number of volunteers is increasing. If you listen to the paramedics and union, they will say that the numbers are overstated and the volunteer system is under stress and threat. If you go to specific towns that you, Tom, would know well—Mt Newman and Kununurra, in both those towns, because of the fly in, fly out situation and the way the society is structured —

Mr T.G. STEPHENS: With 12-hour shifts.

Mr Joyce: — they were having difficulties recruiting volunteers, so they introduced a new concept called a community paramedic. In fact I was at a John's function during the week at which both the two community paramedics were given awards, because part of their job is to recruit paramedics. Both these people achieved top results for recruiting paramedics. The state of the volunteers depends on who you listen to. It is reasonable to assume that in most country towns, particularly close-knit rural communities, there is a real strength in the community system. I come from one in Lake Grace and it is part of the social fabric. They own the system and it is a terrific system that works well.

Mr T.G. STEPHENS: In a region like the Pilbara or wherever there is a combination of industry and growth with 12-hour shifts and fly in, fly out, and the pressure on the concept of volunteerism is huge and the community fabric is destroyed by the economic structure that has taken hold. These country paramedics are vital, but not guaranteed under the existing contract with St Johns.

Mr Joyce: In the new negotiations that are taking place between Johns and the health department a set of standards are being developed that Johns is basing its submission on. It recognises the very point that you, Tom, are making; that is, that volunteers cannot be attracted to some country towns and a community paramedic is located in that town. That is a very expensive model and we heard what those figures are. The bloke at Newman, who was really struggling, recruited, according to what I read, 20 volunteers this year. It can be done through the community paramedic system. Whether it can be sustained is another thing, but it is happening now through that model.

Mr T.G. STEPHENS: Do you have a sense of how many community paramedics there are outside the metropolitan area?

Mr Joyce: Cathy has advised me that there are 10.

Mr T.G. STEPHENS: Do you know where the community paramedics are located?

Mr Joyce: Certainly in the submission that is currently going in between Treasury, country health and Johns, they are asking for significant increases in that model.

Mr T.G. STEPHENS: I understand it, Greg. Sometimes it is like a puzzle when we look at something. Because of the way the system works, does metropolitan Perth not rely on volunteers in the ambulance system? Is that the way it works?

Mr Joyce: That is the way it works, yes.

Mr T.G. STEPHENS: As soon as you get out of the metropolitan area, the system relies upon volunteers, but it is topped up with 10 community paramedics scattered around regional Western Australia.

Mr Joyce: That is right. I can give the figure. In the current negotiations between Johns and the state, Johns is asking for 16 community paramedics in addition to the existing 10, if that figure from Cathy is correct. What they are proposing in the current negotiations is that—they call them activities, but I understand that it is ambulance trips—between 250 to 1 500 trips per annum will attract a community paramedic; between 1 500 and 2 500 trips per annum will attract one paramedic for 24 hours a day; a third level, whereby between 2 500 and 3 500 calls per annum will attract two paramedics; and beyond the 3 500 calls per annum that number attracts a typical sub-centre, as is the case in the metropolitan area. A regime has been developed and is being negotiated between the department and Johns. I think they are all confident that once that is established, and providing the government can finance it, it will go a long way to dealing with the interface between the volunteer system and the professional system and improve the outcomes for patients.

The CHAIRMAN: What is the price tag to satisfy that?

Mr Joyce: I do not have that particular element, but we heard from Johns during the inquiry that the overall cost would be an extra $160 million for 300 officers over five years.

The CHAIRMAN: Were they all for the country?

Mr Joyce: No. I think that 22 per cent of them were country.

Mr T.G. STEPHENS: When you use the figure of one paramedic, does that mean three people?

Mr Joyce: They would work 12-hour shifts, so it would be two people.

Mr T.G. STEPHENS: When you describe a place getting one paramedic, that means two.

Mr Joyce: Yes.

The CHAIRMAN: If they are doing 24-hour shift, you would probably have to have four of them.

Mr Joyce: You certainly do. I do not know the actual number, but I think you are right, Chair; it is three or four because you have to plan for leave et cetera.

The CHAIRMAN: Cathy, you might be able to help me with this. I notice that a number of centres in the wheatbelt and mid-west have royalties for regions funding. Is that for infrastructure or staffing?

Ms Campbell: I cannot answer that.

The CHAIRMAN: Tom, do you have any specific questions about ambulance services generally in regional areas?

Mr T.G. STEPHENS: Greg, there is always the suggestion that the ambulances arriving in country areas are the cast-me-downs from the St John Ambulance system in the metropolitan area. Has that point been made to you in the inquiry?

Mr Joyce: It certainly has, and that is a fact.

Mr T.G. STEPHENS: It is an odd process. For a service that puts older and more vulnerable vehicles further away from support mechanisms that the metropolitan area can provide, one would think it would be the other way around. It would be better to keep the older vehicle closer to where the services are.

The CHAIRMAN: Maybe there are better mechanics in the country areas.

Mr T.G. STEPHENS: There could be better mechanics in the country.

The CHAIRMAN: Does it relate to the number of trips required by that vehicle?

Mr Joyce: Yes, they have a regime whereby they know the number of trips per annum in each sub-centre and that is how they dish out the ambulances. Tom is right, the older vehicles go to the country on the basis that they do fewer miles, but they are good units that have been well maintained. Johns has an extensive garage system whereby they do a lot of maintenance on their vehicles.

Mr T.G. STEPHENS: Was the submission from the Western Australian Country Health Service a tabled submission?

Mr Joyce: It was given to us in confidence. If the committee wants it, I will ask if they would voluntarily give it. It is very well written and it is a very good submission.

The CHAIRMAN: It would be very important to us in our deliberations. We would be formally requesting it.

Mr Joyce: We will get back to you on that point. We should be able to make it available.

The CHAIRMAN: We would rather not have to issue a summons.

Mr Joyce: I see no reason why they would not provide it.

The CHAIRMAN: Is St John's concern about the structure of the contract and its favouring of the metropolitan area, that they will do whatever is required of them but they need more money? I was surprised when you said that they seem to be a bit resistant to working in with the idea of the two call centres.

Mr Joyce: Overall, Johns is an excellent organisation and has served this state over a long time, since 1922. I was told the other day that they have been in the state for 117 years. They are an excellent organisation and are well governed and well managed, and I am sincere in saying that. They are not without fault. They have a range of issues and most of them go to those 12 substantive recommendations in the report. To be fair to Johns, they have responded very thoroughly to that report and are accepting the recommendations. We are now entering this implementation year in which everyone is prepared to roll up their sleeves and get on with it. The government has reviewed the report and accepted the 13 recommendations. They have provided immediate finance to improve the call centre and now there is an expectation by government on the health department that it will get cracking and during this implementation year implement those 12 recommendations.

The CHAIRMAN: I want to get this clear: in relation to regional ambulance services, you are doing further assessment work. It is not simply just implementation; there is this further assessment centring around the contract and centring around the call centre and the call centre's need to provide specialist officers for country.

Mr Joyce: I only got to two of those things. I think there are another four areas. One of the criticisms was that Johns and the health department had stopped talking strategically and

operationally. One of the recommendations was to re-establish a steering committee. That has now been done and is chaired by Peter Flett, the director general, and that has established an implementation process. Part of that implementation process is a process within country health, St John and representatives from the paramedics to get stuck into the six major issues that I have explained, and to do something about it. The minister was very precise in saying that he did not want yet another report; he actually wants some action, so from now on we actually have to get in there and fix things.

[11.16 am]

The CHAIRMAN: There is a slight conceptual problem here, because you are still coming to do your assessment. Can you quickly go through the other points?

Mr Joyce: We have touched on them in various things. Training —

The CHAIRMAN: This is in the regional areas we are talking about, and what you are going to have to do under recommendation six?

Mr Joyce: Yes, and in particular in the country areas we heard evidence that the volunteers have received only minimal training and that their refresher training has got behind. We heard that also from the paramedics and the transport officers, so there needs to be an emphasis from St John on training, including the country areas. The fourth area was the helicopter service. We heard evidence, for example, that the use of the helicopter, which is a very good system and very expensive, had reduced the incidence of it. There were some statistics given to us whereby they used to do three priority ones a day, and it is now reduced to about one and a half per day. We heard evidence from the British model that they get up to five priority ones a day. It depends on whom we talk to, and people can be territorial about the tasking of the helicopter, but there seems to me some evidence to suggest we could be using it better than we currently are.

The CHAIRMAN: In what sense? What do you think is happening that should not be happening?

Mr Joyce: There is a suggestion that rather than task the helicopter, they will use the road transport in certain circumstances. Again, it depends on whom one talks to, whom one listens to, but the people who do the tasking for the helicopter say that they stick strictly to the guidelines, that everything is done properly, and that maybe the guidelines themselves have to be changed. It just seems to me that if we have such an expensive and efficient rescue helicopter service there, we should be using it to the max.

The CHAIRMAN: Your position seems to be that there is some evidence that the helicopter is actually being underutilised.

Mr Joyce: Yes. We got evidence from a paramedic, and a very good paramedic, who is part of the system. Over time the use of the helicopter has decreased.

The CHAIRMAN: That is the number of hours that it is in the air.

Mr Joyce: Yes. The figures we were looking at were the number of priority ones per day. I think that needs a good look at. We did not have time, during the 12-week inquiry, to investigate that. There are other issues with the helicopter and how it interfaces with the Royal Flying Doctor Service when decisions are being made about road transport. It is a very complex tasking area and it needs to be looked at, in my view. There was another area that really emerged during the inquiry and was not in the terms of reference, but it became very important. St John performs two functions for government: in its relationship with hospitals. It does what it refers to as patient transfers from secondary hospitals, primarily in the country, to the tertiary hospitals. That is a separate contract that is with the individual hospitals, and obviously they have the overall contract with the state for ambulance services. We heard evidence, particularly in the Peel region, that the emergency ambulance service was far too often being tasked to do patient transfers—we mentioned this in the report—which reduces the stand-by capacity to do emergency work. That needs to be sorted. Within

that system there is a whole range of issues. For example, a doctor in a secondary hospital will triage a patient according to some priority. Then when they get up to the tertiary hospital, they are re-triaged by another doctor. The argument was put that that was excessive and that we do not need to go through the emergency department at the tertiary hospital; we just admit the patient. They come into the ED, and more and more come in, and then ramping occurs and bypassing occurs. Those sorts of technical areas need to be sorted, but one needs to be a clinical expert and I am not; I have been told several times that I am not!

The CHAIRMAN: I heard about a case of that on Monday night. An 82-year-old bloke with a fractured back was ramped for an hour outside Armadale hospital. He was finally dealt with at about 11 o'clock after an hour on the ramp. He finally got into the hospital and was triaged after about four hours, then sent down to Royal Perth Hospital where he was in emergency for a further 24 hours. It was a total of something like 30 hours before he actually got into a bed.

Mr Joyce: It is unacceptable.

The CHAIRMAN: It is ridiculous; it is a complete waste of effort and resources, with all those ambulances.

Mr Joyce: The clinical arguments that are thrown back are that a patient's condition may change in transit and they may need re-triaging; or that beds are not available. All those sorts of things come into it, but I cannot see why, once a person is triaged by a competent clinical person, he cannot go straight into hospital.

Mr T.G. STEPHENS: People in the country areas have read recommendation six and the government's response to it at the time. Recommendation six was basically that ambulance services in country areas needed further assessment. I know that we have already discussed this with you and pointed out that it is a conceptual issue. You have recommended that the areas of ambulance needs in the country are so complex that they should be subject to further assessment, but the minister is saying that he is not interested in another report, so we will not be left with an assessment.

Mr Joyce: No, we will do an assessment through the process that has been established, but we will not be writing any more reports. We will actually do the assessments and make decisions through the Department of Health and the minister, and get on and fix it.

The CHAIRMAN: We might have to call you back in a few months if there is no document.

Mr Joyce: I would love to.

Mr T.G. STEPHENS: So you will not be giving a document that represents that assessment to the minister?

Mr Joyce: Yes. That is in the context of this jurisdiction and every other jurisdiction in Australia being a graveyard of reports about which nothing has happened, and the minister is very keen to get on and do things.

The CHAIRMAN: At least we have on the record an analysis of the six principal issues that you have identified that require to be addressed further. Obviously, the union will be interested in promoting more employment, but you have here an assessment in which St John is making claims about the number of volunteers, and the union is claiming a much lesser figure. What do you see turning on that, and do you think it is important to get some clarity around that?

Mr Joyce: I think so, yes.

The CHAIRMAN: How would you go about doing that?

Mr Joyce: Short of going out and counting and verifying every person there, I have thought about that question myself: how would you do it?

The CHAIRMAN: You would ask St John to provide a list of the 3 500 and write a letter to them, asking them to confirm that they are actually volunteers, and asking how many hours they do. Presumably that would not be overly bureaucratic, because they would have to have a list of the people who are duly qualified to perform that role.

Mr Joyce: Yes, that is a good suggestion.

Mr T.G. STEPHENS: What are the limits of the helicopter's use outside the metropolitan area? Where does it go to?

Mr Joyce: I have been down to the helicopter service and it has a big plan in its strategic room. There is circle drawn around an area of 250 kilometres within which the helicopter can travel to and from without refuelling. There is a secondary circle of double that distance, for which refuelling would be necessary. Sites have been identified around the second perimeter where fuel can be obtained. The service is saying that it is not constrained within 500 kilometres.

Mr T.G. STEPHENS: Does it actually regularly travel 500 kilometres?

Mr Joyce: I think most of the work is done within the 250 kilometre area, but there have certainly been instances when it has gone out further.

Mr I.M. BRITZA: That is based at Jandakot?

Mr Joyce: Yes.

Mr I.M. BRITZA: It really surprised me when you spoke about training, because it is a genuine front-line service and refresher courses are lacking. I am surprised at that.

Mr Joyce: So were we; Cathy is very strong on training. It is said that the paramedic training refresher course is almost a year behind—about 10 months. We heard evidence from some of the volunteers in Bunbury that they had been inadequately trained. I think it is a serious issue that has to be addressed. At the end of the day, I guess we are talking about money, and that forms part of the negotiations between St John, the Department of Treasury and Finance and the Department of Health.

The CHAIRMAN: So it could be an area where the royalties for regions program is actually used to make upgrades. Have you considered that?

Mr Joyce: Yes, very much so. That is foremost in everyone's mind, that we may be able to tap into that fund.

Mr T.G. STEPHENS: CareFlight is a private organisation. It is a business, is it?

Mr Joyce: Yes. CareFlight is an organisation that is chaired by a bloke the member will remember well—Dr Refshauge. He used to be the Deputy Premier of NSW.

Mr T.G. STEPHENS: Yes, he was Minister for Housing for a while.

Mr Joyce: CareFlight has made submissions offering to provide a service to the state, particularly in the south west. The figures are between $2 million and $5 million, depending on the level of service. Obviously, if the state was prepared to do any of that, there would have to be a public tender system, but that is what we have thus far. We have also had some overtures from Heli West; I am going to meet with that organisation shortly. It says that it can provide a service at a cheaper rate.

The CHAIRMAN: We have had such good examples of privatised hospitals and privatised prison transport! It gives one great confidence!

Mr Joyce: CareFlight actually provides the service in New South Wales and has been successful.

[11.30 am]

The CHAIRMAN: It is just that, in all these things, the idea that the private sector can do it cheaper always has to be carefully reviewed. They need to factor in a whole raft of costs. But they also need to have a rate of return on capital. At the end of the day, you never can contract out responsibility. The responsibility always remains with government. But you do not have the same level of control. Logically, they have cost structures that are higher, because they have to provide a commercial rate of return on capital.

Mr Joyce: But if you look at the current model—the not-for-profit model with St John's—I think in a sense we get the best of both worlds, provided we get the level of service.

The CHAIRMAN: That is right. It is quite different when you are dealing with a not for profit with an institutional framework than when you are dealing with a private.

Mr T.G. STEPHENS: So, Greg, you have got an interface between people calling for an ambulance in a non-metropolitan area. They might call the Royal Flying Doctor Service. Do people call the Royal Flying Doctor Service direct?

Mr Joyce: As I understand it, it is primarily tasked out of the clinics and the hospitals, I am advised, and they have a separate call centre, but there is a relationship between those two call centres. St John's has recently put a clinical person into the Royal Flying Doctor Service. I do not know the real answer to your question about whether an individual can ring up the Royal Flying Doctor Service.

The CHAIRMAN: They must be able to do that. Can people not do that in the Kimberley?

Mr T.G. STEPHENS: If you were on a station, you probably could.

The CHAIRMAN: Yes. If someone fell down a well on a station in the Kimberly or in the Gascoyne, I am sure they would ring the Royal Flying Doctor Service.

Mr T.G. STEPHENS: They once did, but I do not know whether they still do.

Ms Campbell: Since 2006, all the emergency calls have been going through St John's. The 000 calls all go through the Belmont St John's office, and then they get tasked from there.

Mr Joyce: But the Royal Flying Doctor Service has a separate call centre.

Ms Campbell: Yes, but the hospitals would be the ones ringing the Royal Flying Doctor Service.

The CHAIRMAN: But for people in country communities, their knowledge would be to contact the Royal Flying Doctor Service, surely?

Mr Joyce: Tom would know as well as I do, but with the 285 remote Aboriginal communities, I did make inquiries on that, and they are tasked through the clinic centres within those communities. The Royal Flying Doctor is tasked through that, not by the individual. I did ask that question. If someone fell down a well on a farm, that person probably could ring them.

Mr T.G. STEPHENS: You have just said that since 2006, the theory now is that if you are injured in the country, you ring the 000 number, and that goes to St John Ambulance and is tasked from there. It might end up with St John Ambulance tasking it to the Royal Flying Doctor Service.

The CHAIRMAN: That does seem to be a bit bureaucratic. Have you looked at whether that is an efficient way of allocating resources?

Mr Joyce: Certainly, issues have been raised, because on average it is taking, I think, 19 seconds to answer the phone, and you may then have to refer it on to another call centre, so you are right; there are delays. But, no, we have not specifically looked at that.

Mr T.G. STEPHENS: But conceptually, though, if you were in the bush, you would want to ring someone with clinical expertise. St John Ambulance can provide that expertise in an emergency situation anywhere in the state. They assess the situation and make a decision about whether it is low level and not an emergency, in which case it would go to Health Direct, or whether an

immediate evacuation is necessary, and they then work up whether it should be a chopper, land transport or their plane. That does make sense conceptually.

The CHAIRMAN: I suppose it does, except that in some areas there is absolutely no road transport option.

Mr Joyce: In some of the cases I have read about, the Royal Flying Doctor Service says it will be six hours before they can get a plane there, the helicopter service says they can get out there in such and such a time, and a sub-centre in the country says they can get the person to a country hospital in a certain time, and they make clinical decisions on that basis.

Mr T.G. STEPHENS: There is a constant criticism from the aviation industry that they have a lot of private capacity and they can be much faster in moving people in need, without having to rely upon the transport of planes from one end of the state to the other. They say that the Royal Flying Doctor Service is relying upon using a scarce resource to deliver a specialised service, when once upon a time people would just jump on the fastest plane that they could get. If people needed to get to a hospital, they would not wait for a plane to come from Meekatharra. They would just jump on the first plane they could get. But now it has all been slowed down, because it has been professionalised. I am not sure if there is any way back from there.

The CHAIRMAN: It is certainly worth looking at whether we might get better value for money by utilising other resources rather than by constantly expanding the Royal Flying Doctor fleet.

Mr T.G. STEPHENS: Just imagine that you are sitting on the ground in Halls Creek, and you have chopped a piece out of your arm, and you need to wait for a plane to come from wherever it has to come from, whereas if there was a plane on the ground and you had a doctor with you, you could be jumping on that plane and heading off to hospital. But the way it works, it is risk analysis and risk aversion, and everybody hangs around waiting for the Royal Flying Doctor Service.

Mr Joyce: I am old fashioned, and I would say get on the aeroplane. The arguments have been made here in the metropolitan area that in a lot of cases you are better off getting into the family car or getting a taxi.

The CHAIRMAN: Because then you do not have to wait on the ramp; you can get into the waiting room immediately, as some of my constituents are finding.

Greg and Cathy, thank you very much for coming in today. Given that we now know that there is not going to be a formal subsequent report, we may want to bring you back in four or five months' time, just to see how we have gone in progressing these areas in relation to regional ambulance services. Thank you for your evidence today, which has been full and frank, we hope. We will, of course, be sending you the *Hansard* transcript of your evidence today. We ask you to return any corrections that you want to make within 10 working days of receipt of the covering letter. If you do not return the transcript within that period, it will be deemed to be correct. You would understand this, Greg, but you may not, Cathy, because I do not know if you have appeared before these sorts of tribunals before, but no new material can be introduced into the transcript. You cannot alter the transcript and change the evidence. However, you are not confined simply to the transcript of your evidence today. If you want to provide us with additional information or elaborate on particular points, you can certainly make a supplementary submission. Thank you very much.

Hearing concluded at 11.37 am