Government of **Western Australia**
East Metropolitan Health Service

Hon Pierre Yang MLC
Standing Committee on Public Administration
Legislative Council Committee Office
Parliament House
4 Harvest Terrace
West Perth WA 6005

Dear Mr Yang

Response to inquiry into the delivery of ambulance services in Western Australia

Thank you for your letter dated the 1 July 2021 and opportunity to provide a response to the Standing Committee on Public Administration.

How 000 ambulance calls are received, assessed, prioritised and despatched in the metro area and in the regions

In the current model, an automatic algorithm assessment is made to prioritise 000 calls. A senior paramedic is available to advise on any complex cases that may need interpretation and elevation to a higher priority, including in some instances whether helicopter or road transport is needed. This works well for trauma patients who are appropriately prioritised on dispatch at the scene.

St John Ambulance (SJA) phones through priority calls to the site Emergency Department (ED) with key information that largely aligns with site clinical capability. This proactive action is a positive measure that allows sites to prepare for priority arrivals and lead to collaborative transition from SJA to ED teams. Site clinical teams will meet the patient and SJA team. On occasion, SJA will remain on site to provide further assistance such as resus or further patient transport to a tertiary sites e.g. ST-Elevated Myocardial Infarction (STEMI) patient to an angiography sites.

EMHS is not however, informed of key metrics to properly assess if calls are received, assess and dispatched appropriately; including access to response time and any complaint information from members of the public.

The efficiency and adequacy of the service delivery model of ambulance services in metro and regional areas of WA

From a hospital point of view, emergency calls are handled well and SJA has been receptive to change and challenges, including investigating and feeding back to any perceived deviations to standard clinical practice. Some clinical services including the State Major Trauma Service (MTS) have a particularly strong relationship with SJA in terms of clinical practice and governance. Relevant SJA clinical practice guidelines have been developed in consultation with the MTS allowing for more accurate trauma assessment and direct triaging of major trauma patients to MTS where appropriate.

There are, however, perceived fluctuations in the distribution of ambulance patient transfers across metropolitan area both in terms of ED locations, size/capacity and time of arrival throughout the day. When a large numbers of ambulance arrive in quick succession, Eds can experience overload resulting in ambulance ramping and an increase in patient care transfer times. This increased time spent by SJA on the ramp, impacts efficiency. A more dynamic and responsive allocation of ambulances would help to balance the flow of patients across the metropolitan areas and assist with ED surge management. Considerations regarding service availability (e.g. trauma services) should also be factored in dispatching ambulances and assist with the management of demand across the system.

It has also been suggested by hospital staff, that system wide demand is further amplified by a default position of transporting patients to ED in order to reduce risk and responsibility rather than on-site decision making. It is worth noting that ambulance services are incentivised to bring people to the ED rather than managing low risk patients in the community. If we are to reduce ED overload, the system needs a new model of care whereby front line paramedics are supported to either deal with low risk patients on location or transfer care to an appropriate community health service provider eg., local General Practitioner.

Patient transfer between hospital sites or other health service providers is another key service provided by ambulance services. While there has been positive feedback in the routine booking of ambulances through Wilson for patient transport, challenges often occur with all service providers regarding out of hours and/or formed mental health patients transfers.

Of recent times, a SJA Hospital Liaison Manager (HLM) positions have also been assigned to support EMHS hospital sites. Further shaping and integration would help to fully optimise this important role. The critical success factors include:

- Strong and good relationship with site staff (ED, flow & management);
- Senior HLM staff support for emergency demand coordination at sites – i.e. the role should be part of the site team and active in site decisions for management of emergency demand as well as in a position to influence SJA distribution;
- Consistent staffing to build team/ trust;
- Clear and consistent roles and responsibilities;
- Role integration with the site operations hub.

Finally, there is currently a lack of visibility and understanding of ambulance activity and key performance indicators (KPI). Data[1] visibility and sharing is one of greatest opportunities to drive continued improvement. Live dashboards would support load levelling and inbound visibility as well as a range of patient transport consideration including inter-hospital patient transfers.

Greater consistency and alignment of agreed KPIs would also assist in understanding and addressing improvements (eg., transfer priorities, referrals from SJA to community care providers etc). Similarly, it would be benefital to cross reference 'Transfer of

[1] raw data, calculations and KPIs

Care' times against the recorded time a patient is allocated a bed in the ED to assess the timeliness of SJA staff getting back on the road.

EMHS are aware that in the country, the model of either volunteers or a combination of volunteers and paramedics would seem to support service efficiencies with volunteers providing a service to their community and are supported by SJA.

Whether alternative service delivery models in other jurisdictions would better meet the needs of the community

There are a number of workforce reforms worthly of consideration including advanced scope paramedics to increase direct access to care in the community completely avoiding the ED.

Consideration should also be given to leveraging the SJA contract to drive diversion of patients away from ED, when safe and appropriate. Specifically, the EMHS Palliative Care/End of Life Implementation Plan outlines the opportunity to partner with SJA to provide paramedic palliative care services to support continuity of care plans. Alternative service delivery models identified include:

- An emergency medical service (community paramedic service) in the USA which partnered with a palliative care provider to establish a coordinated call response pathway for hospice patients. This service had the benefit of patient continuing of care in line with the hospice care plan resulting in maintenance of hospice status, reduced or avoided ED transportation, and reduced hospitalisation costs.
- Ambulance Service of NSW introduced the Authorised Care Plan Program for patients with a diagnosis of a life-limiting illness. In consultation with the patient and their family, the GP/treating clinician may elect to complete a NSW Ambulance Authorised Palliative Care Plan, which authorises paramedics to deliver treatment based on the individual's care plan. In the event of a Triple Zero (000) call-out by the patient, the plan may be initiated.
- The Extended Care Paramedic Program (South Australia) enables intensive care paramedics to play a more active role in the treatment of palliative patients in their place of residence, avoiding an ED presentation where possible.

The Danish model for non 000 ambulance transfers to hospital is another exemplar model, to be strongly considered in helping to manage demand in our hospitals.

https://sjtrem.biomedcentral.com/articles/10.1186/s13049-019-0676-5

Any other matters considered relevant by the Committee.

Within EMHS we have three EDs working with SJA to deliver emergency care to the community. Some initiatives currently underway and supported by EMHS include:

- Department of Health led project to provide greater medical support to paramedics on scene to reduce unnecessary transfer to emergency departments.
- Proposed SJA paramedic interface with planned ambulatory service creating a diversional pathways using telehealth clinical consultation and advice for hospital/ED avoidance and/or direct admission. This involves a partnerships

with Ambulance services to deliver supported care at the point of triage in the patient's home and transfer to Hospital in the Home (HITH) like services rather than requiring an ED visit/assessment.

- Ambulatory geriatric pathways collaborating with SJA to establish direct admission pathways to ambulatory services/ IP units.

Future service delivery models should consider:

- exploring sharing responsibility for demand management;
- ambulatory services and sites working together to promote ED diverstion and direct admission to the ward where appropriate;
- better coordinate all the different retrieval services around WA (RFDS, SJA, helicopters) and to look at a centralised coordination system rather than the piecemeal one that we have currently;
- a stronger partnership model between ambulance services and WA Health should be explored, or alternatively a solution realigned services within WA Health, rather than the current external model (contracted).

If you require any further information in relation to your request please don't hesitate to contact Susan Mylne, Director Clinical Service Planning

Yours sincerely

Liz MacLeod
Chief Executive
EAST METROPOLITIAN HEALTH SERVICE

22 July 2021