Inquiry into the delivery of ambulance services in Western Australia.

Submission by Geoffrey Pratt.

Introduction.

I make this submission to the Committee representing only myself and I do not purport to espouse the views of any other organisation, stakeholder or individual. I will address the Terms of Reference as they are laid down by calling on my own insights and providing general commentary.

I consider there to be no prerequisite qualifications that must be held to make such a submission other than to be a member of the community with an interest in the matter. I do not purport to be an expert on the topic of delivering a service in one of the largest ambulance jurisdictions on Earth, but the experience I do have is suitable to rest upon when making the statements herein and only these statements. The intent of my submission is not to present data or statistical analysis of the service that St John WA (SJWA) provide to the State; much of this information is already in the public domain and that which is not would certainly be made available to the Committee by the State at this point. This submission is therefore simply commentary on the questions at hand and my own perspective as a member of the community.

It must be noted that the terms of reference for this inquiry are brief, broad and provide little in the way of a clear target except for one organisation and only in generalities. The terms of reference typically make it clear what the purpose of the inquiry is and in doing so, lay expectations for how the Committee may best achieve that purpose. This could be interpreted by some as being either a feature or a bug – an intentional component of an inquiry designed to uphold the appearance of State concern without the promise of accountability, or the unintended consequence of an inquiry commenced in haste with poor regard for its measurable use. I sincerely hope that the inquiry yields salient and actionable learnings for the State and for SJWA. There remains a not insignificant risk of the inquiry being a mantlepiece for the State to portray its desire to understand the issue and be seen to hold its contract partner to account without endeavouring to yield the knowledge, context or the comprehension with which to effectively do so.

A) How 000 ambulance calls are received, assessed, prioritised and despatched in the metropolitan area and in the regions.

I make no submission with respects to Part A).

B) The efficiency and adequacy of the service delivery model of ambulance services in metropolitan and regional areas of Western Australia

Metropolitan services.

The efficiency measure most referenced in public discourse on ambulance services is that of utilisation. Recent history of excessive ramping hours at Perth hospitals are well publicised and data as it relates to the matter is presumably available to the Committee. While industry professionals with more nuanced and granular insight than my own make commentary on the matter, I will say that I believe this issue of ramping is not benefited by public requests for ambulance services for non-emergent purposes. The two arguments I will make with reference to this are that expansion of Urgent Care services in the metropolitan area may reduce this burden on Emergency Departments, and a more persistent public awareness campaign is required to better educate the public.

There are limited options available to the public outside of general business hours with which to address acute medical concerns that are not strictly an emergency. It should be of the utmost priority for the State to build on Urgent Care centre models and securely fund such an expansion long term as a service provided by Health and not the private sector. Such facilities should work as complimentary and parallel to hospitals and remain as much of a public sector endeavour as practicable. Further privatisation of healthcare delivery modes should be avoided.

I will concede that there have been some media advertisements pertaining to the GP Urgent Care model and these do encourage the use of these services, but like the GP Urgent Care pilot program these media ads are not enough, and they come far too late. There is poor health literacy in the community and the basic determination of whether an event requires an ambulance attendance and/or a hospital presentation is something which should be considered as a capacity building venture by State and an investment in its people. The diversion of patients from the ambulance service should also be considered and I will discuss that in part C) of this submission.

Regional Services.

The service delivery model in regional Western Australia is broken, grossly inefficient and unfairly inadequate. The trust that the wider community has in the organisation and the positive brand association that the people of WA have for SJWA works against this reality being more widely understood. It must be said that is not intrinsically bad – the people of WA trust St John to deliver a good, reliable service that will rise to the occasion in their time of need and this is a necessary requirement for a volunteer service, but it doesn't allow space for making a criticism of the status quo. To be clear, when I refer to the regional service or volunteer model I am referring to the practice of having 2 Volunteer Ambulance Officers (ideally 2x EMT but most often 1x EMA and 1x EMT) on a crew and not the hybrid crew of 1 Paramedic and 1 VAO that is seen in larger regional cities such as Kalgoorlie, Albany or Geraldton.

For most routine non-emergent calls or low acuity interhospital transfers, the regional volunteer model provides an adequate level of clinical capacity, but it cannot provide for a comparably capable level of patient care, relative to that provided to residents in Perth, in emergency or time critical situations by virtue of the significantly lower level of education or training. Rates of participation in the volunteer model are declining in many towns and I am yet to come across a subcentre whose members would claim that they have sufficient volunteers to meet the demands of the community. This is true of our other emergency services counterparts too; those of the VFRS, SES and bushfire brigades, though I am not aware of too many localities whose fire brigades or SES units are called upon more frequently than their ambulance service. The resultant outcome is that many subcentres are in dire need of new recruits but unable to seal the deal on many prospects.

Ambulance volunteering attracts a wide array of personalities of various levels of literacy and education. It can be said that whilst every ambulance volunteer means well and wishes to do their best, some are simply not capable of performing the duties of an EMT to the required standard and SJWA is loathed to downgrade these volunteers to the lesser EMA rank, or ever fail their training to upskill to EMT in the first place. Regardless of someone's actual clinical skill level or their suitability for the role, SJWA will never encourage someone to retire who may be at the point where it is time. Training officers are encouraged to continue to sign off volunteers as competent during their yearly skills maintenance assessments because the organisation is too desperate to honestly assess some of its members based on their merits. The overwhelming majority of St John volunteers are hardworking and do a great job, I am not stereotyping volunteers as incapable or uneducated and they do not deserve to have their reputation and goodwill marred. But that should not detract from

a hard conversation that must be had about striking the balance between turning out a crew and ensuring that that crew is sufficiently competent. Is it better to persist with the illusion that the entirety of the service is operating at the same capacity, or would our communities be better served by having a realistic expectation of what is available to them when they are faced with an emergency?

Patients in the country are still furnished with an invoice worth many hundreds of dollars for their ambulance attendance, just as they would if they were calling 000 from the city, yet even with the most capable volunteer crew, they are not afforded the same level of assessment or care that they would receive if a qualified and experienced Paramedic were to attend. It is discriminatory to charge regional patients so highly for a service that they cannot receive simply because they choose not to reside in the city or a populous regional centre. The most common complaint is that the analgesia which may be administered by a volunteer EMT can be insufficient to address the pain some patients may be in. It is true that pain is not life threatening and not the most critical intervention offered by Ambulance Officers, yet if I were a patient who was presented with just paracetamol or methoxyflurane and I paid a bill comparable to a patient in the city who may have had fentanyl or ketamine available to them by a Paramedic crew then I may be inclined to think I was being ripped off. If SJWA are going to charge a “fee for service” then that fee must represent the service available to the customer more fairly.

This billing arrangement is a necessity, though, of the glorified franchise financial arrangement – many members of the community are shocked to learn that their local volunteer subcentre is financially independent and still forced to fundraise locally or “shake the tin” just to pay for a new ambulance vehicle or continue to stock it with consumables and lifesaving equipment. This shock is justified – the organisation must not rely on volunteers to concern themselves with, and in many cases take on an emotional burden of worrying about, the finances of the service with which they are already supporting in kind. This should be undertaken in a central capacity and would reduce the inequality that results – many subcentres in the southern parts of the state continue to maintain exorbitant bank balances while others are unable to purchase new cardiac monitors for themselves. There are some programs in place across SJWA to share these funds in a somewhat equitable manner (such as Looking Forward, Giving Back) but they vary from region to region and are not a far enough reach to ensure true financial equity across the state.

During the ongoing rollout of the Corpuls cardiac monitor there are many examples of subcentres who were unable to afford the tens of thousands of dollars for a monitor/defibrillator who are instead reliant on requesting additional funding from neighbouring subcentres, or regional funding pools entered into by an aggregation of subcentres. If SJWA are going to mandate compulsory equipment then it should not be subject to a special consideration by each subcentre or region, it should just be a given that any ambulance on the road will be kitted out with the requisite equipment without it being something that the volunteers should have to concern themselves with the budgetary requirements of. The principal matter of concern is that the State do not provide sufficient funding for this, though, and SJWA subcentres are reliant on the fee-for-service provision in the SJWA/State agreement to collect funds with which to purchase ambulances and equipment.

A persistent concern that should be apparent to the State is the frequency with which SJWA are unable to provide a crew for a 000 call in the community and patients are left to attend to themselves, find their own way to definitive care or to simply not receive healthcare because they are unable to make their own way to a hospital. This is referred to as knocking back a job or not turning a crew out. I am of the anecdotal understanding that instances of this are increasing but it is perplexing that, when put to SJWA, they are not able to confirm or deny such an assertion as they do

not collect data on the issue. If you were to ask SJWA, for example, how many Priority 1 calls or interhospital transfers any given sub centre were tasked with in any given timeframe, this would be a simple enquiry and the data would be readily available in a matter of minutes. But SJWA cannot provide data as to the occurrences of a "no crew" response or knocking back a job as it does not collect it and is not minded to begin doing so. I view this next scenario as unlikely, but in the event that I am wrong and they are in fact collecting this data, they are not sharing it with members of the organisation who ask for it and I am unable to convince myself that this would be an acceptable alternative.

To my mind, that should be an important statistic that a contract manager, such as the Department of Health, must apprise themselves of. My personal background is in engineering and often in roles where I acted a direct report for contracting firms – were any contractor that I was engaged with ever be unable to commence the most basic function that they were tasked with, in this case turning out an ambulance to attend a 000 call, that would be information that I would consider desirable. Advising the state proactively of how many jobs they are turning down would be against the commercial interests of SJWA and this behaviour is unfortunately to be expected of any business which is protecting its funding stream. It is inadequate that the data is not collected but simply untenable that the State have not considered it an important enough metric to require of their contract partner.

St John WA recently undertook a comprehensive review of the adequacy and efficacy of its Community Paramedic role in the country, and the Country Ambulance service more broadly. I would like to pass comment on the outcomes of this report but I am presently unable to. It was sufficiently important enough that a staff member was seconded purely to undertake the project and it incorporated investigation and wide-ranging feedback from stakeholders within the organisation state-wide. Despite assurances to the contrary in the beginning, the report was never widely disseminated within the organisation and those who made time to provide feedback to the project were never provided with any detail as to what was learnt or how the organisation will use its learnings to improve the role. It is generally understood that the report likely provided a harsh review of the position that SJWA finds themselves in with respects to the Community Paramedic role and the wider country model. I have of course not seen the report, but this presumption would seem likely – I imagine that if the report uncovered a highly functional regional model bolstered by the CP position then the organisation would have been eager to share it.

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

I have been largely critical of SJWA until now, but the question of whether an alternative service delivery model would better meet the needs of the community speaks to a key issue in the context of regional ambulance service adequacy: A State that has been, until maybe now during this inquiry, devoid of clear motivation to seek a more adequate service. The WA Country Health Service (WACHS) largely demand a business-as-usual approach from SJWA and from my position, they do not seem to want to change the present volunteer model in any meaningful way. That may change after this inquiry, and I hope that it does, though I do not remain optimistic as it is not just the ambulance service which needs to change for it to improve.

I make note of the recent increases to funding Health/WACHS provide for Community Paramedic (CP) positions with SJWA and that this will result in extra CP's being deployed top the regions. It remains unclear what this is intended to achieve and how having extra CP's will achieve that. The Community Paramedic role is intended to be that of training and support for the volunteers, not a

24/7 on call resource. Increasing the presence of the CP role will be advantageous to those currently in these positions to relieve some of the stress that can be associated with the role and allow them to "switch off" from work matters more often but it will not address the key concern that it is stated to, principally to increase reliability of service delivery. The CP role is expensive – as a secondment position they are required to provide housing at great expense, and they are paid a higher salary than many conventional Ambulance Paramedic (AP) positions. They have their own dedicated vehicle, which cannot transport a patient, and require costly infrastructure such as medication safes at locations they do not regularly work out of.

I welcome the recent small funding boost to the CP program, but instead of funding more CP's the State would better service the goal of service reliability by investigating innovative ambulance service models such as that of the paid EMT and to ensure that the wraparound services such as primary care physicians, hospitals and nursing posts are sufficiently staffed. There is little to no point having more ambulance staff in regions to boost coverage to 24/7 levels if there are no facilities to deliver patients to at night. If an ambulance service must run at night, then it is crucial that their accompanying Nursing Post or Hospital services will accept their patients at those hours as well. At present, volunteers in day shift only Nursing Post towns are forced to undertook long and arduous transports to adjacent towns with a hospital on highways or roads known to be dangerous at night, when the risk of an animal strike or fatigue related incident is much higher. Many volunteers work during the day and undertaking a 400km return journey in the middle of the night because WACHS don't sufficiently staff a nursing post is the State relying on the altruism of the community to make up for their critical staffing shortfall.

There have been numerous suggestions for a paid EMT model within SJWA in recent years and they will never progress without support from the State. This is the great opportunity of this review and the big positive message of my submission – to highlight that there is space to do something new with regional ambulance services and to start delivering a truly adequate service in the future.

We do not simply have to have three options – Fully paramedic, Hybrid Paramedic/Volunteer or Volunteer/Volunteer crews. Were the State and SJWA to devote genuine efforts to scoping and designing a paid EMT model they would be able to determine that some locations would benefit from this greatly. Having a new hybrid of a paid EMT in some subcentres to operate as a training officer, a Station Manager, a storeperson and ultimately someone that is employed to deliver a high-quality ambulance service at an EMT scope on an on-call basis. Having these people as a paid staff member means that SJWA can expect, and receive, an ongoing commitment to clinical best practice (within that scope) and to facilitate that with block intensive clinical experience in busier locations to maintain skills. It is not unreasonable to expect that you could potentially employ 2x EMT's for the price of 1 CP and there is indeed a pool of capable volunteers ready to step into that role.

Relying wholly on either volunteers or career Paramedic level staff has gotten a lot for WA – SJWA and its staff and volunteers have contributed greatly. But that will not be sufficient in the future and that is why I believe that WA and SJWA need to take this opportunity to sincerely look for alternative country ambulance models.

D) Any other matters considered relevant by the Committee.

I am available and willing to discuss my submission further with the Committee or SJWA. My contact details are provided in this submission for the Committee and I am presently readily reachable by SJWA.

Thank you for the opportunity to make this submission.

Geoffrey Pratt