LEGISLATIVE COUNCIL WESTERN AUSTRALIA

## Report 37

# STANDING COMMITTEE ON PUBLIC ADMINISTRATION

*Delivery of Ambulance Services in Western Australia: Critical Condition*

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Presented by
Hon Pierre Yang MLC (Chair)

May 2022

## Standing Committee on Public Administration

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## Government response

This report is subject to Standing Order 191(1):

> Where a report recommends action by, or seeks a response from, the Government, the responsible Minister or Leader of the House shall provide its response to the Council within not more than two months or at the earliest opportunity after that time if the Council is adjourned or in recess.

The two month period commences on the date of tabling.

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# EXECUTIVE SUMMARY

1 On 17 June 2021 the Standing Committee on Public Administration (Committee) commenced an inquiry into the delivery of ambulance services in Western Australia.

2 The Committee's key findings and recommendations are summarised below.

**Adequacy of emergency ambulance service delivery model in metropolitan Perth**

3 The inquiry has revealed the emergency ambulance service in metropolitan Perth is under significant strain. In 2020/21 St John Ambulance WA was unable to achieve its key performance indicators (KPI) for:

- answering 90 per cent of calls with 10 seconds
- responding to 90 per cent of priority 1 calls within 15 minutes
- responding to 90 per cent of priority 2 calls within 25 minutes
- responding to 90 per cent of priority 3 calls within 60 minutes.

4 The Committee also found ambulance stand–by capacity is currently approximately 30 per cent — well below previously recommended levels.

5 The Committee has recommended the following changes to address these issues:

- The Department of Health review the adequacy of the staffing levels from the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* in 2010, establish minimum staffing levels for the St John Ambulance WA State Operations Centre (with particular emphasis on 000 emergency call takers) and introduce a mechanism to allow the monitoring and reporting of actual staff on shift against contractual KPIs. When determining staffing levels, the Department of Health also consider requiring a demand based rostering system.
- The State Government investigate whether the answering and dispatch of 000 calls by the Department of Health would improve patient outcomes.
- The Department of Health require all emergency ambulance services to maintain minimum levels of ambulance stand–by capacity.

**Adequacy of patient transfer service delivery model in metropolitan Perth**

6 The Committee found the emergency ambulance service and non–emergency ambulance service are not being operated separately as intended. Emergency resources are currently being used to deliver non–emergency patient transfer services outside the hours of operation of the patient transfer service (1am–6am). This diminishes emergency capacity.

7 The Committee heard inter–hospital patient transfers are poorly coordinated on a 'piecemeal basis'. The Committee has recommended the Department of Health establish a centralised coordination centre to organise inter–hospital transfers in metropolitan and regional Western Australia.

**Adequacy of emergency service delivery model in regional areas**

8 In relation to the delivery of ambulance services in regional areas the Committee found:

- regional communities do not have guaranteed access to ambulances services
- 98.5 per cent of the geographic area of the state is not subject to target ambulance response times

- the majority of ambulance services in regional areas are performed by volunteers
- continued reliance on volunteers to perform ambulance services in regional areas is not sustainable.

9 The Committee has recommended the Department of Health investigate extending the current ambulance service delivery model in regional areas with a hybrid model where appropriate.

**Adequacy of patient transfer service delivery model in regional areas**

10 The Committee heard St John Ambulance WA has a right of first refusal for patient transfer services in regional areas. The Committee recommends this be removed to promote competition between alternate providers to perform this work and improve the efficiency of service delivery.

**Workplace and organisational culture**

11 The Committee found workplace culture is an issue at St John Ambulance WA. The Committee has recommended the Department of Health require St John Ambulance WA to comprehensively re–evaluate their organisational and workplace structure and processes.

**Aboriginal and remote communities**

12 The Committee found Western Australia's largest remote Aboriginal community, Bidyadanga regional community does not have guaranteed access to emergency ambulance transport through St John Ambulance WA. The Committee has recommended:

- The Department of Health develop a strategy to ensure a reliable ambulance service is available in Bidyadanaga regional community.
- The Department of Health and the WA Country Health Service (WACHS) identify remote Aboriginal communities which do not have access to an ambulance service and investigate the adequacy of existing emergency ambulance services. The Department of Health develop strategies to enhance access to ambulance services to any communities identified.

**Ambulance service delivery models and related issues**

13 The Committee has made a number of recommendations that aim to address the issues identified above. The State Government should review the implementation of these recommendations within the next five years and consider alternative emergency ambulance service providers or a state–run service if service delivery does not improve.

## Findings and recommendations

**Findings and recommendations are grouped as they appear in the text at the page number indicated:**

**RECOMMENDATION 1** Page 14

The Department of Health establish new key performance indicators for emergency ambulance services that measure patient outcomes and clinical compliance.

**RECOMMENDATION 2** Page 15

The Government and St John Ambulance WA provide a full subsidy on emergency ambulance fees for holders of current pensioner concession cards who are under the age of 65.

**FINDING 1** Page 31

St John Ambulance WA has been unable to achieve their contractual requirement to answer 90 per cent of calls within 10 seconds since 2018/19.

**FINDING 2** Page 31

In 2020/21 Western Australia had the poorest performance of all jurisdictions in Australia against the key performance indicator to answer 90 per cent of calls within 10 seconds.

**FINDING 3** Page 32

Between January 2020 and September 2021:

- the majority of 000 ambulance calls were answered by the St John Ambulance WA State Operations Centre within 5 seconds
- the number of calls answered after 60 seconds rose above 10 per cent of total calls between March and June 2021.

**FINDING 4** Page 34

The number of calls to the St John Ambulance WA State Operations Centre has increased 22 per cent between 2016/17 and 2020/21.

**FINDING 5** Page 39

From a snapshot of data provided, St John Ambulance WA have not complied with their commitment in the 2010 *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* to maintain the following number of communications officers per shift:

- 15 Communications Officers between 7am and 7pm
- 13 Communications Officers between 7pm and 1am
- 12 Communications Officers between 1am and 7am.

**FINDING 6** Page 39

St John Ambulance WA has not been rostering sufficient communications officers in the St John Ambulance WA State Operations Centre to meet their contractual requirement to answer 90 per cent of calls within 10 seconds since 2018/19.

**FINDING 7** Page 40

The number of call takers per capita in Western Australia has almost doubled since the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* in 2010. Despite this, the number of call takers per capita in Western Australia has consistently remained the second lowest in Australia and is below the national average.

**RECOMMENDATION 3** Page 41

The Department of Health review the adequacy of the staffing levels from the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* in 2010, establish key performance indicators (KPIs) for minimum staffing levels at the St John Ambulance WA State Operations Centre (with particular emphasis on 000 emergency call takers) and introduce a mechanism to allow the monitoring and reporting of actual staff on shift against contractual KPIs. When determining staffing levels, the Department of Health also consider requiring a demand based rostering system.

**FINDING 8** Page 44

St John Ambulance WA implemented structured call taking software called ProQA as a result of the *St John Ambulance Inquiry: Report to the Minister for Health* prepared by Greg Joyce in 2009.

**FINDING 9** Page 48

ProQA is a risk–averse system that tends to over–prioritise calls. Approximately 25 per cent of patients categorised as priority 1 actually require urgent treatment. This over–prioritisation can increase wait times for patients who have a time critical condition.

**FINDING 10** Page 49

There is not unanimous agreement among health professionals regarding flexibility in the structured call taking process.

**FINDING 11** Page 50

St John Ambulance WA are required to conduct a quality audit of two per cent of calls to the St John Ambulance WA State Operations Centre each year. The auditing process is a quality assurance function which checks for strict compliance with the ProQA structured call taking process.

**FINDING 12** Page 50

The auditing of call taker performance is performed by St John Ambulance WA staff external to the State Operations Centre. These auditors are qualified as Emergency Medical Dispatchers and separately qualified in the audit process but are not experienced call takers.

**RECOMMENDATION 4** Page 50

The Department of Health require auditing of ProQA be conducted with patient outcomes considered. These audits should involve experienced call takers.

**RECOMMENDATION 5** Page 53

The Department of Health conduct a review of priority codes, acuity filters, urgency codes and final patient outcomes to identify over–prioritisation of 000 calls by ProQA.

**FINDING 13** Page 54

The Department of Health is developing a system to feedback patient outcomes to St John Ambulance WA. This will enable better analysis and assessment of the ambulance service.

**RECOMMENDATION 6** Page 54

The Department of Health prioritise the development of a system to feedback patient outcomes to St John Ambulance WA.

**FINDING 14** Page 57

The Committee received conflicting evidence on whether emergency call takers at the St John Ambulance WA State Operations Centre are able to record a call as being cancelled due to lack of available resources.

**FINDING 15** Page 57

St John Ambulance WA recently developed a live dashboard to share information about emergency ambulance movements with health service providers.

**FINDING 16** Page 59

The Queensland Ambulance Service displays the location of available ambulances on their website.

**RECOMMENDATION 7** Page 59

The Department of Health and St John Ambulance WA investigate publishing emergency ambulance vehicle availability online in a similar fashion to the Queensland Ambulance Service.

**FINDING 17** Page 59

The Department of Health has proposed establishing a State–run Health Coordination Centre staffed by representatives from health service providers and ambulance providers. The proposed Centre could improve information sharing about patients and ambulance availability, leading to improved outcomes for patients.

**RECOMMENDATION 8** Page 60

The State Government investigate whether the answering and dispatch of 000 calls by the Department of Health would improve patient outcomes.

**RECOMMENDATION 9** Page 63

The Department of Health establish a centralised coordination centre to organise inter–hospital transfers in metropolitan and regional Western Australia.

**FINDING 18** Page 65

Non–emergency patient transfers are contracted separately from emergency ambulance services. Despite this, emergency ambulance resources are used to conduct inter–hospital patient transfer services.

**FINDING 19** Page 66

When volunteers perform inter–hospital patient transfers in regional areas the local capacity to respond to emergencies may be diminished.

**RECOMMENDATION 10** Page 68

The Department of Health expand the operational hours of inter–hospital patient transfers to allow all service providers to perform this service 24 hours a day.

**RECOMMENDATION 11** Page 69

The Department of Health remove St John Ambulance WA's right of first refusal for regional inter–hospital patient transfers.

**FINDING 20** Page 69

There are benefits in allowing volunteers to perform inter–hospital transfers. These include:

- sub–centres improving their facilities and equipment from the income they generate
- volunteers having an opportunity to undergo training and maintain their skills.

**FINDING 21** Page 70

Performing inter–hospital patient transfers in regional areas can be time consuming leading to volunteer fatigue and contributing to a diminished emergency response capability.

**FINDING 22** Page 74

The emergency ambulance service in Western Australia has the highest proportion of non–operational personnel in Australia. The proportion of non–operational personnel in Western Australia is almost three times higher than the national average.

**FINDING 23** Page 78

St John Ambulance WA did not meet their target response times for priority 1, 2 or 3 calls in 2020/21.

**RECOMMENDATION 12** Page 78

The Department of Health table the number of priority 1, 2 and 3 calls which did not meet target response times, and by how much, in Parliament on an annual basis.

**FINDING 24** Page 80

The ambulance service in Western Australia records ambulance response times from the moment an ambulance is dispatched. The ambulance services in the Australian Capital Territory, Victoria, South Australia Tasmania and England record response times from the moment a 000 call is received by the ambulance service.

**RECOMMENDATION 13** Page 80

The Department of Health require ambulance response times in Western Australia to be recorded from the moment a 000 call is received by the ambulance service.

**FINDING 25** Page 81

Ambulance ramping is experienced in every jurisdiction in Australia.

**FINDING 26** Page 81

Ramping hours at Perth metropolitan hospitals more than doubled between 2019/20 and 2020/21.

**FINDING 27** Page 82

There is an inverse correlation between fluctuations in ramping hours and St John Ambulance WA's ability to achieve their target response times for priority 1 and 2 cases.

**FINDING 28** Page 82

The extended transfer of care payment provision in the Emergency Ambulance Services Agreement is a potential financial incentive that results in increased ramping.

**RECOMMENDATION 14** Page 82

The Department of Health conduct a complete review of the Extended Transfer of Care payment provision in the Emergency Ambulance Services Agreement.

**FINDING 29** Page 83

Emergency on–demand calls to St John Ambulance WA are at record levels.

**FINDING 30** Page 84

The Department of Health is currently experiencing an unprecedented number of patients presenting to hospital emergency departments with complex illness.

**FINDING 31** Page 84

There is uncertainty between St John Ambulance WA management and frontline paramedics about the circumstances in which paramedics can exercise their discretion to refuse to transport patients. This uncertainty may contribute to ramping.

**RECOMMENDATION 15** Page 85

The Department of Health work with St John Ambulance WA to develop guidelines to support paramedics exercising their discretion in circumstances where they deem transport unnecessary.

**FINDING 32** Page 86

The current levels of ambulance ramping in Western Australia are a symptom of a complex set of factors. Factors contributing to ramping may include:

- an increase in demand for ambulances
- unnecessary transport to hospital emergency department
- the number of patients presenting to hospital
- hospital capacity
- elective surgery
- long–stay patients occupying hospital beds.

**FINDING 33** Page 87

The Department of Health anticipates an additional 602 hospital beds will become available by August 2022. However, this will depend on their ability to recruit staff.

**FINDING 34** Page 90

Ambulance stand–by capacity ranged between 23.5 per cent and 33.5 per cent between November 2020 and September 2021.

**FINDING 35** Page 91

The Emergency Ambulance Services Agreement provides funding for ambulance stand–by capacity of 45.7 per cent. Despite this, the Agreement does not require St John Ambulance WA to maintain a minimum level of stand–by capacity.

**FINDING 36** Page 91

Low stand–by capacity is a factor that contributes to St John Ambulance WA's inability to meet target response times.

**RECOMMENDATION 16** Page 92

The Department of Health require all emergency ambulance services to maintain minimum levels of ambulance stand–by capacity.

**FINDING 37** Page 93

Alternate care pathways to divert patients away from hospital emergency departments can help to reduce ramping and increase the availability of emergency ambulances.

**RECOMMENDATION 17** Page 95

The Department of Health upscale the Fiona Stanley Hospital's Virtual Emergency Medicine program to other hospitals in Western Australia.

**RECOMMENDATION 18** Page 95

The Department of Health investigate the expansion of alternate care pathways in conjunction with St John Ambulance WA and other healthcare providers.

**FINDING 38** Page 100

Since 2015/16 Western Australia has had the worst paramedic witnessed cardiac arrest survival rate in Australia.

**RECOMMENDATION 19** Page 100

The Department of Health investigate cardiac arrest survival rates in Western Australia with a view to improving survival rates to, or above, the national average.

**FINDING 39** Page 101

The Corruption and Crime Commission and the Office of the Information Commissioner have jurisdiction over the public sector in Western Australia. These organisations do not have jurisdiction over St John Ambulance WA.

**FINDING 40** Page 109

Despite the 2009 report *St John Ambulance Inquiry: Report to the Minister for Health* (Joyce Report) identifying clinical governance issues in respect of an independent sentinel reporting mechanism and audit, there is no process to address these issues.

**FINDING 41** Page 109

There are claims that not all Severity Assessment Code 1 events are reported and some Severity Assessment Code 1 clinical incidents were classified as Severity Assessment Code 2.

**RECOMMENDATION 21** Page 109

The Department of Health require an independent body to review all potential Severity Assessment Code clinical incidents involving ambulance service providers in Western Australia.

**RECOMMENDATION 22** Page 109

The Office of the Auditor General regularly audit the works of the independent body responsible for reviewing all potential Severity Assessment Code clinical incidents involving ambulance service providers in Western Australia. The Office of the Auditor General table the results of the audit in Parliament on an annual basis.

**FINDING 42** Page 111

While the current emergency ambulance service delivery model in metropolitan Perth is arguably cost efficient, there are questions about its adequacy and other aspects of efficiency.

**FINDING 43** Page 118

Regional sub–centres run entirely by volunteers are not required to comply with target response times. This means 98.5 per cent of the geographic area of Western Australia has no contractual target ambulance response times.

**RECOMMENDATION 23** Page 118

The Department of Health establish key performance indicators for regional ambulance dispatch times and regional ambulance response times and require ambulance service providers to meet these indicators.

**RECOMMENDATION 24** Page 118

The Department of Health table the number of calls which did not meet the target ambulance dispatch and response times and by how much in regional Western Australia in Parliament on an annual basis.

**RECOMMENDATION 25** Page 118

The Department of Health require daily regional ambulance response times to be published online.

**FINDING 44** Page 121

Regional sub–centres are experiencing an upward trend in demand for ambulance services. In 2020/21, 73 946 calls were responded to. This represents a 22 per cent increase since 2016/17. This is higher than the demand increase in the metropolitan area over the same period.

**FINDING 45** Page 121

The Emergency Ambulance Services Agreement only requires St John Ambulance WA to use their best endeavours to provide an ambulance service in regional areas. This does not guarantee regional communities have access to ambulances services.

**FINDING 46** Page 123

The best endeavours model of delivering ambulance services is inconsistent with Department of Health policy titled: *Ambulance services Western Australia—a framework for statewide ambulance services operations*.

**RECOMMENDATION 26** Page 123

The Department of Health ensure the provision of ambulance services in regional Western Australia is consistent with *Ambulance services Western Australia—a framework for statewide ambulance services operations* with regard to reducing inequity between metropolitan and regional Western Australia.

**FINDING 47** Page 124

The Emergency Ambulance Services Agreement contains a model which determines if career paramedics should be allocated to a regional sub–centre based on the number of calls a sub–centre responds to in the previous year. This model is not satisfactory and does not recognise the specific healthcare needs of individual communities.

**RECOMMENDATION 27** Page 124

The Department of Health implement a policy to guide the establishment of regional career paramedic sub–centres. This policy is to include a methodology based on the specific healthcare needs of individual communities.

**FINDING 48** Page 125

Neither the Department of Health nor WACHS have real–time visibility about whether a regional ambulance sub–centre is able to provide a response at any point in time.

**FINDING 49** Page 128

There is insufficient information with regard to a regional sub–centre's ability to respond to calls. The current system leaves stakeholders unaware whether a sub–centre can or cannot mount a response at any point in time.

**FINDING 50** Page 129

Unlike metropolitan ambulance depots, regional sub–centres that are entirely run by volunteers are required to manage their own finances. This means they are able to keep any income generated from ambulance services they provide. However, they are also responsible for any expenses they incur in providing these services.

**FINDING 51** Page 129

Volunteer–run regional sub–centres are required to absorb their bad debts.

**RECOMMENDATION 28** Page 131

The State Government investigate ways to provide volunteers with opportunities to access specific identified career pathways via TAFE or similar providers. For example, an accredited Certificate IV in nursing or paramedicine.

**FINDING 52** Page 132

Community Paramedics regularly respond to calls for ambulance services despite this not being a requirement of their job.

**FINDING 53** Page 133

Community Paramedics would be better utilised in responding to emergency ambulance calls.

**RECOMMENDATION 29** Page 133

The Department of Health and St John Ambulance WA require paramedics deployed to regional areas to respond to emergency ambulance calls.

**RECOMMENDATION 30** Page 134

The Department of Health and St John Ambulance WA investigate engaging dedicated trainers to provide scheduled training for volunteers in regional areas to free–up Community Paramedics.

**RECOMMENDATION 31** Page 135

Given the challenging nature of the work that paramedics do, the Department of Health require ambulance service providers to implement specific programs to support the welfare of emergency paramedics and mitigate their risk of psychological harm.

**FINDING 54** Page 135

There is no association for ambulance volunteers in Western Australia equivalent to the Association of Volunteer Bush Fire Brigades (WA) Inc.

**FINDING 55** Page 138

The majority of ambulance services in regional areas are performed by volunteers while those in metropolitan Perth are entirely performed by career paramedics.

**FINDING 56** Page 138

Continued reliance on volunteers to perform the majority of ambulance services in regional Western Australia is not sustainable.

**RECOMMENDATION 32** Page 138

The Department of Health investigate extending the current ambulance service delivery model in regional areas with a hybrid model where appropriate.

**FINDING 57** Page 140

There is a lack of trust from frontline staff in senior management at St John Ambulance WA.

**RECOMMENDATION 33** Page 141

The Department of Health require ambulance service providers to undertake regular employee culture surveys and utilise the resulting data to adopt strategies to improve organisational and workplace culture.

**FINDING 58** Page 142

The results of the 2021 Ambulance Employees Association of WA survey results indicate employees lack trust in senior management.

**RECOMMENDATION 34** Page 144

The Department of Health develop workplace culture key performance indicators for ambulance service providers that involve undertaking regular audits of programs designed to improve workplace and organisational culture. The Department of Health table the results of audits in Parliament annually.

**FINDING 59** Page 145

The Committee heard evidence from numerous St John Ambulance WA employees who were concerned about being identified by their evidence due to the potential impact on their career.

**FINDING 60** Page 148

The evidence suggests cultural issues at St John Ambulance WA extends to serious matters such as harassment and bullying and the current processes do not adequately address these matters.

**FINDING 61** Page 149

A number of recent inquiries have considered workplace culture at St John Ambulance WA including:

- *St John Ambulance Inquiry: Report to the Minister for Health* (2009)
- *St John Ambulance Review of Workplace Mental Health Risks* (2016)
- *Review of St John Ambulance: Health and Wellbeing, and Workplace Culture* (2016).

Despite this, there continues to be unresolved issues concerning workplace and organisational culture at St John Ambulance WA.

**RECOMMENDATION 35** Page 149

The Department of Health require St John Ambulance WA to comprehensively re-evaluate their organisational and workplace structure and processes.

**RECOMMENDATION 36** Page 149

The Department of Health require St John Ambulance WA to comply with key performance indicators that measure and map workplace and organisational culture. This requires the identification and implementation of improvement opportunities.

**FINDING 62** Page 152

Patients who are airlifted from a location that is not a defined hospital (i.e. Aboriginal Medical service, pastoral station, mining camp, town/settlement with no designated hospital) may incur a fee for ambulance transport from the airport to a metropolitan hospital. Patients who are airlifted from a hospital are not charged a fee for ambulance transport from the airport to a metropolitan hospital.

**RECOMMENDATION 37** Page 152

The Department of Health cover the cost of ambulance transport from Jandakot Airport to hospital for patients who are airlifted to Perth.

**FINDING 63** Page 154

Patients are charged ambulance fees to be transported from Aboriginal Community Controlled Health Service clinics to hospital.

**RECOMMENDATION 38** Page 154

The Department of Health cover the cost of ambulance transport from Aboriginal Community Controlled Health Service clinics to hospital.

**FINDING 64** Page 155

Aboriginal and Torres Strait Islander people will be eligible for ambulance service concession from 55 years of age under the new Emergency Ambulance Services Agreement.

**FINDING 65** Page 156

Western Australia's largest remote Aboriginal community, Bidyadanga regional community does not have guaranteed access to emergency ambulance transport through St John Ambulance WA.

**RECOMMENDATION 39** Page 156

The Department of Health develop a strategy to ensure a reliable ambulance service is available in Bidyadanaga regional community.

**RECOMMENDATION 40** Page 156

The Department of Health and the WA Country Health Service identify remote Aboriginal communities which do not have access to an ambulance service and investigate the adequacy of existing emergency ambulance services. The Department of Health develop strategies to enhance access to ambulance services to any communities identified.

**FINDING 66** Page 157

St John Ambulance WA has not completed a Reconciliation Action Plan.

**FINDING 67** Page 157

St John Ambulance WA have committed to progress its Reconciliation Action Plan and to further develop diversity and inclusion strategies.

**RECOMMENDATION 41** Page 157

The Department of Health require ambulance service providers to develop a Reconciliation Action Plan before the commencement of any future service agreements.

**RECOMMENDATION 42** Page 157

The Department of Health require St John Ambulance WA to provide all staff with regular cultural awareness training.

**FINDING 68** Page 162

Western Australia is one of two jurisdictions in Australia where the delivery of ambulance services is not governed by legislation.

**RECOMMENDATION 43** Page 163

The State Government investigate:

- introducing legislation to govern ambulance services in Western Australia; or
- implementing a comprehensive policy for ambulance services.

**FINDING 69** Page 165

St John Ambulance WA provides subscriptions for comprehensive ambulance cover in regional Western Australia. These subscriptions are not available in metropolitan Perth.

**RECOMMENDATION 44** Page 165

The Department of Health and St John Ambulance WA investigate expanding the availability of subscriptions for comprehensive ambulance cover to people living in metropolitan Perth.

**FINDING 70** Page 167

In 2010 the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* noted the establishment of the WA Ambulance Standing Committee to set the strategic direction and priorities for the provision of ambulance services. The Committee has since been abandoned.

**RECOMMENDATION 45** Page 167

The State Government and Parliament of Western Australia require an existing parliamentary standing committee be given additional functions to regularly monitor, review and report on the provision of emergency ambulance services. Alternatively a new standing committee be established and given such functions.

**FINDING 71** Page 168

The Department of Health believe a five year term for the next Emergency Ambulance Services Agreement is most beneficial. St John Ambulance WA prefer a 10 year term with two five year options.

**FINDING 72** Page 170

As a not-for-profit St John Ambulance WA has exemptions and concessions from paying Fringe Benefit Tax, Goods and Services Tax and Income Tax. This gives St John Ambulance WA a competitive advantage against other ambulance service providers.

**FINDING 73** Page 170

There is no requirement in the Emergency Ambulance Services Agreement for St John Ambulance WA to reinvest any surplus back into the services and infrastructure for ambulances in Western Australia.

**RECOMMENDATION 46** Page 170

The Department of Health and St John Ambulance WA consider a mechanism in the Emergency Ambulance Services Agreement for an investment plan. This plan should consider reinvestment and oversight of any surplus from government funded activities back into the delivery of emergency ambulances services in Western Australia.

**FINDING 74** Page 171

There is a case to bring the ambulance service into public hands however a private provider may deliver essential government services, so long as it provides the services to a similar or higher standard as would a public entity. Private providers of essential public services must be subject to the same oversight and scrutiny as a public body.

**RECOMMENDATION 47** Page 172

The State Government review the implementation of any recommendations it adopts from this report within the next five years.

**RECOMMENDATION 48** Page 172

The Department of Health develop broader key performance indicators (KPIs) that incorporate the recommendations of this report. If the service fails to meet these KPIs, the State Government should consider alternative emergency ambulance service providers or a state–run service.

# CHAPTER 1
# Introduction

## Commencement of this inquiry

1.1 On 17 June 2021 the Standing Committee on Public Administration (Committee) commenced an inquiry into the delivery of ambulance services in Western Australia. The inquiry's terms of reference are as follows:

> a) how 000 ambulance calls are received, assessed, prioritised and despatched in the metropolitan area and in the regions
>
> b) the efficiency and adequacy of the service delivery model of ambulance services in metropolitan and regional areas of Western Australia
>
> c) whether alternative service delivery models in other jurisdictions would better meet the needs of the community
>
> d) any other matters considered relevant by the Committee.[1]

1.2 On 5 April 2020 the Government of Western Australia implemented a hard border closure on the State of Western Australia to protect the community from the COVID–19 pandemic.[2] The border was re–opened during the course of this inquiry on 3 March 2022. The Committee has not assessed the impact of the border re–opening on the delivery of ambulance services given the limited time between the announcement and the tabling of this report.

1.3 At the time of finalising this report, the Committee notes two recent adverse outcomes involving St John Ambulance WA in April 2022.[3] The Committee extends its condolences to the families of the patients concerned and to all families who have suffered loss.

## Structure of this report

1.4 In order to address the four terms of reference, the report is structured in the following way:

- Chapter 2 provides an explanation of the contracts governing ambulance services in Western Australia
- Chapter 3 considers how emergency calls are received, assessed, prioritised and dispatched
- Chapter 4 considers how non–emergency inter–hospital patient transfers are received and dispatched
- Chapter 5 considers the efficiency and adequacy of the service delivery model of ambulance services in metropolitan Perth

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1 Western Australia, Legislative Council, Standing Committee on Public Administration, report 36, *Terms of Reference: Inquiry into the delivery of ambulance services in Western Australia*, 22 June 2021, p 1.

2 Western Australian Government, *Media Statement*, *Temporary border closure to better protect Western Australians,* 2 April 2020. See: https://www.mediastatements.wa.gov.au/Pages/McGowan/2020/04/Temporary-border-closure-to-better-protect-Western-Australians.aspx. Viewed 18 April 2022.

3 ABC News, *Woman in her 70s dies at Busselton hospital after waiting hours for care*. See: https://www.abc.net.au/news/2022-04-20/woman-dies-at-busselton-hospital-after-waiting-hours-for-care/101003528. Viewed 29 April 2022; ABC News, *St John Ambulance boss orders review, but backs crew after woman dies waiting 30 minutes for help*. See: https://www.abc.net.au/news/2022-04-26/st-john-ambulance-review-after-grandmother-dies-waiting-for-help/101011174. Viewed 29 April 2022.

- Chapter 6 considers the efficiency and adequacy of the service delivery model of ambulance services in regional areas of Western Australia
- Chapter 7 considers workplace culture at St John Ambulance WA
- Chapter 8 considers issues affecting Aboriginal people and remote communities
- Chapter 9 compares ambulance service delivery models in Australia and provides some concluding remarks.

## Procedure

1.5 The Committee called for submissions from the stakeholders listed in Appendix 1 and advertised the inquiry on Facebook and in *The West Australian* newspaper. The Committee received 123 written submissions.

1.6 The Committee conducted 32 hearings between 21 September and 1 December 2021. The witnesses who appeared at public hearings are listed in Appendix 1.

1.7 The Committee extends its appreciation to those who contributed to the inquiry.

## Site visits

1.8 The Committee conducted a number of site visits in order to observe first–hand the delivery of ambulance services in Western Australia. These site visits included:

- a tour of the St John Ambulance WA State Operations Centre (SJA SOC) in Belmont
- an ambulance ride–on to several emergency hospital departments in Perth
- travel to regional and metropolitan St John Ambulance WA sub–centres.

### St John Ambulance WA State Operations Centre

1.9 The Committee visited the SJA SOC in Belmont. The SJA SOC is responsible for processing 000 ambulance calls in Western Australia. The Committee observed how calls are received, assessed, prioritised and dispatched.

### Ambulance ride–on

1.10 Over two days the Committee attended several hospitals in the Perth metropolitan region in a St John Ambulance WA response vehicle. The Committee spoke to frontline staff and observed how patients are transferred to hospital.

### Travel

1.11 Over the course of a week the Committee visited ten St John Ambulance WA sub–centres listed in Table 1 below. The Committee were given a tour and spoke to frontline staff.

Table 1. *St John Ambulance WA sub–centres the Committee visited*

| Location | Metropolitan/Regional |
|---|---|
| Karratha | Regional |
| Wickham | Regional |
| Geraldton | Regional |
| Mullewa | Regional |
| Mingenew | Regional |
| Midland | Metropolitan |

| Location | Metropolitan/Regional |
|---|---|
| Goomalling | Regional |
| Toodyay | Regional |
| Williams | Regional |
| Bunbury | Regional |

## Previous inquiries

1.12 A number of inquiries have previously been conducted on the delivery of ambulance services in Western Australia. The Committee notes the following given their relevance to the terms of reference of this inquiry:

- Donaldson Review (1997)[4]
- Joyce Report (2009) and Implementation of Recommendations Report (2010)[5]
- Auditor General Report (2013)[6]
- Independent Oversight Panel (2016)[7]
- Auditor General Follow–up Audit (2019)[8]
- Country Ambulance Strategy (2019).[9]

1.13 St John Ambulance WA advised 12 reports have been prepared on the organisation since 2009. These include 122 recommendations. All recommendations have either been achieved and delivered (84); achieved and ongoing (32); or were considered unworkable (6).[10]

### Donaldson Review (1997)

1.14 The 1997 report, *The Provision of Ambulance Services in Western Australia: A Model for the 21st Century* (Donaldson Review) was the product of a ministerial–appointed committee and was not publicly released. The review committee identified several issues that needed to be

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4 Hon Bruce Donaldson MLC, *The Provision of Ambulance Services in Western Australia: A Model for the 21st Century*, 27 March 1997.

5 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009. See: https://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports–and–publications/PDF/SJA_Inquiry_Report.pdf. Viewed 15 December 2021; Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010. See: https://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports–and–publications/PDF/SJA_inquiry_implementation.pdf. Viewed 15 December 2021.

6 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services*, June 2013, pp 21–5. See: https://audit.wa.gov.au/wp–content/uploads/2013/06/report2013_05.pdf. Viewed 15 December 2021.

7 Independent Oversight Panel, *Review of St John Ambulance: Health and Wellbeing, and Workplace Culture*, report prepared by Dr Neale Fong, Ian Taylor and Professor Alexander MacFarlane, Perth, August 2016, p 47. See: https://stjohnwa.com.au/docs/default–source/corporate–publications/independent–oversight–panel–report–160908.pdf?sfvrsn=2. Viewed 15 December 2021.

8 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services – Follow–up Audit*, 31 July 2019, p 4. See: https://audit.wa.gov.au/reports–and–publications/reports/delivering–western–australias–ambulance–services–followup–audit/. Viewed 15 December 2021.

9 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 5. See: https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About–us/Publications/Strategic–plans/The–Country–Ambulance–Strategy–Driving–Equity–for–Country–WA.pdf. Viewed 15 December 2021.

10 Submission 71 from St John Ambulance WA, 23 July 2021, p 5.

addressed for the ambulance service to be viable into the future. In particular, greater support for volunteer operations and greater protections for paid and volunteer ambulance officers were considered necessary.

1.15 The review committee's findings and recommendations included:

- a preference for a single State–wide provider of emergency ambulance services
- metropolitan inter–hospital patient transfer be exposed to competition
- inter–hospital patient transfers in the country would not benefit from competition
- in the absence of legislation, minimum regulatory structures should be adopted to protect the just actions of ambulance officers
- volunteers are critical for the delivery of ambulance services in the country
- financial assistance should be provided to country operations that have insufficient access to other income
- more effective and responsive performance management within the contract
- planning for the deployment of more paid ambulance services.[11]

**Joyce Report (2009) and Implementation of Recommendations Report (2010)**

1.16 A program by Four Corners aired in July 2009 titled '*Out of Time*' linked four patient deaths to St John Ambulance WA. The program prompted the State Government to appoint Greg Joyce, former Director General of the Department of Housing and Works, to conduct an independent inquiry to investigate the deaths.

1.17 The inquiry assessed the safety and quality of clinical practices at St John Ambulance WA and the adequacy of its consumer complaint system. The subsequent report, the Joyce Report, noted the Four Corners program was 'fair and Western Australians are grateful for this insight'.[12]

1.18 The Joyce Report recommended the continuation of the existing service model with 13 major recommendations to improve the ambulance service. The Committee notes the cost of the ambulance service in Western Australia being the lowest in Australia was a major factor for the recommendation to continue with the existing provider.[13]

1.19 The Joyce Report's recommendations included increased funding for the ambulance service, a review of country ambulance services and strengthened clinical governance processes that align with Department of Health standards. Major inadequacies were found in the operation of the SJA SOC and recommendations were made to:

- significantly increase staffing levels
- strengthen clinical decision making during call taking and introduce audit processes
- examine the use of structured call taking
- implement staff performance and development programs
- review training and the continuing education of staff.[14]

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[11] Hon Kevin Prince MLA, Minister for Health, *Ambulance review recommends single provider for emergency service in WA*, media statement, Western Australia, 27 March 1997.

[12] Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p iv.

[13] ibid., p 6.

[14] ibid., pp 7–8.

1.20 The *Implementation of Recommendations Completion Report to the Minister for Health* in 2010 noted the Government had approved a significant increase of funds for St John Ambulance WA which enabled the major reforms of the Joyce Report to be implemented.[15]

**Auditor General Report (2013)**

1.21 The 2013 Auditor General's Report found ambulance services (including response times) had improved since the 2009 Joyce Report. Increased funding, more staff and a new call system had enabled St John Ambulance WA to cope with increases in demand although ramping remained a problem.[16]

1.22 Recognising a number of challenges in delivering ambulance services in regional Western Australia (geography, reliance on volunteers, increasing demand and recruitment difficulties), the audit found response locations outside of the southwest were sparse. There was also no clear means of assessing whether paramedics were stationed where they were most needed.[17]

1.23 While St John Ambulance WA's clinical governance framework had improved, clinical audits were largely restricted to the metropolitan area.[18]

1.24 The contract with St John Ambulance WA was considered to be an ineffective measure of quality of service or cost effectiveness. The focus of the contract was to fund additional capacity (particularly through staffing targets) rather than managing and improving outcomes such as patient care.[19] The Auditor General considered:

> The current Contract does not provide an effective framework for future contracts for ambulance services. Future contracts should be more comprehensive with a focus on service delivery, standards, performance and allocation of risk.[20]

1.25 Unlike other states, Western Australia does not have specific legislation governing the delivery of ambulance services, relying instead on a contract and internal regulation by St John Ambulance WA. The audit found the contract at the time did not adequately regulate service standards and 'does not provide an effective mechanism to ensure that patient safety and minimum standards are met'.[21]

1.26 Noting St John Ambulance WA was meeting its response time targets with a significantly lower level of stand–by capacity than the 52.5 per cent funded by the Department of Health, the audit concluded:

> Future contractual negotiations will need to be based in part on a better understanding of how the ambulance service operates and the cost drivers of providing an efficient ambulance service.[22]

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[15] Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010, p 3.

[16] Office of the Auditor General, *Delivering Western Australia's Ambulance Services*, June 2013, pp 21–25.

[17] ibid., pp 28–38.

[18] ibid., pp 40–1.

[19] ibid., pp 45–51

[20] ibid., p 45.

[21] ibid., p 49.

[22] ibid., p 25.

1.27 The audit found there was a gap between senior management at the Department of Health and St John Ambulance WA. It found a committee set up for senior management to discuss complex strategic issues had not met in over a year.[23]

**Independent Oversight Panel (2016)**

1.28 St John Ambulance WA commissioned an Independent Oversight Panel (Panel) review of workplace culture following reported suicides among paramedics and volunteers.

1.29 The Panel was of the view that given the known risk of psychological injury for ambulance officers, St John Ambulance WA should have better anticipated and managed this risk.[24] The unique challenges emergency personnel faced meant they are exposed to post–traumatic stress disorder and other health issues:

> The adverse health outcomes of a career of an ambulance officer are related to a matrix of factors, including the cumulative traumatic stress involved in the role, organisational factors and individual risk factors.[25]

1.30 The Panel noted individuals who work as frontline responders are highly committed to serving their community.[26] The Panel considered it appropriate that the community and employers owe these first responders a particular duty of care if they are injured or become unwell, whether physically or psychologically.

1.31 The Panel concluded certain aspects of organisational culture at St John Ambulance WA were dysfunctional and contributed to employee stress:

> Consultations also revealed that organisational and workplace factors relating to management style and decision–making processes, lack of communication and the existence of bullying as being the major contributors to feelings of stress at work.[27]

1.32 The Panel made 27 recommendations to improve organisational culture and well–being of employees, with genuine employee engagement critical for improvement to occur.[28]

**Auditor General Follow–up Audit (2019)**

1.33 The Auditor General's follow–up report in 2019 found the ambulance service was more efficient and consistently met emergency response time targets. However there had been little improvement in regard to the funding model and contract.[29]

1.34 Without links between funding, demand for services and performance, there were found to be no financial incentives for St John Ambulance WA to improve performance; and no consequences for missing targets.[30]

1.35 Other issues included:

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23 ibid., pp 9, 54–5.

24 Independent Oversight Panel, *Review of St John Ambulance: Health and Wellbeing, and Workplace Culture*, report prepared by Dr Neale Fong, Ian Taylor and Professor Alexander MacFarlane, Perth, August 2016, p 47.

25 ibid., p 41.

26 ibid., p 9.

27 ibid., p 90.

28 ibid., p18.

29 Office of the Auditor General, *Delivering Western Australia's Ambulance Services – Follow–up Audit*, 31 July 2019, p 4.

30 ibid., p 16.

- performance indicators within the contract lack depth, relying on response times to measure performance ('they measure activity but not its value')[31]
- better indicators are needed to evaluate country ambulance performance[32]
- financial reporting requirements under the contract should be strengthened to provide greater transparency and enable assessment of value for money[33]
- internal clinical quality controls are not independently audited and there are weaknesses in the contract regarding data accessibility.[34]

**Country Ambulance Strategy (2019)**

1.36 The WA Country Health Service (WACHS) developed the Country Ambulance Strategy to enable a sustainable, effective and equitable ambulance service for country communities into the future.[35]

1.37 Key findings of the Country Ambulance Strategy include:

- accountability and standards for the delivery of ambulance services are ill–defined due to a lack of a specific policy or legislation[36]
- there is substantial inequity in the provision of metropolitan and country ambulance services[37]
- limitations in the contract with St John Ambulance WA perpetuate inequity between country and metropolitan services. The 'best endeavours' model applicable to most country locations means that ambulance services are provided by volunteers and are not subject to any contractual minimum standards[38]
- funding under the contract is opaque with no requirement for transparency of how funds are spent[39]
- the contract has no requirement for reinvestment of any surplus back into ambulance services[40]
- the current service model is faced with increasing pressure from rising demand (particularly for inter–hospital patient transfers), patient expectations and workforce challenges[41]
- previous reviews and inquiries have not resulted in significant change to the governance of ambulance services or the operating model.[42]

1.38 The Country Ambulance Strategy concludes the existing model is inadequate to meet existing and future demands and challenges:

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31 ibid., p 17.

32 ibid.

33 ibid.

34 ibid., pp 19–20.

35 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 5.

36 ibid., p 13.

37 ibid., p 5.

38 ibid., p 13.

39 ibid.

40 ibid., p 28.

41 ibid., p 19.

42 ibid., p 13.

> The service model—having organically grown from the pro–active and collective good work by St John Ambulance WA volunteers—is under immense pressure from rising demands, particularly from increasing inter–hospital patient transfer and is suffering from significant fragmentation between the multiple system players. The new patterns of demand are not optimally served by the historical model that is in place and equity of service for country patients is unlikely to be achieved without targeted additional investment in the country ambulance service.[43]

1.39 Recommendations for a modified service delivery model include:

- establish a state–wide policy or legislation for ambulance services
- define the level of ambulance service provided to country communities
- develop a patient centred delivery model
- WACHS to manage the country ambulance service contract
- implement the remaining recommendations from the 2013 Auditor General's report
- introduce contemporary contracts for ambulance services that contain minimum performance requirements to ensure timely and consistent access of service
- apply clinical governance and service standards that enable the provision of safe and contemporary patient care
- centralise coordination of inter–hospital patient transport
- adopt initiatives for a sustainable workforce
- contracting that facilitates the delivery of affordable and transparent ambulance services and can demonstrate value for money.[44]

1.40 Some of the outcomes of the inquiries summarised in paragraphs 1.12–1.39 are considered throughout this report.

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[43] ibid., p 31.

[44] ibid., pp 39–61.

# CHAPTER 2
# Contracts governing ambulance services in WA

## Introduction

2.1 The Department of Health has responsibility for ambulance service provision in Western Australia. Delivery of the service is achieved through contracts and agreements with:

- St John Ambulance WA
- WA Country Health Service (WACHS)
- Royal Flying Doctor Service Western Operations (RFDS)
- Wilson Medic One
- National Patient Transport.

2.2 This chapter provides an overview of the agreements governing the following ambulance and patient transport services in Western Australia:

- emergency ambulance services
- non–emergency inter–hospital patient transport services
- mental health patient transport.

## Contractual framework

2.3 The Department of Health agreements for the following ambulance services are described below:

- St John Ambulance WA is the main provider of emergency ambulance services in metropolitan and regional Western Australia
- WACHS provides ambulance services in Derby, Halls Creek and Fitzroy Crossing through the Kimberley Ambulance Service
- RFDS has a contract with WACHS and uses St John Ambulance WA as their primary provider of ambulance transfers
- Non–emergency inter–hospital transport services in the metropolitan region are shared between St John Ambulance WA, Wilson Medic One and National Patient Transport
- St John Ambulance WA has a right of first refusal for non–emergency inter–hospital transport in regional areas and performs the majority of this work
- Wilson Medic One is the exclusive provider of mental health patient transport.

2.4 The contracts governing these services are summarised in Table 2:

Table 2. *Contracts governing ambulance services in Western Australia*

| Contract | Contractor | Description | Term |
|---|---|---|---|
| Emergency Ambulance Services Agreement | St John Ambulance WA | to provide emergency and high acuity patient transfer | 25 September 2020 – 30 June 2022 |

| Contract | Contractor | Description | Term |
|---|---|---|---|
| N/A | Kimberley Ambulance Services (WACHS) | to provide ambulance services in Derby, Halls Creek, Fitzroy Crossing | N/A |
| Non–Emergency Inter–Hospital Patient Transport Agreement | St John Ambulance, Wilson Medic One, National Patient Transport | to provide low and medium acuity patient transfer | 1 July 2015 – 30 May 2022 |
| RFDS Services Agreement | RFDS | to provide emergency aeromedical retrieval and patient transfers | 28 September 2016 – 30 June 2022 |
| Mental Health Patient Transport Agreement | Wilson Medic One | to provide mental health patient transfer | May 2019 – 30 June 2023 |

## Emergency ambulance transport

2.5 St John Ambulance WA is the main provider of emergency ambulance services in Western Australia. It started providing ambulance services in 1904 and assumed exclusive responsibility in 1922 (see Appendix 2 for history of St John Ambulance WA).

### Services provided

2.6 The Emergency Ambulance Services Agreement with St John Ambulance WA requires the following services to be provided:

- management of a state operations centre (SJA SOC) capable of answering and tasking 000 calls as efficiently as possible
- 24 hour a day emergency road–based patient transport service for metropolitan and regional Western Australia.[45]

2.7 The efficiency and adequacy of St John Ambulance WA's delivery of these services is considered in chapter 3 (answering and tasking 000 calls), chapter 5 (ambulance service in metropolitan Perth) and chapter 6 (ambulance service in regional areas).

2.8 Paragraphs 2.8–2.33 provide an overview of the contractual provisions of the current Emergency Ambulance Services Agreement.

### Parties to contract

2.9 The parties to the Emergency Ambulance Services Agreement are the State of Western Australia and St John Ambulance WA.[46] The Director General of the Department of Health is responsible for managing the Emergency Ambulance Services Agreement on behalf of the State of Western Australia.[47]

2.10 Contractual responsibility for ambulance services in regional areas is being transitioned from the Department of Health to WACHS.[48] This transition is expected to be completed when a

45 Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 2.

46 ibid., p 1.

47 ibid., p 46.

48 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 3.

new Emergency Ambulance Services Agreement is entered into following expiry of the current agreement on 30 June 2022.[49]

**Term of contract**

2.11 The current Emergency Ambulance Services Agreement with St John Ambulance WA was signed on 1 July 2015. On 25 September 2020 a deed of amendment, restatement and release was signed. This deed amended the payment mechanism in the contract and extended the expiry date until 30 June 2022.

2.12 A new contract for emergency ambulance services is currently being negotiated between the Department of Health and St John Ambulance WA.

2.13 See chapter 9 for further discussion about the length of term for the Emergency Ambulance Services Agreement.

**Service staff qualifications**

2.14 The Emergency Ambulance Services Agreement requires St John Ambulance WA to ensure all service staff are competent and have certain skills, training and qualifications.[50] This applies to SJA SOC staff, paramedics and volunteers.

**Regional model**

2.15 A model to determine paramedic deployment to regional sub–centres is contained in the Emergency Ambulance Services Agreement (see Table 3). This model is based on the number of calls a sub–centre responded to in the previous year. Of the 160 regional ambulance sub–centres that currently exist in Western Australia only 16 are staffed by paramedics; the remaining 144 are staffed entirely by volunteers.[51]

Table 3. *St John Ambulance WA regional sub–centre model*

| Category | Cases in previous Year | Model | Paramedic Staff | Crew |
|---|---|---|---|---|
| Category 1 | >3000 | Paramedics and volunteers | 9 paramedics.<br><br>8 paramedics working a 2:2:4[52] roster and 1 relief officer. | 2 ambulances with a crew of one paramedic and one volunteer available 24 hours per day. |

49 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 7.

50 Department of Health, *Emergency Services Agreement*, 25 September 2020, clause 2.8, schedule 4 and 9.

51 Submission 71 from St John Ambulance WA, 23 July 2021, p 37.

52 This roster refers to paramedics working 2 day shifts, followed by 2 night shifts, followed by 4 days off.

| Category | Cases in previous Year | Model | Paramedic Staff | Crew |
|---|---|---|---|---|
| Category 2 | 2000 – 3000 | Paramedics and volunteers | 7 paramedics.<br><br>4 paramedics working a 2:2:4 roster, 2 paramedics working 4 days on, 4 days off 11 hours per day and 1 relief officer. | 1 ambulance with a crew of one paramedic and one volunteer available 24 hours a day.<br><br>1 ambulance with a crew of one paramedic and one volunteer available 12 hours per day. |
| Category 3 | 1500 – 2000 | Paramedics and volunteers | 4 paramedics<br><br>4 paramedics working a 2:2:4 roster. | 1 ambulance with a crew of one paramedic and one volunteer available 24 hours a day. |
| Category 4 | 1000 – 1500 | Paramedics and volunteers | 2 paramedics<br><br>2 paramedics working 4 days on 4 days off 12 hours roster | 1 ambulance with a crew of one paramedic and one volunteer available 12 hours per day. |
| Category 5 | 250 – 1000 | Paramedics and volunteers | Support of a Community Paramedic | 1 ambulance with a crew of two volunteers available 24 hours per day. |
| Category 6 | 0 – 250 | Volunteers only | None | 1 ambulance with a crew of two volunteers available 24 hours per day. |

[Source: Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 4.]

**Key performance indicators**

2.16 Response times are the main measure of ambulance performance in the Emergency Ambulance Services Agreement. Key performance indicators (KPI) include:

- ambulance depots in the metropolitan region are required to respond within 10–40 minutes depending on the priority level
- sub–centres run by paid paramedics in regional locations are required to respond to calls within 10km of the town centre within 17–40 minutes depending on the priority level and sub–centre location
- sub–centres run by volunteers are not subject to target response times.

2.17 Recent compliance with these target response times is considered in paragraph 5.13 and 6.22.

### New performance indicators

2.18 Ambulance response times are used by ambulance organisations around the world as one measure of performance—they do not provide a complete assessment of an ambulance service.[53]

2.19 The Auditor General points out response times measure:

> how quickly ambulances respond to a call rather than outcomes such as the wellbeing of patients. Consequently, they measure activity but not its value.[54]

2.20 The Committee asked a number of stakeholders if the Emergency Ambulance Services Agreement could be improved by including new performance indicators to assess performance. The Committee was particularly interested in indicators that would measure patient outcomes. The Committee received the following responses:

- St John Ambulance WA recommended introducing performance indicators focused on patient outcomes such as patient satisfaction, pain reduction and use of alternate care pathways; in other words 'patient–centric' performance indicators.[55]
- WACHS recommended including clinical metrics such as pain relief and cardiac management.[56]
- The United Workers Union recommended introducing performance indicators for patient outcomes.[57] They also recommended compliance with clinical practice guidelines be included as a new performance indicator.[58]

2.21 The Committee notes the following KPIs are used in other jurisdictions in Australia:

Victoria

- percentage of respondents who rated care, treatment, advice and/or transport received from the ambulance service as good or very good.
- percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly
- percentage of adult stroke patients transported to definitive care within 60 minutes.[59]

Queensland

- clinically meaningful pain reduction[60]

South Australia

- percentage of patients who reported a clinically meaningful pain reduction

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53 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services,* June 2013, p 6.

54 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services – Follow–up Audit*, 31 July 2019, p 17.

55 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, pp 8–9.

56 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 3.

57 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 4.

58 Paramedic, United Workers Union, transcript of private evidence, 17 November 2021, p 12.

59 Victorian Government, *Statement of Priorities 2020–21*, 29 June 2021, p 1. See: https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/statement-of-priorities/2020-21/statewide/ambulance-victoria-statement-of-priorities-2020-21.pdf. Viewed: 1 May 2022.

60 Queensland Government, Department of Health, *Public Performance Indicators,* 30 June 2021, p 2. See: https://www.ambulance.qld.gov.au/docs/Public-Performance-Indicators-Fourth-Quarter-2020-21.pdf. Viewed: 1 May 2022.

- percentage of patients who were in out–of–hospital cardiac arrest and had a return to spontaneous circulation at the time of transfer of care to the medical team at the receiving hospital.[61]

2.22 The Committee supports the establishment of new KPIs that measure patient outcomes and clinical compliance.

**RECOMMENDATION 1**

The Department of Health establish new key performance indicators for emergency ambulance services that measure patient outcomes and clinical compliance.

**Cost and funding of emergency ambulance service**

2.23 Ambulance services provided by St John Ambulance WA were initially funded by community subscription. The Lotteries Commission made its first annual grant to St John Ambulance WA in 1933.[62] The State Government began financially contributing towards the ambulance service in the late 1940s.[63]

*Government funding*

2.24 Today the State Government contributes almost half of the total cost of ambulance services in Western Australia. The cost breakdown in 2019/20 was as follows:

- 48.7 per cent Government grants
- 38.7 per cent transport fees collected from patients
- 12.5 per cent subscriptions and other income.[64]

2.25 Western Australians over 65 years of age are entitled to free ambulance services if they receive an Australian Government pension or a 50 per cent discount if they are not in receipt of a pension.[65]

2.26 St John Ambulance advised:

> Ambulance fees for patients aged 65 and over are funded jointly by St John and the Government, with the allocation split:
>
> 50% - Government funding, and
>
> 50% - St John Ambulance WA funding (Pension Card Holders only)
>
> Pension Card holders aged under 65 years and who are eligible for Pension Card Concessions (PCC) receive a 50% concession funded solely by St John WA.[66]

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61 South Australia Ambulance Service, *Key Performance Indicators Master Definition Document 2020–21*, 8 January 2021, pp 19 and 23. See: https://www.sahealth.sa.gov.au/wps/wcm/connect/e2fa26b0-d6e7-4d2f-be3f-d2ca3848113a/SAAS+KPI+definition+Doc_V1.0.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-e2fa26b0-d6e7-4d2f-be3f-d2ca3848113a-o2HddNA. Viewed: 1 May 2022.

62 St John Western Australia, *Historical Timeline*. See: https://stjohnwa.com.au/about–us/our–history/st–john–historical–timeline. Viewed 1 November 2021.

63 ibid.

64 Australian Government, Productivity Commission, *Report on Government Services 2021*, 28 January 2021, Table 11A.1.

65 Department of Health, *Ambulance fees for seniors and pensioners*. See: https://www.healthywa.wa.gov.au/Articles/A_E/Ambulance-fees-for-seniors. Viewed 7 February 2022.

66 St John Ambulance WA, letter, dated 6 April 2022, p 5.

**RECOMMENDATION 2**

The Government and St John Ambulance WA provide a full subsidy on emergency ambulance fees for holders of current pensioner concession cards who are under the age of 65.

2.27 The amounts paid to St John Ambulance WA in government grants in recent years is shown in Table 4. Over the past five years fixed payments have increased by an average of 4.1 per cent per annum while concession payments have increased by an average of 7.7 per cent per annum:

Table 4. *Government funding to St John Ambulance WA 2016–2020*

| Funding | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Fixed Payment | $91 996 908 | $94 900 736 | $97 743 000 | $100 985 000 | $107 109 000 |
| Concession for patients over 65 years | $35 624 739 | $41 482 152 | $45 700 000 | $49 300 000 | $46 700 000 |

[Source: St John Ambulance WA Annual Report 2019/20, 2018/19, 2017/18, 2016/17, 2015/16]

*Total revenue*

2.28 Table 5 compares the revenue of each ambulance service in Australia for 2019/20. The revenue generated by ambulance services represents the cost of the service to the community. The last row of Table 5 shows the ambulance service in Western Australia costs less per capita than any other jurisdiction.

Table 5. *Australian ambulance organisations total revenue 2019/20*

| $ m | NSW | Vic | Qld | WA | SA | Tas | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| Government grants | 873.4 | 875.8 | 834.3 | 159.8 | 160.5 | 94.1 | 63.4 | 34.2 |
| Transport fees | 222.0 | 213.1 | 56.8 | 127.0 | 117.2 | 9.6 | 7.7 | 3.0 |
| Subscriptions and other income | 15.6 | 99.7 | 14.3 | 41.2 | 41.2 | 4.6 | – | 1.3 |
| Total revenue | 1 111.0 | 1 188.6 | 905.4 | 328.0 | 318.9 | 108.3 | 71.0 | 38.6 |
| Per person in the population | 136.68 | 178.70 | 176.48 | 124.28 | 181.26 | 201.70 | 166.17 | 157.59 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2021*, 28 January 2021, Table 11A.1.]

2.29 Table 6 converts the revenue data in Table 5 into percentage terms. This shows Western Australia and South Australia:

- have a much higher proportion of transport fees relative to total revenue (39 per cent and 37 per cent compared to the national average of 18.4 per cent)
- are much less reliant on government grants (49 per cent and 50 per cent compared to the national average of 76 per cent).

Table 6. *Australian ambulance organisations revenue breakdown 2019/20*

| % | NSW | Vic | Qld | WA | SA | Tas | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| Government grants | 79 | 74 | 92 | 49 | 50 | 87 | 89 | 89 |
| Transport fees | 20 | 18 | 6 | 39 | 37 | 9 | 11 | 8 |
| Subscriptions and other income | 1 | 8 | 2 | 12 | 13 | 4 | 0 | 3 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2021*, 28 January 2021, Table 11A.1.]

**New payment mechanism**

2.30 On 25 September 2020 the payment mechanism in the Emergency Ambulance Services Agreement was amended from a fixed payment model to one that is linked to demand for services. The new mechanism is based on demand based growth and ambulance availability. These changes were implemented in accordance with recommendations from the Office of the Auditor General in 2013 and 2019.[67]

2.31 The Department of Health explained the change to a demand based payment mechanism as follows:

> For years, hospital–based services were funded on, basically, it was history, so it was what you got funded last year, plus a percentage increase. That has changed now. Over the last 10–15 years, we get paid on activity–based funding. We can look at every episode of care that we do. We wanted to move to a less historical base of a contract with St John, and that is what has happened. We are slowly modernising the contract.[68]

2.32 The demand based aspect of the new payment mechanism currently accounts for 4 per cent of the total amount paid under the Emergency Ambulance Services Agreement:

> It is determined by the growth in demand for ambulance services each year and the growth of patients, including the dispatch priorities 1, 2 and 3…to try and improve the performance mechanism, but also to improve the ability for us to provide to St John payment when there was demand, whereas the previous model was really just a demand–based thing which did not take into account different cohorts of growth.[69]

2.33 The new payment mechanism also takes into account ambulance availability by including a payment for ambulances that become ramped at a hospital. This payment is intended to fund investment in additional capacity.[70] The Department of Health explained:

> There is a KPI…which is when a patient arrives at a hospital they should be transferred from the care of the paramedics to the care of hospital staff…within 30 minutes irrespective of the patient's acuity…Once we hit 30 minutes…we go into

67 Office of the Auditor General, *Delivering Western Australia's Ambulance Services*, 5 June 2013; Office of the Auditor General, *Delivering Western Australia's Ambulance Services — Follow–up Audit*, 31 July 2019.

68 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 9.

69 Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 September 2021, p 4.

70 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 7.

> what is called extended transfer of care...For every minute or every hour beyond that 30 minutes, we then fund St John a rate to account for that.
>
> The basis for that is that it acknowledges that there are issues in demand for ambulance services, issues in demand for ED [emergency department] services, and that we need to assist St John to build capacity in their system to enable them to get ambulances back on the road or to have more ambulances to meet the needs of clients.[71]

2.34 The amounts paid under the new payment mechanism are not publicly available on the basis they are commercial in confidence.

## Kimberley Ambulance Service

2.35 The Emergency Ambulance Services Agreement with St John Ambulance WA does not require it to provide ambulance services in Halls Creek, Fitzroy Crossing and Derby. WACHS provides ambulance services in these regions through the Kimberley Ambulance Service.

### Governance

2.36 WACHS regulates and governs the Kimberley Ambulance Service. It operates outside any formal contractual relationship with the Department of Health.

2.37 The operations of the Kimberley Ambulance Service are guided by principles and procedures developed by WACHS.[72]

### Services provided

2.38 The Kimberley Ambulance Service operates a 24 hour ambulance service from the hospitals located in Halls Creek, Fitzroy Crossing and Derby.[73] This service provides:

- emergency response to Halls Creek, Fitzroy Crossing, Derby and the surrounding communities
- transfer and transport to and from RFDS
- transfer and transport from neighbouring Health Units and outlying communities for ongoing medical management.[74]

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71 Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 September 2021, pp 4–5.

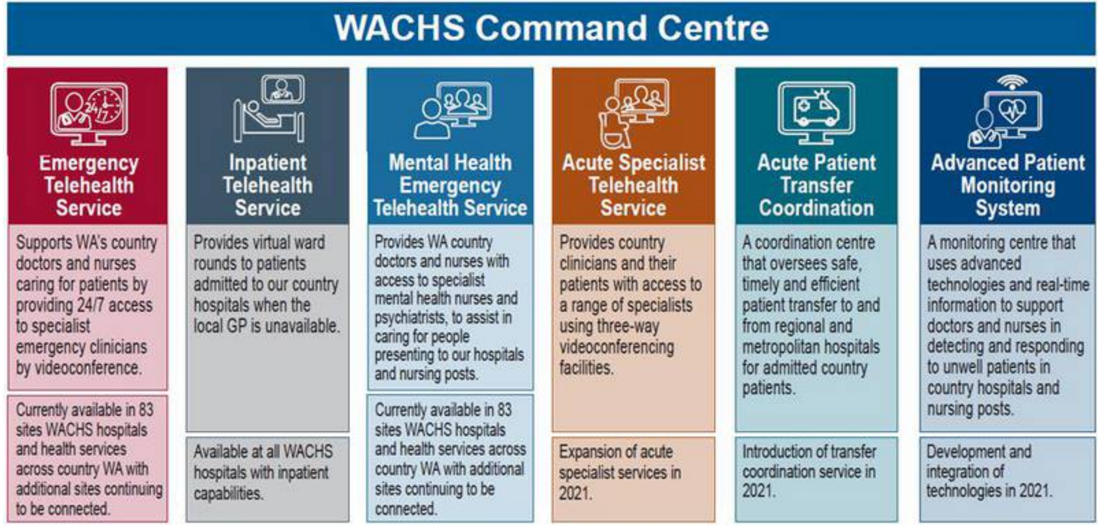
72 WA Country Health Service, *Kimberley Ambulance Service Procedure,* 8 February 2017. See: https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About–us/Policies/Kimberley–Ambulance–Service–Procedure.pdf?thn=0. Viewed 19 January 2021.

73 Kylie Bosich, Director, WA Country Health Service, transcript of evidence, 24 September 2021, p 16.

74 WA Country Health Service, *Kimberley Ambulance Service Procedure,* 8 February 2017.

2.39 WACHS also operates a Command Centre. Its functions are described in Figure 1:

Figure 1. *Functions of the WA Country Health Service Command Centre*




[Source: WA Country Health Service, *Command Centre*. See: https://www.wacountry.health.wa.gov.au/Our–services/Command–Centre]. Viewed 18 January 2022.]

## Staffing

2.40 The Kimberley Ambulance Service is staffed by nurses and orderlies who are employed by WACHS at hospitals in Derby, Fitzroy Crossing and Halls Creek. WACHS explained:

> It is operated with a nurse rostered, who might be also working within the emergency department or working within the hospital, but is an extra nurse to be able to respond with an orderly who has also got other duties during the day. When a call comes through, whether that is through the 000 call centre to one of those facilities to say there is a job, or may have been a phone call direct or may be an inter–hospital patient transfer through to the RFDS jet, they would then hop into their ambulance and travel off to those calls.[75]

## Staff training

2.41 Staff are largely expected to rely on their pre–existing clinical skill and abilities developed and provided through WACHS training. They also receive the following additional training and induction:

- orientation package to the ambulance
- physical orientation to the ambulance
- communication options and training
- equipment inventory and instructions on use
- education on documentation requirements
- ambulance essentials training delivered by St John Ambulance WA
- orientation to St John Ambulance Clinical Practice Guidelines (clinical staff only).[76]

2.42 Staff who are required to drive an ambulance must attend approved driver training within three months of commencing employment. The aim of the training is to provide staff with an

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75 Kylie Bosich, Director, WA Country Health Service, transcript of evidence, 24 September 2021, p 16.

76 WA Country Health Service, *Kimberley Ambulance Service Procedure,* 8 February 2017, p 3.

understanding of the practices they need to employ whilst driving under emergency and operational conditions and provide education about legal obligations.[77]

### Standards

2.43 The Kimberley Ambulance Service follows the St John Ambulance Clinical Practice Guidelines for Volunteer Officers.[78] They do this in recognition of St John Ambulance WA being the 'standard of pre–hospital clinical care in Western Australia'.[79]

2.44 Staff are also required to comply with the WA Health Code of Conduct.[80]

### Key performance indicators

2.45 The Kimberley Ambulance Service KPIs include dispatch time, accuracy of priority codes, treatment outcomes (refused treatment, dead on arrival, transfer to another hospital) and pain relief.[81]

2.46 Unlike the Emergency Ambulance Services Agreement which measures target response times, the Kimberley Ambulance Service Procedure requires compliance with target dispatch times. These are set out in Table 7:

Table 7. *Kimberley Ambulance Service target dispatch times*

| Priority | Australasian Triage Scale | Example diagnosis | Target dispatch time |
|---|---|---|---|
| 1 | Resuscitation | Shock, cardiac arrest, unconscious | 5 minutes |
| 2 | Emergency | Chest pain | 10 minutes |
| 3 | Urgent | Moderate trauma, wrist fracture | 20 minutes |
| 4 | Semi urgent | Acute abdominal pain, sprained ankle | 20 minutes |
| 5 | Non–urgent | Rash, back pain | 20 minutes |
| 6 | N/A | Transport home | N/A |

[Source: WA Country Health Service, *Kimberley Ambulance Service Procedure,* 8 February 2017, p 5. See: https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About–us/Policies/Kimberley–Ambulance–Service–Procedure.pdf?thn=0. Viewed 19 January 2021.]

### New paramedic support for Derby, Fitzroy Crossing and Halls Creek

2.47 In February 2022 it was announced Safety Direct Solutions had been contracted to provide specialist paramedic support to the Kimberley Ambulance Service with Safety Direct Solutions' paramedics expected to be in place by the middle of 2022.[82]

2.48 According to its website, Safety Direct Solutions:

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77 ibid., p 3.

78 ibid., p 2.

79 ibid., p 2.

80 ibid., p 10.

81 ibid., p 8.

82 Government of WA, *Media Statements*. See: https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/02/New-paramedic-support-for-Derby-Fitzroy-Crossing-and-Halls-Creek.aspx. Viewed 1 April 2022.

specialises in the establishment and operation of expert medical services, including remote medical support.[83]

2.49 Safety Direct Solutions' paramedics will work with local WACHS doctors, nurses and orderlies to:

- assist in the delivery of ambulance services
- strengthen training, clinical practice guidelines, operational policies and procedures.[84]

2.50 The need for specialised skills training was identified through consultation for the Country Ambulance Strategy:

> as part of the consultation to develop the country ambulance strategy, [Kimberley Ambulance Service] requested further ambulance skills training and the new contractor is well equipped to provide this.[85]

2.51 According to the Minister for Health the contract will enable the provision of a more flexible and responsive ambulance service in the Kimberley:

> This contract allows different models of care and alternative workforces to be tested to better align staff skills and experience to the needs of patients, benefiting Kimberley communities with a contemporary and patient focused ambulance service.[86]

## Royal Flying Doctor Service emergency aeromedical retrieval & patient transfer

2.52 RFDS provides emergency aeromedical evacuations throughout rural and remote Australia. RFDS staff provide medical treatment on the ground and use dedicated aircraft to transport patients to hospital.[87]

2.53 It operates a 24/7 service across all five of its Western Australian bases in Jandakot, Kalgoorlie, Meekatharra, Port Hedland and Broome.[88]

2.54 On average, RFDS provides aeromedical retrieval for 27 patients a day in Western Australia. In 2020/21, RFDS experienced its busiest year on record, retrieving more than 10 000 patients and flying nine million kilometres across Western Australia.[89]

2.55 RFDS has approximately 180 volunteers in Western Australia. The volunteers' roles are limited to fundraising activities organised through RFDS auxiliaries in regional areas. Volunteers are not used to support operations.[90]

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83 Safety Direct Solutions. See: https://www.sdsaus.com.au/medical. Viewed 1 April 2022.

84 Government of WA, *Media Statements*. See: https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/02/New-paramedic-support-for-Derby-Fitzroy-Crossing-and-Halls-Creek.aspx. Viewed 1 April 2022.

85 ibid.

86 ibid.

87 Royal Flying Doctor Service, *What we do – Aeromedical retrieval*. See: https://www.flyingdoctor.org.au/what-we-do/aeromedical-retrieval/. Viewed 1 April 2022.

88 Submission 100 from Royal Flying Doctor Service, 30 July 2021, p 1.

89 ibid., p 1.

90 Royal Flying Doctor Service, Answer to question on notice 4 asked at hearing held 23 September 2021, dated 19 October 2021, p 3.

### Aircraft and road units

2.56 RFDS currently has 16 Pilatus PC–12 turboprop aircraft and two Pilatus PC–24 Jet aircraft.[91] They have also added two new aeromedical helicopters into the fleet in 2021.[92] The new helicopters will be able to transfer patients within 250 kilometres of their base in Jandakot.[93]

2.57 RFDS has two high acuity road units for road–based patient transfer.[94]

### Royal Flying Doctor Service coordination centre

2.58 RFDS operates a state–wide coordination centre 24 hours a day. RFDS explained the complexity of the system:

> The aeromedical environment and the health environment in the space we operate in is exceptionally complex. It requires intense levels of clinical coordination, operational coordination and reconfiguration, because it is a complex network that can change as it is happening.
>
> To give an example of that, I could have a flight on the way to Port Hedland...Something could happen; that flight could end up being re–tasked inflight, and then the whole network plan has to change across the state.[95]

2.59 A St John Ambulance WA Liaison Officer is stationed in the RFDS coordination centre from 9am until 9pm, seven days per week. Twenty–four hour liaison support is provided by St John Ambulance WA as required.[96]

### Road transport

2.60 RFDS has a contract with WACHS to use St John Ambulance WA as their primary provider for ambulance transfers. If alternative transport is required, RFDS may seek permission to choose from a panel of providers or to conduct the transfer themselves.[97]

2.61 Transfers of RFDS mental health patients within the metropolitan area are performed by Wilsons Medic One.[98]

### Key performance indicators

2.62 WACHS and RFDS have agreed performance indicators relating to the dispatch of inter–hospital retrieval services (see Figure 2).[99]

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91 Royal Flying Doctor Service, *Facts and Figures*. See: https://www.flyingdoctor.org.au/wa/about/facts-and-figures/. Viewed 1 April 2022.

92 Submission 100 from Royal Flying Doctor Service, 30 July 2021, pp 2 and 5.

93 6PR, *RFDS announces two new choppers for WA*. See: https://www.6pr.com.au/royal-flying-doctor-service-announces-two-new-choppers-for-wa/. Viewed 1 April 2022.

94 Anthony Green, General Manager, Royal Flying Doctor Service, transcript of evidence, 23 September 2021, p 3.

95 ibid., pp 5–6.

96 Royal Flying Doctor Service, Answer to question on notice 6 asked at hearing held 23 September 2021, dated 19 October 2021, p 3.

97 Anthony Green, General Manager, Royal Flying Doctor Service, transcript of evidence, 23 September 2021, p 2.

98 ibid., p 1.

99 Royal Flying Doctor Service, Answer to question on notice 2 asked at hearing held 23 September 2021, dated 19 October 2021, p 2.

Figure 2. *Royal Flying Doctor Service key performance indicators*

There are two set of KPIs: one for hospitals in the same town as an RFDS base (ie co-located with a base); and one for hospitals/nursing posts in other towns and communities.

**KPIs for hospitals co-located with an RFDS WO base**
Set according to the timeframe within which the flight is supposed to depart with the patient on board. RFDS WO bases are in Perth, Broome, Port Hedland, Meekatharra and Kalgoorlie.

| **RFDS WO Dispatch KPIs (co-located with base)**<br>Target time to depart with patient on board aircraft. | | |
|---|---|---|
| **Patient Priority** | **Target time** | **Target percentage of patients to achieve these times** |
| 1 | Within 2 hours 15 mins of patient assessment. | 80% |
| 2 | Within 6 hours 15 mins of patient assessment. | 90% |
| 3 | Within 48 hours of patient assessment. | 95% |

**KPIs for hospitals NOT co-located with an RFDS WO base**
Set according to the timeframe within which the flight is supposed to arrive at the pick-up airport.

| **RFDS WO Dispatch KPIs (not co-located with base)**<br>Target time to arrive at pick-up airport. | | |
|---|---|---|
| **Priority** | **Target time** | **Target percentage of patients to achieve these times** |
| 1 | Within 1 hour 15 mins of patient assessment plus average flying time from closes base. | 80% |
| 2 | Within 4 hours 30 mins of patient assessment plus average flying time from closes base. | 90% |
| 3 | Within 48 hours of patient assessment plus average flying time from closes base. | 95% |

[Source: Royal Flying Doctor Service, Answer to question on notice 2 asked at hearing held 23 September 2021, dated 19 October 2021, p 2.]

2.63 Unlike St John Ambulance WA, RFDS does not publish its response times publically. RFDS explained this is due to complexities associated with air retrieval:

> We do not publish them externally…Obviously our KPIs and our response times are going to be more complex, because of the tyranny of distance, and also the completely unforeseen and unpredictable—largely unpredictable variables; so, weather and unserviceability. By unserviceability I do not merely mean aircraft assets; I am talking runway unserviceability. An example of that would be flying to a well–published runway, but not realising there has been an incident, or a runway surface damage event, or an aircraft incident before we got there that has caused damage or blocked the runway.
>
> Other issues we have, for example if we are deploying to a regional medical area or station or something like that, it could be also wet ground, gravel strip, grass runway. We would ask somebody to look at that, and if we land and we feel like we are going to have a problem being bogged—all of those variables, availability of fuel in remote ports; as you can imagine, there are thousands of variables in this environment. That is why our KPIs will be more complex around that, and very

strategically set, but tactically justified and evolved as we move forward with the picture at hand.[100]

2.64 RFDS provided details of response times for 2020/21 (see Appendix 3).

**Funding**

2.65 RFDS explained fees are paid by the State or Commonwealth governments depending on the location of the transfer:

> **Mr GREEN:** there is a financial structure on which we record the number of hours, the retrievals, or the inter–hospital transfers conducted, what type of aircraft they were conducted on, and pricing according, and as part of the contract that is fed back to the contract provider, as the contractor, to tell them what we have done, and to justify the billing arrangements.
>
> **Hon DARREN WEST:** Just to be clear, I think I just heard you say that should a patient be retrieved from a hospital, you are contracted to the state government to provide that service.
>
> **Mr GREEN:** Correct.
>
> **Hon DARREN WEST:** But should a patient be retrieved from an accident site or a remote location, you have a contract with the Commonwealth.
>
> **Mr GREEN:** Yes, so there is an emergency retrieval contract at the Commonwealth level, which is common amongst most RFDS sections nationally in the federation. The primary contract for the WA Country Health Service is for that inter–hospital transfer.[101]

## Non–emergency inter–hospital patient transport

2.66 The Non–Emergency Inter–Hospital Patient Transport Agreement governs transport of low and medium acuity patients in metropolitan Perth. These patients do not require an emergency ambulance but do require some specialised form of transport or care. High acuity patients requiring an emergency ambulance are transported under the Emergency Ambulance Services Agreement.[102]

2.67 St John Ambulance WA has a right of first refusal to perform patient transfers in regional areas however WACHS is seeking to alter this arrangement.[103] The Department of Health explained that:

> The current Service Agreement states that SJA [St John Ambulance WA] acknowledges that WA Country Health Service (WACHS) is seeking to alter the delivery of the services in country WA in the future such that SJA no longer has the exclusive right or a first right of refusal to perform Inter Hospital Patient Transport in Country WA.
>
> WACHS and SJA will meet to negotiate a mechanism for achieving the strategy.[104]

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100 Royal Flying Doctor Service, Answer to question on notice 6 asked at hearing held 23 September 2021, dated 19 October 2021, p 12.

101 Anthony Green, General Manager, Royal Flying Doctor Service, transcript of evidence, 23 September 2021, pp 2–3.

102 Department of Health, *Emergency Services Agreement*, 25 September 2020, clause 2.12(a).

103 ibid.

104 Department of Health, Answer to question on notice 3 asked at hearing held 24 November 2021, dated 20 January 2022, p 2.

2.68 Service delivery of non–emergency inter–hospital patient transport is considered further in chapter 4.

2.69 Paragraphs 2.70–2.78 provide an overview of the contractual provisions of the Non–Emergency Inter–Hospital Patient Transport Agreement.

**Parties to contract**

2.70 The Department of Health contracts the following three organisations to provide non–emergency inter–hospital patient transport in Western Australia:

- St John Ambulance WA
- Wilson Medic One
- National Patient Transport.

2.71 Hospitals in the metropolitan area are required to order transfers through one of these organisations. Fiona Stanley Hospital and the Rottnest Island Nursing Post are exempt from these arrangements.[105]

**Term of contract**

2.72 The Non–Emergency Inter–Hospital Patient Transport Agreement commenced on 1 July 2015 and was due to expire on 30 December 2021. It has been extended until 30 May 2022.

2.73 A new panel contract for non–emergency planned patient transport services has since been developed and is due to commence on 31 May 2022.[106]

**Services provided**

2.74 The Non–Emergency Inter–Hospital Patient Transport Agreement governs transportation for low or medium acuity patients who have been assessed by a health professional as having a clinical need for ambulance transport.[107] A clinical need may be established where the patient:

- requires specialised equipment within the transport vehicle
- requires active clinical monitoring/care or clinical supervision during transport
- is suffering from an illness or disability that makes it impractical or unsafe to use any other form of transport.

2.75 Examples of situations in which non–emergency inter–hospital patient transport may be required include:

- transport for diagnostic procedures
- transport for out–patient services.

2.76 A common situation in which a patient requires inter–hospital transfer is when a patient requires specialist care at another hospital. The Department of Health explained this as follows:

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105 Department of Health, *Road Based Inter Hospital Patient Transport Services Policy,* 12 July 2021, p 2. See: https://ww2.health.wa.gov.au/~/media/Files/Corporate/Policy–Frameworks/Purchasing–and–Resource–Allocation/Policy/Road–Based–Inter–Hospital–Patient–Transport–Services–Policy/MP85–Road–Based–Inter–Hospital–Patient–Transport–Services–Policy.pdf. Viewed 20 January 2022.

106 Department of Health, Answer to question on notice 2 asked at hearing held 24 November 2021, dated 20 January 2022, p 1.

107 Submission 119 from National Patient Transport, 19 November 2021, p 1.

> As we are sitting here today, we would have patients who are being transported from, for example, the Armadale emergency department to Royal Perth because the patient requires the expert tertiary care at Royal Perth or Charlies or Fiona Stanley, that they cannot get at an outer–metropolitan site. Also, sometimes where they need specialist care. The main neurosciences specialist area is Sir Charles Gairdner Hospital. If somebody needs, basically, interventional neuroradiology, they will be moved to Sir Charles Gairdner Hospital.[108]

### Costs

2.77 The Department of Health pays the cost of inter–hospital transfers on behalf of the hospital from which the patient is being transferred.

### Key performance indicators

2.78 The Non–Emergency Patient Inter–Hospital Transport Agreement requires compliance with target response times based on scheduled pick up times.

## Mental health patient transport

2.79 The Department of Health contracts Wilson Medic One as the exclusive provider of mental health patient transport in metropolitan Perth. This service is available to patients who are referred by a psychiatrist, medical practitioner or an authorised mental health practitioner under the *Mental Health Act 2014*.

### Term of contract

2.80 The Mental Health Patient Transport Agreement was piloted in May 2019. It is the first dedicated transport service for mental health patients in Western Australia.[109]

2.81 Prior to the commencement of this service, mental health patient transport was provided under the Emergency Ambulance Services Agreement and the Non–Emergency Inter–Hospital Patient Transport Agreement.[110]

2.82 The Mental Health Patient Transport Agreement initially had an expiry date of 30 June 2021. This has been extended by two years to 30 June 2023.

### Services provided

2.83 Provisions for transport of mental health patients are set out in the *Mental Health Act 2014*. If a person needs to be transported between health facilities or from the community for mental health assessment, examination or treatment, they can travel with a clinician, a family member or by some other safe means. However, when no other safe means of transporting the person is reasonably available, an authorised practitioner can make a transport order under the *Mental Health Act 2014*.

2.84 The Mental Health Patient Transport Agreement requires Wilson Medic One to provide road based transport staffed by suitably qualified mental health transport officers.

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108 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 5.

109 Submission 106 from Department of Health, 31 August 2021, p 4.

110 ibid., p 5.

2.85 Wilson Medic One currently has four vehicles dedicated to mental health patient transport in the metropolitan area. One vehicle is available 24 hours a day 7 days a week while the remaining three are available 18 hours a day (6am–12 midnight) 7 days a week.[111]

[111] Department of Health, *Mental Health Patient Transport Contract Overview,* 1 January 2021. See: https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Mental-health-patient-transport/MH-Contract-overview.pdf. Viewed 1 May 2022.

# CHAPTER 3
# Delivery of emergency ambulance services

## Introduction

3.1 This chapter explains how emergency ambulance calls are received, assessed, prioritised and dispatched in Western Australia—see term of reference (a).

3.2 When a person dials 000, the call is answered by a call taker at a Telstra Emergency Service Answer Point. Telstra Answer Points are located all around Australia to receive emergency calls under the *Telecommunications (Emergency Call Service) Determination 2019* (Cth).[112] Requests for ambulance services in Western Australia are then directed to SJA SOC. SJA SOC staff assign a priority to the call and dispatch an ambulance to the patient (see Appendix 4 for SJA SOC emergency call workflow chart).

3.3 The main issues considered in this chapter are:

- St John Ambulance WA has been unable to meet their KPI of answering 90 per cent of calls within 10 seconds since 2018/19.
- SJA SOC call takers are required to use a structured call taking software program known as ProQA to determine the priority of calls. This software is designed to be risk averse and over–prioritises calls as a result.

3.4 This Committee considers:

- St John Ambulance WA's inability to meet their KPI to answer 90 per cent of calls within 10 seconds.
- strategies to mitigate the over–prioritising of calls by ProQA
- the merits of a proposed state–run health coordination centre staffed by representatives from hospitals and ambulance organisations
- whether or not the answering and dispatching 000 ambulance calls should continue to be provided by St John Ambulance WA.

## How 000 calls are received

### St John Ambulance WA State Operations Centre

3.5 St John Ambulance WA operates the SJA SOC across two sites. The primary site is located in Belmont. A secondary site exists in Wangara in the event the Belmont site is unable to receive calls.[113]

3.6 The Emergency Ambulance Services Agreement requires the SJA SOC to provide the following services:

- receive all 000 ambulance calls
- answer at least 90 per cent of 000 calls within 10 seconds
- answer all calls in an average of no more than 5 seconds
- conduct a clinical assessment using a structured call taking process

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[112] Telstra, *How Telstra works with Emergency Call Services*. See: https://www.telstra.com.au/consumer-advice/emergency-call-service. Viewed 3 February 2022.

[113] Submission 71 from St John Ambulance WA, 23 July 2021, p 10.

- identify callers who require a service and direct all other callers to more clinically appropriate services such as Healthdirect
- assign a dispatch priority to calls requiring a service
- dispatch an appropriate vehicle.[114]

**St John Ambulance WA State Operations Centre Staff**

3.7 Approximately 160 people are employed at the SJA SOC. More than 100 Emergency Medical Dispatchers are employed to answer emergency calls.[115]

3.8 Emergency Medical Dispatchers are required to undertake a 14 week training course. The training includes certification on specialist software such as Computer Aided Dispatch System and structured call taking software known as ProQA. Certification to use ProQA requires re–examination every two years to meet the standards of the International Academy of Emergency Medical Dispatchers.[116]

3.9 ProQA produces a structured set of rapid fire yes/no questions to determine the priority of the call. An ambulance crew is then dispatched based on the priority of the call and the availability of ambulances.

3.10 Figure 3 shows the average time for each component of this process between 1 January 2021 and 30 June 2021:

114 Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 4.

115 Submission 71 from St John Ambulance WA, 23 July 2021, p 10.

116 ibid.

Figure 3. *Average time for components of a triple zero call from 1 January 2021 to 30 June 2021*

Time call was answered by Telstra

Time call taker answered call (automated first key stroke)

Time ambulance first arrives on scene

17 seconds a)

20.5 seconds b)

124 seconds c)

d) Metro Ambulance Response Time

Priority 1 = 10.7 minutes

Priority 2 = 21.2 minutes

Priority 3 = 53.5 minutes

Time call first presented to SJAWA

Incident record automatically first saved in system

Note, flow diagram is not to scale.

a) The average time from when Telstra answered a Triple Zero (000) call to when they first presented it to a St John Ambulance WA (SJAWA) phone line is 17 seconds, for Triple Zero (000) calls coming into the State Operations Centre from 01 January 2021 to 30 June 2021.

b) The average time from when Telstra first presented a call to SJAWA to when a SJAWA call taker answered the call was 20.5 seconds, for Triple Zero (000) calls coming into the State Operations Centre from 01 January 2021 to 30 June 2021. The SJAWA key performance indicator is for 90% of 000 calls answered to be answered within 10 seconds, from first presentation to SJAWA to answer.

c) The average time from when a call taker answered the call to when the incident was first saved by the call taker was 124 seconds, for priority 1-3 metropolitan incidents from 01 January 2021 to 30 June 2021.

d) The average response time for metropolitan ambulance incidents was 10.7 minutes for priority 1, 21.2 minutes for priority 2 and 53.5 minutes for priority 3, for incidents occurring between 01 January 2021 to 30 June 2021.

Priority 4 incidents relate to booked transfers, as such ambulance or patient transfer services attend a booking time, rather than respond to an emergency call. Therefore, metropolitan ambulance response times are relevant for priority 1-3 incidents only.

[Source: St John Ambulance WA, Answer to question on notice 2 asked at hearing held 24 September 2021, dated 19 October 2021, pp 3–4.]

3.11 Operations Support Officers answer non–urgent calls such as bookings for non–emergency patient transfers. This allows Emergency Medical Dispatchers to focus on answering emergency calls.

3.12 Qualified paramedics assume the role of Clinical Support Paramedics within the SJA SOC. They monitor the priority codes allocated by ProQA to ensure an appropriate code has been allocated. They are also available to provide clinical advice to frontline responders.[117]

3.13 For country dispatch, the SJA SOC has a 24/7 dispatch desk for all regional calls, staffed by a dedicated Emergency Medical Dispatcher. Country Response Time Managers manage country dispatch and communications.[118]

3.14 The various staff roles at the SJA SOC are described in Table 8:

117 ibid., p 14.

118 ibid., p 15.

Table 8. *Staff roles at St John Ambulance WA State Operations Centre*

| Role | Description |
|---|---|
| Emergency Medical Dispatchers | Receive emergency, urgent and non–urgent telephone calls and dispatch ambulances. They are qualified to use a medical priority dispatch system to take emergency calls. |
| Operations Support Officers | Receive non–urgent calls to deliver capacity to Emergency Medical Dispatcher.<br>Non–urgent calls include calls to operational ambulance crews, emergency service agencies, hospitals and bookings for non–emergency patient transport. |
| Radio Dispatchers | Dispatch ambulance crews to calls and actively monitor their progress. Radio Dispatchers are used in three different areas:<br>• Country Dispatch Desk<br>• Metro South Desk<br>• Metro North Desk. |
| Clinical Support Paramedics | Provide clinical leadership support and extended decision–making capabilities in support of Emergency Medical Dispatchers and clinical support and escalation for on–road crews. The team of Clinical Support Paramedics rotate through on–road and SJA SOC positions. |
| Duty Managers | Manage the SJA SOC to ensure state–wide ambulance resources are appropriately and effectively deployed, monitoring key performance indicators. This role involves:<br>• ensuring call taking is carried out in the approved process<br>• maintaining adequate staffing levels at the SJA SOC. |
| Response Time Managers | Proactively monitor and advise on the distribution of resources within the metropolitan area to ensure operational resources are available to meet predicted demand and performance targets. |
| Country Response Time Managers | Manage country dispatch and communications. This role involves:<br>• providing leadership and support for the Country Dispatch Team<br>• escalating service delivery concerns<br>• liaising with other emergency services. |
| Ambulance Network Coordinators | Appropriately distribute ambulance attendances in the metropolitan region to hospital emergency departments based on the Department of Health requirements, while taking into account the condition of the patient and the status of emergency departments. The aim is to be pre–emptive and actively manage ambulance distribution. |
| Secondary Triage Team | Re–prioritise ambulance calls by gathering more information and undertaking a clinical review to better understand patient acuity. When appropriate, alternative care pathways are discussed with the caller such as visiting the patient's GP, an Urgent Care centre, or accessing a GP telehealth service. Secondary triage is confined to low acuity calls and occurs prior to the SJA SOC allocating the call. |

[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 11; St John Ambulance WA, Answer to question on notice 11 asked at hearing held 24 November 2021, dated 24 December 2021, pp 17–8]

**Time taken to answer calls**

3.15 The SJA SOC is required to answer:

- 90 per cent of calls within 10 seconds

- with an average of no more than 5 seconds.[119]

3.16 St John Ambulance WA has been unable to achieve the requirement to answer 90 per cent of calls within 10 seconds since 2018/19 (Table 9). Performance against this KPI has fallen from 94.3 per cent to 83.3 per cent between 2017/18 and 2020/21.

**FINDING 1**

St John Ambulance WA has been unable to achieve their contractual requirement to answer 90 per cent of calls within 10 seconds since 2018/19.

3.17 Table 9 shows St John Ambulance WA consistently answered 90 per cent of calls within 10 seconds prior to 2017/18. In 2020/21 Western Australia had the poorest performance of all jurisdictions in Australia against this indicator:

Table 9. *Percentage of 000 calls answered within 10 seconds in Australia between 2012/13 – 2020/21*

| Year | WA | NSW | Vic | Qld | SA | Tas | ACT | NT | Aust. |
|---|---|---|---|---|---|---|---|---|---|
| 2020/21 | 83.3 | 94.1 | 88.9 | 89.1 | 95.4 | 95.9 | 95.2 | 89.2 | 90.8 |
| 2019/20 | 86.2 | 91.5 | 94.4 | 91.3 | 95.4 | 97.7 | 95.9 | 93.6 | 92.1 |
| 2018/19 | 89.5 | 79.6 | 93.7 | 91.5 | 93.7 | 76.9 | 97.0 | 97.7 | 88.4 |
| 2017/18 | 94.3 | 81.5 | 93.9 | 92.1 | 92.6 | 78.7 | 96.5 | 97.7 | 89.4 |
| 2016/17 | 94.5 | 79.7 | 93.8 | 91.9 | 95.4 | 75.6 | 95.8 | 96.5 | 88.9 |
| 2015/16 | 95.2 | 81.2 | 93.1 | 91.6 | 95.3 | 95.3 | 96.6 | 95.9 | 93.2 |
| 2014/15 | 94.4 | 86.1 | 93.3 | 91.2 | 92.3 | 96.8 | 95.8 | 93.4 | 89.5 |
| 2013/14 | 94.1 | 88.5 | 92.8 | 90.7 | 91.3 | 96.2 | 96.0 | 9.0 | 89.4 |
| 2012/13 | 94.4 | 90.9 | 91.4 | 90.6 | 91.3 | 94.2 | 88.7 | 10.4 | 89.9 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 11A.4.]

**FINDING 2**

In 2020/21 Western Australia had the poorest performance of all jurisdictions in Australia against the key performance indicator to answer 90 per cent of calls within 10 seconds.

3.18 Table 10 provides a breakdown of the time taken for the SJA SOC to answer 000 calls from Telstra between January 2020 and September 2021. This breakdown reveals the following aspects of their performance:

- the majority of calls were answered within 5 seconds
- the number of calls answered after 60 seconds rose above 10 per cent of total calls between March and June 2021.

Table 10. *Time taken for St John Ambulance WA State Operations Centre to answer calls from Telstra between January 2020 and September 2021*

| Month | 0–5 sec | 5–10 sec | 10–15 sec | 15–20 sec | 20–25 sec | 25–30 sec | 30–60 sec | > 60 sec | Total |
|---|---|---|---|---|---|---|---|---|---|
| Jan 20 | 17 919 | 535 | 365 | 270 | 208 | 180 | 898 | 1 334 | 21 709 |

[119] Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 4 clause 18(a)(i).

| Month | 0–5 sec | 5–10 sec | 10–15 sec | 15–20 sec | 20–25 sec | 25–30 sec | 30–60 sec | > 60 sec | Total |
|---|---|---|---|---|---|---|---|---|---|
| Feb 20 | 17 856 | 460 | 280 | 240 | 226 | 157 | 629 | 1 028 | 20 877 |
| Mar 20 | 18 867 | 538 | 368 | 238 | 199 | 148 | 636 | 863 | 21 857 |
| Apr 20 | 16 214 | 353 | 211 | 141 | 77 | 72 | 194 | 204 | 17 467 |
| May 20 | 18 066 | 404 | 249 | 158 | 95 | 99 | 275 | 287 | 19 633 |
| Jun 20 | 18 012 | 411 | 237 | 145 | 100 | 74 | 216 | 188 | 19 385 |
| Jul 20 | 18 432 | 441 | 297 | 209 | 151 | 111 | 461 | 644 | 20 746 |
| Aug 20 | 18 955 | 418 | 273 | 203 | 151 | 123 | 478 | 629 | 21 230 |
| Sep 20 | 18 873 | 434 | 250 | 197 | 111 | 108 | 405 | 546 | 20 924 |
| Oct 20 | 19 696 | 443 | 318 | 194 | 147 | 154 | 545 | 844 | 22 341 |
| Nov 20 | 19 709 | 496 | 210 | 218 | 175 | 156 | 623 | 842 | 22 529 |
| Dec 20 | 20 312 | 602 | 334 | 276 | 255 | 245 | 873 | 1 674 | 24 571 |
| Jan 21 | 19 726 | 539 | 343 | 271 | 220 | 238 | 797 | 1 483 | 23 617 |
| Feb 21 | 17 203 | 449 | 318 | 193 | 153 | 118 | 587 | 936 | 19 957 |
| Mar 21 | 17 988 | 526 | 364 | 290 | 266 | 244 | 1,015 | 2 483 | 23 176 |
| Apr 21 | 16 374 | 492 | 333 | 290 | 245 | 241 | 1,132 | 2 616 | 21 723 |
| May 21 | 17 833 | 561 | 396 | 312 | 286 | 240 | 1,199 | 2 934 | 23 761 |
| Jun 21 | 18 735 | 521 | 364 | 267 | 241 | 223 | 1,035 | 2 621 | 24 007 |
| Jul 21 | 19 707 | 453 | 293 | 232 | 176 | 144 | 678 | 1 353 | 23 036 |
| Aug 21 | 21 653 | 448 | 383 | 234 | 175 | 199 | 760 | 1 503 | 25 355 |
| Sep 21 | 21 016 | 479 | 294 | 212 | 143 | 137 | 598 | 836 | 23 715 |

[Source: Telstra Corporation, letter, 25 October 2021, p 5.]

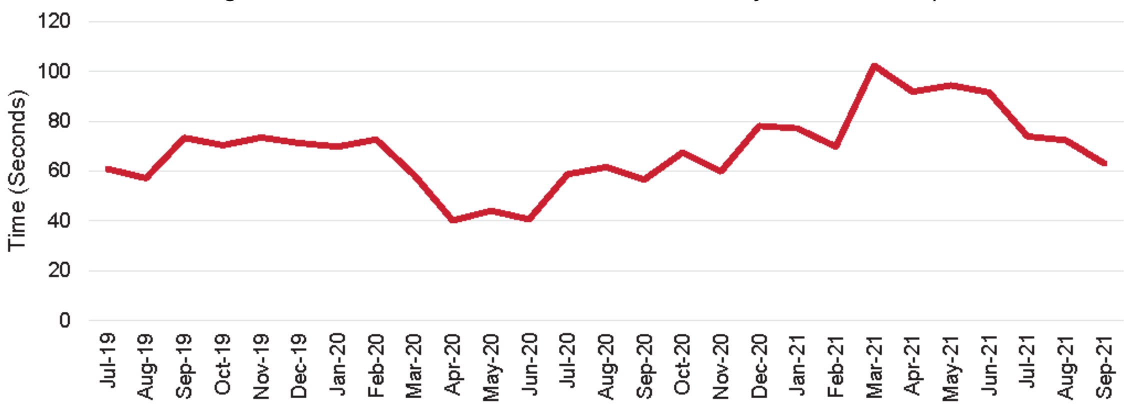
**FINDING 3**

Between January 2020 and September 2021:

- the majority of 000 ambulance calls were answered by the St John Ambulance WA State Operations Centre within 5 seconds
- the number of calls answered after 60 seconds rose above 10 per cent of total calls between March and June 2021.

3.19 Over the last two years, the average time taken to answer calls that were not answered within 10 seconds ranged from 40 seconds to over 100 seconds. This is shown in Figure 4:

Figure 4. *Average time taken for St John Ambulance WA State Operations Centre to answer calls from Telstra (not including calls answered within 10 seconds) from 1 July 2019 to 30 September 2021.*




[Source: St John Ambulance WA, Answer to question on notice 1 asked at hearing held 24 September 2021, dated 19 October 2021, p 1.]

3.20 The Committee received a number of submissions noting delays in calls being answered by the SJA SOC. These include the following:

- Ambulance Employees Association of WA:

> People in the WA community have spent up to 90 minutes trying to connect their calls to our State Operations Centre in order to arrange an ambulance despatch. During emergencies, family members or bystanders have been left with no options other than to attempt resuscitation or medical intervention without trained assistance for up to several hours. This has ended in death or serious injury in some cases.[120]

- Paramedic:

> My experience is purely on–the–ground when attending patients who state that it took longer to get through to the call centre than it did for the ambulance to get there, or the patient's family who state that they had three people trying to get through because the first one was still waiting to be answered.[121]

**Increase in the number of calls to the St John Ambulance WA State Operations Centre**

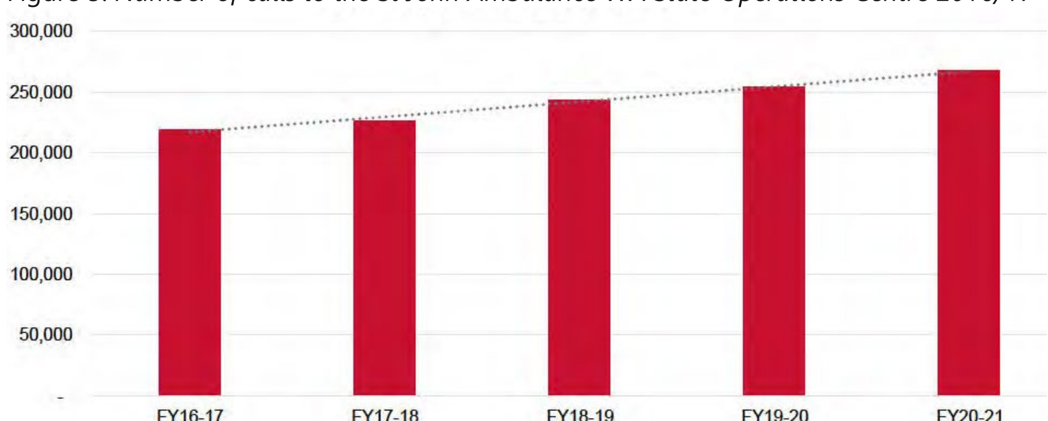
3.21 St John Ambulance WA explained the fall in performance of this KPI (answering 000 calls in the specified time) has been directly affected by an increase in the number of calls for ambulances.[122] Figure 5 shows the number of calls to the SJA SOC has increased 22 per cent between 2016/17 and 2020/21. This is a significant increase:

120 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, p 1.

121 Submission 40 from Private Citizen, 21 July 2021, p 1.

122 Submission 71 from St John Ambulance WA, 23 July 2021, p 16.

Figure 5. *Number of calls to the St John Ambulance WA State Operations Centre 2016/17 – 2020/21*




[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 16.]

**FINDING 4**

The number of calls to the St John Ambulance WA State Operations Centre has increased 22 per cent between 2016/17 and 2020/21.

### Staffing levels

3.22 Staffing levels at the SJA SOC—and the consequences of insufficient staff numbers—have been consistently raised in inquiries about St John Ambulance WA operations in Western Australia.

*Joyce Report recommendations*

3.23 In 2009 the Joyce Report on ambulance services found inadequate staffing levels at the SJA SOC to be a matter of concern:

> Several submissions and stakeholders indicated a pressing need for increased staffing levels in the communications centre due to workload pressures and the potential for mistakes. In recent times, staffing levels are reported to have been lower than the number specified previously (e.g. there may be only two call takers on duty during the busiest times on Friday and Saturday nights).[123]

3.24 At the time of the Joyce Report only 62.7 per cent of calls were answered within 10 seconds.[124]

3.25 The Joyce Report compared the number of call takers in each jurisdiction in Australia. Figure 6 shows the proportion of call takers at the Western Australian SJA SOC per capita was the lowest in Australia. The Joyce Report noted the number of calls the SJA SOC received indicated the need for more staff to ensure compliance with the benchmark of answering 90 per cent of calls within 10 seconds.[125]

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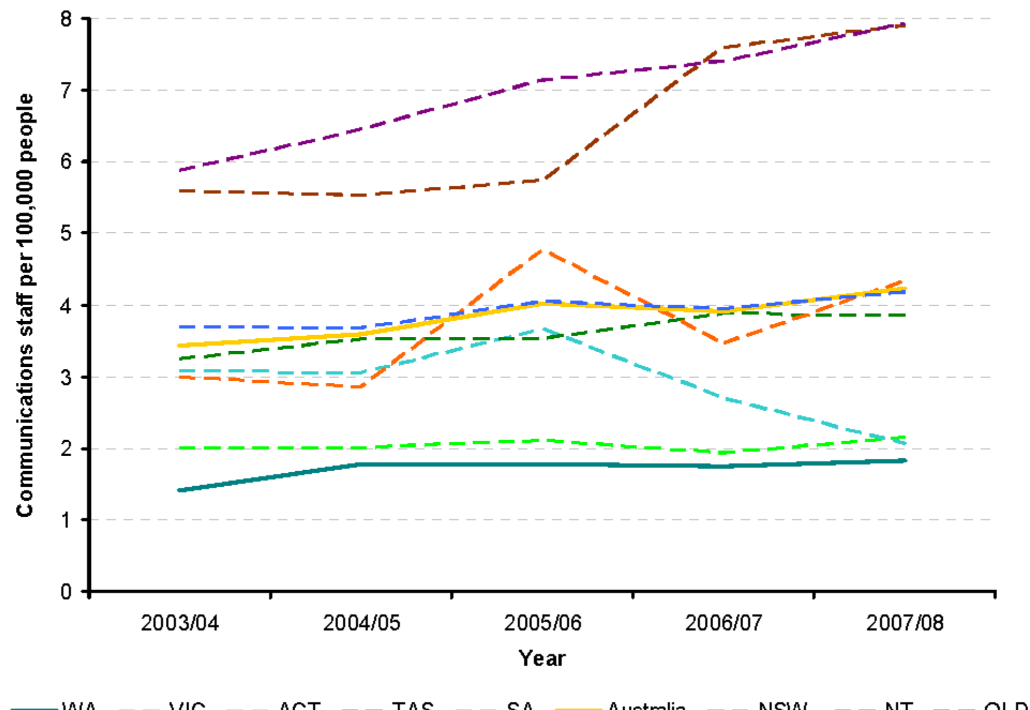
[123] Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 26.

[124] ibid., p 56

[125] ibid., p 27.

Figure 6. *Number of communication staff per 100 000 people in each jurisdiction 2003/04 – 2007/08*




[Source: Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 27]

3.26 A follow–up report in 2010—*Implementation of Recommendations Report*—noted St John Ambulance WA committed to:

- increase staffing levels by 40 FTE[126] in accordance with this recommendation[127]
- achieve staffing at the SJA SOC (inclusive of the additional 40 FTE) as outlined in Table 11 by 2014.[128]

3.27 Figure 7 shows the number of call takers employed at the SJA SOC between 2008/09 and 2020/21. The second column of this table shows St John Ambulance WA made a commitment to employ an additional 40 call takers between 2009/10 and 2013/14. The fourth column of the table shows St John Ambulance WA honoured this commitment between 2012/13 and 2019/20 but fell slightly below the required staffing levels between 2013/14 and 2015/16:

126 Full–time equivalent staff.

127 Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010, p 8.

128 ibid.

Figure 7. *Full–time equivalent call takers in the St John Ambulance WA State Operations Centre 2008/09–2020/21*

| FY | DOH Requirement* | Intake Officers | Total FTE |
|---|---|---|---|
| FY08/09 | | | **31.9** |
| FY09/10 | 10 | 14 | **42.91** |
| FY10/11 | 10 | 36 | **65.41** |
| FY11/12 | 10 | 17 | **72.41** |
| FY12/13 | 5 | 18 | **78.99** |
| FY13/14 | 5 | 4 | **70.78** |
| FY14/15 | | 4 | **69.32** |
| FY15/16 | | 7 | **71.17** |
| FY16/17 | | 4 | **74.62** |
| FY17/18 | | 8 | **76.94** |
| FY18/19 | | 6 | **75.96** |
| FY19/20 | | 23 | **88.98** |
| FY20/21 | | 21 | **93.98** |
| | | As at 30.09.21 | **96.94** |

*positions created and filled as directed under the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, December 2010

3.28 [Source: St John Ambulance WA, Answer to question on notice No 4 asked at hearing held 24 September 2021, dated 19 October 2021, p 8.]

3.29 Figure 7 also shows St John Ambulance WA continued to increase the number of call takers at the SJA SOC after their commitment to increase staffing levels ended in 2013/14. Full–time equivalent call takers have increased by 33 per cent since this time.

3.30 Table 11 shows the staffing arrangements in the SJA SOC in June 2014 following the implementation of St John Ambulance WA's commitment to increase staffing levels:

Table 11. *Expected staffing arrangements in the St John Ambulance WA State Operations Centre in June 2014 following implementation of St John Ambulance WA commitment to increase staffing levels*

| Time | Staff | Total Staff |
|---|---|---|
| 7am – 7pm | • Manager, Clinical Team Leader<br>• Ambulance Network Coordinator<br>• 15 Communications Officers | 18 |
| 7[pm] – 1am | • Manager<br>• Ambulance Network Coordinator<br>• 13 Communications Officers | 15 |
| 1am – 7am | • Manager<br>• Ambulance Network Coordinator<br>• 12 Communications Officers | 14 |

[Source: Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010, p 8.]

*Current staffing levels*

3.31 Submissions to this inquiry insist that current staffing levels at the SJA SOC are still inadequate. For example, the Ambulance Employees Association of WA linked insufficient call centre staff numbers to increasing delays in answering calls:

Members state that the workforce is at breaking point, and that constant audits are pushing staff to high stress levels.[129] High call volumes, low staffing levels and a lack of support are the cause of low morale and an inability to meet demand. Communications centre staff are often unable to take breaks to eat, use the bathroom or rest, as it is 'normal' for dozens of 000 calls to queue and re–queue on their screens.

[St John Ambulance WA] are well aware of these figures and they have been consistently addressed by the [Ambulance Employees Association of WA], but with very few implementations initiated by the organisation to reduce the issue. Some initiatives, such as the hiring of operational support officers, have in fact created more work for our [SJA SOC] staff.[130]

3.32 The Committee asked St John Ambulance WA if the staffing levels in Table 11 have been maintained:

**The CHAIR:** Thank you. Back in 2009, the Department of Health had an inquiry into St John Ambulance, and it was recommended that the staffing level by June 2014 to be at 15 communications officers between 7.00 am and 7.00 pm, 13 communications officers between 7.00 pm and 1.00 am, and 12 communications officers between 1.00 am and 7.00 am. Now we are in 2021, so throughout the past seven years, was this level maintained by St John at the state operations centre?

**Mr BRINK:** I can answer that. We have improved it. It formed part of my directorates for the last two and a half years, and I looked at the numbers in the past. On average for the past month we have 23 on the day shift—average—23 people within the call centre, which includes two managers, one ambulance network coordinator, 16 comms officers, and four operation support officers.

**The CHAIR:** So this is the current situation?

**Mr BRINK:** Yes.

**The CHAIR:** Yes, sure. My question was more in relation to the period between 2014 and now. The recommendation from the Joyce report was to have a certain staffing level as of June 2014. My question is: was that recommendation on staffing level maintained by St John at the state operations centre? Throughout the past seven years, what was the staffing level like?

**Mr BRINK:** I would have to come back. I will give you all the numbers per year.[131]

3.33 During the second hearing the Committee asked whether the recommendations of the Joyce Report about staffing levels within the SJA SOC had been maintained since that time. St John Ambulance WA advised:

**Ms FYFE:** In fact, there are significantly higher levels of staffing in the State Operations Centre over the last two years. Those recommendations were adhered

129 See paragraph 3.75 for information on auditing of 000 calls.

130 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, p 3. See also: Private Submission 43 from Private Citizen, 21 July 2021, p 3; Private Submission 79 from Private Citizen, 23 July 2021, pp 1–2; Submission 47 from Private Citizen, 23 July 2021, p 1; Submission 75 from Private Citizen, 23 July 2021, p 6.

131 Deon Brink, Executive Director Ambulance Services, St John Ambulance WA, transcript of evidence, 24 September 2021, pp 5–6.

to. There was one point where it dropped marginally below the recommendation, but it was brought up to that recommendation.[132]

3.34 After repeated attempts to ascertain staffing levels in the SJA SOC the Committee requested the actual number of call takers on duty during the first week of October over the past five years. This was done in order to provide a snapshot of actual staffing levels in the SJA SOC. Figure 8 shows the number of call takers on duty during the first week of October from 2017 to 2021.

Figure 8. *Staffing levels in the St John Ambulance WA State Operations Centre from October 1 – 7 between 2017 and 2021*

**2017**

| POSITIONS | 1/10/2017 | | 2/10/2017 | | 3/10/2017 | | 4/10/2017 | | 5/10/2017 | | 6/10/2017 | | 7/10/2017 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D | N | D | N | D | N | D | N | D | N | D | N | D | N |
| Duty Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Response Time Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Ambulance network Co-Ordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | 1 | 1 | 1 |
| Country Response Time Manager | | | 1 | | 1 | | 1 | | 1 | | 1 | | | |
| Clinical Support Paramedic | 1 | 2 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| Operations Support Officer | | | | | | | | | | | | | | |
| Dispatcher | 4 | 8 | 5 | 6 | 5 | 5 | 5 | 6 | 5 | 5 | 5 | 5 | 4 | 6 |
| Call Taker | 6 | 7 | 6 | 7 | 5 | 6 | 6 | 5 | 7 | 6 | 7 | 7 | 5 | 7 |
| **TOTAL STAFF ON SHIFT** | 14 | 20 | 16 | 18 | 15 | 15 | 16 | 15 | 18 | 16 | 17 | 17 | 14 | 18 |

**2018**

| POSITIONS | 1/10/2018 | | 2/10/2018 | | 3/10/2018 | | 4/10/2018 | | 5/10/2018 | | 6/10/2018 | | 7/10/2018 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D | N | D | N | D | N | D | D | N | D | N | D | N | D |
| Duty Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Response Time Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Ambulance network Co-Ordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Country Response Time Manager | 1 | | 1 | | 1 | | 1 | | 1 | | | | | |
| Clinical Support Paramedic | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 1 | 2 | 1 | 2 |
| Operations Support Officer | | | | | | | | | | | | | | |
| Dispatcher | 5 | 4 | 8 | 5 | 7 | 3 | 10 | 5 | 9 | 6 | 6 | 6 | 6 | 5 |
| Call Taker | 8 | 6 | 5 | 11 | 5 | 8 | 7 | 4 | 7 | 5 | 6 | 7 | 5 | 6 |
| **TOTAL STAFF ON SHIFT** | 18 | 14 | 18 | 20 | 17 | 15 | 23 | 13 | 22 | 15 | 16 | 18 | 15 | 16 |

**2019**

| POSITIONS | 1/10/2019 | | 2/10/2019 | | 3/10/2019 | | 4/10/2019 | | 5/10/2019 | | 6/10/2019 | | 7/10/2019 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D | N | D | N | D | N | D | D | N | D | N | D | N | D |
| Duty Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Response Time Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Ambulance network Co-Ordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Country Response Time Manager | 1 | | | | | | | | | | | | | |
| Clinical Support Paramedic | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 1 |
| Operations Support Officer | | | | | | | | | | | | | | |
| Dispatcher | 8 | 4 | 7 | 5 | 7 | 6 | 6 | 7 | 6 | 4 | 6 | 5 | 4 | 4 |
| Call Taker | 4 | 7 | 4 | 7 | 4 | 4 | 5 | 6 | 4 | 6 | 5 | 4 | 5 | 3 |
| **TOTAL STAFF ON SHIFT** | 18 | 16 | 16 | 17 | 16 | 15 | 16 | 18 | 14 | 15 | 15 | 14 | 14 | 11 |

**2020**

| POSITIONS | 1/10/2020 | | 2/10/2020 | | 3/10/2020 | | 4/10/2020 | | 5/10/2020 | | 6/10/2020 | | 7/10/2020 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D | N | D | N | D | N | D | D | N | D | N | D | N | D |
| Duty Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Response Time Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Ambulance network Co-Ordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Country Response Time Manager | | | | | | | | | 1 | | 1 | | 1 | |
| Clinical Support Paramedic | 2 | 1 | 2 | 1 | 1 | 2 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| Operations Support Officer | | | | | | | | | | | | | | |
| Dispatcher | 5 | 6 | 6 | 6 | 5 | 5 | 5 | 4 | 6 | 5 | 5 | 6 | 6 | 5 |
| Call Taker | 10 | 8 | 10 | 6 | 8 | 9 | 9 | 9 | 10 | 9 | 10 | 10 | 8 | 10 |
| **TOTAL STAFF ON SHIFT** | 20 | 18 | 21 | 16 | 17 | 19 | 18 | 18 | 21 | 18 | 20 | 20 | 19 | 19 |

132 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 29 October 2021, p 2.

**2021**

| POSITIONS | 1/10/2021 | | 2/10/2021 | | 3/10/2021 | | 4/10/2021 | | 5/10/2021 | | 6/10/2021 | | 7/10/2021 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | D | N | D | N | D | N | D | D | N | D | N | D | N | D |
| Duty Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Response Time Manager | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Ambulance network Co-Ordinator | 1 | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Country Response Time Manager | | | | | | | 1 | | 1 | | 1 | | 1 | |
| Clinical Support Paramedic | 2 | 1 | 1 | 2 | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 2 | 1 | 2 |
| Operations Support Officer | 4 | | 3 | 4 | 5 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 3 | 4 |
| Dispatcher | 5 | 6 | 5 | 4 | 5 | 3 | 5 | 5 | 5 | 4 | 7 | 7 | 7 | 7 |
| Call Taker | 12 | 10 | 12 | 12 | 13 | 14 | 12 | 11 | 13 | 12 | 8 | 11 | 9 | 10 |
| **TOTAL STAFF ON SHIFT** | 26 | 19 | 24 | 25 | 27 | 26 | 27 | 24 | 28 | 24 | 23 | 27 | 24 | 26 |

[Source: St John Ambulance WA, Answer to question on notice 11 asked at hearing held 24 November 2021, dated 24 December 2021, pp 14–6.]

3.35 While direct comparisons with the Joyce recommendations are difficult because the staffing model and shift structure has changed, the evidence shows that:

- Operations Support Officers have been employed since 2021. As outlined previously (see paragraph 3.11) the role of these officers is to receive non–urgent calls.
- Prior to 2021, the staffing levels committed to in the 2010 Implementation of Recommendations Report had not been consistently maintained.
- There has been a noticeable increase in communications staff numbers rostered per shift in 2020 and 2021.

**FINDING 5**

From a snapshot of data provided, St John Ambulance WA have not complied with their commitment in the 2010 *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* to maintain the following number of communications officers per shift:

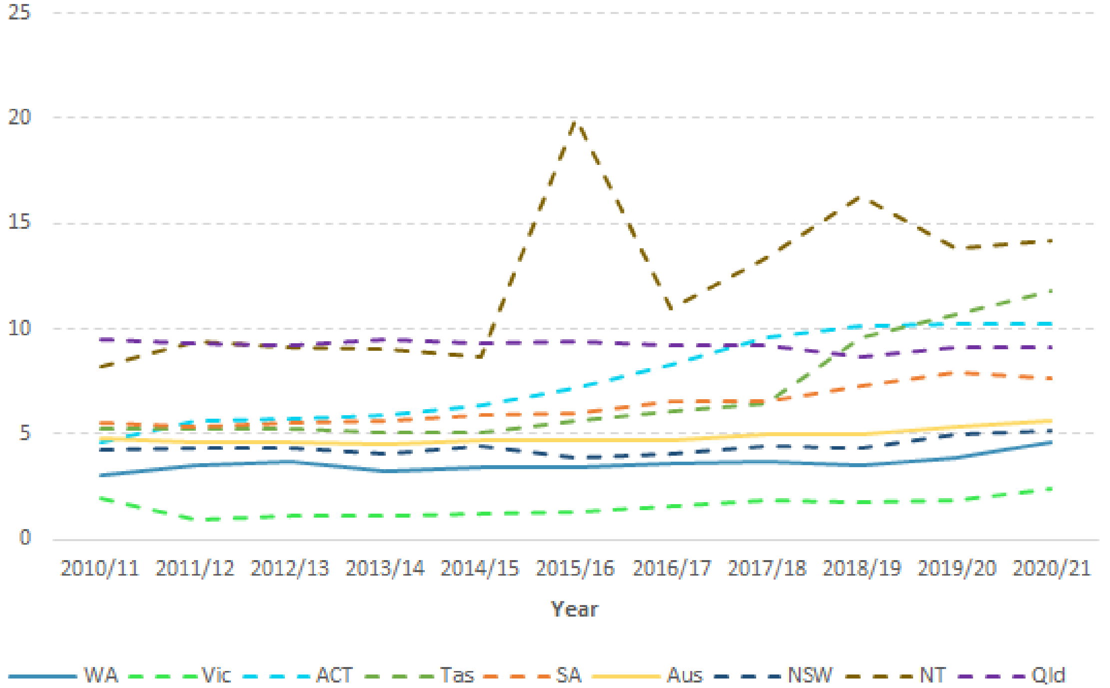
- 15 Communications Officers between 7am and 7pm
- 13 Communications Officers between 7pm and 1am
- 12 Communications Officers between 1am and 7am.

**FINDING 6**

St John Ambulance WA has not been rostering sufficient communications officers in the St John Ambulance WA State Operations Centre to meet their contractual requirement to answer 90 per cent of calls within 10 seconds since 2018/19.

3.36 Although staffing levels at the SJA SOC have improved since the Joyce Report, data from the Productivity Commission shows that Western Australia remains below the national average with the second lowest communications staff per capita in Australia (Figure 9).

Figure 9. *Number of communications staff per 100 000 people in each jurisdiction in Australia 2010/11 – 2019/20*




[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 11A.8; Australian Government, Australian Bureau of Statistics, *Population – states and territories,* 5 February 2022.]

**FINDING 7**

The number of call takers per capita in Western Australia has almost doubled since the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* in 2010. Despite this, the number of call takers per capita in Western Australia has consistently remained the second lowest in Australia and is below the national average.

*Rostering staff at the St John Ambulance WA State Operations Centre*

3.37 The Committee received evidence that staff rostering at the SJA SOC does not accommodate changes in demand for emergency ambulances:

> The organisation adopts an 'establishment' model that provides a given number of staff per roster in the SJA SOC and a set number of crews on the road. This makes creating rosters a relatively easy process. Unfortunately, it provides little scope to match demand, typically resulting in the same number of staff rostered to work a busy Saturday night as are rostered to work a quieter Sunday night.
>
> …
>
> Demand based rostering would alleviate many of the staffing issues, but requires more effort from the workforce planning team. It requires an understanding of the variables that impact service levels and forecasting future demand.[133]

3.38 The Committee asked St John Ambulance WA if the rostering model at the SJA SOC provides additional staffing for busy periods such as weekends, long weekends and holidays. St John Ambulance WA responded they employ certain call takers under casual or flexible

133 Private Submission 79 from Private Citizen, 23 July 2021, pp 1–2.

arrangements in order to achieve this but noted the operating environment in the SJA SOC is not conducive to a flexible workforce.[134]

3.39 Figure 8 confirms the rostering of call takers does not appear to correlate to periods of high demand such as weekends.

3.40 St John Ambulance WA advised they are currently negotiating with the Department of Health to include contractual mechanisms in the new Emergency Services Agreement to ensure SJA SOC staffing levels align with KPI targets:

> St John have commenced contract negotiations with the Department of Health for a new Services Agreement where the focus for funding for the State Operations Centre is aligned with demand to increase staffing as the demand (call volumes) grow. Utilisation of the Erlang C Calculator is being considered as a contract tool to ensure staffing levels align to meet our SOC KPI targets.[135]

3.41 The Committee suggests a demand based rostering system at the SJA SOC be investigated.

**RECOMMENDATION 3**

The Department of Health review the adequacy of the staffing levels from the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* in 2010, establish key performance indicators (KPIs) for minimum staffing levels at the St John Ambulance WA State Operations Centre (with particular emphasis on 000 emergency call takers) and introduce a mechanism to allow the monitoring and reporting of actual staff on shift against contractual KPIs. When determining staffing levels, the Department of Health also consider requiring a demand based rostering system.

### External pressures

3.42 St John Ambulance WA submitted that external pressures on the broader health system such as ramping, hospital bypass and an increase in mental health cases have impacted their ability to comply with the 'answering calls' KPIs.[136]

3.43 These external pressures have tied up ambulances at hospitals and reduced the number of ambulances available in the community to respond to calls. The lack of available ambulances has resulted in Emergency Medical Dispatchers requiring more time to manage crew dispatch:

> Emergency Medical Dispatchers (EMDs) remain on the call for the duration of most Priority 1 calls to support the patient facing a life–threatening situation until the ambulance arrives.
>
> …
>
> Increased extended Transfer of Care (ramping) leads to increased response times which in turn impacts the EMDs ability to take the next call and ultimately impacts St John WA's performance against the KPI to answer calls within 10 seconds.
>
> …
>
> In times of ramping these callers often call 000 multiple times to determine how long the ambulance will be. These calls, known as call–backs, increase significantly

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134 Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 24 September 2021, pp 7–8.

135 St John Ambulance WA, letter, dated 8 March 2022, p 1.

136 Submission 71 from St John Ambulance WA, 23 July 2021, p 16.

during ramping resulting in an increased workload on the SOC and ultimately impacting response times for 000 calls.[137]

3.44 Crews attending to lower priority jobs are now more often diverted to higher priority jobs due to the lack of crews available to respond. Diversion rose from 11 per cent in June 2019 to 14.9 per cent in June 2021.[138]

3.45 The time between a call being received to an ambulance being cleared to return to the road has increased from 92 minutes in June 2019 to 132 minutes in June 2021.[139] This 40 minute increase is a significant constraint on crew availability. It is a result of ambulance ramping, higher demand and hospital bypass. Hospital bypass is where an ambulance is diverted to a hospital further away. It results in crews needing to travel further to respond to cases.

3.46 There has been an increase in mental health cases to which ambulances respond. These can be complex and require significant investment in time. Monthly suicide and self–harm related cases increased by 52 per cent between January 2016 and January 2021.[140]

**Working conditions at the St John Ambulance WA State Operations Centre**

3.47 The Joyce Report recognised the SJA SOC was a complex and high pressure working environment where staff conducted themselves in a professional and dedicated manner.[141]

3.48 The Joyce Report further stated that high intensity work coupled with 12 hour shift rotations requires SJA SOC staff are provided adequate breaks and rotate between functions. St John Ambulance WA's evidence to the Committee was that staff are provided with structured breaks however it is unclear the extent to which the organisation ensures this entitlement:

> **Mr BRINK:** Yes, they do. We have structured breaks. I cannot remember exactly, but it is after a certain amount of hours there is a certain amount of time that they can take breaks for lunch and for them to take a break.
>
> …
>
> Especially when I took over two and a half years ago, some of those breaks did not happen. People were answering calls and it was a completely stressed environment. My understanding is that it is better. My managers in SOC is looking after that. I cannot tell you if it still happens where people work through their breaks, but with the staffing levels that we have now, that should not occur.[142]

3.49 In contrast, the Ambulance Employees Association of WA submitted that:

> Communications centre staff are often unable to take breaks to eat, use the bathroom or rest, as it is "normal" for dozens of 000 calls queue and re–queue on their screens.[143]

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137 St John Ambulance WA, letter, dated 1 March 2022, p 5.

138 Submission 71 from St John Ambulance WA, 23 July 2021, p 16.

139 ibid.

140 ibid.

141 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 26.

142 Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 24 September 2021, pp 8–9.

143 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, p 3.

### Estimated time of arrival

3.50 The Committee heard evidence that call takers are instructed not to advise the estimated time of arrival of an ambulance. The United Workers Union recommended call takers provide callers with an estimated time of arrival to help inform people in making a decision to drive themselves to hospital.[144]

3.51 St John Ambulance WA gave evidence call takers do advise callers if an ambulance is likely to be delayed:

> When a call is made to the operation centre from the community and the patient, if at any point there is going to be a delay that the operations centre believes would be better for the patient to seek alternative arrangements to attend hospital, they will inform the patient on the call. That could be, "You are 500 metres from the hospital, are you able to make it yourself?".[145]

3.52 The Committee suggests it is likely to be helpful for callers to be provided with an estimated time of arrival.

## How 000 calls are assessed

3.53 St John Ambulance WA call takers use structured call taking software called ProQA that tends to over–prioritise calls. This section considers how over–prioritisation can be reduced through:

- auditing of 000 calls
- re–assessment of the ProQA algorithm
- re–assessment of calls at the SJA SOC
- comparing call priority against assessments of acuity made by paramedics on scene
- comparing call priority against clinical outcomes of patients recorded by hospital staff.

### Structured call taking process—ProQA

3.54 St John Ambulance WA use a structured call–taking software package called ProQA. ProQA is a form of Medical Priority Dispatch System (MPDS).

3.55 This system of emergency dispatch was developed by Dr Jeff Clawson in the 1970s. Dr Clawson is a board member of the International Academy of Emergency Dispatchers (IAED) who develop MPDS protocols and provide training to dispatchers around the world, including St John Ambulance WA.[146]

3.56 Dr Clawson is also the founder and Chief Executive Officer of Priority Dispatch Corporation (PDC), the developers of the ProQA software, which has an exclusive contract with the IAED to distribute their MPDS system:

> The content of the MPDS...is developed, approved, and provided by the IAED. PDC has an exclusive contract with the IAED for the distribution of the same.[147]

3.57 PDC highlight one of the major benefits of their system:

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144 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 11.

145 Justin Fonte, Head of Country Operations, St John Ambulance WA, transcript of evidence, 29 October 2011, p 4.

146 International Academies of Emergency Dispatch, *Who We Are*. See: https://www.emergencydispatch.org/who-we-are#iaed-leadership. Viewed: 13 April 2022.

147 Priority Dispatch Corp, *Executive Summary*. See: https://prioritydispatch-media.s3.amazonaws.com/prioritydispatch.net/salessheets/1_PDC_Executive_Summary.pdf. Viewed 13 April 2022.

> ProQA ensures that your communication center meets universal best practice standards that reduce an agency's liability risk to near zero.[148]

3.58 MPDS is one form of dispatch system, commonly used in anglo–saxon countries.[149]

3.59 ProQA was implemented in the SJA SOC after the 2009 Joyce Report recommended examining the use of structured call taking.[150]

**FINDING 8**

St John Ambulance WA implemented structured call taking software called ProQA as a result of the *St John Ambulance Inquiry: Report to the Minister for Health* prepared by Greg Joyce in 2009.

3.60 ProQA produces a set of rapid fire yes/no questions which Emergency Medical Dispatchers follow when answering a call. The software then assigns a priority code based on the information received from the caller.

3.61 The initial priority can be upgraded or downgraded before an ambulance arrives if new information is received.

3.62 ProQA includes treatment sequence protocols to enable Emergency Medical Dispatchers to assist a caller before an ambulance arrives. This includes protocols for cardiac arrest, choking and childbirth.

3.63 The various priority codes produced by ProQA are described in Table 12 below:

Table 12. *Priority codes for ambulances*

| Priority Code | Description |
|---|---|
| Priority 1<br>*High potential for life to be at risk* | Types of calls within this category include 'confirmed not breathing'.<br>Two vehicles (where approved) will respond under emergency conditions.<br>A Clinical Support Paramedic or Area Manager will also be dispatched under emergency conditions to provide additional equipment such as the Lucas Chest Compression System (an external mechanical cardiac compression device). |
| Priority 1<br>*Potential for life to be at risk* | Types of calls that fall under this category include chest pain, shortness of breath, unconscious patient, motor vehicle accidents, industrial accidents and childbirth.<br>One vehicle will respond under emergency conditions. |
| Priority 2<br>*No immediate threat to life* | The ambulance will be dispatched to the location under normal driving conditions.<br>Clinical Support Paramedics in the SJA SOC may re–assess the priority of the case prior to dispatch or while an ambulance is en route. |

148 Bohm and Kurland, *The accuracy of medical dispatch - a systematic review*, Scandinavian Journal of Trauma and Resuscitation and Emergency Medicine 26, 94 (2018). See: https://sjtrem.biomedcentral.com/articles/10.1186/s13049-018-0528-8. Viewed 13 April 2022.

149 Priority Dispatch Corp, *ProQA* See: https://prioritydispatch.net/proqa. Viewed 13 April 2022.

150 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, recommendation 4.

| Priority Code | Description |
|---|---|
| Priority 3<br>*Non–urgent call* | Where there is no threat to life the call may be classified as non–urgent, and the Secondary Triage Team may delay dispatch while speaking with the caller. Specific non–urgent calls may still require a high level of clinical care, however the lower threat to life means they are a lower urgency to attend.<br>Priority 3 calls are reviewed by a doctor and paramedic between 8am and 8pm when capacity permits. |
| Priority 4<br>*Planned patient transfer* | These include non–urgent planned patient transfers.<br>Patient transfer services are primarily booked and dispatched by a dedicated patient transfer call centre. They do not include calls received through the 000 line. |

[Source: Submission 71 from St John Ambulance WA, 23 July 2021, pp 13–4.]

**Over–prioritisation of calls**

3.64 The 2013 Auditor General Report noted ProQA is a risk averse system and that calls prioritised as emergencies increased by 31 per cent following its introduction:

> St John Ambulance WA introduced a structured call taking system as used in other states…Another consequence has been an increase in over–prioritisation of calls as emergencies – from 46 000 cases under the old system to 69 000 now. However, St John Ambulance WA does review and adjust the system for allocating priorities based on clinical evidence.[151]

3.65 Over–prioritisation refers to calls that are initially assessed as being higher priority than they actually are. It can be estimated by the number of calls where an ambulance crew assesses a patient has a lower priority than that determined by ProQA.[152]

3.66 The 2013 Auditor General Report noted the following problems with over–prioritisation:

> Over–prioritisation is a serious issue. Ambulance crews use flashing lights, sirens and exemption from ordinary road rules to rush to arrive at the scene in 15 minutes of a Priority 1 call, if they believe it is safe to do so. In some circumstances, this may create unnecessary risk to road users. If over–prioritisation leads to significant increases in demand it could result in a need for more crews to be on standby which could have a cost implication.[153]

3.67 The Committee received evidence indicating certain symptoms such as bleeding appear to be more prone to over–prioritisation:

- United Workers Union:

> Members have also suggested most calls from the public are being allocated an incorrect priority, with an over–concentration of unwarranted higher priority dispatch allocations. Members consider two major aspects of the current framework to blame for these scenarios.
>
> Firstly, the highly automated ProQA system used by call centre staff. Three–quarters of respondents [to a survey conducted by the United Workers Union] believe it does not properly triage patients with the system structured around leading questions with inflexible, in some cases binary, response options that are

151 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services,* June 2013, p 9.

152 ibid.

153 ibid., p 23.

not fit–for–purpose for appropriate case — with, for example, inputs regarding whether a patient is alert or not, or the extent to which they are bleeding, at times leading to inaccurate assessments.[154]

- Ambulance Employees Association of WA:

> [ProQA] has a tendency to increase the priority of calls throughout the community—Most calls are triaged as Priority 1 or 2. As there are limited, often insufficient numbers of ambulances on the road, this means that calls are constantly needing an immediate response which [Ambulance Employees Association of WA] members and [St John Ambulance WA] staff are unable to meet. This is creating strain and lowering morale in the workforce.
>
> As an example, if a patient cuts their finger and they state the bleeding is serious, an emergency ambulance is dispatched. ProQA in its current form would triage the patient higher than a child having a suspected cardiac arrest. The closest crew to the child cardiac arrest would not get the call, as they would have already been dispatched lights and sirens to the cut finger.
>
> …
>
> If structured call taking is to be continued – and the [Ambulance Employees Association of WA] strongly hope it will not be – then its use and staff understanding of it must improve.[155]

3.68 Some stakeholders noted the over–prioritisation of calls is not a problem in a well–resourced ambulance service but can become an issue when there are insufficient ambulances to meet the inflated demand:

- Paramedic:

> The ProQA system is good if you have 600+ ambulances available to respond to calls or if the number of ambulances in the current fleet is significantly increased overnight.[156]

- Private Citizen:

> In a well resourced ambulance service the effects of over prioritisation are negligible but in a service where ambulance resources do not match demand it can lead to situations in which nearly all ambulances are tasked to priority 1 cases, thus inhibiting the service's flexibility to redeploy ambulances to potentially more unwell patients as new 000 calls enter the system.
>
> It is my opinion that should ProQA remain the triage software employed by St John WA, then more investment in ambulance resources is needed…[157]

3.69 The Committee acknowledges the over–prioritisation of calls could result in genuinely sick patients being missed if there are insufficient ambulances to attend to the inflated number of high priority calls.

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154 Submission 102 from United Workers Union, 3 August 2021, p 3.

155 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, p 12. See also: Submission 25 from Private Citizen, 18 July 2021, p 1; Submission 47 from Private Citizen, 21 July 2021, p 1; Submission 50 from Shire of Manjimup, 21 July 2021, p 1; Private Submission 62 from Private Citizen, 23 July 2021, pp 4–5; Submission 88 from Private Citizen, 23 July 2021, p 1.

156 Submission 88 from Private Citizen, 23 July 2021, p 1.

157 Submission 75 from Private Citizen, 23 July 2021, p 3.

3.70 Dr Paul Bailey, Medical Executive Director at St John Ambulance WA explained ProQA is designed to be risk–averse in order to avoid under–prioritisation of calls:

> ProQA…is designed to miss sick people as few times as possible. The questioning that is undertaken by call takers in our State Operations Centre is focused on high–priority symptoms, which might be chest pain, might relate to a patient's breathing effort, might relate to their conscious state and so on. At the end the call–taking process, patients end up in a number of what we call "call determinants" which are best thought of as baskets or containers of reasonably similar patients. We allocate priorities on the basis of the likelihood of sick people in each of those containers.[158]

3.71 St John Ambulance WA estimate 25 per cent of calls assed as priority 1 are accurately categorised:

> Now, what we recognise is that ProQA is imperfect. Talking to a call taker for 45 seconds or a minute is not a comprehensive medical intervention, and for the group of patients who are in priority 1, roughly speaking, about a quarter of them are actually sick, down to maybe five, 10 per cent in priority 3. What I mean by "sick" is require strong painkilling medication, require treatment for asthma, require chest compressions—there is a wide variety of what that means. But to get to those 25 per cent in priority 1 who are sick, we do need to go to some other—so to not miss them—we need to cast the net broad.[159]

3.72 Over–prioritisation is considered to be a necessary trade–off by St John Ambulance WA. Dr Bailey explained chest pain is one of the most commonly over–prioritised conditions:

> What all that means is that a fair number of the priority 1 cases we go to in the community do not turn out to be sick. If I could give you an example of a priority 1 category with perhaps a very low rate of sick people in it, it is actually chest pain. But a portion of them are having heart attacks, a portion of them have aortic dissections, a portion of them are about to have a cardiac arrest and I would not recommend putting chest pain into priority 3 because actually the consequence of getting that wrong can be severe.[160]

3.73 In a systematic review of the accuracy of emergency medical dispatch, published in the Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine, the authors found:

> The results of the current study show that there is an overall very low to low level of evidence for the accuracy of medical dispatching systems.
>
> …
>
> We gear our emergency response systems so as not to miss patients in need of medical intervention –i.e. to avoid under–triage – and compensate by creating over–triage, i.e. "unnecessary" dispatching. Dispatching systems are e.g. "front loaded", i.e. over–triage is used as a safety rule and we assume that by creating over–triage we are "safe". However, that this is not the case is illustrated by HEMS [helicopter emergency medical service] having an over–triage of 44% and simultaneously, in the same dispatching system, an under–triage of 20%. It is therefore clear that although we need to understand and set cut–off levels for over–triage (so as to avoid waste of resources and risk for personnel) and under–

158 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 11.

159 ibid., pp 11–2.

160 ibid., p 12.

> triage (so as to avoid potentially lifesaving interventions not being given), they are – as measures of a dispatching system – insufficient on their own.[161]

**FINDING 9**

ProQA is a risk–averse system that tends to over–prioritise calls. Approximately 25 per cent of patients categorised as priority 1 actually require urgent treatment. This over–prioritisation can increase wait times for patients who have a time critical condition.

### Auditing of 000 calls

3.74 St John Ambulance WA is required to conduct a quality audit of two per cent of calls to the SJA SOC each year.[162]

3.75 The auditing process reviews emergency calls for strict compliance with the structured call taking process. Call takers are rated on their ability to follow the system. They are discouraged from asking freelance questions.[163] Call takers who fail to follow ProQA's structured questions can be required to undergo retraining.[164]

3.76 St John Ambulance WA explained why freelance questions are discouraged:

> The vendors of ProQA provide the system intact, and, in fact, our call takers are rated on their ability to run the system. So we do not encourage freelancing.
>
> …
>
> We believe this system is better than just freelancing, and yes it provides a degree of even performance across a big diversity of call–taking individuals, which overall we think is useful.[165]

3.77 Other evidence to the Committee provided a contrary view, espousing the benefits of call takers asking additional questions.

3.78 The United Workers Union suggested call takers be trained to ask clarifying questions:

> The system itself is built quite rigidly, but when you go and look at the training package and the information that is offered by the producers of ProQA, it does allow for assumed questions to not have to be asked. It does allow for clarifying questions to be asked. The ability of call takers to have confidence to do that kind of thing, to get better information from call takers is completely dependent on the training offered to those call takers.[166]

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161 Bohm and Kurland, *The accuracy of medical dispatch - a systematic review*, Scand J Trauma Resusc Emerg Med 26, 94 (2018). See: https://sjtrem.biomedcentral.com/articles/10.1186/s13049-018-0528-8. Viewed 13 April 2022.

162 Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 4, clause 18(f).

163 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 12.

164 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 9; Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 6.

165 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 11–2.

166 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 6.

3.79 The College for Emergency Nursing Australia WA Branch recommended call takers be encouraged to exercise their clinical knowledge and expertise rather than having to rigidly follow the ProQA system.[167]

**FINDING 10**

There is not unanimous agreement among health professionals regarding flexibility in the structured call taking process.

3.80 The Committee received evidence that the auditing of 000 calls is not performed by people with experience working as call takers:

- Private Citizen:

> Auditing is undertaken by Business Support Services, not operational staff. The decision to use auditors outside of Operations was to demonstrate impartiality in the process. Unfortunately, staff who do not use the system in the 'live' environment lack an understanding of the pressures associated with answering '000' calls. There are numerous examples here, but the simplest is that call takers are marked down if they fail to advise a caller to 'turn on the outside light' even during daylight hours. The Quality Assurance team claim that this is a requirement of the system, however it is my understanding that no other service in Australia has such rigid requirements. This over–officious auditing creates a perception by staff that feedback is both trivial and punitive, especially as there is no right of appeal.
>
> A lost opportunity here is that audits are not used to support learning. Staff Training is managed by a business unit known as the College of Pre–Hospital Care, separate from the Auditing Team and separate from the State Operations Centre.[168]

- United Workers Union:

> At the point in time when I was working in the State Operations Centre, the auditing was done by people who had not worked in the State Operations Centre, so I think it was the people who worked in the mailroom who did data entry who were doing the audits. They were basically reading straight off a script, to be specific—did they follow the script; did they not follow the script?[169]

3.81 In response, St John Ambulance WA advised auditors are Emergency Medical Dispatchers certified in accordance with international standards:

> Personnel conducting the audit reviews must hold the Emergency Medical Dispatcher – Q (ED–Q) qualification, obtained through the International Academies of Emergency Dispatch and are required to maintain this qualification, recertifying every two years. The recertification process consists of 30 hours of 'Continuing Dispatch Education' (CDE) as well as an exam. A pre–requisite of the ED_Q course if the EMD course.
>
> To ensure independence and minimise personal bias in the process all audits are conducted by personnel with line management outside the SOC.[170]

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167 Submission 98 from College for Emergency Nursing Australia WA Branch, 30 July 2021, p 1. Also see Submission 88 from Private Citizen, 23 July 2021, p 1.

168 Private Submission 79 from Private Citizen, 23 July 2021, p 1.

169 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 6.

170 St John Ambulance WA, letter, dated 4 March 2022, p 1.

3.82 St John Ambulance WA also explained the need for independence in the audit process:

> Using experienced call takers to complete audits would not satisfy the requirement for independence in the process.
>
> Independence is the basis for the impartiality of the audit process. Where possible the individual responsible for the audit should be independent of the function being audited, unbiased and objective.
>
> The Audit process for Calls within the SOC is undertaken by personnel external to the SOC to ensure independence. These people are separately qualified in the audit process and must requalify on a regular basis.[171]

**FINDING 11**

St John Ambulance WA are required to conduct a quality audit of two per cent of calls to the St John Ambulance WA State Operations Centre each year. The auditing process is a quality assurance function which checks for strict compliance with the ProQA structured call taking process.

**FINDING 12**

The auditing of call taker performance is performed by St John Ambulance WA staff external to the State Operations Centre. These auditors are qualified as Emergency Medical Dispatchers and separately qualified in the audit process but are not experienced call takers.

**RECOMMENDATION 4**

The Department of Health require auditing of ProQA be conducted with patient outcomes considered. These audits should involve experienced call takers.

### ProQA call priority algorithm

3.83 ProQA allows St John Ambulance WA to make adjustments to the algorithm that determines the priority of calls. Re–assessment of the algorithm is one way that could correct the over–prioritisation of calls.

3.84 The Committee received submissions claiming St John Ambulance WA does not make appropriate adjustments to the ProQA algorithm.[172]

3.85 A submission recommended investigating whether the ProQA system St John Ambulance WA uses mirrors that used in other states and territories.[173]

3.86 Dr Paul Bailey, Medical Executive Director at St John Ambulance WA explained the adjustments to the ProQA algorithm do not affect the majority of priority codes generated by the system. As such, the system St John Ambulance WA uses generates largely the same priority codes as systems used in other jurisdictions.[174]

3.87 Dr Bailey explained St John Ambulance WA examines the ProQA algorithm most years. They have also conducted a deep dive analysis of the algorithm over the last two years:

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171 ibid., p 7.

172 Submission 40 from Private Citizen, 21 July 2021, p 1; Submission 47 from Private Citizen, 21 July 2021, p 1; Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 7.

173 Submission 75 from Private Citizen, 23 July 2021, p 3.

174 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 11–2.

> We examine it most years but we have recognised the need for a deeper examination, which we have done. What we have actually found is that whilst there is some room for movement relating to the priority codes attached to individual baskets of patients, in actual fact, that opportunity for movement is at the margins rather than different in a quantum level of way.[175]

3.88 PDC notes on the ProQA website:

> The system allows for verbal modifications when speaking with the caller. The call taker may modify statements or questions when there are safety issues ("Are you in danger?"); when making a customer service statement ("I know you are upset right now, but I need you to calm down in order to help your husband."); when clarifying vague statements ("Are you able to be more specific?"); when giving Post–Dispatch Instructions (PDIs, read in a materially identical manner); when making grammatical substitutions ("How old is your mother?" vs. "How old is the patient?"); or when the caller doesn't understand the question as stated.[176]

3.89 Whilst some modifications to questions are permitted, they are relatively minor in nature and the call taker is encouraged to adhere to the structured call taking process.

*Introduction of priority zero code*

3.90 Following recent analysis of the ProQA code, St John Ambulance WA introduced priority zero for callers requiring the most urgent attention, such as those who report choking:

> **Hon COLIN de GRUSSA:** If you want, can you make recommendations to ProQA around things that may not be working properly or can you make those changes yourself? For example, you have got three categorisations—P1, P2, P3. Could you add a P1A, a P1B yourself, or can you; would you?...
>
> **Dr BAILEY:** ...Could we assign nuance to priority codes?—yes, and we are about to implement that. Presently, priority 3 patients are trumped by priority 2 and priority 1. Priority 2 is trumped by priority 1, and we recognise within priority 1— priority 1 is actually an amorphous group. There is a group of very, very sick and unwell patients, so a choking individual, that we think should be allocated to priority zero, the highest—and that would trump everyone. We think within priority 1 there are probably two different levels of priorities within that, once we have taken the P zeros out, that we would call P1 alpha and P1 bravo.
>
> Now P1 alpha would trump P1 bravo under that system and P0 would trump everything. How it works at the moment is an emergency first situation where the first P1 trumps everything else if the system is run with that human intervention.[177]

3.91 The introduction of the priority zero classification will help to address the effects of over–prioritisation by ensuring patients requiring the most urgent treatment are treated ahead of cases that are less time critical.

## Secondary Triage Team

3.92 St John Ambulance recently introduced a Secondary Triage Team to monitor priority codes and review low acuity calls that might have been incorrectly prioritised. This team was

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175 ibid., p 12.

176 Priority Dispatch Corp, *Mythbusters*. See: https://prioritydispatch.net/mythbusters/. Viewed 13 April 2022.

177 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 12.

introduced in response to the COVID–19 pandemic to divert patients to alternative care pathways. It can also be used to mitigate over–prioritisation of calls by ProQA.

3.93 A General Practitioner (GP), a Clinical Manager and a Paramedic make up the Secondary Triage Team. It is operational 12 hours a day.[178]

3.94 The Secondary Triage Team identifies patients suspected of incorrect priority, gathers additional information and undertakes a clinical review to better understand the severity of the patient's condition. Secondary triage occurs prior to an ambulance being dispatched.[179]

3.95 Where appropriate, the Secondary Triage Team may recommend alternative care pathways such as visiting a GP, Urgent Care Centre or telehealth service. In Western Australia, alternative pathways to community–based services are rarely available after hours which limits the effectiveness of this service.[180]

3.96 Between January and July 2021 the Secondary Triage Team reviewed 31 000 calls, successfully returning 3 172 hours of ambulance service to the community.[181]

### Clinical Support Paramedic review

3.97 Clinical Support Paramedics at the SJA SOC provide clinical advice to Emergency Medical Dispatchers and on–road crews. They rotate through on–road and SJA SOC positions.

3.98 Clinical Support Paramedics also review calls suspected of incorrect priority. They are able to change the priority or require a different resource to be dispatched.[182] This review process provides an opportunity to reduce the over–prioritisation of calls.[183]

3.99 Unlike the Secondary Triage Team, this review occurs after an ambulance has been dispatched.

### Paramedic assessment of priority

3.100 The Committee heard evidence that paramedics were previously required to provide an assessment of the priority code ProQA generated. This was facilitated through the electronic patient care record. However, the function no longer exists:

> We had initially on our EPCRs—our electronic patient care records—where there was a tick box where if we thought the priority was inappropriate, we could tick that it was in an inappropriate priority and that information would then be forwarded. Over a period of that time when that function was available, we had that function. Whether they did anything with that data or not I am not sure. But it is not there anymore.[184]

3.101 The Committee asked St John Ambulance WA if paramedics can report when they consider the priority code to be incorrect. Dr Paul Bailey, Medical Executive Director at St John Ambulance WA said paramedics can do this by submitting an acuity assessment through the electronic patient care record:

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178 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 November 2021, p 6.

179 Submission 71 from St John Ambulance WA, 23 July 2021, p 14.

180 ibid., p 18.

181 ibid.

182 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 12.

183 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 2.

184 ibid., p 7.

> The inbound priority is fully available to us on the electronic medical record. We also have an acuity filter where we ask our paramedics to judge the degree of illness in a patient that they first meet.[185]

3.102 St John Ambulance WA also gave evidence that while attending paramedic crews have no input into the priority code ProQA generates, they do determine the urgency code for transport from the scene to hospital.[186]

3.103 The Committee asked the Department of Health if the over–prioritisation of calls by ProQA could be assessed by undertaking a comparison of priority codes, acuity filters, urgency codes and final patient outcomes:

> From an analytics perspective it would be possible to undertake an assessment to determine over–prioritisation of calls, but without access to the ProQA data it is not possible for the Department to confirm which metrics are most appropriate or available for comparison.[187]

3.104 The Committee considers a periodic, specialist review by the Department of Health will provide an opportunity to identify over–prioritisation.

**RECOMMENDATION 5**

The Department of Health conduct a review of priority codes, acuity filters, urgency codes and final patient outcomes to identify over–prioritisation of 000 calls by ProQA.

### Patient outcome feedback from the Department of Health

3.105 The Department of Health are working on developing a system to feedback patient outcomes to St John Ambulance WA. Completing this feedback loop will allow St John Ambulance WA to assess their prioritisation of patients against clinical assessments made at hospital:

> The information we would share back [to ambulance service providers] would be things like what was the triage, what was the disposition—did the patient die or were they admitted or did they just get sent home—and what was our diagnosis of the patient, so then they can compare their diagnosis with ours. Then we hope that that will help them, not because we think they need to improve anything, but there is always that continuous improvement, which we do ourselves in Health. The ability for us to share with them, I know they think is invaluable, and it also helps us to understand some of our issues in terms of priority versus triage.[188]

3.106 Developing a system to feedback patient outcomes to St John Ambulance WA involves linking a significant amount of data. Once completed, it will present many opportunities to analyse the efficiency and adequacy of ambulance and health services including assessing over–prioritisation of calls by ProQA. The Department of Health should conduct a review of the linked data with a view to improving patient outcomes.

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185 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 11.

186 Michelle Fyfe, Chief Executive Officer, Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 24 September 2021, p 13.

187 Department of Health, letter, dated 3 March 2022, p 1.

188 Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 November 2021, p 10.

**FINDING 13**

The Department of Health is developing a system to feedback patient outcomes to St John Ambulance WA. This will enable better analysis and assessment of the ambulance service.

**RECOMMENDATION 6**

The Department of Health prioritise the development of a system to feedback patient outcomes to St John Ambulance WA.

## How 000 ambulances are dispatched

### Computer Aided Dispatch

3.107 Emergency Medical Dispatchers at the SJA SOC use a system called Computer Aided Dispatch (CAD) to dispatch ambulances. St John Ambulance WA developed this software.

3.108 CAD uses GPS to track and display all frontline ambulances. Once a priority code has been determined and the location of the incident is known, CAD will calculate the 20 closest ambulance resources. A Radio Dispatcher will then assign and dispatch an ambulance based on the most efficient route CAD determines.

### AmbiCAD

3.109 Each ambulance has a system called AmbiCAD which connects with the CAD in the SJA SOC. AmbiCAD is located on a terminal inside ambulances and displays the case details, navigation and routes to the scene.

### Capacity at hospitals

3.110 Once an ambulance has been dispatched, an Ambulance Network Coordinator will direct the ambulance to a particular hospital depending on the capacity of hospitals. Ambulance Network Coordinators have access to the number of patients presenting at each emergency department in the metropolitan region. They aim to distribute patients to the most appropriate hospital and minimise the impact of ramping on ambulance resources.

3.111 Ambulance Network Coordinators can see the number of patients presenting at each metropolitan hospital:

> At the St John call centre, they actually have live feeds of our ED [emergency department] systems…So they can see not just their own information; they can see into our hospital exactly what is sitting in each ED.
>
> …
>
> They can also then look at the data in our EDs currently, who is sitting there, and go, "Royal Perth is actually swamped at the moment; let's redirect these ones to Fiona Stanley Hospital or Charlies for a period of time." So, we already data share and make those real–time operational decisions between the two organisations.[189]

### Country dispatch

3.112 CAD identifies calls from regional areas based on the location of the call. CAD will place these calls in the country calls waiting list and identify the closest sub–centre.

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[189] ibid., pp 16–7.

3.113 Country sub–centres with career paramedics are mobilised in a similar way as metropolitan crews through the AmbiCAD system.

3.114 Entirely volunteer run sub–centres are either mobilised using a conference calling facility known as Mobicall or a coordinator will ring around to see if a crew is available. If no one is available, the next closest sub–centre is contacted to see if they have a crew to respond. This process continues until a crew can be located to respond.

3.115 In some areas there are significant distances between sub–centres. For example, if an ambulance is required in Cue and a local resource is not available, the next closest sub–centre is Mount Magnet (over 50 minutes away) and then Meekatharra (over 75 minutes away).

3.116 The Ambulance Employees Association of WA outlined their concerns about this process:

> I will give you a hypothetical. There is a job in Narrogin. It might be a motor vehicle accident. It might be a transfer out of the hospital. The MobiCall will go off. If no–one answers, they will ring back. If no–one answers, they will ring back. They will ring three times and wait for those MobiCalls to ring out. If there is no response to that, they will go to the next volunteer station that is closest, which in this case is Williams. They will ring Williams' MobiCall. If they get a crew then they will go and do the job in Narrogin. If they do not get a call, they will ring Wickepin, Wagin, and they will start spreading out until they get a crew to go and do that call.[190]

3.117 St John Ambulance WA explained that if a volunteer crew is not available, the SJA SOC will attempt to contact other emergency services and neighbouring sub–centres:

> **Hon COLIN DE GRUSSA:** There are obviously going to be circumstances where that response is not able to be provided as timely as you would like. For example, there might not be any volunteers available, depending on the time of day or place, and there is no community paramedic and there is no sub–centre nearby. In that circumstance, is it a case of find another way to hospital?
>
> **Mr FONTE:** In a guided manner find your way to hospital. Our operations centre will maintain conversation with the patient while making contact with other agencies that may be able to assist.
>
> **Hon COLIN DE GRUSSA:** So the operations centre will take that role of, say, contacting police or fire and rescue or whoever?
>
> **Mr FONTE:** Correct.
>
> **Mr BRINK:** Or neighbouring sub–centres. If there are no local sub–centres available, they could use some of the neighbouring sub–centres.[191]

3.118 The process in each case depends on the guidelines in place at the particular sub–centre:

> **Hon WILSON TUCKER:** So that is a judgment call that the operator will make on a case–by–case basis?
>
> **Mr FONTE:** It is case by case. They will attempt to raise an ambulance. At the first sign of there being any difficulty in achieving that, they will go into alternative arrangements.

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190 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 10.

191 Justin Fonte, Head of Country Operations, St John Ambulance WA, Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 29 October 2021, pp 27–8.

> **Hon WILSON TUCKER:** Is there a policy on the St John's site that will describe that interaction or that sort of judgment call that could be made in that case?
>
> **Mr FONTE:** I know it is a process; I do not know if it is in policy. Each location has a set of guidelines that guide the operations centre staff, that actually notes the alternative arrangements that are available for each location as well as what the neighbouring response location is so that they can call them or contact them in order to find the best solution for the patient.[192]

**Unable to respond**

3.119 The Committee heard that when an ambulance is not available to be dispatched, the call is recorded as being cancelled. This would mean there is no record of calls that have not been responded to due to lack of an available ambulance:

> Several members also reported instances where a patient has been advised they would need to get themselves to a hospital to access medical care. Despite the correct outcome of such calls being 'failure to send a crew', St John do not report these results accordingly, instead listing them as job cancellations on the part of the patients.[193]

3.120 The Ambulance Employees Association of WA advised that when there is no ambulance available to be dispatched in regional Western Australia, the SJA SOC operator would ask the patient or the caller to help the patient to get to the hospital themselves and the operator would then cancel the call.[194]

3.121 St John Ambulance WA responded to these claims by advising the Committee that the decision to cancel a call is always made by the caller.[195] St John Ambulance WA also provided a copy of the SJA SOC operational guideline for cancelling or standing down a call. This document indicates call takers are required to take the following steps anytime a call is cancelled before dispatch:

- Confirm with the original caller than an ambulance is not required.
- Enter the caller's name and reason why the call has been cancelled.
- Inform the Radio Dispatcher and Response Time Manger via message system prior to cancelling the call.[196]

3.122 In situations where St John Ambulance WA are unable to assemble a crew, the onus is placed on the caller to cancel their request for an ambulance. The Committee is of the view that this situation may result in erroneous recording of data as to why an ambulance did not attend.

3.123 The Committee sought a response from WACHS which advised it intends to closely monitor this situation when it assumes responsibility for the Emergency Ambulance Services Agreement in regional areas:

> WACHS is not the current contract manager. This data and the need to respond to it operationally and strategically is a good example of why WACHS has sought to become the Contract Manager.

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192 Justin Fonte, Head of Country Operations, St John Ambulance WA, transcript of evidence, 29 October 2021, pp 4–5.

193 Submission 102 from United Workers Union, 3 August 2021, p 5.

194 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 11.

195 St John Ambulance WA, letter, dated 4 March 2022, p 10.

196 ibid., p 11.

> WACHS does not currently monitor the number of calls when an ambulance is not able to respond although this is in the scope of data identified by WACHS to be requested from providers under future arrangements. This has been a learning from the data driven analysis from the Country Ambulance Regional Investment (CARI) project investment process.
>
> …
>
> This information over time would also enable the calculation of the relative likelihood of cancellations as a consideration in response planning (best integrated into a predictive analytics or machine learning model). This might foreseeably prompt coordination teams to consider alternative options at time of first referral in locations related to time of day, type of job or response type preferred (road, fixed wing, helicopter) where cancellation is more likely to occur. This would lead to optimisation of time to retrieval for patients and ultimately improved patient outcomes.[197]

**FINDING 14**

The Committee received conflicting evidence on whether emergency call takers at the St John Ambulance WA State Operations Centre are able to record a call as being cancelled due to lack of available resources.

#### Live dashboard

3.124 St John Ambulance WA recently developed a live dashboard to share information about emergency ambulance movements with the Department of Health. The dashboard allows health service providers to see ambulances that have been dispatched, where they are going, the priority of the call and the assigned hospital. The Department of Health explained this information will give health service providers better visibility of ambulance arrivals:

> We get that now through a live dashboard that St John built and has shared with us, and the [health service providers] all have that, and they can see the calls that have been dispatched, where they are going, the likely priority, and then the hospital they will be assigned to through their matrix so they can see what is potentially coming, and they can also see the crews they still have sitting at their [emergency departments] and so forth.[198]

3.125 St John Ambulance WA advised the 'live, real–time ambulance data' dashboard has been shared with senior leadership at the Department of Health.[199] This includes providing WACHS access to a live dashboard for ambulances dispatched in regional areas.[200]

**FINDING 15**

St John Ambulance WA recently developed a live dashboard to share information about emergency ambulance movements with health service providers.

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197 WA Country Health Service, email, dated 24 February 2022, pp 1–2.

198 Rob Anderson, Assistant Director General, Departmental of Health, transcript of evidence, 24 November 2021, p 16.

199 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 14; Dr David Russell–Weisz, Director General, Rob Anderson, Assistance Director General, Department of Health, transcript of evidence, 24 September 2021, pp 11–2.

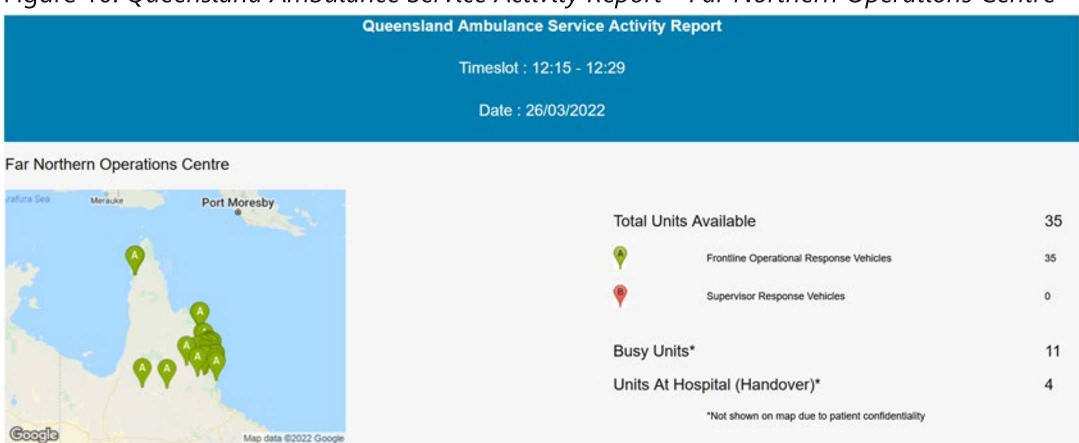
200 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 8.

**Queensland Ambulance Service—publication of availability of ambulances**

3.126 Queensland Ambulance Service publicise the availability of ambulances on their website.

3.127 For instance, the following ambulances were available in the Far Northern region of Queensland on 26 March 2022 between 12.00pm and 12.39pm:

Figure 10. *Queensland Ambulance Service Activity Report—Far Northern Operations Centre*




[Source: Queensland Ambulance Service, *Activity Report Far Northern Operations Centre.* Site: https://www.ambulance.qld.gov.au/iroam/amboMap1.htm. Viewed: 26 March 2022.]

3.128 At the same time, the situation in Brisbane was as follows:

Figure 11. *Queensland Ambulance Service Activity Report—Brisbane Operations Centre*

[Source: Queensland Ambulance Service, *Activity Report Brisbane Operations Centre.* Site: https://www.ambulance.qld.gov.au/iroam/amboMap1.htm. Viewed: 26 March 2022.]

3.129 Although the website does not provide real-time movement of ambulances, anyone can visit this website to see the number of available ambulances.

3.130 St John Ambulance WA pointed out that the location of ambulances is not necessarily useful information for the public:

> **Ms FYFE:** I think it is something that we could consider. Merely displaying locations of ambulances is one thing. What you have to ask is: what is the intended purpose of that? We obviously have a very clear view of where all our ambulances are. Just having a display or a little icon that says, "Here's an ambulance on the corner of Harvest Terrace and Parliament Place", for example, is one thing, but understanding what that ambulance is doing, why it is there and what is going on around the ambulance: "There's an ambulance driving past me. Why isn't it coming to me?" "Well, there is a serious incident over here that it has to go to." While it

> provides visibility, one has to question what is the intended purpose of it. When the intended purpose is defined is when we can make a decision regarding it.[201]

3.131 While noting the point raised above, the Committee supports the Department of Health and St John Ambulance WA investigating initiatives regarding the publication of ambulance locations to assist patients and others at the scene.

**FINDING 16**

The Queensland Ambulance Service displays the location of available ambulances on their website.

**RECOMMENDATION 7**

The Department of Health and St John Ambulance WA investigate publishing emergency ambulance vehicle availability online in a similar fashion to the Queensland Ambulance Service.

### State–run Health Coordination Centre

3.132 The Committee received evidence about a proposal to establish a State–run Health Coordination Centre.[202] This Centre will be staffed by representatives from health service providers and ambulance providers. These representatives will be able to share information about patients and the availability of ambulances in Western Australia:

> We can monitor patients in our hospitals now in real time, we can see someone starting to deteriorate and we know we are going to have to get some type of transport, whether it be air or road, to that particular facility. At the moment, that is really in the dark.
>
> …
>
> You can imagine a great big wall with the whole state up there, and every one of our hundred hospitals is up there, and we know which patient is going well, and up comes the vital signs on this patient. It is going downwards. Have we got an asset nearby? Can we get someone on stand–by?[203]

3.133 St John Ambulance WA acknowledged the benefits of establishing a State–run Health Coordination Centre where all emergency ambulance services could be tracked, monitored and coordinated.[204]

3.134 The proposed State–run Health Coordination Centre could improve information sharing about patients and ambulance availability, leading to improved outcomes for patients.

**FINDING 17**

The Department of Health has proposed establishing a State–run Health Coordination Centre staffed by representatives from health service providers and ambulance providers. The proposed Centre could improve information sharing about patients and ambulance availability, leading to improved outcomes for patients.

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[201] Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 29 September 2021, pp 3–4.

[202] Dr Neil Fong, Board Chair, WA Country Health Service, transcript of evidence, 24 September 2021, p 10; Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 11.

[203] Dr Neil Fong, Board Chair, WA Country Health Service, transcript of evidence, 24 September 2021, p 10.

[204] Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 10.

## 000 calls managed by the Department of Health

3.135 WACHS recommended the State Government undertake oversight and management of 000 calls and tasking functions through the establishment of a State Health Operations Centre:

> This state is unique in that the 000 call line is contracted out. I think we have said previously that is a critical function. It is not contracted out for police or others, and we see that the 000 call line must be part of a state health operations or coordination centre, whatever title you would choose to use, and the parties need to be together.
>
> It is about visibility and transparency. As we are seeing more transport providers—so you have got St John, RFDS, but you have now got four, five or six other providers emerging, and helicopters and aeroplanes and road–based ambulances. As other providers enter the market, as they already have, you cannot just run with a provider–driven system. There is a complete conflict of interest, and, by design, collaboration becomes more difficult when they are In competition with others.
>
> The state must step into a role where it coordinates all of that in a more effective way. To me, that includes a 000 call, and even if that is still run by St John Ambulance, it must be within the purview of the state. I think that might be a point of difference, but we are just very clear that it is a complex system that is getting more complex and there is no conductor of the orchestra and there needs to be one.[205]

3.136 St John Ambulance WA did not support separating the responsibility of answering emergency calls from the dispatch of emergency ambulances:

> I think it has to be set up in a certain way. The way that I would suggest is that 000 emergency call taking and dispatch is very tightly linked. If we are talking about the ambulance service, it is very tightly linked to the ambulance service. That is an operations centre. What I believe the WA Country Health Service and the Department of Health are talking about is the state health operations centre, but from my perspective, I would say it is more of a coordination centre.
>
> So, it is that overarching situational and awareness capability so that you know how many ambulances are out there, how many planes are out there, how many beds are available in whichever regional hospital or metropolitan hospital and an overall view of demand. But the actual call taking and dispatching of that emergency response I think has to stay firmly within the ambulance service.[206]

3.137 The Committee notes the recommendation by WACHS and recommends the State Government investigate whether the answering and dispatch of 000 calls should be undertaken by the Department of Health. Such an investigation should focus on improving patient outcomes.

**RECOMMENDATION 8**

The State Government investigate whether the answering and dispatch of 000 calls by the Department of Health would improve patient outcomes.

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205 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 9.

206 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 10.

# CHAPTER 4
# Non–emergency inter–hospital patient transfer service

## Introduction

4.1 Inter–hospital patient transfers are arranged by individual doctors calling the destination hospital to enquire if a bed is available. If so, a transfer is booked through the St John Ambulance WA Patient Transfer Centre.

4.2 Urgent inter–hospital transfers are governed by the Emergency Ambulance Services Agreement and performed exclusively by St John Ambulance WA. Non–emergency inter–hospital transfers are performed under a separate agreement as follows:

- In the metropolitan area non–emergency inter–hospital patient transfers are performed by a panel of service providers including St John Ambulance WA, Wilson Medic One and National Patient Transport.
- In regional areas St John Ambulance WA has a right of first refusal and performs the majority of non–emergency transfers.

4.3 The Committee identified the following issues in relation to non–emergency inter–hospital transfer:

- hospital staff are required to undertake administrative tasks involved in organising patient transfers
- vehicles and staff dedicated to emergencies are performing non–urgent patient transfers after hours
- regional volunteers become fatigued when performing long distance transfers to Perth
- ambulance crews are often delayed when picking up and dropping off patients at hospital.

4.4 This chapter considers whether:

- inter–hospital transfers would be better managed by the Department of Health
- the panel arrangement in the metropolitan area supports competition between service providers
- St John Ambulance WA's right of first refusal to perform inter–hospital patient transfers in regional areas should be maintained.

## How transfers are arranged

4.5 The process of arranging an inter–hospital patient transfer begins with individual doctors negotiating with other hospitals to accept their patient. St John Ambulance WA indicated there was room for improvement explaining the current process is conducted on a piecemeal basis with St John Ambulance WA as the intermediary:

> The negotiation process for finding a bed for a patient...involves trying to find an accepting facility. Whilst I have not worked in that environment for several years, I could describe the process of being one of testing bed availability at multiple facilities, ultimately sometimes unsuccessfully—sometimes successfully.
>
> ...

> There is no overall tactical viewpoint from the system. We probably have the best overall view in that we know who is going where, but with some frequency, which I think we have discussed before, we find the system could be smoother, either at the hospital of origin or the hospital of destination.[207]

## Inter–hospital patient transfer coordination centre

4.6 WACHS is in the process of establishing the Acute Patient Transport Coordination Centre (APTCC) which will oversee patient transport to and from regional and metropolitan hospitals for admitted country patients.[208] The APTCC commenced a live pilot of coordination services in January 2022. On 9 March 2022 the Committee was advised the APTCC plans to move to 24/7 operations in mid to late March 2022.[209]

4.7 WACHS explained how the APTCC will allow hospital staff to focus on caring for their patients instead of spending time arranging inter–hospital transfers:

> We need to make it much easier for our own staff…So they make one call for a transfer, and then we, the rest of the organisation, supports them in making sure that the destination, the assets that are required and all the prioritisation gets sorted out so they do not have to both care for a patient as well as try and negotiate beds in Perth, police officers for mental health patients, or aircraft or ambulances. It is a very complex job. It can take hours for one patient.[210]

4.8 St John Ambulance WA supports the establishment of a command centre to coordinate inter–hospital transfers:

> [It would] cut down on the horse trading and negotiation that sometimes occurs both with metro–metro transfers and country–metro transfers.[211]

4.9 The Committee considers the following benefits to the establishment of the APTCC could also apply in metropolitan Perth:

- eliminating the piecemeal approach currently being used to arrange transfers
- allowing hospital staff to focus on patient care
- reducing pick–up times by requiring patients to be ready prior to booking
- reducing drop–off times by ensuring a bed is available upon arrival
- eliminating perceived conflict of interest between St John Ambulance WA being responsible for receiving calls while competing against other providers for non–emergency patient transfers
- potentially identifying opportunities for multi–patient transport to conserve resources.[212]

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[207] Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 November 2021, p 19.

[208] WA Country Health Service, *Command Centre*. See: https://www.wacountry.health.wa.gov.au/Our-services/Command-Centre. Viewed 1 April 2022.

[209] WA Country Health Service, email, dated 9 March 2022, p 1.

[210] Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 11.

[211] Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 November 2021, p 19.

[212] Submission 40 from Private Citizen, 21 July 2021, p 3.

**RECOMMENDATION 9**

The Department of Health establish a centralised coordination centre to organise inter–hospital transfers in metropolitan and regional Western Australia.

## Emergency resources being used for non–urgent transport

4.10 Once a doctor has negotiated an availability for their patient, they will contact the Patient Transfer Call Centre to book a patient transfer service. Bookings are by telephone or online.

4.11 St John Ambulance WA operate the Patient Transfer Call Centre from 6am to 10pm.

4.12 The Patient Transfer Call Centre is separate from the SJA SOC where 000 calls are received. A dedicated fleet of patient transfer vehicles perform non–emergency inter–hospital transfers. These vehicles are operational between 6am and 1am the next day.

4.13 The requirement for dedicated patient transfer resources was implemented after the 2009 Joyce Report which noted concerns that inter–hospital patient transfers were negatively impacting the availability of emergency resources.[213] The Joyce Report noted:

> Ambulances can be used for patient transport, and it might be medically necessary for this to occur at times, but doing so prevents those ambulances from being on stand–by to attend to emergencies. Apart from this issue, there is also the view that using specialised vehicles and staff for general patient transport tasks might not be the best use of resources.[214]

4.14 The Joyce Report recommended examining the separation of inter–hospital patient transfer tasking from the emergency tasking process.[215]

4.15 Non–emergency patient transfers are now contracted separately from emergency ambulance services.[216]

### After hours bookings

4.16 The SJA SOC receives bookings for inter–hospital transfer after 1am when the Patient Transfer Call Centre is closed.[217] Unplanned bookings and emergency inter–hospital transfers make it is necessary for the SJA SOC to accept after–hours requests:

> Our inter–hospital transfer is the non–emergency transfer and most of those bookings occur during the day. That is when that operates. Mostly, it is only unplanned bookings or emergency transfers that happen after hours, and that is your priority 1 and priority 2 work, which is predominantly done by ambulance. The volume of calls that comes in [from] the bookings, that is not done via our online booking service, that is an automated service. That is the reason why it comes through the State Operations Centre after hours.[218]

4.17 St John Ambulance WA assured the Committee that emergency ambulances are not used for non–emergency transfers:

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213 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 58.

214 ibid.

215 ibid., recommendation 12.

216 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 29 October 2021, p 21.

217 ibid., pp 19–20.

218 Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 29 October 2021, p 20.

> **Ms FYFE:** The one thing that I can say is that emergency ambulance services are dedicated towards the community in an emergency ambulance scenario and we would never take emergency ambulances away from responding to the community for something that was not an emergency. [219]

4.18 A number of non–emergency transfers are booked to occur after midnight:

> For the financial year 2020–21, 4,059 (8.6%) non–emergency inter–hospital patient transfers were booked for completion after midnight and prior to the Patient Transfer Service (PTS) commencing operational hours at 6:00AM. [220]

4.19 The details of emergency resources performing non–emergency inter–hospital patient transfers after hours was explored further by the Committee. St John Ambulance WA provided the following evidence:

> **Mr BRINK:** As I said before, we have the two contracts and there are very specific definitions of when those contracts occur…there could be a difference between the clinical priority and the transport priority of the patient. It could be that a priority 4 patient which we picked up…has a higher clinical need—they just need some extra pain medication that needs to be done by an emergency ambulance, which is the only place where we currently have paramedics after hours…We actually need to use an ambulance to provide that.
>
> I think where this is sort of going is using emergency ambulances in times of high need to do inter–hospital transfers. As part of my resource escalation plan, when we are really busy and ramping is high, we suspend all inter–hospital transfers unless it is an absolute emergency for that to occur.[221]

4.20 When there is low demand for emergency ambulances, St John Ambulance WA will use all available ambulance resources to perform patient transfers:

> **The CHAIR:** If it is not in high demand, would…emergency ambulance assets and career paramedics assist with St John's non–emergency inter– hospital transfer business?
>
> **Ms FYFE:** How I would characterise it is they assist in decanting a hospital. They assist in moving patients out of a hospital so that those who are coming into the hospital have somewhere to go, which is what patient transport is about. It is about decanting a hospital, moving patients from the hospital either to another hospital, to home, to another service provider. That is what the patient transport part of the business is. Between 1.00 am and 6.00 am, these hospitals are still really, really crowded, and we know that between 7.00 am and 9.00 am we are going to start bringing more patients. So between 1.00 and 6.00, if there is an opportunity to use a crew to decant out of that hospital and free up a bed, then we do that.[222]

4.21 The Committee heard evidence from a paramedic that emergency ambulances are used for non–emergency patient transfers because there are not enough transport crews to complete the bookings:

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219 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 29 October 2021, p 21.

220 St John Ambulance WA, Answer to question on notice 12 asked at hearing held 29 October 2021, dated 22 November 2021, p 25.

221 Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 24 November 2021, p 17.

222 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, p 18.

> We need any entity running the ambulance service to understand that paramedics are best used for emergencies and not to ferry low acuity patients to hospitals, to medical appointments, from hospitals back to nursing homes or the like.
>
> …
>
> How often paramedics, while transferring a low acuity Royal Flying Doctor patient to a hospital, listen to the call that dispatches a far–away ambulance to an emergency that is only minutes away. Paramedics study and train to be able to manage and stabilise a variety of medical emergencies but too often have to simply pass by them because St John has committed them to a number of transport contracts.[223]

4.22 The Committee is not satisfied the contracts with St John Ambulance WA for emergency ambulance services and non–emergency patient transfer are performed entirely separately.

4.23 St John Ambulance WA acknowledge emergency ambulance resources are, on occasion, used to carry out after hours patient transfers. The Committee does not dispute this practice may be a practical use of resources in times of low demand for emergency ambulances. However the Committee is concerned that:

- the current contractual arrangements do not adequately distinguish the use of emergency and non–emergency resources
- using emergency resources for non–emergency hospital transfers will reduce emergency response capacity.

**FINDING 18**

Non–emergency patient transfers are contracted separately from emergency ambulance services. Despite this, emergency ambulance resources are used to conduct inter–hospital patient transfer services.

### Regional areas

4.24 The Committee received submissions from the following stakeholders concerned about regional communities' diminished capacity to respond to emergencies when volunteers are away performing inter–hospital transfers:

- St John Ambulance WA Margaret River Sub–Centre:

> There appears to have been a significant increase in the demand for Inter Hospital…During the provision of this patient transport service by the Volunteer Sub Centre crews a second crew is required to become available to respond to emergency call outs.
>
> The length of time that the first crew is away can frequently be extended by "ambulance ramping" at the receiving hospital. This adds a considerable burden to volunteers to respond to an emergency call out when not "on roster". A typical return trip by an ambulance crew to Bunbury Regional Hospital would take three and half hours if patient reception and transfer to hospital staff is quick. Any "ramping" extends the time. Each "ramping" event places greater demand on a

[223] Submission 25 from Private Citizen, 18 July 2021, p 3. See also Submission 88 from Private Citizen, 23 July 2021, pp 5–6; Submission 75 from Private Citizen, 23 July 2021, p 11; Submission 102 from United Workers Union, 3 August 2021, p 8.

small number of Volunteer Ambulance Officers who may have to provide up to three crews simultaneously while a transfer is in progress.[224]

- Paramedic:

> Transfers in and around the South West region are allocated and ambulances dispatched by [the SJA SOC] without consideration to what resources are still available. St John WA are in a unique position in that the organisation uses Emergency Ambulances in a dual role as they do with Transport vehicles and crews. This has and does leave regions with reduced response capacity both in the amount of resource and the skill set of the responders.
>
> …
>
> One of my most recent transfers was to take a patient for a test at Fiona Stanley Hospital. With an hour and a half wait time I was away from the region for nearly eight hours.[225]

- Shire of Manjimup:

> The volunteer model is no longer fit–for–service for inter–hospital transfer. Most calls within towns only take 1 to 2 hours which is manageable for a volunteer. However calls for inter–hospital transfers (e.g. Manjimup to Bunbury) take 5 to 7 hours each (and an hour longer from Pemberton and even longer when the receiving hospital cannot immediately accept the patient).[226]

- Volunteer Ambulance Officer:

> My second concern is the amount of patients that are being transported via hospital transfers that are utilised as a taxi service. The majority of cases I have been involved with could have been taken by car rather than take two volunteers away from their communities and an additional ambulance.[227]

**FINDING 19**

When volunteers perform inter–hospital patient transfers in regional areas the local capacity to respond to emergencies may be diminished.

## Competition and panel arrangement

### Metropolitan Perth

4.25 Non–emergency patient transfers in metropolitan Perth are performed by a panel of service providers.

4.26 National Patient Transport, a private non–emergency patient transport provider, submitted that fluctuations in the volume of work makes operating in Western Australia challenging:

> The overall volume in WA across all customers over the past four years has varied dramatically from year to year making it challenging to ensure a commercially viable and sustainable business can be maintained. We have completed a total of 23 246 patient movements over the four–year period. With the declining volumes

[224] Submission 33 from St John Ambulance WA Margaret River Volunteer Sub–Centre, 20 July 2021, p 1.

[225] Submission 40 from Private Citizen, 21 July 2021, p 2.

[226] Submission 50 from Shire of Manjimup, 22 July 2021, p 3.

[227] Submission 52 from Rodney Barret, 22 July 2021, p 1.

in the business since 2020 and the Health Services requiring more frequent regional patient movements this is impacting on our productivity and viability.

> Our staffing pool is a 56% casual workforce. With the inability to provide surety of shifts due to unpredictable work volumes the casual cohort remain transient which impacts on the responsiveness of the business.[228]

4.27 Further, the dominance of St John Ambulance WA in all areas of patient transport does not provide an even playing field for other operators:

> From the NEPT [non–emergency patient transport] perspective the St John Ambulance focus has been to dominate and eliminates any opportunity for any dedicated NEPT service providers to exist and provide the important support role to the Ambulance Services. This fact is evidenced by, in recent years, major multinational companies exiting the NEPT sector in Western Australia. The Wilson Group owned and controlled by the Kwok family has exited as has the multinational FALCK group. The market distortions…and the inconsistent pricing has made it impossible for any private providers to compete, grow and support the emergency Ambulance Service in a commercially viable manner.[229]

4.28 National Patient Transport argue the delivery of ambulance services in Western Australia could be improved by separating organisations that provide emergency services from organisations that provide non–emergency services (as occurs in Victoria):

> Ambulance Victoria is responsible for emergency and time critical responses whilst private NEPT [non–emergency patient transport] providers are engaged by both Ambulance Victoria and Health Services to provide NEPT services. Ambulance Victoria sub–contract (via tender) private providers to service their NEPT workload. Health Services engage NEPT providers (via tender) to service inter hospital transfers and transfers to and from outpatients. Admitted time critical patients are transferred by Ambulance Victoria emergency services (000).[230]

4.29 Non–emergency patient transport provider Wilson Medic One also noted the lack of competition in metropolitan Perth. Rather than recommending the separation of emergency and non–emergency services, Wilson Medic One recommend implementing a panel arrangement for both services:

> We are not currently contracted to provide emergency 000 ambulance services, a role exclusively contracted to St. John Ambulance (WA). This monopoly arrangement we believe is financially disadvantageous for the State and offers no choice or redundancy for the Government and the residents of Western Australia.
>
> …
>
> There are a number of requirements that we believe should be incorporated in the Western Australian framework for these services. These include:
>
> - Privately contracted ambulance services supported and managed by the State;
> - A panel of Metropolitan and Regional service providers.[231]

4.30 The Committee considers expanding the operational hours of inter–hospital patient transport service will benefit the system overall by:

[228] Submission 119 from National Patient Transport, 19 November 2021, p 2.

[229] ibid., pp 1–2.

[230] ibid., p 4.

[231] Submission 121 from Wilson Medic One, 26 November 2021, p 4.

- avoiding the unnecessary use of emergency ambulance resources for non–emergency patient transfers
- improving patient flow out of hospitals thereby reducing ambulance ramping.[232]

**RECOMMENDATION 10**

The Department of Health expand the operational hours of inter–hospital patient transfers to allow all service providers to perform this service 24 hours a day.

**Panel arrangement in regional areas**

4.31 St John Ambulance WA has a right of first refusal for inter–hospital patient transfers in regional areas.

4.32 The current Emergency Ambulance Services Agreement contains a clause in which St John Ambulance WA acknowledges WACHS plans to remove their right of first refusal to perform inter–hospital patient transport in regional areas.[233] Removing this right will allow alternate service providers to enter this market as is currently the case in metropolitan Perth.

4.33 WACHS are cognisant of the advantages in removing the right of first refusal in regional areas. Currently, alternate transport providers can easily transport patients from metropolitan hospitals to regional hospitals but have trouble securing work to transport regional patients back to Perth:

> Obviously in general when we are sending a patient from Northam, Bunbury et cetera into Perth it is because they are fairly unwell or less well or critically unwell and they need a higher level of care in Perth. So in circumstances where St John is unable to respond—either there are no volunteers available or the existing paramedic volunteer team are on another job, quite reasonably—then our hospitals have to wait for long periods of time to send patients when there can be [a National Patient Transport] ambulance sitting in the driveway with an appropriate crew. Our issue is that certainly we hear from our clinicians and we see circumstances and we do case reviews on a regular basis that demonstrate that for safety reasons choice is important and the capacity to use other providers that exist is important.
>
> …
>
> There are times when we do use the other metropolitan providers in critical clinical circumstances, but the mechanisms are very clunky; they do not work very well and it is clear that there should be choices.[234]

4.34 WACHS recommended regional hospitals have access to a panel of service providers as is currently available in the metropolitan area:

> Monopoly has its problems. Where that gets in the way of clinical care, which is our focal point—where the clinical care and the clinical response is not adequate—we say that that is not okay and there should be choice even if there is a mechanism to go through before that choice occurs. But patients need to get timely services; that is our view.[235]

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232 Submission 68 from Private Citizen, 23 July 2021, p 1.

233 Department of Health, Answer to question on notice 3 asked at hearing held 24 November 2021, dated 20 January 2022, p 2.

234 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, pp 7–8.

235 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 9.

4.35 The Committee considers removing St John Ambulance WA's right of first refusal to perform inter–hospital patient transfers in regional areas will enable alternative providers to relieve some of the work currently undertaken by volunteers without preventing them from performing this service should they wish to continue.

**RECOMMENDATION 11**

The Department of Health remove St John Ambulance WA's right of first refusal for regional inter–hospital patient transfers.

## Volunteers performing inter–hospital transfers

4.36 St John Ambulance WA volunteers undertake the majority of inter–hospitals transfers in regional areas.

4.37 WACHS report that feedback from volunteers about their role in inter–hospital transfers is mixed. Some volunteers are concerned about the demands on their time outside their community, effectively making them unavailable for emergency calls. Others see a benefit to the work because of the income it generates for their sub–centre:

> When we talked with our current provider St John, who does virtually all of our inter–hospital transfers the feedback through the country ambulance strategy was twofold. There were those sub–centres that said, "Please take away the inter–hospital transfers because they're occurring at all hours of the night. They take us away from community. We're often away for long periods of time." That happens as you would imagine particularly in the wheatbelt but right across the state. There were some other more stable sub–centres with large numbers of volunteers who said, "We actually enjoy the income and it helps us buy our new ambulances and do the things that we need to do." So there is that perspective from the ground.[236]

4.38 A volunteer from the South West noted how the income generated from inter–hospital transfers has allowed their sub–centre to improve its facilities and equipment:

> Most rural sub–centres were started by the community to service their communities. They raised the finance to build sub–centres, purchase ambulances, supply uniforms, buy equipment with little help from Belmont.
>
> Since the Health Department have been paying sub–centres for inter–hospital transfers we have been able to have modern premises, allowed us to keep our fleet of ambulances and equipment updated and have been able to give honorariums to officers for the time they spent giving this life saving service to their community and others.[237]

4.39 The Committee is mindful that inter–hospital patient transfer work is beneficial for training new volunteers and providing experienced volunteers an opportunity to maintain their skills. Volunteers at sub–centres with low volumes of emergency work are particularly reliant on this aspect of performing inter–hospital transfers.

**FINDING 20**

There are benefits in allowing volunteers to perform inter–hospital transfers. These include:

- sub–centres improving their facilities and equipment from the income they generate
- volunteers having an opportunity to undergo training and maintain their skills.

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236 ibid., pp 3–4.

237 Private Submission 91 from Private Citizen, 27 July 2021, p 2.

4.40 The Committee received submissions about volunteer fatigue when performing inter–hospital patient transfers:

- Shire of Wagin:

> Issues do arise however when inter hospital patient transfers to WACHS facilities that do not have the required resources (radiology, surgical, medical, and even staff) to diagnose and treat patients. This results in the transfer of patients to regional or metropolitan facilities at all times of the day and night. This leads to both ambulance volunteers and patients becoming fatigued.[238]

- Shire of Carnamah:

> St John Ambulance WA are requested to transfer at unrealistic times to regional or metro facilities which creates a fatigue and safety issue for both the patient and volunteer.[239]

4.41 The Committee acknowledges volunteers can become fatigued when performing long inter–hospital transfers, especially when balancing this against emergency calls, work and family commitments.

**FINDING 21**

Performing inter–hospital patient transfers in regional areas can be time consuming leading to volunteer fatigue and contributing to a diminished emergency response capability.

## Delays when picking up patients from hospital

4.42 The Committee heard delays can occur when ambulance crews arrive to pick up patients for inter–hospital transfers despite the service being booked in advance.

4.43 The Ambulance Employees Association of WA claim these delays are caused by poor coordination by hospitals:

> Hospitals constantly call St John Ambulance WA straight away to arrange the transfer and only then commence actively performing interventions whilst the crews are waiting. Crews are routinely told to wait until the hospital staff finish, then the paperwork has to be completed and then they need to call the receiving hospital. Most of the time crews wait in excess of 45 minutes whilst this occurs further increasing wait times and straining the ambulance service's capability to respond to calls.[240]

4.44 In order to address this the Ambulance Employees Association of WA recommend a policy be developed for hospital staff on inter–hospital patient transfers.[241]

4.45 St John Ambulance WA confirmed delays occur when ambulance crews arrive to pick up patients but noted there can be good reasons for this such as when a patient unexpectedly deteriorates and requires critical intervention.[242]

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238 Submission 74 from Shire of Wagin, 23 July 2021, p 2.

239 Submission 42 from Shire of Carnamah, 21 July 2021, p 2.

240 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, p 11.

241 ibid., recommendation 7.

242 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 29 October 2021, pp 18–9.

## Delays when dropping off patients at hospital

4.46 The Ambulance Employees Association of WA also noted delays often occur when dropping off patients at the destination hospital because the hospital has failed to make a bed available. When this occurs patients can become ramped:

> Receiving hospitals are not communicating expected wait times clearly to crews, meaning patients are either transferred (sometimes several times) or ramped. Paramedics and crews are not trained nor equipped for long term medical treatment. Some crews have been ramped for 6 hours at a time with a patient. This is not safe for the patient and it takes that crew and vehicle off the road for the duration. While ramped, neither patients nor staff can reliably access bathrooms, food or water.
>
> We are in a time where nearly all non–emergency priority patients are automatically sent to be ramped by hospitals. These patients, who may have serious issues such as diabetes, trauma, psychiatric issues, suspected overdoses, even those with chest pains are deemed a low priority at triage. All of them are capable of deteriorating when left unattended or transferred multiple times. Many do.[243]

4.47 The Shire of Manjimup also noted this occurring in its district when volunteer crews perform inter–hospital transfers:

> Inter–hospital transfers should only be arranged after it is confirmed that the receiving hospital has a bed available for the patient; too often volunteers have to wait for several hours, ramping at the receiving hospital as no beds are available.[244]

4.48 The Ambulance Employees Association of WA recommended receiving hospitals be required to communicate with ambulance crews directly on bed availability and expected admission times for patients.[245]

4.49 The Committee considers the establishment of a state–wide inter–hospital patient transfer coordination centre would reduce delays when picking up and dropping off patients at hospital by improving coordination between hospitals and ambulance transport providers (see Recommendation 9).

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243 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, p 11.

244 Submission 50 from Shire of Manjimup, 23 July 2021, p 3.

245 Submission 78 from Ambulance Employees Association of WA, 23 July 2021, recommendation 6.

# CHAPTER 5
# Metropolitan emergency ambulance service delivery model

## Introduction

5.1 This chapter addresses term of reference (b). It considers the efficiency and adequacy of the emergency ambulance service delivery model in metropolitan Perth.

5.2 Emergency ambulances in metropolitan Perth are entirely staffed by qualified paramedics.

5.3 This chapter considers a range of factors which include:

- ambulance response times
- ramping
- stand–by capacity
- alternative care pathways
- cardiac arrest survival rate
- transparency and accountability.

## Metropolitan ambulance service

5.4 St John Ambulance WA provide 24/7 on demand ambulance services through their Metropolitan Ambulance Operations. In 2020/21 St John Ambulance WA delivered 198 534 instances of on–demand priority 1, 2 and 3 care.[246]

5.5 The Metropolitan Ambulance Operations employs approximately 750 ambulance paramedics and ambulance officers across 29 sub–centres.[247]

5.6 Figure 12 shows Western Australia has the lowest ratio of qualified ambulance officers per head of population (27.3 officers per 100 000), well below the national average of 52 officers per 100 000. Queensland has the highest ratio of 71.3 qualified ambulance officers per 100 000 head of population.

[246] Submission 71 from St John Ambulance WA, 23 July 2021, p 28.

[247] ibid.

Figure 12. *Breakdown of staff roles at ambulance services in Australia*

| Table 11A.8 | Ambulance service organisation human resources | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Unit | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| Human resources | | | | | | | | | | |
| 2020-21 | | | | | | | | | | |
| Salaried personnel (FTE) | | | | | | | | | | |
| Ambulance operatives | | | | | | | | | | |
| Patient transport officers | no. | – | 46 | 230 | 138 | 74 | 20 | 19 | 20 | 547 |
| Students and base level ambulance officers | no. | 386 | 382 | 41 | 177 | 123 | 39 | 42 | 19 | 1 208 |
| Qualified ambulance officers | no. | 3 589 | 3 730 | 3 703 | 730 | 959 | 356 | 177 | 110 | 13 354 |
| Clinical other | no. | 69 | 27 | 3 | 1 | 62 | 14 | – | – | 177 |
| Communications operatives | no. | 422 | 158 | 474 | 125 | 136 | 64 | 44 | 35 | 1 456 |
| Total (a) | no. | 4 465 | 4 342 | 4 451 | 1 171 | 1 354 | 493 | 281 | 184 | 16 742 |
| Proportion of total salaried personnel | % | 83.9 | 81.4 | 89.0 | 60.7 | 78.6 | 80.0 | 82.3 | 74.2 | 81.6 |
| Per 100 000 population (b) | | | | | | | | | | |
| Students and base level ambulance officers | rate | 4.7 | 5.7 | 0.8 | 6.6 | 6.9 | 7.2 | 9.7 | 7.6 | 4.7 |
| Qualified ambulance officers | rate | 43.9 | 56.0 | 71.3 | 27.3 | 54.2 | 65.7 | 41.0 | 44.7 | 52.0 |
| Total | rate | 48.6 | 61.7 | 72.1 | 34.0 | 61.1 | 72.9 | 50.7 | 52.3 | 56.7 |
| Operational support personnel | no. | 527 | 500 | 262 | 229 | 176 | 84 | 37 | 36 | 1 851 |
| Corporate support personnel | no. | 331 | 492 | 287 | 528 | 193 | 39 | 23 | 29 | 1 921 |
| Total | no. | 5 323 | 5 335 | 5 000 | 1 928 | 1 723 | 616 | 342 | 248 | 20 515 |
| Registered paramedics | | | | | | | | | | |
| General | no. | 5 455 | 6 083 | 5 443 | 1 374 | 1 387 | 598 | 328 | 197 | 20 865 |
| Non-practising | no. | 70 | 98 | 83 | 25 | 16 | 9 | 8 | 3 | 312 |
| Total | no. | 5 525 | 6 181 | 5 526 | 1 399 | 1 403 | 607 | 336 | 200 | 21 177 |
| Volunteers | | | | | | | | | | |
| Ambulance operatives | no. | 51 | 1 026 | 126 | 3 767 | 1 239 | 385 | – | – | 6 594 |
| Operational / corporate support | no. | 54 | – | 3 | 565 | 212 | – | – | – | 834 |
| Total | no. | 105 | 1 026 | 129 | 4 332 | 1 451 | 385 | – | – | 7 428 |
| Community first responders | no. | 284 | 257 | 145 | 5 972 | 38 | 20 | – | – | 6 716 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 11A.8.]

5.7 The United Workers Union expressed concern that St John Ambulance WA has under–invested in frontline services but has a top heavy management model. The Union asserts this has implications for service delivery and occupational health and safety:

> Operating on skeletal staffing with very little investment in front–line services with a top–heavy management model. Profits are diverted to the greater St John organisation rather than reinvested in the ambulance service.
>
> …
>
> Health and safety of the WA population is the responsibility of the government (as seen on other states). It is a conflict of interest to have a private organisation that favours profit over patient outcomes in control of the ambulance service. A paramedic workforce openly stating that we need “very public deaths” to highlight the critical failings of the service is a distressing state of affairs and fundamentally wrong.
>
> …
>
> Seems to come down to cost. Maybe other services run better but it means funding far more country paramedics, better funding for admin, more front line

staff. SJA appears management top heavy they have forgotten to prioritise front line staff and as a result it is impacting on service delivery. [248]

5.8 St John Ambulance WA dispute the assertion it has a top heavy staffing model:

> **Ms FYFE:** I would say no, and I think that the counting rules around the numbers need to be looked at as well. I can certainly say that the management of ambulances is definitely not top–heavy; quite the contrary. I am happy to review those numbers and look at the counting rules around the Report on government services. I can tell you that at this point in time, we have 991 paramedics at various levels, whether that be a paramedic, ambulance officer or student ambulance officer. We have 991, plus a management cohort on top of that. I would happily review those Report on government services numbers—their counting rules—and provide a response to your question…
>
> **Mr BRINK:** Part of the total number of paid staff does not just provide services to the paid paramedics. It will also be there to manage and support our volunteer services in the regions as well, through the regional offices and their staff, including admin, finance and training.[249]

5.9 Table 13 shows the proportion of corporate support personnel in Western Australia is the highest in the nation and almost three times higher than that of the national average.

Table 13. *Ambulance corporate support personnel in Australia 2020/21*

| | Unit | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
|---|---|---|---|---|---|---|---|---|---|---|
| Corporate support personnel | no. | 331 | 492 | 287 | 528 | 193 | 39 | 23 | 29 | 1 921 |
| Total personnel | no. | 5 323 | 5 335 | 5 000 | 1 928 | 1 723 | 616 | 342 | 248 | 20 515 |
| Proportion of corporate support personnel | % | 6.22 | 9.22 | 5.74 | 27.39 | 11.2 | 6.33 | 6.73 | 11.69 | 9.36 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 11A.9.]

**FINDING 22**

The emergency ambulance service in Western Australia has the highest proportion of non–operational personnel in Australia. The proportion of non–operational personnel in Western Australia is almost three times higher than the national average.

## Paramedic qualifications

5.10 Paramedics have tertiary qualifications in paramedicine. This includes an advanced diploma or undergraduate degree in paramedicine.

248 Submission 102 from United Workers Union, 3 August 2021, pp 24, 27–8.

249 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 22.

5.11 Since 2018 paramedics must be registered with the Paramedicine Board of Australia and meet the Board's registration standards in order to practice in Australia.[250] This includes satisfying the following conditions on an annual basis:

- compliance with professional standards
- continuing professional development
- minimum hours of practice
- English literacy
- possession of professional indemnity insurance
- satisfy supervised practice requirements.

5.12 St John Ambulance WA paramedics are trained to Advanced Life Support level. This is an additional advanced level of training that provides them with skills in more invasive and higher technical procedures and medications.[251] This training is not required in all states and territories.[252]

## Ambulance response times

5.13 The Emergency Ambulance Services Agreement requires St John Ambulance WA to respond to calls in the metropolitan region within 10–40 minutes depending on the priority level. The target response times in the Emergency Ambulance Services Agreement are set out in Table 14:

Table 14. *Metropolitan sub–centre target response times (excluding inter–hospital patient transport)*

| **Dispatch Priority 1** | |
|---|---|
| Calls responded to within 15 minutes | 90 per cent |
| Average response time | 10 minutes |
| **Dispatch Priority 2** | |
| Calls responded to within 25 minutes | 90 per cent |
| Average response time | 15 minutes |
| **Dispatch Priority 3** | |
| Calls responded to within 60 minutes | 90 per cent |
| Average response time | 40 minutes |
| **Dispatch Priority 4** | |
| Calls responded to within 10 minutes of scheduled arrival time | 90 per cent |
| Average arrival time | N/A |

[Source: Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 3.]

5.14 Figure 13 shows the emergency ambulance response time performance in 2019/20 and 2020/21:

250 *Health Practitioner Regulation National Law (WA) Act 2010.*

251 Submission 71 from St John Ambulance WA, 23 July 2021, p 31.

252 ibid.

Figure 13. *Emergency ambulance response times in 2019/20 and 2020/21*

| Attend 90%of calls | Target time | FY20-21 | FY19-20 |
|---|---|---|---|
| Priority 1 | 15 minutes | 86.1%. | 90.5% |
| Priority 2 | 25 minutes | 78.4% | 84.8% |
| Priority 3 | 60 minutes | 76.4% | 86.2% |

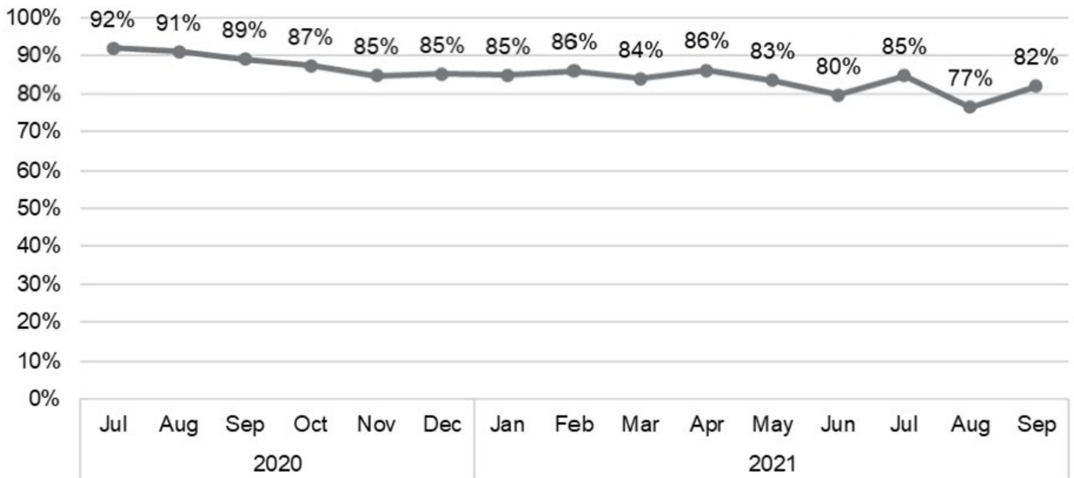
[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 32.]

5.15 St John Ambulance WA met the target response time for priority 1 calls in 2019/20 but not for priority 2 and 3. St John Ambulance WA did not meet priority 1, 2 or 3 target response times in 2020/21.

5.16 Figures 14, 15 and 16 show the percentage of priority 1, 2 and 3 calls responded to within the target time between July 2020 and September 2021.

5.17 Figure 14 shows St John Ambulance WA has not complied with the requirement to respond to 90 per cent of priority 1 calls within 15 minutes since August 2020. During 2020/21 only 86.1 per cent of priority 1 calls were responded to within the target response time of 15 minutes:

Figure 14. *Percentage of priority 1 calls responded to within target response time from 1 July 2020 to 30 September 2021*




[Source: St John Ambulance WA, Answer to question on notice 5 asked at hearing held 29 October 2021, dated 22 November 2021, p 13.]

5.18 Figure 15 shows St John Ambulance WA did not comply with the requirement to respond to 90 per cent of priority 2 calls within 25 minutes throughout all of 2020/21. During this time St John Ambulance responded to 78.4 per cent of priority 2 calls within the target response time:

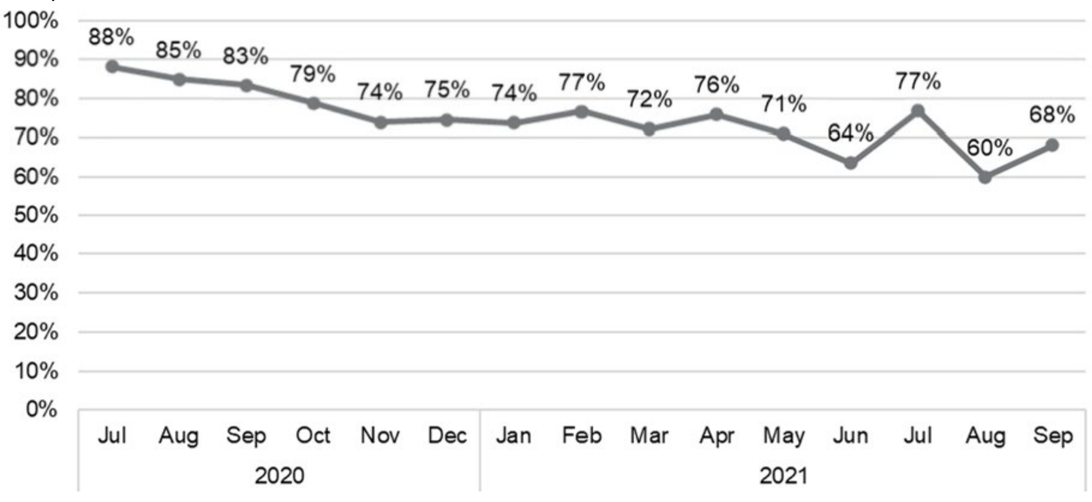
Figure 15. *Percentage of priority 2 calls responded to within target response time from 1 July 2020 to 30 September 2021*

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%
88% 86% 84% 79% 74% 77% 76% 81% 76% 81% 75% 68% 81% 64% 70%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
2020 2021

[Source: St John Ambulance WA, Answer to question on notice 5 asked at hearing held 29 October 2021, dated 22 November 2021, p 14.]

5.19 Figure 16 shows St John Ambulance WA did not comply with the requirement to respond to 90 per cent of priority 3 calls within 60 minutes throughout all of 2020/21. During this time St John Ambulance responded to 76.4 per cent of priority 3 calls within the target response time:

Figure 16. *Percentage of priority 3 calls responded to within target response time from 1 July 2020 to 30 September 2021*




[Source: St John Ambulance WA, Answer to question on notice 5 asked at hearing held 29 October 2021, dated 22 November 2021, p 14.]

5.20 The Committee observed that the actual performance against target response times for priority 1, 2 and 3 has declined since the start of 2022.[253]

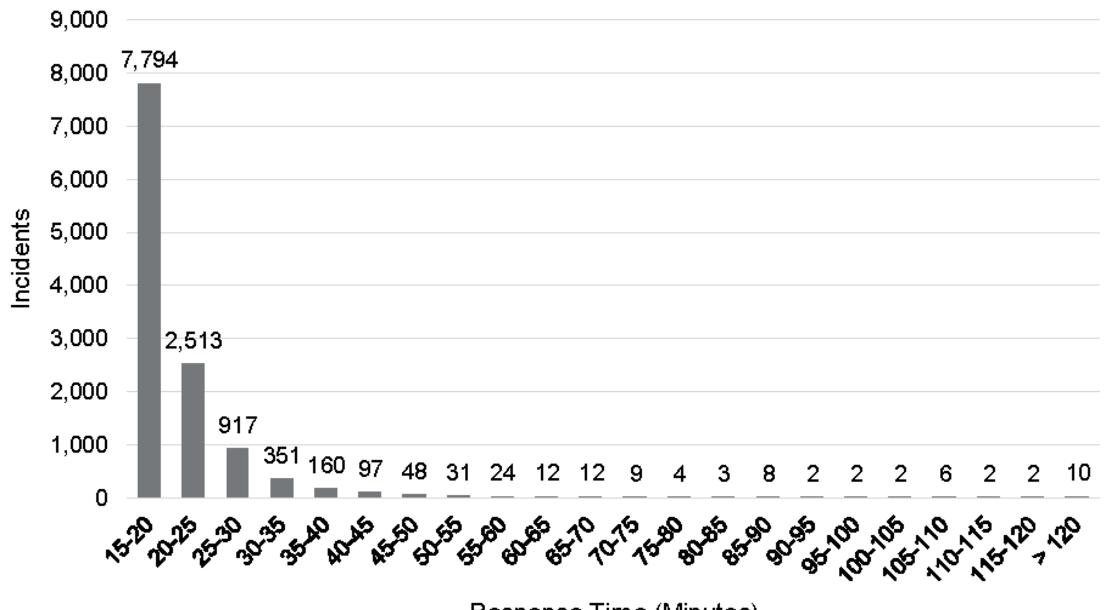
5.21 St John Ambulance WA publishes daily compliance against target response times for priority 1, priority 2 and priority 3 calls for the previous day on their website. This is a good initiative to improve transparency.

5.22 Figure 17 shows the response time of priority 1 calls that did not meet the 15 minute target in 2020/21. This shows:

[253] St John Ambulance WA, *Ambulance Activity and Response Times*, See: https://stjohnwa.com.au/ambulance-and-health-services/metro-ambulance-service/ambulance-activity-and-response-times. Viewed 10 March 2022.

- 785 priority 1 cases took over 30 minutes to be responded to
- 10 priority 1 cases took over 120 minutes to be responded to.

Figure 17. *Metropolitan incidents where initial priority was determined to be priority 1 and the incident was not attended within 15 minutes from 1 July 2020 to 30 June 2021*




[Source: St John Ambulance WA, Answer to question on notice 4 asked at hearing held 29 October 2021, dated 22 November 2021, p 11.]

5.23 The Committee is of the view that the clinical outcome for a priority 1 patient who was attended to one minute outside the target response time and a priority 1 patient who was attended to one hour outside the target response time could be vastly different. It is important the number of calls which did not meet the target and by how much be made available publicly. The Department of Health should table this information in Parliament on an annual basis.

**FINDING 23**

St John Ambulance WA did not meet their target response times for priority 1, 2 or 3 calls in 2020/21.

**RECOMMENDATION 12**

The Department of Health table the number of priority 1, 2 and 3 calls which did not meet target response times, and by how much, in Parliament on an annual basis.

## Calculation of response time

5.24 The Auditor General Report (2013) noted there are variations in the way different jurisdictions calculate ambulance response times:

> Different jurisdictions count response times from different starting points (Figure [18]) making national comparisons difficult. SJA's response times are measured starting from the time that calls are entered into the CAD for dispatch.[254]

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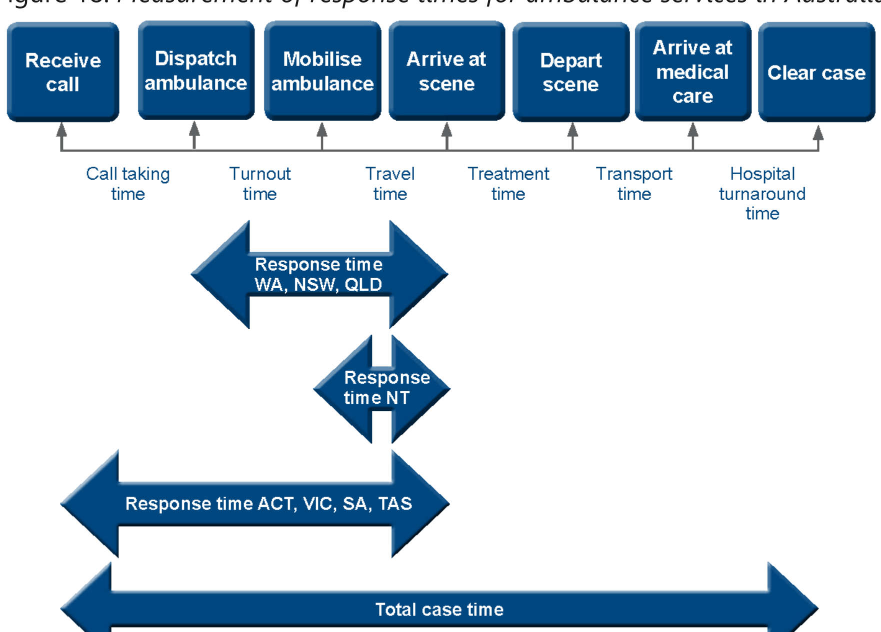
[254] Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services,* June 2013, p 27.

5.25 Figure 18 from the Auditor General Report (2013) shows how differences in measuring response time can influence the time calculation:

Figure 18. *Measurement of response times for ambulance services in Australia*




[Source: Office of the Auditor General, *Delivering Western Australia's Ambulance Services*, June 2013, p 28.]

5.26 The following submission from a paramedic contends the way St John Ambulance WA calculate response time is not an accurate reflection of actual response times. The submission points out that a difference of just minutes can have a critical impact on survival rates:

> Services such as the [ACT Ambulance Service], [Ambulance Victoria], [South Australia Ambulance Service] and [Ambulance Tasmania] are starting the clock effectively as soon as the call is answered in their versions of the SOC, which is a more factual response time. [St John Ambulance WA], [NSW Ambulance] and [Queensland Ambulance Service] start their response times from the moment the ambulance is dispatched, while the contract for [St John Ambulance Northern Territory] starts as soon as the ambulance mobilises (Office of the Auditor General [OAG, 2013]. This 'play' on words regarding ambulance response makes SJAs target easier to reach as a KPI than other States and Territories across Australasia. This allows figures to [be] shown as better than what they are so that less money is required to run the service.
>
> A study by Pell et al. (2001) found that for all the out of hospital cardiac arrests in Scotland (13,822 patients) over the 1991–1998 period there was an increase of 8% in service standard survival rates if ambulances arrived within 8 minutes. An increase in survival rates of 10–11% was seen in cases were ambulances arrived within 5 minutes (Pell et al., 2001). The importance of meeting response times cannot be overstated. It means a service has enough staff and resources to meet a growing demand, crews get to emergency calls quickly and effectively and lifesaving management can be provided.[255]

5.27 In England, the National Health Service calculate response times from the time a call is answered by the ambulance service:

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[255] Private Submission 43 from Private Citizen, 21 July 2021, p 7.

> Response times are calculated from call connect for all categories and so include call triage time before clock start (up to 30 seconds for Category 1 and up to 240 seconds for categories 2–4) and any dispatch delays resulting from queueing calls awaiting a resource to become available. From a patient perspective these times reflect the waiting time from their call being made to arrival of help.[256]

5.28 There is no uniform methodology in Australia for calculating ambulance response times. The Committee recommends ambulance response times in Western Australia be calculated from the moment a 000 call is received by the ambulance service as occurs in the Australian Capital Territory, Victoria, Tasmania, South Australia and England (National Health Service).

**FINDING 24**

The ambulance service in Western Australia records ambulance response times from the moment an ambulance is dispatched. The ambulance services in the Australian Capital Territory, Victoria, South Australia Tasmania and England record response times from the moment a 000 call is received by the ambulance service.

**RECOMMENDATION 13**

The Department of Health require ambulance response times in Western Australia to be recorded from the moment a 000 call is received by the ambulance service.

## Ramping

5.29 'Ambulance ramping' occurs when:

> ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED [Emergency Department] within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED.[257]

5.30 The accepted standard for handover from an ambulance to the emergency department is between 15 and 30 minutes:

> In a well–functioning system, with good access to cubicles and beds, the time interval of ambulance arrival to clinical handover should routinely occur within 15 minutes and never take more than 30 minutes.[258]

5.31 In Western Australia, ramping is formally known as 'Extended Transfer of Care' which is defined in the Emergency Ambulance Services Agreement as:

> the total length of time Transfer of Care exceeds 30 minutes.[259]

5.32 'Transfer of Care' is defined as:

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256 National Health Service England, *Ambulance Response Programme Review (2018)*, p 10. See: https://www.england.nhs.uk/wp-content/uploads/2018/10/ambulance-response-programme-review.pdf. Viewed 24 March 2022.

257 Australasian College for Emergency Medicine, *Position Statement on Ambulance Ramping*, Item 3.1. See: https://acem.org.au/getmedia/9e6c3e78-8cbc-473c-83df-474f6c1eecde/S347-Statement-on-Ambulance-Ramping-Nov-13.aspx. Viewed 1 April 2022.

258 ibid.

259 Department of Health, *Emergency Services Agreement*, 25 September 2020, clause 1.1.

the duration from the arrival of the Patient Transport Vehicle at the receiving Hospital's emergency department to the transfer of the Patient from the care of the Provider's Crew to the care of the Hospital staff.[260]

**Current situation**

5.33 Ramping in not unique to Western Australia. It affects every jurisdiction in Australia and according to the Department of Health, is caused by high numbers of people attending hospital and a difficulty in clearing beds:

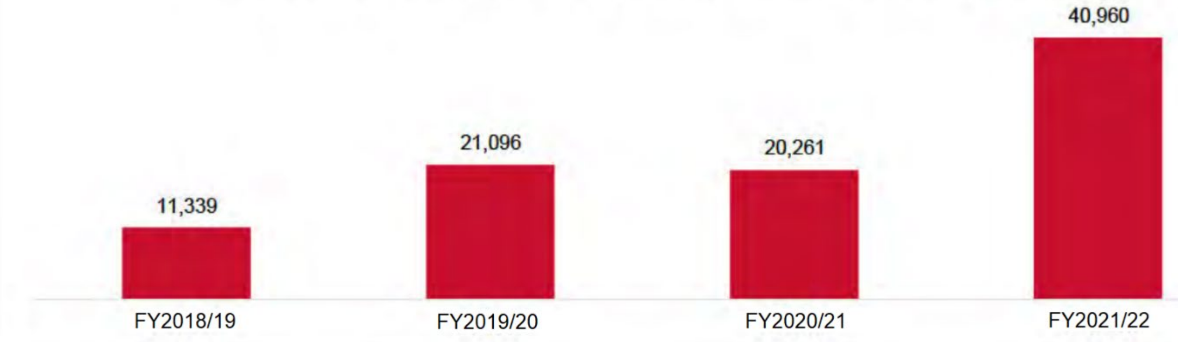
> The actual cause in the system is demand coming in but it is also freeing up beds to get patients out. I think that cannot be forgotten in this debate. So we do talk a lot about the pressures on the front door.
>
> …
>
> We have over 120 patients at the moment spending more than 150 days in hospital. We have patients who wait years in hospital because we cannot get them out to proper disability or long–stay services. That is the cause. So when people get, in a sense, pushed back and it is pushed back and it causes congestion in our emergency departments, the main cause is actually that flow through the hospital; it is occupancy of the hospital.[261]

**FINDING 25**

Ambulance ramping is experienced in every jurisdiction in Australia.

5.34 According to St John Ambulance WA, ramping hours have more than doubled from 2019/20 to 2020/21, equivalent to removing 4.6 ambulances from the road every day.[262]

Figure 19. *Total ramping hours in metropolitan Perth from 2018/19 to 2020/21*




[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 33.]

**FINDING 26**

Ramping hours at Perth metropolitan hospitals more than doubled between 2019/20 and 2020/21.

5.35 The rapid escalation of ramping was not foreseen at the time of negotiating the Emergency Ambulance Services Agreement in September 2020. St John Ambulance WA said:

> When we set that arrangement up with Health in the extended contract we were sitting at 20 000 hours per year—which we thought was high in the first place—to double the next year and now on an even higher trajectory going forward. That

260 ibid.

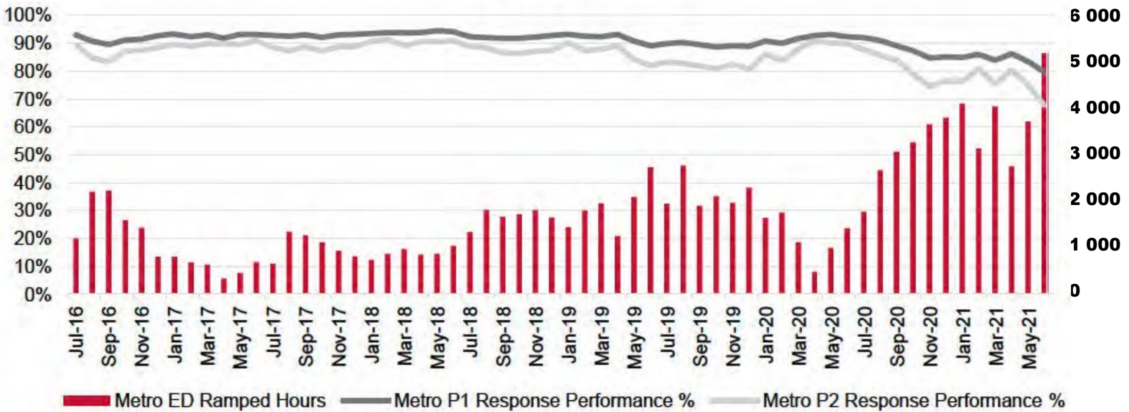
261 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 5.

262 Submission 71 from St John Ambulance WA, 23 July 2021, p 28.

ability to predict is problematic but we are putting those resources on as it becomes apparent that is now the new normal.[263]

5.36 The graph in Figure 20 below shows an inverse correlation between ramping hours and St John Ambulance WA compliance with target response times for priority 1 and priority 2 cases. This suggests increased ramping has contributed to St John Ambulance WA's inability to comply with their target response times.

Figure 20. *Total ramping hours and target response time performance for priority 1 and 2 cases in metropolitan Perth between 2016/17 and 2020/21*




[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 33.]

**FINDING 27**

There is an inverse correlation between fluctuations in ramping hours and St John Ambulance WA's ability to achieve their target response times for priority 1 and 2 cases.

**Extended transfer of care payment**

5.37 The payment for extended transfer of care is discussed in chapter 2. The payments made under the extended transfer of care provision are commercial in confidence.

5.38 The Committee understands there is an argument that the more ambulances are ramped, the more the ambulance provider would receive.

5.39 This provision in the Emergency Ambulance Services Agreement could be regarded as a financial incentive and this should be addressed in future contracts.

**FINDING 28**

The extended transfer of care payment provision in the Emergency Ambulance Services Agreement is a potential financial incentive that results in increased ramping.

**RECOMMENDATION 14**

The Department of Health conduct a complete review of the Extended Transfer of Care payment provision in the Emergency Ambulance Services Agreement.

## What causes ramping?

5.40 Evidence indicates various factors may contribute to ramping including:

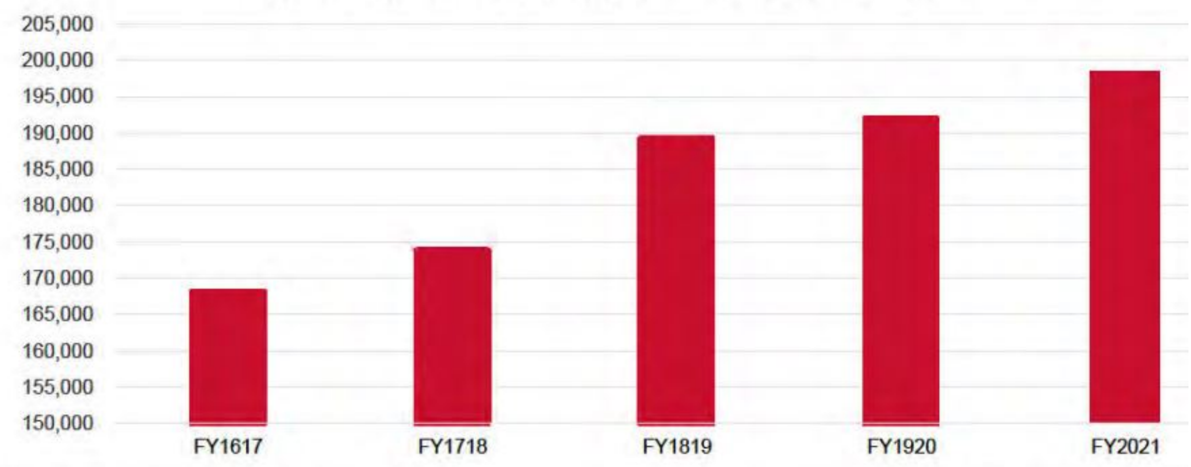
263 Ryan Marshall, Executive Director Finance and Supply, St John Ambulance WA, transcript of evidence, 24 September 2021, p 34.

- increasing demand for ambulances
- unnecessary transportation to hospital
- hospital capacity.

**Increasing demand for ambulances**

5.41 The number of emergency ambulance calls responded to in the metropolitan region has been steadily increasing in recent years (Figure 21). In 2020/21 metropolitan crews responded to 198 534 emergency calls.[264]

Figure 21. *Emergency calls responded to in metropolitan Perth from 2016/17 to 2020/21*




[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 29.]

**FINDING 29**

Emergency on–demand calls to St John Ambulance WA are at record levels.

5.42 The Department of Health advised there has been an 'enormous increase' in the number of patients attending emergency departments as well as an increase in high acuity patients:

> What we saw in December last year was an enormous increase in activity and it was not just a massive increase in our [emergency departments]; it was a change of shift to more acute patients
>
> …
>
> But that is not to overlook the fact that in December last year we saw off–the–chart numbers of people coming to our ED. Then in August this year—and this was driven mostly by what we call winter respiratory illnesses…we saw numbers that were the highest we had ever seen come into our EDs in history.
>
> …
>
> [Ambulances arriving in 2019/20] went up by about 3 000 more ambulances. The following year they went up by another 6 000, and this year to date, we have seen numbers in August which I just spoke of, of 9 700 ambulances, and then again over 9 000 in September, and again 9 000 in October. The numbers of [priority 1] ambulances attending…never had reached 9 000 in the previous 12 months, and that was post COVID.[265]

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264 Submission 71 from St John Ambulance WA, 23 July 2021, p 28.

265 Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 November 2021, p 7.

5.43 The Department of Health considers the increase in complex patients may be due to delayed care during lockdown:

> I think the whole health environment over the next two to three years will change. You have got a living–with–COVID environment which is not over yet. We have got long COVID which Europe is seeing. Long COVID is probably not being talked about very much in Australia but I think needs to be.
>
> Then you have got that, sort of, huge increase in chronic disease that was coming long before the pandemic, and then you have got delayed care because of prolonged lockdowns.[266]

**FINDING 30**

The Department of Health is currently experiencing an unprecedented number of patients presenting to hospital emergency departments with complex illness.

**Unnecessary transportation to hospital emergency department**

5.44 The Committee received submissions from a number of stakeholders claiming paramedics do not have discretion to refuse to transport callers to hospital.[267]

5.45 St John Ambulance WA advised that paramedics do have discretion not to transport patients to hospital and that this occurs in approximately 10 per cent of cases:

> I think the final part of your question related to when we encounter a patient who seems to not need transport to hospital, what does that look like. Now, paramedics certainly have the ability to have patients remain in the community after an assessment in our care. That runs at about 10 per cent, so about 100 cases per 1 000 cases that we are dispatched to remain in the community.
>
> But the issues that face our paramedics trying to do that are similar to the issues facing everyone else. There is a limited number of pathways that they can plug that patient into, so it is often a question between emergency department, your GP or nothing, rather than "You've fallen over. You seem uninjured. You're elderly. You'd be well–suited to an elder patient falls outpatient clinic tomorrow." At the moment, that type of system does not exist.[268]

5.46 This conflicting evidence shows there is confusion between St John Ambulance WA management and frontline paramedics about paramedic discretion to refuse transport. This confusion is a factor that may contribute to ramping.

**FINDING 31**

There is uncertainty between St John Ambulance WA management and frontline paramedics about the circumstances in which paramedics can exercise their discretion to refuse to transport patients. This uncertainty may contribute to ramping.

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266 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 November 2021, pp 7-8.

267 Submission 7 from Private Citizen, 9 July 2021, p 1; Submission 47 from Private Citizen, 21 July 2021, p 2; Submission 75 from Private Citizen, 23 July 2021, p 4; Submission 53 from Private Citizen, 22 July 2021, p 2; Submission 88 from Private Citizen, 23 July 2021, p 4; Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 4; Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 13.

268 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 November 2021, p 6.

5.47 The Committee believes guidelines should be developed to support paramedics exercising their discretion if they deem transport unnecessary and to advise patients:

- to seek alternative care pathways
- against transport in certain circumstances.

**RECOMMENDATION 15**

The Department of Health work with St John Ambulance WA to develop guidelines to support paramedics exercising their discretion in circumstances where they deem transport unnecessary.

### Hospital capacity

5.48 The Australian Medical Association (WA) claimed capacity issues in hospitals causes ramping:

> Ramping is symptom of a sick health system. It is not a symptom or reflection of an ambulance service. Over the last four years we have seen ramping increase by almost 400 per cent. This is a reflection of decreased capacity in the system in Western Australia, with WA having the lowest number of beds per capita of any state of territory and...the lowest number of ICU beds per head of population of any state or territory.
>
> ...
>
> The ramping that we are seeing has got nothing to do with the provision of ambulance services. It has everything to do with a reduced capacity and the inability of our public health system to meet the demands that it is currently seeing.[269]

5.49 The Committee asked the Australian Medical Association (WA) if they were aware of any research to support their submission:

> **Dr DUNCAN–SMITH:** Any research? The short answer is no.
>
> **The CHAIR:** How does the AMA arrive at the conclusion that the ramping problem is attributed to the public health system entirely and nothing to do with the ambulance service?
>
> **Dr DUNCAN–SMITH:** Because the emergency departments are still there, and still working normally. They cannot get their patients out of the emergency departments, which means they get full. There are no beds in the emergency department. Those patients arriving in the ambulance are not causing the inability of the emergency department to get the patients out of the emergency department. The inability of getting patients out of the emergency department is due to a lack of beds in the system and a lack of capacity, and that is reflected by the occupancy of the hospitals being at or around 100 per cent or just over in some circumstances. The actual emergency department, again, has not been flooded with patients coming in over and above what would be predicted. The ambulance arriving does not affect the ability to get those patients out of the emergency department. As far as actually having direct research to show that it is not the ambulances that are causing the ramping, I guess we have never done that because it is obvious that that is the situation.[270]

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[269] Dr Mark Duncan–Smith, President, Australian Medical Association (WA), transcript of evidence, 22 November 2021, pp 2–3.

[270] ibid., p 3.

5.50 Figure 22 shows the number of beds per 1 000 people in Perth is equal to Melbourne:

Figure 22. *Available beds per 1 000 people, by region, public hospitals (including psychiatric)*

| Table 12A.4 | Available beds per 1000 people, by region, public hospitals (including psychiatric) (a), (b), (c), (d), (e) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Unit | NSW | Vic | Qld | WA | SA (f) | Tas | ACT | NT | Aust |
| Public hospitals (including psychiatric hospitals) | | | | | | | | | | |
| Available beds | | | | | | | | | | |
| Per 1000 population | | | | | | | | | | |
| 2019-20 | | | | | | | | | | |
| Major cities | rate | 2.3 | 2.1 | 2.4 | 2.1 | 2.4 | .. | 2.7 | .. | 2.3 |
| Inner and outer regional | rate | 3.2 | 2.7 | 2.7 | 2.4 | 3.0 | 2.8 | .. | 3.4 | 2.9 |
| Remote and very remote | rate | 7.1 | 2.3 | 3.8 | 3.2 | 4.7 | 2.2 | .. | 4.8 | 4.1 |
| All areas | rate | 2.6 | 2.3 | 2.5 | 2.2 | 2.6 | 2.8 | 2.7 | 4.0 | 2.5 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 12A.4.]

5.51 The Department of Health said while hospital capacity contributes to ramping, there are other factors as well:

> Along with capacity we need workforce and staffing as well and every jurisdiction around the world is looking for staffing. We are putting more nursing and midwifery graduates through than we have ever done before—an increase of about 700 to 1 270. So it is not as simple as just beds. Yes, it is capacity [but] it is too simplistic just to say it is just capacity in our hospitals...We should not be having 150, sometimes up to 200 if not more, long–stay patients in our hospitals occupying acute beds who could be looked after better in the community. A huge majority of those would be NDIA patients or patients requiring mental health.
>
> ...
>
> One component is capacity and it was very welcoming to see the additional 270 beds that were announced recently by the government.
>
> I have talked a little bit about demand that is going through our hospitals...we also get walk–ins...It is not just ambulances; it is actually the whole thing, and we have seen a growth in ambulances but more in triage 1s, 2s and 3s.[271]

5.52 The Department of Health also gave evidence about elective surgeries and long–stay patients impacting hospital capacity and ultimately ramping:

> It is not only the front end that is causing some of the issues in the emergency departments; it is also what is going on in the hospitals. We are doing more elective surgery than we have ever done before. If that is the case you are taking up more capacity in the hospitals...We are purchasing provision of services in the community that really is the Commonwealth's responsibility, but we have actually made a choice to do that to try to better patient flow through the hospital.[272]

**FINDING 32**

The current levels of ambulance ramping in Western Australia are a symptom of a complex set of factors. Factors contributing to ramping may include:

- an increase in demand for ambulances

271 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 November 2021, p 6.

272 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 November 2021, p 6.

- unnecessary transport to hospital emergency department
- the number of patients presenting to hospital
- hospital capacity
- elective surgery
- long–stay patients occupying hospital beds.

5.53 The Department of Health said 602 additional hospital beds will become available by August 2022. However, this will depend on the ability to recruit staff from overseas and from the eastern states:

> There is a huge focus now on our health service provider workforce and also we have got particular challenges in midwifery, in theatre nurses and also in our country areas. In our country areas they do rely on overseas and from over east but that obviously has dried up over the last 12 months. Yes it will improve, but it is dependent on capacity, long stay and workforce, and also on us working with our primary health colleagues to do more in the community.[273]

5.54 The Committee acknowledges increasing the number of available hospital beds is an important consideration to address ramping in Western Australia.

**FINDING 33**

The Department of Health anticipates an additional 602 hospital beds will become available by August 2022. However, this will depend on their ability to recruit staff.

5.55 The Department of Health accepts some causes of ramping are outside of St John Ambulance WA's control and contributes to their inability to meet KPIs:

> In August 2021 there was a significant drop, so quite recently, in priority 1 – priority 3 response times…We have asked [St John Ambulance WA] for a remediation response. But prior to that and since then we know that some of the things that are occurring…[such as] the large number of patients who are waiting hundreds of days in our hospitals for suitable accommodation in the community…create a logjam in ED at times and it causes the inability for…transfer of care…KPIs to be met. [274]

## Ambulance stand–by capacity

5.56 One of the areas of concern noted in the 2009 Joyce Report was the need for more ambulance stand–by capacity in metropolitan Perth. Stand–by capacity refers to the availability of ambulances to respond to new emergencies. Emergency ambulance services must maintain an appropriate level of stand–by capacity:

> The nature of providing emergency services requires a 'state of readiness' on the part of the ambulance service and this means that an adequate stand–by rate must be maintained. Every ambulance on stand–by is an ambulance that is ready to respond to an emergency, while each ambulance currently in use is an ambulance not available to respond.
>
> …

---

273 ibid., p 8.

274 Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 September 2021, p 9.

The lower the stand–by rate, the higher the risk that an ambulance will not be available—or will have to travel from a more distant station—when a new emergency arises.[275]

**Work shift models**

5.57 There are two major work shift models used by St John Ambulance WA:

- 2:2:4 model (2 day shifts – 11 hours, 2 night shifts – 13 hours and 4 days off)
- 4x4 model (4 days on – 12 hours each day, 4 days off).

5.58 Paramedics on the 4x4 model can be rostered on an 'Early' shift (7am – 7pm), or a 'Late' shift (10am – 10pm or 12noon – 12 midnight).

5.59 Paramedics are rostered to one of the four colour coded teams, Black, Blue, Red and Green.

5.60 St John Ambulance WA provided the Committee a snapshot of the ambulances rostered in the first week of March 2022 (Figure 23).

Figure 23. *St John Ambulance WA ambulances rostered between 7 and 13 March 2022*

**ROSTERED**

**2022 - March**

| | 224 | 4X4 | HEM |
|---|---|---|---|
| BLACK (B) | 43 | 16 | 2 |
| BLUE(A) | 43 | 17 | 2 |
| RED (D) | 43 | 16 | 2 |
| GREEN (C) | 43 | 17 | 2 |

| ESTABLISHMENT | DAY 43 | EARLY B 16 A 17 D 16 C 17 | LATE B 16 A 17 D 16 C 17 | NIGHT 43 | TOTAL 119 |
|---|---|---|---|---|---|
| 7/03/2022 Mon | 41 | 16 | 19 | 37 | **113** |
| 8/03/2022 Tue | 42 | 15 | 18 | 37 | **112** |
| 9/03/2022 Wed | 46 | 14 | 18 | 40 | **118** |
| 10/03/2022 Thu | 44 | 12 | 17 | 40 | **113** |
| 11/03/2022 Fri | 42 | 13 | 12 | 37 | **104** |
| 12/03/2022 Sat | 40 | 13 | 14 | 37 | **104** |
| 13/03/2022 Sun | 35 | 14 | 17 | 40 | **106** |

| | DAY | EARLY | LATE | NIGHT | TOTAL |
|---|---|---|---|---|---|
| **ESTABLISHED** | **301** | **116** | **115** | **301** | **833** |

| SIA VEHICLE | DAY | | | NIGHT | TOTAL |
|---|---|---|---|---|---|
| 7/03/2022 Mon | 1 | | | 1 | **2** |
| 8/03/2022 Tue | 1 | | | 1 | **2** |
| 9/03/2022 Wed | 1 | | | 1 | **2** |
| 10/03/2022 Thu | 1 | | | 1 | **2** |
| 11/03/2022 Fri | 1 | | | 1 | **2** |
| 12/03/2022 Sat | 1 | | | 1 | **2** |
| 13/03/2022 Sun | 1 | | | 1 | **2** |

[Source: St John Ambulance WA, letter, dated 18 March 2022, p 14.]

5.61 Figure 23 shows St John Ambulance WA rostered the following number of ambulances over a 24 hour period:

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[275] Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, pp 19 and 33.

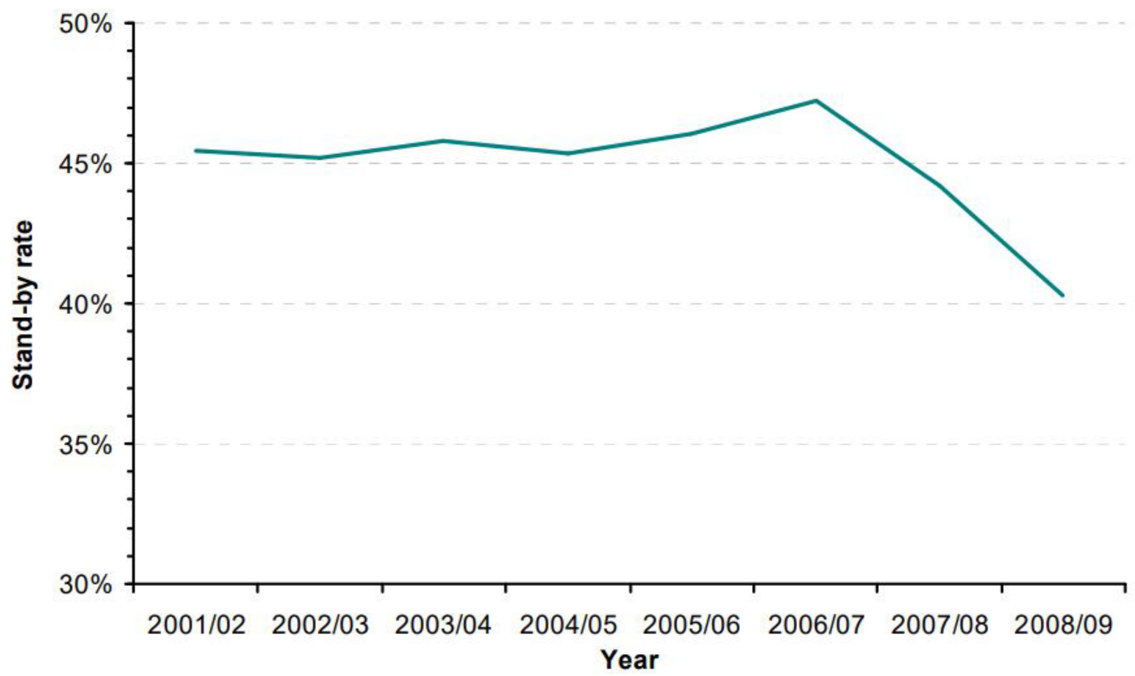
- 43 Day Shifts and 43 Night Shifts – for the 2:2:4 shift model
- 16/17 Early Shifts and 16/17 Late Shifts – for the 4x4 shift model.

5.62 At most there would be 43 ambulances from the 2:2:4 shift model and 34 ambulances from the 4x4 model at any one time in a 24 hour period.

**Stand–by rate**

5.63 The Joyce Report noted the stand–by rate had significantly decreased between 2006/07 and 2008/09 as shown in Figure 24 below:

Figure 24. *Ambulance stand–by rates from 2003/04 to 2008/09*




[Source: Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 19.]

5.64 The Implementation of Recommendations Report in 2010 noted stand–by capacity in 2009 was at 36.8 per cent with an expectation it would be increased to 50 per cent by 2013.[276]

5.65 St John Ambulance WA advised the current stand–by rate is approximately 30 per cent:

> **Ms FYFE:** Stand–by capacity fluctuates on an hourly basis. I can say that before we walked into this inquiry, at 1.15[pm]...stand–by capacity sat at 32 per cent...That is 32 per cent of available ambulances were on stand–by awaiting dispatch to a job. But that would be different now and it will be different again in five minutes' time. It depends upon the calls coming in, but it also depends upon our level of ramping and what crews are available to us.
>
> **The CHAIR:** So over the past 24 hours what was the fluctuation of stand–by capacity?
>
> **Ms FYFE:** Average stand–by capacity was about 30 per cent last night.
>
> **Mr BRINK:** Yes. It was roughly about 30 per cent for last night. How our stand–by capacity works is that we bring more resources on during the day when it is our

276 Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010, p 11.

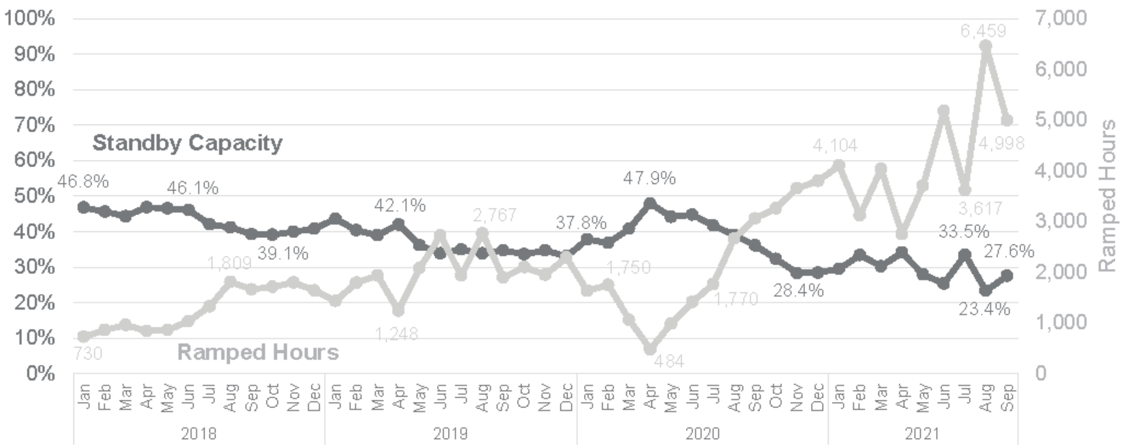
> busiest time and then traditionally we would make up that stand–by capacity in the early morning hours. When you are sitting at high stand–by capacity there are lots of ambulances available. That fluctuates. Some parts of the day you might go down to really low when it is busy and then it goes upwards. That is where you get the number for 24 hours.[277]

5.66 The Ambulance Employees Association of WA claims the current stand–by capacity often reaches zero per cent:

> This is shown not on St John's web but each day managers have it on their vehicle; the actual capacity for response. This means how many crews are actually available should a priority 1, 2 or 3 come in. That regularly gets to zero response capacity. Having reviewed St John's meeting with you they say that that is a very fluid number, which it is, but when you have a number of vehicles—20 or so—ramped, then your capacity diminishes by 50 per cent straightaway. There are very, very few occasions where we have more than one or two vehicles available and our response times are reflected pretty poorly in relation to the KPI requirement.[278]

5.67 Figure 25 shows ambulance stand–by capacity has ranged between 23.5 per cent and 33.5 per cent since November 2020:

Figure 25. *Monthly metropolitan stand–by capacity and ramped hours between 1 January 2018 and 30 September 2021*




[Source: St John Ambulance WA, Answer to question on notice 15 asked at hearing held 24 September 2021, dated 19 October 2021, p 56.]

**FINDING 34**

Ambulance stand–by capacity ranged between 23.5 per cent and 33.5 per cent between November 2020 and September 2021.

5.68 The Emergency Ambulance Services Agreement provides demand based funding based on stand–by capacity of 45.7 per cent.[279] St John Ambulance WA informed the Committee there is no contractual requirement to maintain stand–by capacity:

> The service agreement for existing demand; there is no stand–by capacity element for that. There is a stand–by amount that has been used in the calculation for new

277 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 24 September 2021, p 32.

278 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 2.

279 Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 5, 5.2.

demand, recognising over a long period of time the contract value did not keep up with demand meaning that since the Joyce Report where the target was 52.5 per cent; that had been degraded from there. It does not re–base what is already there; it funds new demand at a rate of 45.7 per cent.[280]

5.69 Despite providing funding for a stand–by rate of 45.7 per cent, the Emergency Ambulance Services Agreement does not include a KPI requiring St John Ambulance WA to maintain this level.

**FINDING 35**

The Emergency Ambulance Services Agreement provides funding for ambulance stand–by capacity of 45.7 per cent. Despite this, the Agreement does not require St John Ambulance WA to maintain a minimum level of stand–by capacity.

**FINDING 36**

Low stand–by capacity is a factor that contributes to St John Ambulance WA's inability to meet target response times.

5.70 The Committee heard evidence that the current emergency ambulance stand–by capacity is inadequate:

- Private Citizen:

The size of the fleet is too small to work this system of ambulance service as ProQA over–prioritises cases.[281]

- Private Citizen:

Often, there is no physical ambulance ready to be utilised by a crew, our fleet of ambulance vehicles being insufficient to enable the oncoming shift of ambulance officers to begin work, and requiring the crew commencing their shift to wait for the off going shifts ambulance to return to base with an ambulance. Again, while there is much talk of ramping, simple, highly controllable factors such as having sufficient ambulance vehicles has hampered our ability or respond to the community.[282]

- Private Citizen:

In the metropolitan area, we need more paramedics and ambulances not only to attend to emergencies in a reasonable time but to have some stand–by capacity in case of small–scale multi–casualty incidents. If stand–by capacity is not a priority, I believe the current number of available paramedics can do a significantly better job at attending to emergency calls in a timely manner if they were relieved from the burden of all the sometimes laughable non–emergency calls that they are expected to shoulder at present.[283]

5.71 The Committee received a submission which compared the number of career paramedics in Western Australia to police and fire–fighting personnel:

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280 Ryan Marshall, Executive Director Finance and Supply, St John Ambulance WA, transcript of evidence, 24 September 2021, p 32.

281 Submission 88 from Private Citizen, 23 July 2021, p 3.

282 Submission 75 from Private Citizen, 23 July 2021, p 4.

283 Submission 25 from Private Citizen, 19 July 2021, p 2.

Over the 2016/2017 period there were 5,949 sworn police officers (WA Police, 2017) who attended 929,070 calls (a ratio of 156.17 calls per police officer – 1:156.17), 1,153 career fire–fighters for 30,478 calls (1:26.23) and SJAWA had 967 career ambulance personnel for 373,579 calls, a ratio of 1:386.32 (AGPR, 2018) which is noted as the worst call to career staff ratio across all States and Territories.[284]

5.72 St John Ambulance WA claimed additional ambulances put on the road in order to improve response times will also become ramped unless underlying issues are addressed:

> We can add additional resources, so we can continue to add additional resources, but if those resources arrive at a hospital that already has five, 10 ambulances ramping, then you are just adding to the number and you are again depleting your resources to again go out and respond to the community. So, for us to be able to address our response time targets, we actually have to have our patients handed over to the hospital within the 30–minute time frame that is agreed to…The system that we greet when we get to the threshold of the hospital actually has to have a flow through.
>
> Therein lies one of the issues—I would say, the most significant issue.
>
> In the periods of time that you are talking about we have had ramping escalate to a point that we have never seen before, to hours that are unheard of, and our ambulances parked up out the front of hospitals and unable to be deployed into the community. The suggestion of, well, just put more ambulances on, like I said, that just creates a bigger queue outside the hospital. So, what needs to happen is the system all working together. We are just one part of the system.[285]

5.73 The Committee received conflicting evidence as to whether having more ambulances and frontline paramedics would help St John Ambulance WA to improve their targeted response times.

5.74 It is the Committee's view that:

- When there is a priority 1 call in the community any additional stand–by ambulance resources would provide a higher likelihood that the patient would be attended to within a reasonable timeframe which is likely to lead to a higher chance of survival.
- It is preferable that patients are being treated by paramedics than receiving no treatment at all.
- High priority patients are likely to be prioritised and not become ramped at hospital.

5.75 It is clear that if there are not adequate emergency ambulances and paramedics it would take longer to attend calls in the community and would contribute to St John Ambulance WA's inability to meet target response times.

**RECOMMENDATION 16**

The Department of Health require all emergency ambulance services to maintain minimum levels of ambulance stand–by capacity.

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284 Private Submission 43 from Private Citizen, 21 July 2021, p 9.

285 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, pp 4–5.

## Alternative care pathways

5.76 St John Ambulance WA advised they have implemented the following mitigation strategies to address ambulance ramping:

- appointing dedicated Hospital Liaison Managers
- Multiple Care Model
- Secondary Triage Team
- Patient Transport Paramedic Trial
- optimising protocols to return ambulances to the road
- improving pre–hospital notifications to hospitals for complex patients
- improving inter–agency cooperation.[286]

5.77 These strategies are claimed to have eliminated more than 1 000 hours of ramping per month.[287]

5.78 Developing alternative care pathways that divert patients away from emergency departments can help to reduce ramping. This in turn will help to free ambulance capacity for emergencies and improve the likelihood of meeting target response times.

5.79 Many requests for an ambulance are not considered to be emergencies from a clinical perspective. St John Ambulance WA estimate only 85 to 90 per cent patients who call an ambulance need to be transported to hospital.[288] Further:

- the 2009 Joyce Report noted only 26 per cent of presentations to emergency departments resulted in a hospital admission[289]
- the Department of Health estimate approximately 20 per cent of patients in emergency departments can be treated by a GP.[290]

5.80 These figures suggest a significant number of patients who call for an ambulance could be treated without being transported to an emergency department. Identifying these patients and referring them to an alternate care pathway will help to reduce ramping and improve the likelihood of meeting target response times.

**FINDING 37**

Alternate care pathways to divert patients away from hospital emergency departments can help to reduce ramping and increase the availability of emergency ambulances.

5.81 The Committee received a number of submissions that claimed ambulance crews currently have no alternative pathways available to them.[291] One of the submissions contended St John Ambulance WA offer no alternate care pathways:

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[286] Submission 71 from St John Ambulance WA, 23 July 2021, pp 34–5.

[287] ibid., p 34.

[288] Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 11.

[289] Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 55.

[290] Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 7.

[291] Submission 7 from Private Citizen, 9 July 2021, p 1; Submission 47 from Private Citizen, 21 July 2021, p 2; Submission 75 from Private Citizen, 23 July 2021, pp 4–5; Submission 25 from Private Citizen, 18 July 2021, p 2; Submission 53 from Private Citizen, 22 July 20221, p 4.

> St John WA offer no alternate care pathways for a patient other than transport to hospital. Despite purchasing an array of 'Urgent Care' centres across Perth, with further Federal funding of $28 million, these centres, advertised as an 'ED avoidance strategy', are virtually unavailable to ambulance officers. Previous alternate care pathways with Silver Chain and Dial a Doctor have been allowed to fail, and have not been supported or encouraged.[292]

5.82 The Committee raised the need for alternate care pathways with St John Ambulance WA. Dr Paul Bailey, Medical Executive Director at St John Ambulance WA responded by recognising the importance of alternate care pathways and explaining some of the projects they are currently involved in:

> There is a recognition across the system that alternate pathways for care compared with taking everyone to an emergency department is the right thing for the future of our system, rather than just building more and bigger of what we have got.
>
> As recently as yesterday, I met with…the CEO of Joondalup Health Campus around trying to construct a proof of concept for a falls program within Joondalup's catchment area. Last week, I was [on] a panel…on this very topic: what can we do differently? That was a multi–tenanted meeting with Royal Perth, Bunbury, Fiona Stanley, Sir Charles Gardiner Hospital and Health talking about this very topic…We have spoken about Virtual Emergency Medicine for aged care and falls.[293]

5.83 Virtual Emergency Medicine is an alternate care pathway that was recently developed at Fiona Stanley Hospital. The program connects ambulance patients to emergency department staff by telephone or video call who undertake a consultation and assessment before the patient's arrival at hospital. If appropriate, the ambulance will be diverted from the emergency department and streamed to another area of the hospital.

5.84 St John Ambulance WA are supportive of expanding this program to other hospitals:

> I think it would be suitable to be rolled out citywide. There is a currently unique constellation of occurrences at Fiona Stanley where they have both the skills to have put this together. Dr Ian Day and his team has managed to establish this. They have an administrative hierarchy that were prepared to support the concept when no–one really knew what it was, and they have partnered with us from day one, so we have actually got a member of my team…working half–time within the sort of system development side of [Virtual Emergency Medicine] so it has been really collaborative. It does also rely on alternate pathways within Fiona Stanley Hospital itself being available. Sometimes we will take a patient directly to medical imaging or directly to their observation ward or directly to another location within the hospital.
>
> …
>
> From what we are seeing at the moment, it is a successful model. I think it does remain to be seen whether it could be implemented in other areas, which I hope it could be.
>
> And in the last few weeks, together we have been performing outreach into residential aged–care facilities, with virtual consultations happening inside our care facilities. That is resulting in that patient's care needs being addressed in situ—where they are—without the need for movement backwards and forwards. I think

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292 Submission 75 from Private Citizen, 23 July 2021, pp 4–5.

293 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 November 2021, pp 34–5.

that is the newest but perhaps the most exciting part of that project would be bringing care to the patient with what they need with an emergency doctor, who is kind of an expert navigator of the system, driving what that patient needs without the need for movement backwards and forwards.

5.85 The Committee supports expanding the Virtual Emergency Medicine program to other hospitals in Western Australia.

**RECOMMENDATION 17**

The Department of Health upscale the Fiona Stanley Hospital's Virtual Emergency Medicine program to other hospitals in Western Australia.

**RECOMMENDATION 18**

The Department of Health investigate the expansion of alternate care pathways in conjunction with St John Ambulance WA and other healthcare providers.

## 'Stopping the Clock'

5.86 The Committee heard evidence that St John Ambulance WA manage their responses to get favourable average response times. This practice was referred to as 'stopping the clock':

> **Paramedic:** We would get calls constantly to go and stop the clock.
>
> **The CHAIR:** Stop the clock? How do you stop the clock?
>
> **Paramedic:** Go to a job.
>
> **Paramedic:** By turning up.
>
> **Paramedic:** When we arrive on scene, that is called the seven–nine time. Like, walk in the room here—bang, the clock stops because I've—or if you have stopped out the front.
>
> **The CHAIR:** Then what would the paramedics do?
>
> **Paramedic:** Depending on the nature of the emergency—if it is a real emergency, then we would have to call the communications centre and hopefully get the chopper if they are available—that is only if they are available. If not, I am then left on my own and hopefully relying on the communications centre to find someone—anyone. In the past that has happened and we have had two volunteers turn up in their pyjamas in their truck to come and give us a hand to try to get a trapped patient out of the vehicle…
>
> There is no guarantee. The danger is that because they are volunteers, there is absolutely no guarantee that if you call for an ambulance in the country…that you will not always get an ambulance.
>
> …
>
> **The CHAIR:** Does that happen in metro?
>
> **Paramedic:** Twenty times a day, easy. We have clinical support officers in cars. We have just doubled our managers on the road. We are waiting to see how that rolls out—how they have increased managers in metro by 15. They are in cars. I do not know whether they are going to be responses. I do not think they are, both in St John will use them as response or "clock stoppers", as we call them. What happens is I am driving around, I might be going to take a lifting device, an ELK, to a crew

to get a large patient off the ground and there will be a priority 1 that they have nobody for. The closest vehicle to Two Rocks may be—this is not uncommon—in Kensington, Fremantle or O'Connor. They will go to the X–ray car, who is a paramedic basically in a clinical role, and say, "We have a cardiac arrest or chest pain. Can you go to it?" They will go there, and as soon as they seven–nine the call, reallocate it, it goes to them, and as soon as they get there, that clock stops. So instead of it being two and a half hours until maybe an ambulance gets there, it might be 26 minutes from when the first responder gets there.

...

**Hon COLIN de GRUSSA:** Just on that clock stopping, as you call it, I mean ultimately the patient gets someone to arrive. Is the patient outcome affected?

**Paramedic:** Depending on what it is.

**Hon COLIN de GRUSSA:** Depending on what it is, so there may be that need to get them to a hospital.

**Paramedic:** We have had cardiac arrests that have waited 26 minutes to get an initial response to them that has come from Fremantle to Riverton.[294]

5.87 The Committee also heard evidence about this practice from other witnesses:

**Hon WILSON TUCKER:** do you think that deliberate gaming of the system is happening, when you talk about regional ambulances being dispatched to metro areas, which essentially is stopping the clock and stopping that KPI from being reported? Is that a deliberate practice?

**Paramedic:** Yes, 100 per cent. That is totally what it is about. Like I say, there are two things. Essentially, the organisation likes the smoke and mirrors of the general public, who are not aware of the system—they assume that anyone who gets out of an ambulance gives the same level of care. Unfortunately, that is not the case. Definitely, they are reportable to the government, to the health department, with their contract, and that contract is to try and meet their KPIs. They already fail to meet their KPIs every day, and then if you throw these figures that I am talking about into the mix, it would just be ballooning it even more and showing really how critical the situation is.[295]

5.88 St John Ambulance WA responded as follows:

St John WA does not conduct practices such as "stop the clock".

St John WA have Area Managers and Clinical Support Paramedics (CSP) who travel in single–occupant response vehicles. Area Managers are senior paramedics who undertake scene control and like CSPs have Lucas machines in their vehicles.

The scope of practice and equipment carried by Area Managers and CSPs means they can provide effective care to patients suffering from cardiac arrest or some other time critical conditions. Where applicable a regular ambulance crew will still attend to provide support and transport the patient to hospital, with initial treatment provided by the Area Managers or CSP.

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294 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, pp 11–2.

295 ibid, pp 3–4.

> For cardiac arrests and other so called "P0" patients it is best practice to dispatch two regular crews and a single responder (Area Manager or Clinical Support Paramedic) to ensure treatment can be commenced as soon as possible.[296]

5.89 The Committee notes there is conflicting evidence about the practice known as 'stopping the clock'.

## Cardiac arrest survival rate

5.90 Table 15 shows Western Australia has consistently been the worst performer since 2015/16 when it comes to survival of paramedic witnessed cardiac arrest incidents:

Table 15. *Cardiac arrest survival event rate in Australia*

| Year | Unit | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
|---|---|---|---|---|---|---|---|---|---|---|
| 2020/21 | % | 43.6 | 58.3 | 58.2 | 37.1 | 41.9 | 54.8 | 55.6 | 70.0 | 49.8 |
| 2019/20 | % | 42.2 | 49.7 | 57.4 | 39.0 | 39.0 | 47.6 | 53.6 | .. | 46.3 |
| 2018/19 | % | 44.4 | 55.2 | 49.4 | 36.4 | 44.3 | 52.6 | 45.7 | 75.0 | 47.1 |
| 2017/18 | % | 43.5 | 53.5 | 55.6 | 37.5 | 40.3 | 60.9 | 53.8 | 60.0 | 48.1 |
| 2016/17 | % | 51.8 | 58.4 | 55.1 | 33.6 | 39.4 | 45.5 | 55.6 | 16.7 | 50.4 |
| 2015/16 | % | 48.7 | 50.0 | 50.4 | 25.7 | 45.2 | 27.0 | 45.8 | 40.0 | 44.6 |
| 2014/15 | % | 53.4 | 49.8 | 45.0 | 30.2 | 39.5 | na | 63.0 | 55.6 | 46.2 |
| 2013/14 | % | 45.4 | 54.7 | 46.1 | 33.7 | 31.4 | na | 36.7 | 37.5 | 46.6 |
| 2012/13 | % | na | 56.5 | 51.3 | 46.6 | 31.3 | na | 34.6 | 12.5 | 49.6 |
| 2011/12 | % | na | 58.2 | 44.1 | 43.3 | 38.4 | 27.3 | 63.2 | 16.7 | 48.0 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 11A.11.]

5.91 In their written submission, St John Ambulance WA attached a report from Acil Allen, an advisory firm specialising in economics, policy and strategy. This report states:

> Western Australia has ranked worst for cardiac arrest survival rate (paramedic witnessed) since 2009–10. Western Australia's expansive geographical area is the primary factor impacting on the cardiac arrest survival rate.[297]

5.92 The Acil Allen document provides no evidence to support this claim.

5.93 The Committee notes Table 15 shows other states with large geographical areas similar to Western Australia have higher survival rates when it comes to cardiac arrests.

5.94 St John Ambulance WA's Out–of–Hospital Cardiac Arrest Report 2019 stated:

> The vast majority (80%) of the West Australian community live in the metropolitan areas of Perth, the State capital, which is where the majority (76%) of OHCA [out of hospital cardiac arrest] cases occur, and where there is better access to tertiary healthcare services. Outcomes in the metropolitan areas subsequently continue to be more favourable.[298]

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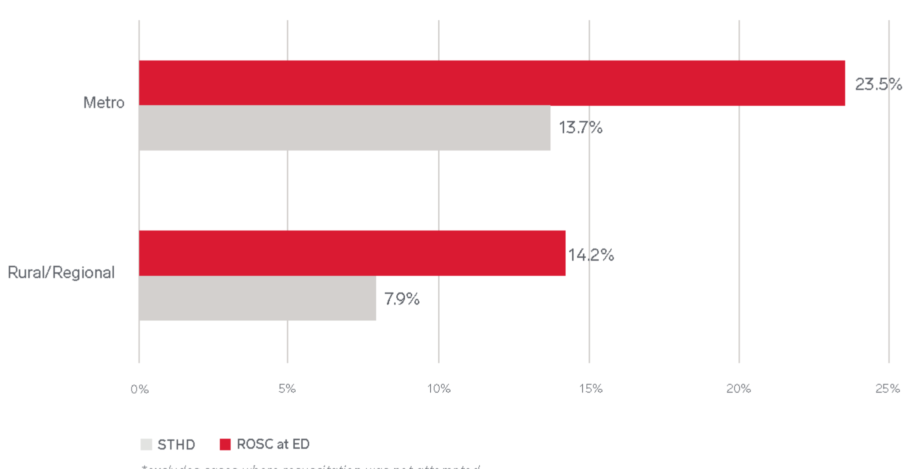
[296] St John Ambulance WA, letter, dated 18 March 2022, p 18.

[297] Submission 71 from St John Ambulance WA, 23 July 2021, p 65.

[298] St John Ambulance WA, *Out–of–Hospital Cardiac Arrest Report 2019*, See: https://stjohnwa.com.au/docs/default-source/corporate-publications/ohca-annual-report-2019_digital.pdf?sfvrsn=da1be9b2_2. Viewed 1 April 2022.

5.95 Figure 26 shows the comparative outcomes of cardiac arrest survival in metropolitan and regional Western Australia in 2019:

Figure 26. *Comparative outcomes of cardiac arrest survival in metropolitan and regional Western Australia in 2019*




[Source: St John Ambulance WA, *Out–of–Hospital Cardiac Arrest Report 2019*, p 33.]

5.96 The Committee heard that paramedics can administer lifesaving medicines for cardiac arrest but volunteers cannot:

> Ambulance Volunteers do not carry Adrenaline anywhere within WA for the treatment of cardiac arrest. St John Ambulance WA may say they do; but the volunteers carry an Epi–Pen which is a muscular injection administered for the treatment of life–threatening Asthma and Anaphylaxis. An intra–muscular injection can not be used in cardiac arrests, this is why the volunteer clinical practice guidelines do not have Adrenaline administration in them.
>
> There has been much research over the years regarding Adrenaline in cardiac arrests. Basically, it states that it could be detrimental. This is what SJA cling to for reducing the numbers of paramedics in regional WA in cardiac arrest. The Ethos, this medication is bed [sic], so it does not matter that we are not using it.[299]

5.97 The Committee also received the following submission:

> Poor staffing levels means fewer ambulances are available to attend emergency calls and can create extended delays in response times, these delays can severely reduce an individual's chance of surviving a cardiac arrest. Previous studies have identified the faster an ambulance arrives on scene the higher the discharge rate with sound neurological outcomes occur (Bürger et al., 2018). Bürger et al. (2018) compared ambulance response times for cardiac arrests (n=10,853) across Germany and found a direct relationship between survivability and ambulance response times. The services with faster response times had better outcomes (7.7 per 100,000) compared to services who had more timely arrivals to the scene (5.6 per 100,000).
>
> …
>
> We have Transport Officers who have defibs in their vehicles and trained to use them driving past cardiac arrests in the community to attend low priority calls as

[299] Paramedic, private email, 13 March 2022, p 1; See also Paramedic, United Workers Union, transcript of private evidence, 17 November 2021, p 9.

SJA will not send them. Even though the organisation knows it could be 45 minutes for paramedics to arrive on–scene.

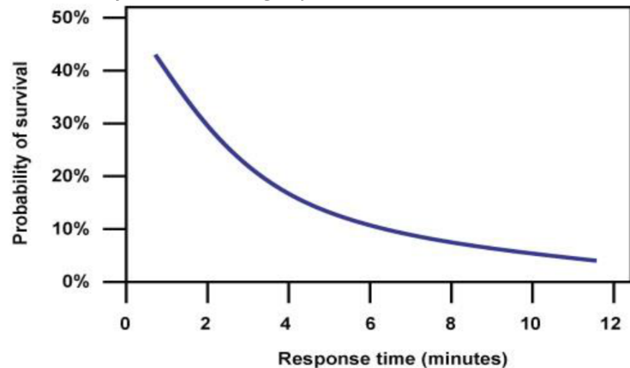
...

Many times, cardiac arrests occur in the community and ambulances that are supposed to be in the area to assist these regional patients are up in Perth.[300]

5.98 Based on this evidence the Committee does not support the assertion from Acil Allen that geography is the primary factor impacting on Western Australia's cardiac arrest survival rate for the past 8 years.

5.99 The Probability of Survival graph is a teaching tool for pre–hospital emergency medical services around the world and its emphasis is on fast ambulance arrival and timely defibrillation in order to ensure patient survival and is the cornerstone of cardiac arrest care for ambulance services worldwide (Figure 27).[301]

Figure 27. *Probability of survival graph*




Note. The survivability of patients in cardiac arrest depends on timely defibrillation, this equates to every minute a patient is not defibrillated they lose a 10% chance of survival. Network (https://psnet.ahrq.gov/webmm/case/155/resuscitation-errors-a-shocking-problem).

[Source: Private Submission 43 from Private Citizen, 21 July 2021, p 9.]

5.100 The Committee received a submission on response times for patients suffering cardiac arrest:

For the lay person, an ambulance arriving in 15 minutes for an emergency call may seem acceptable. However, for a patient in cardiac arrest response times > 8 minutes have a severe detrimental outcome on survivability, and contractual agreements between governments and ambulance services for > 10 minutes will often see poorer survival outcomes.[302]

5.101 *Shortening Ambulance Response Time Increases Survival in Out–of–Hospital Cardiac Arrest*, published in the Journal of the American Heart Association on 27 October 2021 concluded:

Survival to 30 days after a witnessed OHCA [out of hospital cardiac arrest] decreases as ambulance response times increase.

Approximately 350 000 cardiac arrests occur in the United States each year and the mean ambulance response time was around 8.5 minutes in 2014. Our model estimates 48 300 survivors from 350 000 out–of–hospital cardiac arrests, if the

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300 Private Submission 43 from Private Citizen, 21 July 2021, pp 6 and 16–7.

301 ibid., p 7.

302 ibid., p 8.

ambulance response time is 8.5 minutes. Reducing the 8.5 minutes to 6 minutes or less would result in 68 250 survivors, according to our model.[303]

5.102 Although the research paper also listed a number of factors, such as bystanders performing CPR or performing compression only, the sooner an ambulance arrives at the location of a cardiac arrest incident, the more likely the patient survives the incident.

5.103 St John Ambulance WA's Out–of–Hospital Cardiac Arrest Report 2019 reported that:

- median time in which a St John Ambulance reached a patient in the Perth metropolitan area was 9.1 minutes
- median time in which a St John Ambulance reached a patient in rural and regional locations was 13.3 minutes.[304]

5.104 In the United Kingdom:

> Category 1 ambulance calls are those that are classified as life–threatening and needing immediate intervention and/or resuscitation, e.g. cardiac or respiratory arrest. The national standard sets out that all ambulance trusts must respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes.[305]

**FINDING 38**

Since 2015/16 Western Australia has had the worst paramedic witnessed cardiac arrest survival rate in Australia.

**RECOMMENDATION 19**

The Department of Health investigate cardiac arrest survival rates in Western Australia with a view to improving survival rates to, or above, the national average.

## Transparency and accountability

5.105 Transparency and accountability are important to any organisation, public or private. Transparency and accountability in the ambulance service is particularly important given the lives and health of patients are at stake.

5.106 The Australian Institute of Company Directors defines accountability as:

> Accountability exists in a relationship between two parties where one has expectations of the other, and the other is obliged to provide information about how they have met these expectations or face the consequences of failing to do so.[306]

5.107 There are two components of accountability:

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303 Johan Holmén, Johan Herlitz, Sven–Erik Ricksten, Anneli Strömsöe, Eva Hagberg, Christer Axelsson and Araz Rawshani, 'Shortening Ambulance Response Time Increases Survival in Out–of–Hospital Cardiac Arrest', *Journal of the American Heart Association*, 2020, vol. 9, issue 21.

304 St John Ambulance WA, *Annual Report 2019*. See: https://stjohnwa.com.au/docs/default-source/corporate-publications/ohca-annual-report-2019_digital.pdf?sfvrsn=da1be9b2_2. Viewed 1 April 2021.

305 Nuffield Trust. See: https://www.nuffieldtrust.org.uk/resource/ambulance-response-times. Viewed 1 April 2021.

306 Australian Institute of Company Directors. See: https://aicd.companydirectors.com.au/resources/not-for-profit-resources/not-for-profit-governance-principles/principle-7-transparency-and-accountability. Viewed 1 April 2021.

- Answerability – which means providing information and justification for how one's actions align with expectations; and
- Enforcement – which means being subject to, and accepting the consequences of, failing to meet these expectations.

> For accountability to be achieved, there must be transparency.[307]

5.108 Transparency is explained by the Australian Institute of Company Directors as follows:

> Organisations are transparent when they enable others to see and understand how they operate in an honest way. To achieve transparency, an organisation must provide information about its activities and governance to stakeholders that is accurate, complete and made available in a timely way.
>
> Transparency enables accountability.[308]

5.109 The Committee notes transparency does not require all information to be made publicly available (for example, private information such as client records and 'commercial in confidence' material such as tender submissions).

**Oversight in Western Australian Public Sector**

5.110 Legislation and oversight bodies to ensure transparency and accountability in the Western Australian public sector include the:

- *Freedom of Information Act 1992* and the Office of the Information Commissioner
- *Parliamentary Commissioner Act 1971* and the Parliamentary Commissioner for Administrative Investigations – more commonly known as the Ombudsman
- *Corruption, Crime and Misconduct Act 2003*, the Corruption and Crime Commissioner and the Parliamentary Inspector of the Corruption and Crime Commission
- *Public Sector Management Act 1994* and the Public Sector Commissioner
- *Auditor General Act 2006*, the *Financial Management Act 2006* and the Office of the Auditor General.

5.111 As a private organisation St John Ambulance WA is not directly subject to these oversight bodies.

**FINDING 39**

The Corruption and Crime Commission and the Office of the Information Commissioner have jurisdiction over the public sector in Western Australia. These organisations do not have jurisdiction over St John Ambulance WA.

5.112 On the issue of oversight, St John Ambulance WA advised the Committee:

> **Ms FYFE:** we would absolutely welcome any oversight. Obviously, we would look towards what the framework is—those sorts of things—but we welcome oversight. We are open and transparent and we are happy to answer any questions on any subject.[309]

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307 Australian Institute of Company Directors. See: https://aicd.companydirectors.com.au/resources/not-for-profit-resources/not-for-profit-governance-principles/principle-7-transparency-and-accountability. Viewed 1 April 2021.

308 ibid.

309 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, p 4.

5.113 St John Ambulance advised that while it is not directly subject to the *Freedom of Information Act 1992* they are contractually obliged to comply with requests under the Emergency Ambulance Services Agreement:

> In other words, if the department receives an FOI [freedom of information] request from a member of the community regarding services provided by St John under the agreement, under that agreement, the department can seek that information from St John WA. We will, and in fact we do, provide it, and that information is made available to the member of the community under the FOI regime.[310]

5.114 St John Ambulance WA identified the following three clauses in the Emergency Ambulance Services Agreement the Department of Health can use to access their records:

5.5 Access to Records

19.1 Disclosure of Agreement particulars

19.2 Sharing of confidential information of another party.[311]

5.115 Ambulance service providers should have the same accountability as Department of Health under the *Corruption, Crime and Misconduct Act* and the *Freedom of Information Act 1992* as is the case in other Australian jurisdictions.

**RECOMMENDATION 20**

The State Government investigate introducing legislation amending the *Corruption, Crime and Misconduct Act 2003* and the *Freedom of Information Act 1992* so ambulance service providers can be:

- subject to Corruption and Crime Commission oversight
- required to comply with freedom of information requests.

**Issues concerning clinical quality controls**

5.116 The 2013 Auditor General's Report found:

> WA Health has no mechanism to ensure SJA meets outputs, such as ambulance service delivery and performance targets, or clinical or other outcomes, such as standards of patient care. This limits the extent to which WA Health can demonstrate that it is getting value for money.[312]

5.117 The 2019 Auditor General's follow–up report further found:

> Our 2013 audit recommended developing a new funding model focusing on standards, performance and risk. The current contract, which was extended in 2018 to 2020, made no substantial changes to the funding model. It does not connect funding with performance or demand for services, or provide a clear view of the cost of services such as IHPT [inter–hospital patient transport], or facilitate in–depth analysis of complex matters such as the impact of ramping on response times and patient outcomes. While SJA is motivated to perform well by its mission and culture, weaknesses in the contract mean the DoH [Department of Health]

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[310] ibid., p 3.

[311] St John Ambulance WA, Answer to question on notice 9 asked at hearing held 24 September 2021, dated 19 October 2021, p 17.

[312] Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services*, June 2013, p 45.

does not have a clear view of how its funding is being used and if it's getting value for money.[313]

5.118 The Committee asked the Department of Health for a response to the comments from the Auditor General and the response was:

> **Dr RUSSELL–WEISZ:** That is something we have been working on. Since the 2013 contract, they were absolutely right about the ability to look further into St John's performance. We have been working with them, even since 2019 now, to get more visibility of their data. We are not trying to control their data, but we want more visibility of their data, and Mr Anderson can talk —
>
> **The CHAIR:** Have you been successful in that?
>
> **Dr RUSSELL–WEISZ:** We have been more successful in that recently.
>
> **The CHAIR:** In what aspect?
>
> **Mr ANDERSON:** We now get a far more detailed dataset from St John which shows far more granularity around the types of patients that are coming in, the types of calls and so forth, and we are working with St John to improve their data collection...[314]

5.119 The Department of Health advised their visibility of St John Ambulance WA's service delivery has improved:

> **Dr RUSSELL–WEISZ:** Has it improved? From my perspective—I think that is a question St John's can answer as well—yes, the visibility has improved.[315]

5.120 St John Ambulance WA informed the Committee:

> We are open and transparent with regards to our information, and any information requests from the Department of Health are responded to. Part of the issue we have is about data linkage. So, we send an awful lot of information to the Department of Health—that is about: how do you link that information with their information? One of the pieces of work that we want to work on now is that whole patient journey that you spoke about. They get all of our patient information through an electronic patient care record. That goes into their system. It is then what we are looking for is feedback about what happens with the patient whilst they are in the health system, so that we are able to get that feedback. That linkage feed is not working.[316]

5.121 The Committee also notes the following regarding compliance with clinical quality controls from the 2019 Auditor General's follow–up report:

> SJA [St John Ambulance WA] has substantially improved its internal clinical quality controls and in 2017–18 achieved 95% against its target of 90% compliance with the clinical guidelines agreed with the DoH [Department of Health]. However, how individual cases comply with guidelines is not independently audited and the contract does not give the DoH any visibility of cases that did not comply other than their total number. This contrasts with other jurisdictions where ambulance services are part of the government health system and a single authority holds the

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313 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services – Follow–up Audit*, 31 July 2019, p 45.

314 Dr David Russell-Weisz, Director General, Rob Anderson, Deputy Director General, Department of Health, transcript of evidence, 24 September 2021, p 11.

315 Dr David Russell-Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 13.

316 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 18.

data. Patients can complain to the Health and Disability Services Complaints Office and the DoH has access to detailed clinical data for critical incidents. But its lack of broader access makes it harder for the DoH to assess the continuous improvement in patient care over time that is required by the contract.[317]

5.122 In 2017/18, St John Ambulance WA attended a total of 335 609 cases in the metropolitan area. Five per cent, or around 17 000 of these cases were not compliant with clinical quality guidelines.[318]

5.123 In 2020/21, St John Ambulance WA audited 10 736 cases. Of these 10 481 (97.6 per cent) were found to be complaint with Clinical Practice Guidelines.[319]

*Reportable Severity Assessment Code (SAC) events*

5.124 The Department of Health website explains that there are three WA health system Severity Assessment Codes or SAC:

- SAC 1 – A clinical incident that has or could have (near miss), caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.
- SAC 2 – A clinical incident that has or could have (near miss), caused moderate harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.
- SAC 3 – A clinical incident that has or could have (near miss) caused minor or no harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.[320]

5.125 The Department of Health advised the Committee that:

> Sentinel events are a subset of SAC 1 clinical incidents considered to be wholly preventable and resulted in serious harm to, or death of, a patient.
>
> …
>
> St John Ambulance (SJA) are required to notify the [Department of Health] Patient Safety Surveillance Unit (PSSU) of all SAC 1 Clinical Incidents.
>
> There is no requirement of SJA to notify SAC 2 or SAC 3 Clinical Incidents to PSSU.
>
> SJA notified the following number of SAC 1 clinical incidents to PSSU for the period 01/07/2016 to 10/10/2021. None of these SAC 1 clinical incidents were categorised as sentinel events.[321]

5.126 The Department of Health advised the following number of SAC 1 incidents were reported between 2016 and 2021 (Table 16):

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317 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services – Follow–up Audit*, 31 July 2019, p 19.

318 ibid.

319 St John Ambulance WA, letter, dated 6 April 2022, p 2.

320 Department of Health, *Severity Assessment Codes.* See: https://ww2.health.wa.gov.au/Articles/S_T/Severity-assessment-codes. Viewed: 1 April 2022.

321 Department of Health, Answer to question on notice 6 asked at hearing held 24 September 2021, dated 21 October 2021, p 149.

Table 16. *Severity assessment code 1 events reported by St John Ambulance WA to Patient Safety Surveillance Unit between 2016/17 – 2021/22*

| Year | SAC 1 |
|---|---|
| 2016/17 | 4 |
| 2017/18 | 7 |
| 2018/19 | 9 |
| 2019/20 | 3 |
| 2020/21 | 2 |
| 2021/22 | 2 (year to date 10/10/2021) |

[Source: Department of Health, Answer to question on notice 6 asked at hearing held 24 September 2021, dated 21 October 2021, p 149.]

5.127 The Committee asked St John Ambulance WA which organisation provides oversight concerning clinical breaches:

> **Ms FYFE:** That oversight is provided through the Department of Health as the system manager and the contract owner, so we report through to the Department of Health.[322]

5.128 St John Ambulance WA advised:

> **Dr BAILEY:** That is correct that we do not share broad–scale breaches of protocols with health. However, like every other health system in this setting, we report SAC 1 events to the patient safety and surveillance unit, PSSU.[323]

5.129 The Committee asked St John Ambulance WA which organisation audits their assessment process concerning sentinel (SAC 1) clinical incidents:

> **Dr BAILEY:** We have an externally based neutral doctor on the root cause analysis committees and we have a consumer representative on those committees as well, and we submit our findings to the patient safety and surveillance unit. In the event that they have any questions about our findings or activities, we field questions. To answer what I think is your specific question, "Does anyone audit that process in its entirety?": no, that is not audited.[324]

5.130 The Committee heard from stakeholders that the current SAC reporting system is not working:

- Private Citizen:

> In a system that focuses heavily on average response times (hit or miss) to the exclusion of individual case factors there is a tendency for the data to become too 'anonymous'. A missed target by 30 seconds, associated with a good patient outcome is considered a simply a 'missed target'.
>
> Conversely, for a child who has drowned in a backyard pool but who waited 40 minutes for an ambulance, that failure holds the same 'weight' in terms of simply being considered 'missed target' statistic as the above case.

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322 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 20.

323 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 24 September 2021, p 19.

324 ibid., p 20.

> Behind each missed target is a human being, and if that case of delayed response to a child occurred in hospital, it would be considered a SAC1 sentinel event (Severity Assessment Code), but with ambulance it is simply a 'missed target', with no investigation ever to occur concerning root cause analysis and no effort on behalf of the organisation to prevent such future occurrences.[325]

- Private Citizen:

> St John categorise [SAC events], as far as I understand. That is why none of these deaths have actually made news headlines anywhere. What St John do is they go, "Oh, the person would have died in any case, so we'll make that a SAC 2." If it is a SAC 2, then it does not become a sentinel event, and if it does not become a sentinel event, no–one investigates it.[326]

5.131 St John Ambulance WA responded as follows:

> The St John WA Clinical Incident Management (CIM) policy, shared with the committee in our response to the second Question taken on notice in the Hearing on November 24th, outlines our approach to CIM. This policy was developed in line with Department of Health CIM policy in our efforts to provide a consistent approach to CIM across the system. When a Clinical Incident has occurred, staff must notify Clinical Governance through the clinical incident notification process (workflow). Clinical Incidents may also be identified through audit, customer feedback, reports by external health service providers as well as self–reports.
>
> When a clinical incident is identified, immediate action must be taken to ensure any person affected by the incident is safe and all necessary steps are taken to support and treat the person(s) and prevent further injury. The notification is then reviewed by the Clinical Services Department and an initial response is determined against the WA health system Severity Assessment Codes (SAC). According to Department of Health, the definition of a SAC 1 incident is "A clinical incident that has or could have (near miss), caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness". An investigation is then conducted to establish and analyse the course of events leading up to the clinical incident to identify the contributing factors.
>
> Clinical Incidents are complex and can have multiple contributing factors. The WA health system SAC summary provides guiderails relating to types of SAC 1 incidents and sentinel events, however, not all are relevant to the ambulance setting. It is important to note that this process is not black and white, and a consultative approach is taken when allocating the SAC level. On occasions we may consult with PSSU [Patient Safety Surveillance Unit] for guidance. We may also ask the Clinical Quality and Safety Committee, our peak clinical incident review body, to provide guidance on the SAC level allocation, specifically with regards to SAC 2 cases.
>
> When an event is classified as SAC 1, 2 or 3, the organisation is confirming that health care provision (or lack thereof) was a factor in the patient outcome (DoH CIM Guidelines, 2019). The SAC level does influence the level of investigation and escalation required. While we only report SAC1 events to the DoH Patient Safety and Surveillance unit, this does not mean that other clinical incidents are not investigated.

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325 Submission 75 from Private Citizen, 23 July 2021, p 10.

326 Private Citizen, transcript of private evidence, 21 September 2021, session two, p 10.

SAC 2 and 3 events are reviewed under processes as described in the St John WA CIM. Furthermore, our Clinical Quality and Safety Committee (CQSC) fulfils the oversight function in relation to clinical incidents, clinical audits and review outcomes. Membership of the CQSC includes internal representatives from both clinical and operational departments, as well as a consumer representative, medico–legal subject matter expert and independent external specialist medical practitioners.

We have undertaken steps to improve our processes, including engaging CIM subject matter experts in the delivery of training. We acknowledge there is always room for improvement, and we will continue our efforts to promote a positive patient safety culture.[327]

5.132 During a private hearing a witness was asked about independent auditing of SAC events:

**Hon COLIN de GRUSSA:** That is not independently audited or anything—that is totally done in–house?

**Paramedic:** Yes. That was the last problem we had before…That is why a lot of the paramedics will not come forward—nothing changes. We move a manager there and we move a manager there, we put an ambulance over there and change the number over there and then everyone is happy and everything just becomes quiet again and they just come and do what they do for you.[328]

5.133 The Committee was told volunteers do not receive training on how to report SAC events:

I spoke to some volunteers before I appeared here today and I asked them a very simple question. I asked three of them. One of them has been a volunteer for, I would say, 25 or 30 years, and then probably five years and probably three years. I asked them: what training do you get in reporting a clinical incident or a sentinel event? And the answer from all three was, "Nothing." One of them said something was spoken about but it was glossed over, and the other two had said to me, "We never had any training on how to report a clinical incident or on how to report a sentinel event".[329]

5.134 The Committee heard in evidence from a paramedic that an adverse outcome for a patient from a cardiac arrest with a 30 minute response time would not be considered a sentinel event.[330]

5.135 The Committee asked whether paramedics could provide feedback regarding sentinel events and the Committee was advised that the evidence provided by the witness contained identifying information. The Committee therefore resolved to summarise the aforementioned evidence as follows:

- Example One: a patient was experiencing heart condition. Incorrect medication was administered. The patient's condition was worsening. It took some time for the referral to be accepted as an SAC 1 clinical incident.[331]
- Example Two: there was a delay of several minutes when paramedics were sent to attend to a patient who was attended by volunteers; shortly after paramedics arrived the patient

327 St John Ambulance WA, letter, dated 6 April 2022, pp 4–5.

328 Private Citizen, transcript of private evidence, 21 September 2021, session two, p 10.

329 Private Citizen, transcript of private evidence, 22 November 2021, session five, p 10.

330 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 17.

331 ibid., p 18.

died. This incident was not reported to the Department of Health as a SAC 1 clinical incident.[332]

- Example Three: A child was choking. An ambulance 15 km away was dispatched. The obstruction was cleared but the child died. There were multiple available ambulances much closer than the dispatched ambulance. One of the three ambulance was approximately 5 km away from the incident and offered to go to the incident but was told not to by the SJA SOC. This incident was not reported to the Department of Health as a SAC 1 clinical incident as senior personnel in St John Ambulance WA said the child was going to die anyway.[333]

5.136 The Committee heard further evidence:

> **Hon WILSON TUCKER:** I just have one question. It is about the sentinel events. I am just curious to get your take on what triggers a sentinel event and if you think there is room for improvement in that process.
>
> **Paramedic:** I will just give an example. If the sentinel event was triggered by a member of the public, so if your family member spoke to St John and said, "I don't believe the right clinical treatment was given", and there was a sentinel event that occurred to yourself, St John will investigate that. They are not very supportive. Their first line of inquiry is always to sort of attack, I suppose, for paramedics. So we kind of feel like there is no trust there in it being a fair process. If it is something that I trigger myself, I believe with the outcome of the patient, there was lots of things that probably contributed to the sentinel event, and I would like them investigated…it is handled within and just kind of quietly, so there is not much to it. There is no actual line of process. It is whoever gets back to me on the day, and that could take a day, a week or a month. But if it is the public, it is a completely different process altogether. [334]

5.137 St John Ambulance WA advised in response:

> According to the Department of Health Clinical Incident Management Policy (2019), St John WA must investigate clinical incidents to establish and analyse the course of events that led to the clinical incident, and to identify the contributing factors. The level of investigation and reporting required is determined by the SAC level allocation. All clinical incident notification should be acknowledged within 5 working days.
>
> Our overarching aim when investigating a clinical incident is to identify if there is a system or process we can improve on. Providing feedback to officers involved is a key part of our clinical incident management processes and where possible, we also share lessons learned with the wider workforce in a deidentified manner upholding the confidentiality of all participants and stakeholders.
>
> St John WA is committed to a "just culture" and believe our systems and processes apply the principles of transparency, fairness, and accountability that underpin patient safety. Furthermore, all Clinical Quality Managers responsible for reviewing Clinical Incidents are AHPRA registered Paramedics who undergo appropriate training in the Clinical Incident Management process.
>
> Whilst the data does not support that this is a widely held view, it is nevertheless disappointing to read. Our records indicate an increasing reporting culture within

332 ibid.

333 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 14.

334 ibid., p 19.

our organisation as demonstrated by the increasing number of clinical incidents reported internally (please include table from QoN 04). We believe this is due to our work in promoting a patient safety culture and we continue our work in this area to ensure we provide robust patient safety systems and processes.[335]

5.138 The Joyce Report identified 'clinical governance issues in respect of practice guidelines, an independent sentinel reporting mechanism and audit, and a structured process in the communication centre' as one of the six major issues emerged during their inquiry. The Joyce Report made the following recommendations:

> Recommendation 8: SJA develop and implement clinical governance structures and processes that align with the Strategic Plan for Safety and Quality in Healthcare 2008–2013 and the WA Clinical Governance Framework.
>
> Recommendation 9: SJA notify and report sentinel events to DoH's Director Office of Safety and Quality in Healthcare.[336]

5.139 Both of these recommendations were certified as 'Recommendation Achieved' in the 2010 Implementation of Recommendations Report.[337]

5.140 Nevertheless, these recommendations failed to ensure that the process was independent and external audits were conducted.

5.141 The Committee is of the view that the assessment of any reporting of SAC 1, SAC 2 and SAC 3 clinical incidents should be conducted by an independent organisation and their assessments be audited externally.

**FINDING 40**

Despite the 2009 report *St John Ambulance Inquiry: Report to the Minister for Health* (Joyce Report) identifying clinical governance issues in respect of an independent sentinel reporting mechanism and audit, there is no process to address these issues.

**FINDING 41**

There are claims that not all Severity Assessment Code 1 events are reported and some Severity Assessment Code 1 clinical incidents were classified as Severity Assessment Code 2.

**RECOMMENDATION 21**

The Department of Health require an independent body to review all potential Severity Assessment Code clinical incidents involving ambulance service providers in Western Australia.

**RECOMMENDATION 22**

The Office of the Auditor General regularly audit the works of the independent body responsible for reviewing all potential Severity Assessment Code clinical incidents involving ambulance service providers in Western Australia. The Office of the Auditor General table the results of the audit in Parliament on an annual basis.

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335 St John Ambulance WA, letter, dated 6 April 2022, p 6.

336 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, recommendation 8 and 9.

337 Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010, pp 14–5.

## Is the service delivery model of the ambulance service in metropolitan Perth efficient and adequate?

5.142 In considering the efficiency and adequacy of the ambulance service delivery model in metropolitan Perth (term of reference (b)), the Committee has made a number of concerning findings and they include:

Finding 1: St John Ambulance WA has been unable to achieve their contractual requirement to answer 90 per cent of calls within 10 seconds since 2018/19.

Finding 5: From a snapshot of data provided, St John Ambulance WA have not complied with their commitment in the 2010 *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* to maintain the following number of call takers per shift:

- 15 Communications Officers between 7am and 7pm
- 13 Communications Officers between 7pm and 1am
- 12 Communications Officers between 1am and 7am.

Finding 6: St John Ambulance WA has not been rostering sufficient communications officers in the St John Ambulance WA State Operations Centre to meet their contractual requirement to answer 90 per cent of calls within 10 seconds since 2018/19.

Finding 7: The number of call takers per capita in Western Australia has almost doubled since the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* in 2010. Despite this, the number of call takers per capita in Western Australia has consistency remained the second lowest in Australia and is below the national average.

Finding 18: Non–emergency patient transfers are contracted separately from emergency ambulance services. Despite this, emergency ambulance resources are used to conduct inter–hospital patient transfer services.

Finding 23: St John Ambulance WA did not meet their target response times for priority 1, 2 or 3 calls in 2020/21.

Finding 35: The Emergency Ambulance Services Agreement provides funding for ambulance stand–by capacity of 45.7 per cent. Despite this, the Agreement does not require St John Ambulance WA to maintain a minimum level of stand–by capacity.

Finding 36: Low stand–by capacity is a factor that contributes to St John Ambulance WA's inability to meet target response times

Finding 38: Since 2015/16 Western Australia has had the worst paramedic witnessed cardiac arrest survival rate in Australia.

Finding 40: Despite the 2009 report *St John Ambulance Inquiry: Report to the Minister for Health* (Joyce Report) identifying clinical governance issues in respect of an independent sentinel reporting mechanism and audit, there is no process to address these issues.

Finding 41: There are claims that not all Severity Assessment Code 1 events are reported and some Severity Assessment Code 1 clinical incidents were classified as Severity Assessment Code 2.

5.143 There have been more than 12 inquiries over the past 25 years. There appears to be a lack of progress in the areas identified by the Committee.

5.144 The Committee is of the view that the current delivery model of ambulance services in metropolitan Perth is arguably cost efficient as it is the least expensive ambulance service in Australia. There are questions about its adequacy and other aspects of efficiency.

**FINDING 42**

While the current emergency ambulance service delivery model in metropolitan Perth is arguably cost efficient, there are questions about its adequacy and other aspects of efficiency.

# CHAPTER 6
# Regional ambulance service delivery model

## Introduction

6.1 This chapter addresses term of reference (b). It considers the efficiency and adequacy of the service delivery model of ambulance services in regional areas.

6.2 Unlike metropolitan Perth where all services are performed by qualified paramedics, regional sub–centres operate under one of the following three models:

- entirely staffed by volunteers
- staffed by a combination of volunteers and career paramedics
- entirely staffed by career paramedics.

6.3 This chapter considers the follow issues in relation to the delivery of ambulance services in regional areas:

- most regional areas are not required to meet target ambulance response times
- St John Ambulance WA is only required to use their 'best endeavours' to provide a service in regional areas—they are not under a contractual obligation to actually provide a response
- how the location of regional sub–centres should be determined
- how to predict the availability of volunteer sub–centres to respond to calls
- regional sub–centres that are entirely run by volunteers are required to manage their own finances
- the qualifications that volunteers obtain are not recognised outside of St John Ambulance WA
- the viability of the current service delivery model in regional Western Australia.

6.4 This chapter then describes St John Ambulance WA's regional Community Paramedic program. Community Paramedics help to recruit and train volunteers and provide administrative support to sub–centres. The Committee considers:

- whether Community Paramedics should be required to respond to calls
- whether volunteer training could be performed by a dedicated trainer
- mental health risks faced by Community Paramedics.

## Regional ambulance service

6.5 There are 160 St John Ambulance WA sub–centres operating across regional Western Australia. This includes:

- 144 volunteer run sub–centres
- 15 sub–centres staffed by a combination of volunteers and career paramedics
- 1 sub–centre entirely staffed by career paramedics.[338]

[338] Submission 71 from St John Ambulance WA, 23 July 2021, p 37.

6.6 WACHS plan to appoint paramedics to three more volunteer sub–centres, bringing the total number of hybrid sub–centres to 18.[339]

6.7 The majority of the regional ambulance workforce are volunteers. They account for approximately 90 per cent of personnel.[340]

6.8 The Committee notes that Western Australia relies heavily on volunteers in the provision of emergency ambulance services. Without the 4 332 volunteers who dedicate their time and service for our Western Australian community, there would be almost no emergency ambulance service in regional Western Australia.[341]

6.9 The Committee also notes that Western Australia has more than 58 per cent of all Australian ambulance volunteers. [342]

## Funding for regional ambulance service

6.10 The Country Ambulance Strategy noted that:

> There is no single agreed view of the costs attributable to country ambulance service as there is no contractual requirement for SJA to report expenditure for the operation of country ambulance services to WACHS or the Department of Health. Additionally, the contract is silent on the allocation of General Service Payment between metropolitan and country services. The perceived lack of financial equity between the country and metropolitan ambulance services was an area of concern highlighted by many stakeholders. The financial analysis undertaken supported this perception; [Figure 28] below provides an overview of this financial inequity using the data that was made available.[343]

Figure 28. *Financial overview of St John Ambulance WA services*

| Area (WA) | FY'16 Activity (Incidents) | FY'16 Operating Expenditure | FY'16 Bad Debts | FY'16 Estimated Population | Expenditure per activity | Expenditure per capita | Bad Debt per capita |
|---|---|---|---|---|---|---|---|
| Metropolitan | 227,063 | $194,414,419 | $13,339,213 | 2,022,044 | **$856.21** | **$96.15** | **$6.60** |
| Country | 62,022 | $46,934,943 | $7,520,018 | 536,907 | **$756.75** | **$87.42** | **$14.01** |
| Total | 289,085 | $241,349,362 | $20,859,231 | 2,558,951 | **$834.87** | **$94.32** | **$8.15** |

Source:
- FY'16 Operating Expenditure and Activity data taken from the SJA FY'16 Annual Report
- FY'16 Bad Debts taken from Finance data supplied by SJA for FY'16
- FY'16 Estimated Population taken from the Australian Bureau of Statistics, Estimated Resident Population as at 30 June 2016

[Source: WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 28.]

6.11 The Country Ambulance Strategy further noted that:

> Information contained within SJA's FY'16 Annual Report indicates that SJA spends roughly $100 more in metropolitan WA than in country WA per completed incident (Primary Response or IHPT). Furthermore, SJA's spend per capita is $9 lower in country WA compared with metropolitan WA. This runs counter to the pattern in healthcare more broadly where rural and remote delivery costs are higher; a fact recognised by the rural loading applied by the Independent Hospital

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339 ibid., p 22.

340 ibid., p 37.

341 Australian Government, Productivity Commission, *Report on Government Services 2021*, 28 January 2021, Table 11A.8.

342 ibid.

343 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 28.

Pricing Authority (IHPA). Bad Debts are also more pronounced in country WA, with per capita debt more than double that of the metropolitan area during FY'16, representing 26% of the income received for Primary Response cases (fees for IHPT are invoiced to WACHS facilities).

In FY'16, SJA reported a surplus of $22.2M after tax across both metropolitan and country services (During FY'15 SJA posted a surplus of $21.5M after tax). There is no requirement in the contract for an investment plan to reinvest any surplus back into the services and infrastructure for ambulances in WA. The lack of direction provided in the contract limits the analysis that can be performed by the contract holder regarding whether funding is allocated efficiently and effectively.[344]

6.12 The Committee asked St John Ambulance WA and WACHS whether visibility has improved:

- St John Ambulance WA response:

  In 2019 the WA Treasury Corporation were engaged by the Department of Health to undertake a review of the funding model specific to ambulance services in WA. The outcome of this piece of work supported the cost attribution methodology utilised by St John WA.

  Where appropriate costs are attributed to country and calculated estimations are made around the apportionment of our overhead costs to country.[345]

- WACHS response:

  WACHS's engagement with SJA through the development of the Country Ambulance Regional Investment (CARI) initiatives has provided improved visibility of some of the costs attributable to country services with respect to these joint projects, however the transparency of costs for country services as a whole remains limited. Greater visibility of these costs is an effective step in establishment of an equitable statewide model of service for ambulance services in WA.[346]

6.13 The Committee asked St John Ambulance WA and WACHS to provide updated figures from the Country Ambulance Strategy:

- St John Ambulance WA response:

  The cost to deliver the service in country is more significant than that of the metropolitan areas. As such the user fees from the metropolitan area do subsidise those in the country.[347]

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344 ibid., p 24.

345 St John Ambulance WA, letter, dated 8 March 2022, p 4.

346 WA Country Health Service, email, 8 March 2022, pp 2–3.

347 St John Ambulance WA, letter, dated 8 March 2022, p 3.

Figure 29. *St John Ambulance WA view of cross–subsidisation required for country ambulance—2021/22*

[Source: St John Ambulance WA, letter, dated 8 March 2022, p 3.]

- WACHS response:

> Regrettably there is an even greater gap between Metro WA and Country WA with state investment highly biased towards metro services. By way of example, it remains the case that Bunbury is the only regional subcentre in WA that has dual paramedic crews, noting that all other surrounding subcentres within the greater region mixed crews of paramedics or fully volunteer crews. All metro crews are dual paramedics. In areas not financially supported by the state, volunteers and regional communities wear these costs including in the provision of fees for service not matched to costs of delivery. High risk and vulnerable remote Aboriginal populations within country WA experience even greater challenges in financial equity and support, with high levels of bad debt in these areas a reflection of socio demographic challenges and likely substantial unmet need as a result of service barriers and out of pocket costs.[348]

## Volunteer qualifications

6.14 Volunteer ambulance officers are required to do training that St John Ambulance WA provides. Unlike paramedics, they are not required to undertake tertiary education and be registered with the Paramedicine Board of Australia.

6.15 Volunteers have a lower scope of practice than paramedics. St John Ambulance WA explained the difference in scope of practice as follows:

> The volunteer scope of practice [is focused] on important issues that they are likely to encounter, but also the need for clinical safety. For instance, there are medications that are in the hands of our paramedic staff that need a lot of training, vigilance, use and continuous refreshing of skills that just are not practical to

348 WA Country Health Service, email, 8 March 2022, p 2.

deliver into a volunteer workforce that might be encountering a smaller group of patients, or less complex.[349]

6.16 Pain relief is an example of the difference in scope between volunteers and paramedics. Even the highest trained volunteers are only able to administer two forms of pain relief—paracetamol and methoxyflurane. Both of these medications are administered orally. In addition to these medications, Paramedics can also administer fentanyl, an intravenous narcotic.[350]

6.17 There are three levels of volunteer ambulance officer as described in Table 17:

Table 17. *Volunteer ambulance officer roles*

| Level | Role | Training |
|---|---|---|
| Level 1<br>Emergency Medical Responder | They assist level 3 volunteers and are not involved with patient assessment and management decisions. | They complete a two–day training program where they are assessed as competent in the use of all ambulance equipment. |
| Level 2<br>Emergency Medical Assistant | They do not administer medication but will assist in medication handling with level 3 volunteers. | They complete a four–day training program on patient assessment and initiation of care in accordance with the organisation's Clinical Practice Guidelines. |
| Level 3<br>Emergency Medical Technicians | They perform patient assessments and initiate care in accordance with the organisation's Clinical Practice Guidelines. They are also permitted to administer oral medications and an EpiPen to deliver intramuscular medication. | They complete a six–day training program and must also complete 12 months of work as a Level 2 Emergency Medical Assistant. |

[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 41.]

## Ambulance response times

6.18 The Emergency Ambulance Services Agreement requires regional sub–centres with career paramedics (i.e. career sub–centres) to achieve target response times for patients within 10km of the town centre. The target response times for each sub–centre range from 15–40 minutes depending on the priority level and location of the sub–centre (see Table 18). Sub–centres run entirely by volunteers are not required to comply with target response times.

Table 18. *Career paramedic regional sub–centre target response times (within 10km of town centre and excluding inter–hospital patient transport)*

| Dispatch Priority 1 (highest priority) | | | |
|---|---|---|---|
| **Career sub–centre** | **Calls responded to within 15 minutes (%)** | **90$^{th}$ Percentile Response Times (min)** | **Average Response Times (min)** |
| Albany | 83 | 17.5 | 11 |
| Australind | 80 | 19 | 12 |

349 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of evidence, 29 October 2021, p 26.

350 ibid.

| | | | |
|---|---|---|---|
| Broome | 90 | 15 | 10 |
| Bunbury | 82 | 18 | 11 |
| Busselton | 86 | 17 | 10 |
| Collie | 86 | 17 | 10 |
| Geraldton | 84 | 19 | 11 |
| Hedland | 84 | 17.5 | 11 |
| Kalgoorlie | 80 | 23 | 12 |
| Karratha | 52 | 25 | 15.5 |
| Kununurra | 60 | 23 | 14.5 |
| Northam | 75 | 19 | 12.5 |
| **Dispatch Priority 2** | | | |
| **Career Sub–Centre** | **Calls responded to within 15 minutes (%)** | **90th Percentile Response Times (min)** | **Average Response Times (min)** |
| Albany | 90 | 25 | 15 |
| Australind | 86 | 29 | 17 |
| Broome | 90 | 25 | 15 |
| Bunbury | 90 | 25 | 15 |
| Busselton | 90 | 25 | 15 |
| Collie | 85 | 31 | 16 |
| Geraldton | 85 | 30 | 16 |
| Hedland | 90 | 25 | 15 |
| Kalgoorlie | 85 | 29 | 16 |
| Karratha | 85 | 32 | 20 |
| Kununurra | 85 | 28 | 17 |
| Northam | 80 | 50 | 21 |
| **Dispatch Priority 3** | | | |
| Calls responded to within 15 minutes | | 90% | |
| Average response time | | 40 minutes | |
| **Dispatch Priority 4** | | | |
| Calls responded to within 10 minutes of scheduled arrival time | | 90% | |
| Average arrival time | | N/A | |

[Source: Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 3.]

6.19 WACHS advised only 1.5 per cent of the total area of Western Australia is subject to target response times and recommended introducing target dispatch times for regional areas:

> The data is only reported at the moment for 15 or 16 sub–centres within a 10–kilometre radius of [the town centre]. This is the way the contract is defined. So data for response times is only reported for about 1.5 per cent of the geographic area of the state. It is for metropolitan Perth and then a 10–kilometre radius around the base of a sub–centre.
>
> So for 98.5 per cent of the geography of the state there are no reported KPIs and we say that it is important to have KPIs for everywhere. One of the arguments about that has been response times in geographically dispersed locations are not a great measure. We would agree with that. We think dispatch times make much more sense, which is really how we work with the Royal Flying Doctor Service, basically, on a dispatch time methodology.[351]

**FINDING 43**

Regional sub–centres run entirely by volunteers are not required to comply with target response times. This means 98.5 per cent of the geographic area of Western Australia has no contractual target ambulance response times.

6.20 WACHS expanded on their recommendation for regional sub–centres to comply with dispatch times rather than response times arguing response times are not realistic:

> If it was two and a half or three hours away on the Broome–Port Hedland road, expecting someone to arrive in 15 minutes is not realistic whereas expecting a dispatch time of 15 minutes, I think, would be reasonable. We do that with Royal Flying Doctor Service as well because of the tyranny of distance. So what we seek is responsiveness and standards and measurement against indicators there.[352]

6.21 The Department of Health expressed support for the introduction of KPIs for ambulance dispatch times in regional areas.[353]

**RECOMMENDATION 23**

The Department of Health establish key performance indicators for regional ambulance dispatch times and regional ambulance response times and require ambulance service providers to meet these indicators.

**RECOMMENDATION 24**

The Department of Health table the number of calls which did not meet the target ambulance dispatch and response times and by how much in regional Western Australia in Parliament on an annual basis.

**RECOMMENDATION 25**

The Department of Health require daily regional ambulance response times to be published online.

## Target response time performance

6.22 Figure 30 below shows the performance of regional sub–centres in achieving their target response times in 2020/21. It shows all regional sub–centres were within target or within

351 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 14.

352 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 2.

353 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 November 2021, p 4.

tolerance for year to date priority 1, 2 and 3 calls. The final row of the table shows 22.1 per cent of priority 1 calls outside 10km of town centres were responded to within target.

Figure 30. *Career paramedic regional sub–centre target response time performance (within 10km of town centre) excluding inter–hospital patient transfers and transfers to and from airports 2020/21*

| | Priority 1 | | | Priority 2 | | | Priority 3 | | | Priority 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Percentage** | **MTD** | **YTD** | **Target** | **MTD** | **YTD** | **Target** | **MTD** | **YTD** | **Target** | **MTD** | **YTD** | **Target** |
| Albany | 87.6% | 88.2% | 83.0% | 92.1% | 94.2% | 90.0% | 91.0% | 94.5% | 90.0% | 71.0% | 76.7% | 80.0% |
| Australind | 76.3% | 79.2% | 80.0% | 83.0% | 85.2% | 86.0% | 84.8% | 87.9% | 90.0% | 42.9% | 48.1% | 80.0% |
| Broome | 94.4% | 93.3% | 90.0% | 97.8% | 95.6% | 90.0% | 96.1% | 95.3% | 90.0% | 88.9% | 79.4% | 80.0% |
| Bunbury | 85.3% | 86.3% | 82.0% | 84.6% | 89.9% | 90.0% | 89.9% | 91.7% | 90.0% | 57.5% | 71.2% | 80.0% |
| Busselton | 85.3% | 85.7% | 86.0% | 80.8% | 88.8% | 90.0% | 88.6% | 89.6% | 90.0% | 60.5% | 72.9% | 80.0% |
| Collie | 95.2% | 93.4% | 86.0% | 93.8% | 95.4% | 85.0% | 90.0% | 94.4% | 90.0% | 54.5% | 74.2% | 80.0% |
| Geraldton | 78.6% | 86.7% | 84.0% | 86.7% | 88.8% | 85.0% | 87.7% | 90.5% | 90.0% | 69.4% | 78.7% | 80.0% |
| Hedland | 91.8% | 87.6% | 84.0% | 90.5% | 92.3% | 90.0% | 88.9% | 92.6% | 90.0% | - | 42.9% | 80.0% |
| Kalgoorlie | 68.6% | 78.4% | 80.0% | 81.7% | 86.1% | 85.0% | 79.4% | 87.5% | 90.0% | 64.0% | 70.9% | 80.0% |
| Karratha | 85.4% | 84.5% | 52.0% | 80.0% | 89.3% | 85.0% | 55.6% | 87.6% | 90.0% | 100.0% | 82.4% | 80.0% |
| Kununurra | 75.6% | 80.9% | 60.0% | 93.8% | 95.4% | 85.0% | 75.0% | 91.1% | 90.0% | 100.0% | 82.6% | 80.0% |
| Norseman | 83.3% | 64.3% | N/A | 100.0% | 86.4% | N/A | - | 100.0% | N/A | - | 33.3% | N/A |
| Northam | 71.4% | 79.2% | 75.0% | 84.0% | 87.9% | 80.0% | 81.0% | 86.5% | 90.0% | 40.5% | 64.8% | 80.0% |
| Others - Outside 10km | 17.1% | 22.1% | N/A | 30.4% | 36.7% | N/A | 68.0% | 74.3% | N/A | 20.0% | 37.4% | N/A |

Within target | Within tolerance | Outside tolerance

[Source: St John Ambulance WA, *Report to the Department of Health – Annual Report 2020/21 Financial Year*, 30 June 2021, p 20.]

6.23 Figure 31 shows the average response times for volunteer sub–centres in 2020/21. Volunteer sub–centres achieved an average response time of 20.8 minutes for priority 1 responses over the year.[354]

[354] Submission 71 from St John Ambulance WA, 23 June 2021, p 42.

Figure 31. *Average response time for volunteer sub–centres 2020/21*

**Average Response Time by Priority - Volunteer Sub Centres**[1 2]

| Minutes | Full Year 2019/20 | Full Year 2020/21 | Full Year Variance |
|---|---|---|---|
| Priority 1 - Emergency | 21.77 | 23.08 | 6.03% |
| Priority 2 - Urgent | 26.18 | 28.17 | 7.60% |
| Priority 3 - Non-Urgent | 32.16 | 35.88 | 11.58% |

**Average Response Time by Location - Volunteer Sub Centres**[1 2 3]

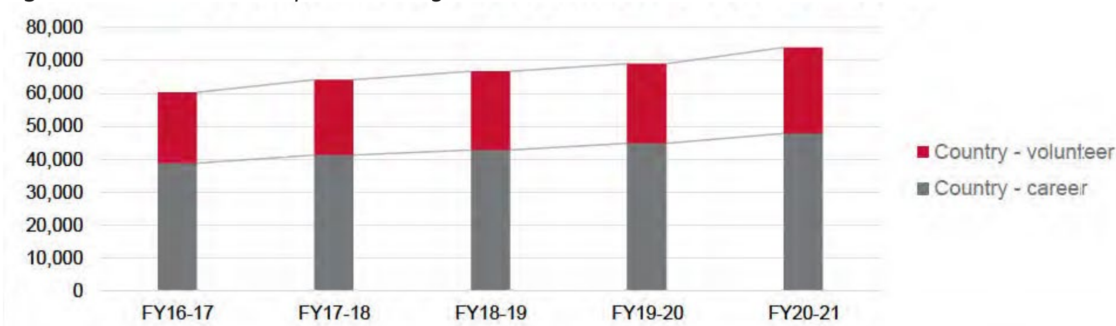
| | 2020/21 | | | | | |
|---|---|---|---|---|---|---|
| | Priority 1 | | Priority 2 | | Priority 3 | |
| Minutes | MTD | YTD | MTD | YTD | MTD | YTD |
| Augusta | 17.07 | 17.63 | 21.78 | 23.62 | 23.96 | 33.04 |
| Boyanup | 22.97 | 17.04 | 0.00 | 19.19 | 0.00 | 22.91 |
| Bridgetown | 23.77 | 21.36 | 33.56 | 35.04 | 33.96 | 39.57 |
| Brunswick | 13.17 | 19.83 | 41.10 | 29.73 | 64.35 | 39.52 |
| Carnarvon | 19.51 | 22.82 | 20.62 | 24.94 | 24.74 | 27.93 |
| Denmark | 18.41 | 21.47 | 17.58 | 20.30 | 27.95 | 30.32 |
| Dongara | 23.80 | 21.87 | 17.87 | 25.34 | 37.66 | 32.07 |
| Donnybrook | 19.99 | 21.54 | 27.30 | 27.25 | 40.59 | 35.78 |
| Dunsborough | 16.88 | 17.29 | 31.80 | 23.46 | 22.75 | 28.52 |
| Esperance | 14.63 | 14.87 | 16.49 | 19.12 | 36.42 | 26.76 |
| Harvey | 20.18 | 19.10 | 22.35 | 22.28 | 25.81 | 32.05 |
| Katanning | 16.84 | 18.85 | 23.46 | 25.56 | 35.19 | 29.85 |
| Lancelin | 35.71 | 23.53 | 39.92 | 31.68 | 0.00 | 31.15 |
| Laverton | 21.68 | 27.32 | 30.01 | 31.51 | 50.56 | 37.47 |
| Manjimup | 34.70 | 18.30 | 23.69 | 22.06 | 41.50 | 37.07 |
| Margaret River | 19.38 | 20.87 | 27.50 | 26.44 | 19.50 | 32.92 |
| Merredin | 12.37 | 17.23 | 14.79 | 18.71 | 30.39 | 29.96 |
| Mt. Barker | 19.23 | 21.93 | 21.47 | 25.55 | 42.07 | 36.29 |
| Narrogin | 17.24 | 17.63 | 34.10 | 26.69 | 46.05 | 32.53 |
| Newman | 20.96 | 24.18 | 34.21 | 29.68 | 37.85 | 40.17 |
| Roebourne | 0.00 | 24.17 | 0.00 | 31.25 | 0.00 | 23.94 |
| Tom Price | 41.03 | 41.14 | 68.82 | 45.34 | 105.73 | 60.84 |
| Toodyay | 26.29 | 24.86 | 28.90 | 32.48 | 42.10 | 40.54 |
| Waroona | 23.84 | 20.32 | 30.08 | 26.47 | 36.33 | 35.72 |
| Wickham | 19.74 | 21.56 | 19.03 | 25.13 | 26.57 | 33.67 |
| Wundowie | 17.44 | 19.24 | 39.43 | 24.73 | 70.19 | 35.71 |
| York | 19.74 | 22.84 | 25.48 | 25.34 | 34.87 | 30.43 |
| Others | 28.22 | 26.18 | 34.99 | 32.31 | 40.98 | 40.13 |

[Source: St John Ambulance WA, *Report to the Department of Health – Annual Report 2020/21 Financial Year,* 30 June 2021, p 23.]

## Demand for ambulance services

6.24 Figure 32 shows the number of calls responded to by regional sub–centres between 2016/17 and 2020/21. Regional sub–centres responded to 73 946 calls during 2020/21. This represents a 6.5 per cent increase from the previous year and a 22 per cent increase since 2016/17.

Figure 32. *Ambulance responses in regional Western Australia from 2016/17 to 2020/21*




[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 42.]

**FINDING 44**

Regional sub–centres are experiencing an upward trend in demand for ambulance services. In 2020/21, 73 946 calls were responded to. This represents a 22 per cent increase since 2016/17. This is higher than the demand increase in the metropolitan area over the same period.

## Best endeavours model

6.25 The Emergency Ambulance Services Agreement only requires St John Ambulance WA to use their 'best endeavours' to provide a service in regional areas. The Agreement states:

> The Provider must use its best endeavours to:
>
> (a) Provide a Country Sub Centre at all locations stipulated on the Country Sub Centre list in Schedule 2; and
>
> (b) Maintain optimum numbers of volunteers in all Country Sub Centres.[355]

6.26 This means St John Ambulance WA is not under a contractual obligation to respond to calls for an ambulance in regional Western Australia.[356]

6.27 WACHS noted the 'best endeavours' model does not provide adequate clarity for the delivery of ambulance services. It recommended a standard for the delivery of ambulance services be clearly set out in policy or legislation:

> So right now the best endeavours model basically says whilst there are best endeavours in 98.5 per cent of the state's geography to provide a service there is no actual contractual obligation to do so…Inevitably good services do get provided in any event. But the reality is the lack of definition where a service must be provided in policy or in statute means that we do not set a standard; we do not measure it; we do not invest; we do not plan, and we do not risk manage.[357]

**FINDING 45**

The Emergency Ambulance Services Agreement only requires St John Ambulance WA to use their best endeavours to provide an ambulance service in regional areas. This does not guarantee regional communities have access to ambulances services.

355 Department of Health, *Emergency Services Agreement*, 25 September 2020, clause 2.4

356 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 13

357 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 18.

6.28 WACHS expanded on the need for policy or legislation recommending ambulance services be declared an essential service and to guarantee an ambulance response for anyone who calls for one in Western Australia:

> For every major service provided within the WA health system…there is a geographic definition of the level of service from 1 to 6. Emergency care is probably the best example of this where a level 6 service is the Fiona Stanley–type service that is fully–fledged, specialist–led, fully diagnostically capable with all the back–of–house functions of a major tertiary hospital through to level 1 really being a part–time response.
>
> …
>
> We would say that the same should happen for ambulance services. There should be a definition around the state geographically where, clearly, in your larger regional centres we would expect…what we…call a level 4 service. That is paid paramedics with appropriate dispatch and response times…
>
> Dumbleyung or Pingelly or many small sites across the state where you are relying on a volunteer service. That would be a defined level 1 or level 2 service. You would have a lower level of performance requirement as a result of the level of investment…We see the lack of definition as being a significant problem at the moment because it is not measurable and there is no basis for reasonable expectation of what a member of the public should expect to receive.[358]

6.29 The Department of Health published a document titled *Ambulance services Western Australia—a framework for statewide ambulance services operations* (Framework) on 13 December 2021.[359] The Framework acknowledges ambulance transport is an essential emergency service.[360] It is based around the following eight domains of ambulance operations:

- patient–centred services
- safety and quality
- service integration and coordination
- workforce
- Aboriginal cultural competency
- transparency and accountability
- sustainability
- equity of access of health outcomes.

6.30 The Framework notes all Western Australians must have access to timely ambulance services.[361] It also makes a commitment to reducing inequity between metropolitan and country ambulance services.[362] The best endeavours model is not consistent with the Framework.

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358 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 2.

359 Department of Health, *Ambulance services Western Australia—a framework for statewide ambulance service operations,* 13 December 2021. See: https://ww2.health.wa.gov.au/~/media/Corp/Documents/Reports–and–publications/Ambulance–services–framework/Ambulance–Services–Framework.pdf. Viewed 21 January 2022.

360 ibid., p 2.

361 ibid.

362 ibid., p 9.

**FINDING 46**

The best endeavours model of delivering ambulance services is inconsistent with Department of Health policy titled: *Ambulance services Western Australia—a framework for statewide ambulance services operations*.

**RECOMMENDATION 26**

The Department of Health ensure the provision of ambulance services in regional Western Australia is consistent with *Ambulance services Western Australia—a framework for statewide ambulance services operations* with regard to reducing inequity between metropolitan and regional Western Australia.

## Methodology for determining locations of career sub–centres

6.31 The Emergency Ambulance Services Agreement contains a model which determines if career paramedics should be allocated to a regional sub–centre (see Table 3). This model is based on the number of calls a sub–centre responds to in the previous year. Under this model only 16 of the 160 regional ambulance sub–centres are supported by career paramedics.

6.32 The Committee asked St John Ambulance WA whether they undertake any internal modelling to determine when a regional sub–centre should become a career sub–centre. St John Ambulance WA said they have modelling however the decision to establish a career sub–centre ultimately depends on the Department of Health providing funding.[363]

6.33 St John Ambulance WA's internal modelling determines where to allocate career paramedics in regional areas. Population, tourism and demand for services are factored and considered:

> There are a number of determinants with regards to where paid resources are going to be placed in regional Western Australia and part of that is actually negotiation with the state and with the Department of Health. We would say that the point that needs to be considered when determining whether a paid resource is placed into a regional location would be population, but that population probably should take into consideration things like surges in population.
>
> If you think about the south west, in pre–COVID times we would have a surge of visitors in the summer months for holidays, festivals—those sorts of things. You have a surge but then it drops off during the winter months...What also needs to be taken into consideration is the requirement for services—so, the job numbers and the characteristics of those calls for assistance from the community.[364]

6.34 The United Workers Union recommended a methodology based on the greater healthcare needs of a particular community and geographical span:

> The general view of the Union was that it was based on community need, geographical span, equitable workload distribution and service reliability and sustainability. So, as the country health service had expanded since back in 2008, job volume tended to be a thing that was used, but looking at the geographical span of where a service could actually operate from, looking at actually being able to achieve a response to a wide range of the population within a certain time frame was not really looked at. It did not actually factor in the needs of the local community as well because some local communities will have greater healthcare needs than others irrespective.

363 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, pp 30–1.

364 ibid.

> It might be because one local community, let us take Toodyay for example; it is 30 minutes from a hospital, as opposed to Donnybrook that has a hospital in town and will have very different needs because we are going to have to manage patients for longer and they still have a pretty similar workload. So, the service that you deliver to that location might be different from a service you deliver in another even though job volume and population and ambulance demand might be similar. So, when you look at distribution like that, when you are looking at the expansion of the community paramedic model, we want a more equal distribution to be able to support volunteer sub–centres to be able to lessen the burden on community paramedics because at the moment you have got community paramedics trying to sustain volunteer sub–centres that are far greater than the capacity that they have to be able to do that.[365]

6.35 The Committee supports the development of a methodology to guide the establishment of regional career sub–centres based on the specific healthcare needs of individual communities.

**FINDING 47**

The Emergency Ambulance Services Agreement contains a model which determines if career paramedics should be allocated to a regional sub–centre based on the number of calls a sub–centre responds to in the previous year. This model is not satisfactory and does not recognise the specific healthcare needs of individual communities.

**RECOMMENDATION 27**

The Department of Health implement a policy to guide the establishment of regional career paramedic sub–centres. This policy is to include a methodology based on the specific healthcare needs of individual communities.

## Availability of volunteers

6.36 The current model heavily depends on the availability of volunteers and does not guarantee service delivery for regional Western Australians.

6.37 The Country Ambulance Strategy noted:

> The contract places no requirement for a volunteer Sub Centre to respond to a request for either an IHPT [inter–hospital patient transfer] or Primary Response request. This represents a considerable risk to patients if long delays occur if multiple volunteers decline to respond.[366]

6.38 The Committee heard evidence from the Ambulance Employees Association of WA and the United Workers Union that there are instances where volunteer crews are not available and the patient (or the caller) is asked get to the hospital themselves.[367]

6.39 The Committee has no doubt that all volunteers involved in ambulance services endeavour to serve their community to the best of their ability.

6.40 The Committee asked the Department of Health if it is advised in real–time if a volunteer sub–centre is not able to assemble an ambulance crew:

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365 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 15.

366 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 18.

367 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 11; Submission 102 from United Workers Union, 3 August 2021, p 5.

> **Dr RUSSELL–WEISZ:** No. No, I do not think it does real time. I will check on that, if you want me to, but I do not think it does real time, but they will escalate if they have an issue which they cannot resolve with the sub–centre.
>
> **The CHAIR:** How do they escalate?
>
> **Dr RUSSELL–WEISZ:** Well, I think it could be through the contract management, but I know that if the chief executive has got an issue with a St John Ambulance provision, she would contact me or she would contact Rob [Anderson, Deputy Director General]. You know, the chief executive currently is very open about issues facing St John.[368]

6.41 WACHS does not currently monitor the number of calls when an ambulance is not able to respond.[369]

**FINDING 48**

Neither the Department of Health nor WACHS have real–time visibility about whether a regional ambulance sub–centre is able to provide a response at any point in time.

6.42 The Committee also heard evidence about the decline of ambulance volunteerism, in line with the decline of volunteerism in the wider community generally:[370]

- Private Citizen:

> In many (mostly inland) communities, the available pool of volunteers is shrinking as the population clusters toward the younger and older age range, leaving fewer adults to volunteer.[371]

- Shire of Manjimup:

> The Shire of Manjimup has 4 Volunteer St John's Ambulance Service Sub Centres...The reliance on a decreasing number of volunteers, matched with an increasing population, is of increasing concern.[372]

- Royal Australian College of General Practitioners:

> It is a struggle to recruit volunteer ambulance crews in parts of Western Australia. In Meekatharra, for example, there are only 4 volunteers who also have full time jobs. There appears to be a lack of awareness in the community about the demand for ambulance services and volunteers required to support that service. We would like to see a stronger public engagement campaign to recruit volunteers with great emphasis on community responsibility.[373]

6.43 As shown in Table 19 the number of ambulance volunteers in Western Australia has increased in recent years:

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368 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 November 2021, p 15.

369 WA Country Health Service, email, 24 February 2021, p 1.

370 University of Wollongong Australia, *Researcher helping to address a divesting decline in volunteers.* Site: https://www.uow.edu.au/media/2021/researcher-helping-to-address-a-devastating-decline-in-volunteers.php. Viewed: 3 May 2022; Australian Bureau of Statistics, *Volunteering data*. Site: https://www.abs.gov.au/statistics/research/information-needs-volunteering-data#appendix-volunteering-data-in-abs-collections. Viewed 3 May 2022.

371 Submission 20 from Private Citizen, 15 July 2021, p 1.

372 Submission 50 from Shire of Manjimup, 22 July 2021, p 1.

373 Submission 95 from Royal Australian College of General Practitioners, 27 July 2021, p 1.

Table 19. *Ambulance service volunteers in Western Australia 2016/17 – 2019/20*

| Year | Volunteers |
|---|---|
| 2020/21 | 4 332 |
| 2019/20 | 4 287 |
| 2018/19 | 3 626 |
| 2017/18 | 3 532 |
| 2016/17 | 3 455 |

[Source: Australian Government, Productivity Commission, *Report on Government Services 2022*, 1 February 2022, Table 11A.8.]]

6.44 The percentage of country Western Australian population that are volunteers is decreasing:

Figure 33. *Percentage of country Western Australia population that are volunteers*

| Year | Volunteers as % of Population |
|---|---|
| 2014 | 0.68% |
| 2015 | 0.70% |
| 2016 | 0.69% |
| 2017 | 0.69% |
| 2018 | 0.66% |
| 2019 | 0.67% |
| 2020 | 0.63% |
| 2021 | 0.59% |

[Source: St John Ambulance WA, letter, dated 24 January 2022, p 31.]

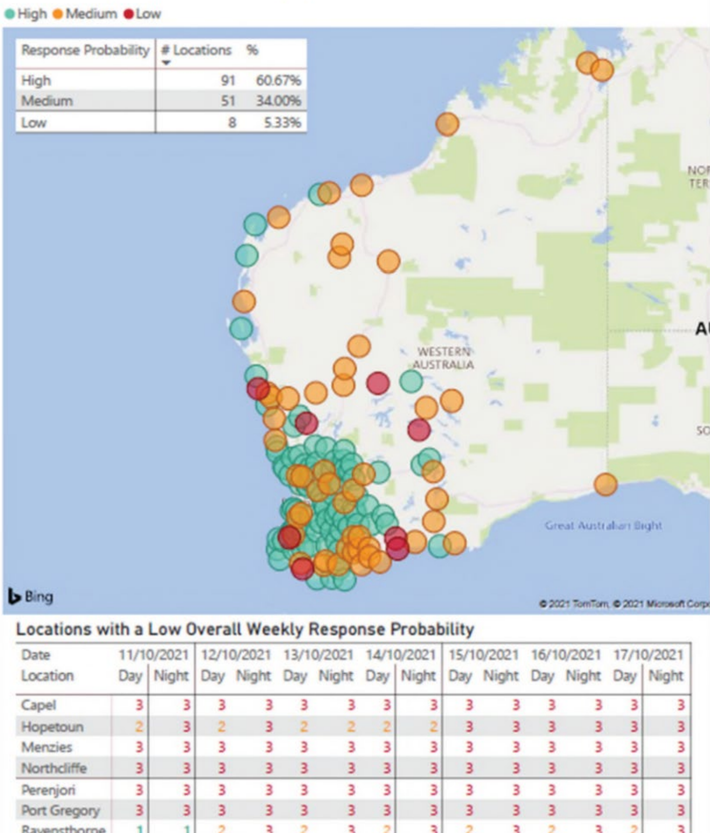
6.45 Volunteer numbers continue to decline in real terms as a percentage of population. More needs to be done to encourage volunteers and support them to serve their local community.

## Probability map

6.46 The Committee understand volunteers are generally not required to respond to calls or advise of their availability. While some sub–centres use rostering systems where volunteers remain at the sub–centre to provide a guaranteed response there is generally little visibility of volunteer availability to respond to calls.

6.47 Without knowing how many volunteers are available at any given time, St John Ambulance WA prepare probability maps to give some indication of volunteer availability. Figure 34 is an example of a probability map prepared in October 2021:

Figure 34. *Regional sub–centre probability map October 2021*




| Response Probability | # Locations | % |
|---|---|---|
| High | 91 | 60.67% |
| Medium | 51 | 34.00% |
| Low | 8 | 5.33% |

Locations with a Low Overall Weekly Response Probability

| Date | 11/10/2021 | | 12/10/2021 | | 13/10/2021 | | 14/10/2021 | | 15/10/2021 | | 16/10/2021 | | 17/10/2021 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Location | Day | Night | Day | Night | Day | Night | Day | Night | Day | Night | Day | Night | Day | Night |
| Capel | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Hopetoun | 2 | 3 | 2 | 3 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 3 |
| Menzies | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Northcliffe | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Perenjori | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Port Gregory | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Ravensthorpe | 1 | 1 | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 3 | 2 | 3 |
| Sandstone | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |

[Source: St John Ambulance WA, Answer to question on notice 8 asked at hearing held 24 September 2021, dated 19 October 2021, p 16.]

6.48 Probability maps are reviewed each week with a particular focus on locations with availability issues in the past.

6.49 Probability maps are shared with WACHS on a weekly basis.[374] WACHS gave evidence there is a need to improve visibility of volunteer availability to allow for contingency planning. The current system leaves them unaware whether any sub–centre can or cannot mount a response at any point in time:

> We would want to know if tonight in, say, Laverton [or] Leonora…whether there is capacity for an ambulance response to be mounted. If there is not, we will prepare ourselves to support them or with local police at times in advance.
>
> …
>
> Part of their current system for those sub–centres that cannot guarantee a response is to have a call around system…where they will ring various sub–centres. Obviously, a lot of time can be lost while you are trying to work out who is available and who is not. We would far rather see a system similar to our emergency departments where we know what the status is at any point in time and we learn over time about where we need to invest in the state…so that we have a more predictable and planned way of doing the business.[375]

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374 St John Ambulance WA, Answer to question on notice 8 asked at hearing held 24 September 2021, dated 19 October 2021, p 17.

375 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, pp 11–2.

6.50 St John Ambulance WA said it is intending to work with WACHS to develop a live feed of volunteer availability:

> We currently provide a probability map that is developed by the local leaders of those sub–centres, where they give an indication, I guess, of the volunteer health of respondability of those locations. The next step is what we are working on with the country health service, which is on how we turn availability and put it in the hands of the volunteers, in order to say, "Yes, I am available," and have that feed into a live idea of this is what availability looks like now. That is for the future. That is not something that we have now, but it is something we are intending to build.[376]

6.51 The Committee supports developing a live feed of volunteer availability.

**FINDING 49**

There is insufficient information with regard to a regional sub–centre's ability to respond to calls. The current system leaves stakeholders unaware whether a sub–centre can or cannot mount a response at any point in time.

## Volunteer sub–centres are largely required to manage their own finances

6.52 Regional sub–centres that are entirely volunteer–run are required to manage their own finances. This means they are able to keep any income generated from ambulance services they provide. However, they are also responsible for any expenses they incur in providing these services. WACHS explained these financial arrangements:

> From a financial perspective, those sub–centres have been largely independent in lots of ways— supported, you know, and provided a level of support. But they have purchased their own ambulances; they buy their own consumables; they manage their own debt; they are responsible for their own training. So, we regularly hear when we go on regional visits, for example, in Beacon and Bencubbin last year they had just raised $300 000 through the community for new ambulances. Similarly, in Kununurra, they have to manage a fair bit of bad debt and that makes it very difficult for them.[377]

6.53 In addition to being required to fund the cost of their own equipment, regional sub–centres are also required to absorb their bad debts.[378] In 2016 bad debts for regional sub–centres amounted to 26 per cent of the total income they generated from emergency responses.[379]

6.54 WACHS was critical of sub–centres being required to fund the delivery of an essential service that is provided for free in metropolitan Perth:

> They have to essentially manage their own accounts with, I guess, with a parent company that supports at the end of year; and the department does deal with some extraordinary costs and issues from time to time, year in, year out through a contract mechanism. But in the first instance the sub–centres essentially have to fundraise to an extraordinary level to provide service. One of the big issues for us is that country communities deserve the same level of access and a level of equity

[376] Justin Fonte, Head of Country Operations, St John Ambulance WA, transcript of evidence, 24 September 2021, p 15.

[377] Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 4.

[378] Ryan Marshall, Executive Director Finance and Supply, St John Ambulance WA, transcript of evidence, 29 October 2021, p 31.

[379] WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 28.

> in disadvantaged circumstances around the ambulance service provision. It is an essential service and, from our view, it is certainly that communities should not be expected to have to purchase their own ambulances when, if you live in metropolitan Perth, that will be purchased for you, and so on and so forth.[380]

6.55 St John Ambulance WA responded to these comments by emphasising that while sub–centres are responsible for covering expenses from the revenue they generate, volunteers themselves are not left out of pocket for any expenses a sub–centre incurs.[381] They also noted wealthier sub–centres provide financial assistance to those that are not as financially well off:

> as a not–for–profit organisation with a purpose to serve humanity, we ensure that these communities do not go without.[382]

6.56 The United Workers Union noted that changing the system so sub–centres are not responsible for purchasing their own equipment means the sub–centres cannot keep the income they collect from performing ambulance services. Changing the system in this way may be detrimental to certain sub–centres. Ultimately, shifting the responsibility for purchasing equipment would not impact patient outcomes:

> **Paramedic**: I think it causes issues from the fact that communities would feel better if that were provided. There are other things, like they also bill, so they take the income themselves as well. I think when you start changing that, you could turn around and go, "Well, we'll take all your income but then we'll pay for everything", then that might annoy them even more than some people that say, "Well, no, we want the income; we'll do it ourselves." Ultimately stuff like that, as long as there is governance surrounding the fact that, however it comes, the ambulances are roadworthy, they have got the right amount of gear, they have got the right amount of medications, I do not think that kind of thing—in my mind with all this, this is all about actually getting a level of care reliably to people that call for an ambulance and trying to narrow the disparity between what people get in metropolitan WA as opposed to what people get in country, understanding you will never get the same but there is such a —
>
> **Hon COLIN de GRUSSA**: It should be a bit closer.
>
> **Paramedic**: Yes, absolutely. Do I think that those kind of things specifically change patient outcome? I would say no.[383]

**FINDING 50**

Unlike metropolitan ambulance depots, regional sub–centres that are entirely run by volunteers are required to manage their own finances. This means they are able to keep any income generated from ambulance services they provide. However, they are also responsible for any expenses they incur in providing these services.

**FINDING 51**

Volunteer–run regional sub–centres are required to absorb their bad debts.

380 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 5.

381 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, p 3.

382 ibid.

383 Paramedic, United Workers Union, transcript of private evidence, 17 November 2021, pp 6–7.

## Accreditation for volunteers

6.57 Volunteers are required to undertake in–house training provided by St John Ambulance WA. There are three levels of volunteer depending on the amount of training undertaken (see Table 17). Each level of volunteer has a different clinical scope of practice.

6.58 In order to retain their qualifications volunteers are required to attend about 40 training sessions per year.[384] If this training is not undertaken volunteers can be required to re–start their training as if they had no previous experience.

6.59 The qualifications that volunteers obtain are not recognised outside of the St John Ambulance WA organisation.[385]

6.60 WACHS recommended volunteers receive formal accreditation for their training and experience. This would develop a career pathway for regional volunteers to become paramedics:

> Currently, there is no articulation of training towards certifications or diploma level. What we would see is [a] young person in Dalwallinu or wherever it might be the case that is interested in being a vollie can actually do some training, together with St John and us, because we run a hospital there, to articulate towards a paramedicine career at some point, just like we do with enrolled nurses and Aboriginal health workers and some allied health assistants. We want to support vollies to have choices to move into a profession if they want to.[386]

6.61 WACHS explained providing accreditation would benefit people in regional areas who do not want to leave their community to undertake training:

> **Mr MOFFET**: In places like Katanning, we know there was a volunteer who wanted to have a pathway and struggled to get into training but they ended up leaving the service and going to Queensland, for example. You do not want to lose that sort of community capital. You want to be able to train people in situ. We as an organisation in country health are very happy to work with St John around supporting training for volunteers as well as in our facilities and EDs and other settings and make our trainers available. We have a lot of capacity around that too.
>
> **Hon DARREN WEST**: And training in terms of qualifications and skills rather than just first aid training.
>
> **Mr MOFFET**: Yes, absolutely; vocationally recognised training that articulates to a career paramedic pathway for those who want to choose it, because there are a lot of young people who live in the bush who do not really want to come to Perth to train and if they can do the majority in the bush with us and St John, why would we not do that?[387]

6.62 The United Workers Union and the Ambulance Employees Association of WA support opportunities for volunteers to obtain accreditation.[388]

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384 Submission 33 from St John Ambulance WA Margaret River Sub–Centre, dated 20 July 2021, p 1.

385 St John Ambulance WA, Answer to question on notice 9 asked at hearing held 24 November 2021, dated 24 December 2021, p 11.

386 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 9.

387 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, p 12.

388 Paramedic, United Workers Union, transcript of private evidence, 17 November 2021, p 12; Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 14.

6.63 St John Ambulance WA advised volunteers were previously given an opportunity to obtain a Certificate IV in Health Care (Ambulance) in 2015.[389] Fifteen volunteers commenced the program with 11 obtaining the qualification.

6.64 St John Ambulance WA is a registered training organisation capable of offering Certificate IV qualifications and recently released a survey to all volunteers seeking their interest in undertaking accredit training.[390] The results of this survey were not available at the time of writing this report.

6.65 St John Ambulance WA have engaged in discussions with the Australian Paramedicine College to provide scholarships for volunteers to complete a Diploma of Emergency Health Care.[391] The College has provisionally offered six scholarships, one for each region.

**RECOMMENDATION 28**

The State Government investigate ways to provide volunteers with opportunities to access specific identified career pathways via TAFE or similar providers. For example, an accredited Certificate IV in nursing or paramedicine.

## Community Paramedics

6.66 Currently 31 Community Paramedics work in regional Western Australia.[392] They provide support to designated regional areas by helping to recruit volunteers, train volunteers and provide administrative support to sub–centres. Each area can include up to 6 sub–centres.

6.67 The Community Paramedic model was only recently introduced and it is yet to be fully evaluated.

6.68 Some stakeholders support the Community Paramedic model. The consensus is Community Paramedics provide exceptional support to their sub–centres however the Committee considers it too early to fully consider this program.[393]

### Requirement to respond to calls

6.69 Community Paramedics are not required to respond to calls. The following stakeholders recommend Community Paramedics be required to respond to calls:

- WACHS:

> We would not agree that community paramedics should not respond to calls. They have a role to build volunteers, and train and develop capacity, but countervailing all of that is to respond for the service of humanity; their job is to respond. There may be some cultural or other issues within St John. What we see is variation, probably, between how much a community paramedic is prepared to do and not. We have never been of the view that a community paramedic should not go on calls, and we will never have that view, because they are usually in the smaller sites where there are low volumes, and they have a duty of care to respond as well.
>
> …

[389] St John Ambulance WA, Answer to question on notice 9 asked at hearing held 24 November 2021, dated 24 December 2021, p 11.

[390] ibid.

[391] ibid.

[392] Submission 71 from St John Ambulance WA, 23 July 2021, p 22.

[393] Private Submission 79 from Private Citizen, 23 July 2021, p 5; Submission 63 from Private Citizen, 23 July 2021, p 1.

> We developed the country services investment package just after the Joyce inquiry in 2010 or 2011, which was the beginning of the aetiology of the community paramedics. The intention was always to strengthen clinical response. That was about training volunteers and supporting them as well is actually responding, noting that of course you have got to manage fatigue and all those usual things—so they deserve breaks and time away. At the moment, our view would be those community paramedics would provide clinical responses.[394]

6.70 The Ambulance Employees Association of WA said there is high demand for Community Paramedics to respond to calls despite this not being a requirement of the job and they regularly respond:

> St John has always maintained that a community paramedic—you are not there to do jobs. That is usually the first thing that is said, "Thank you, Sir; thank you, my colleagues. Just go and support the vollies", which is fine. Recruit, encourage, skill them up, train and teach, but you are not there to do jobs. It is not saying do not do the job, but your role is not to do jobs. But...that phone is running hot.[395]

6.71 Figure 35 clearly shows Community Paramedics do respond to calls. In 2020/21 Community Paramedics attended 7.35 per cent of cases within Community Paramedic serviced areas.

Figure 35. *Percentage of cases attended by one or more Community Paramedics within Community Paramedic serviced areas by region from 1 July 2020 to 30 June 2021*

| Year | Month | Goldfields | Great Southern | Midwest | Northwest | Southwest | Wheatbelt | Total |
|---|---|---|---|---|---|---|---|---|
| 2020 | July | 10.9% | 2.4% | 7.0% | 63.1% | 1.2% | 3.1% | **6.62%** |
| | August | 13.8% | 4.6% | 5.4% | 76.9% | 0.9% | 2.8% | **7.76%** |
| | September | 6.7% | 1.8% | 3.8% | 80.2% | 1.4% | 2.2% | **5.89%** |
| | October | 7.2% | 8.5% | 8.4% | 84.6% | 1.7% | 3.5% | **7.99%** |
| | November | 6.4% | 5.6% | 2.3% | 57.1% | 4.7% | 3.3% | **6.61%** |
| | December | 12.9% | 8.0% | 10.3% | 88.2% | 0.6% | 3.3% | **9.78%** |
| 2021 | January | 8.8% | 6.1% | 5.5% | 76.9% | 2.4% | 2.6% | **6.89%** |
| | February | 4.0% | 5.0% | 4.8% | 82.1% | 2.5% | 2.2% | **6.40%** |
| | March | 9.2% | 3.0% | 5.0% | 75.8% | 3.6% | 3.6% | **7.45%** |
| | April | 5.9% | 6.2% | 11.4% | 49.2% | 1.1% | 4.5% | **7.02%** |
| | May | 12.9% | 7.5% | 4.8% | 69.7% | 1.7% | 3.7% | **8.14%** |
| | June | 7.7% | 4.5% | 4.6% | 80.9% | 2.3% | 4.2% | **7.41%** |
| ***FY2020/21*** | | ***9.00%*** | ***5.45%*** | ***6.30%*** | ***73.52%*** | ***2.07%*** | ***3.26%*** | ***7.35%*** |

[Source: St John Ambulance WA, letter, dated 18 March 2022, p 22.]

**FINDING 52**

Community Paramedics regularly respond to calls for ambulance services despite this not being a requirement of their job.

394 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 1 December 2021, pp 10–1. See also: United Workers Union, Answer to question on notice 3 asked at private hearing held 17 November 2021, dated 14 December 2021 p 2; Paramedic; Private Submission 91 from Private Citizen, 27 July 2021, p 3; Submission 40 from Private Citizen, 21 July 2021, p 4.

395 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 13. See also: Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 13.

6.72 St John Ambulance WA are currently reviewing the role of Community Paramedics with a view to requiring them to respond to calls:

> About eight months ago, we embarked on a process—we call it the community paramedic modernisation project…We are starting the process and making them respond to more clinical cases to support the regions from a response perspective. So a short answer to your question is yes; making them more clinical is definitely first.[396]

6.73 The Committee considers Community Paramedics would be better utilised in responding to emergency ambulance calls.

**FINDING 53**

Community Paramedics would be better utilised in responding to emergency ambulance calls.

**RECOMMENDATION 29**

The Department of Health and St John Ambulance WA require paramedics deployed to regional areas to respond to emergency ambulance calls.

### Volunteer training

6.74 Community Paramedics are required to assist volunteer training. This can be time consuming at sub–centres with high volunteer numbers.

6.75 The Ambulance Employees Association of WA recommended hiring dedicated trainers to train volunteers instead of requiring Community Paramedics to conduct training. The advantage is this frees up Community Paramedics to respond to calls:

> We also suggested that in line of a resource well trained and well equipped to go out and do training of the volunteers is to get a dedicated trainer to do that to free up the community paramedic…[St John Ambulance WA] implemented that in the south west region.[397]

6.76 WACHS was supportive of dedicated trainers conducting volunteer training while noting the existing practice of Community Paramedics working alongside volunteers to provide training is a solid model:

> **Mr MOFFET**: Geography is obviously the issue, and access and how much you can do virtually versus physically. I am pretty sure they do have trainers who do work for the regional volunteers. How that is delivered, I do not know.
>
> **Ms BOSICH**: It depends on location. That is understanding whether there is a dedicated trainer. I have heard during the community consultation that a community paramedic working alongside volunteers and continuing to train was a solid model as well.
>
> **Mr MOFFET**: We have about 4 000 nurses around the state and the nursing profession has lots of specialties. One of them is around staff development and training. I think, when you get to a certain scale, it is good to have someone who is dedicated to adult learning principles and new curricula—I guess, the nuances of training. People learn in different ways and I think really good trainers are slightly

[396] Deon Brink, Executive Director Ambulance Operations, St John Ambulance WA, transcript of evidence, 24 November 2021, p 22.

[397] Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 13.

> different and better skilled at training, obviously, than just standard professionals like a physio or nurse sitting here.[398]

6.77 The United Workers Union noted volunteer training could be more efficiently delivered by trainers.[399] However certain training such as continuous education and needs based training is more effectively delivered by qualified paramedics.[400]

6.78 St John Ambulance WA advised they are supportive of training being performed by dedicated trainers and are currently trialling this in the South West:

> It is currently happening as part of a trial within the south west. We are currently trialling…a non–paramedic trainer who delivers the volunteer training and actually lives in these areas as well. We have more access to training for volunteers. It is important to note that we still feel that having the community paramedics available as part of a volunteer's fully rounded training is very important to be able to provide the experience and things like that. The bulk of the training can— and our future will have more non–paramedic trainers in the community as we grow that model but we will also have paramedics delivering some part of training and mentoring to volunteers as an important part of that training.[401]

6.79 The Committee supports employing dedicated trainers to provide training for volunteers in regional areas to free–up Community Paramedics to respond to calls.

**RECOMMENDATION 30**

The Department of Health and St John Ambulance WA investigate engaging dedicated trainers to provide scheduled training for volunteers in regional areas to free–up Community Paramedics.

### Mental health

6.80 In 2016 St John Ambulance WA commissioned a review of workplace mental health risks (Phoenix Report).[402] It noted two key sources of stress affecting Community Paramedics were professional isolation and feeling responsible for volunteers. In relation to the latter the Phoenix Report stated:

> Community Paramedics described feeling compelled to be available 24/7 as volunteers are "on their own without you". The concern was both for the wellbeing of the volunteers as well as the wellbeing of the community, of which they are a part. Although counselled by managers not to take on this responsibility, they reported feeling professionally and ethically compelled to do so. It would seem that some Community Paramedics leave their phones switched on during days off to ensure they are accessible 24/7.[403]

6.81 The Ambulance Employees Association of WA also identified stress of professional isolation as a risk factor for Community Paramedics:

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398 Jeffrey Moffet, Chief Executive, WA Country Health Service, Kylie Bosich, Director, WA Country Health Service, transcript of evidence, 1 December 2021, pp 11–2.

399 United Workers Union, Answer to question on notice 3 asked at private hearing held 17 November 2021, dated 14 December 2021, p 1.

400 ibid., p 2.

401 Justin Fonte, Head of Country Operations, St John Ambulance WA, transcript of evidence, 24 November 2021, p 26.

402 Phoenix Australia – Centre for Posttraumatic Mental Health, *St John Ambulance Review of Workplace Mental Health Risks,* February 2016.

403 ibid., p 19.

> When the community paramedic program was floated, we were very sceptical, and the reason for that is that an individual in a remote area by themselves is not good for mental health. It is not good for the individual, and it puts a lot of pressure on that individual with community expectation.[404]

6.82 The two sources of stress identified in the Phoenix Report could be alleviated by requiring paramedics to be deployed to regional areas in pairs. This will enable each paramedic to have scheduled time off and minimise risk of psychological harm. It will also have the added benefit of providing a 24/7 response crew. St John Ambulance WA support this change:

> I would say where there is a community paramedic, it should not be a single paramedic, it should probably be two community paramedics so when one is having some downtime, there is another one out there to support volunteers rather than having one community paramedic that just gets burnt out because their phone rings 24 hours a day, seven days a week.[405]

**RECOMMENDATION 31**

Given the challenging nature of the work that paramedics do, the Department of Health require ambulance service providers to implement specific programs to support the welfare of emergency paramedics and mitigate their risk of psychological harm.

## Volunteer association

6.83 The Committee also asked a former St John Ambulance WA volunteer Charles Wroth about whether it would be worthwhile to have an association for volunteers:

> Most definitely. I have been doing a lot of research into it prior to this, because I could see the need for it, and I know Tasmania has one, an association. The bush fire brigades have one. I was a member of that association for a while, so you have a voice, someone that can have your back and it would be of a great benefit for volunteer ambulance officers to have an association.[406]

**FINDING 54**

There is no association for ambulance volunteers in Western Australia equivalent to the Association of Volunteer Bush Fire Brigades (WA) Inc.

## Sustainability of the current service delivery model in regional Western Australia

6.84 The Committee wishes to extend its gratitude to all volunteers in Western Australia for their dedication and commitment.

6.85 In considering the efficiency and adequacy of the service delivery model in regional Western Australia (term of Reference (b)), the Committee is of the view:

- it is a cost efficient service due to its reliance on volunteers
- it provides variable service in regional Western Australia depending on the volunteer base and capacity of local sub–centres
- the best endeavours model is not sustainable or adequate.

404 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 18.

405 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, p 5.

406 Charles Wroth, Private Citizen, transcript of evidence, 23 September 2021, p 6.

6.86 The Committee asked a number of stakeholders about the sustainability of volunteers performing ambulance services in regional areas. Evidence indicated this model is not sustainable:

- WACHS:

> No, I think we have heard very, very clearly during the review that it is not sustainable. Now, if you were talking about somewhere like Esperance, it probably is looking okay. It is a good, robust, healthy site. But you have only got to go back really to the 2009 inquiry and to this time, if you look at the sites that were struggling where we have now put community paramedics—the Newmans, the Wyndhams and the Kununurras, they were some of the first sites—they were regularly unable to deliver a response. Now that they had investment through a community paramedic, they have been fantastic. They have got great numbers of volunteers and providing, you know, really good services. And there are many other sub–centres in that position.[407]

- Ambulance Employees Association of WA:

> Whereas once upon a time volunteers liked to come along and lend a hand and help drive an ambulance, or help to get somebody out of a car, that has changed, so they are treated more now like paid staff, without actually getting paid, and they have voiced that. I think we have outgrown that particular model. In saying that, a hybrid model in a lot of remote areas would suffice and take the pressure off volunteers.[408]

- United Workers Union:

> So, the short answer is in its current form, no. I will always support that the volunteers will remain an integral part of the service that we deliver, but the reliance on them to provide a service of reliability is 100 per cent not sustainable. It is not now and it is only going to get worse. There is a whole range of issues because of that. People's health problems are more complex. If you rely on the level of skill and care that can be delivered by volunteers at the moment, yet you keep expanding what paramedics in metro can do or career paramedics in country can do, you then start creating a greater divide in the level of care that people get in the country when they do not have access to paramedics.[409]

6.87 St John Ambulance WA see the sustainability of the volunteer model differently. They acknowledged volunteers are the foundation of service delivery in regional areas but accepted there are opportunities to increase the number of hybrid sub–centres and Community Paramedics in regional areas:

> **Ms FYFE:** The volunteer model has served us well for 130 years. It continues to serve us well today, and I think it will continue to serve us well tomorrow. It works. We have a higher level of volunteerism in some areas compared to what we do in others, and I think that also comes down to the demographic of the country region that you are talking about…I do think that there is an opportunity moving forward for us to put a more career resource out there into regional WA to support the volunteers—not necessarily to take over from them, but to support them.
>
> **Hon COLIN de GRUSSA:** That is the community paramedics.

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407 Jeffrey Moffet, Chief Executive, WA Country Health Service, transcript of evidence, 24 September 2021, p 12.

408 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 19.

409 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 16.

> **Ms FYFE:** That is the community paramedic model, and then I think there is also opportunities to expand some of those regional sub–centres from being purely volunteer into the hybrid model, where you have got both career and volunteer working alongside each other.[410]

6.88 St John Ambulance WA identified Newman, Bunbury, Geraldton and Kalgoorlie as areas that need to be transitioned to full–time career centres.[411]

6.89 Other stakeholders favoured increasing the number of hybrid sub–centres:

- Ambulance Employees Association of WA:

> A lot more money needs to be spent in the country. Somewhere like Esperance and Margaret River…should at minimum be hybrid models. Some of the larger areas at Broome, Port Hedland, Karratha, they should be fully paid. The stress on us as professionals, or even with volunteers, who we take our hat off to, to perform at the same clinical level standard as here in metro, it is impossible; it cannot happen.[412]

- United Workers Union:

> Volunteers are necessary, they will always be necessary in the geographical landscape that we operate under, especially with distance between towns. But you cannot get reliability for people that are not paid to be there 100 per cent of the time, and this blended model needs to be expedited and probably we need to take a better look at the data to know the centres that are under most pressure.[413]

6.90 Stakeholders called for more paramedics to be deployed to regional areas:

- Department of Health:

> We have recognised in the country there is a need for increased paramedics. I do not want to detract from the extraordinary good volunteer service that we have had through St John and lots of other volunteer services that we have throughout this state of WA. But we do recognise this and we are working with St John and WACHS at providing funding for more paramedics into country health service.[414]

- Professor Cobie Rudd, Edith Cowan University:

> In order to promote high–quality emergency and unscheduled healthcare services, there should be career qualified and Australian Health Professional Regulation Agency (AHPRA) registered paramedics in all but the most remote rural areas.[415]

6.91 This evidence reveals a consensus among stakeholders that the current volunteer model in regional Western Australia requires more funding and more career paramedics. These views are supported by the following evidence:

- The number of volunteers per capita in Western Australia is decreasing
- the average number of jobs per volunteer has increased over the last 6 months

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410 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 30.

411 ibid.

412 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 19.

413 Paramedic, United Workers Union, transcript of private evidence, 17 November 2021, p 4.

414 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 September 2021, p 20.

415 Submission 57 from Professor Cobie Rudd, Edith Cowan University, 22 July 2021, p 2.

- the average number of emergency jobs per volunteer has increased over the last 6 months
- the average number of inter–hospital patient transfers performed by volunteers has increased over the last 6 months
- there is a heavy reliance on a small number of active volunteers:
    - in 2021 the most active 10 per cent of volunteers were involved in 56.3 per cent of country cases that involved at least one volunteer
    - the same 10 per cent of volunteers were involved in 49.2 per cent of all country cases (including cases where both officers were paid paramedics)
- volunteer attrition has been increasing over the last 4 years
- the amount spent by St John Ambulance WA to attract volunteers is generally increasing (the amount spent in 2020/21 is 2.7 times greater than the amount spent in 2011/12)
- there has been a steady increase in the average time to form an ambulance crew in regional Western Australia since 2011/12
- there has been a general increase in the average response time of regional sub–centres (the highest number of jobs was recorded in 2021)
- there has been a general increase in the average number of jobs per sub–centre per year (the highest number of jobs was recorded in 2021).[416]

**FINDING 55**

The majority of ambulance services in regional areas are performed by volunteers while those in metropolitan Perth are entirely performed by career paramedics.

**FINDING 56**

Continued reliance on volunteers to perform the majority of ambulance services in regional Western Australia is not sustainable.

**RECOMMENDATION 32**

The Department of Health investigate extending the current ambulance service delivery model in regional areas with a hybrid model where appropriate.

[416] St John Ambulance WA, letter, dated 24 January 2022, pp 1–71.

# CHAPTER 7
# Workplace and organisational culture

## Introduction

7.1 This chapter considers workplace and organisational culture at St John Ambulance WA under term of reference (d).

7.2 The main issue identified is a cultural divide between management and frontline employees. This divide involves a breakdown in communication and lack of trust between management and employees.

## Senior management

7.3 The Ambulance Employees Association of WA claim senior management at St John Ambulance WA is disconnected from frontline workers.[417] The United Workers Union also gave evidence about a divide between management and frontline workers contributing to cultural issues at St John Ambulance WA.[418]

7.4 Issues between frontline staff and senior management have consistently been raised in previous inquiries into St John Ambulance WA including the following:

- Phoenix Report (2016):

> Consultations with staff suggested that the most salient sources of stress for St John employees were workplace bullying and feeling unsupported [and] undervalued by senior management.[419]

- Independent Oversight Panel (2016):

> Some of the participants who approached the Panel expressed a lack of trust in management and a perception of a lack of impartiality in management decisions and actions.[420]

- Joyce Report (2009):

> Paramedics who responded to the Inquiry portrayed their work environment as negative and unnecessarily stressful in parts. They described a workplace with minimal communication and processes lacking in transparency. They claimed that, although there is an inherent stress with their occupation, issues with management have compounded the situation.[421]

7.5 The Committee heard that prior to the appointment of the current Chief Executive Officer, St John Ambulance WA had only two CEOs over 37 or 38 years.[422] As the reports above

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417 Paramedic, Ambulance Employees Association of WA, transcript of evidence, 24 November 2021, p 15.

418 Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 3.

419 Phoenix Australia – Centre for Posttraumatic Mental Health, *St John Ambulance Review of Workplace Mental Health Risks,* 29 February 2016, p 1.

420 Independent Oversight Panel, *Review of St John Ambulance: Health and Wellbeing, and Workplace Culture*, report prepared by Dr Neale Fong, Ian Taylor and Professor Alexander MacFarlane, Perth, August 2016, p 10.

421 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 59.

422 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 23 September 2021, p 3.

indicate, organisational culture issues were identified prior to the appointment of the current Chief Executive Officer.

7.6 A number of previous inquires have also noted similar issues in other jurisdictions:

- Joyce Report (2009):

> Recent inquiries into ambulance services provided by other states in Australia have revealed they are experiencing similar issues raised by the [St John Ambulance WA] Inquiry. Given the services in other states are government run, this suggests there is no guarantee a government run ambulance service in WA would reduce issues being raised.[423]

- Chief Psychiatrist Review (2015):

> Reviews in other jurisdictions have also identified the 'cultural divide' between management and paramedics as a problem (NSW Ambulance Service, 2008: ACT Ambulance Service, 2015).[424]

7.7 According to the Ambulance Employees Association of WA, in 2018 St John Ambulance WA conducted a survey of their employees which revealed 66 per cent of respondents lacked confidence in senior management.[425]

7.8 In 2021 the Ambulance Employees Association of WA conducted a cultural survey which indicated frontline staff lack trust in senior management. In responding to the cultural survey question 'I trust senior management to implement the best decisions for me' a significant majority of respondents (86.83 per cent) indicated they do not (see Table 20 for additional survey answers).

**FINDING 57**

There is a lack of trust from frontline staff in senior management at St John Ambulance WA.

## Frontline management

7.9 St John Ambulance WA recently created new frontline management roles which were largely filled by paramedics. The Ambulance Employees Association of WA claim this has reduced the number of experienced paramedics available to respond to calls and negatively impacted morale amongst paramedics:

> I was working Friday night and it was quite disappointing; I have never seen sort of my colleagues more broken than they were Friday night. The capacity was diminished and they are frustrated because St John have just introduced a management model, which would probably…be the most ineffective resources and cost that I have ever seen. You could probably employ another 50 [paramedics] over a five–year period…for the cost of this management model which is going to show them absolutely no benefit. People on the road see that and they are just disillusioned.[426]

7.10 As noted in Finding 22, the emergency ambulance service in Western Australia has the highest proportion of non–operational personnel in Australia. The proportion of non–

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423 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 59.

424 Office of the Chief Psychiatrist, *St John Ambulance Paramedic and Volunteer Suspected Suicides*, November 2015, p 20.

425 Ambulance Employees Association of WA, letter, 29 November 2021, p 1.

426 Paramedic, Ambulance Employees Association of WA, transcript of private evidence, 24 November 2021, p 14.

operational personnel in Western Australia is almost three times higher than the national average.

7.11 St John Ambulance WA acknowledge there are people within the organisation that do not want the frontline management model to be introduced.[427] Despite this, they were positive about the introduction of this model on the basis that it will improve workplace culture by improving communication between management and frontline staff.[428]

## Culture survey

7.12 Since 2016 St John Ambulance WA have conducted annual culture surveys of their employees. These were designed to review workplace culture and employee engagement.

7.13 St John Ambulance WA was due to conduct a culture survey in 2021 but decided not to do so because it is implementing a new program in 2022 that will involve conducting surveys on an almost weekly basis:

> Rather than just running a one–off survey…we are moving to a more contemporary process. At the beginning of next year, we will be implementing our Listening Program which is essentially a culture survey that is run on a regular basis—an almost weekly basis—so we listen to our organisation through the highs and the lows so you actually get a better picture of the culture of an organisation.[429]

7.14 The 2022 culture survey is planned to be released to the workforce on 27 April 2022.[430]

7.15 The Ambulance Employees Association of WA claim the decision not to conduct a culture survey in 2021 is an admission that St John Ambulance WA expects the results will be worse than before.[431]

7.16 The Committee is of the view that healthy workplace and organisational culture contributes to a more productive and efficient workplace.

7.17 The Committee considers that employee culture surveys should be undertaken more frequently and survey results must be the trigger for revised processes to address organisational and workplace issues identified.

**RECOMMENDATION 33**

The Department of Health require ambulance service providers to undertake regular employee culture surveys and utilise the resulting data to adopt strategies to improve organisational and workplace culture.

7.18 The Ambulance Employees Association of WA prepared their own survey based on the St John Ambulance WA culture survey in 2018. Many of the survey questions received over 484 responses.

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427 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of private evidence, 24 November 2021, p 2.

428 Deon Brink, Executive Director Ambulance Operations, Justin Fonte, Head of Country Operations, St John Ambulance WA, transcript of private evidence, 24 November 2021, pp 2 and 4.

429 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of private evidence, 24 November 2021, p 1.

430 St John Ambulance WA, letter, dated 6 April 2022, p 6.

431 Paramedic, Ambulance Employees Association of WA, transcript of evidence, 23 September 2021, p 3.

7.19 A number of survey questions relating to workplace culture have been extracted in Table 20. The results of this survey indicate a lack of trust in senior management. The results also show 58.35 per cent of respondents report experiencing conflict, harassment or bullying at work.

Table 20. *Ambulance Employees Association of WA culture survey 2021 (Note 486 responses received)*

| No. | Question | Yes | No | Unsure | Total responses |
|---|---|---|---|---|---|
| 9 | I have good working relationships with my co–workers | 95.26% | 2.27% | 2.47% | 485 |
| 15 | Senior management (Operations Managers/General Mangers/Directors) listen to staff | 4.32% | 84.57% | 11.11% | 486 |
| 18 | Ours is a supportive and emotionally safe work environment | 15.29% | 71.9% | 12.81% | 484 |
| 19 | St John is socially responsible | 11.73% | 64.61% | 23.66% | 486 |
| 20 | Bullying and abusive behaviours are prevented and discouraged | 18.97% | 61.03% | 20% | 485 |
| 21 | St John is ethical | 13.64% | 64.46% | 21.9% | 484 |
| 24 | I trust senior management to implement the best decisions for me | 3.91% | 86.83% | 9.26% | 486 |
| 34 | Senior management (CEO, Directors, General Managers and senior managers) listen to staff | 2.88% | 83.74% | 13.37% | 486 |
| 37 | Have you experienced conflict, harassment or bullying at work? | 58.35% | 38.35% | 3.3% | 485 |

[Source: Ambulance Employees Association of WA, *Culture Survey 2021*. See: https://www.aeawa.com.au/wp-content/uploads/2021/11/AEAWA-Cultural-Survey-Results.pdf. Viewed 30 January 2022.]

**FINDING 58**

The results of the 2021 Ambulance Employees Association of WA survey results indicate employees lack trust in senior management.

## Current wellbeing programs at St John Ambulance WA

7.20 St John Ambulance WA claim to have one of the best ambulance wellbeing programs in the country.[432] Some of the wellbeing programs offered to staff are described in Table 21 below:

[432] Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of private evidence, 24 November 2021, p 4.

Table 21. *Wellbeing support at St John Ambulance WA*

| Program | Description | Commencement date of program | Initiated by SJA |
|---|---|---|---|
| St John External Provider Network | Network of psychologists across WA who can provide support to meet the specialised needs of emergency service workers. Six sessions are available for every staff member, volunteer and immediate family member per year. Extra sessions are available if clinically indicated. | 2014 | Y |
| Traumatic Cases Report | Staff or volunteers involved in a potentially distressing job are contacted within 48 hours to offer support. | August 2019 | Y |
| Mental health and wellbeing training | Regular meetings are held with operational leadership to support leaders to facilitate a mentally healthy workplace, discuss staff and volunteers who may need support. This is based on a trauma–informed practice model.<br>The Wellbeing and Support team regularly visits metropolitan centres and travels to about 70 regional locations each year to deliver mental health and wellbeing training. | August 2019 | Y |
| Phone line | A 24 hour phone line is available to all members of the St John workforce and family members as a personal, confidential point of contact. | 2015 | Y |
| Mediation | A member of the Wellbeing and Support team is an accredited mediator. External mediation is also available if required. | 2014 | Y |
| Return–to–work process | This process provides a coordinated plan to reintegrate staff members into the work community in a safe and streamlined manner via an individualised program supported by a clinical psychologist and coordinated across Employee Relation, Operations, Injury Management and Occupational Safety and Health. | 2016 | Y |
| Chnnl | A mental health check–in App. It allows regular anonymous check–ins to provide real–time feedback on staff wellbeing. | 2008 however has evolved since that time to become more substantial | Y |
| Wellbeing Champion Program | To source and upskill paid and volunteer workforce advocates to provide a supportive conversation or an initial point of wellbeing contact for peers, promote wellbeing and support initiative and link peers to the external St John WA psychologist network. | August 2020 | Yes in conjunction with other ambulance services |

| Program | Description | Commencement date of program | Initiated by SJA |
|---|---|---|---|
| MyOSH | To deliver flexibility around the management of incidents, actions, hazards, inspections and risk assessment. | April 2021 | Y |
| Customised third space program | To promote wellbeing and connectedness. | August 2018 | Y |
| Gatekeeper Suicide Prevention Training | Provide skills and confident to support staff and volunteers who may experience suicidal thoughts or behaviours. | March 2019 | Y |
| COVID Support Line | Provide staff and volunteers information related to COVID including risk assessments and safety plans. | March 2020 | Y |

[Source: Submission 71 from St John Ambulance WA, 23 July 2021, pp 52–3; St John Ambulance WA, letter, dated 18 March 2022, pp 1–3.]

7.21 St John Ambulance WA have implemented a number of complaints procedures and wellbeing programs to address workplace culture within the organisation. Despite this, the Committee heard there continues to be a divide between senior management and frontline staff.

7.22 In New South Wales, the services agreement with NSW Ambulance requires compliance with specific performance indicators relating to workplace culture and the results of the 'People Matter' culture survey.[433] The Committee suggests the Department of Health develop similar workplace culture KPIs for ambulance service providers in Western Australia.

**RECOMMENDATION 34**

The Department of Health develop workplace culture key performance indicators for ambulance service providers that involve undertaking regular audits of programs designed to improve workplace and organisational culture. The Department of Health table the results of audits in Parliament annually.

## Alleged workplace issues

7.23 The majority of paramedics in Western Australia are employed by St John Ambulance WA. This causes difficulty for those should they choose to leave the organisation.

7.24 The Committee received numerous submissions and heard from witnesses about the workplace culture of St John Ambulance WA and how complaints are managed.

7.25 The Committee heard allegations concerning:

- inappropriate workplace incidents such as sexual assault, sexual harassment, racism, bullying
- lack of faith in the complaints process (and personnel leaving the organisation as a result)

433 New South Wales Government, NSW Health, *Services Agreement 2021/22,* pp 23–7. See: https://www.ambulance.nsw.gov.au/__data/assets/pdf_file/0010/673372/NSWA-2021-22-Service-Agreement.pdf. Viewed: 1 May 2022.

- personnel being sacked after raising complaints.

7.26 The Committee notes that almost all paramedics who were critical of St John Ambulance WA asked for their submissions either to be kept as private or their identity anonymised for fear of repercussion:

> **Paramedic:** I feel like if they had read everything that I have presented to you today, they would find a way to make my life extremely difficult.[434]

7.27 The Committee heard numerous examples of employees who were in fear of reporting their issues to come forward and air their concerns because of possible ramifications. June Congdon, an Organiser from the United Workers Union explained as follows:

> I will let the guys answer, but for the same reasons that we de-identified the responses to our survey in here—because people have a very real fear of losing their job or facing some kind of retribution from St John, because that is the culture of the organisation.[435]

**FINDING 59**

The Committee heard evidence from numerous St John Ambulance WA employees who were concerned about being identified by their evidence due to the potential impact on their career.

7.28 One witness told the Committee:

> I am unable to work for an organisation that continually undermines me and refuses to take action when I am sexually harassed. They will always find a reason not to investigate issues that are raised and blame the victim.[436]

7.29 St John Ambulance WA provided the following information about staff complaints:

> St John WA have received 30 reports of [sexual harassment, sexual assault, bullying and discrimination] in the previous 12 months.[437]

7.30 St John Ambulance WA provided their Code of Conduct and provided a summary of their complaint handling process drawing attention to performance management, conflict resolution and misconduct management processes (Appendix 5).

7.31 When asked to advise what support is provided to victims of sexual assault or sexual harassment, St John Ambulance WA provided the following information:

> All victims have access to our extensive well-being program offered to all members of the organisation. The Well-being program includes:
>
> - Access to Psychologists
>
> - 24 x 7 telephone support hotline
>
> As part of the complaint and investigation process (see Additional Question No. 04 – Workplace complaints response for more information) complainants are offered wellbeing and support. For sensitive complaints employees are offered a named contact in the Wellbeing and Support team to provide consistency. Should a

434 Paramedic, transcript of private evidence, 21 September 2021, session six, p 10.

435 June Congdon, Organiser, United Workers Union, transcript of private evidence, 23 September 2022, p 3.

436 Paramedic, transcript of private evidence, 21 September 2021, session six, p 2.

437 St John Ambulance WA, letter, dated 18 March 2022, p 4.

complainant require wellbeing and support during a complaint process that contact is made and actioned at the time.

> Additionally, complainants are provided with an Operational and Employee Relations contact.
>
> The Wellbeing and Support team connect employees with specialised psychological support if required or requested.[438]

7.32 The Committee asked St John Ambulance to respond to concerns that staff within the organisation do not feel they are able to speak up and raise issues with senior management for fear of repercussions. Michelle Fyfe, Chief Executive Officer of St John Ambulance WA responded as follows:

> In my time as the CEO I have terminated the employment of a number of people for a number of things…but I have never terminated the employment for anyone for being a whistleblower or bringing information to the attention of leadership, so I find that very disappointing that people will come to the committee and say "We'll get the sack if we speak.".[439]

7.33 Dr Paul Bailey, Medical Executive Director at St John Ambulance WA also provided evidence in terms of how approachable and accessible senior management are in regard to fear of speaking up:

> I was just going to add that I agree this feeling is deep within our culture, but I do not know where it has come from either. During my entire tenure of six and a half years, the only people to have lost their job from a clinical perspective were people stealing narcotics. The only time. We have a discussion on Yammer, which is our social media platform that, kind of, we were getting a bit of what you might call rough feedback and being spoken to in a way that—I put my personal phone number on that post. The entire organisation has my phone number.[440]

7.34 The Committee heard an alleged inappropriate comment about people of LGBTQIA+ background which could constitute the basis for a complaint for workplace harassment.[441] There appears to be a general permissive culture about such comments within the organisation.

7.35 The Committee asked a witness about incidents of sexual harassment and assault and whether these complaints were referred to the Western Australian Police Force or the Fair Work Commission. The Committee acknowledges this is hearsay evidence but given the seriousness of the allegations and the complicated nature of reporting sexual complaints considers it important to be noted in this report:

> **Paramedic:** I know of one that was referred to WA police. The victim went to make a statement. My understanding is that the police asked St John about the investigation and St John told them not to worry about it; it was being dealt with internally. Then the victim went to the Sexual Assault Resource Centre because I think the police had kind of—it was a failure on multiple levels.
>
> …
>
> They did go to the Sexual Assault Resource Centre and tried to get some support

438 ibid., p 16.

439 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of private evidence, 24 November 2021, p 2.

440 Dr Paul Bailey, Medical Executive Director, St John Ambulance WA, transcript of private evidence, 24 November 2021, p 3.

441 Paramedic, transcript of private evidence, 21 September 2021, session six, p 4.

that way. I think they knew that a couple of other staff had been assaulted by the same person. The Sexual Assault Resource asked St John for the names of those people and I believe St John refused to give them any details or cooperate with anything. The investigation was closed without any action being taken.[442]

7.36 St John Ambulance WA advised the Committee they have procedures in place to protect employees including complaints procedures, employee representatives, Fair Work Commission, WorkSafe WA and whistle–blower processes:

> We see the organisation as having a number of levels within the organisation that matters can be escalated to, including up to me as the Chief Executive Officer. For those paid employees, they have union and association representation who are able to advocate on their behalf should they wish to.
>
> There is a Fair Work process, should they wish to. If it is a workplace safety issue, then there is WorkSafe that they are able to make those complaints to. We have a whistle–blower process, so if people feel that they are not getting heard at certain levels and there are matters that need to be brought to the attention of senior leadership, there is a whistle–blower process for that. All of those processes go towards the different areas in the organisation.[443]

7.37 The Committee heard:

> **Hon SANDRA CARR:** …is there no designated workplace harassment officer or someone who is assigned that specific role to provide that safe space?
>
> **Paramedic:** …None of our operational managers get any training in how to manage reports of sexual assault or sexual harassment. I have raised this so many times through different means with different people and there has been no outcome.[444]

7.38 St John Ambulance WA outlined the training provided for managers and leaders:

> Since 2018 St John have provided full day Performance, Conflict and Conduct training to new and existing People Leaders and Managers across the organisation. Additionally, an abridged version is provided in leadership inductions for positions such as Clinical Support Paramedic and Area Manager pools. The training is also included in Country inductions for employees who are expected to provide leadership to volunteers. The agenda of the full day training is:
>
> - Introduction
> - Unlawful Behaviour
> - Sexual Harassment
> - Managing Performance
> - Managing Conflict
> - Managing Conduct
> - Personal Leave
> - Fitness for Work

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442 ibid., pp 5–6.

443 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 25.

444 Paramedic, transcript of private evidence, 21 September 2021, session six, p 3.

- Considerations during the Processes
  - o Procedural Fairness
  - o File Notes o Employee's Wellbeing during the Process
  - o Wellbeing and Support Services
  - o Support Person

For all formal complaint matters Managers are supported through the investigation process by Employee Relations. Advice and assistance is available for informal matters and any time support is required.[445]

**FINDING 60**

The evidence suggests cultural issues at St John Ambulance WA extends to serious matters such as harassment and bullying and the current processes do not adequately address these matters.

7.39 The Committee heard evidence from witnesses about the complaints process at St John Ambulance WA:

- Employee:

...they had very negative things to say about the process and how they found it to be. One described it as actually ending up going to the CEO directly because they wanted a good outcome for people, but they felt the process was not supporting that, and advised complainants to have a meeting directly with the CEO to get an outcome.

...

Policy and procedure that exists already needs to be updated. There are gaps in the workplace behaviour, training and also policy that does not adequately cover off the legislation...I do not have confidence in the complaints process.[446]

- Paramedic:

I know that if I submit a concern about another staff member that there is no confidentiality at all. Like, it will go to the safety department. The entire department can look at it. All of our operational managers, whoever it gets assigned to, they can look at it.[447]

7.40 The Committee heard evidence regarding Charles Wroth, a long serving St John Ambulance WA volunteer in Toodyay who was asked to leave the organisation in 2019:

**Paramedic:** There was a chairperson in Toodyay who was dismissed by St John Ambulance because he decided to voice concerns over the volunteer cohort he represented at a National Party gathering to try to figure out how they could best represent volunteers in the Wheatbelt region. He said a few things that St John did not like, so they dismissed him for it.[448]

7.41 This version of events was confirmed by Mr Wroth:

[445] St John Ambulance WA, letter, 18 March 2022, p 17.

[446] Employee, transcript of private evidence, 22 September 2021, p 6.

[447] Paramedic, transcript of private evidence, 21 September 2021, session six, p 3.

[448] Paramedic, United Workers Union, transcript of private evidence, 23 September 2021, p 3.

> Often with St John they make changes without any rhyme or reason. You do not get an opportunity to find out exactly why this has happened there. It is more of a dictatorship, "This will be done". A lot of the problems we have had at sub-centres is not getting any response from the hierarchy, from the management, and after a while—all volunteers are busy people; the majority of us work. We have got our own businesses to run. We do this as volunteers, so expect them to get back to us. So, it is very frustrating when you raise issues and you do not hear a thing, and after three or four emails still nothing. That is still occurring today, according to volunteers. Volunteers do not have a lot of faith in the management. The reason why I was sacked was because I spoke up, raised concerns of the way volunteers are treated, and the way that the operation runs with regard to volunteers.[449]

7.42 St John Ambulance WA denied this was the reason for Mr Wroth's termination, and instead pointed to other workplace behaviours as the trigger.[450]

**FINDING 61**

A number of recent inquiries have considered workplace culture at St John Ambulance WA including:

- *St John Ambulance Inquiry: Report to the Minister for Health* (2009)
- *St John Ambulance Review of Workplace Mental Health Risks* (2016)
- *Review of St John Ambulance: Health and Wellbeing, and Workplace Culture* (2016).

Despite this, there continues to be unresolved issues concerning workplace and organisational culture at St John Ambulance WA.

**RECOMMENDATION 35**

The Department of Health require St John Ambulance WA to comprehensively re-evaluate their organisational and workplace structure and processes.

**RECOMMENDATION 36**

The Department of Health require St John Ambulance WA to comply with key performance indicators that measure and map workplace and organisational culture. This requires the identification and implementation of improvement opportunities.

449 Charles Wroth, Private Citizen, transcript of evidence, 23 September 2021, pp 6–7.

450 Michelle Fyfe, St John Ambulance WA, transcript of private evidence, 24 November 2021, p 3.

# CHAPTER 8
# Aboriginal people and remote communities

## Introduction

8.1 This chapter considers a number of issues the Committee heard affect Aboriginal people and remote communities. These include:

- patients transported from remote communities to Perth can be transported to Perth at no cost only to be charged full price for transport between the airport and their destination hospital in Perth
- patients transported from Aboriginal Community Controlled Health Service clinics to hospital are charged full price for transport
- the age of ambulance concession for Aboriginal people should be reduced from 65 to 55 years of age
- some remote communities do not have access to an ambulance service including Western Australia's largest remote Aboriginal community, Bidyadanga regional community
- St John Ambulance WA provides some cultural awareness training for staff
- St John Ambulance WA does not have a Reconciliation Action Plan and are in the process of developing one.

8.2 The Committee has made the following findings and recommendations in relation to these issues:

- ambulance transport fees from Jandakot airport or Aboriginal Community Controlled Health Service clinics should be paid by the Department of Health as if they were inter–hospital patient transfers
- the age of ambulance concession for Aboriginal people will be reduced to 55 years of age under the new Emergency Ambulance Services Agreement
- the Department of Health and WACHS should ensure people in remote communities have access to a reliable ambulance service.

## Ambulance fees from Jandakot airport

8.3 The Committee received evidence that patients transported from remote communities to Perth can be transported to Perth at no cost only to be charged full price for transport between the airport and their destination hospital in Perth:

- Robby Chibawe:

> Aboriginal patients from remote areas face huge ambulance bills for ambulance transfer from the airport (following RFDS flight) to hospital. Patients are often only on Centrelink payments and cannot pay an $800 ambulance bill. It should be treated as inter–hospital transfer with costs covered by the government. Some people are making a choice whether to be evacuated by RFDS or not on cost grounds, putting their health at risk.[451]

[451] Submission 4 from Robby Chibawe, 2 July 2021, p 1.

- Aboriginal Health Council of WA:

  Aboriginal patients transferring from Kimberley or Pilbara community care to Perth are transported by RFDS at no cost, but charged from $489 to $1006 [sic] for [St John Ambulance WA] services from the local airport in Perth to the metro hospital. Patients therefore reluctant and/or refusing to use RFDS emergency flights. (AHCWA understands that for inter–hospital transfers from regional to metro areas, the fee is not charged to the patient which raises further equity concerns).[452]

8.4 In response, WACHS and St John Ambulance WA explained that patients airlifted to Perth from a location not defined as a hospital can be charged for ambulance transport from the airport to the receiving hospital:

- WACHS:

  Patients who are seen at a Hospital* and airlifted from that hospital are deemed as an inter-hospital patient transport response# and are not charged for the transport from airport to metropolitan hospital.

  Patients who are seen or airlifted from a location that is not a defined hospital (ie Aboriginal Medical service, pastoral station, mining camps, town/settlement with no designated hospital) are deemed as Primary** evacuations and may incur a cost.

  ***Hospital** means all public hospitals, regional resources centres, integrated district health services and small hospitals/primary health care centres included in the Metropolitan and WACHS Hospital Services Matrices in the WA Health Clinical Services Framework 2014–2024.

  **#Inter - hospital (planned) patient transport response** means how ambulance services are accessed to transport a person between Hospitals. This may include providing a stage or leg of the transport between ambulance services. Under the contract, this is defined as Category C. This is payable by the relevant hospital that requested the service.

  ****Primary ambulance response** means how a person located in the community accesses ambulance services capability which may include transportation to a hospital. Under the contract, Primary ambulance response is defined as a category A service. For a category A service if the recipient of the service is not a concession patient then the current practice of the Provider is to seek to recover up to 100% of the fee from the patient or a 3rd party.[453]

- St John Ambulance WA:

  The individual or organisation charged for this service is dependent upon where the patient commences their journey.

  In the majority of cases the patient journey has originated in a regional health facility (Nursing Post/Hospital) and the charge is borne by that originating facility provided the patient is not being transferred as a private patient. The remaining cases are charged per standard arrangement which could include:

  - A discounted invoice funded by the State's Seniors Ambulance policy
  - Invoiced to Insurance Commission of WA for motor vehicle related cases

[452] Submission 96 from Aboriginal Health Council of WA, 27 July 2021, p 4.

[453] WA Country Health Service, email, dated 17 March 2022, pp 1–2.

- Invoiced to the Department of Veteran Affairs for valid card holders
- Invoiced to the individual who may be able to claim via their Health Insurance Fund.

A transfer from the RFDS facility to a metropolitan hospital is generally charged as a booked transfer at the rate of $612.[454]

8.5 WACHS and St John Ambulance WA were both supportive of funding to cover the cost of ambulance transport from the airport to hospital for patients who are airlifted to Perth:

- WACHS:

  Given these are patients and

  - they have health care needs which cannot be provided to them at their location; o the need to transfer has been determined by a health care provider at the AMS or by RFDS; and
  - given many of these patients experience barriers arising from socioeconomic factors or other patient specific disadvantages;

  We would support a recommendation to cover the cost, in a similar way to how concession card holders are provided with free ambulance services by the Department of Health.[455]

- St John Ambulance WA:

  In the same way that St John WA advocate for vulnerable members of our community being fully funded, St John WA support a recommendation where the cost of our service is fully funded for public patients who are transported from an air facility to a metropolitan hospital. It would be reasonable for a private patient to continue to be funded via their private health fund.[456]

**FINDING 62**

Patients who are airlifted from a location that is not a defined hospital (i.e. Aboriginal Medical service, pastoral station, mining camp, town/settlement with no designated hospital) may incur a fee for ambulance transport from the airport to a metropolitan hospital. Patients who are airlifted from a hospital are not charged a fee for ambulance transport from the airport to a metropolitan hospital.

**RECOMMENDATION 37**

The Department of Health cover the cost of ambulance transport from Jandakot Airport to hospital for patients who are airlifted to Perth.

## Ambulance fees from Aboriginal Community Controlled Health Service clinics

8.6 Derbarl Yerrigan Health Service, an Aboriginal Community Controlled Health Service (ACCHS) in the Perth metropolitan area advised the Committee their patients are charged a fee when

454 St John Ambulance WA, letter, dated 18 March 2022, p 1.

455 WA Country Health Service, email, dated 17 March 2022, pp 1–2.

456 St John Ambulance WA, letter, dated 18 March 2022, p 2.

transported from one of their clinics to a hospital. In 2020/21 Derbarl Yerrigan contributed $12 500 in ambulance fees for patients who were unable to meet this cost:

> When we call an ambulance from any of our four clinics for our patients, Derbarl fills that bill. When we call an ambulance for any of our patients…we also pick up that bill. I have just got some financial data here that we have paid, this last financial year, $12 500, and that is a combination of assisting patients, settle their bills, but also in covering transport costs where we have needed emergency care for our patients. Then we have also paid $7 500 for a lot of our patients who have high health risks and chronic conditions, to ensure that their health is not compromised should they need an ambulance. However, we have only been able to afford these costs through a special grant, and that grant has now finished. While we will continue to meet our own costs when we have to call an ambulance when patients present at any of our services, unfortunately, we may not be able to continue to support our patients for their subscription for St John Ambulance, which is really going to compromise health outcomes.[457]

8.7 WACHS and St John Ambulance WA confirmed patients transported by ambulance from ACCHS clinics to hospital are required to pay full price:

- WACHS:

> As a ACCHS clinic is not defined as a hospital, patients would be required to pay. WACHS does not have any visibility of the amount charged to those individuals and cannot comment if it is full price.[458]

- St John Ambulance WA:

> With the exception of those residents who belong to communities holding St John Ambulance group membership, the charged for transport are borne by the individual. The standard arrangement where the sending facility is invoiced for transportation costs has not been accepted by ACCHS clinics.[459]

8.8 WACHS and St John Ambulance WA are also aware that ACCHS clinics will pay the fee on behalf of patients who are not able to afford the cost of ambulance transport:

- WACHS

> We have heard some clinics and/or community foundations are paying these. This is ad hoc and we do not have any visibility of which clinics or communities are doing this.[460]

- St John Ambulance WA:

> Yes, St John WA is aware of community clinics covering the ambulance fees for patients who are unable to meet the costs personally.
>
> For some time, St John WA has actively advocated for support to be given to those members of the public who are vulnerable or unable to meet the financial obligations associated with calling an ambulance.

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457 Tracey Brand, Chief Executive Officer, Derbarl Yerrigan Health Service, transcript of evidence, 22 November 2021, p 8.

458 WA Country Health Service, email, dated 17 March 2022, p 2.

459 St John Ambulance WA, letter, dated 18 March 2022, p 3.

460 WA Country Health Service, email, dated 17 March 2022, p 2.

> It is the standard arrangement in Western Australia, via the Service Agreement and the separate NEIHPT contract that a sending facility is invoiced for the road-based transport costs of a public patient.[461]

8.9 WACHS and St John Ambulance WA were both supportive of concessions to cover the cost of ambulance fees for patients transported from ACCHS clinics to hospital:

- WACHS:

> ...given these are patients and
>
> - they have health care needs which cannot able to be provided to them at their location;
> - the need to transfer has been determined by a health care provider at the AMS or by RFDS; and
> - given many of these patients experience barriers arising from socioeconomic factors or other patient specific disadvantages;
>
> We would support a recommendation to cover the cost, in a similar way to how concession card holders are provided with free ambulance services by the Department of Health.[462]

- St John Ambulance WA:

> St John WA has been advocating for some time for this change and funding to be provided for the vulnerable members of our community.[463]

8.10 The Committee supports the Department of Health providing financial assistance to cover the cost of ambulance transport from ACCHS clinics to hospital.

**FINDING 63**

Patients are charged ambulance fees to be transported from Aboriginal Community Controlled Health Service clinics to hospital.

**RECOMMENDATION 38**

The Department of Health cover the cost of ambulance transport from Aboriginal Community Controlled Health Service clinics to hospital.

## Concessions

8.11 The State Government subsidises ambulance fees for Western Australians over 65 years of age.[464] The Aboriginal Health Council recommended these concessions be available to Aboriginal and Torres Strait Islander people over 55 years of age in line with other health concessions.

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461 St John Ambulance WA, letter, dated 18 March 2022, p 4.

462 WA Country Health Service, email, dated 17 March 2022, pp 2–3.

463 St John Ambulance WA, letter, dated 18 March 2022, p 6.

464 Department of Health, *Ambulance fees for seniors and pensioners*. See: https://www.healthywa.wa.gov.au/Articles/A_E/Ambulance-fees-for-seniors. Viewed 7 February 2022.

8.12 The Department of Health confirmed Aboriginal and Torres Strait Islander patients will be eligible for ambulance service concession from 55 years of age under the new Emergency Ambulance Services Agreement.[465]

**FINDING 64**

Aboriginal and Torres Strait Islander people will be eligible for ambulance service concession from 55 years of age under the new Emergency Ambulance Services Agreement.

## Availability of service in remote communities

8.13 Under the Emergency Ambulance Services Agreement, St John Ambulance WA is required to provide an ambulance sub–centre at certain regional locations listed in the Agreement.[466]

8.14 Where there is no local ambulance sub–centre, ambulance services are often provided by a WACHS nursing post or Aboriginal Medical Service.[467] In these locations, local staff attend with off–road vehicles as opposed to a fully outfitted ambulance.

8.15 The Committee heard St John Ambulance WA will not send an ambulance to the Bidyadanga regional community—the largest Aboriginal community in Western Australia. There is no local ambulance sub–centre in Bidyadanga.[468]

8.16 The Committee asked the Department of Health to investigate these claims. It advised St John Ambulance WA are not funded or contracted to provide ambulance services to Bidyadanga under the Emergency Ambulance Services Agreement.[469]

8.17 St John Ambulance WA explained that they are not required to provide ambulance services to Bidyadanga but they will when it is feasible to do so:

> It is often faster for the emergency needs of the community to be services by RFDS when an aeromedical response is warranted. Low and medium acuity transfers can be assisted by meeting the St John WA crew halfway to transport a patient to Broome.[470]

8.18 Table 22 shows the number of ambulance road transfers and aeromedical transfers from Bidyadanga between June and December 2021:

Table 22. *Number of responses provided to Bidyadanga regional community between June and December 2021*

| | Road Transfer | Aeromedical Transfer |
|---|---|---|
| June | 1 | 7 |
| July | 0 | 3 |
| August | 1 | 1 |
| September | 1 | 2 |

[465] Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 November 2021, p 20.

[466] Department of Health, *Emergency Services Agreement*, 25 September 2020, schedule 2.

[467] WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 19.

[468] Dr Lorraine Anderson, Medical Director, Kimberley Aboriginal Medical Services, transcript of evidence, 22 November 2021, pp 4–5.

[469] Department of Health, Answer to question on notice 1 asked at hearing held 24 November 2021, dated 20 January 2022, p 1.

[470] St John Ambulance WA, letter, dated 24 January 2022, p 1.

| | Road Transfer | Aeromedical Transfer |
|---|---|---|
| October | 1 | 5 |
| November | 0 | 1 |
| December | 1 | 9 |

[Source: St John Ambulance WA, Answer to question on notice 1 asked at hearing held 24 November 2021, dated 24 December 2021, p 1.]

**FINDING 65**

Western Australia's largest remote Aboriginal community, Bidyadanga regional community does not have guaranteed access to emergency ambulance transport through St John Ambulance WA.

8.19 The Committee is concerned about the lack of ambulance services in Bidyadanga regional community. The Department of Health should develop a strategy to ensure the availability of ambulance services to local residents.

8.20 The Committee also recommends the Department of Health and WACHS identify any other regional communities that do not have access to ambulance services and develop strategies to address this service gap.

**RECOMMENDATION 39**

The Department of Health develop a strategy to ensure a reliable ambulance service is available in Bidyadanaga regional community.

**RECOMMENDATION 40**

The Department of Health and the WA Country Health Service identify remote Aboriginal communities which do not have access to an ambulance service and investigate the adequacy of existing emergency ambulance services. The Department of Health develop strategies to enhance access to ambulance services to any communities identified.

## Cultural awareness training

8.21 The Aboriginal Health Council of WA told the Committee that St John Ambulance WA does not provide regular cultural awareness training to their staff.[471]

8.22 St John Ambulance WA provided the following evidence about the organisation's cultural awareness training:

> St John WA, engaged Opportunities Without Boundaries Pty Ltd in 2013 to design an Aboriginal Cultural Awareness Training Program to provide a framework for all front–line Ambulance Officers (completing a degree in paramedical science) to improve their understanding of and interaction with Aboriginal peoples of WA…
>
> In 2016 St John WA engaged Kim Bridges and Associates (Indigenous Consulting Group), to develop an Essential Cultural Awareness Training package [for paramedics] that focused upon the history of our Indigenous population and how to enhance St John WA interactions with this community…
>
> Commencing in 2018, St John WA have ensured that all Student Ambulance Officers, Transport Officers and State Operations Call Takers commencing with the

471 Ciaran Summerton, Policy and Strategy Manager, Aboriginal Health Council of WA, transcript of evidence, 22 November 2021, p 8.

> organising complete the WA Government Diverse WA Education program. This program covers all cultures within WA and has links to the government Indigenous education training...
>
> Currently, paramedics who are deployed to any of the six WA regions on a temporary or permanent basis do not have specific Indigenous education due to the diversity of the Indigenous cultures within each region. Upon arriving in the region the paramedics receive an orientation that informs them of the Indigenous cultures within the region.
>
> St John WA is currently developing a cultural awareness program as part of Diversity and Inclusion Strategy and Reconciliation Action Plan, that will be rolled out to all volunteers and paid staff in 2022.[472]

8.23 The Committee considers the development of a Reconciliation Action Plan to be an important step forward for St John Ambulance WA. St John Ambulance WA explained the plan will 'embed policies, procedures and programs that support our strategic objective of building resilient communities'.[473]

8.24 Specific action being undertaken by St John Ambulance WA includes:

> We acknowledge our commitments in the area of reconciliation action plans and diversity and inclusion have been a while in the making, but we are taking purposeful action. We have formed an internal working group to progress a reconciliation action plan. We have engaged the Indigenous Professional Services consultants group to facilitate this process, and we continue to work on our diversity and inclusion strategy to ensure that it is aligned with the best practice guidelines of the Diversity Council Australia.[474]

**FINDING 66**

St John Ambulance WA has not completed a Reconciliation Action Plan.

**FINDING 67**

St John Ambulance WA have committed to progress its Reconciliation Action Plan and to further develop diversity and inclusion strategies.

**RECOMMENDATION 41**

The Department of Health require ambulance service providers to develop a Reconciliation Action Plan before the commencement of any future service agreements.

**RECOMMENDATION 42**

The Department of Health require St John Ambulance WA to provide all staff with regular cultural awareness training.

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472 St John Ambulance WA, letter, 24 January 2022, p 5.

473 Submission 71 from St John Ambulance WA, 23 July 2021, p 50.

474 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, p 3.

# CHAPTER 9
# Ambulance service delivery models and related matters

## Introduction

9.1 This chapter addresses terms of reference (c) and (d). It compares ambulance service delivery models in Australia. This chapter also examines the following issues:

- legislation for Ambulance Services
- St John Ambulance NT
- need for ongoing scrutiny
- length of contract term
- St John Ambulance WA as a not-for-profit organisation
- issues relating to St John Ambulance WA as a private provider.

## Ambulance service delivery models in Australia

9.2 Western Australia is one of only two jurisdictions in Australia where ambulance services are contracted to a private organisation.

9.3 Table 23 sets out an inter–jurisdictional comparison of ambulance organisations in Australia:

Table 23. *Inter–jurisdictional comparison of ambulance organisations in Australia 2019/20*

| | WA | NT | Tas | Vic | NSW | ACT | QLD | SA |
|---|---|---|---|---|---|---|---|---|
| Name of organisation | St John Ambulance WA | St John Ambulance NT | Ambulance Tasmania | Ambulance Victoria | New South Wales Ambulance | Australian Capital Territory Ambulance Service | Queensland Ambulance Service | South Australia Ambulance Service |
| Private/ Public | Private | Private | Public | Public | Public | Public | Public | Public |
| Entity type | An incorporated not for profit organisation under contract to the WA Government | An incorporated not-for-profit organisation under contract to the NT Government | A statutory service of the Department of Health and Human Services | A separate statutory body reporting to the Minister for Ambulance Services | A division of the ministry of Health reporting to the Minister for Health | Government department that reports to the ACT Minister for Police and Emergency Services. | A division of the Department of Health | A statutory incorporated entity reporting to the Minister for Health |
| Legislation | N/A | N/A | *Ambulance Service Act 1982* (Tas) | *Ambulance Services Act 1986* (Vic) | *Health Services Act 1997* (NSW) | Emergencies Act 2004 | *Ambulance Services Act 1991* (Qld) | *Ambulance Services Act 1992* (SA) |
| CCC (or equivalent) oversight of ambulance service | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Metropolitan fees | $1 006 | $815 incl 10km + $5.25km | Free for residents | $1 265 | $401–$6571 (50% for NSW residents) | $982 | Free for residents | $1 044 +$6km |
| Regional fees | Varies | | | $1 866 | | $681 | | $233 |
| Treat and not transport | N/A | N/A | N/A | $546 | N/A | $681 | N/A | $233 |
| Total revenue | $328m | $38.6m | $108.3m | $1 188.6m | $1 111m | $71m | $905.4m | $318.9m |

| | WA | NT | Tas | Vic | NSW | ACT | QLD | SA |
|---|---|---|---|---|---|---|---|---|
| Total revenue per population | $124.28 | $157.59 | $201.7 | $178.7 | $136.68 | $166.17 | $176.48 | $181.26 |
| Total incidents | 339 496 | 45 533 | 83 947 | 972 290 | 960 749 | 53 735 | 1 175 736 | 306 530 |
| Total incidents per 1 000 population | 128.6 | 186 | 156.3 | 146.2 | 118.2 | 125.7 | 229.2 | 174.2 |
| Response locations per 100 000 population | 7.2 | 3.3 | 10.1 | 4.2 | 3.5 | 2.1 | 5.3 | 6.8 |
| General purpose ambulance vehicles | 535 | 43 | 114 | 720 | 1 085 | 30 | 974 | 250 |
| Ambulance response times (mins) | 15.4 | 17.8 | 25.6 | 15.8 | 22.2 | 14.3 | 18.3 | 20.6 |
| Percentile of 000 calls answered within 10 seconds | 86.2 | 93.6 | 97.7 | 94.4 | 91.5 | 95.9 | 91.3 | 95.4 |
| Percentage of patients who reported a clinically meaningful pain reduction | 83.5 | 56.9 | 83.5 | 96.6 | 82.8 | 88 | 82.9 | 70.9 |
| Communications operatives | 103 | 34 | 58 | 127 | 406 | 44 | 472 | 140 |

| | WA | NT | Tas | Vic | NSW | ACT | QLD | SA |
|---|---|---|---|---|---|---|---|---|
| Qualified ambulance officers per 100 000 population | 25.3 | 43.5 | 59.4 | 53 | 40.8 | 34.3 | 69.9 | 53.8 |
| Volunteers | 4 837 | – | 486 | 1 033 | 170 | – | 140 | 1 680 |

[Source: Submission 106 from Department of Health, 31 August 2021, p 9; Australian Government, Productivity Commission, *Report on Government Services 2021*, 28 January 2021.]

## Legislation for ambulance services

9.4 The Country Ambulance Strategy noted there is no legislation governing ambulance services in Western Australia:

> There is no policy or legislation for country ambulance service delivery which causes a lack of clarity over roles, accountabilities and standards.[475]

9.5 Most jurisdictions in Australia do have specific legislation governing ambulance service delivery:

> Across Australia, the legislative framework for ambulance services varies. In New South Wales, South Australia and the Australian Capital Territory, ambulance services are governed by legislation that also governs health or emergency services. Additionally, in Tasmania, Queensland and South Australia the legislation relevant to ambulance services also addresses non-emergency patient transport. Victoria has explicit legislative coverage for non-emergency patient transport.[476]

**FINDING 68**

Western Australia is one of two jurisdictions in Australia where the delivery of ambulance services is not governed by legislation.

9.6 Previous inquiries in Western Australia have discussed the introduction of legislation governing the provision of ambulance services.

9.7 The Joyce Report supported the introduction of legislation with regard to the following issues:

- registration of paramedics
- involvement of the Office of the Auditor General
- freedom of information
- regulation and control of ambulance services, including KPIs
- application of other State legislation.[477]

9.8 The Auditor General Report (2013) noted:

> The [Joyce] Inquiry considered legislation and registration to be important to better control the operations of emergency ambulance services and the conduct of paramedics.
>
> …
>
> There are ambulance services other than SJA operating in WA, providing non-emergency patient transport. Without legislated or other contracted standards in place, these services are subject to internal regulation only. This is a potential risk to patients as well as a clinical governance risk for WA Health, unless adequate contractual arrangements are made with all ambulance services operating in WA.[478]

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475 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 32.

476 Submission 99 from Ray Bange OAM, 30 July 2021, p 17.

477 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 58.

478 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services,* June 2013, pp 9 and 50.

9.9 The Country Ambulance Strategy recommended:

> Establish clear state-wide policy on ambulance services as a minimum and consider enacting legislation in line with other states and territories.[479]

9.10 In December 2021 the Department of Health published *Ambulance services Western Australia – A framework for statewide ambulance services operations* (Framework) which states:

> The Framework provides a conceptual infrastructure for Western Australian ambulance service operations conducted within the scope of the Health Services Act 2016 sets out the fundamental principles and overall direction for delivering ambulance services, providing guidance on the expectations of government, and the Department of Health Chief Executive Officer (the health system manager). guide futures development of more detailed service delivery and procurement requirements, including for specialist ambulance capabilities.[480]

9.11 The Committee considers that while the Framework is a step in the right direction, legislation or a comprehensive ambulance policy for the provision of ambulance services is needed to improve accountability, transparency and standards.

9.12 The Committee encourages the Government to investigate legislating ambulance services in Western Australia or implementing a comprehensive ambulance policy.

**RECOMMENDATION 43**

The State Government investigate:

- introducing legislation to govern ambulance services in Western Australia; or
- implementing a comprehensive policy for ambulance services.

## St John Ambulance Northern Territory

9.13 St John Ambulance NT is the only other private provider of emergency ambulance services in Australia.

9.14 There are some significant differences between St John Ambulance NT and St John Ambulance WA.

### St John Ambulance NT Volunteers not part of pre-hospital and emergency road transport

9.15 Unlike St John Ambulance WA volunteers, the role of volunteers in St John Ambulance NT is:

> operationally separate from the ambulance service and does not form a formal component of the pre-hospital and emergency road transport delivery model. The commercial operations and the volunteer service are separately incorporated bodies.[481]

9.16 The 2017 NT Road Ambulance Service Scoping Review stated that:

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479 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, recommendation 1, p 37.

480 Department of Health, *Ambulance services Western Australia – A framework for statewide ambulance services operations*, December 2021, p 2.

481 Government of Northern Territory, Department of Health, Professor Neale Fong, *NT Ambulance Service Scoping Review*, 1 December 2017, p 47.

The [St John Ambulance NT] volunteer workforce provides first aid at events and is only considered for active operational support when a critical incident response is required (notably in Alice Springs and Darwin).

It is challenging to achieve a stable and sustainable volunteer workforce. In remote settings, many volunteers are employed [St John Ambulance NT] staff or health personnel who themselves are involved in rosters. [482]

**St John NT Ambulance Cover**

9.17 St John Ambulance NT offers ambulance cover for all Territorians. For the St John Ambulance Subscriber, there is no charge for emergency ambulance transport.[483]

9.18 The cost of the cover is shown in Table 24:

Table 24. *St John Ambulance Northern Territory Subscription Scheme*

| | 1 year | 2 years | 3 years |
|---|---|---|---|
| Individual | $110 | $180 | $238 |
| Family | $130 | $238 | $335 |

[Source: St John Ambulance NT, *Subscription Scheme*. https://stjohnnt.org.au/img/documents/forms/ambulance-cover/subscription-scheme.pdf. Viewed 1 April 2022.]

9.19 Country Ambulance Cover in Western Australia is available to all residents living in regional Western Australia.[484] The cost of the cover is shown in Figure 36:

Figure 36. *St John Ambulance WA Country Ambulance Cover*

Memberships

Single Membership – One person per membership.

Family Membership – Includes up to two adults and any children, under 18 years old, that are under the care of the card holders.

Pricing - Country Volunteer Sub Centres

Year

2021-2022

**South of the 26th Parallel**

| | |
|---|---|
| Family | $96 |
| Single | $58 |

[Source: St John Ambulance WA, *Country Ambulance Cover.* See: https://stjohnwa.com.au/ambulance-and-health-services/country-ambulance-service/country-ambulance-cover. Viewed 13 April 2022.]

9.20 The Committee is of the view that people in metropolitan areas could also benefit from ambulance cover.

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482 ibid., p 47.

483 St John Ambulance NT, *Ambulance Cover*. See: https://www.stjohnnt.org.au/ambulance/ambulance-cover.php. Viewed 1 April 2022.

484 St John Ambulance WA, *Country Ambulance Cover.* See: https://stjohnwa.com.au/ambulance-and-health-services/country-ambulance-service/country-ambulance-cover. Viewed 13 April 2022.

**FINDING 69**

St John Ambulance WA provides subscriptions for comprehensive ambulance cover in regional Western Australia. These subscriptions are not available in metropolitan Perth.

**RECOMMENDATION 44**

The Department of Health and St John Ambulance WA investigate expanding the availability of subscriptions for comprehensive ambulance cover to people living in metropolitan Perth.

## The need for ongoing scrutiny

9.21 The 2010 Implementation of Recommendations Report noted that the WA Ambulance Standing Committee was established:

> jointly by the Department of Health and St John Ambulance WA in 2010 to set strategic direction and priorities for the provision of ambulance services; at the same time the SJA Contract Management and Compliance Standing Committee was also established to ensure appropriate management and compliance with the contractual obligations.[485]

9.22 The membership of the WA Ambulance Standing Committee consisted of senior representatives from St John Ambulance WA and the Department of Health including the Director General of the Department of Health and the Chief Executive Officer of St John Ambulance WA.[486]

9.23 In 2013, the Auditor General noted that this high level planning committee had not met for over a year:

> The Ambulance Standing Committee set up under the Contract to enable WA Health and SJA to discuss and resolve strategic and complex issues, such as the funding model and ramping, has not met for over a year.[487]

9.24 Similarly, in 2019 the Auditor General indicated that meetings of the committee were irregular:

> The DoH addresses complex issues with SJA at CEO level through the WA Ambulance Standing Committee. This committee meets quarterly or as necessary to consider SJA reports and issues needing attention (e.g. ramping) as well as planning (e.g. the Winter Strategies).[488]

9.25 Evidence from the Department of Health indicates a perception that the main purpose of the WA Ambulance Standing Committee was to oversee the implementation of the Joyce Report recommendations. Once that process was finalised, it appears the Committee became defunct, with meetings ceasing after 2018:

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485 Department of Health, *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health*, report prepared by Greg Joyce, Independent Reviewer, December 2010, p 21.

486 ibid., p 28.

487 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services,* June 2013, p 54.

488 Office of the Auditor General Western Australia, *Delivering Western Australia's Ambulance Services – Follow–up Audit*, 31 July 2019, p 27.

> **Dr RUSSELL-WEISZ:** ...most of [the Joyce report's] recommendations were closed off and then the actual reporting, the meetings with St John, went down to our contract management team.[489]

9.26 St John Ambulance WA were also asked about this committee:

> **Ms FYFE:** As the chief executive officer of St John WA, I have been to exactly one ambulance standing committee meeting, and that was at the beginning of my tenure at the end of 2018...whilst there have not been ambulance standing committee meetings, there has been a concerted effort by both myself and St John WA and the Department of Health and the director general of Health to have more regular meetings, more regular discussion and exchanges of information. All the outcomes to be derived from an ambulance standing committee are being derived in other ways.[490]

9.27 The Committee was advised that the Department of Health is reviewing its communication arrangements with St John Ambulance WA:

- St John Ambulance WA:

> The Department of Health abandoned the WAASC [WA Ambulance Standing Committee]. St John has requested on numerous occasions for the WAASC or a suitable alternative to be re-established to provide a platform for emergency ambulance issues and set strategy and policy directives.
>
> The Department of Health has since confirmed that it is currently reviewing the WAASC, including existing communication processes with contracted patient transport providers with a view to identify and address gaps as required.
>
> St John seeks the restoration of the WAAASC (or alternative) for emergency ambulance services with the Department of Health. St John are advocating for a forum to provide responsible stewardship of the current and future ambulance service in WA, including strategic direction setting and governance functions.[491]

- Department of Health:

> The Department is undertaking a review of the current meeting structure and existing communication processes with contracted patient transport providers to identify and address gaps as required.
>
> There are numerous committees and groups (including Emergency Access Response Group and the contract management team) that meet with SJA on a regular basis to discuss issues relating to patient transport, emergency department avoidance and patient flow, and mattes associated with the WA Ambulance service agreement.[492]

9.28 The Committee is of the view important strategic discussions should take place in a formal setting as was the case with the WA Ambulance Standing Committee where there is a degree of accountability and transparency.

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489 Dr David Russell-Weisz, Director General, Rob Anderson, Assistant Director General, Department of Health, transcript of evidence, 24 September 2021, p 19.

490 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 29 October 2021, p 33.

491 St John Ambulance WA, letter, dated 10 March 2022, p 2.

492 Department of Health, letter, dated 3 March 2022, pp 3–4.

9.29 The Committee was advised that the Contract Management and Compliance Standing Committee continues to meet however evidence from the Department of Health shows that they are not conducted on a regular basis.[493]

**FINDING 70**

In 2010 the *St John Ambulance Inquiry: Implementation of Recommendations Completion Report to the Minister for Health* noted the establishment of the WA Ambulance Standing Committee to set the strategic direction and priorities for the provision of ambulance services. The Committee has since been abandoned.

9.30 Inquiries and reviews into ambulance services in Western Australia over the last 30 years have been ad hoc. Despite some positive outcomes the ad hoc nature of these reviews means that issues are not assessed and reviewed on a regular basis.

9.31 For this reason, the Committee considers there should be ongoing parliamentary oversight over emergency ambulance services in Western Australia.

9.32 The Committee suggests an existing parlaimentary standing committee be given additional functions to monitor, review and report on the provision of emergency ambulance services or a new standing committee be established and given such functions.

**RECOMMENDATION 45**

The State Government and Parliament of Western Australia require an existing parliamentary standing committee be given additional functions to regularly monitor, review and report on the provision of emergency ambulance services. Alternatively a new standing committee be established and given such functions.

## Length of contract term

9.33 Historically contracts for emergency ambulance services in Western Australia were for a term of five years.[494] Recent versions of the Emergency Ambulance Services Agreement have had terms of 3 and 2 years:

- In 2015 an Emergency Ambulances Services Agreement was signed with an expiry date of 30 June 2018.
- In 2018 the expiry date of the Emergency Ambulance Services Agreement was extended until 30 June 2020.
- On 1 October 2020 a Deed of Amendment, Release and Restatement was signed extending the Emergency Ambulance Services Agreement until 30 June 2022.

9.34 A five year term provides the Department of Health flexibility in contracting a service provider. The potential downside of a five year term is that it may not incentivise contractors to make investments beyond the five year term.

9.35 The Country Ambulance Strategy commented that the current contract term does not foster long term strategic investment.[495] It recommended contractual periods align with

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493 Department of Health, Answer to question on notice 8 asked at hearing held 24 September 2021, dated 21 October 2021, p 152.

494 Department of Health, *St John Ambulance Inquiry: Report to the Minister for Health*, report prepared by Greg Joyce, Independent Chairman, October 2009, p 16.

495 WA Country Health Service, *Country Health Strategy*, 2019, p 60.

contemporary best practice; and are long enough to enable providers to invest for effective service delivery.[496]

9.36 St John Ambulance WA advised the current term of the Emergency Ambulance Services Agreement hinders large–scale investment decisions:

> While the partnership between the state and the St John organisation stretches over a century, the contractual relationship of the services agreement is one that has not been certain in nature. The current agreement has been short term and subject to rollover and that hampers any large–scale investment decisions that we would make.[497]

9.37 St John Ambulance WA considers the optimum contract length to be 10 years with two 5 year options. In their view this would better service the community. Department of Health contracts hospitals for 20 years which provides certainty to invest in the hospital system, technology and equipment:

> If you look at the way the Department of Health contracts with hospitals, those contracts go out over 20 years and there are a number of points within that contract. But that enables considerable investment into the hospital system and hospitals' technology equipment. All of those infrastructure—all of those sorts of things. An extended contract like that would better serve the Department of Health. It would better serve St John, but also would better serve our patients and our community, because there would be some continuity and certainty. So, I would say a minimum of 10—five plus five—but I do believe that it should stretch out to 20.[498]

9.38 The Department of Health prefers a five year term:

> The Department believes that a five year term for the next contract with SJA is the most beneficial option to ensure a contemporary Service Agreement.
>
> This will enable both the Department and SJA to have the flexibility to implement service improvements, whilst providing SJA with a level of certainty and commitment that fosters positive negotiations and enables further investment in capacity.[499]

**FINDING 71**

The Department of Health believe a five year term for the next Emergency Ambulance Services Agreement is most beneficial. St John Ambulance WA prefer a 10 year term with two five year options.

## St John Ambulance WA as a not–for–profit organisation

9.39 St John Ambulance WA is a not–for–profit private company. It is subject to the *Corporations Act 2001* (Cth) and is regulated by the Australian Securities & Investments Commission and the Australian Charities and Not–for–profits Commission.

9.40 A not–for–profit organisation means the organisation does not operate for the profit or gain of its individual members.

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496 ibid., recommendation 19.

497 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 November 2021, p 2.

498 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 24 September 2021, p 34.

499 Department of Health, letter, dated 3 March 2022, pp 4–5.

9.41 There are no incentive or bonus payments to the Chief Executive Officer, board or senior management related to individual performance or the profitability of the organisation.[500]

9.42 National Patient Transport submitted that St John Ambulance WA's status as a not–for–profit provides them with an unfair competitive advantage against other providers:

> Not for Profit status afforded to St John's Ambulance results in competitive distortions. Tax exemptions, such as payroll tax, on inputs can provide a competitive advantage to the company creating a difference between the prices paid for inputs and their cost to others in the market. NFP's [not–for–profit] employment cost structure enables them to under bid commercial entities who are ineligible for the concessions afforded by this status.
>
> NFPs have the additional benefit of attracting a greater staff pool, as their staff are offered more generous after–tax remuneration packages. As outlined in the consultation paper 'better targeting of not–for–profit tax concessions', a fairer way of assessing pricing submissions is to account for the concessions that have been afforded to those NFPs, providing a level playing field for commercial and NFP entities. St John as a NFP in the [non–emergency patient transfer] sector has significant advantages and it our belief that if a NFP is operating in open commercial market it should be treated as a commercial business for that segment of its business.[501]

9.43 As a not-for-profit St John Ambulance WA has exemptions and concessions from paying Fringe Benefit Tax, Goods and Services Tax and Income Tax.[502]

9.44 The Department of Health advised there are other not–for–profit organisations that operate in the healthcare sector such as St John of God Healthcare.[503]

## Issues relating to a private provider

9.45 St John Ambulance WA told the Committee some of their net reportable surpluses are reinvested back in the organisation:

> That takes the form of capital investment. For example...the Ellenbrook sub–centre being built. That comes out of the net reportable surplus. That is the reinvestment into the organisation, and vehicles, equipment—all those things. The net reportable surplus is generated for us to be able to reinvest back into the organisation.
>
> ...
>
> There is a very extensive forward estimates process that we undertake—so, a forecasting process and a budgeting process, all of which is ultimately taken to the board of St John WA. But I should clarify that we run five businesses and that net reportable surplus has contributions from all those businesses.[504]

9.46 The Country Ambulance Strategy pointed out the Emergency Ambulance Services Agreement does not require reinvestment of profit back into ambulance services:

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500 St John Ambulance WA, letter, dated 24 January 2022, p 80.

501 Submission 119 from National Patient Transport, 19 November 2021, pp 3–4.

502 St John Ambulance WA, *Annual Report 2020/21*, See: https://stjohn.org.au/assets/uploads/annual%20reports/2021_Annual_Report.pdf, p 2. Viewed 13 April 2022.

503 Dr David Russell–Weisz, Director General, Department of Health, transcript of evidence, 24 November 2021, p 21.

504 Michelle Fyfe, Chief Executive Officer, St John Ambulance WA, transcript of evidence, 29 October 2021, p 34.

> In FY'16, SJA reported a surplus of $22.2M after tax across both metropolitan and country services (During FY'15 SJA posted a surplus of $21.5M after tax). There is no requirement in the contract for an investment plan to reinvest any surplus back into the services and infrastructure for ambulances in WA. The lack of direction provided in the contract limits the analysis that can be performed by the contract holder regarding whether funding is allocated efficiently and effectively.[505]

9.47 St John Ambulance WA is a financially successful enterprise with net reportable surplus of $31.9 million in 2020/21 and $14.3 million in the 2019/20.[506]

9.48 There is no requirement in the Emergency Ambulance Services Agreement for an investment plan to reinvest any surplus back into the services and infrastructure for ambulances in Western Australia. Furthermore, there is no oversight that can investigate how surplus funds can be reinvested in the organisation.

9.49 The Committee suggests the Department of Health and St John Ambulance WA consider a mechanism in the Emergency Ambulance Services Agreement for an investment plan. This plan should consider reinvestment and oversight of any surplus from government funded activities back into the delivery of emergency ambulances services in Western Australia.

**FINDING 72**

As a not-for-profit St John Ambulance WA has exemptions and concessions from paying Fringe Benefit Tax, Goods and Services Tax and Income Tax. This gives St John Ambulance WA a competitive advantage against other ambulance service providers.

**FINDING 73**

There is no requirement in the Emergency Ambulance Services Agreement for St John Ambulance WA to reinvest any surplus back into the services and infrastructure for ambulances in Western Australia.

**RECOMMENDATION 46**

The Department of Health and St John Ambulance WA consider a mechanism in the Emergency Ambulance Services Agreement for an investment plan. This plan should consider reinvestment and oversight of any surplus from government funded activities back into the delivery of emergency ambulances services in Western Australia.

## Moving forward

9.50 Term of reference (c) requires the Committee to consider:

> whether alternative service delivery models in other jurisdictions would better meet the needs of the community.

9.51 This inquiry has identified a number of shortcomings in the provision of ambulance services in Western Australia. In addressing these shortcomings, the Committee's recommendations seek to improve the adequacy and efficiency of our ambulance service. To this end the

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505 WA Country Health Service, *The Country Ambulance Strategy: Driving Equity for Country WA*, 2019, p 28.

506 St John Ambulance WA, *Annual Report 2020/21*. See: https://stjohnwa.com.au/docs/default-source/annual-report-2015/20-21-annual-report_digital.pdf?sfvrsn=6134ebb2_4. Viewed 1 April 2022; St John Ambulance WA, *Annual Report 2019/20*. See: https://stjohnwa.com.au/docs/default-source/corporate-publications/annual-report-2019-2020-digital.pdf?sfvrsn=f762e9b2_2. Viewed 1 April 2022.

section below examines whether an integrated ambulance service would provide better outcomes for the community.

### Integrated healthcare

9.52 The Committee heard integrated health services work better to provide public health care:

> Numerous research studies (Suter, 2009), Government reports (Goodwin) and consulting reports (McKinsey, 2011) have identified that integrated health services work better in providing public health care than a series of non-integrated services…An ambulance service where the only option is to transport to an emergency department will increase emergency department presentations, result in ambulance ramping and may not result in the most optimal health pathway for the patient, thus decreasing satisfaction with the government and the health system in general.
>
> …
>
> A private ambulance service, as is run in Western Australia, does not promote integration because the providers focus is on revenue to ensure sustainability, rather than providing an integrated service which will take pressure off hospitals, and improve cost efficiency across the entire health system.
>
> …
>
> There are numerous examples interstate of alternative care pathways reducing pressure on transports to hospital, including referral to urgent care (Agency for Clinical Innovation, n.d.), community paramedics (National Centre for Biotechnology Information, 2017) (Blacker, 2009) and telehealth (Bergrath, 2021) (James, 2021) which could be implemented in WA, however there is no incentive for the private ambulance service to do so. An integrated government service could have these incentives. [507]

9.53 The key points of relevance to this inquiry are:

- integrated health services work better in providing public health care than a series of non-integrated services
- if the provider's focus is on revenue to ensure sustainability, rather than providing an integrated service which will take pressure off hospitals, and improve cost efficiency across the entire health system, it does not promote integration.

9.54 The Committee acknowledges there are likely to be benefits of an ambulance service that is integrated with the broader public health system.

**FINDING 74**

There is a case to bring the ambulance service into public hands however a private provider may deliver essential government services, so long as it provides the services to a similar or higher standard as would a public entity. Private providers of essential public services must be subject to the same oversight and scrutiny as a public body.

9.55 Despite a number of previous inquiries and reports, many of the issues identified have not yet been resolved.

[507] Submission 57 from Professor Cobie Rudd, Edith Cowan University, 22 July 2021, p 2.

9.56 The Committee believes that the State Government should review the implementation of any recommendations it adopts from this report within the next five years.

**RECOMMENDATION 47**

The State Government review the implementation of any recommendations it adopts from this report within the next five years.

9.57 The Department of Health should develop broader KPIs that incorporate the recommendations of this report. If the service fails to meet these KPIs, the State Government should consider alternative emergency ambulance service providers or a state–run service.

**RECOMMENDATION 48**

The Department of Health develop broader key performance indicators (KPIs) that incorporate the recommendations of this report. If the service fails to meet these KPIs, the State Government should consider alternative emergency ambulance service providers or a state–run service.

## Concluding remarks

9.58 The Committee would like to extend its appreciation to all those who have contributed to this inquiry, including but not limited to career paramedics, staff members in the SJA SOC, volunteers, St John Ambulance WA, WACHS, the Department of Health and community members who take a keen interest in the ambulance services in Western Australia.

9.59 The Committee concludes this report by quoting the following passages from a submission:

> St John WA have been subjected to several reviews and investigations during my career as a Paramedic. Some reviews have focused on clinical response and care, others have focused on health and wellbeing while others have focused on wellbeing and culture.
>
> St John WA have responded to these reviews and investigations with a mix of success and change. There has also been a healthy dose of rhetoric which theoretically ticks the box but stops short on substance. The organisations response to the latest culture survey is testament to this.
>
> I have to admit, that the ambulance service of today in Western Australia is vastly improved from the ambulance service of…years ago. It puzzles me therefore why I am witness to the lowest staff morale and distrust of management I have ever seen in my career.
>
> As a carer [sic] Paramedic I feel nothing more than a number. I have been recognised on multiple occasions by the community I have served, however I feel I am despised and treated with indifference by management…
>
> I am not alone. Career Paramedics have a desire to help people. I along with others do not believe that our reason for doing our job is replicated by our employer. This is having an effect on the delivery of our service.
>
> Paramedics are booking off work and not being replaced, compounding the frustrations and fatigue issues being experienced by other crews. This is happening within the call/dispatch centre and on the road. St John management talk about their recruitment program, however they don't talk about their attrition rate. They also don't talk about the number of management positions that have been created, many of which have removed clinical staff off the road to occupy ineffective positions.

From a clinical perspective, St John WA Paramedics have never been in a better position with medications and skills they can utilise when required. Western Australian community members are well placed to take advantage of the scope and skill of Western Australian Paramedics if they get one allocated to them.

This inquiry is being followed with a great degree of hope. Ramping at hospitals is a key frustration with clinical crews however as mentioned above, until a coordinated approach between the Health Department and the ambulance service can be reached to explore and try other options, the problem will continue to grow.

I once again thank the Public Administration Committee for the opportunity to make a submission to the inquiry into the delivery of ambulance services in Western Australia.[508]

Hon Pierre Yang MLC
**Chair**

[508] Submission 40 from Private Citizen, 21 July 2021, p 8.

# APPENDIX 1

## STAKEHOLDERS, SUBMISSIONS RECEIVED AND PUBLIC HEARINGS

### Stakeholders contacted

| Number | From |
|---|---|
| 1. | Department of Health |
| 2. | Silver Chain Group |
| 3. | Australian Medical Association |
| 4. | Australian Medical Association (WA) |
| 5. | Royal Australian College of General Practitioners WA |
| 6. | WA Primary Health Alliance |
| 7. | Royal Australian and New Zealand College of Psychiatrists |
| 8. | Chief Psychiatrist of Western Australia |
| 9. | Australian Nursing and Midwifery Federation |
| 10. | Allied Health Professionals Australia |
| 11. | Australian Psychological Society |
| 12. | Aboriginal Health Council |
| 13. | South West Aboriginal Medical Service |
| 14. | Kimberley Aboriginal Medical Services |
| 15. | NDIS State Director Western Australia |
| 16. | Office of the Public Advocate |
| 17. | Health and Disability Services Complaints Office |
| 18. | Fiona Stanley Hospital Group |
| 19. | King Edward Memorial Hospital |
| 20. | Child and Adolescent Health Service |
| 21. | St John of God Health Care |
| 22. | Sir Charles Gairdner Osborne Park Health Care Group |
| 23. | Armadale Health Service |
| 24. | Osborne Park Hospital |
| 25. | Rockingham General Hospital |

| Number | From |
|---|---|
| 26. | East Metropolitan Health Service |
| 27. | Royal Perth Bentley Group |
| 28. | Fremantle Hospital |
| 29. | Joondalup Health Campus |
| 30. | Peel Health Campus |
| 31. | St John of God Midland Public Hospital |
| 32. | Hollywood Private Hospital |
| 33. | St John of God Hospital Subiaco |
| 34. | St John of God Hospital Murdoch |
| 35. | St John of God Health Care |
| 36. | WA Country Health Service |
| 37. | Glengarry Private Hospital |
| 38. | Jane Mouritz |
| 39. | St John of God Health Care Bunbury |
| 40. | St John of God Geraldton Hospital |
| 41. | Busselton Hospice Care Inc. |
| 42. | St John of God |
| 43. | WA Centre for Rural Health |
| 44. | University of Western Australia Division of Psychiatry |
| 45. | University of Notre Dame, School of Medicine |
| 46. | Murdoch University College for Science, Health, Engineering and Education |
| 47. | Curtin University, Health Sciences |
| 48. | Western Australian Local Government Association (WALGA) |
| 49. | WA Country Health Service – Broome |
| 50. | Broome Regional Health Campus |
| 51. | West Kimberley Health Service |
| 52. | WA Country Health Service – East Kimberley |
| 53. | WA Country Health Service – Pilbara |
| 54. | WA Country Health Service – East Pilbara |

| Number | From |
|---|---|
| 55. | WA Country Health Service – Pilbara Mental Health and Drug Service |
| 56. | WA Country Health Service – Karratha |
| 57. | WA Country Health Service – Midwest |
| 58. | Geraldton Hospital |
| 59. | Carnarvon Health Campus |
| 60. | WA Country Health Service – Goldfields |
| 61. | Kalgoorlie Regional Hospital |
| 62. | Esperance Hospital |
| 63. | WA Country Health Service – Wheatbelt |
| 64. | Northam Health Service |
| 65. | Merredin Health Service |
| 66. | WA Country Health Service – Narrogin |
| 67. | WA Country Health Service – South West |
| 68. | WA Country Health Service – South West Inland |
| 69. | Collie Hospital |
| 70. | Kalamunda District Hospital Palliative Care |
| 71. | Busselton Health Campus |
| 72. | WA Country Health Service – South West Leeuwin |
| 73. | WA Country Health Service – South West Coastal |
| 74. | WA Country Health Service – Great Southern |
| 75. | Albany Health Campus |
| 76. | WA Country Health Service – Great Southern |
| 77. | Spinifex Health Service Tjuntjuntjara |
| 78. | Bega Garnbirringu Health Service |
| 79. | Ngangganawili Aboriginal Health Service Wiluna |
| 80. | South West Aboriginal Health Service |
| 81. | Moorditj Koort Aboriginal Health Service |
| 82. | Derbarl Yerrigan Health Service |
| 83. | Geraldton Regional Aboriginal Medical Service |

| Number | From |
|---|---|
| 84. | Carnarvon Medical Service Aboriginal Corporation |
| 85. | Puntukurnu Aboriginal Medical Service |
| 86. | Mawarnkarra Health Service |
| 87. | Wirraka Maya Health Service |
| 88. | Kimberley Aboriginal Medical Service |
| 89. | Broome Regional Aboriginal Medical Service |
| 90. | Milliya Rumurra Aboriginal Corporation |
| 91. | Derby Aboriginal Health Service |
| 92. | Nirrumbuk Aboriginal Corporation |
| 93. | Beagle Bay Community Health Service |
| 94. | Nindilingarri Cultural Health Service |
| 95. | Ord Valley Aboriginal Health Service |
| 96. | Halls Creek Aboriginal Medical Service |
| 97. | Ngnowar Aerwah Aboriginal Corporation |
| 98. | Yara Yungi Aboriginal Medical Service |
| 99. | Great Southern Aboriginal Health Service |
| 100. | Nganyatjarra Health Service |
| 101. | Bidyadanga Aboriginal Community Health Service |
| 102. | Sirens of Silence Charity Inc. |
| 103. | Council of Ambulance Authorities |
| 104. | St John Ambulance Western Australia Ltd |
| 105. | Royal Flying Doctor Service WA |
| 106. | Department Fire and Emergency Services |
| 107. | Western Australia Police Force |
| 108. | South Australian Ambulance Service |
| 109. | United Workers Union |
| 110. | College of Emergency Nursing Australasia |
| 111. | University of Western Australia – Centre for Clinical Research in Emergency Medicine |
| 112. | Edith Cowan University – School of Medical and Health Sciences |

| Number | From |
|---|---|
| 113. | Australian College of Rural and Remote Medicine |
| 114. | Australian College of Emergency Medicine |
| 115. | Health Consumers' Council of WA |
| 116. | Carers WA |
| 117. | Rural Health West |
| 118. | Consumers of Mental Health WA |
| 119. | Western Australian Association for Mental Health |
| 120. | Australian Federation of Disability Organisations |
| 121. | Ethnic Communities Council WA Inc. |
| 122. | Albany Community Hospice |
| 123. | Minister for Health – Western Australia |
| 124. | Minister for Health – Australian Capital Territory |
| 125. | Minister for Health – New South Wales |
| 126. | Minister for Health – South Australia |
| 127. | Minister for Health – Victoria |
| 128. | Minister for Health – Tasmania |

## Submissions received

| Number | From |
|---|---|
| 1 | Private Citizen |
| 2 | David McCallum |
| 3 | Ashley Coles |
| 4 | Robby Chibawe |
| 5 | Linton Rumble |
| 6 | Private Submission |
| 7 | Private Citizen |
| 8 | Doughlas Dias |
| 9 | Private Submission |
| 10 | Private Citizen |
| 11 | Private Citizen |

| Number | From |
| --- | --- |
| 12 | John Macdonald |
| 13 | Greg Drew |
| 14 | David Booth |
| 15 | Private Citizen |
| 16 | Private Citizen |
| 17 | Shire of Lake Grace |
| 18 | Donna Livingstone |
| 19 | Pat Elliot |
| 20 | Private Citizen |
| 21 | Chamber of Commerce and Industry WA |
| 22 | Private Citizen |
| 23 | Regional Medical Specialists Association |
| 24 | John McCallum |
| 25 | Private Citizen |
| 26 | Private Submission |
| 27 | Private Citizen |
| 28 | Gale Williams |
| 29 | Charlotte Della Vedova |
| 30 | Judy Gibson |
| 31 | Private Submission |
| 32 | Shire of Mt Marshall |
| 33 | Margaret River Sub Centre, St John Ambulance |
| 34 | Susan Barrett |
| 35 | Prof Daniel Fatovitch |
| 36 | Hon Martin Aldridge MLC |
| 37 | Anthony Charlton |
| 38 | John Honey |
| 39 | Headspace |
| 40 | Private Citizen |

| Number | From |
|---|---|
| 41 | Private Citizen |
| 42 | Shire of Carnamah |
| 43 | Private Submission |
| 44 | Mitchell Shand |
| 45 | Private Citizen |
| 46 | Private Citizen |
| 47 | Private Citizen |
| 48 | Kon Karalis |
| 49 | Private Citizen |
| 50 | Shire of Manjimup |
| 51 | Paul Filing |
| 52 | Rodney Barrett |
| 53 | Private Submission |
| 54 | Private Citizen |
| 55 | Nancy Habermehl |
| 56 | Private Submission |
| 57 | Edith Cowan University |
| 58 | St John Ambulance Katanning |
| 59 | Wayne Fletcher |
| 60 | Tjerk Slagman |
| 61 | East Metropolitan Health Service |
| 62 | Private Submission |
| 63 | Private Citizen |
| 64 | Derek Jobe |
| 65 | Private Citizen |
| 66 | Private Citizen |
| 67 | Health Consumers’ Council |
| 68 | Private Citizen |
| 69 | Private Citizen |

| Number | From |
|---|---|
| 70 | Johnbosco Njuguna |
| 71 | St John Ambulance WA Ltd |
| 72 | Australasian College of Paramedic Practitioners |
| 73 | Byron Bacchioni |
| 74 | Shire of Wagin |
| 75 | Private Citizen |
| 76 | Private Citizen |
| 77 | Simone Stiles |
| 78 | Ambulance Employees Association of WA |
| 79 | Private Submission |
| 80 | Rob Gibson |
| 81 | Private Citizen |
| 82 | Kulin Shire Council |
| 83 | Private Submission |
| 84 | Western Australian Local Government Association (WALGA) |
| 85 | Private Citizen |
| 86 | Private Citizen |
| 87 | Private Submission |
| 88 | Private Citizen |
| 89 | Geoffrey Pratt |
| 90 | John Clark |
| 91 | Private Submission |
| 92 | Australian College of Emergency Medicine |
| 93 | Derbarl Yerrigan Health Service |
| 94 | Charles Wroth |
| 95 | Royal Australian College of General Practitioners |
| 96 | Aboriginal Health Council of Western Australia |
| 97 | Health and Disability Services Complaints Office |
| 98 | College for Emergency Nursing Australasia WA Branch |

| Number | From |
|---|---|
| 99 | Ray Bange |
| 100 | Royal Flying Doctor Service (WA) |
| 101 | Australian Medical Association (WA) |
| 102 | United Workers Union |
| 103 | Private Citizen |
| 104 | Not accepted |
| 105 | Private Submission |
| 106 | Department of Health |
| 107 | Child and Adolescent Health Service |
| 108 | WA Country Health Service |
| 109 | Private Citizen |
| 110 | Private Submission |
| 111 | Private Submission |
| 112 | Private Submission |
| 113 | Private Submission |
| 114 | Private Submission |
| 115 | Private Citizen |
| 116 | Australasian College of Paramedicine |
| 117 | Anna Gillespie |
| 118 | Private Submission |
| 119 | National Patient Transport |
| 120 | Private Submission |
| 121 | Wilson Medic One |
| 122 | Private Submission |
| 123 | Private Submission |

# APPENDIX 2

## HISTORY OF ST JOHN AMBULANCE WA

## BLESSED ORDER OF ST JOHN

2.1 Established in 1048AD by the Blessed Brother Gerard at the time of the Crusades, the Order began as a hospice for pilgrims and the local population and served people of all faiths.

2.2 The Order of St John remains among the oldest chivalric and religious organisations in the world. The Order's motto: Pro Fide, Pro Utilitate Hominum (For Faith, For Service to Humanity) serves as a member's moral compass and is upheld by all members while they strive to serve the sick, poor, and the needy worldwide to the best of their ability.

2.3 Membership of the Order is by invitation only. The vision of the Order of St John is:

> To be an Ecumenical Order, with its roots deep in Knighthood, seeking in today's society to:
>
> promote Christian unity.
>
> practise charity.
>
> inspire compassion.
>
> To unify, under the Constitution of King Peter II, Units and Orders now separated.[509]

## ST JOHN AMBULANCE WA

2.4 The St John organisation dates back to 11th century Jerusalem, when a hospice was established to provide care and shelter to pilgrims and crusaders. Its modern roots derive from UK–based organisations established in the 1870s which aimed to provide first aid training to treat workplace injuries and provide medical assistance during times of need.

2.5 St John began offering medical services in Australia in 1883. In 1891 it expanded its service to include a centre in Perth. Initially the service involved providing first aid training. The first training class in 1892 was attended by 20 police, 10 railway workers and two members of the community. By 1900, 176 students had passed St John Ambulance first aid courses.

2.6 At this time, there was no ambulance service in WA and patients were transported to hospitals by various ambulance corps including the Fire Brigade, Police, Railways, and the Fremantle Port Authority.

2.7 As WA began to grow in the 20th century, demand for a central ambulance service was recognised. In 1922, following the completion of a new ambulance depot in Murray Street, Perth, St John assumed full responsibility for Perth's ambulance service. In its first full year of operation, St John attended 1911 calls covering 9180 miles. The total cost of $2836 was met entirely by community subscription.

2.8 By 1930, there were 3277 patients transported in the Perth area. Ambulance services were extending to regional areas with the several sub–centres established including in Kalgoorlie, Boulder and Fremantle. In addition to community donations, St John was receiving some

[509] Order of St John of Jerusalem Knights of Hospitaller – Australasia. See: https://osjaustralasia.org.au/. Viewed 1 April 2022.

funding from municipalities and Road Boards, although these contributions were minor relative to the cost of operation.

2.9 In 1933 the Lotteries Commission made its first of many annual grants to St John, beginning what was to be a long standing financial relationship between the two organisations. It was not until the end of the 1940s that the State Government began contributing to the service.

2.10 During the 1940s St John operations escalated significantly, with World War II stimulating unprecedented demand for first aid training. Between 1939 and 1945 St John issued 41 962 certificates, which was equivalent to one in every 12 West Australians.

2.11 Growth was steady in the 30 years to 1970. Patient calls in 1970 had increased to 17 381 in the metropolitan area. The number of regional sub–centres had grown to nearly 100. In 1979 St John changed its structure from a charity to a not–for–profit organisation, allowing it to move towards more reliable funding sources than donations such as an ambulance contribution scheme and government subsidies.

2.12 The 10 years to 1984 saw dramatic changes to ambulance services. In 1983/84, 51 000 patients were transported in the metropolitan area and 15,942 in regional areas. Regional sub–centres had increased to 103 of which 8 had paid staff in conjunction with the traditional volunteer base. The Government subsidy had increased to in excess of $6 million at this time and the Lotteries Commission provided grants for capital works in regional areas totalling $450 000. A 1985 structural review resulted in all states being brought together under one entity: St John Ambulance Australia.

2.13 Since this time, St John has continued to grow and expand its services. In 1995 it opened a new branch, Community Care, which expanded its scope of service from first aid and medical assistance to providing general support to the elderly via shopping, excursions and social contact.

2.14 In the more than 100 years that St John Ambulance WA has operated, its model has changed from a first–aid provider with strong roots in the UK to a non–for–profit organisation with WA leadership that is the exclusive provider of ambulance services in Western Australia.

# APPENDIX 3

## ROYAL FLYING DOCTOR SERVICE (WA) RESPONSE TIMES 2020/21

| Hospitals NOT CO-LOCATED with an RFDS base | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2021 | | | | 2020 | | | | Variance | | | | Variance % | | | |
| **DESCRIPTION** | **P1** | **P2** | **P3** | **All** | **P1** | **P2** | **P3** | **All** | **P1** | **P2** | **P3** | **All** | **P1** | **P2** | **P3** | **All** |
| **Number of patients** | 500 | 3,173 | 2,707 | 6,380 | 394 | 2,846 | 2,375 | 5,615 | 106 | 327 | 332 | 765 | 27% | 11% | 14% | 14% |
| **Target response times** | | | | | | | | | | | | | | | | |
| Authorisation to arrival at pickup airport less average flying time | 1:15:00 | 4:30:00 | 48:00:00 | | 1:15:00 | 4:30:00 | 48:00:00 | | | | | | | | | |
| Monthly percent of target contract response times met | 80.0% | 90.0% | 95.0% | | 80.0% | 90.0% | 95.0% | | | | | | | | | |
| **Actual response times** | | | | | | | | | | | | | | | | |
| Monthly 80th percentile of contract response time | 1:22:00 | 6:47:00 | 41:11:00 | | 1:19:00 | 6:25:00 | 42:11:00 | | | | | | | | | |
| Monthly percent of target contract response times met | 77.0% | 75.9% | 97.6% | | 77.2% | 79.5% | 97.2% | | -0.2% | -3.6% | 0.4% | | -0.3% | -4.5% | 0.4% | |

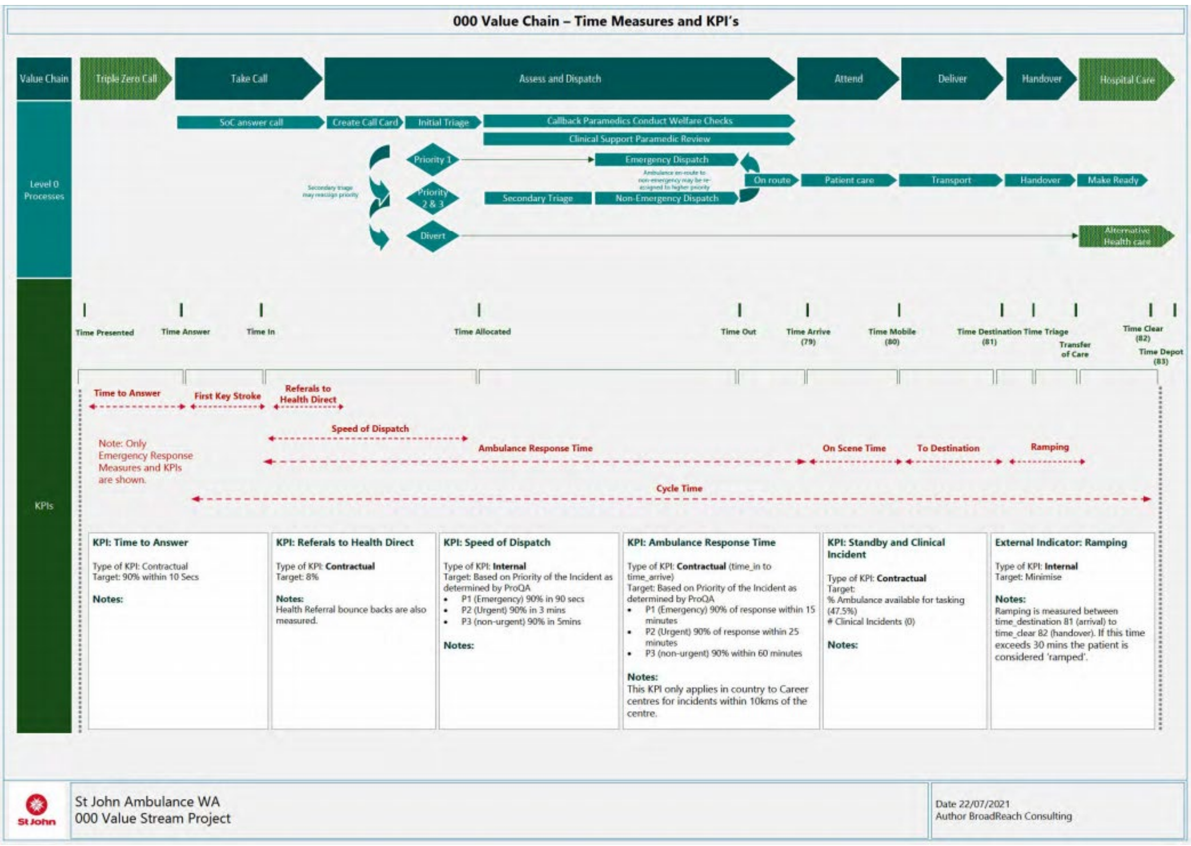
| Hospitals CO-LOCATED with an RFDS base* | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2021 | | | | 2020 | | | | Variance | | | | Variance % | | | |
| **DESCRIPTION** | **P1** | **P2** | **P3** | **All** | **P1** | **P2** | **P3** | **All** | **P1** | **P2** | **P3** | **All** | **P1** | **P2** | **P3** | **All** |
| **Number of patients** | 74 | 596 | 939 | 1,609 | 55 | 597 | 796 | 1,448 | 19 | - 1 | 143 | 161 | 35% | 0% | 18% | 11% |
| **Target response times** | | | | | | | | | | | | | | | | |
| Authorisation to depature with patient less average flying time | 2:15:00 | 6:15:00 | 48:00:00 | | 2:15:00 | 6:15:00 | 48:00:00 | | | | | | | | | |
| Monthly percent of target contract response times met | 80.0% | 90.0% | 95.0% | | 80.0% | 90.0% | 95.0% | | | | | | | | | |
| **Actual response times** | | | | | | | | | | | | | | | | |
| Monthly 80th percentile of contract response time | 5:30:00 | 9:26:00 | 40:45:00 | | 4:17:00 | 9:52:00 | 46:08:00 | | | | | | | | | |
| Monthly percent of target contract response times met | 31.1% | 72.1% | 97.3% | | 41.8% | 73.7% | 96.6% | | -10.7% | -1.6% | 0.7% | | -25.6% | -2.2% | 0.7% | |

*Where hospital patients are co-located with an RFDS base, KPI data does not accurately reflect the complex RFDS response to high acuity patients (particularly P1s). The metrics do not account for the practice of RFDS clinicians going into the hospital to assist in stabilising and/or packaging a patient for flight prior to ambulance transfer to the airport. This process is can be lengthy, but critical to quality patient outcomes.

[Source: Royal Flying Doctor Service, Answer to question on notice 5 asked at hearing held 23 September 2021, dated 19 October 2021, p 12.]

# APPENDIX 4

## ST JOHN AMBULANCE WA STATE OPERATIONS CENTRE EMERGENCY CALL WORKFLOW CHART




[Source: Submission 71 from St John Ambulance WA, 23 July 2021, p 176.]

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# APPENDIX 5

## EXTRACTS FROM THE ST JOHN AMBULANCE WA CODE OF CONDUCT

### Performance management processes

| STEP 1 | STEP 2 | STEP 3 |
|---|---|---|
| Performance concern identified | Formal performance process | Remedial Action |
| The first step is for a performance concern to be identified and communicated to you. This will likely involve a conversation (or informal counselling) between you and your Line Manager and should be done as soon as possible after a performance concern arises.<br><br>You will be given the opportunity to respond and to discuss any factors that may be impacting on performance.<br><br>This may be a difficult conversation to hear – Wellbeing and Support are available on 9373 3827 if you need support. The Line Manager may pause the process at any time if they have concerns about your health or wellbeing also.<br><br>If the performance concern is resolved within a timeframe agreed between yourself and your Line Manager, then no further action is required.<br><br>If the performance concern is not resolved, then the ongoing expectations regarding performance will be clarified and the formal performance management process will be implemented.<br><br>Where a formal process is to be used, it will be mandatory for you to participate in the process. | You will be asked to attend a meeting (likely with your Line Manager and Employee Relations). Your Line Manager will give a general description of their concern, and invite you to bring a support person with you to the meeting when they notify you.<br><br>At this meeting, you will be notified of the specific performance concern(s) including recent examples. You will also be told how your performance is failing to meet expected standards.<br><br>This process may be paused if you, or any person in the meeting has valid concerns for your wellbeing. Wellbeing and Support will be contacted immediately.<br><br>Your Line Manager will develop a performance improvement plan (**PIP**), designed to help you achieve expectations. A PIP will usually include the following information:<br>• what needs to be achieved to improve performance (i.e. targets and time frames); and<br>• how performance during the PIP will be monitored (i.e. review).<br>You will be given an opportunity to discuss the PIP with your Line Manager, and your support person, and to make suggestions and comments regarding the contents of the PIP. The final contents of the PIP are at the discretion of the relevant Line Manager.<br><br>Once the PIP is in place, performance will be monitored against the targets within the timeframes set in the PIP.<br><br>It is St John's goal that any performance concerns are resolved at this level. St John supports employees, and views this process as an opportunity to support and guide your professional training and development, rather than a punitive process. | If performance targets have not been (or are not being) met at the conclusion of the PIP, your ability to meet the relevant expectations of your role will be reviewed.<br><br>As a result, St John may take appropriate remedial action, including (but not limited to) retraining, transfer to another position or location, demotion, issuing a warning or, where appropriate, terminating employment.<br><br>The appropriate action will be determined by the Line Manager. Where possible, it is St John's preference to support, train and guide you to meet performance expectations.<br><br>Disciplinary action will be considered only in the most serious of circumstances, and will be determined in a procedurally fair manner.<br><br>Concerns about the performance management process may be raised with Employee Relations. |

**Conflict resolution process**

| STEP 1 | STEP 2 | STEP 3 |
|---|---|---|
| Approach the other person directly | Approach your Line Manager | Refer to Employee Relations |
| St John encourage Personnel to attempt to resolve workplace disputes, in the first instance, by approaching the other person involved to let them know about the issue.<br><br>Communication is important. For example, you may find the other person is unaware of the effect their behaviour has on you.<br><br>Keep in mind that this is probably an uncomfortable discussion for both you and the other person. Be respectful, but explain the issue and, ideally, suggest a solution.<br><br>Wellbeing and Support are available on 9373 3827 when you need support.<br><br>There will be times when approaching another person directly will not resolve a dispute satisfactorily. This might occur where an initial discussion is not successful or where you feel it is not appropriate to raise the matter directly with the other person (e.g. if the matter is sensitive or serious). | If you are unsuccessful in resolving the matter yourself or you feel you cannot approach the individual, the next step is to raise the matter with your Line Manager. You can also talk to Wellbeing and Support on 9373 3827 when you need support.<br><br>Your Line Manager can assist you to resolve the issue directly with the other person or, where appropriate, will intervene. You should explain to your Line Manager what you would like as an outcome of the process.<br><br>In determining the best way to manage the situation, your Line Manager may ask you what steps you've taken to resolve the dispute yourself.<br><br>Your Line Manager has discretion to determine how to approach and resolve the matter, including through direct intervention or through escalation. Where appropriate, the matter should be resolved informally.<br><br>Your Line Manager may ask you for further information regarding the dispute (e.g. who was involved, what happened, when it happened, where it happened and how the behaviour affected you).<br><br>If the issue involves your Line Manager, you should escalate the matter to a Senior Manager. | If you feel the matter remains unresolved after approaching your Line Manager or a Senior Manager please refer to Employee Relations.<br><br>They can be contacted via email er@stjohnambulance.com.au<br><br>You can discuss the situation confidentially, and receive advice about appropriate steps to address the unresolved issue.<br><br>Wellbeing and Support are also available on 9373 3827 when you need support. |

Misconduct management process

| STEP 1 | STEP 2 | STEP 3 | STEP 4 | STEP 5 |
|---|---|---|---|---|
| Allegation of misconduct | Notification | Investigation | Making findings | Disciplinary outcome |
| The first step in the process is for an issue to be identified, and considered by St John.<br><br>A complaint can be made verbally or in writing to a Line Manager (or a Senior Manager if the issue involves the Line Manager) or to the Employee Relations team directly.<br><br>This may be a difficult conversation to have - Wellbeing and Support are available on 9373 3827 to provide support to assist you to come forward with your concerns.<br><br>You may be asked to formalise a complaint in writing.<br><br>St John may make such further enquiries as it considers appropriate to clarify the complaint or related allegations.<br><br>Your complaint will be acknowledged within a reasonable time of being received. | The next step is for the respondent to be notified that an allegation of misconduct has been made.<br><br>This will involve a meeting with the respondent to advise them of the allegation.<br><br>As a respondent, you firstly will be asked to attend a meeting (likely with your Line Manager and Employee Relations). Your Line Manager will tell you the date, time and location of the meeting, give you a general description of their concerns, and invite you to bring a support person with you. The Line Manager will ensure the meeting occurs in a timely manner after this conversation.<br><br>This may be a difficult conversation to hear - Wellbeing and Support are available on 9373 3827 to provide support.<br><br>At the meeting, the Line Manager will inform you of the allegation (as best known at the time).<br><br>You may elect to give your initial explanation of the facts verbally, after hearing the allegation. You may also request time to consider the allegation before providing a verbal and written response.<br><br>The information provided will assist St John in determining what further action, if any, is required.<br><br>This may include conducting an investigation, referring the matter to Conflict Resolution, addressing the matter through Performance Management, closing the matter or referring you to Wellbeing and Support Services. | If St John determines an investigation is necessary, investigator(s) will be appointed.<br><br>The investigation may be conducted internally or externally. St John may decide to engage external investigator(s).<br><br>The investigation involves collecting and considering relevant evidence and giving the respondent an opportunity to respond to the allegations made against them.<br><br>During an investigation, the respondent and the complainant must comply with all lawful and reasonable directions of St John. For all investigations, this includes:<br>• cooperating with the investigation;<br>• remaining contactable and available during business hours; and<br>• if directed to do so, perform alternative duties or redeploy if it is inappropriate, unsafe or unsuitable for you to continue in your usual duties.<br><br>St John will take reasonable steps to ensure that the investigation is conducted fairly and efficiently.<br><br>The investigation may be paused or suspended if any person in the meeting has valid concerns for your wellbeing in continuing. Wellbeing and Support will be contacted immediately, and you may be asked to see a medical practitioner or specialist to assess your fitness to continue the process. | Following completion of the investigation, the investigator(s) will consider the available information and make findings as to whether the allegations are substantiated.<br><br>Findings will be determined based on the balance of probabilities, which is the appropriate standard for such an investigation.<br><br>The respondent and complainant(s) will be informed of the finding in relation to each allegation made (i.e. whether the allegation has been substantiated on the balance of probabilities or not). | After the investigation is finished, it may be appropriate for Disciplinary Action to be taken against the respondent (or another person) as a result of the findings.<br><br>The nature of the Disciplinary Action will depend on the circumstances. Examples of "Disciplinary Action" are provided in the Glossary at the end of the Code.<br><br>The respondent will be informed of any Disciplinary Action being taken against them.<br><br>If the proposed Disciplinary Action includes termination of employment, the person will be given a reasonable period of time (usually 7 days) to show cause why their employment should not be terminated. |

[Source: St John Ambulance WA, Answer to question on notice 12, asked at hearing held 24 September 2022, dated 19 October 2021, pp 21, 39, 40, 43.]

# GLOSSARY

| Term | Definition |
|---|---|
| **ACCHS** | Aboriginal Community Controlled Health Services |
| **CAD** | Computer Aided Dispatch |
| **Committee** | Standing Committee on Public Administration |
| **ED** | Emergency department |
| **FOI** | Freedom of Information |
| **FTE** | Full–time equivalent |
| **GP** | General Practitioner |
| **IHPT** | Inter–hospital patient transfer |
| **KPI** | Key performance indicator |
| **PDC** | Priority Dispatch Corporation |
| **PSSU** | Patient Safety Surveillance Unit |
| **SAC** | Severity assessment code |
| **SJA SOC** | St John Ambulance WA State Operations Centre |
| **RFDS** | Royal Flying Doctor Service |
| **WACHS** | WA Country Health Service |

## Standing Committee on Public Administration

**Date first appointed:**

17 August 2005

**Terms of Reference:**

The following is an extract from Schedule 1 of the Legislative Council Standing Orders:

'**5. Public Administration Committee**

5.1 A *Public Administration Committee* is established.

5.2 The Committee consists of 5 Members.

5.3 The functions of the Committee are to —

(a) inquire into and report on —

(i) the structure, efficiency and effectiveness of the system of public administration;

(ii) the extent to which the principles of procedural fairness are embodied in any practice or procedure applied in decision making;

(iii) the existence, adequacy, or availability, of merit and judicial review of administrative acts or decisions; and

(iv) any Bill or other matter relating to the foregoing functions referred by the Council;

and

(b) consult regularly with the Parliamentary Commissioner for Administrative Investigations, the Public Sector Commissioner, the Information Commissioner, the Inspector of Custodial Services, and any similar officer.

5.4 The Committee is not to make inquiry with respect to —

(a) the constitution, function or operations of the Executive Council;

(b) the Governor's Establishment;

(c) the constitution and administration of Parliament;

(d) the judiciary;

(e) a decision made by a person acting judicially;

(f) a decision made by a person to exercise, or not exercise, a power of arrest or detention; or

(g) the merits of a particular case or grievance that is not received as a petition.'

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