UNITED VOICE
AMBULANCE UNION WA

UNITED VOICE SUBMISSIONS ON THE INCLUSION OF APPROPRIATE KEY PERFORMANCE INDICATORS IN SERVICES AGREEMENT BETWEEN THE STATE OF WESTERN AUSTRALIA AND ST JOHN AMBULANCE

JUNE 2019

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Executive Summary

United Voice WA (**United Voice**) is the union that represents Paramedics, Communications Officers, Transport Officers and First Aid Officers in Western Australia (**Members**), and we welcome the opportunity to make submissions on behalf of our Members in relation to the Services Agreement between the State of Western Australia and St John Ambulance (**Contract**).[1]

Ambulance services play a critical role in protecting the health and welfare of the Western Australian community and United Voice believes the provision of quality ambulance services goes to the core of government responsibilities toward its citizens.

United Voice particularly welcomed the McGowan Labor Government's two year Contract extension to develop a contemporary contractual framework, and its commitment to consulting with "key stakeholders, to identify the service and performance measures that should underpin the contract".[2]

United Voice also welcomed the review into the provision of ambulance services in country WA, and has subsequently provided a comprehensive submission[3] to WA Country Health Service (**WACHS**) in response to the Draft Ambulance Strategy.[4]

United Voice Paramedic Delegates have previously met with the Minister for Health to lobby for an increase in country staffing and the inclusion of appropriate Key Performance Indicators (**KPIs**) in the Contract.

The health and wellbeing of ambulance service personnel is an issue of significant concern to United Voice. We have been lobbying for significant improvements to organisational health and wellbeing strategies, workplace culture, and government oversight over a number of years.

A number of reviews into the health and wellbeing of first responders working for St John Ambulance have been conducted in recent years, which all recognise that mental health issues for front line emergency workers are inherent to the nature of their work, and that the contracted provider in this state, St John, needs to be held accountable for the mental health and wellbeing of their staff.

The WA Labor party in 2017 also recognised that first responders are continually exposed to negative trauma as an inherent part of their work, and resolved that the Health Department would, 'hold the ambulance services contractor accountable for the health and wellbeing of

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[1] Department of Health, Government of Western Australia: 'Services Agreement Between State of Western Australia and St John Ambulance Western Australia Ltd 2015' ('*Contract'*).

[2] Hon Roger Cook MLA, 'St John Ambulance WA contract extension' (Media Release, Tuesday 26th June 2018).

[3] United Voice Western Australia, 'Submission to the WA Country Health Service – Country Ambulance Strategy Response to Recommendations' (2018), <http://www.wacountry.health.wa.gov.au/fileadmin/sections/country_ambulance/Submissions_2019/eDoc_-_CO_-_2018-12-12_-_Submission_-_CAS_-_9_-_United_Voice.PDF>.

[4] Ernst and Young, 'The Country Ambulance Strategy Driving Equity for Country WA – Final Draft September 2018' ('*Strategy*').

its workforce by enforcing contractual obligations that mitigate the risk of negative health and wellbeing outcomes'.[5]

We support the inclusion of clear, measurable and reportable KPIs into any future Contracts for the provision of ambulance services, and believe that the inclusion of enforceable KPIs in relation to health and wellbeing in particular, of both paid staff and volunteers, is essential.

United Voice Members are also firmly committed to a high quality, emergency pre-hospital care ambulance service. To this end, Members have also expressed their concerns that the Contract does not adequately require of the service provider measurable and meaningful KPIs, which best represent quality of care for the Western Australian community.

This submission discusses four areas of contractual oversight; Governmental, Staff Health and Wellbeing, Care for Patients and Service Delivery, which United Voice Members firmly believe would best represent the 'service performance measures that should underpin the contract'.

[5] Labor State Platform 2017, Resolution 96, 125.

1. Government Oversight

The call for increased Government oversight of the service provided by St John to the state of Western Australia is not a new one. The Office of the Auditor General ('**OAG**') noted in 2013[6], that the Department of Health needs to consider how to apply financial incentives and disincentives to the outcomes and outputs it is purchasing from St John.

In particular, the OAG identified in its findings that any future Contracts need to "be more comprehensive and focus on service delivery, standards, performance, allocation of risk and value for money", concluding that:

> *"WA Health's contract management has been effective but inadequacies in the Contract between WA Health and SJA need to be addressed. The Contract was designed to fund an increase in SJA's capacity but it lacks mechanisms for WA Health to monitor the quality of the service provided, such as standards of patient care, staff training or conduct, and equipment. It includes no incentives for SJA to meet agreed outcomes and does not assist WA Health to demonstrate whether the State is receiving value for money*."[7]

In 2017, the Labor State Platform ('**Platform**')[8] outlined resolutions in relation to the maintenance of the outsourced and publicly funded ambulance service. There was a clear commitment from WA Labor that the oversight of funding would be best practice, with a requirement of increased transparency in financial reporting.

In March of 2018, the Federal Senate referred to the Education and Employment References Committee ('**Senate Committee**') the terms of reference for an inquiry into the mental health of first responders, and their report was handed down in February of this year ('**Senate Report'**).[9] One of the relevant recommendations arising out of the findings of the Committee in relation to the provision of ambulance services in Western Australia was very pointed:

> *Recommendation 3: The committee recommends that federal, state and territory governments work together to increase oversight of privately owned first responder organisations.*[10]

United Voice Members believe that, at a minimum, a strengthened Ambulance Standing Committee and the appointment of a Chief Paramedic Officer/Ambulance Inspector would go some way to provide mechanisms for increased Government oversight of the ambulance service.

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[6] Office of the Auditor General, Government of Western Australia, *Delivering Western Australia's Ambulance Services*, (June 2013), ('*OAG Report'*)45.
[7] Ibid, 8.
[8] Labor State Platform 2017, Resolution 96, 126.
[9] Senate Education and Employment References Committee, Parliament of Australia, *The people behind 000: mental health of our first responders*, (February 2019), (*'People Behind 000 Report'*)
[10] Ibid, vii.

1.1 Ambulance Standing Committee

The OAG describes the purpose of the Ambulance Service Committee, which was established under the Contract, as a vehicle for the Health Department and St John to 'discuss and resolve strategic and complex issues'.

The Terms of Reference, according to the 2013 OAG report, are to:

- Provide strategic and policy advice on the provision of ambulance services in WA.
- Provide a link between executive management of WA Health and St John to enable complex or strategic issues to be discussed; and
- Ensure a good understanding of pre-hospital care provided by St John.[11]

The Contract should be more prescriptive in relation to the Ambulance Standing Committee, its meeting schedule and also have the ability to compel information in relation to any matter outlined in the agreement or the provision of the service to the State more generally, with provision for penalty if not complied with.

The terms of references need to include oversight of health and wellbeing contractual performance indicators, with consideration to be given to a representative from the relevant union (as determined by Unions WA) to be able to attend the committee on matters that have significant impact on the workforce.

1.2 Chief Paramedic Officer/Ambulance Inspector

United Voice Members propose that a permanent position of Chief Paramedic Officer or Ambulance Inspector is created within the Department of Health; the person appointed would be responsible for all ambulance issues that arise from the Agreement and would answer directly to the Director General for Health (the Principal Officer in relation to the Agreement) and the Minister for Health.

The position should have the capacity to be delegated powers of the Principal in relation to the Agreement, supported by the ability to impose penalties for non-compliance from the Provider.

The Officer/Inspector would sit on both the Ambulance Standing Committee and the Contract Management and Compliance committees to provide a link between executive management of WA Health and SJA to enable complex or strategic issues to be discussed.

The position would include oversight of staff Health and Wellbeing matters, and it would be in the best position to:

- Collect and inform government in relation to data in relation to all of the proposed health and wellbeing performance measures included in the Contract.

[11] *OAG Report*, above n 6, 54 - 55

- Collect and inform government in relation to the data collection that is recommended by the Senate Report.
- Work with the Federal and State Government to achieve increased oversight of privately run ambulance services (not only St John) as recommended by the Senate Report.[12]
- Inform any formal entity established by the State government 'which provides wellbeing and support to all emergency service agencies'.[13]
- Properly inform the Emergency Services platform as recommended by the Toll of Trauma Report[14] (**Toll of Trauma**).
- Co-ordinate with other emergency services in relation to first responder mental health and wellbeing.
- Sit on any national stakeholder working group established by the Commonwealth Government as recommended by the Senate Report.[15]

The current Agreement provides scope for the appointment of such an Officer/Inspector, as a Principal's Representative.[16]

[12] *People Behind 000 Report,* above n 9, vii.
[13] Independent Oversight Panel, 'Review of St John Ambulance: Health and Wellbeing, and Workplace Culture' (2016), ('*IOP Report*'), 103
[14] Legislative Assembly Community Development and Justice Standing Committee, Parliament of Western Australia, *The Toll of Trauma on Western Australian Emergency Staff and Volunteers* ('*Toll of Trauma'*), 59
[15] *People Behind 000 Report,* above n 9, vii.
[16] *Contract,* above n 1, 12.

2. Staff Health and Wellbeing Performance Measures

> ***"…****it is vital that all police and emergency services agencies develop a comprehensive workplace mental health strategy that has sustained and authentic commitment, where workplace mental health is seen to be as important as other health and safety or business improvement initiatives and is integrated and considered part of core business."*[17]

Beyond Blue, in its recent survey of over 21,000 emergency personnel within Australia, found that there were common themes across all of the emergency service agencies:

- A concerning number of employees with poor mental health.
- High rates of psychological distress and probable PTSD.
- Personnel with mental health conditions who did not seek/were not receiving adequate support.
- Staff perceive stigma and adverse career impacts as barriers to seeking mental health support.[18]

The Contract in its current iteration does not require St John to provide to the State a report on the health and wellbeing of its staff. The Independent Oversight Panel Review of St John (**IOP Report**)[19] found that the Government should be provided with data in relation to staff health and wellbeing, as a part of any occupational safety and health KPIs in the Contract.[20]

Not only will the inclusion of robust health and wellbeing KPIs in the Contract improve health outcomes for ambulance services staff, but will also go some way to changing the stigma of mental health issues, workplace culture and will mitigate the risk of negative health and wellbeing outcomes.[21]

The State Government and CEO SJA are responsible for the health and wellbeing of staff.

> *"There is growing and widespread support for wellness as a developing key performance indicator (KPI) for the board to consider, and against which to hold the Chief Executive Officer (CEO) and senior management team accountable*."[22]

Less than three years ago the IOP Report was published, which found that the "psychological risk and care of the ambulance service workforce could be improved by insertion of key performance indicators in the Chief Executive Officer's performance

[17] Beyond Blue Ltd, 'Answering the call national survey, National Mental Health and Wellbeing Study of Police and Emergency Services – Final report', (2018) ('*Answering the Call*'), 117.
[18] Ibid, 117.
[19] *IOP Report,* above n 13.
[20] *IOP Report*, above n 13, 118.
[21] Labor State Platform, 2017, Resolution 93, 125.
[22] Andrew Clarke, 'Developing a KPI for Measuring Staff Wellbeing: Implications for Australian Law' (2017), *Victoria University Law and Justice Journal* 7(1), 22

agreement". This recommendation followed on from a similar recommendation from the Toll of Trauma, that departmental chiefs of emergency services should be made personally responsible for the psychological health of their staff and volunteers - the obligation should be reflected in their performance agreements .[23]

The IOP also recognised that the Board of St John also had a responsibility for the health and wellbeing of their staff, and held the view that psychological risk and care be regularly reported to the Board, and that it become a standing item on the Board's agenda.[24]

The ambulance service provider should not solely shoulder the responsibility and accountability for the mental health and wellbeing of ambulance service personnel, the State also needs to actively operate in this space.

The inclusion of a requirement for the Provider to report to the State in relation to the psychological risk and care of the workforce in the Contract was one of the recommendations of the IOP Report.[25] This proposed reporting mechanism needs to be supported by strong accountability measures.

WA Labor committed to investigating options such as the establishment of a panel of independent and suitably qualified experts to hold St John to account in relation to the provision of health and wellbeing services.[26] This commitment has yet to be fulfilled, and Members encourage that this occur as soon as practicable.

2.1 Staff Satisfaction and Culture Survey

> "*…the organisational culture of St John requires improvement. The long term success of St John's efforts to improve the psychological wellness of its workforce requires a culture that is genuinely nurtured from the top down, and at all levels. Critical to this is strong and effective employee engagement at all levels*."[27]

There has, for many years, been a deeply held mistrust of St John by staff; that management lacks impartiality to the extent that staff are "reluctant to come forward, to tell their stories or formalise their complaints."[28]

Whilst it is understood that St John does survey its staff annually via its St John Culture Survey, ultimately St John controls the content of the survey and the results. A KPI is required that as a part of mental health and wellbeing reporting, that the Health Department have oversight of an annual staff survey.

[23] *Toll of Trauma*, above n 14, 11.
[24] *IOP Report,* above n 13, 118.
[25] *IOP Report,* above n 13, 20.
[26] Labor Platform 2017, Resolution 93, 125.
[27] *IOP Report,* above n 13, 116.
[28] *IOP Report,* above n 13, 114.

An independent and impartial survey would better inform the Department and the Minister of any areas of concern. .

2.2 Employee Attrition

> *"…the Committee is not aware of any exit surveys or interviews that directly ask if trauma is a motivator in the separation. It is the Committee's view that in order to gauge the effectiveness of an agency's welfare responses, a comprehensive exit interview should be offered and that it be conducted by a person of a relatively senior level."*[29]

The Productivity Commission Report on Government Services[30] (**ROGS**) currently measures operational workforce attrition, as "the number of FTE salaried staff who exit the organisation as a proportion of the number of FTE salaried staff. [It] includes staff in operational positions where paramedic qualifications are either essential or desirable to the role"[31].

Whilst this information is useful for Government to determine the sustainability of the ambulance service, it does not properly inform either the ambulance service provider or the State in relation to how best to improve trauma management procedures[32], particularly with regard to those who are transitioning to retirement.

The Toll of Trauma recommended that all of the State's emergency service agencies offer exit interviews[33], and this should include St John. The Senate Committee also identified the need for ongoing mental health support to staff that have left frontline emergency services[34], and formed the view that:

> *"…insufficient data exists on the prevalence of mental health conditions in retired first responders. However, anecdotal evidence suggests that this cohort may be at even higher risk of suffering from conditions such as PTSD than colleagues who are still working"*.[35]

The development of the format of any exit interview in relation to mental health and wellbeing, should be developed according to best practice, and ideally would be independent of St John.

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[29] *Toll of Trauma,* above n 14, vi.
[30] Productivity Commission: Government of Australia, *Report on Government Services - Ambulance Services* ('*ROGS*').
[31] Ibid, 11.
[32] *Toll of Trauma,* above n 14, 104.
[33] Ibid.
[34] *People Behind 000 Report,* above n 9, vii.
[35] *People Behind 000 Report,* above n 9, 105 at [5.42].

2.3 Crew Safety Index

> *"Violence against paramedics threatens hundreds of professionals every year in Australia alone. Although the SWA [Safe Work Australia] data are sufficient to show that the problem is large and growing, more detailed data owned by the ambulance agencies is needed to conduct specific analyses and develop interventions."* [36]

Working with the public invariably will result in unpredictable and often dangerous or violent working environments. As a direct result, ambulance personnel have a high risk of personal harm from physical abuse by violent or intoxicated patients.

The proposed Crew Safety Index measure provides an indication of the rate of exposure of operational paramedics to deliberate physical violence and verbal abuse by patients and/or bystanders. The Queensland Ambulance Service currently publically reports these occurrences, calculated as the number of reported cases of occupational violence per 100,000 hours worked.[37]

Currently, staff are 'self-reporting' incidences of occupational violence; however there are no reporting obligations of St John in relation to this issue. Public reporting of the occurrence of violence against ambulance personnel will raise community awareness and will better inform the State on the scope of the issue, with a view to implementing effective solutions.

Reports of violence should be reported to the public monthly via the Health Department, and include appropriate demographics.

2.4 Shift Extension Overtime

> *"It's also important to ensure that personnel are not exposed to high intensity of work on an ongoing basis. This may mean ensuring that police and emergency services agencies have sufficient resources to respond to the level of emergency events occurring in their communities and managing workloads to ensure no individuals or teams are regularly being stretched beyond reasonable expectations. It may also involve designing flexibility into work flows and rosters, and monitoring the nature and frequency of events, so that personnel can have downtime built into their schedules when they need it."*[38]

Shift extension overtime is unscheduled overtime that occurs beyond the rostered end of a shift, as a result of a Dispatch Priority call being received either late in the shift, or a complex

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[36] Brian J Maguire, 'Violence against ambulance personnel: a retrospective cohort study of national data from Safe Work Australia', (2018) *Public Health Research and Practice* 28(1), 6 http://www.phrp.com.au/wp-content/uploads/2018/03/PHRP28011805.pdf.

[37] Department of Health: Government of Queensland, *Queensland Ambulance Service Public Performance Indicators* https://www.ambulance.qld.gov.au/docs/QAS_QTR-2-Public-Performance-Indicators-FY18-19.pdf.

[38] *Answering the Call*, above n 17, 118.

job that takes a Paramedic crew past their scheduled finish time. Shift extensions may also occur as a result of a Dispatch Priority call being received and accepted by a crew prior to their regular scheduled shift commencement time.

Current reporting requirements are limited to reporting on Dispatch Priority 3 calls.
To best ensure that crews are not being 'stretched beyond reasonable expectations'[39], robust reporting is required of shift extensions that are incurred on all Dispatch Priority calls, hospital ramping, and on Royal Flying Doctor Service transfers, Newborn Emergency Transport Service calls, Complex Patient Ambulance Transport calls and inter-hospital transfers.

The increased reporting requirement should occur monthly, and also reflect the geographical region, and individual depots.

2.5 Injury Downtime Rate

This information is currently not reported to the Government, which is in contrast to the Queensland Ambulance Service, who publicly report this KPI, which "measures lost time at work due to injury as a percentage of total hours worked".[40] It is a way for the Queensland Ambulance Service to assess the effect of its staff rehabilitation strategies.

This measure should be reported to the Health Department monthly, with data reflecting injuries occurring both in the metropolitan and country areas.

2.6 Wellbeing and Support Team Qualifications

> *"Engagement of appropriate qualified mental health professionals in the development, implementation and ongoing evaluation of the Wellbeing and Support Model will be critical to its effectiveness and in its credibility amongst a highly trained clinical workforce."*[41]

In 2016, Phoenix Australia reviewed St John's workplace mental health risks[42] (**Phoenix Report**) and found that whilst efforts had been made by St John to improve the systems of support for staff[43], they highlighted that an area requiring priority attention was the inclusion of "qualified and experienced mental health practitioners"[44] in the Wellbeing and Support team.

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[39] *Answering the Call*, above n 17, 118.
[40] Department of Health: Government of Queensland, *Queensland Ambulance Service Public Performance Indicators* https://www.ambulance.qld.gov.au/docs/QAS_QTR-2-Public-Performance-Indicators-FY18-19.pdf.
[41] *IOP Report,* above n 13, 99.
[42] Phoenix Australia: Centre for Posttraumatic Health, (2016), 'St John Ambulance Review of Workplace Mental Health Risks', ('*Phoenix Report*').
[43] Ibid, 43.
[44] Ibid, 43.

The IOP Report also highlighted the importance of St John engaging "qualified mental health professionals in the development, implementation and ongoing evaluation of the Wellbeing and Support Model".[45]

United Voice Members support these findings, and believe that the Wellbeing and Support team should comprise of qualified mental health practitioners, led by a clinical psychologist and who are informed by the literature available that describes the psychological risks associated with ambulance work.[46]

The requirement in relation to the composition of the Wellbeing and Support team should be reflected in the Contract, that all members of the wellbeing and support team hold relevant professional qualifications and the team is to be led by a clinical psychologist, "anything less is not adequate"[47].

2.7 Wellbeing and Support Team Resourcing

United Voice Members are concerned that with any increase in the size of the workforce, the staffing of the Wellbeing and Support team will remain stagnant. There should be some consideration of a 'ratio' of Wellbeing and Support staff to ambulance service personnel reflected in the Contract.

2.8 Wellbeing and Support Team Reporting

> "*Police and emergency services agencies were found to be among the highest risk organisations for exposure to traumatic events and the development of high psychological distress, PTSD and related mental health conditions*."[48]

Measures:

- The number of times the wellbeing and support team is engaged by employees.
- Number of incidents that are flagged as critical incidents or code black.
- Number of critical incidents or code blacks that were followed up by the Wellbeing and Support team.

The IOP has described that, "an increase in activity alone should not be relied upon as the key indicator of success of the wellbeing and support model as it does not reflect the clinical effectiveness of any interventions. This would be the basis of reporting the true success of the model".[49]

[45] *IOP Report*, above n 13, 99.
[46] *IOP Report*, above n 13, 96.
[47] *IOP Report*, above n 13, 105.
[48] *Answering the call*, above n 17, 114.
[49] *IOP Report*, above n 13, 97.

The "ongoing monitoring and evaluation of the model will be critical to ensure it remains based on evidence".[50] United Voice Members believe that provision for the oversight of the Wellbeing and Support model should also be reflected in the Contract.

2.9 Mental Health Screening

> *"Early intervention is fundamental to successful outcomes for individuals suffering PTSD or other psychiatric disorder. Continued exposure to traumatic stress by an individual with depression or PTSD poses a significant risk of increasing the severity of the disorder and decreasing the probability of a good treatment outcome. Systems that ensure early identification include screening, removing stigma and trauma tracking. This is in addition to appropriate reactive or treatment strategies and regular ongoing education programs".*[51]

Mental Health screening for staff is not a new concept. The Phoenix Report recommended that regular mental health screening of staff wellbeing is undertaken and that, staff undertake an anonymous online mental health screening at least annually. This would ideally provide feedback on wellbeing, guidance on self-care, and if necessary, recommendations for an appropriate level of support and professional care, where required.[52]

Similarly, the IOP found that "screening of the frontline workforce should occur prior to, and periodically throughout employment. This needs to be undertaken in a transparent and integrated framework of identification, follow up and treatment as required, and be mindful of the law relating to privacy and employment conditions".[53]

Whilst the evidence supports some form of screening being undertaken, including the potential use of trauma tracking, United Voice Members note that any approach will require significant consultation with the workforce by the Health Department to determine its viability and to ensure that it is received positively by staff.

3. Care for Patients

> *"SJA reports its performance on national indicators in the Report on Government Services* (**ROGS**). *These include: cost per capita; cost to government per capita; patient numbers; and patient satisfaction. While ROGS notes that comparisons across jurisdictions can be difficult and clinical indicators are still under development, the data shows that for most indicators SJA's performance is on par with or better than other jurisdictions.*

[50] *IOP Report*, above n 13, 99.
[51] *IOP Report*, above n 13, 98.
[52] *Phoenix Report,* above n 42, 6.
[53] *IOP Report*, above n 13, 104.

The majority of ROGS indicators are not reported to WA Health as part of the Contract."[54]

United Voice Members consider high quality patient care to be the overarching purpose of their work. There is a strong belief amongst the membership that the metrics that currently exist within the Agreement, do not go far enough to demonstrate that a quality service is being provided to the Western Australian community.

Currently, patient care data is collected by St John and reported on via the ROGS; however it is not reported to the State. United Voice Members believe that the patient care performance indicators described below should not only be reported to ROGS, but monthly to the Health Department, broken down into country and metropolitan regions.

3.1 Out of Hospital Cardiac Arrest Survived Event Rate

"Nationally, the survival rate from paramedic witnessed out-of-hospital cardiac arrests is higher than for other adult out-of-hospital cardiac arrests. Cardiac arrests that are treated immediately by the paramedic have a better likelihood of survival due to immediate and rapid intervention".[55]

The three separate measures that are reported by St John to ROGS are:

1. Adult cardiac arrest where resuscitation attempted, where:
   – A person was in out-of-hospital cardiac arrest (which was not witnessed by a paramedic).
   – Chest compressions and/or defibrillation were undertaken by ambulance or emergency medical services personnel.
2. Adult Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT) cardiac arrests where:
   – A person was in out-of-hospital cardiac arrest (which was not witnessed by a paramedic).
   – The arrest rhythm on the first ECG assessment was either VF or VT.
3. Paramedic witnessed cardiac arrest — where a person was in out-of-hospital cardiac arrest that occurred in the presence of an ambulance paramedic or officer.[56]

3.2 Pain Management

"A higher or increasing percentage of patients who report a clinically meaningful reduction in pain severity at the end of ambulance service treatment suggests appropriate care meeting patient needs".[57]

[54] *OAG Report,* above n 6, 50.
[55] *ROGS*, above n 30, 11.17.
[56] *ROGS*, above n 30, 11.16.
[57] *ROGS*, above n 30, 11.19.

This measure would reflect the number of patients who, from the first to final recording of their pain score (1 – 10 pain intensity scale), report a clinically meaningful pain reduction of a minimum of two points. It would include patients who:

- Are aged 16 years or over and received care from the ambulance service, which included the administration of pain medication (analgesia);
- Recorded at least 2 pain scores (pre- and post-treatment); and
- Recorded an initial pain score of 7 or above (referred to as severe pain). Patients who refuse pain medication for whatever reason are excluded.

3.3 Sentinel Events

> *"Sentinel events' are defined as the number of reported adverse events that occur because of ambulance services system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition.* ***A low or decreasing number of sentinel events is desirable****"*.[58]

The Health Department Severity Assessment Codes (SAC) are listed below:

SAC 1: includes all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. In WA, SAC 1 also includes the 10 national sentinel event categories.

SAC 2: includes all clinical incidents/near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.

SAC 3: includes all clinical incidents/near misses where minimal or no harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.[59]

3.4 Patient Satisfaction

> "'*Patient satisfaction' is defined as the quality of ambulance services, as perceived by the patient. It is measured as patient experience of aspects of response and treatment that are key factors in patient outcomes*."[60]

This measure is taken from those patients who are transported under a Priority One or Priority two and their experience is represented by the responses to the following, which in turn are reported by St John to ROGS:

1. Proportion of patients who felt that the length of time they waited to be connected to

[58] *ROGS*, above n 30, 11.10.
[59] Health Department, Government of Western Australia, *WA Health Severity Assessment Codes (SAC) to be used by Public Hospitals and Health Services*
<https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/patient%20safety/PDF/WA-Health-Severity-Assessment-Codes.pdf>
[60] *ROGS*, above n 30, 11.11.

an ambulance service call taker was much quicker or a little quicker than they thought it would be.

2. Proportion of patients who felt that the length of time they waited for an ambulance was much quicker or a little quicker than they thought it would be.
3. Proportion of patients who felt that the level of care provided to them by paramedics was very good or good.
4. Proportion of patients whose level of trust and confidence in paramedics and their ability to provide quality care and treatment was very high or high.
5. Proportion of patients who were very satisfied or satisfied with the ambulance services they received in the previous 12 months.[61]

[61] *ROGS*, above n 30, 11.11.

4. Service Delivery Key Performance Indicators

> *"On its own, response time is a limited measure of performance as it does not inform WA health whether the services is delivered cost effectively and represents value for money."*[62]

4.1 Response Time Targets

The response time targets for the metropolitan area are set out in the current contract as a state-wide collective, with specific targets for each Dispatch Priority 1 through 4. It is the time from when a call is answered and registered until an ambulance service vehicle arrives at the scene.

KPI's must be applicable and presented for each metropolitan suburb, rather than a state-wide collective. For example, under the current collective system, areas where response times are rapid (i.e. inner city) serve to falsely reduce average overall response times, and masks the fact that other areas commonly experience significant delays in ambulance response times.

Currently, there is monthly reporting to the Health Department of state-wide metropolitan response performance for each Dispatch Priority call, including year to date and a comparison to the previous year's result. There is also monthly reporting of the number of cases outside of the 90th percentile target for each priority, including year to date, and comparison to the previous year.

Finally, this target is reported annually to the public by way of the annual report. This KPI should be reported monthly not annually. The method of annual reporting means quick response times for some months can offset the slow response times for other months. This fails to identity defined periods where performance is not meeting expected standards.

There is also an issue with only reporting the time on 'arrival at scene'. Arrival at scene is automatically logged by the system when the paramedic is within approximately 50m of the address. It can then take some time to actually reach the patient this can be problematic where there is no address supplied (i.e. car accident). Paramedics can override the automatic recording, which will then be logged as the arrival time.

4.2 Strengthened Reporting Obligations

1. Public reporting monthly on the Health Department website, for response times for each priority call type, and for each metropolitan suburb.

2. Public reporting annually in the Annual Report of response times for each priority call type for each metropolitan suburb.

[62] *OAG Report*, above n 6, 50.

3. Monthly reporting to the Health Department of response times for each priority call type for each metropolitan suburb.

4. Monthly reporting to the Health Department outlining where response targets are not being met, and the reasons for underperformance.

5. Monthly reporting to the Health Department outlining where Priority 1 Dispatch Call response targets are not met and by how long.

6. Monthly reporting to the Health Department outlining the average time that Priority Two Dispatch Calls have missed the response time target by.

4.3 Arrival to Patient Time

> *"The arrival-to-patient contact interval adds a variable and potentially lengthy amount of time to the total prehospital response time interval, and barriers impeding paramedic movement to the patient prolong this time interval. In 25% of all observed paramedic calls, the arrival-to-patient contact interval was more than four minutes. Measurement of the time from ambulance arrival on the scene to paramedic arrival at the patient is necessary to appropriately determine the relationship among total prehospital response time, paramedic interventions, and patient outcome."*[63]

'Arrival to patient contact time' is the time from when a paramedic arrives at the scene to the time they arrive at the patient. This measure provides an indication of the ability of the metropolitan service to provide hands on care to patients in a reasonable timeframe. This is to be differentiated from "response time" as it provides an indication of how long it takes a crew to get to the patient compared to how long it takes the crew to arrive at the scene.

This indicates the number of times where there are delays getting to the patient i.e. where paramedic has arrived at scene but has to wait due to factors outside of the Paramedic's control. Reporting of this time would assist in identifying and rectifying any process deficiencies.

New reporting obligation:

1. Monthly reporting to the Health Department of the difference between arrival time and hands on patient time, and the reasons for the delay of gaining access to the patient.

4.4 Response Time Targets for Country

> *"The current contract is limited in the detail of the services being purchased and of the outcomes required for the majority of the country locations. With*

[63] Campbell JP, Gratton MC, Salomone JA 3rd, Watson WA, (1993), 'Ambulance arrival to patient contact: the hidden component of prehospital response time intervals' *Annals of Emergency Medicine* 22(8), 1254-7 <https://www.ncbi.nlm.nih.gov/pubmed/8333623>.

85% of locations without performance indicators, there is no mechanism for measuring the reliability, timeliness and safety of the service".[64]

Country response and arrival times targets provide an indication of the ability of the individual country sub centres to respond to incidents under contracted time limits, however it is currently only for incidents within 10km of the town centre. This means incidents that occur outside of the 10km radius are not being reported on and are not subject to response time targets.

Response time targets for the country are established in the current contract with specific targets for Dispatch Priority 1 and Priority 2 calls for each career paramedic country sub centre and as a collective for Dispatch Priority 3 and Priority 4 calls.[65]

Strengthened KPIs will relate to all incidents, and would not be limited to those within 10km of the town centre.

Strengthened Reporting Obligations:

This additional data is already collected by St John.

1. Monthly public reporting (on the Health Department's website) of the country response performance for each Dispatch Priority, broken down for all country sub-centres **including** volunteer sub-centres.

2. Annual public reporting (in St John's Annual Report) of country response performance for each Dispatch Priority call, broken down for all country sub-centres **including** volunteer sub-centres.

3. Monthly reporting to the Health Department, explaining where response targets are not being met and the reasons that have attributed to the failure.

4.5 Volunteer Turn Out Response Times

Volunteer sub-centres are not subject to reporting on response times and do not have contracted response time targets. This new measure will provide an indication of the county service to turn volunteer crews out to an incident within set response times.

The response reporting needs to identify that there is a volunteer turn out time that is in addition to the reported response times. Currently, St John allows for a 15 minute turn out time for volunteers. This is in addition to the response time target.

New reporting obligation:

[64] *Strategy*, above n 3, 41.
[65] *Contract*, above 1, 57 – 58.

1. Monthly reporting to the Health Department of the volunteer turn out time for each Dispatch Priority call, identifying turnouts of 0 – 15 minutes and over 15 minutes.

4.6 Volunteer Turn Out

This measure provides an indication of the ability of the country ambulance service to turn volunteer crews out to an incident in their region. This measure will highlight sub-centres that are unable to turn out crews to Dispatch Priority calls 1 – 4.

New reporting obligation:

1. Monthly public reporting (on the Health Department's website) of volunteer turn out for each Dispatch Priority call, broken down for all country sub-centres.

4.7 Response Time Targets – Cardiac Patients and Confirmed Unconscious

> *"Cardiovascular disease is the leading cause of death in Australia. Most of these deaths are unexpected and occur outside the hospital, and survival rates have been poor (< 5%). When emergency medical services arrive early, most cardiac arrest patients are found in ventricular fibrillation (VF). Defibrillation is the definitive treatment for VF, but is rarely successful if the duration of VF extends beyond 10 minutes."*[66]

This measure provides an indication of the ability of the metropolitan and country services to respond to cardiac patients and confirmed unconscious patients within contracted time limits. Currently Dispatch Priority 1 calls are required to be responded to within 15 minutes.[67]

KPIs related to cardiac arrest and confirmed unconscious Dispatch Priority calls need to be presented separately from the overall response time body of data for Dispatch Priority 1 calls as a stand-alone category.

This additional reporting data is already collected by St John.

New reporting obligations:

1. A new KPI that measures the percentage of incidents where cardiac patients and confirmed unconscious patients are responded to within 8 minutes.
2. Public reporting of this KPI monthly (on Health Department website), broken down into metropolitan (suburb) and country (sub-centres) response performance.
3. Monthly report to the Health Department describing why the KPI was not met for each incident.

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[66] Karen L Smith and John J McNeil, (2002), 'Cardiac arrests treated by ambulance paramedics and fire fighters', *Medical Journal of Australia* 177 (6), 305-309. || doi: 10.5694/j.1326-5377.2002.tb04788.x
Published online: 16 September 2002 https://www.mja.com.au/journal/2002/177/6/cardiac-arrests-treated-ambulance-paramedics-and-fire-fighters

[67] *Contract*, above n 1, 56.

4. Public annual reporting (St John Annual Report), broken down into metropolitan (suburb) and country (sub-centres) response performance.

4.8 Metropolitan Crews Dispatched to the Country

Metropolitan crews being utilised for a shortfall in the capacity of country crews to service country regions is an indicator of a failure of the system or at least a system under stress. There is an impact on metropolitan crews in relation to fatigue, and also leaves a shortfall of cover in the metropolitan area, increasing workloads for those crews servicing the metropolitan area.

This new measure would measure the percentage of incidents where metropolitan crews were dispatched to the country, providing an indication of the country service's ability to respond as contracted.

New reporting obligation:

1. Monthly reporting to the Health Department of the number of incidents where metro crews are dispatched to the country, broken down to indicate which metropolitan and country depot is affected.

4.9 Volunteer Country Crews Dispatched to the Metropolitan Area

Similarly to the above new KPI, this would measure the ability of the metropolitan service to respond the Dispatch Priority calls in the metropolitan area.

New reporting obligation:

1. Monthly reporting to the Health Department of the number of incidents where volunteer country crews are dispatched to the metropolitan area, broken down to indicate which metropolitan and country depot is affected.

4.10 Country Volunteer Depot Availability

This measure will provide an indication of the ability of the country service to respond to cases in the country as contracted, and would show the number of times that volunteer stations are unattended. The country service must be available 24/7.

New reporting obligation:

1. Monthly reporting to the Health Department the number of shifts that the depot/sub-centre was not able to fill.

4.11 Standby Capacity

This measures the percentage of the fleet that is able to respond to incidents, which St John reports as 47% currently. Anecdotally, United Voice Members believe that this percentage is incorrect. More often than not, the full fleet is being utilised, which has an impact to the ability to meet response time targets.

New reporting obligation:

1. Monthly reporting to the Health Department of standby capacity, broken down into data for:
    a. Day of the week,
    b. Times 0600 – 1800 and
    c. Times 1800 - 0600

4.12 Booked Transfers for Corporate Clients

KPI's relating to booked transfers for corporate clients to and from hospitals and care facilities need to be held separate from those related to community jobs.

Currently, these calls are prioritised over calls in the community, so patients in the community wait for ambulance attendance for even longer as crews are dispatched to non-urgent booked transfers between facilities.

Often, crews are allocated these transfers at emergency departments immediately after clearing a previous job.

Consequently, this reflects a response time of one or two minutes, while community calls wait 20 plus minutes for an ambulance.

As these response times are rolled into the overall average response times by the organisation, improving averages, and thus a misrepresentation of the actual situation.

Corporate client transfer response times should not be calculated with the response times for community priority dispatch calls.

4.13 Paramedic Identification

Paramedicine has recently become a health profession that requires individuals to become registered with the Australian Health Practitioners Regulation Agency (**AHPRA**). The qualifications and skill set of paramedics is greatly different to those who volunteer in the country, and for St John Event Health Services.

Currently, registered paramedics are mostly indistinguishable from volunteers. This creates a perception from the public that they are receiving care from a skilled paramedic, when it is very often not the case. Volunteers and career paramedic staff have a widely different skill set, and the public should be able to distinguish between the two.

The Contract already includes a provision in relation to Service Staff and identification badges[68]; however, United Voice Members strongly believe that Paramedics, as registered health practitioners, should have a different coloured uniform to all other staff, both volunteer and paid. This requirement needs to be clearly reflected in the Contract.

Conclusion

United Voice Members understand that included in this submission are a number of proposed KPIs, however Members believe that these will go some way towards ensuring that the State Government and the people of Western Australia are the beneficiaries of a high quality, emergency pre-hospital care ambulance service.

[68] *Contract,* above n 1, 17.