

Submission to - The Country Ambulance Strategy 2018.

Policy & System

Whilst it is clear that a standardised framework and policy is needed to define the parameters and responsibilities of a country ambulance service the following should be considered:

- In defining the level of ambulance service to be provided to country communities is the level of hospital care within those communities also going to be considered? For example, many smaller country hospitals are little more than nursing posts connected to a residential aged care facility. Many do not have a resident doctor or a GP with admittance rights to that hospital, placing increased demand on ETS. This situation also places far more responsibility on a primary response ambulance crew to provide care than one in a larger regional centre.
- The smaller hospitals are also under resourced and under staffed. For example primary response volunteer ambulance crews have been called in by hospital staff to help with resuscitations as they do not have the staff available at the time of need. Another example of under resourcing is the placement of mobile x-ray machines in smaller hospitals but failing to train enough staff to operate the machines. This necessitates the further transport of patients from small hospital to larger hospital for nothing else than an x-ray. This places undue demand on ambulance personnel for a service that could have been carried out locally.
- Service delivery models and measurable performance indicators – Currently ambulance officers, both transport and volunteer are audited via their Patient Care Records. These include response times as well as the patient care and hospital handover record. Will distances be factored in to the performance indicators? Will the measurable performance indicators also apply to WACHS staff? For example the ISOBAR handover is not always given by WACHS staff when the patient is transferred to the hospital.
- Engagement forum – this is an excellent idea and would be particularly beneficial if held on a regular basis (quarterly? At the very minimum). This would also allow for clearer communication between the stakeholders as policies, procedures and clinical practice guidelines evolve.

Timely Access

In introducing contemporary contracts a clear policy needs to be agreed and understood by WACHS. Many hospitals at present fail to understand the differing scope of practice between Volunteer Ambulance officers, Patient Transport officers, Nurse crews and Paramedic crews.

Hospitals also need to understand that if they state that the patient is ready for transport, then the patient should be ready ie paperwork done, staff ready to carry out handover, patient packaged ready for travel and medications packed for travel. The discrepancies in the crew's arrival time and departure time is available on the Patient Care record and would be useful as a performance indicator.

System Coordination

All excellent points outlined the draft strategy however these need to be clearly communicated to WACHS staff. I would suggest a mandatory training program for all clinical staff, including Medical Officers would be beneficial. Simply placing another policy and procedure on the intranet will not suffice.

Sustainable & Skilled Workforce

Many sub centres now have paid administrative staff reporting to their regional office, they also have a small cadre of Volunteer Support Role officers to carry out the tasks that are not a part of on road services. This trend started approximately 5 years ago and is gaining momentum as more sub centres become aware of the advantages.

With regard to on road volunteer staff it needs to be highlighted that many volunteers also take part in paid employment. In our subcentre 86% of volunteers work for at least 4 days per week. This makes it difficult for our sub centre volunteers to attend to low acuity hospital transfers during work hours. On the whole our employers are understanding and will release volunteers for the higher acuity call outs. However I would point out that this heavily depends upon the supervisor at the time, personally I have had 3 supervisors at WACHS all with very different ideas about whether I should be released to attend jobs.

The majority of volunteers would welcome the opportunity to acquire qualifications that are nationally recognised. Though I am not sure that this should be led by WACHS. In my experience the training program the St John Ambulance provides is more in depth and regulated than the training program provided at present by WACHS through their LMS system.

I would also like to point out that St John Ambulance has made great advances over the past 10 years with their alternate workforce and training models. The implementation of Voluntourism for alternate workforce in sub centres, Community Paramedics and Volunteer Development Officers who drive the continuing education program, along with flexibility in providing upskilling all backed up by the Learning Management system, VIP and Vollie TV. The training for volunteers is carried out all year and monitored by St John through the departments of Volunteer Education and Clinical Governance. Patient transport officers are also tested on their competencies on an annual basis and by their peers.

In closing I would like to thank you for the opportunity to make a submission, I believe the current system should be inspected and overhauled, however I would stress the need for clear communication between ALL the stakeholders and suggest that involvement of the on road or front line staff is paramount.

Thanking You

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Goomalling

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