SUBMISSION – Legislative Review Committee's Inquiry into House of Assembly Petition No 84 of 2021 – SA Ambulance Service Resourcing

To the Honourable, the Members

Thank you for allowing me to make this submission

My name is Paul Stratman, I'm an Extended Care Paramedic (ECP) within SA Ambulance Service (SAAS); and have been a Paramedic in various guises since 1983. By way of disclosure, I am a career-long member of Ambulance Employees Association SA.

I write this submission do with trepidation, and a heavy heart, but with a great deal of conviction; I have no doubt that those Paramedics of my generation have seen the best of the Ambulance Service.

I have never seen, in nearly 40 years of employment, the Ambulance Service in such a state of dysfunction! Low morale, high absenteeism, seriously broken colleagues, and colleagues leaving the service, inability to recruit appropriate numbers.

Please consider every time the word patient is used in this submission, it is a PERSON, who has their needs, their emergency no matter how urgent, it is still their emergency this should never be trivialised. REMEMBER a person with their emergency.

As stated, I am an Extended Care Paramedic, a senior clinical position that involves additional ongoing study and training the that of an Intensive Care Paramedic. ECPs role includes attending, treating, and managing low acuity, high complexity patient with multiple co-morbidities in the community and that of Emergency Operation Centre Clinician (EOCC) in the SAAS Emergency Operations Centre (EOC). Extended Care Paramedics have been in existence in SAAS since 2007. Current roster requirement to fulfill all positions is 36FTE + 2 Team Leaders over 4 shifts 4 on 4 off, available ECP FTE sits at 24 including TL. (See Attachment 3)

On road ECPs for the past 6 years (ECP data directly from cases cards) have attended, treated, and managed in close conjunction with multiple other pathways, almost 18500 patients – with an 86% hospital avoidance rate! This includes (but not limited to) wounds requiring suturing, infections including the administration of antibiotics, pain management, community Palliative care which is rapidly increasing role.

These are only examples of what ECPs do, I can guarantee the EVERY ECP has spent extra time including lengthy post shift overtime; planning, scheming, and purchasing (mostly at their own expense) food, drinks, medications, and equipment to keep a patient safely and appropriately at home (includes RCFs). ECPs have sat with patients and families while loved ones succumbed to their illness. This is a group of clinicians who take it personally when a patient goes to ED, we also realise that sometimes it cannot be avoided.

Emergency Operation Centre Clinician (EOCC) role includes, but not exclusively, oversite of events that come through the 000 calls, review of interhospital transfers to ensure appropriate level of care. Clinical support for Call Takers (EMDSO) on complex acute calls requiring additional clinical input. Taking consults from AO's Paramedics and Intensive Care Paramedics depending on the patients they are attending. Liaising with other health care providers including MedSTAR, country Hospitals, other community providers, etc. EOCC's also select patients for ECPs on the road to attend, this was initially our prime role, but has now been superseded by risk managing delayed SAAS attendances.

EOCC also work collaborate with Dispatchers and State Duty Manager to risk manage Ambulance attendances state-wide on daily basis. It is this role that has increasingly taken up ECPs time over the past 4 years!

EOCC's are required to do clinical call backs to patients when SAAS attendance is delayed. We are required to do this for all priorities. This involves re-assessing their clinical status and whether they can "safely" be delayed – we did this 4353 times for the month of May 2021 alone. That is 4353 times SAAS has been unable to attend people within time criteria as allocated by SAAS. (**P1 -8min = cardiac arrest; P2 – 16min = heart attack, asthma; P3-30min= broken bones, acute pain; P4,5- 60min = falls, chronic medical conditions** - these times apply to urban areas only). That 4353 times my colleagues and I have had to start a conversation and assessment with the words "the Ambulance has been delayed or Sorry".

I have included a graphical representation (see Attachment 1) of these call back numbers in this document. You will observe 2 indicators the first April 2020 – this is the first COVID-19 lock down, the second November 2021, this is when SAAS change the call back time criteria – effectively doubling the time a person waits before a call back. This DOES NOT indicate those waiting extended times has dropped, it just means that get a call back at 60 - 120min instead of 30 - 60min, as examples. This was done to reduce the workload, stress, and psychological distress to ECP's as expressed to Minister Wade in a face to face at a meeting late last year.

Each of these represents a patient, a person, each of these represents a call to a person with their own emergency – it may not be life threatening, but its theirs. Their merits are equal.

Each of these represents an ECP calling back, sometimes repeatedly, to assess and manage the risk of an ongoing delay to that person and their emergency.

I have personally been brought to tears by a 95yo lady who I called to advise of ongoing delays, she had already waited alone for two hours. She then wanted to cancel the Ambulance when I spoke to her. She is 95yo, she could not get out of the chair she was in due to pain! She had heard the news regarding ramping and how busy SAAS was. She persisted in apologising to me for calling an Ambulance, she kept saying it was not an EMERGENCY and not worthy of SAAS attendance, she kept on trying to cancel. This is a 95yo lady, is this the way we treat our elders, our community? Are these the trivial 000 calls the Minister refers to in the media, and in SAAS adverts? We now have patients like this lady NOT calling SAAS because they think they are TRIVIAL and not worthy! I am ABSOLUTELY sure that I am not alone in this.

I know of at least 7 (7 of 24) of my ECP colleagues who are broken, who are on personal leave or have augmented there working hours to reduce their exposure to this destructive environment. How do I know, because I am regularly checking to make sure they are OK!!

As ECPs are taken off the road to manage the call back volume in EOC, the patients that could easily be managed away from ED or hospital has reduced. This now means SAAS ambulance crews must attend and either transport the patient risking ramping or attempt to negotiate an alternate pathway of care, either way the Ambulance is not available. (See Attachment 2)

There is not one ECP who does not value the face-to-face interaction with patients, this is what we signed up to when we chose to be ECPs. The smile or quiet thanks from a patient is what drives us!!

I can go through the failed “alternate” pathways to divert patients to that I have seen and attempted to implement in the 12yrs as an ECP. I can highlight the Hospital community service patients that ECPs attend because these services have been withdrawn or business cases shelved. I can highlight how factionalised LHNs affect the ability of services to be provided to patients. Further I could highlight how the scope of practice of RCF staff that have been restricted or reducing corporate liability has affected patients. When is the realisation we all deal with people, not the small thiefdoms with in SA Health and SAAS, going to happen?

The so called trivial 000 calls are screened out, they do NOT get ambulances, they get referred to ECPs, PCCs, their own GPs, etc. Why aren’t the Directors of Emergency Departments screaming down the phone to SAAS Interim CEO or Chief Medical Officer about these patients?

I have listened to former SAAS CEO, Minister for Industrial Relations and Minister of Health blame shift times or where crews have meal breaks for the problems of SAAS. Reducing hours just means reducing meal breaks from 2 to one per shift. Shift length is NOT an Ambulance crew issue, it is rarely raised by crews. SAAS already has 8hr, 10.5hr, and 12hrs shifts. This is just a SMOKE SCREEN.

Crews having meal breaks at the nearest station will mean outlying areas – Gawler, Adelaide Hills, Aldinga / McLaren Vale, etc will end up being uncovered at these times, or it will end up with crews being moved around metropolitan areas in never ending "standbys" for area coverage. Most likely prolonged response time and further delays.

Shift length / meal break will NOT put one more crew on the road. If you shorten the shift length, then you will need more personnel to keep shift going for 24hrs. You will need to increase the number of Paramedics by 30-40% to run the roster = 300-400 increase in Paramedic numbers.

None of this will fix ramping – if you can't empty and Ambulance, you can't use it!! This goes to too crews spending increasing longer times with attempting/waiting to refer to alternate pathways.

The ramping issue is a HOSPITAL ISSUE, not and ED or Ambulance issue. EDs and Ambulance are victims of ramping. If a patient is awaiting discharge in a hospital bed; then you cannot admit a patient from ED to that bed. Fix the back end and you will fix ramping; putting more beds in ED, just means more patients in ED, and ramping will continue. Discharge wards, better transitional care, more effective and active community services; these are the areas to make profound change to Health.

I work in a broken organisation in a broken system. I am continually told by the Minister that patient is the problem for calling 000 or by SAAS (as a Union member), that I must be the problem because I work a 12hour shift and I want a meal break at my home station – REALLY? I am extremely proud of my colleagues, I at times struggle to make honest promises or make excuses of behalf of SA Health and SAAS to patients. I have worn the uniform of a Paramedic for many years with pride, but not so now. It is sad that I needed to wear it in protest to bring attention to these issues!

The platitudes and professional disrespect from the past SAAS CEOs, Health Minister, Treasurer/Industrial Relations Minister and the Premier by omission; towards me and my

colleagues and now to patients (in advertising) is an insult. None of these people have any credibility within SAAS, we stopped listening long ago.

I go to work on every rostered shift to do the best by patients and people, and for a system to “harm” them vicariously is in my belief uncaring and insulting to the community!

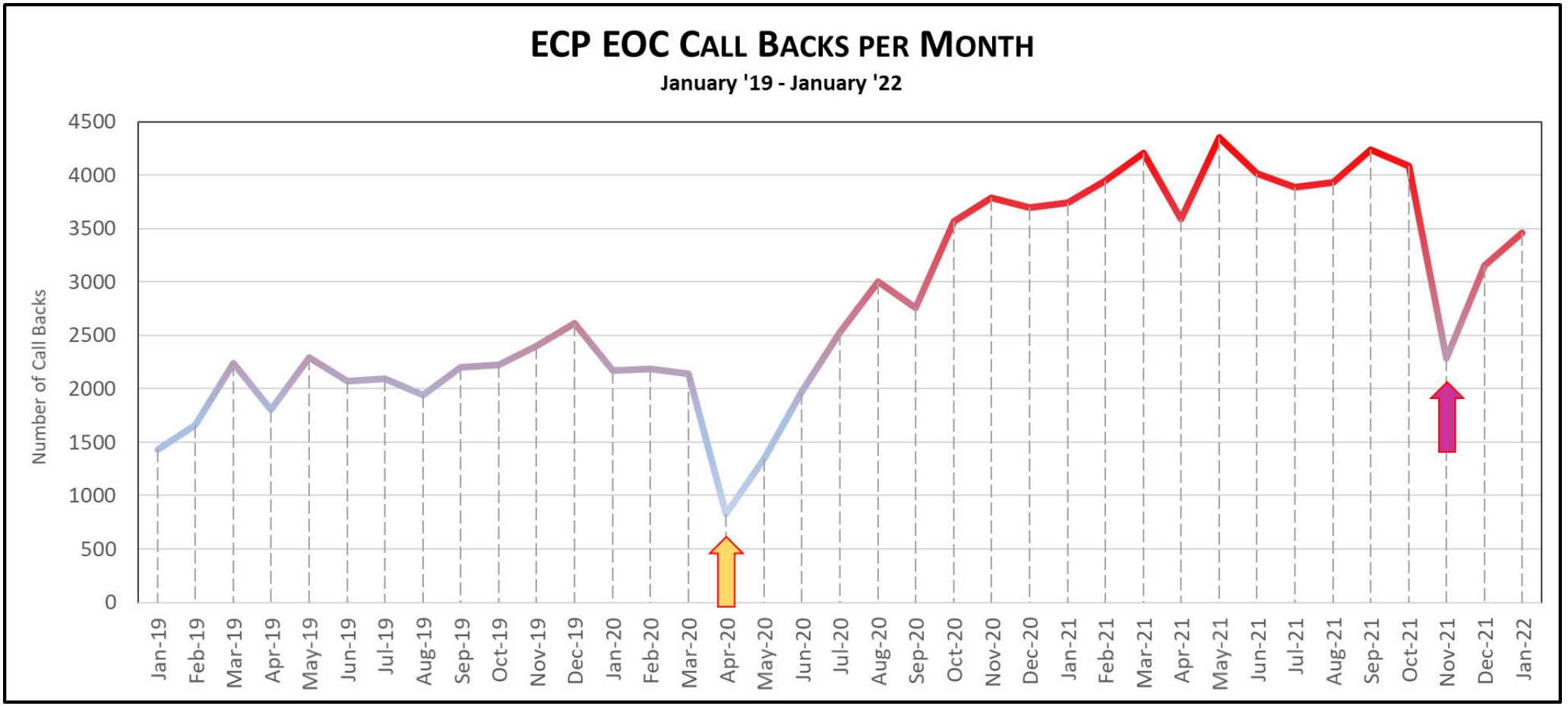
Again, thank you for your time and the opportunity to present.

Paul Stratman

Extended Care Paramedic

[redacted]

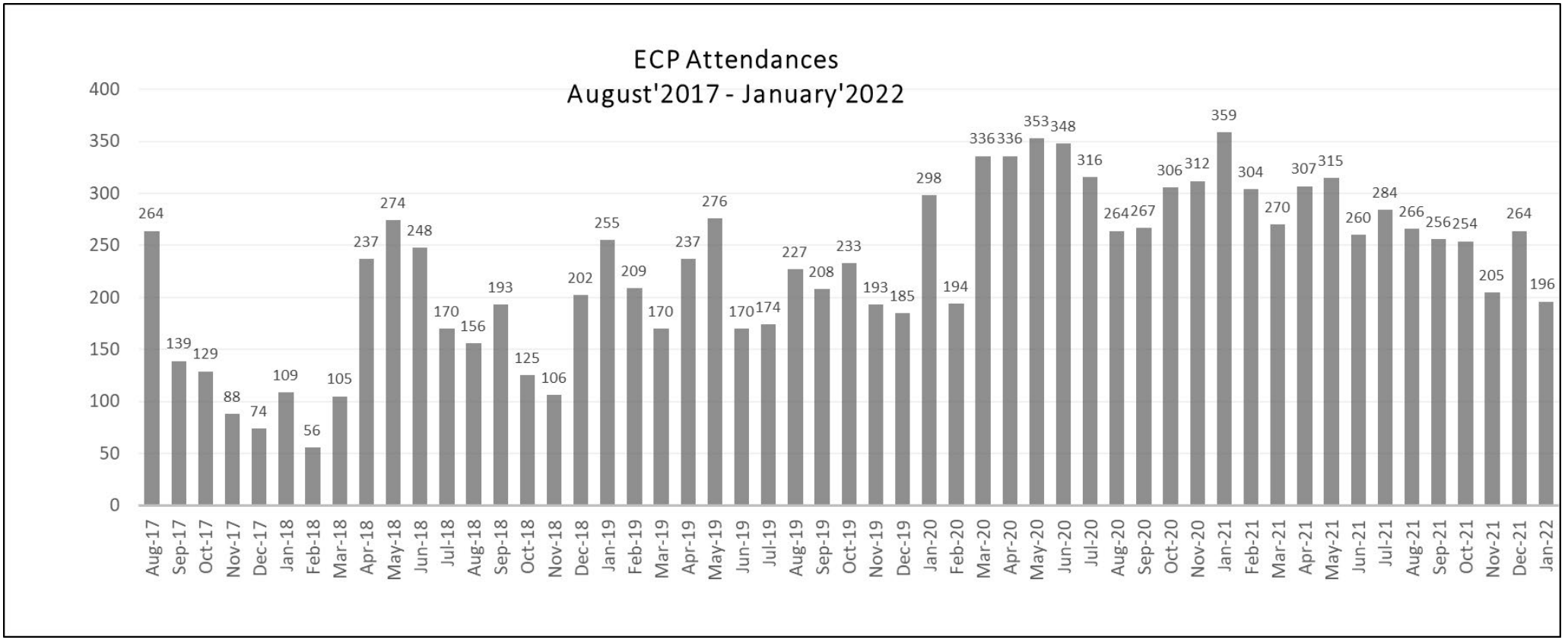
Attachment 1



This graph indicates the escalation in clinical call back (SAAS delays predominantly) numbers for ECPs since January 2019 and January 2022.

The ORANGE arrow indicates is the first COVID 19 state shutdown, the PINK arrow indicates when SAAS doubled the “time to call back” (30min to 60min, 60min to 120min) to reduce the pressure on ECPs, people still wait, but now double the time, has NOT reduced the delays.

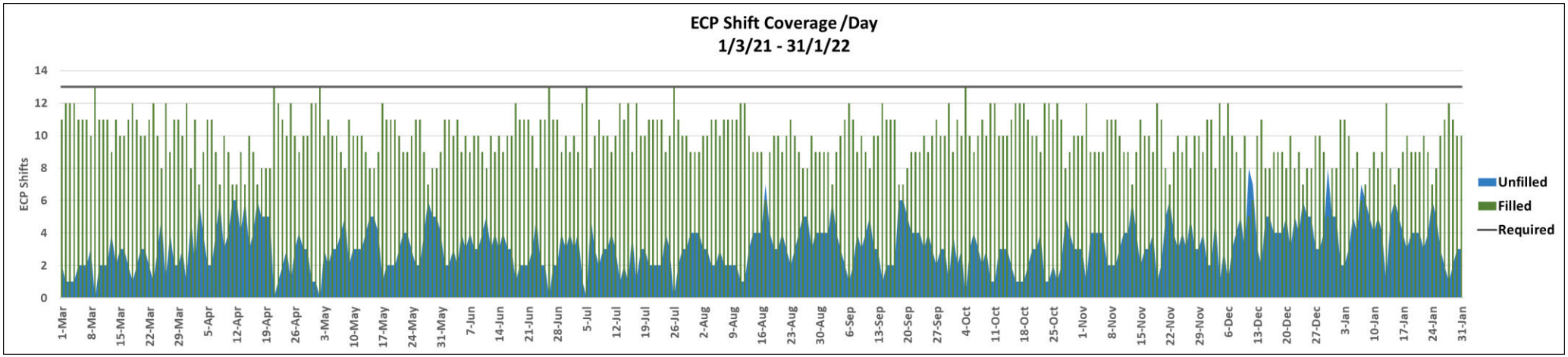
Attachment 2



This graph indicated patients attended by on-road ECPs since August 2017 which is a point when ECPs were compelled to prioritise Call Backs over attending patients in the community.

Why August 2017? – this is when SAAS electively too the decision to reduce on-road capacity in prefernce to EOC, it has also coincided with reduction in ECP overall FTE (full time equivalent)

Attachment 3



This graph represents ECP shifts filled since 1/3/21 until 31/1/22

The grey line represent required sfts to be filled, BLUE line indicates actual shifts filled – on only 7 days have all required shifts filled

Blue shading shows shifts unfilled

This highlights the lack of capacity to attend people in the community as ECPs are take from the road to the EOC.