Project Report

Consumer experiences of WA ambulance services

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We acknowledge the Whadjuk Noongar and Wardandi Noongar people, who are the traditional owners of the lands on which work on this project was undertaken. We pay our respect to all elders past, present and future and extend our respect to all other Aboriginal and Torres Strait Islander cultures.

Contents

1. Executive summary

On April 11, 2019 The WA Department of Health (DoH) commissioned the Health Consumers' Council of WA Inc. (HCC), in partnership with The Behaviour Change Collaborative (The BCC), to deliver a project to capture consumer experiences of road-based ambulance services in Western Australia (WA).

The purpose of the project was to collect actionable insights that could be used by DoH to ensure future procurement of road-based ambulance services are informed by the lived experiences of recent service users, in keeping with the Western Australian Government's focus on patient-centred care and its increased emphasis on citizen-informed policy.

The key consumer engagement mechanisms used were the development and distribution of an online survey, and the planning and delivery of consumer forums in metropolitan Perth, Bunbury and Broome. The project targeted people living in WA who had used an ambulance service in the past five years. This included patients, carers, and anyone who had phoned an ambulance service for a third party. Particular emphasis was placed on obtaining feedback from Aboriginal and mental health consumers.

While the overall level of consumer satisfaction with road-based ambulance services was relatively high, several areas for improvement were identified. The key findings outlined below are based on an analysis of the online survey data and feedback from the public forums. The data and feedback reflects lived consumer experience of ambulance services and that this will necessarily include elements of subjective perception and opinion.

Key findings

Cost

- The cost of ambulance services is considered too high by many health consumers.
- High costs can act as a barrier to access, particularly for disadvantaged and vulnerable populations.
- A high proportion of consumers were not aware of the cost of accessing ambulance services until they used them.
- Twenty percent of survey respondents said they are still not fully aware how much it costs to use an ambulance service, even though they had used the service within the past five years.
- There is a lack of awareness about stand-alone insurance cover for ambulance use.

Response times

- Eighty-seven percent of respondents who have used an ambulance in the past five years were satisfied with the response time.[1]
- Ramping is perceived by respondents as a major contributor to delays.
- A heavy reliance on Global Positioning Systems (GPS) can contribute to delays.
- The use of fully equipped ambulances for patients who do not require them (e.g. mental health, homeless and rough sleepers) reduces availability to those who do.

Access

- Ninety-two percent of survey respondents felt confident they could access an ambulance service when they needed to.
- Most ambulances cannot transport the patient's wheelchair to hospital, resulting in considerable difficulty for those affected.
- Ambulances are not well-equipped to deal with overweight and obese patients, which leads to considerable discomfort, and at worst may result in an inability to safely secure patients for the journey.
- Access to translation services is not always available, and many Culturally and Linguistically Diverse (CALD) consumers are unaware they can request it.

[1] 87% of respondents lived in metropolitan Perth.

Workforce

- The survey and face-to-face consultations suggest that health consumers are extremely appreciative of the work conducted by paramedics and volunteers.
- Ninety-two percent of patients were satisfied with communication from ambulance staff.
- Despite consumer recognition that the standard of care provided is very high, Aboriginal health consumers believed that there is a lack of cultural awareness and sensitivity within ambulance services.

Quality of service

- Ninety-two percent of respondents were satisfied with the quality of service they received.
- Whilst only 4% (n.20) of respondents have submitted a complaint, half of those complainants were dissatisfied with the way in which it was handled by the ambulance service, and only 20% (n.4) were satisfied.
- There is a perceived lack of opportunities for health consumers to provide feedback about ambulance services to the providers.
- The is currently no real time access to patient health data, including previous ambulance records and My Health Record.
- Mental health consumers feel response protocols reflect structural stigma which in turn leads to inflexible, unnecessarily traumatic interactions with ambulance services and police.
- 22% of patients and carers surveyed said there was no check for a medic alert bracelet. A similar proportion of public forum attendees indicated the same.

Key findings were used to inform recommendations outlined in Section 2.

This project clearly aligns with the Western Australian Government's Blueprint for Reform, and specifically Direction 1, which seeks to build "*a public sector based on community needs*"[2] . The project findings and recommendations will be used by DoH to deliver citizen-informed procurement of road-based ambulance services and is predicated on an improved quality of engagement which is more sharply focused on community needs.

[2] Service Priority Review Blueprint for Reform – Department of Premier and Cabinet, October 2017

2. Recommendations

This section comprises formal recommendations for consideration by DoH, categorised under the themes of cost, response times, access, workforce, and service improvement.

During the public forums, we received in excess of 100 recommendations from service users, all of which are included in the main body of this report. While our recommendations do account for all consumer feedback, we have sought to ensure that these formal recommendations are of clear and practical use to DoH.

2.1 Cost

2.1.1 Review of existing charges and billing processes

A review of the existing pricing structure, which better accounts for disadvantaged and/or vulnerable health consumers. Many health consumers we spoke to felt that services should be provided at no charge (e.g. Aboriginal health consumers, homeless, children and babies). While we recognise that this may not be financially viable, consideration should be given to:

- Discounted and/or subsidised fees for Aboriginal health consumers, socio-economically disadvantaged and other at-risk populations. This might include individuals on a healthcare card.
- Who should pay the ambulance call-out fee when a third party calls an ambulance for someone who did not want or need it? Could this be disincentivised?
- Increasing the ease with which service users can access payment plans on the basis of financial hardship.
- Review of debt collection processes to ensure ethical and safe practices.

2.1.2 Alternative ways to pay

A number of suggestions were provided to reduce the adverse financial impact a high ambulance bill (or bills) can have on ambulance users. Several suggestions were made during the public forums and via the survey, and the following options should be considered:

- Charging a levy for ambulance coverage when an individual gets their drivers' licence or vehicle registration.
- Including a levy in local government rates. The later could be collected in the same way that local governments collect the bushfire levy for DFES.

2.1.3 Increase awareness and understanding of cost and cover options

About 20% of survey respondents indicated they were not fully aware of how much it costs to use an ambulance service. A lack of awareness about coverage options was also a key theme throughout the consultation process.

Many consumers were unaware that ambulance cover could be obtained from health insurers as a stand-alone item, without the need to take out a comprehensive health policy. Also, many Aboriginal health consumers were unaware that they could potentially get coverage through services such as Derbarl Yerrigan.

A targeted, low-cost consumer awareness campaign to increase baseline awareness about these ambulance cover options should be considered.

Conversations with insurance providers to encourage them to more clearly promote available options for ambulance coverage would also be beneficial.

2.1.4 Free service to Aboriginal people over-50

The life expectancy gap between indigenous and non-indigenous people is approximately 11 years[3], and many middle-aged Aboriginal people live with chronic health conditions that don't typically arise in non-

[3] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

indigenous Australian's until they're eligible for the pensioner card (and consequently free ambulance services). Providing Aboriginal people who have reached 50 years-of-age with a similar card that entitles them to free ambulance coverage is a more equitable approach than the current system which doesn't account for the gap in life expectancy or quality of life between Aboriginal and non-Aboriginal service users. The actual age at which coverage applies should be proportional to this gap.

2.1.5 Roundtable to explore feasibility of human service organisations providing clients with coverage

Consideration should be given to the viability of human service organisations having some form of ambulance service membership fee or enter into a contractual arrangement with insurer(s) so that they can cover the cost of accessing ambulance services for their clients. A range of social and health service providers and their members could benefit from such an approach. An exploratory roundtable with targeted Not-for-profits, ambulance service providers and insurers is recommended to establish feasibility.

2.2 Response times

2.2.1 West Australian dispatch for all '000' calls

An emerging theme in the survey and during the consultations was that the speed with which calls were processed would have been better if the operator had local knowledge. It is recommended that all WA emergency calls are routed directly to a WA-based dispatcher, rather than to a national call centre.

2.2.2 Less reliance on GPS

Many consumers shared experiences of being in an ambulance where the drivers were reliant on a GPS which did not plot the fastest route to hospital.

While it's acknowledged that ambulance crews cannot be expected to know every road in town, it may be possible to increase knowledge by providing additional training, and/or allocating drivers to specific geographical areas.

2.2.3 Holistic behaviour change strategy to address pressure on emergency departments

Ramping results in less ambulances being available to respond to callouts, thereby increasing response times. There are a range of strategies already being developed by the Western Australian State Government to address this issue, but one approach that may not have been fully considered is the development of a holistic behaviour change strategy to address unnecessary attendances at emergency departments, including walk-ins. A multi-disciplinary strategic behaviour change strategy accounting for upstream, midstream and downstream behavioural drivers is recommended.

2.2.4 Investment in small first responder vehicles

In the absence of dedicated emergency lanes, and in light of the increased levels of traffic congestion, investment in smaller, more manoeuvrable first aid vehicles such as motorcycles is recommended. These would allow paramedics to reach patients more quickly and provide potentially lifesaving first aid until the ambulance itself arrived.

2.2.5 Advise caller of anticipated response time

In many situations, callers to 000 may have the option of sourcing an alternate means of transport, and/or need to do so to ensure they get to hospital as quickly as possible. This is particularly the case in regional areas where response times can be over an hour.

It is recommended that consideration be given to requiring the dispatch operator to inform the caller of the anticipated response time. This would allow callers to make an informed choice about whether to wait for the ambulance or seek an alternative method of transport to the hospital.

2.3 Access

2.3.1 All ambulances equipped for wheelchairs

All new ambulances to be equipped to carry foldable wheelchairs, and where practicable, all existing stock to be retrofitted to allow the same.

2.3.2 Further consultation about access with priority populations

A constant theme throughout the consultation process was the need to ensure all West Australians are able to access ambulance services, and to remove barriers to access for at risk populations. To this end, we recommend additional targeted community consultation with CALD consumers, and people with a disability to (a) better understand what the barriers are, and/or (b) co-design solutions.

2.3.3 Needs assessment and audit - translation services

A large number of people we spoke to indicated that their access (and/or that of someone they cared for) was limited by their inability to speak fluent English.

While translation services are theoretically available upon request, there is (a) a lack of knowledge that they are available, and (b) an apparent scarcity of translators, evidenced by several consumers stating that their request for a translator wasn't met.

A community needs assessment followed by an audit of available translators would identify gaps and allow for remedial contractual measures to be developed.

2.3.4 Improved options for overweight and obese patients

Overweight and obese patients and their carers consistently reported access difficulties. Where practicable, ambulances should be equipped with gurneys and safety restraint systems that cater for all patients.

2.4 Workforce

2.4.1 Consider measures to increase number of Aboriginal staff

There was a firm belief amongst Aboriginal people we spoke with that there are not enough Aboriginal staff employed in the ambulance service. The introduction of a quota system (as exists in other parts of the health service) would increase workforce diversity. Given the strong views that surround the use of quotas (e.g. tokenistic, increases diversity not inclusion) we recommend a cautious approach. However, it is clear that more Aboriginal staff would benefit the service and end-users.

2.4.2 Potential additional training topics for ambulance staff

It has been widely acknowledged throughout this report that in general, the quality of service provided by ambulance service staff is exceptionally high. However, during the course of this consultation, a number of suggestions were made regarding additional training that could be provided to ambulance crews to further improve the performance of some individuals. Training would be improved by addressing:

- Local knowledge (roads)
- Working with people from diverse cultural backgrounds
- Cultural competency (ATSI)
- Mental health conditions and working with mental health patients
- Active listening
- Calming techniques

Furthermore, in light of the survey findings and feedback in forums, a refresher on the import of checking for medic alert bracelet is warranted.

2.4.3 Consider introduction of an on-call mental health professional at dispatch

The needs of people living and/or experiencing mental health illnesses can be complex. The availability of an on-call mental health professional to assist callers support the patient and/or to proffer direct support to the patient themselves would be beneficial.

2.4.4 Gratitude portal

Survey respondents and forum attendees consistently expressed high levels of appreciation for paramedics and volunteers. But, dozens of those we spoke to expressed varying degrees of disappointment that they were unable to get in touch with the staff member to let them know how much they appreciated their help.

The establishment of a 'gratitude portal' or similar feedback mechanism allowing service users was a popular idea.

2.4.5 Mixed gender crews

Where practicable, ambulance crews should comprise one male officer, and one female officer.

2.5 Service improvement

2.5.1 Improved collection and use of consumer feedback

One of the most surprising themes to emerge during the community consultation phase was that very few consumers had been asked to provide feedback to the ambulance service about their experiences. Typically, less than one in ten attendees recalled being asked for feedback.

While this evidence is purely anecdotal, there is sufficient reason to believe that a more robust approach is needed. Ideally, all service users would be approached for feedback about their experiences.

Suggestions made by consumers worth considering included automated text messaging, and the inclusion of a survey mechanism with the bill.

2.5.2 Access to My Health Record

At present, there is no current patient data or even previous ambulance records available in real-time to ambulance staff. As first-responders, paramedics should have access to the My Health Record to ensure the most appropriate care is provided to patients. This issue was of particular import to those with pre-existing health conditions, and those with complex medical needs or medication regimes.

2.5.3 Review of complaints handling

While only 20 of 452 respondents reported lodging a complaint about the ambulance service, 50% (n10) were dissatisfied with the way it was handled, and only 20% (n4) were satisfied. Although a very small data set, the results suggest there is room for improvement. A small, cost-effective review may be beneficial and warrants consideration.

2.5.4 Review mental health response protocols

Key concerns raised by mental health patients and carers included the frequency with which WA Police attend with the ambulance service. Based on the feedback we obtained it seem likely that in many instances, the police presence escalates situations that could be resolved more favourably by properly trained and supported paramedics. The use of chemical and/or physical restraint is an option that anecdotal evidence suggests is at times avoided by paramedics, with the WA Police used to cuff and transport mental health patients, often in marked cars.

A review of the response and treatment protocols for mental health patients with particular emphasis on the use of WA police, and ambulance service use of restraint is recommended. If police must attend it would be helpful if (where practical, perhaps just in metro areas) a plain clothes, specially trained mental health team could do so.

2.5.5 Explore other means of transport for low-risk trips

Several mental health consumers expressed guilt about using ambulances for travel to hospital when they had no need for any of the medical equipment it carried. A review of ambulance usage for mental health (and other identified consumer segments and incident types) could be conducted with the aim of establishing what alternate transport options might be more appropriate (and less costly) than fully equipped ambulances.

3.Survey findings

3.1 Service improvement

This section provides a summary of key data obtained from the online survey. Notably, a comprehensive summary of all survey responses has been provided to DoH in the *Survey Summary Report (September 2019)*.

The purpose of the online survey was to capture consumer perceptions of WA ambulance services, and to draw out lived experiences from service users that could be used to inform future contracting of ambulance services in WA.

The survey was open between 15 August 2019 and 2 September 2019. It was closed early due to an excellent response. A target of 300 responses had been set, and by 2 September, 452 valid responses had been received. To be eligible to complete the survey, respondents must have used the WA ambulance service within the past five years.

Of the 452 responses, 213 were completed by patients, and 214 by carers. The remaining 25 responses were completed on behalf of the service user by a family member/friend or carer.

The majority of respondents lived in Perth (87%), were female (60%), and of white Australian, British or Irish descent.

Aboriginal and Torres Strait Islander peoples, CALD populations, other vulnerable populations, and young people were all under-represented in the survey.

The relatively low proportion of rural and remote respondents was an intended outcome of the recruitment methodology. In light of work already undertaken by WACHS in drafting of the Country Ambulance Strategy 2018, the project control group were directed to focus most of its attention on metropolitan service users.

Eighty-nine percent of patients were conscious when they travelled in the ambulance, and six percent were under the influence of alcohol or other drugs at the time of accessing the service. Eight percent of patients required clinical care for a mental health condition.

3.2 Classification data

3.2.1 Circumstances of use

Forty-two percent of respondents (n.190) called 000 and/or attended an emergency department, the majority of whom 84% were patients.

Thirty-one percent of respondents had most recently used the Metro Community Transport Service, of which the majority (94%) were carers.

Response	PATIENT	CARER	ON BEHALF	TOTAL	%
Dialled 000 and / or attended an Emergency department	160	12	18	190	42.0
Planned transfer between public hospitals	7	15	0	22	4.9
St Johns Metro Community Transport Service	8	131	1	140	31.0
St Johns Country Community Transport Service	2	35	3	40	8.8
Other (please specify)	36	21	3	60	13.3
TOTAL	213	214	25	452	100

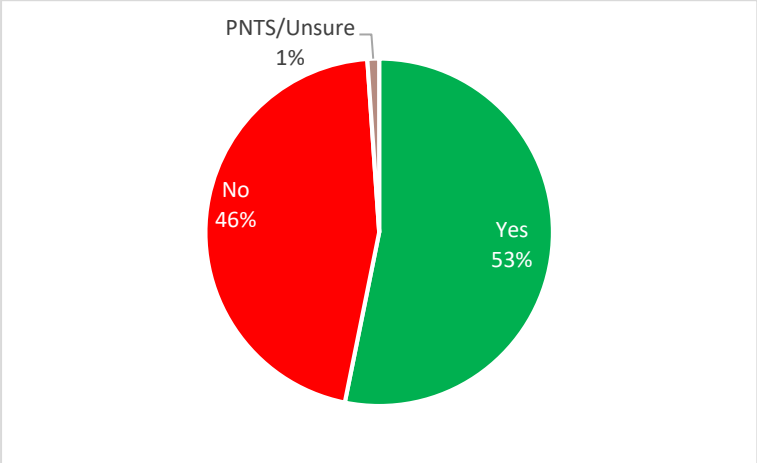
3.2.2 Caller data

Fifty-seven percent (n.257)of those completing the survey were the person who called the ambulance. Of those who called the ambulance, 68% (n.174) were carers.

Response	PATIENT	CARER	ON BEHALF	TOTAL	%
Yes	78	174	5	257	56.9
No	135	40	20	195	43.1
TOTAL	213	214	25	452	100

3.2.3 Aware of being charged

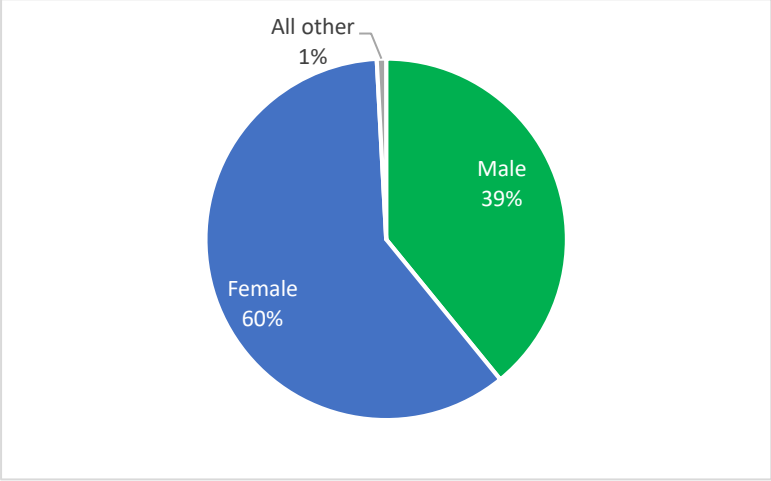
Nearly half of all respondents (n.209) indicated they were not aware how much they'd be charged to be transported by ambulance.



3.2.4 Gender

We received a relatively high proportion of responses from females (n.287), likely due to the fact women are statistically far more likely than men to have caring roles[4].

While the gender balance between patients was relatively similar (120 female vs. 101 male), there was a large discrepancy in the proportion of male and female carers who completed the survey (158 female vs. 71 male).



[4] Carers NSW Policy Statement – Female Cares [online]

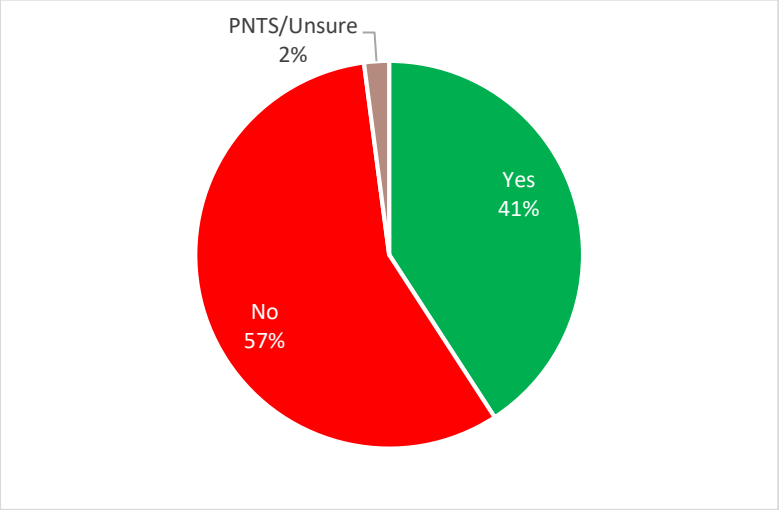
3.2.5 Age

Sixty-four percent of respondents were aged between 45 and 75 years (n.305). Young adults, particularly 18-24-year-olds, were significantly under-represented. Under-18's were not targeted as they were not within the project's scope.

Response	PATIENT	CARER	ON BEHALF	TOTAL	%
Under 18 years	0	0	4	4	0.8
18-24	7	6	3	16	3.3
25-34	19	24	0	43	9.0
35-44	19	28	0	47	9.8
45-54	40	42	4	86	18.0
55-64	51	53	1	105	22.0
65-74	51	58	5	114	23.8
75 years and over	36	19	8	63	13.2
TOTAL	223	230	25	478	100.0

3.2.6 Pensioner concession card holders

Forty-one percent (n.98) of eligible respondents held a current pensioner concession card and were therefore eligible for free access to ambulance services.



3.2.7 Place of residence

Eighty-seven percent (n.394) of all respondents lived in the Perth metropolitan area. As already noted, the low representation of country residents was a function of our targeting, which was metropolitan centric in light of the work already undertaken by WACHS on its Country Ambulance Strategy.

Response	PATIENT	CARER	ON BEHALF	TOTAL	
Perth	187	186	21	394	87.2
Wheatbelt	6	2	1	9	2.0
South West	10	15	1	26	5.8
Midwest	2	4	0	6	1.3
Great Southern	3	4	1	8	1.8
Goldfields	4	1	0	5	1.1
Pilbara	0	1	1	2	0.4
Kimberley	1	1	0	2	0.4
Outside WA	0	0	0	0	0.0
TOTAL	213	214	25	452	100.0

3.2.8 Proportion of Aboriginal respondents

Only two percent of respondents (n.10) identified as Aboriginal or Torres Strait Islander. Of this number, four were patients and six were carers. There were no respondents from a Torres Straits Islander background.

This level of under-representation was anticipated. Two face-to-face sessions were planned and held with Aboriginal service users, the key findings of which are outlined in sections 4.7 & 4.8.

3.2.9 Cultural background

White Australians and people from British or Irish descent were significantly over-represented, comprising 87% (n.398) of all respondents.

All other nationalities and cultural backgrounds were significantly under-represented, which was likely a result of the survey recruitment process which relied heavily on the use of consumer panels (70% of all responses).

Almost all (99 percent) of respondents indicated they understood English "very well", with only two responding that they needed an interpreter.

Response	PATIENT	CARER	ON BEHALF	TOTAL	%
White Australian	140	154	17	311	67.9
Oceanian	3	3	0	6	1.3
British or Irish	45	38	4	87	19.0
North-West European	6	5	1	12	2.6
Southern or Eastern European	6	5	2	13	2.8
South-East Asian	6	4	1	11	2.4
North-East Asian	0	1	0	1	0.2
Southern and Central Asian	2	1	0	3	0.7
North, Central or South American	1	2	0	3	0.7
Sub-Saharan African	3	0	0	3	0.7
Other	6	2	0	8	1.7
TOTAL	218	215	25	458	100.0

3.2.10 Mental health status

Sixteen percent (n.73) of respondents indicated they were living with a mental health condition at the time of their last ambulance use. As already noted, only half this number (8% of respondents) received treatment for a mental health condition the last time they used an ambulance service.

Of the 16% living with a mental health condition, 33 said they had depression and 21 indicated they suffered from anxiety. In many cases, respondents were experiencing both conditions.

3.2.11 Chronic illness and conditions

Almost one-third of all respondents (n.148) indicated they had a chronic illness of condition. Of this number, 66% (n.98) were patients, and 32% (n.47) were carers.

3.2 User experiences

In the first part of the '*your experience*' section, respondents were read a series of statements and asked to indicate their level of agreement using a 5-point Likert scale. Statements related to one of five areas of interest identified by DoH, namely:

a) dispatch
b) communication with ambulance staff
c) access
d) quality of care, and
e) time.

This section provides the mean scores for each of the statements by respondent type. Mean scores across each of the five areas of interest were relatively high, indicating that respondent experiences of ambulance services were generally positive.

Mean scores from respondents completing the survey on behalf of the patient were consistently lower than those of patients and carers.

3.3.1 Dispatch (call handling)

Overall, the quality of service received when calling an ambulance in an emergency or booking an ambulance for patient transport was perceived as very high (mean 4.6 & 4.5 respectively). There were considerable drops (up to 10%) in levels of satisfaction amongst respondents completing on behalf of a service user.

Statement	PATIENT	CARER	ON BEHALF
17. The person answering my call was professional	4.6	4.6	4.4
18. The person answering my call was courteous and kind	4.6	4.6	4.1
19. The person answering my call understood my needs	4.4	4.5	4.2
20. The person answering the respondent's call dispatched help quickly	4.5	4.5	4.2
21. Overall, I was satisfied with the quality of service I received when calling for an ambulance (emergency calls)	4.6	4.6	4.2
22. Overall, I was satisfied with the quality of service I received when booking an ambulance (patient transport)	4.5	4.6	4.2

3.3.2 Communication

Overall, respondents were highly satisfied with the quality of communication with ambulance staff. Notably, patients consistently rated communication more highly than carers, and carers rated communication more highly than those completing on behalf of the service user.

For example, there was an 8% drop in overall satisfaction between patients completing the survey for themselves, and those for whom the survey was completed on their behalf.

Statement	PATIENT	CARER	ON BEHALF
23. Ambulance staff respected my/patient privacy	4.6	4.6	4.3
24. Ambulance staff treated my/patient condition seriously	4.7	4.5	4.3
25. Ambulance staff explained things in a way in which I could understand	4.7	4.6	4.3
26. Ambulance staff listened to me carefully	4.7	4.5	4.3
27. Ambulance staff answered my questions in a way I could understand	4.6	4.6	4.4
28. Overall, I was satisfied with the quality of communication from ambulance staff	4.7	4.5	4.3

3.3.3 Quality of care

Overall levels of satisfaction with the quality of care received from ambulance staff was very high. Pain management and cultural sensitivity scored slightly lower than interpersonal indicators (courtesy and kindness).

The level of agreement that ambulance staff checked for a medic-alert bracelet was significantly lower than all other scores (3.9). This suggests that over 1 in 5 (22%) of respondents did not recall the patient being checked

for a medic-alert bracelet. Notably, only 75% of patients used the ambulance in an emergency situation, but since the issue was also raised by attendees further scrutiny is recommended.

Statement	PATIENT	CARER	ON BEHALF
29. Ambulance staff were courteous	4.7	4.6	4.5
30. Ambulance staff were kind	4.7	4.6	4.5
31. Ambulance staff seemed to have access to the equipment they needed to deliver high quality care	4.7	4.5	4.6
32. Ambulance staff adequately controlled my pain	4.5	4.4	4.3
33. Ambulance staff checked if I had a medic-alert bracelet	3.9	3.9	4.2
34. Ambulance staff demonstrated an appropriate level of cultural sensitivity	4.4	4.3	4.3
35. Overall, I was satisfied with the quality of care the respondent received from ambulance staff	4.7	4.6	4.4

Seventy-eight percent of patients and carers recall their being a check for a medic alert bracelet. This is the same proportion of patients who were seen in an emergency which could explain the apparent low number. However, when we asked consumers and carers at public forums if they recalled being checked there was a similar proportion of people who were aware of what was happening at the time and said they weren't asked if they had one or checked for one.

3.3.4 Timeliness

In general, satisfaction with the time taken to answer calls, and with ambulance response times was relatively high.

Notably, 87% of respondents live in the Perth metropolitan area where response times are considerably better than regional and remote areas.

Statement	PATIENT	CARER	ON BEHALF
36. I was satisfied with the time it took to answer their call	4.5	4.5	4.5
37. I was satisfied with the time it took for the person answering their call to take the necessary details	4.5	4.6	4.5
38. I was satisfied with the ambulance's arrival time	4.4	4.3	4.6
39. Overall, I was satisfied with the ambulance response time.	4.4	4.3	4.3

3.3.5 Access

Overall, confidence and knowledge about how to access the ambulance service was high, particularly amongst patients and carers. However, awareness about the costs associated with using an ambulance were significantly lower than other access related responses.

Statement	PATIENT	CARER	ON BEHALF
40. I am confident I can access the ambulance service when I need to	4.6	4.6	4.3
41. I know how to access the ambulance service when I need to	4.7	4.7	4.4
42. I am comfortable accessing the ambulance service when I need to	4.5	4.4	4.4

Statement	PATIENT	CARER	ON BEHALF
43. I am fully aware how much it costs to use an ambulance service	4.0	3.8	4.1
44. It is clear to me when to use an ambulance and when to use another option to access health services	4.4	4.4	4.2

In conclusion, these results indicate that consumer experiences of ambulance services are generally very positive.

Key areas for improvement (which will be specifically addressed in the recommendations) related to medic-alert checks, and costs associated with using the ambulance service.

Notwithstanding frequent public and media discourse around response times, this data indicates people were generally satisfied with the time taken for ambulance services to respond. However, it should again be noted that 87% of respondents lived in the metropolitan area where response times are mandated, and service parameters are markedly different to those experienced by people living in regional WA.

3.3.6 Complaint handling

Only 20 of 452 respondents had ever made a complaint about an ambulance service to a service provider. This supports the view that generally, consumers are very satisfied with the level of service received. However, those who did complain were generally dissatisfied with the way in which their complaint was handled by the service, as indicated in the table below.

Level of satisfaction	PATIENT	CARER	ON BEHALF	TOTAL
1 = not at all satisfied	6	0	1	7
2	1	1	0	2
3	0	0	1	1
4	1	1	0	2
5	0	0	0	0
6	1	0	1	2
7 = completely satisfied	1	1	0	2

3.4 Open responses

In this section, we outline the key themes which arose from an informal review of the open responses received. The approach has been to establish a 'theme' when ten or more respondents commented on the same issue.

We received hundreds of open comments via the online survey, most of which do not fit into any one theme and are therefore not included in this report. However, the insights the comments afford are considerable, and they can all be found in the *Survey Summary Report (Sept 2019)*

In the online survey, we asked three broad questions to obtain consumer feedback on (a) areas for improvement, (b) areas that are working well, and (c) an open comment field in which respondents could say anything they liked.

Notably, all of the themes identified in the survey re-surfaced during the public forums and are discussed in more detail in Section 3.

3.4.1 Identified themes – areas for improvement (n.453)

Areas for improvement were identified by asking: ***"what one thing could the ambulance service have done to make your experience better?"***

Notwithstanding a number of areas for improvement being identified, a narrow majority of responses to this question conveyed positive sentiment and indicated that "nothing" could be done to make the service better.

Furthermore, dozens of respondents provided detailed written responses about how good their experience had been.

Finally, many of the areas identified for improvement were also cited by others as things that the service did very well (e.g. response times). The feedback received reflects the reality that each service user's experience is unique.

3.4.1.1 High cost to patients

The cost to patients of accessing ambulance services was a major theme throughout the consultation process, including the online survey. The financial cost of accessing the service was viewed as being too high, and for many, made access unaffordable.

"To not charge… the next time I have a heart attack, I would like to drive myself the 1km to the hospital except it seems I'm going to be forced to sell my car to pay the ambulance bill."

"To not charge as much. Hope you look after poor people…"

"Advised me that the cost to travel 400m to the nearest hospital would be over $600."

Many respondents also bemoaned a lack of knowledge about the cost of using an ambulance prior to accessing the service. Respondents would have preferred to be informed up-front, rather than receiving a bill in the mail after the fact.

"Told about the costs."

"Let us know how much it would cost as she was shocked by the bill when she received it and wasn't given the option not to go to the hospital."

Finally, several respondents indicated they'd have liked ambulance service staff to provide alternate options where financial hardship was clearly a factor.

"I could be given other options. The ambulance wasn't urgent, and I could have been transported by a family member and not get a $500 + bill."

Check whether I actually need an ambulance, and more importantly, whether I can afford to pay for one."

3.4.1.2 Slow response times

Dissatisfaction with the time taken for the ambulance service to respond was one of the most commonly cited areas in need of improvement. However, it should be reiterated that overall, 88% of patients, and 84% of carers said they were "satisfied" with the time it took for the ambulance to arrive.

Response times are a function of several aspects of the service interaction, which, in the case of emergency calls, typically commences with a call to an operator (dispatch).

"Key details were missed on the call."

"The call was deferred so there was a delay in being put through to an ambulance."

Once dispatched, the ambulance arrival time was also deemed to be to slow by several respondents.

"Arrival time. Unfortunately, it was Saturday night and it took 45 minutes."

"Respond in the timely manner that was required."

3.4.1.3 Ride quality

The majority of respondents recognised that comfort was not an over-riding priority when using an ambulance service, particularly in an emergency. However, many comments about various aspects of ambulance ride quality, most of which pertained to passenger/carer comfort and/or safety, were received.

Travel in the back of an ambulance, particularly for carers, could be uncomfortable for a variety of reasons.

"More comfortable journeys, springing poor."

"Just the bumpy ride. I had no idea how bumpy it could be in the back of an ambulance."

"Better shock absorbers – patients with back pain very sensitive to road bumps."

3.4.1.4 Communication

Overall, the level of satisfaction with communication amongst patients and carers was 92% (4.6/5). However, several respondents suggested there was room for improvement to the way in which ambulance staff communicated with the patient and/carer.

The majority of negative comments about communication related to patients and carers not feeling listened to.

"They did not seem to take me seriously when I have been in this situation with a family member numerous times."

"The staff member did not listen to us closely enough."

"Respondent was under instruction from a surgeon, but the ambulance officer refused to listen."

"Listened carefully to my concerns."

"Listened better to me as I knew the gentleman concerned and had his medical records."

Concerns of this type tended to come from carers and family members of the patient, who often felt they had important or helpful information that might assist with treatment.

In addition, a small number of respondents indicated that it would be useful if there had been an interpreter available given English was a second and/or unspoken language.

3.4.2 Identified themes – what's working well (n.453)

In addition to identifying areas for potential improvement, we wanted to find out from recent ambulance users what aspects of the service worked well for them. We asked: **"What one thing is the ambulance service doing really well."**

In this section we again highlight key themes.

It should be noted that across all three open text questions there were significantly more positively framed responses than suggested areas for improvement. So while themes may appear to off-set each other, the reality is that in all instances where there is overlap, positively framed responses were in the clear (at times overwhelming) majority. *(See Survey Summary Report, September 2018)*.

2.4.2.1 Fast response times

While some respondents were disappointed with the time taken for the service to respond, we received significantly more responses that indicated response times were very good. As previously noted, 87% of respondents were based in metropolitan Perth.

"They did attend in a timely manner looking after my medical needs to get me to hospital as quickly as possible."

3.4.2.2 Empathetic response

The empathetic response of ambulance service personnel was a feature of all three open text questions. That is, when asked what could be improved, many respondents said "nothing" and instead wrote of the positive way in which they were treated by staff. Frequently occurring words that support this theme included:

- Kindness
- Professionalism
- Caring
- Friendly
- Calm
- Compassion

"They explained to me what I asked - there was even laughter they were professional, friendly and put me at ease."

"I was reassured constantly during the journey by the kind ambulance staff."

"Fantastic paramedics, kind, compassionate and caring."

"Dealt with a tragedy with professionalism, care and compassion."

"Listened to the patient and accepted what was said."

The empathetic way in which ambulance service staff interacted with service users was the defining sentiment of all our engagement (survey and public forums) with service users.

Many service users noted that their fears were lessened as a result of the reassuring way in which they were treated by ambulance staff.

"Remained calm and very reassuring that they would be able to help me."

3.4.2.3 Quality of care

The overall level of satisfaction with the quality of care received was generally very high (4.7/5 patients, 4.6/5 carers), and the open text responses reinforced this data.

In addition to the interpersonal qualities like empathy, kindness and compassion outlined in 2.4.2.2, respondents also cited effective pain management, professionalism and clinical competency when asked what worked well the last time they used an ambulance service.

"Swiftly grasped the patient's condition and medicinal regime then commenced treatment quickly."

"I felt safe. They were in control and knew what they were doing. I think they do a wonderful service."

"Supplied the appropriate pain medication as needed."

3.4.3 General comments (n.226)

The general comments section was non-compulsory but 50% of survey participants chose to complete a response, which is a relatively high proportion based on our previous experiences of conducting consumer surveys.

Respondents typically used this section to provide more detailed accounts of their personal experiences, and consequently, few specific themes emerged. Responses were also more evenly split between positive and negative sentiment, unlike elsewhere in the survey where positive sentiment was clearly more prevalent.

In this section, we have selected individual responses that either;

a) Speak to a common theme or sentiment, and/or
b) Provide insight that warrants inclusion for DoH consideration.

The issue of ramping and the adverse impact it has on response times and ambulance availability was raised by numerous respondents but is outside of the project scope.

3.4.3.1 General comments – quality of care (+)

Many respondents wrote favourably about different aspects of the quality of care they received, including clinical excellence, communication and empathy.

"My child has regularly required a Priority 1 ambulance on many occasions in the past, unfortunately. He has a severe respiratory condition where he has needed to be resuscitated and treated with nebulised adrenaline and oxygen whilst being rushed to hospital.

"Ambulance Paramedics and Officers have always been prompt, caring, courteous and just wonderful under such stressful circumstances. I adore them all and are truly grateful that we have such a fantastic emergency service available to us. Thank you."

"Have needed to use the ambulance service four times in the last 7 years due to heart problems. All experiences in Perth and the south west have been positive, professional and medically excellent. They are responsible for keeping me alive whilst getting me to hospital."

3.4.3.2 General comments – Australia's best (+)

Numerous respondents expressed a belief that WA had the best ambulance service in Australia, if not the world.

"WA Ambulance service is the best in Australia."

"Wonderful service in WA!!"

3.4.3.3 General comments – response times (-)

Several comments identifying slow response times were received. Ramping and a perceived shortage of ambulances in service were seen to be the primary drivers of delays.

"We need more of them to enable faster response times. They do an amazing job but are stretched due to ramping at hospitals."

"The operator took a very long time to answer the call and then kept apologising as they were having trouble contacting an available crew. I was on the phone for 15 minutes."

"It took forever to answer the phone and the it took about an hour for an ambulance to come - not acceptable! We need more ambos in ambulances and on the phone!"

3.4.3.4 General comments – dispatch (-)

Concerns about dispatch typically centred around two issues, namely the interpersonal skills of the dispatch operator, or a centralised call centre leading to delays.

"I did have a negative interaction with the call centre many years ago. I am a Registered Nurse of at the time 25 years' experience, and was resuscitating a child and the call centre person was giving conflicting advice to my treatment at the scene via the Father who was on the phone with them…"

"…centralised call centre for 000 does provide some delays."

3.4.3.5 General comments – cost (-)

Several comments were submitted pertaining to the high cost of ambulance services.

"The cost of an ambulance service is a huge deterrent to calling an ambulance. Even with a concession it's over $400. Yes, I know insurance is available but there are many reasons why someone may be uninsured."

"It is far too easy for just anyone to act as a 'good Samaritan' and call an ambulance for someone who doesn't need it and/or cannot afford it, especially when there are numerous other modes of transport easily accessible. In my case there was a panicked bystander who probably just came out of hospital himself (apparently had a hospital id on his wrist) and overreacted significantly leaving me with a $967 bill which then meant I had to claim WorkCover and open a whole case for insurance cover and ongoing series of medical assessments (also at outrageous cost). I have had to manage a whole trail of paperwork and additional appointments that have added another whole layer of unwanted stress to my life, while the caller walks away thinking he's done a good deed. Meanwhile services are not being used where they should be, and costs are spiralling ever higher for everyone..."

"I will not call for an ambulance for myself--or anyone else--unless I have no other option. Taxis, buses, trains will be preferred as the cost is unsustainable for me and the people I know. I will risk problems by taking alternate travel to hospital even if quite unwell--a risk I have to take."

However, it should be noted that other respondents felt that: "the cost is immaterial when there's an emergency."

3.4.3.6 General comments – more ambulances needed on the road (-)

Respondents expressed a view that more ambulances are needed to meet existing and future needs.

"There are 2 ambulances based in the town. The town has a high population of elderly people, plus a sizeable elderly respite and care facilities. The ratio of elderly people per population is higher than average due to the caring facilities. It is apparent that 2 ambulances do not manage to cope with the demand sometimes and an ambulance has to be diverted from elsewhere…"

"It is not acceptable that a city like Bunbury only has one 24-hour ambulance."

"I do have concerns about ambulance service in the Southwest even though I haven't had need to call them. There is only ONE paramedic and he has to sleep and have a day off occasionally. It is volunteer staffed and as far as I know do a good job, but I understand a callout can take a while."

4. Public consultations

4.1 Overview

Eight public consultations were scheduled for delivery in September and October 2019 to obtain additional feedback from ambulance users about their experiences in the past five years and to provide specific focus on targeted groups.

Two forums were planned for regional WA (Broome and Bunbury), and an additional six forums were planned for metropolitan Perth. Due to insufficient numbers, the Broome session was cancelled, and The BCC conducted scripted phone interviews (Appendix 1) with three individuals who had booked to attend.

Of the six metropolitan sessions, two specifically targeted Aboriginal service users, and two focused on people living with a mental health illness or condition. Aboriginal and mental health consumers were also able to attend the other public forums.

Attendees were recruited using several methods including email promotion through key stakeholder groups, and social media marketing. This included regular promotion via HCC and The BCC Facebook pages, and the use of Twitter, Instagram and LinkedIn. The HCC directly approached numerous community organisations by phone to encourage attendances. However, the vast majority of participants were sourced through direct panel recruitment.

Example of social media post image

All public sessions were led by Luke van der Beeke (The Behaviour Change Collaborative) with logistical support from Nadeen Laljee-Curran (Health Consumers Council).

A clear agenda was developed for each of the sessions, but the facilitation team adopted an adaptive, fluid approach to allow space for each forum to flow in their unique way.

The approach taken at each of the forums was relatively informal in order to encourage friendly exchange, trust and encourage participation. This approach was adapted for each audience with particular care taken to ensure the delivery style adopted (including attire, language and use of humour) were appropriate.

The project team's experience in community consultation has shown this type of approach is more likely to engender trust and establish open dialogue more quickly than traditional public sector consultative methods.

Based on the feedback from consumers, (many of whom reflected the sessions were amongst the best they'd attended) and the quality of the insight obtained, the approach to facilitation was advantageous. The team has acquired detailed, honest, granular feedback that contained insights DoH could use to inform future procurement.

Consistent with best practice in engaging with consumers, attendees at all sessions were provided with a $70.00 consumer payment.

4.1.1 Forum statistics

Table: Forum statistics

Forum name	Date	Location	Attendees
Perth - general	20th September, 2019	The Rise, Maylands	26
St Pat's - homeless	23rd September, 2019	St Pat's, Fremantle	19
Mental Health 1	25th September, 2019	Telethon Speech and Hearing Centre	17
Broome	Telephone interviews	N/A	3

Forum name	Date	Location	Attendees
Bunbury	4th October, 2019	Hudson Road Family Centre	17
Aboriginal 1	9th October, 2019	Langford Aboriginal Association	9
Aboriginal 2	10th October, 2019	Royal Perth Hospital	22
Mental Health 2	16th October, 2019	CoMHWA	8
		TOTAL ATTENDANCE	**121**

4.2 Perth forum

The first public forum held was an open session convened at The Rise, Maylands. It was well attended by 26 health consumers and carers.

The opening presentation was well-received and generated several questions, particularly in relation to project scope.

Attendees were advised that the topics of ramping, and the Royal Flying Doctor Services (RFDS) were not within scope. However, the transition between the RFDS and ambulance services was permitted brief discussion, and it was also acknowledged that ramping and the RFDS impacted ambulance service delivery in different ways.

The agenda for the forum was as outlined in the table below.

Table: Agenda (Perth forum)

Time	Agenda item
11.00 – 11.10	Welcome and acknowledgement of country
11.10 – 11.20	Scene setting (including presentation)
11.20 – 11.35	Group discussion – sharing experiences
11.35 – 11.55	Feedback
11.55 – 12.00	Stretch and refresh
12.00 – 12.20	Group discussion – role play
12.20 – 12.40	Feedback
12.40 – 12.55	Open discussion and Q&A
12.55 - 13.00	End

All bullet points in sections 4.2.1 – 4.2.7 are a direct transcription of notes taken by attendees on the butcher paper provided.

4.2.1 Group discussion Perth – what went well?

During the first group discussion, participants were invited to consider their previous experiences of dealing with the ambulance service. The focus was on encouraging participants to share experiences with other group members.

- Polite.
- Reassuring. Kept the patient and families calm.
- Very timely. Prompt.
- Talked through the process and treatment.
- Telephonists were great monitoring on call back.
- Paramedics went beyond what was expected in terms of follow-up.
- Ambulance services are generally very good.
- Lots of great service examples.
- I was in a car accident. Fire truck and ambulance arrived quickly and communicated well.
- Caring. Held my hand all the way. My needs were met well.
- Very respectful.
- Felt very safe.
- Helped to calm me over the phone.
- Arrived promptly and were respectful.
- Very kind and treated me with care.
- Arrived quickly after the doctor called them.
- Treated with respect and listened to.

- Felt safe at all times.
- Kind and caring.
- 5-Star service.
- All went well (+ morphine).
- No bill because I was a pensioner.
- One person had to pay [table of 5].
- Arrived with doctor.
- It was a good experience.

4.2.2 Group discussion Perth– what could've gone better?

- Forty-five-minute wait and a detour that seemed unnecessary (they thought they'd left the ambulance shed open).
- Lack of urgency and knowledge about how to access the regional ER.
- More training needed for volunteers.
- SOS phoneline kept cutting out and needed call back numerous times (regional).
- Handover at ER could've been better.
- Health system transparency isn't 180 degrees.
- Sort out billing and handover at hospital.
- Had pre and post ambulance issues. Call interactions were poor, as was handover at the hospital.
- More acknowledgment of reason for the call, i.e. understand caller motives and anxiety (also am I a nuisance?)
- They don't listen. They assume what you need; the don't ask questions; judging what they see without ascertaining what its relevance it. I definitely don't feel safe because of these reasons.
- I need to remain upright so can't be placed on a stretcher. The only option was to have me manhandled up the steps into the ambulance.
- [Paramedics] dismissed my issue as the flu after being told of procedure just days prior that had sepsis as a possible complication. They came across as dismissive and know it all. My needs were met, but I didn't feel listened to.
- It cost me $900.00 for a Panadol.
- No cost explanation on the phone.
- Slight delay.
- There was a language barrier.
- Got to the hospital, then "bye."
- Bad experience by a non-resident with no ambulance cover. Lack of access, difficult to communicate.
- No cover for ambulance only. [In response to this feedback, another attendee mentioned that this is available].

4.2.3 Group discussion Perth – were your needs met?

- Not if you can't pay for it.
- In the main, a big YES!
- Felt my needs were met better in the ambulance than in the ER.
- Met my babies' need for immediate care.

4.2.4 Group discussion Perth – did you feel safe?

- All felt pretty safe.
- Drove too fast – felt unsafe on a winding regional road.

4.2.5 Group discussion Perth – were you treated respectfully?

- Telephonist was a little impatient on call back.
- Paramedics are exceptional communicators. They need more respect and recognition themselves.
- Acknowledge consumer understanding of effective priority communication.

4.2.6 Group discussion Perth – role play scenario

In the role-playing session, consumers were asked to imagine themselves in the role of contract managers at the DoH. They were to pretend that their table group was responsible for drawing up and awarding the next ambulance services contract for WA. We provided participants with non-compulsory prompts to consider and told them they could include any other contract terms they felt necessary to ensure a world-class ambulance service for WA.

4.2.6.1 What key performance indicators would you include?

- Efficiency of call centre.
- Clear communication (verbal)
- Calm but assertive, understanding but firm.
- All personnel adequately trained paramedics.
- Response time.
- Fleet of ambulance vehicles all should have the correct specifications.
- Response time.
- Listen actively rather than making assumptions.
- Ask multiple questions.
- Always look and ask for instruction cards related to the patient's health which will provide insight into the relevant requirements.
- Staff wellbeing. Team building and buddy system.
- Personal safety. Reliable communication between base and ambulance officers.

4.2.6.2 Bonuses or incentives would be awarded for…

- If KPI's are met, contract is rolled over for a period of time based on good performance.
- Patient follow-ups.
- Monetary bonuses based on group and/or station performance.
- Extra training undertaken – e.g. officers with a second language, or specialist skills.
- Loyalty bonus for remaining with the service.
- Not applicable as it can cause corners to be cut just to get the bonus.

4.2.6.3 Penalties would be imposed for…

- Mistakes made due to poor communication.
- Unprofessional conduct.
- Not following up when promised.
- Tardiness.
- Failing to deal properly with complaints.
- Contract termination for extreme breaches – especially around clinical care and response times.

4.2.6.4 Most important KPI

- Time!! Response time is definitely the most important.
- Training, skills and knowledge also important.
- Communication skills.
- Fast response.
- Experienced staff – demonstrated empathy.
- State of the art equipment (vehicles and medical)
- Ensure there are enough vehicles for staff.
- Access for wheelchairs.
- Response time very important.
- Response times absolutely the most important.

4.2.7 Perth – general comments and recommendations

There were periods of open discussion immediately following group discussions (when providing table feedback), and during a small period of time allocated for open mic at the end of the session. Recommendations were unsolicited, and several have been used to inform our own formal recommendations in section 5.

- There is a need to ensure there are avenues for praise of paramedics and ambulance staff, not just criticism.
- Don't move to the American system.
- Recognise excellence.
- Need better recognition of country volunteer skills.
- Effective first. Efficient is less important.
- Keep costs down.
- More experience – especially in the country.
- Cost is prohibitive. We need to not have to hesitate to call because of the financial implications.
- We should not have to pay a bill when someone else calls and we don't need the service.

- Need better communication skills, especially listening. Not everyone fits "normal."
- There's a need to account for advanced care directives when delivering ambulance care.
- Complaints should be used as a learning experience. No closing ranks.
- Why can't paramedics insert catheters?
- It'd be good for the regions to have qualified paramedics too.
- Could we have better advertising about ambulance only cover?
- Offer service users the ability to pay before they use the service.
- Trainee doctors should ride with paramedics and volunteer as part of their training.
- Don't handle bill directly with health funds.
- Paramedics to have experience with different groups (and be dispatched accordingly).
- Have training at university with practical component specifically for aged care.
- Teach calming techniques.
- Increase awareness of autism and unorthodox responses to "normal" questions and situations.
- Offer interpreters. [NB: In response to this recommendation, another attendee (an interpreter) said that if requested by the caller an interpreter had to be provided).
- Efficient, informative and respectful handover at hospital remembering that the patient is always present.
- If an ambulance is called for without your knowledge, reduce or waive costs (if not used).
- Adopt Queensland system in which all service is paid for by taxpayers, so no out of pocket expense to the user.
- Provide extra leave for staff to reduce tiredness.
- Introduce a city – rural exchange program to allow paramedics and volunteers to see "both sides of the fence."
- Provide financial tax breaks for volunteers to attract more of them.
- There needs to be more (accessible) options for feedback on ambulances. This was often for people wanting to give compliments. Could there be an easy access feedback link with the bill?
- Retraining following errors suggested.
- Paramedics need to be trained in calming techniques.
- Paramedics need to be trained in active listening.
- Paramedics need to be made aware of special communication needs like autism.
- Could ambulance officers be asked to remind the patient to take their house key, wallet, shoes and phone? In the panic of an emergency people forget and then they are having to walk home from hospital barefoot or break into their own house.

4.2.8 Perth – concluding remarks

The Perth session was well attended. Feedback was varied and diverse. Most attendees were appreciative of the quality of ambulance services provided in WA, and St John Ambulance was consistently lauded for the quality of care provided by its staff.

One clear area of concern was accessibility. Access difficulties were raised by several tables independently, and discussion in the open section on this topic was robust.

Access issues included the inability for people with physical disabilities to bring their wheelchair with them on the ambulance. For full time wheelchairs users, the problem is exacerbated because they are left unable to move to discharge as they are at the hospital without their wheelchair. One wheelchair user pointed out that it's not always practical to ask a friend or family member to go to the home and collect the wheelchair and then come back (to the hospital).

Other access issues included language barriers experienced by CALD consumers (with comment that translators were likely available but not used), and difficulties experienced by larger than average patients with (a) boarding the ambulance, and/or (b) fitting safely on the gurney.

Many attendees voiced concerns about the cost of the ambulance service to end users being too high, and in some cases, a barrier to access. However, conversation around cost wasn't limited to the actual out of pocket expense involved in using an ambulance service.

Numerous attendees were annoyed that the cost wasn't communicated up-front. If it had been, several people indicated they would have made alternate arrangements (when usage wasn't for a life-threatening situation). Others were frustrated that they had to pay for an ambulance being call-out by somebody else, even though they didn't want or need it.

Notwithstanding their misgivings about the cost to end-users, attendees recognised that providing the ambulance service was expensive and needs to be covered. One attendee noted that: "you can't put a cost on a life." Several recommendations were made by attendees, some of which have been used to inform our formal project recommendations outlined in Section 5.

Ramping was flagged on numerous occasions as a major issue, with many attendees relaying accounts of their own experiences waiting in the back of ambulances for hours outside Perth ED departments. While the topic wasn't dwelt upon, we did acknowledge feedback that ramping would have an impact on the number of ambulances available to respond at any given point in time.

4.3 St Pat's forum

The St Pat's forum was held at the St Pat's Community Support Centre on Monday 23rd September. It was attended by 19 homeless people and rough sleepers, all of whom were approached and recruited by St Pats Support Centre Manager, Traci Cascioli.

Notably, the project team took onboard the advice of St Pats to hold the session at their Community Support Centre so as to ensure clients would feel safe and have access to their familiar support workers. At the advice of St Pats, the attendees were given their consumer payment in the form of Coles-Myer and Transperth gift cards.

During project commissioning, the Project Control Group had planned for one open consultation slot, which would be filled after a review of consumer survey data revealed an appropriate target group or issue.

The decision to fill the targeted consultation slot with a socio-economically disadvantaged cohort was made by the Project Control Group following a conflux of circumstances, including a direct approach by Michael Piu, CEO of St Pat's Community Support Centre, to The HCC seeking to provide feedback about the unique challenges facing homeless and rough sleepers with regard to ambulance usage. Michael also raised the issues faced by his staff when they are asked (by clients) not to call an ambulance due to cost despite a perceived need. In addition, Traci Cascioli and Luke van der Beeke had met at a Climate Health WA Inquiry consultation and discussed the project and the need for the homeless voice to be included in the week prior. Most importantly, the issue cost and affordability was a strong theme in the online survey. A targeted session with some of WA's most financially disadvantaged health consumers seemed a logical step, particularly given the relatively high incidence of usage amongst homeless and rough sleepers.

The agenda for the forum was as outlined in the table below.

Table: Agenda (St Pat's forum)

Time	Agenda item
09.30 – 09.40	Welcome and acknowledgement of country
09.40 – 09.50	Scene setting (including presentation)
09.50 – 10.10	Group discussion – sharing experiences
10.10 – 10.25	Feedback
10.25 – 10.35	Stretch and refresh
10.35 – 10.55	Group discussion – role play
10.55 – 11.10	Feedback
11.10 – 11.25	Open discussion and Q&A
11.25 – 11.30	Closing remarks

All bullet points in sections 4.2.1 – 4.2.7 are a direct transcription of notes taken by attendees on the butcher paper provided.

4.3.1 Group discussion St Pat's – what went well?

During the first group discussion, participants were invited to consider their previous experiences of dealing with the ambulance service. Discussion was robust and at times colourful.

- Ambulance arrived within 5-6 minutes.

- The two ambulance workers were fantastic. They were very caring and explained everything that they were doing.
- They were very professional.
- The whole service.
- I wasn't arrested.
- The two ladies who responded were courteous and attentive and as I was a priority 1 the cost of transport was waived.
- I was treated well.
- Respected.
- I was a compliant patient. There were no problems.
- Arrived in 5 minutes. Time wasn't an issue.
- When I said I was worried about the money the guy said, "don't worry about it," and I never got a bill.

4.3.2 Group discussion St Pat's – what could've gone better?

- For me, nothing could have gone better.
- Didn't feel affected until I walked outside.
- Response took 45 minutes as only volunteers were available [regional].
- Her experience [carer of patient] was somewhat of a bad one, maybe for the fact she had no medication and was homeless.
- Slow response time. The traffic slowed down the ambulance.
- The bill.
- Understand mental health.

4.3.3 Group discussion St Pat's – were your needs met?

- Yes. My needs were met.
- Yes.
- I was very pleased as I am alive!
- There was a presumption that she was a drug addict and therefore received the absolute minimum care.
- Yes, I was comfortable.
- Yes. Attentive.
- No fault. They [are] doing their jobs well.

4.3.4 Group discussion St Pat's – did you feel safe?

- I felt safe and looked after really well.
- I did feel safe.
- Yes.
- I trusted the knowledge of the paramedics.
- They're knowledgeable.

4.3.5 Group discussion St Pat's – were you treated respectfully?

- Yes, I was.
- Yes.
- I felt I was in great care.

4.3.6 Group discussion St Pat's – role play scenario

In the role-playing session, consumers were asked to imagine themselves in the role of contract managers at the DoH. They were to pretend that their table group was responsible for drawing up and awarding the next ambulance services contract for WA. We provided participants with non-compulsory prompts to consider and told them they could include any other contract terms they felt necessary to ensure a world-class ambulance service for WA.

4.3.6.1 What key performance indicators would you include?

- Communication.
- Let them do their job without expecting to be treated to a certain standard. It must be a hard job without worrying if complaints are going to be made about conflicting attitudes.
- Don't make assumptions.
- Equal care for all, including drug addicts, alcoholics, mental health)

- Everybody receives equal and professional care.
- No judgement.

4.3.6.2 Bonuses or incentives would be awarded for…

- Those who go above and beyond in their work. Those who show compassion and professionalism at their job should be reward. One's with work ethics.
- Professionalism.
- Being down to earth. Approachable.
- Reward people who do more training. Esp., diversity, people, communication, mental health, addiction.
- Saving lives.
- A reward for natural respect.
- Higher payments for fast arrival time and respect.

4.3.6.3 Penalties would be imposed for…

- Penalise poor driving.
- Bad attitudes.
- [Poor] self-appearance.
- Poor work ethic.
- Poor communication.
- Not treating people with dignity.
- Racism.
- Negative words.
- Assumptions.

4.3.6.4 Most important KPI?

- Quicker response.
- Equal care.
- Quick response.
- Training updated regularly.
- Response times.

4.3.7 St Pat's – general comments and recommendations

This section lists comments and recommendations made by participants during open discussion. Recommendations were unsolicited, and several have been used to inform our own formal recommendations in section 5.

- Cost involved is a big issue for homeless people.
- We can be guilty by association. [i.e. homeless and therefore must be on drugs].
- Don't make assumptions.
- [Require] appropriate medication and care.
- Why are they so expensive? Is there any way the money can be taken out of payments without all the stress of paperwork?
- Most people think the ambulance costs too much.
- I have never been charged a fee, most likely due to paying [lots of] income tax.
- The need for private health funds is understandable, as the public health system is strained and priority for effective treatment costs a lot.
- Need to find a way to be respectful of everyone.
- Solution – reducing time and increasing understanding.
- What about people with disabilities?
- Sometimes paramedics have a "fearful look."
- They assume we've just called the ambulance to get a bed for the night.
- Make subsidies available for those on Newstart.
- Some sort of subsidy available through Centrelink for ambulance cover.
- Access should be subsidised.
- More training in how to defuse situations – not escalation.
- Train and pay paramedics to work in the country.
- Could payments be made by injury types – e.g. alcohol, tobacco, vehicle. [Idea was that instead of universally applied fees, fees are applied based on what the ambulance is called for].

- Is there a chance for mediators that can [calm things down] between patient and the worker? [Advocate].
- One recommendation (applauded by others) was that rather than handing unpaid bills off to the debt collectors so quickly, the ambulance service should allow a payment schedule so people with no money could pay the debt off over time instead of being penalised.
- Many threw the bill in the bin upon receipt and were then chased by debt collectors.
- One man spoke of his mental health issues and said that whenever an ambulance was called the police were called. This only escalated the situation. He likes paramedics but felt the police don't treat him fairly and make him angry.
- Suggestion to be able to nominate a paramedic who does well for an award.
- Use of mobile phone with important details that can be accessed in an emergency without a pass code instead of a medic-alert bracelet.
- Service to spread the word about ambulance services. Teach it in schools, Cubs, clubs etc.
- Perhaps a clause needs to be put in for people that use ambulance services but don't receive any government dollars from Australia.

Several attendees spoke of ambulances being called and not wanting to get in because they were worried about the cost.

Another man relayed a story that he didn't have $2 to get a bus to hospital, so he got an ambulance instead. He's not paid the bill.

4.3.8 St Pat's – concluding remarks

The session at St Pat's was honest, forthright and fruitful.

Attendees genuinely appreciated the opportunity to provide input which they understand will inform future procurement of ambulance services. Many observed that they'd not been given the opportunity to participate in this way previously and were effusively thankful to the facilitation team. The quality of input received was exceptionally useful because it tapped into lived experiences of regular ambulance service users who often have previously had no input into the design and/or delivery of a service that so significantly affects them.

The strongest theme to emerge from the St Pat's session was stigma. Attendees felt a great deal of prejudice and judgement from ambulance staff, and others. All agreed that assumptions were frequently made that they were on drugs or alcohol,(when in fact they had underlying health conditions) or that calling an ambulance was a way to get a bed for the night. Several felt that this stigma and associated assumptions clouded practice and in some cases led to a failure to treat the health issue itself.

The other key issue raised was cost. Most felt that the cost was a barrier to access for homeless people, and other people experiencing some level of poverty. Many said they simply threw the bills away when they received them, others simply avoided using the ambulance service wherever possible. Several bemoaned the fact that passers-by would see them lying on the ground (sleeping) and call an ambulance, leaving them liable for the bill.

In addition to the cost itself, there was widespread agreement that the way in which the ambulance service sought to collect overdue monies lacked compassion or any understanding of personal circumstances. Debt collection agencies were engaged very quickly, and some claimed the way in which debt collectors behaved created considerable additional stress.

This was clearly a challenging session for many in attendance. Two had to leave during the session due to onset of illness, and another became visibly distressed as another attendee shared a personal story. Appropriate support was provided to all three participants by St Pat's social workers.

In conclusion, this was a valuable session for the facilitation team and the attendees themselves. Participants were extremely supportive of one another, often congratulating other participants after shared personal stories about extremely difficult circumstances and experiences.

4.3.9.1 Ambulance use past six months

Following the session Leah Watkins from RUAH spoke to Traci Cascioli our host at St Pats and offered us the following information to be included in the report. The data is from the VI-SPDATS completed since 2014 and shows ambulance usage amongst the homeless.

Based on the numbers below, it is reasonable to conclude that over one-quarter of all homeless people had used an ambulance in the past six months, and there's an indication that 5% of the homeless population use ambulances at least monthly.

Table: Ambulance use by homeless

AMBULANCE IN PAST 6 MONTHS	n.	%
0	1029	56%
1	320	18%
2	180	10%
3	80	4%
4	70	4%
5	50	3%
6-9	38	2%
10+	54	3%
Not stated	3	0%
Total	1824	100%

4.4 Mental health 1

Mental health consumers were one of two priority target groups identified during project commissioning. The other was Aboriginal health consumers.

This session at Telethon Speech and Hearing Centre was the first of two consultations targeting people living with mental health conditions and their carers. The 17 attendees were either carers, or people living with mental health conditions such as depression and anxiety.

The format was the same as that used in the previous two forums but given the potential for discussion to trigger strong emotions and/or responses amongst participants, a counsellor from HCC, Kerry Mocevic, was present at all times to monitor and to provide assistance if required.

Table: Agenda (Mental Health 1)

Time	Agenda item
09.30 – 09.40	Welcome and acknowledgement of country
09.40 – 09.50	Scene setting (including presentation)
09.50 – 10.10	Group discussion – sharing experiences
10.10 – 10.25	Feedback
10.25 – 10.35	Stretch and refresh
10.35 – 10.55	Group discussion – role play
10.55 – 11.10	Feedback
11.10 – 11.25	Open discussion and Q&A
11.25 – 11.30	Closing remarks

All bullet points in sections 4.4.1 – 4.4.7 are a direct transcription of notes taken by attendees on the butcher paper provided.

4.4.1 Group discussion Mental Health 1 – what went well?

Participants were invited to consider their previous experiences of dealing with the ambulance service.

- Excellent response time. Less than five minutes.
- Very happy with the treatment. They put my mother at ease.
- Friendly and responsive.

- Fast response time.
- Very helpful. Very clear and informed about treatment. Couldn't faulty them.
- Polite, efficient and professional.
- Rapid response.
- Respectful.
- Professional.
- Maintained good sense of humour.
- Better than the doctors.
- Arrived quickly.
- Used the [St John] app. It was very good.
- Good response time.
- Good physical transfer.
- Treated really well.
- Responded according to need.
- Nothing – perfect.

4.4.2 Group discussion Mental Health 1 – what could've gone better?

- The ambulance was called for my niece who has a mental health issue. I was not impressed. They took a longer route to the hospital and there was a long response time.
- Called in for ectopic pregnancy by GP and given morphine – low pain score of two when ambulance arrived. Pain score was rounded down by paramedic at the hospital – patient said 9 pre-morphine, 6 after. Paramedic reported 7 per-morphine, 4 after.
- Called for my father-in-law who had a heart attack. Long response time (15 mins). Scary waiting (19 years-old at the time). Traumatic.
- Called for ex-partner (self-harm/suicide) who was under the influence of unknown drug. Thirty minutes an no attendance. Felt unsafe due to late ambulance.
- Frequent ramping at ED.
- Patient couldn't be handed over at ED until canula or pulse/blood pressure elevated. Took eight minutes.
- Route selection was poor. Lacked local knowledge.
- Didn't check the medic alert bracelet.
- Couldn't take their wheelchair.
- Couldn't work out how to use the app.
- Didn't involve the support worker.
- Didn't advise the price – still in debt.
- Got their quicker by car than ambulance.
- They wouldn't let me ride with my partner.

4.4.3 Group discussion Mental Health 1 – were your needs met?

- Partially. Couldn't take the wheelchair.
- Very much so.
- Yes – ambulance crew contacted their specialist.
- Definitely.
- Yes.
- Yes, and they went above and beyond.
- Yes.

4.4.4 Group discussion Mental Health 1 – did you feel safe?

- I could've been secured better. No seatbelt.

4.4.5 Group discussion Mental Health 1 – were you treated respectfully?

- Yes.
- Yes, they know me.
- Definitely.
- Yes.
- Felt like I wasn't listened to [carer].
- Polite, professional, respectful.

4.4.6 Group discussion Mental Health 1 – role play scenario

As with previous sessions, during this second group discussion, participants were asked to imagine they were responsible for procuring WA ambulance services. Prompts were provided, but participants were encouraged to think broadly and include anything they wished.

4.4.6.1 What key performance indicators would you include?

- Response time.
- Prioritising according to patient need (response time)
- Accurate first responder.
- Ongoing training.
- Local knowledge [of roads].

4.4.6.2 Bonuses or incentives would be awarded for…

- Consider implementing a bonus scale, where if performance exceeds 85% on any given indicator there's a bonus provided. Examples included: response times, follow-up with patient; satisfaction with quality of care.
- Meeting KPI on response time.
- Positive patient outcomes.
- Receiving good feedback from the customer or the public.
- Up to date training.
- Not a bonus per say – but paid stress leave for critical incidents.

4.4.6.3 Penalties would be imposed for…

- Dropped calls (dispatch)
- Getting lost i.e. ambulance unable to find location of patient or taking too long to get to hospital because they don't know route.
- Equipment failure.
- Causing accidents.
- Negative patient outcomes.
- Bad feedback.
- Staff shortages.
- Not meeting KPI's for response times.
- Penalties for high levels of staff turnover.

4.4.6.4 Most important KPI?

- Response times.
- Response time.
- Number of staff available.
- Number of depots.
- Public awareness of what to call an ambulance for.
- Number of ambulances.
- Response time is important, but it's not the most important.
- There should be a tracker in the ambulance for the route and time taken. Time taken should be under a certain limit.

4.4.7 Mental Health 1 – general comments and recommendations

This section lists general comments and recommendations made by participants during open discussion. Recommendations were unsolicited, and several have been used to inform formal recommendations outlined in section 5.

- Cost of calling an ambulance is high. Some people must think of the cost before calling an ambulance and consider alternative travel. This isn't always the safest thing to do but if on a pension or Newstart allowance, cannot afford $960.00.
- Queensland, New South Wales and New Zealand are free. The service should be free.
- When people call on behalf of someone else they don't consider the cost. I can't afford to pay the bill for an ambulance I didn't need in the first place.
- Constantly spoke to the patient (who couldn't respond) and didn't listen to me (the carer).
- Need to value employee mental health.

- Do St John do a customer service survey? [This stemmed from conversation around customer satisfaction measures, and follow-up with patients].
- St John had debt collectors chasing us within three weeks.
- There's a lack of follow-up with patients. Would like to see more follow-up. If they can send a bill as quickly as they do, they can send an email asking how it went.
- My medication list wasn't available to the paramedics. They're first responders. They should have access to it.
- Unable to access MyHealth Record (where the most up-to-date medication list is). Confused patient had to try and remember 14 different medications.
- When measuring response times – recognise that there are three aspects that are important, (1) Time to location, (2) Time at location making assessment and delivering treatment, (3) Time from location to hospital.
- Too much reliance on Satnav systems. Maps and satnav cannot replace local knowledge.
- Equipment must be of the best quality and up to date. This includes in country areas.
- Call centres out of WA should not exist.
- Staff turnover is too high, esp. in country areas. This reduces availability of local knowledge.
- Ambulance officers to be more proactive about getting to know the local community.
- Cost of calling ambulance to be waived/reduced if the service is called for by a third party and isn't actually needed.
- Dispatch must be WA-based so that they have appropriate level of knowledge. [Several attendees had noted dispatchers not having heard of suburbs, therefore taking time to clarify/need to spell out etc.
- Better access to health records for paramedics.
- Free ambulance for those on benefits and/or Health Care card.
- In the UK there are paramedics on motorcycles to get through traffic and reach the patient more quickly than the ambulance itself can. Could this be done in Perth?
- Staff should be given automatic paid stress leave after a critical issue/incident.
- Public awareness campaign, re. what is/is not an emergency. [In response to discussion about shortage of available ambulances and the need to ensure they're only used when absolutely necessary].

4.4.8 Mental Health 1 – concluding remarks

The session was well received by participants and we again received positive verbal feedback from attendees following the session. Notably, not all discussion was about ambulance use for mental health reasons, and some people did not discuss their mental health illness at all.

As with the previous sessions held in Perth and St Pat's, there was general agreement that ambulance officers do a very good job under difficult circumstances.

An emerging theme in this session was that carers reported feeling and/or being ignored by ambulance staff because they weren't the patient. The entire group agreed that this was an issue for carers. Attendees acknowledged the need for the patient to be at the centre of care, but not to the exclusion of the carer, who in many instances would be better able to provide useful information about the patient than the patient themselves. This included information pertaining to both the underlying health condition, and medication.

4.5 Broome

Initially scheduled as one of two regional consultations, the project team made the decision to cancel the on-site forum when it became clear numbers were insufficient to justify the expense of flying two personnel to Broome. Prior to cancelling, the three attendees who had booked were contacted and all indicated they would be prepared to participate in a depth phone interview instead. Notably, two of the three respondents were current or former St John Ambulance volunteers.

An interview call sheet was developed, and three depth phone interviews were conducted by Luke van der Beeke with Broome-based service users, each of which lasted 20-30 minutes.

Questions posed were based on those used in the forums. The interview was kept relatively informal, and follow-up questions were asked to allow for a conversational tone. A copy of the interview run sheet can be found in Appendix 1.

All interviewees indicated that there needs were met, that they felt safe, and that they were treated respectfully.

4.5.1 Broome - General experiences and reflections – what went well?

- Arrived in 10 minutes.
- Caring and kind.
- Couldn't fault them.
- They provided medication to help with my breathing. By the time I got to the hospital [about 4 minutes away], it was much better. I was still ill, but I was OK.
- They answered the call quickly.
- Officers treated him on the ground. He made a full recovery.

4.5.2 Broome - General experiences and reflections – what could've gone better?

- Nothing. May be re-potholed the driveway!
- There'd been a car accident and the bike rider was injured, not moving. I felt there were a lot of questions. A lot of unnecessary question and mucking about with dispatch. I just felt they could've done it quicker.
- Ambulance officers could have assessed the situation a little better before the police arrived. They could've possibly controlled the situation a little better. It was good but could've been better.

4.5.3 Broome – role play scenario

Interviewees were asked to imagine they were responsible for developing and signing-off on the next WA ambulance service contract.

4.5.3.1 What key performance indicators would you include?

- More training for staff, particularly re-fresher training.
- Response times are important.
- More staff are needed, particularly in regional areas.
- More staff.
- Answer calls in a timely manner. [Just a few rings].
- The operator needs to speak clearly and be reasonable.
- Operator needs to speak good English. Have a good phone manner.

4.5.3.2 Bonuses and incentives would be awarded for…

- Long-service of staff.
- Response times.
- Treating people with respect and dignity. We have a lot of drunks. Don't pass judgement.

4.5.3.3 Penalties would be imposed for…

- Nothing. I wouldn't impose penalties.
- N/A
- N/A

4.5.3.4 Most important KPI

- Response times.
- Time constraints on different priorities to be established. For example, reduced time for priority one calls.
- Provide the right equipment (interviewee noted that in her experience the equipment is in good order).
- Customer satisfaction.
- Ambulance needs to project a good image. Keep it good and clean.

4.5.4 Broome – general comments and recommendations

- They were exceptional. SJA delivers an exceptional service under very trying circumstances.
- Some people think the ambulance is a taxi service.

- Broome has about 7 paramedics on staff, plus volunteers. They try to mix the shifts so that a volunteer is paired with a paramedic. This generally works very well.
- Paramedics are generally on during the day, where-as if you need an ambulance at night or over the weekend you're likely to get a volunteer.
- SJA trains us really, really well.
- Volunteers can't administer Schedule A drugs.
- Volunteer treatment is limited to non-invasive measures.
- Our volunteers are as good as our fully trained paramedics. They get the same training. They're all excellent. No difference.
- Couldn't fault the service.

4.5.4 Broome – concluding remarks

The decision to cancel the facilitation team's onsite visit to Broome was difficult. The Project Control Group had been keen to send a clear signal to regional service users that their views were valued and a physical presence in the town was always the preferred option. However, the costs associated with flying the facilitation team to Broome to speak with three service users (two of whom were current or former St John personnel) was deemed too high. Significantly, the final decision was only made when all three registered participants had been contacted and confirmed availability for interview.

4.6 Bunbury

The Bunbury consultation attracted 17 attendees from the city itself and surrounding districts. It was open to any member of the public who had used a WA ambulance service within the past five years. All participants were middle-aged or older, with the majority over-55. There was also a relatively high number of carers in attendance.

The session was held at the Hudson Road Family Centre.

Table: Agenda (Bunbury)

Time	Agenda item
12.00 - 12.10	Welcome and acknowledgement of country
12.10 - 12.20	Scene setting (including presentation)
12.20 – 12.35	Group discussion – sharing experiences
12.35 – 12.55	Feedback
12.55 – 13.00	Stretch and refresh
13.00 – 13.20	Group discussion – role play
13.20 – 13.40	Feedback
13.40 – 13.55	Open discussion and Q&A
13.55 – 14.00	Closing remarks

All bullet points in sections 4.6.1 – 4.6.7 are a direct transcription of notes taken by attendees on the butcher paper provided.

4.6.1 Group discussion Bunbury – what went well?

During the first group discussion, participants were invited to consider their previous experiences of using the ambulance service.

- 000 worked quickly and effectively.
- Response time was immediate as the ambulance was based two streets away.
- Attentively listened to daughter as mum couldn't talk. Daughter was allowed to travel with the mother, and they kept her informed.
- Father transported from SJOG Stroke Unit in Midland to a Bunbury nursing home. Fantastic service.
- Carer experience – 95% of attendances are OK.
- Response time was excellent.
- Got vital signs very quickly.
- Made me feel safe.
- Fast response.

4.6.2 Group discussion Bunbury – what could've gone better?

- Response time was too long, 20-35 minutes. Situation was urgent and was told if things changed: "call back." Caller wasn't kept on the line.
- Called ambulance for a client who'd collapsed on the floor. They were very blasé and pulled her by her arms to get her up, without checking head/neck injury. She was in her 90's. [Carer has therapy background and felt manual handling was "sub-standard].
- Older lady with COPD and emphysema. Ambulance called 1-2 times per week for breathing difficulties. Scared of getting a particular male ambulance officer as he was rough and told her not to keep calling.
- Thought daughter was having a heart-attack. Female attending officer in her 20's was rude and dismissive, but older male officer quickly took over and was brilliant.
- Better springs. It was a noisy engine and very bumpy.
- Could've been more comfortable in the back of the ambulance.
- I was constantly asked to check my blood sugar. I felt this was intrusive.
- I crashed car into back of a truck. The ambulance crew were terrific. They continued to go with me to ED to confirm I was OK. Ambo's stayed in back with me.
- Took over an hour to arrive. Had to come from Capel to Bunbury.

4.6.3 Group discussion Bunbury – were your needs met?

- Yes.
- Yes. They kept calling to check how I was feeling.
- Yes. I thought they were terrific.
- They were very supportive, caring and friendly.
- Yes.

4.6.4 Group discussion Bunbury – did you feel safe?

- Yes. Very well trained.
- Yes.
- Yes, volunteers and paid officers were both equally trained and as good as doctors.
- Yes, I felt very safe. Officers provided constant supervision.

4.6.5 Group discussion Bunbury – were you treated respectfully?

- Very much so.
- Yes. They treated me respectfully.

4.6.6 Group discussion Bunbury – role play scenario

As with previous sessions, during the second group discussion participants were asked to imagine they were responsible for procuring WA ambulance services. Prompts were provided, but participants were encouraged to think broadly and include anything they wished.

4.6.6.1 What key performance indicators would you include?

- More staff.
- Minimum training level.
- Minimum staffing levels.
- More ambulances.
- Dispatch to be training to triage callouts.
- Highly/well trained staff.
- Fast response times.
- Well maintained vehicles.
- Better pay scale.
- More ambulances.
- More staff.
- Minimum training for (1) patient care (specialising in elderly; mental health; officer safety; children), (2) patient movement (physical and manual handling), and (3) cultural awareness (religious, indigenous, ethnic).
- Administration of treatment.
- After-care follow-up.
- Response times (adjusting for delays at hospital).

- They were fantastic.

4.6.6.2 Bonuses would be awarded for…

- Quicker operator.
- Good mannerisms of operator dispatching ambulance.
- Up to date training.
- When response time is high.
- Good communication and/or interaction.
- Good feedback from service users.
- Evidence from feedback from each customer – best service delivery, especially in country areas should be rewarded with extra funding, equipment or staff.
- Regular and ongoing manual handling training.
- Interpersonal skills.
- Reward staff who are continually praised by service users.
- If you conducted survey's with service users and these happened to highlight KPI's in a positive manner.

4.6.6.3 Penalties would be imposed for…

- Poor feedback from service users.
- Rudeness
- Bad attitude.
- Poor response times.
- Lack of training.
- Unprofessionalism.
- For negative KPIs.
- There should be a minimum fleet available at all times. If not, penalty.

4.6.6.4 Most important KPI

- Response time is the most important KPI.
- Response times.
- Response times aren't the most important but are certainly fairly important.

4.6.7 Bunbury – general comments and recommendations

Notes in this section were taken by the facilitation team during group feedback, and at the end of the session during Q&A.

- Costs need to be reviewed, with particular emphasis on ensuring equity.
- Need to ensure there are sufficient staff.
- If ambulances are delayed its important to have constant contact to relieve your stress.
- In country areas there can be a wait on ambulances coming from another country town. It can take up to 40 minutes.
- St Johns should provide plenty of stress days for PTSD, and team building days.
- Weed out the people [staff] who continually have bad feedback [from service users].
- Recognise that the response times ultimately lies with the amount vehicles available, and the performance of ambulance officers.
- There's not enough advertising on TV and other media about the cost of the service, nor ways to ensure you are covered should you need an ambulance.
- There needs to be more liaison with private health organisations so that they're not only covering priority call outs.
- Save time and check medic alert bracelet/necklace.
- Faster response time needed.
- Need to be more fast response vehicles for accessing hard to reach places and stabilising patients (e.g. 4x4's or motorbikes).
- CEO's should have "on the ground" experience, especially in country areas, to see how things really work in terms of distance, and response times.
- Training in cultural and religious difference for staff, around how to deal with people from CALD backgrounds, sensitivities etc.
- Could there be free ambulance cover for staff/volunteers and their families?

- If the cost is going to exceed a certain amount, people should be told upfront (i.e. before the ambulance is dispatched) so they can make an informed choice. [This suggestion was made with respect to non-urgent calls].
- Carry a rack for wheelchairs on the back of each ambulance.
- Ambulance cover should be mandatory and covered as part of driver's licence fees [like third party insurance].

4.6.9 Bunbury – concluding remarks

An engaging session in which participants were actively involved throughout. There were at least six (6) attendees who'd driven in from rural locations, and at least one from Busselton. It is perhaps unsurprising then that response times were seen to be the most important KPI by almost everybody in the room.

Discussion about the cost of accessing the service was less prevalent than in our previous sessions. However, a suggestion from one lady that ambulance cover be included in all West Australian's drivers licence fees was unanimously endorsed with a show of hands by all attendees.

There was recognition that country areas were more difficult to resource than larger population centres, but nonetheless, several attendees felt that a more equitable service should be provided. And although there was a consensus that staff and volunteers were generally excellent, several participants felt strongly about the need for them to be provided with more training in manual handling, cultural awareness and patient care for children and people with mental health illnesses.

4.7 Aboriginal consultation 1

This session was the first of two consultations targeting Aboriginal ambulance service users. The session was held at Langford Aboriginal Association, and the project team liaised closely with the association to ensure it would be delivered in a culturally appropriate way.

In keeping with the wishes of those in attendance, the workshop format was very informal. Upon arrival the facilitation team spent about 30 minutes sharing a light morning tea with several visitors to the centre.

The session commenced just after 11.00am with the welcome and acknowledgement offered by Lanford Chairwoman, Raelee Cook. Following the welcome, Luke van der Beeke provided a short presentation (seated) and then facilitated an open, at times robust, yarning session.

Attendees and the facilitation team sat together in a circular formation, which was very conducive to group discussion. In addition to the nine (9) active participants, a further 5 adults (and several children) attended. These other attendees spoke up occasionally but were not included in the main discussion which was held in a circular seating arrangement. The additional attendees sat outside the circle and the facilitation team followed the lead of the presiding elder in this regard.

Table: Agenda (Aboriginal consultation 1)

Time	Agenda item
11.00 – 11.10	Welcome and acknowledgement of country
11.10 – 11.20	Scene setting (including presentation)
11.20 – 13.00	Yarning
13.00	Close

4.7.1 Aboriginal consultation 1 – what went well?

- No complaints about the actual ambulance officers who attended incidents.
- Manner, communication, treatment etc. could not be faulted.
- No issues with dispatch.
- Female patient with ECG found ambulance officers were polite and let he know what they were doing before placing the sticky nodes.

4.7.2 Aboriginal consultation 1 – what could've gone better?

- Cost. Billing is a major reason Aboriginal people don't call ambulances.

- Family member got taken to a hospital far away from their mob and the ambulance officer did not explain why.
- One consumer spent a day driving around 3 hospitals - Armadale [no surgeon), Freo [no bed] and then The Mount.
- A consumer had an experience where the school did not ring the ambulance for a kid having a seizure (epilepsy) even though the parent requested one. School's answer was that they did not want the parent to get the bill.
- One consumer had trouble explaining where she was and thought it was because the person on the other end of the phone was in another state.
- Response time was slow.
- Mental health case – the ambulance waits for the police before they treat the patient.

4.7.3 Aboriginal consultation 1 – role play scenario

The nature and format of the session did not lend itself well to the role play scenario used in other settings. However, we did ask participants what they thought should be included in any future WA ambulance service contracts.

The three responses we received were:

- Cultural awareness training compulsory. It's important to have LOCAL training in this regard.
- Questions for ambulance to ask when attending an incident: (1) Where do you come from? (2) Which nation do you belong to, (3) Which mob do you belong to?
- Response time.

All points were discussed at length by the group and were agreed to by all in attendance.

4.7.4 Aboriginal consultation 1 – general comments and recommendations

- Why do they charge $900? Where do they get that number from?
- Why can't the government pay for it? They do in other States.
- A lack of insurance amongst Aboriginal people stops them calling.
- Pension card discount is good but should apply to everyone.
- Some people did not know how (cheap) ambulance cover is on its own (without buying other PHI)
- In the absence of an accompanying adult, the point was made that in Aboriginal law 13-year-old boys are considered men. In some instances, children may be more suitable to talk to than adult. Many already have caring duties and are considered 'adult' in the Noongar community.
- Can there be more than one or two next of kin? Aboriginal people have a family system that differs from the Western system.
- Ambulance workers must find it very traumatic. It's a very tough job.
- Ambulance officers also get abused. Drugs are a problem in this day and age.
- What do you do if you have to go in an ambulance with one kid but you have others to look after?
- It would be ideal for ambulance services to be free all across Australia, but if not, then for certain people, e.g. chronic illness.
- Direct route to hospital and local knowledge is important - not depending on maps/navigation is important.
- Avoid speed bumps because its bumpy!
- One person suggested you should be able to SMS dispatch to save time. [This was not supported by the group].
- People in the regions suffer due to wait times.
- One attendee said she felt ambulance response times depended on the area in which you lived, and that people like her in poor areas had slower response times.
- I wasn't asked by dispatch if I was Aboriginal. That's fine with me but others may want to be asked about it.
- One person said you can request a bigger ambulance for heavier patients. The rest of the group were unaware of this – thought it would be good to educate others.
- Children, pensioners and all Aboriginal people should be covered [financially].
- Given the gap in life expectancy, the pension card for 65+ years is of little use to many of us. We're dead by then. Couldn't it be provided to Aboriginal people who reach 45+ years [they're health is similar to 65+ in main population].
- If you get taken in an ambulance, a next of kin or family member should be notified.

- In the absence of an ID card, could other people at the scene be told where the patient is being taken? Word would get around to family.
- Ambulance cover through drivers' licence (previously flagged at another session) was deemed to be a good idea by all attendees.
- Need to find ways to increase awareness about insurance cover [Bupa mentioned] and Derbarl Yerrigan Health Service.
- More Aboriginal ambulance staff to go out into the community to market ambo insurance. People probably could afford it but they do not know about it.
- Training for Aboriginal people to train as paramedics or ambulance volunteers.
- Debriefing and counselling for ambulance officers when they've attended very traumatic events.
- Ambulances should be accompanied by security [private security] so that when attending potentially dangerous incidents they can focus on the patient rather than being distracted and/or driving away due to concerns for their own safety.
- Cultural awareness for paramedics. They need to know who your mob is.
- There should be more defibrillators available in the community.
- More first aid training for people in the local community.
- It would be good to see Aboriginal Liaison Officers on-board, or at least available by phone to support response personnel.
- Could chronically ill patients pay less for ambulance services?
- Ambulances should have a 'first nations map' on-board so that Aboriginal people can point to where they're from. This information can then be used to help ensure family etc are notified.
- Avoid paperwork.
- Need more diversity in ambulances – gender, ethnicity, race and age.
- Ambulance should be connected to MyHealth Record so that important information can be accessed at the time of need.
- Ambulance services should have a system that alerts them to "dangerous houses to visit."

4.7.5 Aboriginal consultation 1 – concluding remarks

The nature of this session was considerably more informal than those held previously, very much in keeping with the wishes of those we sought to engage. At times discussion was very robust, and the facilitator allowed a considerable amount of flexibility to allow conversational threads to follow their natural course. Attendees reflected afterwards that they enjoyed the session and were thankful for the opportunity to contribute to the process.

A key theme to emerge was the genuine concern among attendees for the safety of ambulance drivers. They were very critical of the behaviour of the public, especially in terms of the high incidence of alcohol and other drug use. Several had seen ambulance personnel leave dangerous situations, and all agreed that when treating a patient, they should be able to do so without suffering abuse and/or the threat of harm from bystanders.

The cost to access ambulance services was a major concern for all in attendance. All wanted services to be provided free of charge to Aboriginal people. The basis for this suggestion was two-fold, firstly that as first nation people it was warranted, and secondly, that given the socio-economic disadvantage experienced by Aboriginal people, it was necessary.

The group also considered if there could be a middle ground where services are provided at no cost to Aboriginal people when they reached middle age. The rationale was that the life expectancy gap between indigenous and non-indigenous people is approximately 11 years[5], and that many middle-aged Aboriginal people experience health conditions (particularly NCD's) that most non-indigenous people only experience when they're eligible for a pensioner card. The idea was universally endorsed, with the caveat that the facilitation still ask for services to be provided at no charge for all Aboriginal people.

Overall, attendees were very satisfied with the service provided by the ambulance service, and particularly effusive in their praise of its frontline staff.

[5] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

4.8 Aboriginal consultation 2

The second of the targeted aboriginal consultation sessions was held at Royal Perth Hospital (RPH) on October 10, 2019. The session attracted 22 participants and was structured along the same lines as other mainstream public forums, with additional time allocated for open discussion.

Particular care was taken to ensure the comfort of several attendees with chronic health conditions, and as with the Langford session, the facilitation team mingled informally and offered to make tea and coffee as people arrived.

The majority of attendees were female, but almost a 1/3 were men. In our experience this is a higher proportion than usual for a consultation of this nature. Most attendees were over 35 years-old, though there were at least five aged in their early-mid-twenties.

Table: Agenda (Aboriginal consultation 2)

Time	Agenda item
11.00 - 11.10	Welcome and acknowledgement of country
11.10 - 11.20	Scene setting (including presentation)
11.20 – 11.35	Group discussion – sharing experiences
11.35 – 11.55	Feedback
11.55 – 12.00	Stretch and refresh
12.00 – 12.20	Group discussion – role play
12.20 – 12.40	Feedback
12.40 – 12.55	Open discussion and Q&A
13.55 – 14.00	Closing remarks

4.8.1 Group discussion Aboriginal consultation 2 – what went well?

During the first group discussion, participants were invited to consider their previous experiences of dealing with the ambulance service. Attendees were seated in groups of 5 – 8 and discussion was robust. Group feedback tended to be consensus based, rather than detailed accounts of individual experiences.

- The ambulance arrived on time, quickly.
- I was looked after quote well.
- Under a 10-minute wait.
- Ambulance took only 3 minutes – I live close to Fiona Stanley.
- They were professional and caring.
- Compassionate towards me.
- I called them myself – they were culturally appropriate to me.
- My daughter is in a wheelchair and can't speak. It was good.
- Very polite towards patients.
- The service was great.
- Good communication on the phone. Caring and polite.
- Responded quickly to the callout.
- Transporting was smooth.
- Hospital to hospital transport being free is good.
- It went good. They came within 15 minutes.
- Response was well [good].
- Many ambulance experiences and always treated good.
- Transfer from RFDS to ambulance was very efficient.
- Freo to RPH transfer was free. No bill which was good.
- I got a follow-up from the ambulance officer a few days later.
- Requested to be taken to RPH instead of FSH as records were at RPH and they obliged. It was helpful.
- Son's treatment was delayed. Violent mental health episode so the ambulance waited for the police. This affected the outcome.

4.8.2 Group discussion Aboriginal consultation 2 – what could've gone better?

- They wanted to take the patient to Fiona Stanley, but all my records are at RPH and I live close to RPH.

- I don't call very often. We cannot bring her wheelchair which makes it hard.
- More disability friendly paramedics with more awareness.
- The cost of the bill is very high.
- The A/C was too cold.
- Communication was a bit awkward with satellite on some mobile, but the two-way was OK.
- Ambulance takes you to the hospital, so they should take you back home.
- Former paramedic did not continue as she felt worried about patients refusing treatment from her due to her Aboriginality.
- I found one of my family under an alias and then the rest of the family couldn't find which hospital he was in. [Police used an alias due to stabbing].
- My daughter is small and so the ambos took us to PMH. She's an adult. They didn't ask. It was an emergency and they wasted time. When she realised we had to argue with them, and they re-routed to RPH.

4.8.3 Group discussion Aboriginal consultation 2 – were your needs met?

- Happy with the service.
- I was satisfied with how they cared for me. My needs were met.
- Yes.

4.8.4 Group discussion Aboriginal consultation 2 – did you feel safe?

- Yes, I felt safe.
- I felt safe.
- Yes.

4.8.5 Group discussion Aboriginal consultation 2 – were you treated respectfully?

- Yes.
- I was treated respectfully.
- I was treated with respect and well looked after.
- Yes.

4.8.6 Group discussion Aboriginal consultation 2 – role play scenario

Participants were asked to imagine they were responsible for procuring WA ambulance services. Prompts were provided, but participants were encouraged to think broadly and include anything they wished. As with the first group discussion, bullet points below typically reflect a group's consensus agreement, rather than one individual's opinion.

4.8.6.1 What key performance indicators would you include?

- Cultural awareness.
- Must have cultural sensitivity.
- State-wide training for all ambulance and volunteers in mental health.
- Cultural sensitivity towards patients.
- Response times 30 minutes at the most in the metro area.
- Male and female ambulance teams.
- Lower cost by kilometres.
- Room for large people.
- More appropriate cultural training for staff.
- In depth training in all areas of mental health.
- Gender balance of male and female.
- More Aboriginal staff. 3% requirement in line with public sector target and use of substantive equality measures to ensure number of Aboriginal employees is increased.)

4.8.6.2 Bonuses or incentives would be awarded for…

- Training.
- Cultural awareness training.
- Response times.
- Contact with patients.
- Award them for arriving on time.
- Knowing nationality. It shouldn't be asked.

- Response time.
- A quick service.

4.8.6.3 Penalties would be imposed for…

- Not addressing language barriers.

4.8.6.4 Most important KPI

- Go to the nearest hospital.
- Response time the most important. Link penalties and bonuses accordingly.

4.8.7 Aboriginal consultation 2 – general comments and recommendations

- Needs to be more awareness of how to cover yourself for ambulance transport (private health funds).
- Ambulances need to be more wheelchair accessible.
- Ideally, ambulances services would be free across all of Australia.
- Regardless of the patient – time should always be important.
- Government should pay for all services to Aboriginal people.
- Government should pay ½ the ambulance bill.
- There should be equal wages.
- Need to provide support and security for ambulance officers.
- Pension age is not appropriate for Aboriginal people who don't live as long.
- Needs to be more access for overweight people.
- The service was quick.
- Need to check our identity. Do we have ID? Need to let family know where we're going.
- Need more Aboriginal people in the service.
- More training opportunities for Aboriginal people.
- Needs to be more affordable.
- Remember that people don't often use phones.
- Mental health is a real problem.
- Our use of words can be different. This is why we need more cultural awareness training.
- Bills cause stress. Many of us have chronic diseases. We don't need stress.
- If you need more than one ambulance [e.g. for road traffic ambulance] you have to pay for them all.
- Ambulance officers should ask your normal hospital or consult with you about where you are being taken.
- I live in a country town. I felt ill. It was quicker to drive myself. [This led to further conversation about the risk this would pose to others travelling on the roads].
- Derbarl Yerrigan will sign people up for ambulance cover for free.
- LvdB asked: "What does "lack of cultural awareness look like." Response: they stereotype; Women's business and men's business can be issues; Proportion of M/F officers is very important.
- Cost linked to income to make it easier financially.
- More Aboriginal paramedics.
- More wheelchair friendly ambulances.
- Mental health workers to be on-board/call for support for both patient and ambulance workers.
- Government should pay pensioner for ambulance fund.
- Billing should be based on the distance of the call out. If you're within 1km it should be ¼ or ½ of the normal total. [Additional discussion on this point led to a general consensus that call out fees should be linked to distance travelled – particularly if within a relatively short distance of the hospital (e.g. under 5km)].
- There should be security traveling behind the ambulance and with the ambulance when patients are being treated. Ambo's should be able to focus on treatment, not safety.
- Provide on the job training for Aboriginal people to fill staffing/volunteer gaps in the regions. This should include resume building, first aid, etc.
- Dispatch should ask about the mental health of each patient.
- Larger ambulances are needed for larger people.
- Need in-depth cultural awareness training. Not a tokenistic 2 hours.
- There needs to be trained paramedics in all [major] country towns.

4.8.8 Aboriginal consultation 2 – concluding remarks

The RPH session generated useful insight and robust discussion.

As was the case at Langford, the perceived high cost of ambulance services was a key focus, and many expressed a view that free access for Aboriginal people was needed. However, recognising that such an outcome was unlikely, other suggestions included linking cost of accessing the service to income.

The need for more Aboriginal staff, especially paramedics, was a clear priority for many in the room. On the job training for Aboriginal people to fill staffing gaps in the regions was also suggested. However, attendees felt that there should be trained paramedics in all major country towns.

A lack of cultural awareness amongst Ambulance staff had been observed by many, and several noted that in addition to more Aboriginal staff, there was also a need for more staff and greater awareness of the needs of CALD people as well. Cultural awareness training also needed to be in-depth, rather than a *"tokenistic two-hours."*

Continuing the cost theme, it was suggested that the amount charged should be commensurate with the distance the ambulance was required to travel to reach the patient. One gentleman had been charged the full amount when he only lived 250m from the emergency department. There was unanimous agreement.

Finally, as with the first Aboriginal consultation, there was extensive general discussion about the dangers facing ambulance service staff and criticism of the behaviour of many members of the public. Ambulance officers should be able to focus on treatment without having to worry about their own safety. Praise for ambulance service staff was considerable.

4.9 Mental health 2

The second mental health session was a specially designed workshop developed by Rhianwen Beresford of CoMHWA) with support from Luke van der Beeke of The Behaviour Change Collaborative. The session was held on October 16, 2019 at Lotteries House West Perth.

The session was designed to provide a safe and supportive environment within which mental health consumers, including those who'd experienced particularly traumatic events, felt able to provide insight into their lived experience.

Considerable care was taken by the facilitator to ensure the ecology was safe for sharing, and written consent was obtained from all participants prior to commencement. The structure of the session differed from all previous workshops to account for the nature of questioning, and to ensure the safety of all participants.

Table: Agenda (mental health 2)

Time	Agenda item
13.00 – 13.10	Welcome Acknowledgements of country, and of lived experience. Housekeeping What to expect – Purpose of the day and agenda Consent forms
13.10 - 13.25	Creating a safe place to share Introductions Guidelines Personal reflection activity
13.25 – 13.45	Group discussion – ratings and feedback on current services (topic 1)
13.45 – 14.10	Group discussion – Using feedback for improvements (topic 2)
14.10 – 14.25	Comfort break
14.25 – 14.50	Group discussion – tailoring mental health transport to people's needs
14.50 – 15.00	Other feedback/comments Payments Acknowledgements

Conversation was fluid during the group discussion which resulted in aspects of topics one and two being covered concurrently prior to the comfort break. There was also a considerable amount of conversation that fell out of project scope, particularly with regard to the WA Police service.

4.9.1 Mental Health 2 – what went well?

Unlike in other forums, participants weren't specifically asked or prompted "what went well?". Rather, notes were taken during the session and comments classified so as to remain consistent with feedback format used in earlier community consultations.

- Felt safe and assured by ambulance staff.
- The staff listened even when I was manic. They said, "I'm not going to hell" [as was patients concern] and reassured me.
- They kept me updated which reduced my anxiety.
- They helped me to dispute my irrational thoughts.
- Very good.
- The ambulance was good – a function of my feelings more so than treatment.
- The ambulance was calming. It was a smooth handover.
- Difficult when in the ambulance to remember feedback because I was not in the right headspace. But in hindsight, I think it was very good.
- I have nothing bad to say about the ambulance.
- Paramedic calmed me – asked, "how you been going" etc. Engaged me in conversation to ease my anxiety.
- I was in a drunken state, but I know I was treated well.
- The paramedic came to see me three days after they'd bought me in on the mental health ward. That did wonders for my self-worth. I'm on the ward feeling frightened and anxious but the ambo's visit told me, "I must be OK, I can't be too bad."
- There's a lot of power in kindness and compassion. It still affects me today.
- I was in a catatonic state so don't remember much, but ambos were nice and kind and lovely.
- They felt so bad for me that they got rid of the bill.
- The staff were lovely and kept me informed.
- The ambos shared their lunch with me while I was in the ambulance.
- The transfer stuff [from ramp to hospital] hadn't come through, so they stayed with me and chatted. They gave me a hug when I left.
- I was fully conscious and able to walk, but protocol required a stretcher.

4.9.2 Mental Health 2 – what could be improved?

- There was a lack of beds, so I had to be transferred.
- It was embarrassing with the police in ED.
- Need more mental health training.
- I won't call the mental health emergency numbers – they're dangerous. You can't talk to them.
- I didn't understand why the ambulance had been rung. There was no opportunity to get my things.
- I was taken to a room and then at 6am in the morning they said I was fine and could go. I had to walk from Joondalup to Mindarie.
- There was a lot of shame. They offered to take me out on their board thing. I was fine, like I am now. I could walk myself.
- It felt strange to be in an ambulance. I'm not sure why it was needed. All that equipment and things – none of which I needed. It could've been used by someone else. I could have just been taken in a van.
- I was taken by taxi when I should've been taken by an ambulance. I then had to walk [a long way] with my bag, at night in a not so good area of town. The taxi dumped me with my bag – I was alone, frightened and scared.
- I was hallucinating but it took ages to fine where I needed to go.
- I had to use two buses and two trains to get home. It was overwhelming. Not good.
- Don't judge people who've attempted suicide.
- The cost of the service is too high.
- I can't afford it. I have a $3,000 bill.

4.9.3 Mental Health 2 – experience of WA Police services

Despite instruction to participants that the WA Police service was outside of the project's scope, discussion invariably led to the topic due to the high incidence of police attendance at callouts.

This section lists comments about the WA Police service where the consumer's experience was directly impacted by their attendance at the scene.

Many comments were made about the WA Police that did not directly relate to an ambulance service incident and these have not been included in this report.

- Ambulance and police are chalk and cheese – ambulance empathetic, police shameful.
- I was praying for medication to shut me down. I know if I play up a bit for the police I will get seen a bit quicker. [This relates to being seen quicker in hospital, which in turn increases the speed with which the patient will be provided with appropriate medication(s) to ease symptoms].
- The police need a mental health taskforce.
- I was being carted off against my will. I was distressed. It was dreadful. I got dumped in Joondalup ED. I had no money, no phone, nothing.
- Memory of bad experiences with police continue to traumatise.
- Police officers turned up in a van. Told me to #@** get in or they'd call the ambulance and I'd get stuck with the bill. I was so ashamed I couldn't leave my house for three weeks.

4.9.4 Mental Health 2 – consumer recommendations

- When the ambulance comes to pick people up, check they have money, keys and ID so that they're not left in difficult and/or dangerous positions when not admitted and/or discharged.
- Physical and mental health patients should be treated the same.
- Need to include space for peer support / lived experience workers.
- Talk to universities re. tertiary training for all medics, police, and teachers. Teachers are becoming social workers.
- More training on kindness and compassion.
- Introduce a mental health police task force.
- Charlies need a mental health ED.
- More training for police.
- No taxis to be used for inter-hospital transport of mental health patients. It happened to me when by law I should've been taken by an ambulance.
- Don't use ambulances [for MH patients] when they're not needed. Use another less expensive form of transport (e.g. a van).
- People on the autism spectrum find it very traumatic. Staff have no understanding or training. It would therefore be good to have trained peer support workers.
- Peer support to accompany transport and in the ED's.
- Peer support person to follow-up after discharge in the home, maybe after 4 weeks.
- More education [about mental health patient needs].
- End to end communication [to aid with handover and so the hospital is prepared for the patient's arrival].
- Transport should be fit for needs – personal circumstances.
- I recommend they keep doing what they're doing!
- Specialised police mental health response unit.
- Police officers in plain clothing to avoid shame, embarrassment.
- What happens with kids? Are they left alone? We need a mechanism to deal with the children. They're the next candidates for the mental health system.
- Ambos need top-up training.
- They need empathy, trauma informed care.
- All we want is empathy.
- Consumers need to [be able to] work with ambulance and police to decrease the need for police involvement [in callouts].
- Just send a van, not an ambulance.
- Have our details at dispatch. Safe and discrete.

4.9.5 Mental Health 2 – closing remarks

One of the key messages we left with from this deeply informative session was that ambulance experiences can go on to affect mental health patients for some time. While bad experiences continue to traumatise mental health patients long after the event, good experiences can have positive impacts well into the future. The stories shared were intensely personal and the motivation for doing so was a genuine hope that the information provided would be used to improve services for all mental health consumers.

Although there was mention of calling the police in order to avoid ambulance fees, there was a generally feeling that on the whole the use of police to accompany ambulances services for mental health was

unnecessary and caused embarrassment and shame (in front of friends, neighbours etc.) Attendees felt this could be alleviated by a more patient-centric approach to delivering services to mental health consumers, and more flexible policies and procedures which allow for staff to use greater discretion at the point of contact.

There was general consensus that the use of ambulances was often unnecessary for their transport to hospital, and genuine concern that the ambulance could have been used for other patients with more urgent care needs.

All acknowledged that ambulance crews were excellent but believed outdated, inflexible protocols and policy were to blame for poor user experiences. Mental health stigma (structural and personal) was a major issue, and attendees believed that the needs of mental health patients are poorly understood.

Notably, this was the only session in which cost was not raised as a major issue by the majority of attendees. Instead, the focus was conveying the need to be treated with respect, empathy and compassion.

5. Acknowledgements

The project was co-delivered by the Health Consumers' Council of WA and The Behaviour Change Collaborative.

Key personnel involved in project delivery are listed below:

Project Control Group

- Luke van der Beeke, Founder, The Behaviour Change Collaborative
- Pip Brennan, Executive Director, Health Consumers Council
- Fiona Emmett, Manager Procurement Policy, WA Department of Health
- Genevieve Woodward, A/Senior Procurement and Contract Manager

Project Delivery

- Luke van der Beeke, Founder, The Behaviour Change Collaborative
- Nadeen Laljee-Curran, Project Officer, Health Consumers Council

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- Traci Cascioli, St Patricks Community Support Centre (St Pats)
- Langford Aboriginal Association Inc.
- Linkwest
- Consumers of Mental Health WA (CoMHWA)
- Royal Perth Hospital
- Thinkfield Market Research

Appendix 1 – Broome interview guide

I'm now recording.

My name is Luke van der Beeke, Founder of The Behaviour Change Collaborative. The BCC is a Perth based social enterprise that works collaboratively to influence behaviours and improve lives.

Your contact information was provided by Thinkfield Market Research with your consent.

Can you confirm you provided consent?

This phone interview comprises informal research that will be used by The BCC, and its delivery partner, The Health Consumers Council of WA, a non-profit health consumer advocacy body, to develop a report for the Department of Health WA outlining consumer experiences of WA ambulance services.

The research is part of a DoH commissioned community consultation project targeting West Australian community members who've used an ambulance in the past 5 years.

Can you confirm you've used an ambulance in the past 5 years?

Feedback obtained through the consultation will be used by DoH to inform future procurement of ambulance services.

Your participation is completely voluntary, and you may terminate the interview at any time.

Do you understand?

During the interview I will ask a series of scripted questions and may also ask follow-up questions based on your responses. The interview may feel quite conversational at times. The interview will last about 20-30 minutes.

All information gathered during this interview will be treated confidentially. The BCC will keep a copy of the interview on file, and deidentified copies of any notes taken may be provided to The Health Consumers Council of WA and the DoH WA.

Do you have any questions?

Are you happy to continue?

Thinking about the last time you used an ambulance… How was the experience for you? Tell your story.

- What went well?
- What could've gone better?
- Were your needs met?
- Did you feel safe?
- Were you treated respectfully?

If you were responsible for writing the contract to deliver WA's ambulance services.

- What key performance measures would you include in the contract?
- What might you award bonuses for?
- What might you penalise?
- Are response times the most important performance indicator?

Thank you. That concludes the interview.

Bank details.

Questions?

Provide Luke's contact details.

Appendix 2 - Photos

Langford Aboriginal Association

Telethon Speech and Hearing Centre

Telethon Speech and Hearing Centre

Bunbury

Appendix 3 – Summary of activities inc. timeline

Timeline

Activity	Timeframe
Literature review	April – May 2019
Survey design (inc stakeholder engagement)	May – August 2019
Fieldwork	August - September 2019
Survey analysis and reporting	September 2019
Public forums (inc reporting)	September – October 2019
Final report	December, 2019

The project commenced in mid-April with a desktop review which included consideration of the public consultation work already undertaken by the WA Country Health Service (WACHS) and its Draft Country Ambulance Strategy.

Following the desktop review and further consultation with key stakeholders at DoH, the project control group decided to focus specifically on the lived experiences of people who had used a WA road-based ambulance service in the last five years. This included OOO services, inter-hospital patient transport services, and booked transport services. A consumer survey draft was developed accordingly.

Development of the consumer survey was a protracted process, due to the complexity of the survey design (to capture the relevant experience of users and callers and patients and carers alike), and the need to ensure all key stakeholders were properly consulted. Launched in July 2019, 452 responses were received, which was well in excess of the targeted number of 300.

A total of nine public forums were held in September and August. Open sessions in Perth, Broome and Bunbury were accompanied by specifically tailored sessions targeting Aboriginal and mental health consumers, and socio-economically disadvantaged. The latter group were selected for a targeted session following analysis of the online survey feedback and an approach by a key stakeholder in the sector.

Summary reports for the survey findings and each of the nine public forums were provided to DoH immediately following their conclusion. In this final report, the content of each of the summary reports has been collated. In addition, a series of additional recommendations for DoH consideration have been included, most of which are based on the insight and lived experiences of the many hundreds of health consumers consulted during this project.