St John Ambulance Western Australia Ltd

Ambulance Officers'/Paramedics Enterprise Agreement 2021

Third Meeting – 17 March 2021 9:00 – 16:00 – Attendance confirmed

St John WA	United Workers Union	AEAWA
Deon Brink (DB)	Scott Fitzpatrick (SF) AL	John Thomas (JT)
Paul Bailey (PB)	Paul Davies (PD)	Donelle Carver (DC)
Rene Anderson (RA)	Patrick O'Dal (PO) AL	Lee Waller (LW)* ON
Ryan Marshall (RM)	June Congdon (JC)	Dave Higgins (DH) ON
Tara Doyle (TD)	Dave Barker (DK)*	Martin Kelly (MK)
Justin Fonte (JF)	Wendy Blackman (WB)* ON	Dave Bryant (DY)* ON
Kathryn Smith (KS)	Rachel Lamb (RL)* AL	Gary Davies (GD)* AL
Hayden McGregor (HM)	Fiona Scalon (FS)*	Michael Hardwick (MH)
Apologies		
	Ben Throp (BT)*	Dave Abbott (DA)

*Online

St John WA	United Workers Union	AEAWA
Introduction		
DB will take it on notice and get back to you.	SC – concern on road that the Yammer group is open to all including volunteers.	
Combined Log of Claims		

CSP, Special Ops & Industrial claim items	Will provide to parties next week in advance of next meeting.	
We want to understand if there are any more claim items outside of what we have put forward (special ops etc.)		
Leave Claim Items		
RA – hoping to understand what is being proposed by the parties. What do UWU want to present by introducing smaller leave blocks. And flexibility	PO – rather than taking their leave in 4 week blocks, want to be able to take in 1,2,4 or 8 week blocks. For example, families may want blocks over school holidays.	
Would employees nominate the blocks they want to take?	SF I don't think there was any change to the current leave block system, but if they wanted to take a 1 or 2 week block, we weren't looking to change the current allocation. If the leave is available.	
How far in advance? Eligibility, how to manage it?	PD – what is the system now? If it is up and running, use the same system, based on the number. Lead time, I think it is 6 week lead time is that correct?	
Can be challenging now, if we move to smaller locks there could be more movement advice, and balancing the shifts. For full flexibility.	PD – in todays, wellbeing and long term, times between drinks, that week or 2 weeks. They	JT - Annual Leave flexibility is paramount.

We have an annualised salary – in terms of how it is calculated. As you know from the splitting shift process. DB – so leave the 8 weeks as is, and just have the ability there if required.	might of themselves out. (say its 3 shifts) it is what a lot of people do want. PO – Opt-in, just option for those who want it.	Should be allowed to take 8 weeks in any combination (from 1 week to 8 weeks) 7 days notice for single day leave 28 days notice for week of annual leave St John will allocate the 52 leave blocks e.g. 2022 – 52 leave blocks there. If they want to split it up, they make application of their leave block in advance of the following year for the combination of the leave. 1 year in advance.
RA – as each person took a single day off, that would be removed from the future leave block (where weeks are scheduled).		If someone wants to take a single day, then come back in a week. They may have more days on, than days off. w
With the annualised salary, how would you envisage that working? We would need to unwind the salary to be paid as per shift worked.		If you're paid 56 days at your salary, how is that different? How is that different?
When we take into account your 56 days, it includes all shift types (days, nights etc.)		I think your confused about calculating admin versus paramedic.
When you take a day off. For example if you took all night shifts at annual leave.		e.g. I take 8 single weeks off.

You would get more. E.g. if you kept taking 2 nights each set of 4.		Doesn't matter if I take 4, or 1 of those, because I'm coming back to work the other day I'm programmed for? Taking 1 of my rostered 4 days off.
DB – just want to understand the notice period, and make sure everyone is trying to take all their leave at the same time. RA – keep the same process of where we have a certain number of people off during each leave block.		Currently you roster 8 week blocks and you write to rosters to change your leave. I want to take 4 week block here* and then these are the 4 weeks over there.
DB – anything else?		LW – a lot of it has come from the membership, and the reports from the chief psychologist, all the reports and every other organisation allows staff to take time off, there is plenty of evidence that St John need to be more flexible with staff taking leave.
RA – confirmed it is on the agenda, next 12 months and it is before ethe project board. DB MyOSH is coming to an end.	PD – last EA, we talked about the new rostering project and rollout of a new system. That was meant to streamline everything, and make everything a lot easier. Is it a priority at the moment?	
TD – Service delivery tot eh community, if we could go to down to smaller leave blocks, we	PO – there might be 8 people who need to take, the last day of their roster is a Saturday, i.e.	

would be looking at smaller staffing numbers. School holidays will eb popular – the Q I have is: if we moved to this system of the same leave block. How we make decisions of who gets it?	Special leave to have the shift off. First in, first served. Similar system? Or if someone has made a request in the past. Build in a system that is fair.	
TD – need to assure service delivery to community, leave in regards to specific location as well. Balance the operational leave with the requests of staff as well. I just want to put that as something I am thinking about. First in best dressed may not be the best service in considering individuals needs and gaps in some parts of the year. RA – any further questions on annual leave flexibility.	PD/SF – how are the 4 weeks done now? First in. SF I think we can come up with a system that is fair. PO I think there is a different system of placing people on demand systems, there is different systems on how things work, I don't think its easy, but I don't think its unachievable to balance the flexibility of the staff and balancing the needs of meeting the needs of the community. PD – Transport can balance their leave already, and it works with a smaller group. With less than 4 weeks.	JT – there is no difference now, but if you move it into next year you have more time to plan. First in best dressed went out a long time ago. If someone comes to you, with I ant A, B C leave types. And now I want to move it again (e.g., Christmas) if you can accommodate him, then you can. If you cant, you cant. Currently your fox-holed into a leave block once you change. Now you have to go find your own one to swap with. The current popular ones is up to management and how you want to deal with it.
RA – confirm that flexibility applies across Country as well?	YEs	Yes
Annual leave at half pay – UWU?	You get paid half of your normal pay and get double the leave block.	
Defining, is that what 'Option' means?	By application?	

Is there a thought around the base numbers again? Leave allocation?	Yes	
Did you have thoughts around percentages, or numbers? We need to look at the total number of people, the type of numbers needed? Establishment is based on 8 weeks leave per year – this will have an impact on how many we need to fill those gaps? Who is taking 16 instead of 8? Parental Leave can access that – no actual impact.	PD – Transition to retirement	What's the current pressure on the organisation for requests at leave at half pay?
RA – on occasion on compassionate grounds, or through injury we may engage in that. We don't have the data and that is outside the norm.	PD – Defacto leave without pay, if I have back-to-back, might want it halved – take 32 weeks. Whoever takes it, is going to take it. it is still a big hit. There are a number of people who probably can't afford it anyway.	JT – it is the same, may take paid annual leave twice as much leave, on half pay. By application and agreement
Need to be able to model it and understand how to calculate the cost of backfilling it. Spots available.		DC – so many spots available, that it would apply per group as well? I.e. 4x4, Country etc. so that there is a fair spread of those who can apply.

DB – at other places I have worked, you had to take 2/3s o your leave block.		DA – weeks of leave – difficulty in working, or balancing shifts – if you split your 8 weeks into 1 week. Would there be consideration to convert that 8 week block into an hours? e.g. take 2 day shifts – take 22 hours, so there is no need to balance those out. DA – feel like it might address some of those issues.
Standalone work acquired illness RA – evidence required?	PO – our members state there are a lot more demand on their sick leave, exposure to infections at work – proposal is to have a non-defined amount of days, where your illness is most likely to have originated from an infectious disease at work (verified by a medical practitioner) – no cap or accumulation. PO – definitely need an aspect of that – need to be a linked case that is likely have resulted in this? With discussion with a GP that it agrees it is most likely the case. PD – Transport Officer's – they transported 2 elderly cases then the next day they were sick. That captures those people who get ill through their job. Without the entitlement abused. PD/PO – Anything infectious – i.e. pick a patient up who assaults you, then you have WC or get	

	the time off. While it is unfair if you catch something infectious. Its not a simple thing – its not an unfair ask in todays world. You don't want us coming to work sick do you? More likely than not it has come from work.	
Personal Leave – Mental Health days – UWU log of claims, #7 from yours. UWU do you want to go first?	JC we want 2 days mental health leave. Aligns with what Admins get, it is what we want. All covered by the same stressors from day to day, I know a condition a lot of the staff enjoy, so want the day that admin get.	
The 2 days leisure days that admin get related to public holidays, it is not specific to mental health days. RM – Leisure days are currently planned in advance.	Take days, when they don't feel well, but not sick, when they need to get their head right. As it currently works in Admin. PO – this would be used at their own will, I think Police have a thing where they automatically get stood down for a few days after a traumatic event? I'm not sure specifically. Basically get 2-3 days for any kind of significant event.	DA – popular proposal from our membership, feel strongly, that it is a fair request allocated to mental health or leisure to align with Admin. And associated with eh type of work we do. Progressive step of the organisation to look at that.
Organisationally SJA used MDL when a traumatic event occurs, RM we reviewed it recently when we spoke about the contract.		DC – is there a process, didn't know it existed, in 20years, I've never heard of it. LW – the difference is where we take a day off, or a day off 3 months later, there area a myriad of other things that occur that is hard to do when they go to a traumatic event.

DB – you want a guaranteed 2 days access, outside of the current entitlements? And if you don't use it, you lose it for that year (non-cumulative). RA – not linked to Crit inc. but take the 2 days when you need it? Could be without notice. RM – applies the same in Country.	PO – Post critical incident rest period – 72 hours, mandatory stand-down. If it was the 2 days – were not saying how to define this, but what effects each individual, there needs to be flexibility. And it depends. PO – yes, not specific to an incident, flexible to each individual, each person will have their own.	DC – it shouldn't be an issue, i.e. if they are on personal leave, same applies. JT – some sort of policy on this, Transperth WA if you are driving a train and runover someone, you're relieved immediately. There's a process. Very subjective, depends on who your AM is. Everyone processes things differently.
RM – are we talking about two different things? Critical incident or 2 separate days? RM – more aligned with how Admin works, that is why I was asking. But its more how Admin use it as planned leave (aligned to annual) where I wanted clarity that its next day, or unplanned. JF – from operational perspective covered by personal leave.	PO they are interlinked, anything that has a negative psychological impact on someone whether it is a critical incident or not. don't have to think about what they do, or post on FB or whatever. Regardless of the underlying stressor. That is the purpose of the 2 days. PO was just using the Police thing as other ideas from another organisation.	DH – not a sick day, just needs a day. to claim a sick day, would be inappropriate. LW – we haven't really done anything here for it, from the R U triple OK. fire, police etc all do it, but not us.
Pandemic Leave RA – for personal travel? We currently provide for work related exposure. It is a negative. Work exposure is MDL	JC -we have had this ask on St John since the beginning, it's a shame that we have had to provide this at the EA. PD – if someone comes to work and they're sent home, does it come out of their sick?	DH – we tabled this one – we have had a lot of our membership, who suffered a loss of sick leave ho were instructed to isolate in the early days of the pandemic. Who flew back into the country at the time. Govt. run Ambulance Services, would provide a Pandemic Leave allowance. and State govt.

Personal Exposure is Negative 152 But for personal exposure, we have provided the leave to those. RM – if someone chooses to go on holiday for example, is it covered? RA – yes, if we direct an employee home because we consider them to be sick, then it comes out of the sick leave. Especially during the current pandemic response. Alternatively, if an employee is vomiting and we send them home, then it comes off their personal leave. They can lodge a dispute for PL if they disagree.	PD – what recourse would an employee have if they felt they were fit for work?	provides 20 days Pandemic leave. Not linked to COVID. Any internationally WHO declared pandemic, who is required to isolate through govt. direction. We have a draft clause from State Govt. as you know, we've written to MM for the extension of this as the Govt. provider. We still feel there is obligation from the employer to assist us, for those who are forced to isolate (as outlined in the draft clause). Being asked to isolate for 2 weeks of an AO – would decimate their balances. We recognise it is unprecedented and that pandemics are rare events and believe that there wont be one for a while. Want a safeguard and surety to our members in the future when there is govt. Open to negotiation on hours and days. But want something in there to protect them. **We can provide the draft (8 shifts)** That should get them through a 14 day isolation window. A number of sub-headings on the clause.
TD – Personal Leave, being able to work a half shift or less? UWU	PD – basically this is around where we don't have a lot of sick leave, quite a lot of people make appointments, etc. and they cannot change	

	those. And they may have it at 9am and back on at 10am. No – you have to take the full day off. St Johns different to other employers. To lose a whole day, when they can be available again from say 10am. It is unfair. JC – same as childcare, but you just need to sort out your kids childcare and come in a little bit later. Without losing the whole day.	
TD – how might that work operationally? TD – what type of medical appointment? Dentist etc.	P8 card on sick leave from 8am to 10am – the partner sits and waits for 2 hours. SF – non-operational for 2 hours OR lose the crew for the whole day, or fill it on ICB. JC – more like a specialist appointment, where you have a long lead in and you really need an MRI. Its not like a basic dental appointment etc.	
DB – I see your point, but stuff you think about. Childcare aside, if we know ahead of time, we can fill the whole shift. I'm not sure if it is booked we lose the crew per se as we have time to plan ahead. If I know you take the whole day off, and fill the crew on overtime.	PD – but at the same time, if you have an appt. at 2pm you might have people come in and BO at 1pm to attend the appointment. Its something we can look at. In looking at one or 2 hours instead of a whole day. SF – need to be more specific, mindful of the impact on operations so focus was on specialists and short time.	

TD – what is the unintended consequence of this? What are the numbers. TD – special leave is first option?	SF – specialist appointment, no special leave etc. specific smaller item. SF – currently yes, only option. PD – but its less about the special leave, more about not burning a whole day of leave or special leave for example.	
DB – Operationally it would be challenging to manage.	SF – loudest thing is not enough sick leave, and org encourages people to book off. 10 days is not off, and take a full day sick for 1 hour appointment, they shouldn't have to and they're fit for it.	
DB – book it on the days off.	RL – my post op appointment was 15mins 6 weeks after my surgery, and I was on a late day van, and appointment was 9:30am and my Day Van starts at 10am. I was willing to come in and start 1 hour late, but I wasn't allowed to start. So want to know why it was such a big problem.	DC - can I add to that, operationally, it won't work out. Gave a whole lot of people the night off to go the Awards night – but no consideration was given. JT – 10 vehicles down, for an awards night?
RA would need to get back to that. Flexibility depending on the role that is taken. DB/TD – we will get back on that matter DC (Awards release)	PD – how do the office staff work when they have an appointment?	DC – can you clarify how those officers were selected for that time off on the Friday?
P8 Card – clarify>	UWU – its specific, e.g. Appointment for my MRI, the appointment is not flexible, that is such a waste to take a whole day off for such a small period of time.	

20-minute break (10:50am)		
Carers leave not to take from personal leave balance	UWU – carers leave, not taken. JC – I get 10 days personal leave, and 5 days carers leave. Personal accrues, but 5 days doesn't. So Carers leave doesn't accrue each year.	
RA – confirm, new entitlement	Yes, don't have a quantum. If you use 5 days (example) could still use Personal Leave post, those 5 days.	
KS – quantum – cost at 5 days? And go from there? Evidence?	JC – yes, and no thought yet to evidence, have never had to provide evidence for carers leave before so had not contemplated it. PO – (confirm with PO)	
RA – Long Service Leave Flexibility (smaller blocks)	UWW – yes, as above for AL	AEAWA – more than one portion, 7 days notice for single day (single day LSL) and 28 days for one week or more.
KS confirm single days, as LSL act states one week. RA – LSL nothing further.		

RA – Parental Leave clause, want to ensure there is clarity on the part-time employees access to pro-rata parental leave clause.		
KS – Increase special leave from 6% to 8%?		DH – A lot of the discussion has been about flexibility. Increasing the % of staff allowed off, less people using sick leave. Hours already worked, on most days they have already decided they're not coming (whether it is sick leave or special leave). More flexibility, Mental Health, balance their work life.
KS – last agreement, we agreed to a 6%, how does an increase need an increase in %.		700 officers at last agreement, now about 900 there must be an increase. DH – if they're using hours already accrued, no negative benefit to organisation. JT – if you're a football fan, you have 3 months to book off. True special leave, is when you have a day or two's notice. What is next response? They book off sick.
KS – how does an increase in SL % change that circumstance? Yes, we will get the data for access to special leave. RA – is the claim that the % is not sufficient right now, do you need it to increase?		Do you have a printout of that data? Correct, increase in % so there are more spots.

TD – confirm question		Increased flexibility, that is why we want more special leave. Whether it is single AL, LSL, shift exchange etc. Trying to open as many avenues as we can to stop those from taking PL when they cant get traditional leave off. 8/11 crews off. The person is not going to come to work, as the employer – how can I get that person to work or accommodate that leave?
DB – what happens when we move from 6 to 8, what stops the 9th person? The same still applies, what is the difference between 7 and 9? Sickies are common		DH – well it wouldn't, but you have more spots to plan ahead. You know about it straight away, where you can put that plan in place to fill that vacancy. Understand it is a headache, but more of advanced plan. Emma Newman has given figures at 10:10 for unplanned book offs, if you're aware (there is always going to be some book offs) it make sense to accommodate that if you know that there are going to be so many people off. Say 8%.
RM – have we seen an improvement from the last agreement? For example special leave shift exchange. KS – we will get that data.		DH – planned and organised, there is no flex in the system, we're running on the bare minimum.

RM – if we increase flexibility, we need to plan for more people to be off and that will need to be filled. DB – where I'm from, they come and knock on your door, it's a different system where we are more lenient here.		
KS – increase Special Leave – 96 hours positive Understanding increase	PD – 48 in credit and wanted to add to that number, to run into 48 negative to use 96 hours to go back to Wales. Would rather book up 96 hours in advance, like a credit card type thing. Build the hours up for those plans. I don't see a negative point being those credit hours. Because I need to go negative 48, its harder to earn back. For example. That is the rationale for increasing to 96.	AEAWA – same argument for the positive.
KS – leave liability is a consideration, as we have to pay it out.		JT – but If you took it as overtime, you pay it out anyway don't you? What is the different?
KS – leave liability – increases with salary as well.	PD – you can easily find someone to pay you back in cash. But when it comes to special leave it's a bit harder.	DH – it is hard for Ambulance workers to take a week off, if you wanted a week off and then workload wont allow it. we have no real system to do it aside from special leave. That is why we are trying to expand the current system without resorting to sick leave etc.
KS – Special leave portability between Metro and Country	PD – couple of points – if you're in Country and you're coming back to metro. You cant bring your hours back. Why not?	

	It's the same company, its like a credit card with eh same bank – why cant she take it back? Rachel mentioned issues with getting the SL in Country. Each time you go back and forth you've got to take it and pay it out. Going into the Country, that is more problematic, but you could ring-fence it. surely in regional centres its easier.	
KS – what do you mean by Ringfence?	PD – limited people in Kalgoorlie or Hedland, it might be harder, but Australind/Bunbury it would be easier to take the hours as there are more issues. Country to Metro – should be easier as it can be managed. Consider different areas. RL – if you're on relief you cannot accrue special leave in the Country.	JT – if you're country on relief, you cant accrue hours full stop. Hedland Christmas time – all officers on leave at same time and cant use Perth limit to pay out. We are the one service. What is the difference to go to Kalgoorlie or 2 or 3 shifts and come back to Perth and acquit. When you come back, what is the difference between country and metro. And cannot use your balance outside of metro. Cant use some of that to take some days int eh country
JF – may need one day at the end of the set of 4 while on relief. When we consider a reliever accumulating from Metro and coming to country and then books off a whole heap of shifts. They may get the local paramedics to take the shifts off them and you've taken the country officers to do that work.	PD -what is the harm in accumulating it in country and spending that when you go back? Nothing at the moment, so that could be something we look at?	

Haven't thought about going back to Metro. JF – problematic bring hours back into country, we don't have spare officers in remote country locations, if we are down a member of staff it is hard to over. Long absences that would hurt us. Ringfence to shorter number of days.		
Drafting for clarity? Proposed wording?	UWU – people get confused about how SL work. Spell it out better – what goes in, and how it gets paid out? Yes, can provide one in the future. SF – some of the staff deployment officers provided the wrong information and maybe are confused about how it is to be paid out. Just making sure I get clarity on this. i.e. what is double, what is normal time etc.	
Defence Service Leave – AEAWA can you provide more information?		JT – currently the Commonwealth is 10 days per annum and we get 4. We are asking for an increase on the current 4 days. Maybe not to 10, but an increase. All other emergency services offer 10 days (as they are all linked to Govt.) confirmed, All other Ambulance, Police and Fire.

Lunch Break		
CAMC Feedback		
DB – move back to CAMC item now that Paul is back with us, and seek some feedback from AEAWA/UWU	PO – Similar, no one came back and was supportive of the model. Main concerns were: QP position – no appetite to reduce the pay of a registered paramedic. Concerns around the internship program, mainly around – with a program, 2 year fixed-term program. Potential to recruit mature age who could be good at the job. May not be appetising to those who want a career pivot to Paramedic. 2yr FTC in general was unsupported – there wasn't much of an appetite for Critical Care, less support than we thought.	JT – surveyed our membership, every member who has provided feedback has said they are unsupportive of the CAMC model. JT – one of the things, getting smashed on the road, unprecedented. Obvious problem, not getting to the call, and take patient to hospital, current ramping is 6 hours. Transport on 24/7 – a lot of the jobs, are Transport, even though most are called P2 – however, we make the decision is urgent/non-urgent etc. we know when we take them to hospital, most will transport instead of ANR. You give us a job, if we have to wait 6.5 hours
PB – which rotation was 6.5 hours? Data for March yesterday, Ramping is (- 30 minutes) we only had 14 patients over 5 hours in March.		JT – First night shift at Joondalup (Sunday Night) This is what Hospital was telling us as we walked in – 6 hour wait for care (Sunday night).
DB – not true, we're not putting 82 trucks on at 3am in the morning, I need more trucks when the community needs it. its not just a demand management tool – it's a clinical model as well. Allow us, we struggle to get people to come into the orgs. When we grow. When they come out of		Not going to demean the patient call, you know that person is going to get ramped, and hospitals are reluctant to put people in wait rooms. More than an appetite to put transport into Community on Low acuity calls. Unfortunately – most calls want a paramedic.

Uni, this new model will allow us to bring them in readily. One of the factors to bring them in. Not about getting rid of paramedics, but to get care for patients. We know crit care is needed in certain parts of city. Low acuity – happy to discuss this. I think using transport is that is because that's the way we've done it before. Maybe it sits somewhere else, outside of the transport.		Diminish my role long term. Your going to split APs and make them work with an unqualified paramedic each.
One thing, is that they are registered paramedics stepping through the process. If it's the view, that we put 2 QPs to address the low acuity model? TD - There may be a view that we need to look at addressing the low acuity model and have constructive conversation about addressing this. There are also alternatives to this. DB – if we take the volume of P3s away, I don't need more Paramedics on road.	PD – VAO changed to EMT overnight, they are similar to Transport. PD – we noticed the difference when Transport were doing more community jobs. At the time, it appeared to be taking a load off of metro. St John were happy to allow that to happen. People on road, are asking if you're introducing cheaper paramedics.	JT – The question is – obligation to government. How are the response times? Cheaper to put Transport on instead of Paramedics.
Response times are poor Patients were waiting too long, needed to be separated to get patients faster.	PD – don't put a Paramedic on a cheaper rate. PO – not a lot of evidence, a lot of what we are assuming, there are a lot of different ways we could be doing things.	

Don't have capacity to have them to come in and do that … check with DB. PB – BLS tier to takeover low acuity?	Lower acuity – could be addressed by nurse practitioner/paramedic practitioner. Some places around the world that works. As opposed to say a BLS tier? We're not presented with that information, from our side of the table – we have to protect our worth. There should be a reward for registration. Were not saying reduce the scope of a paramedic.	
PB – happy to provide that data to you for Critical Care. P0 priority / core patient group for critical care. More importantly, seeing the consequences of not seeing crit care on road. e.g. getting major trauma straight to RPH – geographically its more difficult in some areas to achieve this. Slightly more than half our patients, get them to major trauma first go. Other centres are 70/80%. Generally we should be getting them there at the same rate. E.g. things such as blood and IV instead of peripheral hospitals.	Need to protect the level of pay for what makes up a registered Paramedic. That's similar in pay to filling out a census form. It takes into account all of it, but hourly rate of $35 is what makes up our value – and its not palatable. Model of care needs to be based on evidence. The evidence that is supplied. If you're looking at doing a critical care, what is the evidence, and amount of patients to achieve that.	
PB – focussed on higher complexity, low occurrence tasks. If dilution, there may be changes to skill mix on airways for example. Yes.		MK – with the projection of putting Crit Care on road, a need or dilution of paramedic skill as we see it today. MK – I work in an outer metro area, I cant remember getting a back-up, AM or CSP since

PB – I agree with what you've said, greatest need is those on the periphery of the city, particularly as the 24/7 cycle, we all get sucked towards those hospitals. Our model is to have sufficient numbers of CCP and CSP who are able to get to you, and we know where the incidences occur. We know the time, and what the reasonable response time is, for road based response.		we have had this system. I think that's where we need them. Can be nervous driving past perfectly good hospital on way to RPH. Wondering at Rationale? How it going to apply, I've never seen a backup come to me. Unless we are going to put a lot on? What is the worth?
When a resource in a response car – has 'nothing to do" – the answer is not to drive to a hospital, but remain responsive. Need to the new model t be useful and time responsive. My undertaking is that we will have sufficient numbers to meet you and your patients. Understand that 1 North and 1 South is not ideal. That is the system we've inherited.		DC – those of us, that last week we responded from Joondalup from Ballajura, reason we were at hospital was P2s that took us to hospital where we got stuck. That P2 could have waited and that could impact on our response to P1s.
DB – there are things that happen outside the eA, work we are doing on the ProQA and SOC to address. We are all, might not agree on everything, I don't think the model devalues the paramedic. This model provides them the opportunity to get experience, whether they work for us, or for others at the end, they still have built that experience for the internship.		DH - business perspective, probably valid perspective. This doesn't appeal to those who are ramped and are unable to respond to P1. I was countering what Deon is saying, but there is little appetite, because it doesn't address issues of day to day basis.

DB – 100 extra Paramedics onboarded to assist the workload, but this wont specifically address ramping. New model will improve the way we attend to patients. Ramping sits outside the model we are trying to achieve.		
PB – I don't think its EA related, but Ramping, the model we run – is based on sufficient ambulances to respond (abundance) probably since the end of 2018, but also end of 2020 Ambulances are relatively scarce and parked outside hospitals. The decisions to ramp us is 1 sided. Based on perceived capability to takeover care. Does not consider our outstanding work,. Decision to ramp should be based on 2 sided conversation – we need to decide what our primary role is. But holding up hospital walls is becoming more apparent. When we are particularly busy – we don't ask them to come out and attend to patient. We never agreed to ramp for 9 or 6 hours ramped.		
Phrased as we gave an inch, and they've taken a mile. I'm working on protocols that would enforce transfer of care for selected patients.		
Around half of ramped patients are not being provided with any meaningful service from us. I		

don't think its an EA discussion, but its what I'm working on. Difficult situation.		
Getting Health, to define in writing, who has clinical governance of patient post-triage. (its them) even though they're on our trolleys per se.		
DB – Secondary triage is also part of it. all of our previous pathways, was guaranteed attendance. Secondary triage, stood down 18 ambulances down yesterday, so we were able to reclaim that time for us. On average 8-9 per day.	PO – in regards to devalue, want your thoughts – 3 year degree from 2nd year onwards – finish at Year 4. That's when they graduate as Ambulance Paramedic. $38.61 New proposal, they'll do 3 year degree, then 2 years as an Intern, then in 5th Year they are Qualified Paramedic $35.50 how is that not devaluing.	
DB – when you said devaluing, in terms of monetary terms, yes they are being paid less. But that's not specifically devaluing their skill overall.	PO – in terms of the dollar value, that is where we are saying they are being devalued.	
TD – for me, its establishing what we think the appropriate model of care is one thing. To work out what is best for our patient, and then what the renumeration is to me. That's my perspective.	PO - the model of care, is that the QPs and APs where there is no tangible difference, so I think that the monetary difference does come into it in terms of what we are saying. It makes no sense.	
TD – If that is not the model that is not preferred and seeking your feedback – ideas around that, a reasonable question to ask. If you don't agree, what is it that you would agree would work better.	Crit Care, although there wasn't a massive amount of support, no one was against it. If you want to propose a model that delivers something differently, then present that? We are trying to protect paramedics.	LW – it comes through, the dollar value, if you drop the value $35k a year – then you wont attract the right people. If you offered secondary triage for grads, you wont get the people you want. We just want to protect paramedics pay.

RM – what about AP3 versus, AP1 how is there a difference there?	PO – agree, but I think AP1s should be paid AP3 if we could,	DB – we need to look at their model and all aspects of it. collective outcome, I don't think we can pick one part and say, lets just try that. Even if we talk about BLS – move through the levels.
PB – agree with you on that, keep people out of hospital FSH using virtual trial at the moment. Agree on multi-phased approach. Based on work with our hospital colleagues.	PD – St John funding model, $1k a pop. If you've got awesome people knocking off ambulances in one area, you are not getting the funding you need by not attending. The funding model is out of whack.	
DB – what do you think our funding model would look like if we were a govt. funded?	PD – not attacking you, looking that the govt. need to be paying more for our service.	
RM – part of our conversation, including diversion and capacity with health meeting. Ongoing discussion with Dept. of Health. DB -Absolutely, trying to do things, to support our new model. PB focus to take care of the patient on both sides of the table we agree what our primary objective in, to help the patient. Up to us, to make the argument with govt. of money saved with them, by avoiding hospitalisations. DB – agree with David, look at whole system – build that capacity.		JT – current challenge today. You've said you're not putting on more night trucks. How is that going to achieve this orgs. Ability to get to P1s that are waiting 20/25 minutes,

a large portion of our fleet are siting outside of hospitals, we need more demand crews during the high demand times to address. Its not a single thing. RM – bringing more people allows us to ensure the establishment is filled each night.		JT – does not address the fact, were going to calls that are not urgent.
DB – we cant just move them along.		JT – but they can go in later, why don't our comms team talk to the hospitals. JT – e.g. swollen foot for 3 weeks who now wants to go to hospital – I have to take him, why cant I call comms and say its not necessary? Could say – not in a hurry, SJA will call back when they are ready. Window for collection (example).
DB – I have hospitals ramping at all times of the day, where do we shift that patient too? Patient will still need to be taken in at some point. Want to get back to Lower acuity.	PD – have we trialled it? is there a harm on trialling something like this.	
Health trial last year. 80% needed – 60% admitted to hospital. Not masses of patients out there that don't need hospital. Cant just ask to keep doing what were doing.	JC – Can I ask what is establishment – is it people, or trucks?	
Establishment – takes into account: e.g. 500 Paramedics to fulfil frontline	RL – if we weren't ramped etc. on a shift.	

Of that, I have unplanned absences, Leave Backfill – up to 600 Country Relief – 700 When I don't use them for relief, leave etc. it moves depending on leave/country. Supposed to be funded to standby capacity. Not the case at the moment. Next years negotiations – aiming for this. 52% not accepted as agreed number, not funded. Low 40% is where the funding covers us. i.e. funded at 40% standby capacity.		
TD – to fill for Metro is standby. Need to add more for leave, country etc. Cycle time increases, leads to reduced capacity. Pushes standby capacity down because of ramping.		DC – when we are down 9 vehicles, then ramped for 6 hours then more and more vehicles join the queue.
It's a 24 hour capacity. Which fluctuates through the day.	PD – should have a live standby capacity, that can guide when a patient gets collected.	
Resource escalation plan – where we can work through issues such as that, to release us to attend the right jobs at the right time.		JT – establishment, does that include the 20 extra vehicles the govt. has given us.
TD – St John funded the new vehicles that we put on last year, yes.	RL – if they are part of a establishment, 6 down on establishment, but the there are 4 x 27 crews – why are we still down 2?	

TD – 27 crews are temporary to pair people up to fill the roster, it's a separate conversation about how to fill the roster.	SF – that's an example, of where you close a 22 vehicle, but open a 27 vehicle?	
DB – nay more comments?		JT – not being able to sell what you've put forward.
TD – Graduates, is there are objections that we're bringing in graduates? What is unpalatable?	PD – unpalatable is where they are moved on, where they are not guaranteed a role at the end of the 2 years. It is unkind to give them some kind of security.	JT – what is unpalatable, is that they come in, achieve their qualification and continue to progress.
	JC – be kind to the ones you employ. PD – you vet them, you mentor them, probation for 3/4/6 whatever if they've met the clinical markers etc. why wouldn't you let them continue as employment. But after 2 years, they're not right for the job. PO – it makes no financial sense, to put the investment in, and not get a job.	
PB at point of employing them, we don't know what there clinical skillset is, at the end of 2 years we know what they're good at. Currently a high number of ECU grads who aren't getting a shot, but need to compete to get in at the first rate through Curtin.	PD – why are you against making them permanent? SF – are you not able to find that out within 6 months instead?	Dave – how badly are people now that you take on? Like if you bring in 100 and cut 50?
RA – when we get to progression, we will address the intern thing.	PD – they're going to come in, do probation, got your eyes on you. After a fair period of time. Well	

	done. You can still performance management them.	
RM – number has yet to be decided, we haven't sat down and nailed it. Its not about just cutting pure numbers, but looking at getting the right mix here.	SF – its not right to expect someone to work on a contract for 2 years, at the end, catch you later. Its not fair.	Dave – does the single mum who has less time miss out? JT – Orgs, getting confused by SAO versus Graduate. They couldn't go to a Uni and ask for more graduates. We bought in a number of paramedics from everywhere. If they've got a parchment and knock on the door. Some have been doing other jurisdictional work, while others are working at Maccas. But we bring them both in at the same time.
DB – when I came on, I had to show I had 2 years experience to get myself in. Currently those in ECU don't have that experience, and cannot qualify – this gives them a chance to get the experience they need. We are creating pool of people who we can pull from when we need to. When they get the employment, they know when they come in, that it is a 2 year contract. If we need, we may take all of them (based on vacancies).	What will that do to those who are thinking of applying? it will be the younger ones.	JT – People coming from other ambulance jurisdictions, then come and told that they need to 2 years on-road (Grads to AO2) based on some skills. There is no norm. as it currently stands. Fact is there is disillusionment, where a huge number of people will be stabbing each other int eh back when you set 5 spots for 500 paramedics. Its not Kocher.

DB – People who are out there who have gained registration through grandfathering, its not purely education. But your skills in other states are different as they are based on what each jurisdiction dictates RM that hasn't been done. Talking is maybe 25% more? But we haven't landed on how that will look yet. Financially there is no reason to take more than we need. DB – my head is a quarter, it doesn't make sense taking double or more. We'll currently get around 40 from Curtin, and some from direct entry. PB – in my time, we have under-recruited a since I've been here.	PD – modelling predicts, 50 each year. How many interns would you take, if you needed 50. What is the number we would take on. PD over the last 10 years, how have we performed based on previous modelling? PD – if you recruited 50 when you need 60, would you take them all?	
DB – out of this process, I don't want to take on people who are not meeting this standard. DB – if Bill smith is performing but there are no vacancies, we cant offer him anything. But if a role comes up in 3 months time, then he can apply. He doesn't redo the Intern program, still eligible for application.	PD – at what point do they not perform? Where is the level?	JT – Bill Smith, joins, does all the right things. But there is no vacancy. What happens? Unlikely you're going to take someone from outside if you've got people already waiting. Like a Carousel. You have one chance to get in.

When 2 / 6 months time, a role is advertised – they can still apply.		
Yes, of course – they're still eligible to apply.	PD – if they've gone out, for a building site for 12 months post internship, can they till apply.	
Its not something we have thought specifically, or whether it is 6 months, 12 months. RA – registration, recency of practice are all factors. RA – currently we don't take them when they graduate, so they are already looking elsewhere. PB – You know from the outset that its 2 years, you wont be blindsided.	PO – what's the length of time they can be out of the job if they were to reapply? PO – its another issue, if they finish an internship and don't have a great length of time to find a new job. PO – they don't come in knowing they can get a job with St John, for those, it is definitely better than what they've got at the moment. But its weird, that you can only offer it and then take it away at the end.	
DB that is not true - those first two statements, its not a sudden love for ECU, they are an example of a local university and where we may get Interns from.	SF – again, what does that do to those who might apply? What impact or influence will it have on those who are looking to apply. For those who have a family etc.	LW – we've got 87 comms people and ear drums blown out and people getting belted on the ramp. Where is the love for the ECU students suddenly?
Happy to discuss that after the break.		DC – another model. Looking at a model that doesn't affect our current model, but looks at lower acuity and addressing those P2 hospital calls.

		I know you say Deon, 11 to 11. There is something in the middle. There is nothing to capture that right now.
Break		
DB – Donelle to begin		DC – a model, that doesn't impact current model or progression. Lower acuity model. Not suggesting anybody. But encapsulate graduates or something similar. Address the lower acuity cases, hospital P2s.
PB – Clearly a group of patients in pre-hospital with modest care requirements. Be happy to expire, what that looks like. If we were to go down that path, would need to be a clearly dedicated resource. When I started, Transport were already moving away to their own model. From that era, they felt like they were not servicing both models well. And moved to focus on intra-hospital transfers. Scope for providing a dedicated resource for those lower acuity cases. I go back to fast-track from hospitals from what I know best. There would be a dedicated resource. There would be a question of what that size would be.		

Define a pt. population. Estimate might be 5-10 vans on a day shift. That would cover P3. Not all, BLS appropriate or similar. There would certainly be a number. Must be separate from Transport. PTS need to focus on PTS. If we did this, we would need to add to what we already have. Question – what does that crew configuration look like? ProQA review, have demonstrated there are sick people in each determinate – sick people in P3 are often septic – or fractured long-bones with no serious. Design a system with analgesia – maybe sepsis protocol. They present with falls. But BP whatever it is (hard to identify until on scene). Most orgs will be BLS level. No clear view about the mix. Whether that might be QP/QP or Transport Off/Transport Off.		
Pure estimate only, 500 a day, maybe 50 in that area. Perth is huge, no point having single resource in rocky when needed in Quinn's.		JT – 5 – 10 days vehicles, what is the capture in this field?
PB – some of those jobs may be better dealt with by current Transport cohort. Depending on job. Matching the resource on what it might be. Mechanical approach to interhospital transfer. Your right, that some patients just need their location changed, and maybe analgesia on route.		DC – P2 where hospital is asking for P2 and ProQA identifies the case. That doesn't actually require clinical intervention, a lot of catchment in those P2s as well.

Care requirements can be variable. Primary – purpose built system. Inter-Hospital – PTS Proximity to Hospital is sometimes reason we call Paramedic for transfers.		
PB at point of tasking some P2s are hard to determine sickness, maybe 20% we don't know until we get there. Nature of the system PB – Nothing is off the table in terms of our discussion. The other question is, is 2 visits to a patient worthwhile? Happy to discuss further on what that system might look like. DB – Lets take ramping out of it. longest time we spend is getting to scene to assess the patient. We are good at picking, who is not dying now. Make a decision, pt. can stay at home, then next time, 2 hours later a different crew arrives and decides they should be.	PD – currently some crews do community calls late at night. St John don't allow it, where we turn up to a P2 for Transport Crew, but were told to transport.	JT – massive void between Transport and Paramedics. What is the area in the middle. 150 calls a day fall into that area, maybe a touch beyond Transport skillset. But certainly transport for Paramedic.
RM - what you're suggesting, is that the P2s are not genuine P2s and Docs are trying to clear patients.		DC – what I'm hearing is that we don't need 2 Paramedics to attend to the jobs. JT – understand the risk int eh community, interesting to know – of 168, how many came out of 1 ED going to another ED. Normally if that pt. is at risk, they'll get a doctor. Put those community call P2s, and Hospital Transfers into P3 and a fair old workload, as DC

		explained, is a model that is void. (as mentioned above).
DB – this goes towards it, as part of the SOC redesign. It's not just a hospital requests a P2. Want to go into a system where we ask – what do you need? Happy to talk – had those discussions before, why is this a P2?		The result is, that it must go Paramedic via the current ProQA system. Whatever you want to call it.
PB – We could be having that discussion with a Doctor, in SOC – that is how RFDS works. They're a smaller system however. We take a Logistics heavy process and allow originating ED to set priority. RFDS has a medical heavy process to set priority. Working for WACHS looking at interhospital country transfers. We struggle with short-distance transfers after midnight, and general Bunbury – Perth transfers. DB – some these items are part of other projects that we are working on outside the eA.	PD – do you keep the numbers from P2/P3s when they went in at one end, and then out at another Priority. If we could identify where someone has got it wrong?	
PB – we look at the priority of the Ambulance on the ATS. Triage nurse, "this patient should see a Dr. within". Different to when a patient should be moved.	SF – shouldn't there be more a stronger conversation with Drs who are giving the wrong priority. Educating them?	

PB, SF Agreed, yes.		
DB – difference between clinical priority and transport priority. That is something else we are working on.		
PB – thoughts on crew configuration of this P3 crew looks like? Any ideas? PB – we just grab some of the fleet (section off a small group per shift). One of the problems, the unacceptability of nan on the floor. Need to stop P2s trumping P3s. One option we sequester some of the fleet per shift. OR Build a service with a different crew configuration than how we currently run the service. The beauty of the current service we have the right crew to triage the cases. Versus if we had BLS type level who may be out of their depth. Keen for some feedback on that.		Not today, need more time to consider it.
DB – I think we might call it a day.		
END MEETING – 15:30		