

LEGISLATIVE ASSEMBLY



NSW Public Accounts Committee

Inquiry into the NSW Ambulance Service: Readiness to Respond

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Public Accounts Committee

Inquiry into the NSW Ambulance Service: readiness to respond / NSW Public Accounts Committee.
[Sydney, N.S.W.] : The Committee, 2004. – xvii, 96 p. ; 30 cm. (Report no. 146 / Public Accounts Committee) ([Parliamentary paper] ; no. 3/53)

At head of title: Legislative Assembly.

“June 2004”.

Chair: Matt Brown.

ISBN 0734766289

1. New South Wales. Ambulance Service.
2. Ambulance service—New South Wales.
- I. Brown, Matt.
- II. Title
- III. Series: New South Wales. Parliament. Public Accounts Committee. Report; no. 146
- IV. Series: Parliamentary paper (New South Wales. Parliament); no. 53/3

DDC 362.188

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Charter of the Committee

The Public Accounts Committee has responsibilities under Part 4 of the *Public Finance and Audit Act 1983* to inquire into and report on activities of Government that are reported in the Total State Sector Accounts and the accounts of the State's authorities.

The Committee, which was first established in 1902, scrutinises the actions of the Executive Branch of Government on behalf of the Legislative Assembly.

The Committee recommends improvements to the efficiency and effectiveness of government activities. A key part of committee activity is following up aspects of the Auditor-General's reports to Parliament. The Committee may also receive referrals from Ministers to undertake inquiries. Evidence is gathered primarily through public hearings and submissions. As the Committee is an extension of the Legislative Assembly, its proceedings and reports are subject to Parliamentary privilege.

Terms of Reference

At its meeting of 2 July 2003, the Committee resolved to conduct a follow-up inquiry on the Auditor-General's report titled *Ambulance Service of NSW: Readiness to Respond*. The Terms of Reference were:

1. Implementation of the report's recommendations; and
2. The value of the audit report, in terms of accountability and in improving the performance of government.

Chairman's Foreword

In March 2001 the Auditor-General published a performance audit report into ambulance response times. The report noted that response times in the Sydney Metropolitan Area were considerably higher than those in other states. The report made eight recommendations, which included 27 sub recommendations.

The key areas for the Service to address were:

- the further collection and analysis of operational data through the computer aided dispatch system (CAD), which will better align staffing and rostering to workload; and
- the Service's relationship with the Health system, which affects how long it takes the Service to handle each patient.

This follow-up report examines the progress of the Service's attempt to address the Auditor-General's concerns. The Committee was pleased to note that in most areas progress has been made to implement the recommendations.

It must be stressed however, that the Auditor-General's report is still relevant to the Service as there is still much to be done to achieve the Service's goal of being Australia's best.

I would like to thank the Service, NSW Health and the Health Services Union for their assistance throughout this inquiry. I would also like to thank David Monk and Christine Lloyd for their efforts in drafting this report.



Matt Brown MP
Chairman

Executive summary

Introduction

This report is a follow-up inquiry into the Auditor-General's report *Ambulance Service of NSW: Readiness to Respond*.

It reviews the extent to which the Service has implemented the recommendations of the Audit Office and makes further recommendations to support future implementation. The Committee's terms of reference for the inquiry were to establish the extent to which the Service had implemented the audit report's recommendations and the value of the audit report in terms of accountability and performance of government.

The discussion in relation to each recommendation is divided into three sections. Section one briefly describes the Auditor-General's findings, which generated each recommendation. Section two covers the action taken by the Service to address the recommendation and section three discusses the extent of progress and where and whether further progress is required.

The Auditor-General chose to undertake the first performance audit of the Ambulance Service because of performance concerns with ambulance response times and allegations of waste and corruption made to the Independent Commission Against Corruption. During the audit, the terms of reference were extended to include interactions between the Department of Health and the Service, as this also impacted on the Service's ability to respond effectively.

The final audit was not favourable to the Service. It indicated that the Service had considerable work to do to address ineffective and inefficient management structures and procedures. These problems reduced the Service's ability to meet workload demands and improve response times.

The Service responded to the report by acknowledging there was scope for improvement and made an undertaking to implement most of the recommendations. However, the Service noted that it did not support the audit report's recommendation in relation to governance. It argued that the governance structure of the Service must be considered in the context of the broader health system and that clear lines of accountability exist which are consistent with those of other NSW Health agencies.

Recommendation 1 - Accountability

Areas of accountability discussed in the audit report relate to simplification of governance frameworks, accountability and reporting requirements of the CEO, increased performance indicators, and to review the accountabilities between area and operations managers.

The 2001 performance audit affirmed the Auditor-General's recommendations in previous performance audits regarding corporate governance that the functions of boards can be easily replicated through the use of consultants or technical staff. Non-

commercial or non-regulatory boards should also be reviewed to determine their relevance and effectiveness.

The Committee considered whether the Board was necessary. Under Standards Australia's *Good Governance Principles* the Board is responsible for the strategic direction of the Service. However, the Board and CEO are effectively appointed by the Minister and they can also be dismissed by the Minister. This ultimately leaves the Service in the control of the Minister. The Minister and NSW Health intervened with the functions of the Board, which ultimately blurred lines of accountability for the Service's performance. This also spilled over to the reporting requirements of the CEO who was accountable to the Board, the Minister and the Director-General of Health.

The Committee acknowledged that the blurring of accountabilities between the Board, the Minister and the Department stemmed from auditing arrangements of the Service. The Service is audited as a controlled entity of the Department under s45A(1A) of the *Public Finance and Audit Act 1983*. The status given to the Service as a controlled entity explains why the Department oversees its operations and the Act determines that the Minister fulfils this function.

The Service, as a controlled entity, is not required to prepare an annual report under the Annual reporting legislation. However, it does report on an annual basis to the Director-General of Health, and the Department includes information about the Service in its annual report due to its controlled entity status.

The Committee considered how the Service could ensure more effective accountability arrangements without separating from Health. The Committee considered that the Board should only comprise members who acted in the best interests of the Service and who were independent of Health. An independent Board would improve the Service's ability to negotiate with Health on a more equal footing rather than in its present position of continually adapting to the needs of hospitals, which impacts on its ability to control response performance.

The Committee also reviewed the reporting arrangements of the CEO. Prior to the inquiry, the Service had simplified reporting requirements of the CEO. The CEO was initially reporting to the Board, the Director-General of Health and the Minister. In the restructure of 2000/2001 the CEO was provided with a clearer performance agreement that is reviewed annually by the Board and provides that the CEO reports to the Director-General of Health through the Board. Furthermore, under the provisions of the *Ambulance Services Act 1990* the Service is only required to consult with the Department.

Under the annual appropriation acts, the Department receives recurrent funding. The Department then allocates funds to the Service. The Committee considered the most appropriate solution to the inconsistencies in the funding of the Service would be for the Service to receive separate funding which means changes to the appropriation acts.

In order for the Service to be a stand-alone agency, the Service would also need an appropriate administrative framework including financial annual reporting, auditing

and employment arrangements. This would require changes to the *Public Finance and Audit Act 1983* and the *Public Sector Employment and Management Act 2002*.

The Committee considered that ambulance response times are the main performance indicator of the Service and should be accurately recorded. With the advent of AmbCAD, a computerised dispatch system, implemented in 1998/99, the Service has the ability to collect accurate performance data and extend the range of performance indicators available for reporting. Yet, there has not been significant change in the performance indicators reported in the 1999/2000 and the 2002/03 annual reports.

Data collected from AmbCAD recorded against targets derived from the ORH review for response times, show 61% for response times less than 10 minutes and 87% for response times less than 15 minutes. This is an improvement for the Service in achieving desirable response times. Responsiveness targets are included in reports to the Board and to Parliament. In addition, the Ambulance Service provide information on its response times on its website as part of its public reporting. It is suggested that the Service in NSW take note of the Queensland Ambulance Service's use of benchmarks in its annual report and follow this example. It is also noted that whilst the ORH review only devised targets for the Sydney area, performance indicators and appropriate benchmarks should be devised for regional areas.

Historical communication problems between area and operations centre management also affected accountability. The 2000/2001 restructure aimed to flatten the structure to increase accountabilities of managers at lower levels as well as provide a more compatible organisational structure between areas and operations.

Recommendation 2 – Performance Reporting

The community has an interest in the performance of the Service. The Service has an obligation to the community to gather and present reliable responsiveness data in a manner that is easy for the public to understand. The Committee found that the Service has made significant progress in developing reliable response times data.

Further, there is an obligation on the Service to consult with the community on their expectations on the content and dissemination of performance information. With the improvement in the range of responsiveness data available through the implementation of AmbCAD the Service could potentially widen responsiveness reporting to include community radio, newspapers and improved website information.

Comparative performance data is also important. The Service participates in the Convention of Ambulance Authorities (CAA). The CAA compares response performance of Services around Australia. The Service should provide links to the CAA's website and Annual Report on its own website.

Recommendation 3 – Relationship with the Department of Health

While the audit report recommended a "whole of health" approach to the delivery of services to the community, it noted that this was largely dependant on improved communications between Health and the Service. Both the audit report and the present report acknowledge there were committees and reforms in place as a result of previous inquiries that assisted in improving integration of service delivery.

However, the ongoing problems of ‘trolley block’¹ and ambulance diversion were evidence that the integrated approach was not based on an equal partnership. The Service appeared to be on call to NSW Health by providing its own staff in emergency wards, which impacted on its ability to carry out its role in pre-hospital emergency care. The Committee were of the view that the Service should be transferred to Emergency Services portfolio if such issues cannot be resolved.

The Committee also recommended that the Service be vigilant in using its own resources effectively and efficiently particularly during peak workload periods. It suggested the collection and analysis of data would be important to plan workload and rostering.

Keeping abreast of innovations in other Services would also be helpful for the Service in finding ways to use resources effectively. Whilst, the Service has implemented a Patient Transport Service (PTS) to transport non-emergency patients whose medical condition renders them medically unable to utilise other forms of transport, schemes adopted in other Services go further by classifying all patients as requiring emergency or non-emergency transport. This means that resources can then be deployed to better match each clinical situation. It is also a potentially good source of revenue for the Service.

The Service also has an historical role in rescue operations. Although there had been moves to sever this link to the emergency services, community opposition was so strong it was decided to continue to monitor the workload so that more informed decisions about the Service’s future contribution could be made.

Recommendation 4 – Management Information

The audit report recommended that the Board be provided with better management data to improve decision-making to meet workload demands.

At the time of the audit report, the Service was to implement a fully automated rostering system. This strategy has not yet happened. The Committee suggested that implementation of an automated roster system be a matter of priority. The Committee also noted that as a result of AmbCAD data, new rostering and workload distribution was being trialed and should be ready for implementation within the next 12 months. This more sophisticated use of AmbCAD data will assist the Service in making immediate decisions in relation to prioritising deployment. The Committee encourages the Service to implement the new dispatch system as a matter of priority.

Recommendation 5 – Flexible Staffing

Flexibility of award conditions in the areas of meal breaks, calls outs, overtime and rostering was identified by the audit report as contributing to high response times.

The Service is presently negotiating a new enterprise bargaining agreement with the Health Service Union (HSU) which addresses some of these areas. The new award, a plain English document, reflects the recommendation from the audit report regarding

¹ Trolley block, or access block as it is formally defined, is the proportion of admitted patients not moved to a hospital ward within 8 hours from commencement of active treatment.

the need for management to communicate more clearly with staff on the interpretation of award conditions to minimise confusion and misinformation.

One area of particular interest to the Committee was the use of the Service's resources for sporting events. The Committee noted that the Service is encouraging negotiations with sporting bodies within the whole state. The potential revenue for the Service is substantial.

Recommendation 6 – External Stakeholders

As the Ambulance Service has moved from a fairly autonomous service in the early 1970s into a state managed organisation there has been a lapse in consulting with stakeholder groups including the community. The audit report suggested building a more outward looking service, which incorporated community liaison and involvement.

Services such as the Queensland Ambulance Service who have been proactive in community awareness, education and injury prevention campaigns provide excellent examples of community involvement. Using the data collected and produced in the annual reports, the Service can identify areas of pre-hospital care that could be then used in community education programs. This would potentially assist in increasing response times by lowering the need for emergency care through better community education and awareness.

Recommendation 7 – Staff Development

Management training and development is an important area in response times. Highly skilled managers can motivate and organise staffing to encourage peak performance. The Committee noted that six of the seven senior executives of the Service were employed from outside the Service because they had the additional skills required to participate in the necessary reforms emanating from the implementation of AmbCAD.

The Service has been active in addressing management training by employing a training and development officer to plan and implement training programs to suit the individual needs of managers.

The Committee noted a clinical governance committee is part of the Ambulance Board. The Board should include in its meetings progress reports from the manager of training and development. A budget should also be provided to the management/training officer.

The Committee would like to see senior managers have the opportunity, through sound management training, to successfully move across to Health and Emergency Services agencies as well as participate in secondments.

Recommendation 8 – Culture and Ethics

At the time of the audit report the Service was being monitored by the ICAC because of allegations of corruptions and roster rorting.

Since the audit report the Service has implemented its own Professional Standards Committee and the ICAC has stated that the Service does not require further monitoring.

The Value of the Report

In terms of improving the performance of the Ambulance Service, the Committee found that the Service significantly improved its response times in the year following the release of the audit report. The Service's performance since then, however, has plateaued due to factors such as increased activity and hospital delays, which have both exceeded expectations. Nevertheless, the Committee encourages the Service to continue implementing the audit report recommendations

In terms of accountability, the Committee came to the conclusion that the Audit Office effectively held the Service to account. The Committee then suggested a number of ways in which future audits could better hold agencies and other stakeholders to account.

The original objects of the Audit Office inquiry included examination of management accountability and information gathering and reporting. As the inquiry progressed, the Audit Office recognised that the scope of the audit needed to be expanded to include relations with health and clinical structures such as the use of paramedics and emergency transport officers.

In its review of the Audit Office, Acumen Alliance² affirmed the Auditor-General's right to expand the scope of an inquiry. However, Acumen Alliance recommended that when the scope of an inquiry was expanded it should be clearly identified and explained in the final audit report. The Audit Office inserted this explanation in the report, which provided useful context to the Committee.

Although in its response to this review, the Audit Office did not accept this recommendation, the Committee finds this information useful and would encourage the Audit Office to include it in future performance audits.

Audit conclusions and recommendations should also be clearly supported by evidence. The Committee is of the view that clarity of information is fundamental to performance audit reporting, particularly as such reports act as a starting point for agency reforms.

The level of consultation conducted by the Audit Office was also raised as part of the inquiry. In evidence, the Health Services Union stated that it was not adequately consulted in the audit. The Auditor-General is not obligated to consult with external stakeholders. As a matter of natural justice, however, the Committee suggest that in future it would be appropriate to see bodies, such as unions or businesses which are often directly involved be consulted.

² See Public Accounts Committee, *Review of the Audit Office under section 48A, Public Finance and Audit Act 1983*, November 2003.

List of Recommendations

1. Governance framework of the Ambulance Service

RECOMMENDATION 1.1: The Service's Board should only comprise members who act in the best interests of the Service and who are independent of the Department of Health.

RECOMMENDATION 1.2: If the current funding structures remain unchanged following the current review, future appropriation acts should include a separate allocation for the Ambulance Service.

RECOMMENDATION 1.3: The Ambulance Service be listed as an individual agency in Schedule 2 of the *Public Finance and Audit Act 1983* and Schedule 1 of the *Public Sector Employment and Management Act 2002*.

2. Performance Indicators

RECOMMENDATION 2.1: Future annual reports of the Service should include benchmarks for performance information.

RECOMMENDATION 2.2: The Ambulance Service to collect, analyse and report data on response times by clinical category.

RECOMMENDATION 2.3: The Service to expand performance indicators in its Annual Reports to include regional breakdowns.

3. Public Reporting

RECOMMENDATION 3.1: The league table published in the Convention of Ambulance Authorities annual report to be included in the Service's future annual reports.

RECOMMENDATION 3.2: The Service to promote the Convention of Ambulance Authorities in its Annual Report, website and other publications.

4. Future Directions and Clinical Relationships and Networks

RECOMMENDATION 4.1: The NSW Ambulance Service be transferred to the Emergency Services portfolio if issues such as trolley block and ambulance diversion are not resolved within two years.

RECOMMENDATION 4.2: That the Service collects data on ambulance diversions, including the times and hospitals at which they occur. This should then be used to plan workload and rostering at the Service level.

RECOMMENDATION 4.3: The placement of Ambulance Officers in emergency wards be discouraged as it is outside their primary role.

RECOMMENDATION 4.4: The Service should review the 2001 resource modelling analysis for Sydney to ensure the deployment of ambulance resources reflects

peak call periods and takes into account the impact of peak periods of hospital demand. The Service should continue to liaise with the HSU to ensure working agreements and relief arrangements are sufficiently flexible.

RECOMMENDATION 4.5: The Service establish strategies where middle and senior operational management are seconded to work in Services in other states and overseas and report back to the Service on possible innovations.

5. Non-Emergency Transport Services

RECOMMENDATION 5: That the Service ensures that the provision of non-emergency transport is appropriately co-ordinated. In particular, that clear lines of communication for arranging such transport are in place.

6. Deployment of Paramedics and Roster Preparation

RECOMMENDATION 6.1: The Service should continue to monitor the workload of the emergency rescue units in metropolitan and non-metropolitan areas through data collection so that more informed decisions about the continued use of the Service in this area may be obtained.

RECOMMENDATION 6.2: The Committee encourages the State Rescue Board to re-visit the question of appropriate allocation of metropolitan rescue units, including the use of the Ambulance Service in rescue operations.

RECOMMENDATION 6.3: That the Service makes it a matter of urgency to implement a suitable automated networked roster system which will assist in making rostering co-ordination activities easier.

7. Training and Development

RECOMMENDATION 7.1: The Service organise opportunities for external management secondments.

RECOMMENDATION 7.2: A specific section of the Annual Report be devoted to information about the training of officers in the use of data produced by AmbCAD.

RECOMMENDATION 7.3: A specific section of the Annual Report be devoted to information about the provision of computers and intranet access.

RECOMMENDATION 7.4: The Board to take a greater role in co-ordinating and integrating training and development courses across the organisation.

8. Arrangements for Honorary Officers

RECOMMENDATION 8: The Service use the experiences in other States as a model for the recruitment and management of honorary officers.

9. Improving Audit Office Reports

RECOMMENDATION 9.1: The Audit Office should clearly identify and explain any changes in the scope of a performance audit in the final audit report.

RECOMMENDATION 9.2: The Audit Office ensure the findings and recommendations clearly demonstrate the factual evidence and context, particularly in the absence of agency agreement with a performance audit report.

RECOMMENDATION 9.3: The Audit Office consult with organisations to ascertain their point of view prior to making findings or recommendations that directly affect them.

RECOMMENDATION 9.4: Recommendations be placed in the body of the report immediately after the discussion of the issues which raise the recommendation. Recommendations should also remain at the front of the report but include a page reference to match the relevant discussion in the body of the report.

Chapter One - Introduction

THE AUDITOR-GENERAL'S REPORT

1.1 In March 2001 the Auditor-General completed a performance audit into Ambulance Response times, titled *Ambulance Service of NSW: Readiness to Respond* (the audit report).¹ The Auditor-General initially undertook the audit for several reasons:

Mr SENDT: One is that health is a major expenditure area of government. We are almost always doing at least one if not two performance audits into the health area at any time. We had not looked at the ambulance component before. There were a number of other reasons. We were aware that there were performance concerns with ambulance response times. We had received a number of written allegations of waste and corruption. Some of those also, I understand, were made to the Independent Commission Against Corruption. They had a consistent theme of problems within the service around rostering and deployment of resources.

We also saw, from a seamless government point of view, that it appeared that there were significant interface issues between the Ambulance Service, hospitals and area health services. We also had some reason to believe that the Government's arrangements may not be as robust as they could be and we thought we would look at those in the same audit.²

1.2 The performance audit examined the efficiency and effectiveness of staff deployment practices and systems within the Ambulance Service of NSW. This included the extent to which resources were managed to meet variations in demand, rostering, leave, work practices, training, governance and how effectively the ambulance operations integrated within the NSW health system. The report divided these issues into three areas, which were referred to as barriers to performance. They comprised:

- strategic barriers in the Service's relationships with the Health System;
- structural barriers in the Service's own structure; and
- management and operational barriers in the Service's systems and processes.

1.3 The final audit opinion was not favourable to the Service:

This performance audit indicates that the Service has considerable work to do to reach its aspirations of being recognised amongst leading examples of best practice services ... a number of barriers to performance will need to be overcome for the Service to perform as well as it would wish.³

1.4 The Auditor-General made eight significant recommendations regarding efficiency and effectiveness of staff deployment practices and systems within the NSW Ambulance Service. The recommendations were:

Recommendation One

Enhance the accountability framework for the Service:

¹ www.audit.nsw.gov.au/reports.htm

² Transcript of evidence 5/11/03, p 1

³ Audit Office of NSW, Performance Audit Report entitled *Ambulance Service of NSW: Readiness to Respond*, p 2, March 2001 (hereafter referred to as *Readiness to Respond*).

- the government framework for the Service should be simplified to reinforce direct lines of accountability of the Service to its Board, and of the Board to the Minister;
- expand the range of key performance indicators for performance measurement;
- review relationships and accountabilities between Area and Operations Centres in the new Metropolitan/Rural structure;
- consider additional change management techniques to address more effectively barriers and impediments to the effective implementation of new technologies and structures.

Recommendation Two

Enhance public performance reporting:

- re-establish public reporting of reliable responsiveness data and trend's
- finalise deliberations with the Convention of Ambulance Authorities to benchmark and report the comparative performance of ambulance services.

Recommendation Three

Work towards a "whole of Health" delivery of ambulance services:

- clearly set out future directions and clinical relationships and networks within the Health System;
- identify external relationships to ensure interchange of information and consistency of standards;
- review the Service's revenue sources and charging structures;
- develop an appropriate package of non-emergency transport services for hospitals;
- review strategies for deployment of Paramedics;
- review the contribution the Service makes to the State's rescue capabilities.

Recommendation Four

Further develop management information capabilities to support decision making:

- ensure that the Board regularly receives reports which address issues of levels of activity, staffing levels/utilisation and significant equipment deficiencies;
- fully implement rostering automation software for all roster preparation;
- develop and implement resource modelling tools to determine optimal staffing levels and deployment strategies;
- develop capabilities to analyse workload, utilisation and responsiveness at station and shift level.

Recommendation Five

Identify and remove barriers to flexibility of resource deployment:

- review interpretation and application of current Award conditions;
- improve flexibility of Award conditions;
- review management and work practices contributing to inflexibility;
- monitor developments in best practice within the Service and elsewhere.

Recommendation Six

Enhance consultation with external stakeholders:

- implement means of regularly identifying customer and stakeholder expectations and perceptions of the Service's performance;
- develop means of keeping the broader community informed of the Service's progress, directions and plans.

Recommendation Seven

Review recruitment and development strategies:

- implement enhanced management training and development programs;
- maximise opportunities for workplace-based distance learning and training;
- review arrangements and strategies for Retained and Honorary Officers, Patient Transport Officers and communications officers.

Recommendation Eight

Continue to place a high priority on addressing issues relating to culture and ethics:

- increase ethics training and awareness activities;
- review and update previous risk assessments and control reviews, including approval of overtime.⁴

THE SERVICE'S RESPONSE TO THE AUDIT

1.5 The then Minister for Health, The Hon. Craig Knowles MP endorsed the report and said it would form a blueprint for reform.⁵ Mr Knowles stated:

My agenda is a simple one. I want a public sector ambulance service delivering better response times and providing a decent return for the taxpayer's investments.⁶

1.6 The Annual Report for the Service in 2000/01:

...acknowledged that there was scope for improvement in all areas of the Service.

Reform processes were commenced to improve such areas as efficiency in the deployment of resources, the development of management information capabilities to support decision-making and greater involvement by the community in decision-making processes.⁷

1.7 The following year, as a further commitment to reforms generated by the audit report, the Service formed a committee comprising members of staff, management, unions, contracted consultants (Operational Research in Health Limited) and Deloitte Touche Tohmatsu. The Annual Report of 2001/02 noted:

Their task was to undertake an independent Operational Review with an overall objective to improve the appropriateness and timeliness of services to patients.⁸

1.8 The result of their report confirmed the Auditor-General's findings and set targets for appropriate response times within the available resources. This is discussed further in Chapter Two.

⁴ *Ibid*, pp 6 - 8

⁵ *Sydney Morning Herald*, 8 March 2001, p 2

⁶ *Sydney Morning Herald*, 15 March 2001, p 3

⁷ Ambulance Service of NSW, *Annual Report 2000/01*, p 2

⁸ *Ibid*, p 4

- 1.9 It is a requirement under the annual reporting legislation that external reviews be discussed in annual reports.⁹ During evidence the Audit Office commented:

Mr HORNE: ...to be fair, I do not think that any organisation had ever been as fulsome in their dealings with the performance audit report as the service was, publicly. It made very clear statements that the things that had been found in the audit were serious and needed to be fixed and there were a whole range of things they proposed to do to fix them. They declared those in their annual report so we were very encouraged by that.¹⁰

THE PUBLIC ACCOUNTS COMMITTEE'S FOLLOW-UP INQUIRY

- 1.10 Under its power to follow-up Auditor-General's reports under section 57(1) of the *Public Finance and Audit Act 1983*, the Public Accounts Committee resolved in its meeting of Tuesday, 15 July 2003 to conduct a follow up inquiry on the report. Specifically, the Committee set itself the following terms of reference in relation to the report:
- Implementation of the report's recommendations; and
 - The value of the audit report, in terms of accountability and in improving the performance of government.
- 1.11 The Committee examined the progress the Ambulance Service of NSW (the Service) had made in implementing the recommendations. The Committee also reviewed the value of the audit report, in terms of accountability and in improving the performance of government.

Call for submissions

- 1.12 The Committee invited submissions to the inquiry from the NSW Ambulance Service NSW Health and the Health Services Union. One other private submission was received. These submissions are available on the Parliament website. A list of submissions is at Appendix One.

Site visit

- 1.13 Members of the Public Accounts Committee undertook a site visit on 31 October 2003 to the Headquarters of the Ambulance Service in Rozelle. The Committee inspected the Service's various ambulance vehicles.
- 1.14 The Chief Executive Officer gave an overview to the Committee on the changes to Service relevant to the recommendations of the audit report.
- 1.15 The Committee also inspected the operations unit in Redfern. The Committee was able to see first hand the workings of the new Computerised Aided Dispatch System (AmbCAD).

Public Hearing

- 1.16 On 5 November 2003, the Committee held a public hearing at Parliament House. Witnesses from the Audit Office, Ambulance Service NSW and Health

⁹ Schedule One of the *Annual Report (Statutory Bodies) Regulation 2000*. As noted in Chapter 2, the Ambulance Service is not required to comply with the annual reporting legislation.

¹⁰ Transcript of Evidence 5/11/03, p 2

Services Union gave evidence. The transcript of evidence can be found on the NSW Parliament website. The list of witnesses is at Appendix Two.

Present report

1.17 This report addresses the recommendations of the audit report. It takes the following format for each recommendation. Firstly, it provides:

- a brief overview of the findings of the audit report;
- the action taken by the Service to address concerns from the report; and
- discussion and recommendations are offered for further action.

Secondly, this report then examines, in Chapter Ten, the value of the audit in relation to accountability and improving the performance of government.

Chapter Two - Recommendation 1: Enhance the accountability framework for the Service

SIMPLIFY THE GOVERNANCE FRAMEWORK OF THE SERVICE TO REINFORCE DIRECT LINES OF ACCOUNTABILITY OF THE SERVICE TO ITS BOARD, AND OF THE BOARD TO THE MINISTER

The Audit Report

- 2.1 The Auditor-General has previously identified the need for simplification of the corporate governance framework of agencies of the NSW Public Sector.¹ In 1997, the Auditor-General recommended that the Government review the boards of non-commercial and non-regulatory organisations. The reason was that the functions of most boards overlap with the relevant Minister's functions. In the private sector, the board acts as the link between the organisation and the public. In the public sector, the Minister takes this role.²
- 2.2 The Auditor-General argued that the other functions of the board can be replicated easily. If specific technical skills are required, consultants or technical staff can be hired. If the organisation needs to consult with staff or community interests, a consultative or customer council can be appointed.³
- 2.3 The Auditor-General recommended that the Government review all boards of non-commercial and non-regulatory organisations to determine their relevance and effectiveness with a view to rationalisation.⁴
- 2.4 The 2001 audit report on the Service affirmed the Auditor-General's previous recommendations and noted steps taken by NSW Health to comply with the corporate governance recommendations:
- NSW Health and the Health Services Association of NSW initiated a licence agreement with the Audit Office to develop a health specific version of the guide ... but there is also a need to implement the full range of best practice principles contained in the guide.⁵
- 2.5 The report went on to say:
- The Audit Office would encourage that the further step be taken of simplifying higher-level governance and accountability arrangements across the portfolio to reflect better practice principles.⁶
- 2.6 The audit report noted some cases where the Department of Health intervened in the Service's activities, such as during industrial disputes. Further, the report discussed how the CEO's performance agreement was reviewed annually with the Director-General of the Department.

¹ Audit Office of NSW, Performance Audit Report - *Corporate Governance Volume 1: in Principle* and *Volume 2: in Practice*, June 1997

² *Ibid*, p 17

³ *Ibid*, p 60

⁴ *Ibid*, p 12

⁵ *Readiness to Respond*, p 49

⁶ *Ibid*, p 49

- 2.7 The Auditor-General's concerns were that these arrangements made it less clear who was accountable for the Service's performance. If no-one is accountable, then staff and management have less incentive to perform well. For example, if responsibility needed to be ascertained for an issue with the Service's performance, both the Department and the Service could plausibly argue that the other party was responsible.

Action Taken

- 2.8 Shortly after the release of the audit report the Minister replaced the twelve member Board with a smaller Board of eight. Some Board members were reappointed.
- 2.9 From 1 July 2002 to 30 June 2003, the Board comprised:
- The Hon Barrie Unsworth (Chairman)
 - Jon Isaacs (Executive Coach and Mediator)
 - Greg Rochford (CEO of the Service)
 - Robert McGregor (Deputy Director-General (Operations) NSW Health Department)
 - Angeline Oyang (Social Work and Communication Management)
 - Maria Pethard (representative for Australia, New Zealand and the South Pacific for Banca Intesa)
 - Robyn Kruk (Director-General NSW Health Department)
 - Jim Arneman (Ambulance Service)⁷
- 2.10 Since then there have been some changes to the Board. Robyn Kruk and Robert McGregor have resigned and a new independent Board member, Linda Barach, was appointed in November 2003. There have also been changes to the membership of the committees of the Board. For instance, in evidence, the Auditor-General noted that the Department no longer has a representative on the Audit Committee.⁸

Discussion

- 2.11 The Minister appoints the Board of the Service. The Governor appoints the CEO (also on the Board) on the advice of the Minister. The CEO manages the Service in accordance with the directions of the Board, who can be directed by the Minister. The Governor, on advice, may remove members of the Board, including the CEO.⁹ The *Ambulance Services Act 1990* does not give the Department any role in managing the Service. The only requirement is in section 12(1)(f), where the Service is to consult with the Department.
- 2.12 The arrangements in the *Ambulance Services Act 1990*, however, are not consistent with other legislation. In the *Public Sector Employment and Management Act 2002*, Schedule 2 does not list the CEO of the Service as a

⁷ Ambulance Service of NSW, *Annual Report 2002/03*, pp 14 - 15

⁸ Transcript of Evidence 5/11/03, p 3, where it was noted that the Service had "reached a sufficient state of maturity and understanding of governance issues that it could operate its own audit committee."

⁹ *Ambulance Service Act 1990* ss 7-11

chief executive position. Rather, it is classified as a statutory senior executive position, similar to the head of an area health service or a Deputy Ombudsman.

- 2.13 Similarly, for the purpose of financial reporting and auditing, the Service is not listed as a statutory body in Schedule 2 of the *Public Finance and Audit Act 1983*. Rather, the Service prepares reports and is audited as a controlled entity of the Department under section 45A(1A) of the Act. The concept of a controlled entity, and when an entity's accounts are consolidated into its parent's accounts, is discussed in accounting standard AAS 24, "Consolidated Accounts." Clause 9 (xxi) of the standard states:

The concept of control employed in this Standard is defined in terms of dominance of both the financial and operating policy decisions, which implies a singular line of power.

- 2.14 Clause 9 (xxiii) states:

The capacity of one entity to dominate decision-making, in relation to the financial and operating policies of another entity, is insufficient in itself to ensure the existence of control as defined in this Standard. The parent entity needs to be able to dominate decision-making so as to enable that other entity to operate with it as part of an economic entity in pursuing its objectives.

- 2.15 Given the Service is a controlled entity of the Department, it is not surprising that many aspects of its operations are also overseen by the Department. The reference to "singular line of power" in the standard indicates that the Audit Office, in its financial audits, has determined that the Service reports directly to the Department. The *Ambulance Services Act 1990* envisages that the Minister fulfils this function.
- 2.16 Another legal consequence for the Service of being a controlled entity and not listed in Schedule 2 is that it does not provide its annual report to the Minister under section 10 of the *Annual Reports (Statutory Bodies) Act 1984*. Instead, the CEO submits the Annual Report to the Director-General of the Department. The Service is not required to prepare an annual report under the legislation, but does so voluntarily as a transparency measure.
- 2.17 Under Schedule 1, Report of Operations, in the *Annual Reports (Departments) Regulation 2000*, the Department is required to include commentary in its annual report about its controlled entities, which include the Service.
- 2.18 The way the Service receives its budget also confirms its controlled entity status. Currently, the Service does not receive a separate allocation in the Budget. In the current year, s. 13 of the *Appropriation Act 2003*, provides recurrent allocations for the Department of Health and the Health Care Complaints Commission. It also provides a capital allocation to the Department. The Service, however, is not listed because its funding is included in the Department's allocation.¹⁰ This appears to have been the practice since the *Ambulance Services Act 1990* commenced.
- 2.19 The Committee is not aware of any basis for the Department of Health to transfer such a significant sum (over \$200M per annum) to a separate

¹⁰ The Treasurer's Speech, 2003-2004 Budget Papers No 1, p 10 and Estimates, 2003-2004 Budget Paper No 3, pp 10-23

statutory authority. Section 127 of the *Health Services Act 1997* allows the Minister to fund area health services listed in Schedule 1 of the Act. The Service, however, does not fall into this category. Sections 128 and 129 provide for the Minister to fund affiliated health organisations. These are listed in Schedule 3, but they do not include the Service. Nor is the Service listed as a statutory health corporation in Schedule 2.

- 2.20 For the first time, the Treasurer in the 2003 Budget Speech provided a breakdown of the funding for the area health services, as well as the Ambulance Service. Section 34 of the *Interpretation Act 1987* allows the use of extraneous material to interpret legislation, but only to confirm a provision's ordinary meaning or determine a provision's meaning if it is ambiguous or obscure, or if the ordinary meaning is manifestly absurd or unreasonable. Whether the Treasurer's Statement provides adequate authority in this case is a matter for legal interpretation.
- 2.21 In its report, the Audit Office stated that the Service did not have to be completely separate from the Department to ensure proper accountability. It would be sufficient if there were clear and unambiguous arrangements in relation to:
- accountabilities of all parties;
 - the Service's relationships with the Department, hospitals etc;
 - performance measures for the Service and hospitals;
 - targets and methods of review; and
 - funding arrangements for the Service.¹¹
- 2.22 Such arrangements do not appear to have developed since the audit report. For instance, the Service's performance agreement with the Department is expressed purely in terms of what the Service will do, without any reciprocal action by the Department.¹² The nature of the performance agreement is a significant factor in preventing better relationships with the Department and hospitals.
- 2.23 The Committee recognises that the Department and Service have commenced clarifying accountability at the Board level. There are fewer departmental representatives on the Board, and a representative of the Department no longer sits on the Service's Audit Committee.
- 2.24 The Committee is of the view that, to ensure proper levels of accountability, this process be extended to make the Service independent of the Department, but to remain within the health portfolio. This approach will also be consistent with the framework in the *Ambulance Services Act 1990*. Separation will also assist in implementing recommendation 12, ie that the Ambulance Service charge area health services for being diverted away from the nearest hospital or waiting for an excessive period. Otherwise, the effect of the recommendation could be reduced by internal transfers of funds.

¹¹ *Readiness to Respond*, p 51

¹² Ambulance Service of NSW, *Annual Report 2002/2003*, p 8

- 2.25 The Department and Service will need to take a number of steps to make the Service independent. One step is to make the Service's accountability absolutely clear by removing all representatives of the Health Department from the Service's Board. It might be argued that such a representative would add useful skills and help improve communication between the Service and the Department. However, other people would have similar skills and there are other ways of maintaining communications with the Department, such as liaison committees.
- 2.26 Further, the Service is a separate statutory authority of the Department. It is not subject to directions from the Department, only the Minister. Under Section 12(f) of the *Ambulance Service Act 1990*, the Service is only required to consult with the Department. Standards Australia's *Good Governance Principles* require board members to avoid conflicts of interest and act in the best interests of the entity.¹³
- 2.27 There was no suggestion during the inquiry of any improper conduct or lack of diligence by the Departmental representatives on the Board. The Committee understands that Department of Health board members were only part of a transition period. However, a key theme of the inquiry is that many of the Service's difficulties in improving its performance are due to the perceptions that it is a Service of "last resort" and continually adapting to the needs of hospitals with little evidence of return for the Service (eg ambulance diversion and trolley block – see Chapter Four). Having an entirely independent board would assist the Service in addressing this issue.
- 2.28 The next step will be to change the method of appropriation for the Service. The current system demonstrates the governance role played by the Department of Health. It also raises issues about whether spending has been made without parliamentary sanction.
- 2.29 The Committee is of the view that the simplest approach to resolving this uncertainty is to separately fund the Service in the appropriation legislation. This method would also be consistent with the governance issues raised by the Auditor-General relating to lines of accountability.
- 2.30 In order to become a stand-alone agency, the Service would also need an appropriate administrative framework, such as audit, annual reporting and employment arrangements. The Schedules to the *Public Finance and Audit Act 1983* and the *Public Sector Employment and Management Act 2002* will need to be amended.
- 2.31 It should be noted that the Service has advised the Committee that there are substantial reviews of the health system structures currently underway that may impact on the funding and financial arrangements for the Ambulance Service.

RECOMMENDATION 1.1: The Service's Board should only comprise members who act in the best interests of the Service and who are independent of the Department of Health.

¹³ Standards Australia, *Good Governance Principles* AS8000-2003, p 23

RECOMMENDATION 1.2: If the current funding structures remain unchanged following the current review, future appropriation acts should include a separate allocation for the Ambulance Service.

RECOMMENDATION 1.3: The Ambulance Service should be listed as an individual agency in Schedule 2 of the *Public Finance and Audit Act 1983* and Schedule 1 of the *Public Sector Employment and Management Act 2002*.

EXPAND THE RANGE OF PERFORMANCE INDICATORS FOR PERFORMANCE MEASUREMENT

The Audit Report

2.32 The audit report focused on response times as the main performance indicator stating:

Because of the time critical nature of much of their activity, responsiveness is the standard by which all ambulance services are judged.¹⁴

2.33 The Auditor-General also identified performance indicators that were included in overseas and other Services within Australia. They included:

...means of prioritising incoming emergency calls to identify those cases which are time critical...

All services visited are striving for improved clinical performance indicators and for a better understanding of how the community perceives their performance. The Annual Reports of ambulance services in other States contain indicators which give a more comprehensive overview of performance than does the NSW Annual Report. Of particular interest are those indicators which relate to cost and operational data.¹⁵

2.34 Acknowledging that reliable performance indicators were unavailable at the time of the Audit, the Service advised in its response to the audit report:

Expanded indicators for performance measurement are being developed within the Service. The advent of the AmbCAD system along with the current project to integrate information from patient case records and the dispatch system will enable a new set of indicators for both organisational performance and clinical quality to be derived. The new reporting processes are expected to be introduced from 1 July 2001, following the achievement of statewide coverage for the AmbCAD network.¹⁶

Action taken since the Report

2.35 The submission to the present inquiry stated:

The Ambulance Service continues to report an extensive range of key performance and activity based indicators on a daily, weekly and monthly basis such as incident and response activity

The Ambulance Services' Computer Aided Dispatch (CAD) system is the major source of operational performance data. Major data items are extracted for the purpose of preparing and maintaining a robust data set.

¹⁴ *Readiness to Respond*, p 79

¹⁵ *Ibid*, p 79

¹⁶ *Ibid*, p 100

A data warehouse has also been established to integrate Patient Health Care Record, CAD and other data sets within the Service enabling a wider range of reports and analysis.¹⁷

- 2.36 Following the audit report the Service contracted the services of Operational Research in Health (UK) (ORH) and Deloittes to undertake a separate review of the operational activities of the Service.¹⁸ This review established target response times of 61% within 10 minutes and 87% within 15 minutes for the metropolitan areas. These targets were devised taking into account the available resources and should be met by 2005 when reforms are fully implemented. It should be noted, that achieving these targets may be inhibited by a deterioration in hospital turnaround times.
- 2.37 The 1999/2000 Annual Report, tabled six months before the audit report, had the following performance information:
- annual caseload (ie number of cases);
 - caseload split between emergency, urgent and non-urgent cases;
 - breakdown of different type of trauma cases;
 - breakdown of the types of emergency cases;
 - breakdown of the main medical emergencies;
 - total patients by age and gender;
 - kilometres travelled; and
 - response times for the year for within five minutes, five to ten minutes, ten to 15 minutes, and 15 to 20 minutes.
- 2.38 The Service's most recent Annual Report, that of 2002/03, provided the following data:
- monthly incidents, responses, and transports for the past three years;
 - monthly emergency incidents, responses, and transports for the past three years;
 - types of cases;
 - total patients by age and gender;
 - monthly mobilisation times;
 - monthly response times within 10 minutes;
 - air ambulance caseload;
 - age profile of air ambulance patients;
 - patient diagnosis of air ambulance patients; and
 - patient survey (in the appendices).
- 2.39 No benchmarks were provided in either annual report. The main enhancements to performance reporting over the three year period were:
- mobilisation times;

¹⁷ Submission by the Ambulance Service of NSW, p 2

¹⁸ Submission by Health Services Union, p 8

- outputs (ie, work done) for the air ambulance;
- the patient survey; and
- much data is now reported on a monthly, rather than annual basis.

Discussion

- 2.40 The Committee welcomes this additional reporting on the Service's performance, including the patient survey, which was one of the Audit Office's suggestions. However, the other data that the Audit Office emphasised in its report, namely clinical outcomes, cost and operational data (eg cost per patient) are yet to be reported. In particular, the data to produce efficiency information (eg cost per patient) would be available. The Committee would encourage the Service to expand its performance reporting along the lines of that suggested by the Audit Office.
- 2.41 It appears from the comparison of the annual reports that the range of performance information that was to be gathered from AmbCAD has not been realised in the reports. This is indicated by the comparatively little change in reporting between the reports over the period from 1998-99 to 2002-03. However, it should be noted that performance reporting has improved somewhat by the inclusion of reports by month and the separation of mobilisation data. Despite these changes, the current standard of reporting is disappointing considering the time elapsed since the audit report, coupled with the expense of installing AmbCAD to acquire this information and the commitment of the Service to using AmbCAD.
- 2.42 The CEO in evidence was not entirely disposed to the use of benchmarking as a part of performance information and excused its continued lack of inclusion in reporting due to the reforms of the Service:
- Mr STEVE WHAN:** On that benchmarking issue, the Auditor-General's report made a number of comments about benchmarking against other areas. I guess I have not seen how you are establishing what you are benchmarking against for a lot of those indicators. How is it that you are able to say, "We are achieving 80 per cent of our target?" How do the people of New South Wales know that the targets you are setting are actually a challenge for you, and not something that you can achieve?
- Mr ROCHFORD:** ...In terms of benchmarks and what is right, you can look around the world and find a whole range of targets that have been mandated or have been just used as a guide. We have taken the approach that we would like to see ourselves across a range of indicators as the best or up with the best of ambulance services in Australia, as a first stage. We are sort of getting towards that. As I said earlier, just to mandate a target can in fact be unhelpful when you are trying to reform an organisation or reform an industry at the same time as maintaining a service.¹⁹
- 2.43 However, the CEO had indicated in response to the audit report and subsequently that data was being developed through AmbCAD to include expanded operational and clinical data. The ORH review also allowed for the development of targets that could have been included in the Annual Report, such as a response time rate of 61% within 10 minutes in Sydney. The Service

¹⁹ Transcript of Evidence 5/11/03, p 25

reported a 61% target in the 2003 budget papers and reports them to the Board, although these figures were not used in the Annual Report for 2002-03.

- 2.44 In addition to targets, benchmarks should be used by the Service when reporting its performance. Benchmarks would provide an indication of how well the Service is improving its performance through its reforms and enable comparison across entities. The Committee suggests that benchmarks are included in future annual reports. By way of comparison, the Queensland Service provides simple but clear performance reporting in its Annual Report, including benchmarks. Its report serves as a model for the Service for response reporting. In evidence, representatives from the Audit Office noted the importance of benchmarks:

Mr HORNE: We still find generally, in looking at agency annual reports, that there is a lack of benchmarking. Agencies will put in information about what they do themselves but not necessarily how well they compare to others. That is not just the service; it is typical of most agencies, so that makes it more difficult to publicly know whether their performance is as good as it should be. We think there should be more of that done.

Mr McLEAY: More of what, in particular?

Mr SENDT: A lot more benchmarking of an organisation's performance against like agencies interstate or overseas, for example. Part of the performance audit we did on the Ambulance Service was to look at performance in other jurisdictions, metropolitan and non-metropolitan. Our view is that government entities largely being monopolies have an obligation to provide that sort of information to the public and to Parliament so that their performance can be gauged.²⁰

- 2.45 The use of performance indicators such as benchmarks are critical to the performance information that is provided to the community on how well the service is meeting reform objectives and measuring performance against its own reforms. The Service has the data and should provide that data to the community in annual reports.²¹
- 2.46 In its annual reports, the Service reports on clinical matters such as the types of cases treated and the age and gender of transports.²² Further analysis should continue which show that patterns occur between cases treated with gender, age, geographical and seasonal factors. Patterns could then lead to targeted community education programs (also discussed in Chapter Seven) and better planning of services. The Queensland Ambulance Service bases its community education programs and first responder (volunteer) programs on this kind of data.²³
- 2.47 In evidence, the CEO discussed the need to develop response times and effectiveness data for clinical categories.

²⁰ Transcript of Evidence 5/11/03, p 2

²¹ It should be noted that the Annual Report is not the only public reporting that is done by the Ambulance Service. Performance information on the Ambulance Service of NSW can also be found in the Convention of Ambulance Authorities (CAA) annual reports and the Council on the Cost and Quality of Government reports on Government Services. In addition, performance information is available from the Ambulance Service's website.

²² Ambulance Service of NSW, *Annual Report 2002/03*, p 2

²³ Queensland Department of Emergency Services, *Annual Report 2001/02*, p 37

Mr ROCHFORD: By looking at other indicators of clinical care—and the most obvious indicator is around cardiac cases because there is clear evidence about response times affecting outcomes of the cardiac cases—we could look at the number of indicators, such as the time that we get to a specific cardiac case; the nature of the intervention we employ, whether it is aspirin or something more sophisticated; and increasingly whether we can return spontaneous circulation to someone who has had a cardiac arrest by the time they get to the hospital. As we get smarter with our data, we are also on the edge of being able to link those cases to whether patients walk out of hospital. Obviously with the ultimate success rate for each clinical condition, there is a range of indicators of that nature that we can collect and use to report on the quality of the service we deliver, not just the pace of it.²⁴

2.48 This discussion is consistent with the audit report, which noted comments from interstate services such as:

a 12 minute response time is too late for a cardiac arrest, but a waste of resources for a sore thumb.²⁵

2.49 The Committee agrees with the CEO's comments on the potential gains from collecting and analysing this data. Response times to specific clinical areas should then be reported in the annual reports.

2.50 The Service also discussed in evidence some of the issues it faced in regional NSW in relation to allocation of new positions and new ambulance officers:

Mr ROCHFORD: ...Initially we are taking the approach of building education and clinical support for rural and regional areas. It is important for two reasons. Firstly, over the next four years, taking into account natural attrition and other factors, we will probably need to train between 800 and 1,000 ambulance officers....There is a need to build a capacity for particularly the larger centres in the bush to take on a training load. Increasingly we are doing that. At this time almost 75 officers are training in the bush. That will grow in future years. With the first of this year's allocation, 10 officers are going to four new regional training centres. They will be dedicated clinical educators and they will not only help support trainees but also help keep qualified officers current with their skills as they develop, and they do develop from year to year.

The next most pressing need was on the Central Coast, where there was a clear mismatch in the demand-resource ratio....So the balance for the first year will go in there. That will take us up until the 2004-05 year. That gives us time to really plan where we can get the biggest impact for the officers that are available in that year. That will depend on the structures that we put in place. I have seen a proposal that would allow all 230 officers to be allocated to places in the bush that would provide no expansion of service and no improvement of response times; it would merely provide extra relief for leave purposes. We do not intend to go down the line of that proposal. Depending on how effective are the systems for deploying honorary officers in small communities, there may well be opportunities to have a team approach where some professional officers work alongside honorary officers. There may well be a capacity for very small communities to have effective honorary services available backed up by professional officers and nearby larger centres. As those schemes evolve it will give us better information about what we need to do with professional officers: should they go to regional centres or should they go to in-between communities and in what order should they be rolled out to be fair? At the

²⁴ Transcript of Evidence 5/11/03, p 24

²⁵ *Readiness to Respond*, p 79

moment there are approximately 40 communities of a reasonable size that do not have a local ambulance service. We would like to attend to them in the very first instance and then go about supporting the growth areas up and down the eastern seaboard. But that would be an annual modelling basis in consultation with the staff and unions and local communities to try to get those answers as best we can across the State.²⁶

- 2.51 The Committee takes the CEO's equity point very seriously. It should be noted that the Board meeting papers clearly demonstrates information about response times but that performance targets are not available for the Northern, Southern and Western NSW divisions. This is as the target response times developed as part of the review conducted by ORH only relate to the Sydney metropolitan area. Adequate planning for future services in regional NSW will be limited until such information is gathered, analysed and reported.

RECOMMENDATION 2.1: Future annual reports of the Service should include benchmarks for performance information.

RECOMMENDATION 2.2: The Ambulance Service to collect, analyse and report data on response times by clinical category.

RECOMMENDATION 2.3: The Service to expand performance indicators in its annual reports to include regional breakdowns.

REVIEW RELATIONSHIPS AND ACCOUNTABILITIES BETWEEN AREA AND OPERATIONS CENTRES IN THE NEW METROPOLITAN/RURAL STRUCTURE

CONSIDER ADDITIONAL CHANGE MANAGEMENT TECHNIQUES

The Audit Report

- 2.52 The Audit Office identified long-standing management challenges which date back to the 1982 Gleeson Report.²⁷ These historical inefficiencies were regarded as major barriers to the restructuring necessary to effectively implement the new AmbCAD system and the restructure accompanying its implementation. The concerns focused on poor communications, accountabilities and responsibilities internally between:

- communications and road officers;²⁸
- divisional and operations managers;²⁹
- within the Service in general;³⁰ and
- the Service and external stakeholders, in particular hospitals.

- 2.53 The audit report stated the fact that such issues still exist today may indicate “the resilience of such problems and the degree of difficulty associated with

²⁶ Transcript of Evidence 5/11/03, pp 29 - 30

²⁷ *Readiness to Respond*, pp 54-55

²⁸ *Ibid*, p 58

²⁹ *Ibid*, p 59

³⁰ *Ibid*, p 60

resolving them.”³¹ The Audit Office went on to note that the Service had attempted to address the concerns about communication, responsibility and accountability in a major structural change in 1998. This restructure separated the four divisions which covered the State into eight areas and eleven manual communications centres were rationalised into four operations centres. Despite this restructure the Audit Office were of the opinion that communication and accountability concerns still existed and may in fact have been compounded:

...the change, and the contemporaneous implementation of CAD, appears to have had a profound effect on relationships between *Areas* and *Operations*, some of which is not positive. Existing differences appear to have been compounded by the organisational and functional separation of the two groups.³²

- 2.54 At the time of the audit report, three metropolitan areas were serviced by one communications (operations) centre and three communications centres serviced the five rural areas. The audit report stated:

Replacing the Divisional structure (which operated prior to 1998) with one which managed Area and Operations Centres separately is seen to follow international best practice. However, it presented a considerable change management challenge. Whether it was intended or not, such a change concentrated most of the management information (and hence much of the decision making power) in the hands of Operations Centre management. This was a major change in the operational status quo, and requires not just new policies and practices, but the development of new relationships and a new culture if it is to be effectively implemented.

Such a change was not evident from the Position Descriptions of the Operations Centre and Area Managers which were developed at the time of implementation.³³

- 2.55 The audit report went on to add:

The consistency and strength of these problems has led the Audit Office to conclude, with the benefit of hindsight, that such matters warranted significantly greater attention as part of the change management process. Without dealing effectively with such issues, change efforts may continue to be impeded.

The Service does not fully share the Audit Office’s strength of view on this matter. However, it implemented the change of structure mentioned above (structurally dividing rural and metropolitan operations) during the course of the audit and redefined responsibilities. The Service believes that these changes will be sufficient to resolve the difficulties observed during the audit.³⁴

- 2.56 The audit report also suggested the Service might take the lead from interstate Services who had undergone significant restructuring at different times and had implemented change management techniques. The other Services were all achieving better response times than the Service.

Action Taken

- 2.57 The Service’s immediate response to the report was to agree:

³¹ *Ibid*, p 55

³² *Ibid*, pp 55 – 56

³³ *Ibid*, p 59

³⁴ *Ibid*, p 61

The Service has long recognised the need to develop a range of additional skills and experience, including change management techniques within the organisation. The selection of external candidates to the four most senior executive posts within the Service over the last two years, including that of Chief Executive Officer, is evidence of this recognition. The management development program identified by the Service will also assist in improving the range of skills and techniques utilised by middle managers.³⁵

- 2.58 The model described in the audit report and introduced to the Service in 2000 is no longer in place. The Service undertook a further organisation restructure in 2000/2001.³⁶ This restructure was a two-step process. In the first instance, the executive management reporting to the CEO was restructured. The focus of which was to remove old tenured positions and bring in new officers who would be subject to performance agreements. This new management team was responsible for implementing reforms into the Service. The second phase of the restructure involved those positions below senior management and a number of issues raised in the Audit Report were picked up. The new structure has four divisions being Northern, Western, Southern and Sydney. Each division has operations centres located within it based in Charlestown, Dubbo, Warilla and Sydney, respectively. (Refer to Appendix 3)
- 2.59 The aim of the restructure was the flattening of the organisation to give responsibility and accountability at the operational level, creating a team based, multi-skilled workplace in the operations centres. For example, the communications staff provides advice on first aid to members of the public who call for assistance as well as taking details of emergencies and dispatching ambulances.
- 2.60 In its submission to the inquiry, the Ambulance Service listed a large number of change management techniques that were being applied to support the Service's move towards a computerised Service. Most of the strategies emphasised competency based management training, communication and consultation at all levels in the organisation. They included the following examples:
- annual staff workshops to involve staff in changes;
 - management workshops in Regional Areas;
 - a bulletin to keep officers informed of progress of reforms;
 - development of management competencies;
 - creation of advisory committees, which reports to a peak committee comprised of the CEO, Secretary of the HSU, United Services Union and Labor Council, chaired by the Director-General of Health; and
 - a management development program involving formal assessment, training and performance appraisals for senior managers.³⁷
- 2.61 The HSU stated:

³⁵ *Ibid*, p 100

³⁶ *Ibid*, p 57

³⁷ Submission by the Ambulance Service of NSW, p 3

This process of change is still subject to being ‘bedded down’ from a Divisional level to Station level, and is the subject of discussions between the Service, staff, and the HSU. In part, the integration of activities and accountabilities between each Division and its Operations Centre is still somewhat uncertain until proposed changes to the Operations Centre technology and working environment are resolved.³⁸

Discussion

- 2.62 The Service has undergone significant changes since the report through its two-step process of restructuring. Carrying the historical management and communication problems highlighted in the audit report into the restructure could only add to the difficulties that normally accompany any restructure.
- 2.63 The CEO during evidence acknowledged that internal communication had been poor. Strategies were being undertaken to redress this situation:

Ms BEREJKLIAN: I am interested in the staff response to the structural and operational changes that have taken place. Do you have any data on that? Have you done surveys of the staff? What are the general response and attitude to the changes that have taken place in the last, say, 18 months or two years?

Mr ROCHFORD: Yes, 2000-01 was a big year. We had the performance audit and we had our very first staff survey, which we shared with staff. I think it came as a bit of a surprise because it was not a happy work force that was in the Ambulance Service at that time. We have repeated the survey. It showed a couple of things. Communications and understanding of the corporate reforms and the changes that are coming through the ambulance service through our Best Again corporate strategy document are much more understood by staff and much better accepted. It is showing that the level of reliance on management for communication has improved. Previously most staff relied on the union to get their information about the service. Now there is a slightly heavier reliance on management than the union. Staff perceptions of the level of change in the service have also started to improve. The formal analysis is clearly that the changes that have happened over the last three years since the performance audit have been well received by the majority of staff and are better understood.

Evidence is also clearly there that more of those changes are required, particularly in rural locations, where the structural reforms have not been as apparent. In some cases they have not started yet. There is a need to do a great deal more. I think that is evident in the view of staff as well. With Mr Whinfield's new operational team we have been able to get out and about with staff more and we now regularly visit stations, publish newsletters, publish discussion documents about ideas we are having even before they have been approved for change and getting active discussion going both directly with the staff and also through the more formal union consultation structures that have been developed over the years. There are several consultation committees where staff who are particularly interested in uniforms, for example, will get together and talk in quite some detail about the requirements of the future uniform. That helps take some of the uncertainty out of the future. It also

³⁸ Submission by the HSU, p 10

gives people a chance to ventilate and generally improves everyone's understanding of the issues that are going on inside the service.³⁹

- 2.64 The submission by the Service indicates that it is prepared to consult more thoroughly with staff at all levels about organisational procedures and changes. Communications with NSW Health is discussed more fully in Chapter Four.

³⁹Transcript of Evidence 5/11/03, p 30

Chapter Three - Recommendation 2: Enhance Public Performance Reporting

RE-ESTABLISH PUBLIC REPORTING OF RELIABLE RESPONSIVENESS DATA AND TRENDS

The Audit Report

3.1 The audit report suggested that:

...for the purposes of accountability, transparency and better community relations, the Service should act to improve its public performance reporting.¹

3.2 In its response to the audit report the Service asserted that public reporting has always been incorporated into the Service's Annual Reports and monthly reports to the Board.²

3.3 Furthermore, the Service did acknowledge in its submission that the implementation of AmbCAD and the establishment of the Convention of Ambulance Authorities working group meant that reliable data for publication was more readily available.³

Action Taken - Introduction of AmbCAD for performance measurement

3.4 Following trends in overseas and interstate Services, the NSW Service has invested heavily in the implementation of the Computer Aided Dispatch System (AmbCAD) in the expectation that it could assist in improving services.

3.5 The AmbCAD system was first introduced to the Service in 1998. AmbCAD can be briefly defined as "a high technology decision support tool".⁴

3.6 The intention of AmbCAD is to assist in emergencies by providing ambulance dispatchers with accurate information concerning the type and location of an emergency and the availability of the nearest ambulances. A communications officer at the operations centre receives the location and a brief description of the incident, enabling them to make informed decisions about the dispatch of resources. The major functions of the AmbCAD system are:

- call entry and scheduling of bookings;
- dispatching of ambulances;
- status monitoring and management of ambulance resources;
- scheduling the transport of routine patients;
- an audit trail of all events; and
- management information and reporting.⁵

¹ *Readiness to Respond*, p 80

² Submission by the Ambulance Service of NSW, p 3

³ *Ibid*, pp 8 - 9

⁴ Ambulance Service of NSW Website www.asnsw.health.nsw.gov.au/areas/ambulance/communications.html accessed 12/12/2003

⁵ *Ibid*

- 3.7 At the time of the audit report, the AmbCAD system, although in use, was in a hybrid stage with some data being electronically collected and some data still being collected manually through case sheets. This meant there was no store of accurate data for the Service to monitor its staffing and rostering to match the workload.
- 3.8 The AmbCAD system is now functioning at a level which the CEO informed the Committee, provided the major source of operational performance data.⁶ Importantly, AmbCAD provides information about:
- mobilisation times i.e. time taken to dispatch an ambulance following an emergency) within 1, 2 and 3 minutes and greater than 3 minutes; and
 - response times (i.e. time taken from when a call is received until the arrival of an ambulance at the scene) within 5, 10, 15 and 20 minutes, and over 20 minutes.
- 3.9 The Service has collected enough data to allow comparative analysis of the response times from 2000 – 2001 to 2002 – 2003. This allows an analysis of the response time improvements from year to year. Monthly figures for the last three years are reported in the annual report.
- 3.10 The Service's Board has endorsed the targets for the 10-minute interval at 61% and for the 15-minute interval at 87% in Sydney, contingent on several reforms being fully implemented by 2005.⁷ These reforms involve matching resources to demand through:
- re-rostering and the introduction of a Sydney-wide Transport Service;
 - the introduction of a Rapid Response tier;⁸
 - an improvement in hospital turnaround times; and
 - the introduction of skill mix.
- 3.11 The Service is also looking at publicly reporting comparative data against other services across a range of targets in Australia. (See next section on Convention of Ambulance Authorities and previous chapter on performance indicators).

Discussion

- 3.12 The Service has available the ability to present to the public an improved range of responsiveness data due to implementation of AmbCAD.
- 3.13 Chapter Seven, which deals with community and stakeholder interests, also touches on this issue. Acknowledging that the Service does undertake public reporting it is then important to ascertain if the public reporting matches community expectations of what should be reported and how user friendly the responsiveness data is for the community to understand. During the process of building community consultation groups it is suggested that the Service

⁶ Submission by the Ambulance Service of NSW, p 2

⁷ Supplementary Submission by the Ambulance Service of NSW, p 1

⁸ Grading of emergency calls so that the appropriate ambulance response team can be dispatched. The aim is to utilise resources to best meet each emergency situation

include in discussions a survey to find out the perceptions of the extent and content of public reporting.

- 3.14 It is also suggested that the Service discuss ways of presenting information in a user-friendly manner which is easily understood by diverse community groups. Apart from improving the presentation of standard reporting methods to the community, innovative suggestions that could be employed to inform the community include announcements on community radios or in newspapers, and summaries of the main points from the annual report. The Service has commenced this type of experiment by publishing each month's 10 minute response rate on its website. The Committee feels this is a positive step and encourages the service to continue its experiments as to the content and dissemination of performance information to the community.
- 3.15 A survey could be developed to ascertain from the community what they want to find out from the Service about response data and what improvements could be identified to improve dissemination of that information to the community.

FINALISE DELIBERATIONS WITH THE CONVENTION OF AMBULANCE AUTHORITIES TO BENCHMARK AND REPORT THE COMPARATIVE PERFORMANCE OF AMBULANCE SERVICES

The Audit Report

- 3.16 The audit report relied on data from the Convention of Ambulance Authorities (CAA) to demonstrate the Service's response times performance. The NSW Service performed poorly in comparison to most states in response times. The report conceded that there was a lack of consistent data definitions across each state that may have affected the accuracy of the data.
- 3.17 The report went on to add that in March 2001 the Convention was meeting to review and finalise consistent comparative data definitions.

Action Taken

- 3.18 The Service now reports in its submission that:
- ...deliberations with the Convention regarding data consistency have been finalised and performance in a number of key areas such as mobilisation, response and hospital turn around times is now reported through the Convention's Annual Report.⁹
- 3.19 However, the Acting CEO went on to say in the supplementary submission that:
- ...benchmarks have not been set and are considered unachievable until such time as each service is able to compare groups of stations with similar demographic characteristics.¹⁰
- 3.20 The CAA's Annual Report features a table comparing response times across jurisdictions. The Committee acknowledges the comments of the Service that there are still discrepancies between jurisdictions. For example, in Western Australia response times only relate to city cases, which are easier to manage.

⁹ Submission by Ambulance Service of NSW, p 4

¹⁰ Supplementary Submission of the Ambulance Service, p 3

Discussion

3.21 The Committee is of the view that there is value in reporting these comparisons, even though there are discrepancies in data categories. The differences can be explained in the report. In evidence, the CEO supported the publication of this data despite limitations:

Mr STEVE WHAN: On that benchmarking issue, the Auditor-General's report made a number of comments about benchmarking against other areas. I guess I have not seen how you are establishing what you are benchmarking against for a lot of those indicators. How is it that you are able to say, "We are achieving 80 per cent of our target"? How do the people of New South Wales know that the targets you are setting are actually a challenge for you, and not something that you can achieve?

Mr ROCHFORD: Going back to the 2001 performance audit, I think there is a fairly detailed table in there that compares us to other ambulance services in Australia. With the exception of Tasmania, we were responding more slowly than the other major developed ambulance services. What we have been able to do since then is move ourselves up the league table, if you like, to be at about the middle of the pack. That is largely on the basis of reforms that we have introduced in metropolitan Sydney. As we move now into the bush with the additional resources we have available to us in the next four years, we will be able to progress further through that league table. In terms of benchmarks and what is right, you can look around the world and find a whole range of targets that have been mandated or have been just used as a guide. We have taken the approach that we would like to see ourselves across a range of indicators as the best or up with the best of ambulance services in Australia, as a first stage. We are sort of getting towards that. As I said earlier, just to mandate a target can in fact be unhelpful when you are trying to reform an organisation or reform an industry at the same time as maintaining a service.

Mr PAUL McLEAY: Have you published this league table? Is it in your annual report?

Mr ROCHFORD: It is published in the Convention of Ambulance Authorities annual report, the third edition of which is due to be released in the next month.

Mr PAUL McLEAY: Do you have the intention of putting it in your annual report?

Mr ROCHFORD: That is a comment that has been made to me more recently. It would be our intention to do that. We have moved quite a bit towards publishing response times more widely over recent years. We have got it on our web site. It is not a secret any more. We are happy to discuss them and we need to continue that. I think the next stage in the evolution is that the convention has agreed on the right definitions so that the comparison is fair. We will be in a position to do that from next year's annual report. One of the things we have to do before that final stage of getting meaningful comparisons is look at our emergency response load. Other ambulances at the moment report just life-threatening emergencies whereas we report everything that is coming through the 000 emergency line. Our emergencies are about 66 per cent of the workload whereas other services show that their emergencies that they are reporting are between 20 per cent and 35 per cent of the workload, so they are looking at the top end. At the moment we are not quite comparing accurately but by next year the national Convention of Ambulance Authorities will have sorted that out and we will be able to participate.¹¹

3.22 It is also important to note that it is now three years since the meeting of the CAA to bed down definitions. The Committee is further of the view that the cost of further postponements would exceed the benefits to the public and the

¹¹ Transcript of Evidence 5/11/03, p 25

Parliament. Comparative reporting will also encourage more open analysis of issues that affect response times that can only be beneficial to the Service and the people of NSW.

RECOMMENDATION 3.1: The league table published in the Convention of Ambulance Authorities annual report to be included in the Service's future annual reports.

- 3.23 Despite its role, the CAA has a low profile. The Committee found it difficult to readily access information on the CAA or produced by it. The Committee suggests that the Service promote the Convention in its publications.

RECOMMENDATION 3.2: The Service to promote the Convention of Ambulance Authorities in its annual report, website and other publications.

Chapter Four - Recommendation 3: Work towards a “whole of health” delivery of ambulance services

CLEARLY SET OUT FUTURE DIRECTIONS AND CLINICAL RELATIONSHIPS AND NETWORKS WITHIN THE HEALTH SYSTEM

The Audit Report

- 4.1 Under section 12 of the *Ambulance Services Act 1990* the Service has a legislative obligation to consult with the Department of Health. The report noted a range of formal and informal communications committees and agreements¹ at a senior level between the two organisations.
- 4.2 The Service and the Department of Health also have agreements with relevant Area Health Services and hospitals covering inter-hospital ambulance transport, booking procedures, funding arrangements, the provision of nurse escorts and transporting of mental health patients.
- 4.3 The report went on to state that:
Although there were extensive agreement mechanisms in place it is not sufficiently apparent that effective integration has been achieved.²
- 4.4 The report went on to state that although agreements were in place:
Both Area Health Services and hospitals visited by the Audit office reported friction and poor coordination between elements of the Health system and the Service.³
- 4.5 These issues were also raised in the Sinclair Report, which reviewed services to rural communities.⁴
- 4.6 This situation is significantly different in other States. The audit report asserted that:
Interstate ambulance services visited have reporting structures different to the NSW Service. However, all services claim to have healthy and constructive relationships with the government departments through which they report, and with their respective health and hospital systems.⁵
- 4.7 The report stated that the future directions and clinical relationships between the Service and the Department of Health lie with both parties holding each other to account for their performance. The audit report did not favour the Service either moving to Emergency Services such as in Queensland and South Australia or alternatively immersing the Service further into area health services. In the US, ambulance services are often part of the fire department.⁶

¹ *Readiness to Respond*, p 47

² *Ibid*, p 45

³ *Ibid*, p 47

⁴ *Report to the NSW Minister for Health: A Framework for Change*, NSW Ministerial Advisory Committee on Health Services in Smaller Towns, February 2000

⁵ *Readiness to Respond*, p 50

⁶ See for example, the District of Columbia Fire/EMS Department. Information on the Department can be found at the following website: <http://www.dcfcd.com/> and the California Department of Forestry and Fire Protection see

Fire officers also receive first aid training and the ambulance and fire divisions share the work.

Action Taken

4.8 In its submission, the Service provided examples of committees, which enhanced communications with Health. They were not substantially different from the ones mentioned in the audit report, and some committees were the same. Examples included the Medical Retrieval Committee, the Public Health Emergency Management committee, and Counter Disaster Management bodies.

4.9 The Service had also created Ambulance Liaison Officer positions. These were intended to build:

... a close network with hospital bed management staff that has assisted in dealing with surges in demand for emergency services in a timely fashion and limiting the impact on ambulance operations. The program has involved establishing liaison posts in each metropolitan health service to work along side hospital bed planners, coordinating ambulance movements between hospital and emergency departments.⁷

4.10 The Service also stated that:

The Senior Executive Team and senior management are very much aware of far-reaching changes being implemented across the spectrum of health care delivery in NSW under ..Government Action Plan for Health (The GAP). These changes stem from the recommendations of the Health Council (Menadue) and Rural Health (Sinclair) reports released in February and March 2000.

As the front line, emergency arm of Health Services, the Ambulance Service of NSW service delivery is inextricably linked to changes occurring in the rest of the health system.⁸

Discussion

4.11 The broad sweep of activities listed in its submission by the Service is a base from which the integration of the Service into Health may be forged. The examples provided by the Service also included GAP initiatives. They demonstrate attempts by the Service not only to meet consultative obligations and ensure the effective provision of services to the community but also a commitment to providing a smooth transition from one service to another.

4.12 In their evidence, both the CEO for the Service and the CEO for Southeast Sydney Health supported a teamwork approach between both the Service and NSW Health in clinical care.

Mr PAUL McLEAY: ...Do you believe that the ambulance service should have more autonomy from New South Wales Health, and what roles and responsibilities do you think should be changed to achieve that autonomy, if you believe there should be? Are you at the beck and call of the rest of the health system?

Mr ROCHFORD: ...The debate that probably goes on more often in the ambulance industry is whether an ambulance service is the health bit of an emergency agency or whether an ambulance service is the emergency bit of a health agency. In the

the website http://www.fire.ca.gov/php/fire_er.php for further information on the Department's Fire and Emergency Response.

⁷ Submission by the Ambulance Service of NSW, p 4

⁸ *Ibid*, p 4

ambulance service of New South Wales we hold the view, and I personally hold the view, that our ambulance officers are health professionals, that they deliver an ever-increasingly sophisticated range of clinical interventions to their patients, that their business of delivering care to the community is much more like other health professionals: doctors, nurses, physiotherapists. So being part of the health system is appropriate. It is appropriate in terms of providing safe care, having proper clinical governance interactions, and it is appropriate in terms of being able to deal with the great increase in demand that we have talked about earlier which is confronting all health systems. What we have been able to do in recent years is work much more closely with hospitals and nurses in emergency departments to understand the issues that confront the hospitals and for the hospitals to understand the issues that confront ambulance services in maintaining availability to respond.

I think those pressures affect our organisation as well as hospital organisations a great deal. Our job is to manage them and we are better placed to manage them as a team approach rather than separately going about our business. There is very little point in responding rapidly, delivering effective CPR, and then taking a patient to a hospital that is not able to cope, for whatever reason. We should be taking them to the correct hospital where they are going to get the quickest care. That is part of the teamwork approach that we have developed with the network access advancements in Sydney.

Mr PAUL McLEAY: Ms Green, do you wish to comment?

Ms GREEN: Just from my perspective, the episode of care commences with the arrival of the ambulance and the professional in that ambulance that delivers that care. So the episode does not start once the patient arrives at the emergency department. We regard ambulance officers as health professionals, as we do with those working within our hospitals and Area Health Services. I agree with Greg, that there is a range of professional services that are about high-quality safe care delivered to the community. The ambit of an Area Health Service or of an ambulance is within the Health Services Act; there is a range of opportunities to have a certain level of autonomy. That has also been discussed in the recently released Independent Pricing and Regulatory Tribunal [IPART] report. With autonomy goes responsibility and ultimately I think that responsibility to the community is one that is best met under the current arrangement.⁹

4.13 There are several comments the Committee would like to make about this evidence:

- There is little evidence of a “teamwork approach” between the Service and the Department. Trolley block and ambulance diversion demonstrate that the Department has been able to transfer some of its risk to the Service with little evidence of return to the Service. Another example is the Service’s performance agreement with NSW Health.¹⁰ All the obligations lie with the Service, which is even required to report to the Department on its financial liquidity.
- The witnesses’ emphasis on the health component of the Service’s work is not consistent with the Audit Office’s evidence that response times are the most important indicator for the Service. The Convention of

⁹ Transcript of Evidence 5/11/03, p 33

¹⁰ Ambulance Service of NSW, *Annual Report 2002/03*, pp 8-13

Ambulance Authorities and the Service publish considerable information on response times, but very little on clinical outcomes.

- The Service is not covered by the *Health Services Act 1997*. Its obligation to the Health Department is to consult.¹¹ Commitment to a “whole of Health” approach should be reflected through mutual legislation.
- Current legislation does not appear to regard ambulance officers as “health professionals”, a term that is generally limited to vocations such as doctors, nurses, dentists, psychologists, chiropractors and pharmacists. For example, see the *Health Professionals (Special Events Exemption) Act 1997* and section 117 of the *Health Services Act 1997*.

4.14 Emergency work is the core function of the Service, comprising 67% of the Service’s workload. As mentioned previously, under present arrangements, the Service doesn’t have equal partnership with Health. The Committee therefore suggests that it may be in the best interests of the Service for it to move under the umbrella of Emergency Services if present issues cannot be resolved. It would not detract from the Service’s ability to integrate with Health in the continuum of care. The Service’s separation from Health, however, would ensure that the Service could participate equally by being financially and structurally independent.

RECOMMENDATION 4.1: The NSW Ambulance Service be transferred to the Emergency Services portfolio if issues such as trolley block and ambulance diversion are not resolved within two years.

4.15 Ambulance diversion and trolley block continue to attract community concern. On 6 January 2004 the headlines of the *Daily Telegraph* reported that six emergency departments had closed and ambulance paramedics were quoted as saying they were “baby-sitting” patients. It is evident that ambulance diversion and trolley block, raised in the report, are still not resolved.

4.16 In contrast to the situation reported by the media, the Service stated in its submission that:

Relationships with metropolitan Area Health Services have developed considerably particularly with hospital emergency Departments.¹²

4.17 The submission from the Service suggested the issues surrounding emergency transport had been addressed by the creation of an ambulance liaison officer position implemented in all major metropolitan emergency hospitals and the implementation of Emergency Network Access Project (EDNA).

4.18 EDNA was the result of a working group comprising representatives from the department, various health services, both senior managers and clinicians, the Service and the HSU in an attempt to improve access to emergency departments. EDNA attempted to distribute patient loads across metropolitan Sydney. According to the Ambulance Service submission:

¹¹ *Ambulance Service Act 1990* s12 F (i)

¹² Submission by the Ambulance Service of NSW, p 4

EDNA has provided the Service with enhanced communication of the status of emergency departments across Sydney. This information has assisted ambulance operations in that more informed decisions can be made by the treating officers regarding the most appropriate destination for non life threatening cases. EDNA, supported by Ambulance Diversion Guidelines, has enabled a more consistent and coordinated approach between the Service and hospitals, particularly when managing periods of peak demand.¹³

- 4.19 The HSU argued that despite increases in officer numbers, rostering and workload changes:

It is still one of the most problematic areas for the service and EDNA has not provided the tangible and practical benefits envisaged or expected.¹⁴

- 4.20 In the Audit report *Code Red: Hospital Emergency Departments* (Code Red) the Auditor-General stated:

Since EDNA was introduced, there has not been an overall reduction in ambulance delays at hospitals. EDNA has had some impact on sharing demand but it is limited by the fact that there is very little spare capacity available in the network. Under these conditions, EDNA cannot markedly improve patient access.¹⁵

- 4.21 One of the key findings of the Code Red report stated:

It is difficult to measure the affect of EDNA as there is no data on the number of ambulance diversions that occur in response to changes of status.¹⁶

- 4.22 In contrast to the situation in NSW, hospitals in New York City must request permission from the New York City Fire Department to be placed on diversion status.¹⁷ This procedure is based on the requirement of all hospitals in New York City to accept patients and so such a protocol may not be appropriate in NSW. However, the “Hospital Diversion Verification Form” used to record the diversion status of a New York Hospital may be a useful reference for adoption by the Service in collecting of data relating to diversions in NSW hospitals. This may then assist in future planning for workload and rostering during peak emergency periods. (Refer to Appendix 4)

RECOMMENDATION 4.2: That the Service collect data on ambulance diversions, including the times and hospitals at which they occur. This should then be used to plan workload and rostering at the Service level.

- 4.23 During evidence, the Audit Office advised the Committee that although the issue of trolley block was not the fault of the Service and emanated from the volatile nature of emergency departments and staff organisation in hospitals, the Service had assisted the health service:

Mr Horne: I note that the service has now instituted a practice of putting officers of its own people there to take over that problem and get the ambulances out before the hospital can necessarily process the people through. This is not a permanent solution; that is only an interim step.

¹³ Supplementary Submission by Ambulance Service of NSW, p 5

¹⁴ Submission by the HSU, p 11

¹⁵ Performance Audit Report *Code Red: Hospital Emergency Departments* December 2003, p 3

¹⁶ *Ibid*, p 3

¹⁷ Fire Department City of New York Emergency Medical Service Command Operating Guide Third Quarter 2003 EMSC OGP 115-01 – Emergency Department Ambulance Diversions and Appendix C

There is going to have to be resolution of this between the service and the hospitals.¹⁸

4.24 The HSU further elaborated:

Mr Whan: There is a trial—I do not know whether it is a permanent arrangement— involving stationing ambulance officers in hospitals. Do you think that has proved successful?

Mr WILLIAMSON: That arrangement is being trailed at the moment.

Mr RAVLICH: A smaller trial is happening at the Hunter involving a couple of hospitals, which is clearly more of a reflection of a combination of outcomes, including in some instances ambulance officers being paid to look after ambulance cases so that other officers can leave. However, that is underpinned by a number of activities that the hospital puts in place. It has involved a couple of discrete hospitals. There was a similar suggestion for the metropolitan setting, but the announcement was made by the service one Sunday afternoon without any consultation with us. We copped that on the chin—although we were not happy about it—but there was no consultation with any Area Health Services or individual hospitals.

At the forum established by the previous Health Minister to investigate ambulance access to the emergency departments the committee or group was not referred to. Indeed, it was quite rightly a bit annoyed that when it met next—a number of senior clinicians, administrators, managers, the ambulance service and us were there— there was no discussion among the broad interest groups to resolve the issue of how it would work. Many hospitals said, "We don't have beds to put them in". It is not just a question of finding a bed; it is also about the appropriate environment for a patient to exist in. Does a patient need the support and infrastructure? Ambulance officers are often still administering the service oxygen and monitoring patients with the service electrocardiogram machines. They may also be actively intervening using their protocols and giving drug therapy in the hospital. That whole superstructure would have to be replaced. We have indicated that we are interested in talking about additional staffing of some nature—whether it comprises ambulance officers or an embellishment of ambulance officers and hospital staff. But it is not a simple matter of finding a bed and saying, "We have someone to stand next to it".¹⁹

4.25 The Committee understands that only two hospitals (Hunter and Nepean) employ off-duty ambulance officers where difficulties are experienced in supplying nurses for emergency department work. The Committee congratulates the Service on this initiative that provides ambulance officers with the opportunity to undertake secondary employment in the hospital system.

4.26 However, in other instances, placing an ambulance officer in the emergency ward is a situation that relates to previous issues about the roles and responsibilities of the Service within the health system in the continuum of care. Staffing of emergency wards with off duty ambulance staff may be perceived as stretching the functions of the Service beyond its responsibility. Furthermore, there is an issue of who should pay these off duty ambulance officers that are working in hospitals.

¹⁸ Transcript of Evidence, 5/11/03, p 6

¹⁹ Transcript of Evidence, 5/11/03, p 16

RECOMMENDATION 4.3: The placement of Ambulance Officers in emergency wards be discouraged as it is outside their primary role.

4.27 The Auditor-General of NSW stated in his evidence:

Mr SENDT Rostering and timing of resources was an issue with emergency departments and that quite often the resources were not there at the time when demand was greatest, which is typically weekends and evenings. That was quite often the time when blockages from the emergency departments into general wards occurred, and when blockages from the ambulances to the emergency departments occurred.²⁰

4.28 The Auditor-General suggested that the Service should also be ensuring that ambulances were fully operational during peak times. He suggested that a review of more flexible working conditions,²¹ and review of non-emergency transport services could assist in this area.²² These are all issues that can only progress with ongoing negotiations with the HSU.

RECOMMENDATION 4.4: The Service should review the 2001 resource modelling analysis for Sydney to ensure the deployment of ambulance resources reflects peak call periods and takes into account the impact of peak periods of hospital demand. The Service should continue to liaise with the HSU to ensure working agreements and relief arrangements are sufficiently flexible.

4.28 A report entitled *Access Block in NSW hospitals 1999-2001: does the definition matter?* explored the magnitude of access block in NSW hospitals.²³ The study compared four varying definitions of access block, used by different hospitals to determine whether they affected patient ability to access a bed after emergency department treatment. The study indicated that:

After adjusting for triage category, and year of presentation, the mode of arrival, time of arrival, type of hospital, age and sex were significantly associated with access block.²⁴

4.29 The results of the study indicated that regardless of the definition of access block, from 1999-2001 there was an increase of 1%-2% per year. The study also showed that:

Depending on the definition, the rate of access block in the past 3 years ranged between 15% and 30%.²⁵

4.30 The report also noted that access block adversely affected clinical outcomes. The most significant increases in access block were in principal, referral hospitals, late at night.

4.31 The report recommended that NSW and Australia move to one standard definition of access block.

²⁰ Transcript of Evidence 5/11/03, p 7

²¹ *Ibid*, p 7

²² *Ibid*, p 6

²³ Robert Forero, Mohammed Mohsin, Adrian E Bauman, Sue Ieraci, Lis Young, Hai N Phung, Kenneth M Hillman, Sally M McCarthy and C David Hugelmeyer from www.mja.com.au/public/issues/180_02_190104/for10259_fm.html 21/01/2004 MJA 2004; 180 (2), pp 67-70

²⁴ *Ibid*, p 67

²⁵ *Ibid*, p 69

- 4.32 Although the report recommendation is substantially concerned with changes in the hospital system, the Committee endorses the recommendation because of its impact on the Service. The Committee also notes that from July 2001 the definition of access block used by NSW Health has been the proportion of admitted patients not moved to a hospital ward within 8 hours from commencement of active treatment.²⁶

IDENTIFY EXTERNAL RELATIONSHIPS TO ENSURE INTERCHANGE OF INFORMATION AND CONSISTENCY OF STANDARDS

The Audit Report

- 4.33 The audit report identified that other agencies within Australia were valuable references due to apparent strong partnerships with their health systems, particularly in clinical directions:

In supporting the clinical aspects of their operations, ambulance services of Victoria, Queensland and South Australia seemed to network quite extensively with their respective health systems at both the corporate and local levels. This has the objectives of ensuring the exchange of clinical information and skills, and facilitating smoother working together of their organisations.²⁷

- 4.34 The report also noted that while other agencies actively encouraged local relationships between area health and hospital systems, this had not been successful in NSW because most senior managers spend their time on administrative management. In discussions with the Audit Office, many officers and managers indicated that they felt there would be value in having the Service's clinical directions more clearly articulated.

Action Taken

- 4.35 The Service provided examples where it liaised with external agencies through various consultative committees. However, some of these committees were already in existence at the time of the audit report. Examples included the Convention of Ambulance Authorities, the Clinical Governance Committee, and the Medical Retrieval Unit. In addition, the Service stressed its awareness of the changes being implemented across Health through the implementation of the Government Action Plan (The GAP) and the recommendations flowing from the Menadue Report and the Rural Health (Sinclair) Reports all released in 2000.

Discussion

- 4.36 From the information provided in its submission, the Service's communication with other Services in exchange of information and consistency of standards appears to be focused at the CEO and senior management level. Examples provided by in the Service's submission included:
- The Chief Executive Officer's participation at the Senior Executive Forum and convention of Ambulance Services of Australia (&NZ);

²⁶ NSW Health, *Annual Report 2002/03*, p 111

²⁷ *Readiness to Respond*, p 73

- The General Manager, Medical Directorate & Health Counter Disaster Services' participation or representation in a wide ranging group of strategic State and National policy making committees; and
 - The Ambulance Service has responsibility for coordinating and planning for health system response to disasters and mass casualty events.²⁸
- 4.37 As the Service is at the lower end of the response table according to the CAA, and the clear statement by the Audit Office that other services were participating more evenly within the health framework, it is possible that the Service could engage more closely with other Services to understand more fully how these relationships have been forged, not just at the policy level but importantly at the operational level.
- 4.38 The Committee suggests that a component of management training and development programs for middle and senior management (discussed in Chapter Eight) should incorporate study of initiatives and programs in other Services. In this way, the future management of the Service is more likely to reflect best practice.
- 4.39 The Service may also seek advice from other Services in relation to other matters raised in the Audit report. These include funding of non-emergency transport and improving relationships with other states (recommendation 3), comparisons of flexible working conditions (recommendation 5) and resource management (recommendation 8).

RECOMMENDATION 4.5: The Service establish strategies where middle and senior operational management are seconded to work in Services in other states and overseas and report back to the Service on possible innovations.

REVIEW THE SERVICE'S REVENUE SOURCES AND CHARGING STRUCTURES

The audit report

- 4.40 The report noted that interstate services have had higher charges and access to greater revenue. The Audit Office, however, stated this was not the focus of the audit.

Action Taken

- 4.41 In its submission the Service stated:

The relative contribution of funding from Government sources to user charges is ultimately a matter of Government policy.

The Service keeps under review fees and charges and sources of revenues in NSW and other States. Revenue from user fees and charges for ambulance services in NSW are lower and the NSW Government provides a higher level of direct funding for ambulance services when compared to other States.²⁹

²⁸ Submission of the Ambulance Service of NSW, p 5

²⁹ *Ibid*, p 5

Discussion

- 4.42 In the *Daily Telegraph* of 6 January 2004 the acting Chief Executive Officer, Mr Steve Whinfield, announced a major fee restructure. The paper suggested that the fee restructure might include charging for people using the Service but not needing hospitalisation after treatment.
- 4.43 The article acknowledged that fees were among the lowest in Australia with many people, including pensioners paying nothing. Mr Whinfield stated in the article “An increase would still keep us very low.”
- 4.44 The issue of fee charging by the Service is another area where information exchange with other States may be useful to ascertain their funding criteria and arrangements.
- 4.45 Given the Auditor-General’s lack of priority for this recommendation, the Committee makes no further comment.

DEVELOP AN APPROPRIATE PACKAGE OF NON-EMERGENCY TRANSPORT SERVICES FOR HOSPITALS

The Audit Report

- 4.46 Both NSW Health and the Service expressed concern about the lack of co-ordination in non-emergency transport. The Service commented that non-emergency transport was often requested during the peak demand for emergency work.
- 4.47 On the other hand, hospitals complained that non-emergency transport came at a high cost. This was because hospitals needed to ensure patients were moved in a specific time-frame to maximise the availability of services such as x-rays and specialist services. When organising non-emergency transport, hospital staff were unsure as to who they should be communicating with to arrange transport of patients i.e. area management representatives or operations centre staff.
- 4.48 This prompted some hospitals such as Gosford to provide their own transport and at a lower cost.
- 4.49 It was noted that in other States non-emergency transport was:
Viewed, treated and priced as a separate business which is operated on a commercial basis with different standards of clinical support available.³⁰
- 4.50 The Service also proposed a new fee structure and the recruitment of Patient Transport Officers (PTOs). These officers do not have the intense training regime of other officers. In addition, vehicles used by PTOs cost less to set up and maintain, as they are less equipped.
- 4.51 In some cases, patients require a nurse escort if they need monitoring. The skill level of nurses is required when patients need on-going hospital style interventions en-route with patients. However, when nurses are unavailable because of staff shortages the Ambulance Service is required to provide

³⁰ *Readiness to Respond*, p 41

another skilled officer, taken off core ambulance duties. The Service is then subsidising the Health Department.

Action Taken

4.52 The Service indicated that in 2001 a Sydney wide Patient Transport Service was introduced. This was reliant on an increase in Patient Transport Officers from 43 to 80 to service metropolitan Sydney.

4.53 This initiative was supported by the establishment of:

A dedicated control position and dispatch board has been established within the existing Sydney Operations Centres establishment for the planning, scheduling and radio control of Patient Transport Services vehicles. The Service is currently implementing a reorganisation of Operation Centre functioning, which incorporates reviewing Patient Transport dispatch operations within the Sydney Operations Centre.³¹

4.54 The submission went on to state:

The Patient Transport Service has become an integral part of the State's non-emergency patient transport system, providing a range of transport options to both stakeholders and patients. Its major role is the transportation of non-emergency patients whose medical condition renders them medically unable to utilise other forms of transport.

The efficient use of Patient Transport Service resources is assisting in freeing up emergency ambulances for "000" calls and will contribute to a reduction in response times to emergency cases. The Transport Service is firmly established in metropolitan Sydney and undertaking 80% of non-emergency transports for Sydney. The efficiency of specialised Patient Transport resources in lower population centres has not been established but is being considered as part of the current round of rural enhancements and reforms.³²

Discussion

4.55 The issues raised by the Service and NSW Health again hark back to a lack of communication between the two organisations. The Service did appear to have addressed the main issues raised in the audit report relating to co-ordination of PTO's, nurse escorts and costs associated with patient transport services by increasing the employment of PTOs. The figure of 80 PTO's arrived at was the result of modelling which the Service stated had proved to be effective.³³ The use of PTO's also acknowledges the effectiveness of tiering patients according their clinical assessment and providing quality care in a cost effective manner.

4.56 The Service also indicated that the modelling for PTO's would be reviewed as workload changed.

4.57 In evidence the Auditor-General reiterated earlier comments that non-emergency transport was a significant part of the work of the Service that did not require the sophisticated, expensive equipment of emergency

³¹ Submission by the Ambulance Service of NSW, p 6

³² *Ibid*, p 6

³³ Transcript of Evidence 5/11/03, p 24

- ambulances.³⁴ The use of non-emergency transport is agreed to be a more logical and efficient use of resources.
- 4.58 The use of PTOs brings in funding for the Service, which offsets costs of emergency transport. However, there has been some competition from hospitals that believe they can compete for the income from non-emergency transport than the present system offered by the Service. The area of savings is primarily in wages.
- 4.59 The HSU indicated in evidence that Central Coast Area Health Service employs transport officers at a lower wage than the Ambulance Service.³⁵ Although the HSU argue that it is irrelevant who transports patients these workers should be paid at the same rate, particularly if they are doing exactly the same job in terms of patient care and responsibility.³⁶
- 4.60 The use of PTOs is increasing. It has the potential to provide a significant source of increased income for the Service. The Service was questioned about the competition for business with Area Health Services and the CEO stated that:
- The appropriate balance between hospital and ambulance based Patient Transport Services across metropolitan, rural and remote communities is not clear at present, particularly given historical charging arrangements that do not reflect cost structures of the new tiered system of ambulance operations. Charges are currently under review.³⁷
- 4.61 When questioned specifically about the provision of PTO services by Gosford Hospital, the Service indicated that presently there was no shortfall from the increase in competition. Apart from Gosford it was indicated that even though other hospitals are also implementing internal transport services there had been no shortfall in their revenue from non-emergency transport. In fact revenue had been increasing.³⁸
- 4.62 The Committee suggests that the Service would need to build stronger community ties to implement such a volunteer arrangement. This is also consistent with discussion in Chapters Seven and Eight.

RECOMMENDATION 5: That the Service ensures that the provision of non-emergency transport is appropriately co-ordinated. In particular, that clear lines of communication for arranging such transport are in place.

REVIEW STRATEGIES FOR DEPLOYMENT OF PARAMEDICS

The Audit Report

- 4.63 The issue of skill mix is an ongoing debate and was mentioned as early as 1982 in the Gleeson Report. That report recommended that no further expansion of the use of paramedics be undertaken until an evaluation had been conducted. The Committee is not aware of any evaluation that has been

³⁴ *Ibid*, p 5

³⁵ *Ibid*, p 16

³⁶ *Ibid*, p 17

³⁷ Supplementary Submission from the Ambulance Service of NSW, p 5

³⁸ *Ibid*, p 5

conducted in NSW. However, the use of paramedics has expanded, not only in NSW, but across all states.

- 4.64 The Auditor-General raised the issue of skill mix i.e. whether paramedics work with officers of a lesser grading or in pairs. In NSW, paramedics work in pairs and have resisted attempts to be matched with officers at a lower grade. The Audit Office reported that some mixing occurs interstate, but there was no consensus on this issue.³⁹

Action Taken

- 4.65 The HSU affirmed in its submission that the ORH report recommended an increase in paramedics in the Sydney Metropolitan area, which the Service was implementing.⁴⁰
- 4.66 The Service submission indicated that paramedics are now deployed with general duties officers providing for a greater dispersal of paramedic intervention:

The previous practice of deploying two paramedics in a vehicle now is used for training purposes as 200 additional paramedics are trained during 2002-2004. The new paramedic deployment regime is being gradually implemented as numbers increase and through natural staff movements. Currently 36 of the 47 ambulance stations in the Sydney Division deploy Paramedic Officers whereas 19 stations deployed paramedic officers together in dedicated paramedic vehicles in 2000/2001.

In addition, the future clinical and training direction has been set and a strategy developed to provide fairer access to paramedics across NSW. The first phase of the strategy will be the introduction of Paramedics to all twenty-four hour stations in rural NSW and the provision of paramedics on helicopter services.⁴¹

- 4.67 The HSU also added that the Service had raised the issue of clinical profiling of Stations with them.

Discussion

- 4.68 On the evidence presented to the Committee, this matter appears to have been addressed.

REVIEW THE CONTRIBUTION THE SERVICE MAKES TO THE STATE'S RESCUE CAPABILITIES

The Audit Report

- 4.69 Historically the Service has been an important provider of rescue services throughout the state. The exercise and functions of the Ambulance Service in emergencies and rescue operations has legislative authority through the *State Emergency and Rescue Management Act 1989* and Section 12 of the *Ambulance Services Act 1990*.

³⁹ *Readiness to Respond*, p 91

⁴⁰ Submission by the HSU, p 13

⁴¹ Submission by Ambulance Service of NSW, p 6

- 4.70 The audit report identified conflicting opinions within the Service about the continuing role of the Service in rescue operations. Arguments for the retention of this function by the Service included the need to retain highly skilled officers in rescue situations to ensure quality patient care and the historical significance the Service had played in rescue.
- 4.71 Conversely, the report also noted arguments that the rescue workload varied from area to area. In some areas, where the workload was very low, some rescue units played a stand in role if required. Busier units still only performed a small number of rescues because other services were able to serve that rescue function more effectively.
- 4.72 The report concluded that the Service should review the contribution it makes to the State's rescue capabilities.⁴²

Action Taken

- 4.73 In 2001 the Service attempted to divest itself of rescue operations functions in the metropolitan area. This led to a strong response from the community, including a petition of 32,000 signatures demanding the retention of the Ambulance Rescue units being forwarded to the NSW State Rescue Board.⁴³
- 4.74 As a result, the State Rescue Board recommended that the Service maintain its rescue operations at this time. However, the Service did undertake a review of the rescue functions to explore ways in which the rescue operations could be maintained more effectively.⁴⁴
- 4.75 In its submission the Service identified the need to:
- ... strengthen management focus for regular rescue and communication functions.
- Other reforms include updates for clinical skills, rotating rescue paramedics through rapid response and skill mix crews; improve activation, response and utilisation procedures, updating equipment; re-establishing specialist rescue training as well as rescue awareness training for all employees; and the development of accurate data collection systems.
- The State Rescue Board will continue to have a watching brief over this matter.⁴⁵
- 4.76 The HSU supports retention of the emergency rescue service. They asserted that the decision to review rescue operations from the Service in metropolitan areas was more a financial consideration rather than a decision based upon the welfare of the community.
- It is also little understood the robustness that a multi-agency approach provided to the community, especially in regards to the ability of the state's emergency services to respond comprehensively to Chemical, Biological and Radiological "CBR" incidents.⁴⁶

⁴² *Readiness to Respond*, p 97

⁴³ Submission by the HSU, p 13

⁴⁴ Submission by the Ambulance Service of NSW, p 6

⁴⁵ *Ibid*, p 6

⁴⁶ Submission by the HSU, p 13

Discussion

- 4.77 It appears that the continued participation by the Service in emergency rescue is consistent with community expectations. The review of and upgrading of management units also indicates that the Service is supportive of community expectations. In order to allow the community to fully assess the value of Ambulance rescue, the Committee would suggest that the Service report cost efficiency data for its rescue operations. It can be argued that withdrawing from rescue work would allow the Service to concentrate on its core functions or pre-hospital emergency care, especially in metropolitan NSW
- 4.78 The Service stated in a submission:
- Should sufficient capacity currently exist across other emergency service agencies in the Sydney metropolitan area to absorb rescue services in the 5 Ambulance areas and maintain the standard required by the Rescue Board, the Service would consider withdrawing from the 5 areas.⁴⁷
- 4.79 When not involved in emergency rescue operations the rescue units are employed in core service work. If an emergency rescue matter arises while the ambulance is otherwise engaged this can impact on the response times for emergency rescue.
- 4.80 The pressure on the Service to maintain acceptable response times is difficult as the Service grows. Although the Service requested to be withdrawn from five of the 24 primary rescue areas in metropolitan areas, pressure to remain has prevailed.
- 4.81 The issue of whether the Service should continue to provide clinical care in emergency rescue operations further complicates the debate about integration into the health system. If the Service continues to move towards an integrated whole of health care there is a fear that the Service may be merged into Area Health Services. This perception may already exist to some extent due to the use of ambulance officers as de facto nurses in emergency wards.
- 4.82 The community support for the retention of the emergency rescue arm of the Service also adds weight to the previous argument relating to the need for the Service to maintain autonomy from Health while participating in the continuum of care, and the need to simplify funding arrangements further suggests that the Service may be better under the emergency services portfolio.
- 4.83 The Service advised the Committee that several reviews suggested that better use could be made of available rescue resources. The continuing debate in relation to rescue resources highlights a need for the State Rescue Board to revisit the question of appropriate allocation of metropolitan rescue units.

RECOMMENDATION 6.1: The Service should continue to monitor the workload of the emergency rescue units in metropolitan and non-metropolitan areas through data collection so that more informed decisions about the continued use of the Service in this area may be obtained.

⁴⁷ Supplementary Submission from the Ambulance Service of NSW, p 8

RECOMMENDATION 6.2: The Committee encourages the State Rescue Board to re-visit the question of appropriate allocation of metropolitan rescue units, including the use of the Ambulance Service in rescue operations.

Chapter Five - Recommendation 4: Further develop management information capabilities to support decision making

ENSURE THAT THE BOARD REGULARLY RECEIVES REPORTS WHICH ADDRESS ISSUES OF LEVELS OF ACTIVITY, STAFFING LEVELS/UTILISATION AND SIGNIFICANT EQUIPMENT DEFICIENCIES

The Audit Report

- 5.1 A strong theme of the audit report was the inconsistent use of management information to improve decision-making. Such information would allow the service to ensure that the staffing at each station matched its workload.
- 5.2 The audit report noted that the Service was committed to developing the wider availability of management data from AmbCAD. The report went on to state:

It also requires a commitment by managers at all levels to use information to improve business, and to be pro-active in improving the quality and application of the management information itself.

To lead by example, and to enhance further the governance role of the Board, the Audit Office believes that information provided to the Board should be enhanced. It is recommended that the Board regularly receive reports, which address issues of levels of activity, staffing levels/utilisation and significant equipment deficiencies.¹

Action taken

- 5.3 The Ambulance Service submission stated that through the adoption of the AmbCAD system the Service:
- ...had strengthened its capacity to analyse workload and deployment issues at station and shift levels in detail.²
- 5.4 This could be achieved through data mining, quantitative analysis, and operational modelling. The audit report noted that the Service appeared to have commenced using such tools to monitor workload and staffing levels.³
- 5.5 The CEO during evidence provided examples of the how the data collected can be utilised. One example was changing rostering to meet peak emergency periods. Another was differentiating between those

¹ *Readiness to Respond*, p 64

² Submission by the Ambulance Service of NSW, p 8

³ *Readiness to Respond*, p 28

patients that required a rapid emergency response and those that could wait and be given non-emergency transport at a convenient time.⁴

5.6 In his submission to the inquiry the CEO provided a table that showed reporting requirements to the Board.

Executive capabilities	Annually
Finance/KPIs	Monthly
Asset Management	Six Monthly
OH&S	Monthly
Workforce Planning	Annually
Public Awareness Community consultation	Annually
Clinical Quality and Improvement	Six Monthly
Ethical Governance	Six Monthly
Strategic Planning/Board/CEO Performance Agreement with Health	Six Monthly
Strategic Partnerships	Annually
IT Strategy	Annually
Statutory and regulatory compliance	Annually

Discussion

- 5.7 In November 2003, the Committee asked the Service to provide a copy of its most recent Board papers. The Service provided a copy of the Board Meeting Papers for Friday, 25 July 2003. The meeting papers indicate a wide range of information being provided to the Board. The report includes a performance summary report, actions arising from Board Meetings and action required by the Board.
- 5.8 The Board reviews a significant amount of operational data related to mobilisation and response times. The data is presented in both graph and table form. Included in the response and mobilisation graphs are logarithmic averages of the response data.
- 5.9 The tables (but not the charts) have approved performance targets for emergency response times less than 10 mins, 15 minutes, routine cases on time and urgent cases on time. Including the approved performance targets in the charts would also alert the Board as to the disparity, where it occurs, between response times and performance targets to be achieved. These targets are important for the Board so that they can realise how well the Service is performing and they can identify issues for future planning for the Service.
- 5.10 In the table headed Performance Standards and Targets it should be noted that the Northern, Southern and Western areas do not have approved performance targets. Although Sydney carries the burden of much of the Service's workload, it is the only area where approved

⁴ Transcript of evidence 5/11/03, p 23

performance targets are provided. The Service should be moving towards performance targets for other areas.

- 5.11 The Board is also provided with detailed reports on motor vehicle costs and claims.
- 5.12 The Board report indicates that verbal reports are given by the CEO. In addition, the Board is kept informed through the minutes, which are included as part of the meeting papers.

Discussion

- 5.13 Although there is room for improvement, the Service appears to have largely implemented this recommendation.

FULLY IMPLEMENT ROSTERING AUTOMATION SOFTWARE FOR ALL ROSTER PREPARATION

The Audit Report

- 5.14 The audit report found difficulties with the roster administration process. Area management prepared rosters and faxed them to the operations centres. Problems arose around the accuracy of rosters which operations centre staff had to reconcile. The faxing of rosters from area centre to the operations centre meant that operations staff had to load the information into their computers, which was time consuming.

- 5.15 The report noted that:

Alternatives to automate roster preparation and improve quality and timeliness have been considered by the Service, and Service-wide adoption of the AMROS software is intended. Implementation is currently partially completed. This will be of considerable benefit and should continue to receive priority.

To maximise the potential benefit of the new system, as previously mentioned action needs to be taken to integrate leave systems with overall resource management systems. It is noted that this will be possible with the new AMROS software.⁵

Action Taken

- 5.16 It appears that AMROS cannot be implemented. The Service submission stated:

The Service has resolved that the continued development and implementation of roster automation software (AMROS) identified in the Auditor-General's Report will not be compatible with recent changes to management, performance and resource utilisation reporting and AmbCAD operations.⁶

⁵ *Readiness to Respond*, p 89

⁶ Submission by the Ambulance Service of NSW, p 8

5.17 On further enquiries with the Service it was established that a review is underway on roster packages that “might” be used across the Service.⁷

5.18 The Service also stated that:

In the Sydney Division, new crew deployment patterns were introduced on 23 November 2002 to provide a better match of resources with demand.

The new deployments enabled the Service to have more crews available during peak workload times when compared to previous deployments. The number of crews deployed is the key indicator of roster success and actual deployments have been significantly greater between peak workload hours, 7am to 12 midnight, when compared to the previous deployments.⁸

Discussion

5.19 The HSU commented in their submission:

The lack of any systemised or ‘software’ approach is a significant contributor to the confusion that can still exist on a daily basis as to which officers or crews are available. This delays expeditious decision making as to crew levels, additional staff required, staff movements.⁹

5.20 In their evidence the HSU gave examples of current rostering practices:

Mr RAVLICH: Certainly some of the first discussions that we had with the service were about rostering and crew deployments. The report that it was relying upon, which was provided by international providers ORH, indicated that the service needed to think through a better match of crew deployments to staff. However, as it turned out, it required only varying in no great degree something like 18 per cent of all rosters in metropolitan Sydney. Most rosters remained as they were or became more tightly focused on what we call “four on, four off”. We have not even begun those discussions in rural New South Wales as yet, but clearly that will be something we progress over the next six months.

There is a confusion—I may have referred to confusion several times in the submission so I am not quite sure to which confusion you are referring—that we are still talking to the service that turns on the lack of a centralised information technology platform for rostering. On a day-to-day basis, our members have a bugbear that certainly impacts on service delivery. Operation centre staff look at the rosters in front of them in good faith to see what crew deployments they will have throughout the metropolitan Sydney area on a particular day. Then at eight o'clock they suddenly discover that at a station where they thought they would have four officers, two have turned up—perhaps not on unexpected leave but sick leave, which you cannot do much about unless it is long-term sick leave and you can plan around it. The roster that is provided by individual stations via an area management structure and eventually to the operations centre often does not mirror the crew deployments of the day.

In planning for the number of hours leading to eight o'clock, centres might assume that they have five officers, for example, at a particular station.

⁷ Supplementary Submission by the Ambulance Service of NSW, p 2

⁸ *Ibid*, p 2

⁹ Submission from HSU, p 15

They might decide that two officers will remain at the station to provide two crews and the single officer is progressed to a particular station to team up with another spare officer. However, at eight o'clock when they seek those officers to call on the air they are told, "Joe is off duty because he was called to the training school. Didn't you know". We are provided with information on a semi daily basis about staff movements. It is lost time when an officer or officers are not as productive as they could be. Somebody mentioned to me an incident that occurred on Sunday—it was the subject of some discussion in another forum yesterday—when a crew from Auburn was sent elsewhere then another crew was sent to Auburn. There was a kangaroo-hopping of staff. That might have been a genuine attempt to minimise the distance that people travel, but at the same time it reflects a degree of uncertainty. You do not need too many of those things to happen to throw out all your plans.¹⁰

- 5.21 The HSU also noted that more efficient rostering systems in regional areas have not fully commenced.
- 5.22 According to the HSU roster patterns are not the problem. It is more a case that roster efficiency through the communication of staff activity needs to be better recorded and disseminated at the station level.
- 5.23 It should also be noted that the CEO of the Service has commented that roster patterns are not always lined up with demand and implied that this was due to the current award rather than inefficiency in rostering:

Every place does not have the roster that matches the available staff or that matches the requirements of the community in terms of when ambulances need to be on duty. In many towns the greatest workload is in the evenings on certain days during the week. Yet most of our rosters focus on day-time duty or on-call at night. The reasons for that are very much structural: they go to the nature of the ambulance officers' award, and historical practices amongst some long standing staff members. I think the solution is to address a more flexible and appropriate structure, and the award proposals that we are about to begin negotiating with the union start to touch on some of those issues.¹¹

- 5.24 The comments of the CEO and the HSU highlight that more is required than simply automating the rostering process to ensure efficiency. However, automation should alleviate some of the confusion currently experienced in relation to staff movement. The Service has advised the Committee that it is currently centralising rostering and is working towards automation.

RECOMMENDATION 6.3: That the Service makes it a matter of urgency to implement a suitable automated networked roster system which will assist in making rostering co-ordination activities easier.

¹⁰ Transcript of Evidence 5/11/03, p 14

¹¹ *Ibid*, p 34

DEVELOP AND IMPLEMENT RESOURCE MODELLING TOOLS TO DETERMINE OPTIMAL STAFFING LEVELS AND DEPLOYMENT STRATEGIES

DEVELOP CAPABILITIES TO ANALYSE WORKLOAD, UTILISATION AND RESPONSIVENESS AT STATION LEVEL

The Audit Report

5.25 Prior to the audit report, between 1996 and 1999, the Service had completed a staffing review in conjunction with the HSU. The audit report noted that it was:

An ambitious attempt to produce a sophisticated and agreed staff deployment plan.¹²

5.26 While acknowledging the staffing review was a positive initiative, the process of review had limitations and created problems of its own. There was industrial unrest at the time which resulted in the centralisation of staffing matters instead of them being part of the area and operations routine planning processes.¹³

5.27 Another comment in the report was that area management were not given sufficient quality data on workload and leave to calculate their staffing requirement, yet were accountable for outcomes over which they had little input or involvement.¹⁴

5.28 The Audit Office encountered difficulties obtaining accurate staffing numbers. Nevertheless, the Audit Office calculated that the Service was running below the staffing establishment levels agreed to in the review. To compound this situation, the Audit Office noted that the current rate of leave/training per Sydney officer was assumed at the time of the audit to be twelve to thirteen weeks per annum. A previous Sydney staffing review, however, put the figure at nine to ten weeks, which meant the shortfall could be even greater.

Action taken

5.29 The Audit Office's point was that there was no particular set level of full staffing for the Service. Rather, staffing and productivity needed to be continually matched against workload.

5.30 As a response to the recommendations from the audit report the Service commissioned its own independent review of the Service Operational Research in Health Limited (ORH). The review centred on the Sydney area. The review identified the areas that the Service had to focus on to improve performance. They included among other issues a focus on staffing, rostering and deployment as areas where significant

¹² *Readiness to Respond*, p 68

¹³ *Ibid*, p 69

¹⁴ *Ibid*, p 69

improvements could be made. To correctly gauge these areas to match emergency calls requires sound resource modelling.

- 5.31 The Service indicated that it had progressed the recommendations through the establishment of an Operational Information Unit, which enabled it to analyse workload, and deployment at station and shift levels. The Service also indicated that in future it would be able to conduct the following types of analysis:
- *data mining* to examine AmbCAD information to locate patterns;
 - *quantitative analysis*; and
 - *operational modelling* as a potential tool for operations environment.
- 5.32 The improved data collection procedures were evidenced by improved deployment patterns in place in Sydney. Activity and performance reports were also provided to station levels to assist in local management and planning.

Discussion

- 5.33 In its submission the HSU stated that:
- ... the sophistication to examine and analyse capacity and actual outcomes at a station and/or shift level has not been evidenced by the Service to date that would productively assist in the debate.¹⁵
- 5.34 The Service's submission informed the Committee that the tools are in place for resource modelling to take place. The computerisation of the emergency calls through AmbCAD allows for the collection of information at the operational level. This information can be accurately used to undertake resource modelling.
- 5.35 The AmbCAD system provides the Service with the data to undertake modelling. The AmbCAD system allows for information received during the emergency phone call to be prioritised so that appropriate ambulance crew and ambulance vehicles can be deployed. In his evidence the CEO verified that AmbCAD was being used to collect data for resource modelling. However, it was at a stage where they were checking the reliability of the data to ensure decisions of which ambulance to send were correct. Mr Rochford stated:

Mr ROCHFORD: ... So at the moment our computer aided despatch [AmbCAD] system has really computerised the previous practice. We are now at the phase of changing those work practices to use more of the tools that are available in the AmbCAD. For example, the system now is able to prioritise calls on the basis of information taken from the caller. The default will always be to make the call at the most urgent category but quite often you get sufficient information on the telephone to determine that it is not an urgent call. That will enable us to make a decision about whether to send an ambulance immediately with lights and sirens, whether to send a

¹⁵ Submission received from the HSU, p 16

paramedic or a general duties officer, whether to send a rapid response vehicle, or whether at times of very high demands, such as on New Year's Eve, it is quite appropriate to say, "We will send you an ambulance in one hour". We have not taken that decision yet, we have not introduced that, but we are on the edge of being able to make those decisions quite safely.

....

Mr PAUL McLEAY: Are you saying that you can now interrogate the data but you are not actually utilising that information yet?

Mr ROCHFORD: Yes, in a way. The work practice changes that are involved in making those adjustments are quite significant. But first and foremost, we have to be absolutely sure that it works in Australia, in Sydney. In our rural communities we have gone through a process of using the call taking methodology now for six months and we have a reliable set of data that we can check to make sure that if our decision was that the person who is complaining of shoes that were too tight got a very nice 10 minute response time to them, that that had not delayed the next caller who had chest pain. We need to make sure we are making those decisions safely before we start changing the way we deploy ambulances. We are going through that quality assurance checking phase at the moment to make sure the staff are using the system correctly, which they seem to be, and making sure that the system provides reliable decision points, which it does seem to be. We are now able to go to the next step to actually make decisions based on the data.

Mr McLEAY: When do you expect that to happen?

Mr ROCHFORD: That will be happening over the next 12 months.

Mr McLEAY: When do you expect that to impact on your key performance indicators [KPIs], or is it already?

Mr ROCHFORD: No, it is not impacting at the moment. It will impact as it is introduced. Obviously we will be needing the control for how that affects performance indicators from one year to the next.¹⁶

- 5.36 The Committee appreciates the CEO's thoroughness in ensuring that AmbCAD data collected is trialled prior to full implementation. It is encouraging that the CEO has determined that decisions using the data may be utilised within the next 12 months. This more sophisticated use of AmbCAD data will assist the Service in making immediate decisions in relation to prioritising deployment. It appears from the CEO's evidence that the Service will adjust the crew deployment by focusing on prioritising the ambulance response. The Committee would encourage the Service to implement the new dispatch system as a priority.

¹⁶ Transcript of Evidence 5/11/03, p 31

Chapter Six - Recommendation 5: Identify and remove barriers to flexibility of resource deployment.

REVIEW INTERPRETATION AND APPLICATION OF CURRENT AWARD CONDITIONS

IMPROVE FLEXIBILITY OF AWARD CONDITIONS

REVIEW MANAGEMENT AND WORK PRACTICES CONTRIBUTING TO INFLEXIBILITY

MONITOR DEVELOPMENTS IN BEST PRACTICE WITHIN THE SERVICE AND ELSEWHERE

The Audit Report

6.1 The audit report identified inflexibility of current award conditions in regard to:

- meal breaks;
- call out costs in rural areas;
- refusal by staff to work in other stations to cover vacancies or sporting venues unless overtime was paid; and
- the inflexibility of roster starting times.¹

6.2 The report noted that quality management information was now available to predict the number and workload of staff at different times for all stations.²

6.3 The report also suggested that proactive management, through better communications lines to staff, should counter misunderstandings about the interpretation of the award or operating procedures. The report stated:

Whatever the situation for any given issue, the process for overcoming impediments to flexibility is similar. It requires discussion, attitude changing, problem solving, constructive negotiation and commitment to implementation.³

Action taken

6.4 The current award with the HSU has expired and the Service has developed a simplified plain English award based on the concept of

¹ *Readiness to Respond*, p 86

² *Ibid*, p 86

³ *Ibid*, p 87

composite salary.⁴ The award is currently under negotiation with the HSU.

Discussion

- 6.5 While negotiations are under way between the HSU and the Service, the Committee considers it inappropriate to comment on interpreting the award. However, the Committee commends the efforts of the Service to have written the enterprise agreement in clear language compared to the previous agreement. The use of plain English should broaden the level of understanding of award conditions. Further, it should allow for less ambiguity in the interpretation of awards during negotiations between the Service and the HSU.
- 6.6 The Committee notes that the issues raised in the audit report regarding overtime (s22), on-call and recall to duty (s19), meal allowance (s22.5) and relieving staff at other stations (s24.3) have been included in the new draft agreement. However, the Committee notes that staggered rostering was not mentioned in the new draft agreement. In evidence, the CEO discussed some of the issues raised in the audit report relating to rostering inflexibility:

Mr STEVE WHAN: Following from what the union said earlier on, the point was made about the allocation of ambulance resources and the fact that decisions were being made about where to allocate crews. The example they gave was a station that might be supposed to have five people and a decision is made in advance to plan to send one of those to fill a position somewhere else but somebody is sick and does not turn up at work and that is not communicated quickly. They are suggesting that there was a bit of a breakdown in communication in the planning process from local stations through to the overall planning and distribution of the resources. Have you got any comment on that?

Mr ROCHFORD: Particularly in rural areas where staff numbers are low, casual vacancies for whatever reason—sickness, resignation or whatever—clearly are a challenge. Communication in those places is also a challenge. So I have no doubt that we can work to improve communication up the management line and with staff about how to deal with the ad hoc situation which will always be present. I think, more importantly, underlying that is devising deployment structures that fit the needs of staff. Every place does not have the roster that matches the available staff or that matches the requirements of the community in terms of when ambulances need to be on duty. In many towns the greatest workload is in the evenings on certain days during the week. Yet most of our rosters focus on daytime duty or on-call at night. The reasons for that are very much structural: they go to the nature of the ambulance officer's award, and historical practices amongst some very longstanding staff members. I think the solution is to address a more flexible and appropriate structure, and the award proposals that we are

⁴ Submission by the Ambulance Service of NSW, p 8. A composite remuneration package is one that includes allowances for overtime, meal allowances and other penalty payments in addition to salary and employer's contribution to superannuation.

about to begin negotiating with the union start to touch on some of those issues.

By way of example, officers, on average, enjoy a reasonable take-home pay. Their base rate is reasonably low compared with other industries; they are quite reliant on penalty rates and other factors in shiftwork to maintain their income. It is our view that that reliance can be diverted somewhat by offsetting the base rate of pay, which would provide a greater level of flexibility and less of a hurdle to overcome when it comes to changing rosters to ensure that people are working at the times when they are most needed. It would be less of a financial impost for officers, and therefore a more agreeable proposition. Some of those underlying structural impediments remain with us. I think many have been overcome, but the ones associated with the current award document are only just beginning to be addressed after a great deal of research and analysis. We are looking forward to using the much-improved communication and relationships that have developed with the union to allow some of those changes to be implemented. I think the solution to the problem to which you alluded lies in that approach in the longer term.⁵

- 6.7 The Committee supports roster review which reflects workload. It encourages negotiations through the new award agreement between the Service and the HSU regarding the improvement of rostering flexibility.
- 6.8 Conditions applicable for duty at sporting venues have not been included in this agreement although they were included in the previous agreement.⁶ The 2002/03 Annual Report makes mention of the Sports and Services Unit,⁷ which is responsible for the provision of ambulance services at major, special and sporting events. One of the major goals of this unit is decentralisation to the Division sections of the Service. Another goal is the development of service agreements with established sporting bodies to provide more permanent service. In 2002/03 the Service received income of over \$900,000 for sporting and special events in the Sydney Division alone. This potential source of income, when spread across NSW, should encourage the Service to maintain a section in the enterprise agreement that gives guidance on employment conditions. This is particularly so since the Service is encouraging the expanded use of the Service to cater for these events, through decentralisation. The Committee notes that these matters are under discussion.
- 6.9 The clear style of the new enterprise agreement is evidence that the Service understands management's obligation to keep staff informed of workplace rights and entitlements. Accurate communication assists staff in understanding conditions of employment and alleviating unnecessary industrial problems. In evidence the CEO stated the

⁵ Transcript of Evidence 5/11/03, p 34

⁶ The Ambulance Service of NSW *Operational Ambulance Officers (State) Award 1998* S16, p 15

⁷ Ambulance Service of NSW, *2002/03 Annual Report*, p 18

Service had made progress in this area as was previously noted in chapter 2.⁸

- 6.10 Within the draft enterprise agreement there is further evidence of the Service's commitment to greater transparency. S18.2 relating to roster allocations stipulates rosters are to be displayed seven days before the roster commences. This provision was not mentioned in the previous agreement. This requirement should be encouraged to extend to display of overtime rosters particularly where notice of overtime is given not less than 24 hours in advance. It would also serve to address issues around unfair overtime allocation mentioned in Recommendation 8 of the audit report.
- 6.11 The current draft workplace agreement takes on board many of the concerns raised by the Audit Office. The Committee would encourage the Service and the HSU to revisit the audit report and address as many of the Auditor-General's concerns as possible, when negotiating the new agreement.

⁸ See pages 19 - 20

Chapter Seven - Recommendation 6: Enhance consultation with external stakeholders

IMPLEMENT MEANS OF REGULARLY IDENTIFYING CUSTOMER AND STAKEHOLDER EXPECTATIONS AND PERCEPTIONS OF THE SERVICE'S PERFORMANCE

DEVELOP MEANS OF KEEPING THE BROADER COMMUNITY INFORMED OF THE SERVICE'S PROGRESS, DIRECTIONS AND PLANS

The Audit Report

- 7.1 The audit report referred to the Ambulance Service's requirements for consultation under the *Ambulance Services Act 1990*. These are:
- 12. (1) (e) to consult and co-operate with individuals and organisations (including voluntary agencies, private agencies and public or local authorities) concerned with the provision of ambulance services;
 - (f) to co-ordinate and plan the future development of ambulance services, and towards that end:
 - (i) to consult with the Department of Health; and
 - (ii) to support, encourage and facilitate the organisation of community involvement in the planning of those services.
- 7.2 The report noted that in 1972, the Service was managed by 56 District Committees that had a fair degree of autonomy in staffing, raising finance and in expenditure.
- 7.3 The audit report asserted that since its move from private funding to state controlled funding, the Service:
- had appeared not to have maintained its mechanisms for community involvement. While the Service is currently represented on a multiplicity of consultative committees, it had no specific mechanism for consultation with the local communities.¹
- 7.4 One reason that the audit report gave for the importance of building community relations was the mismatch between the historical locations of ambulance stations and the often differing locations of the current workload. Better community relations would make it easier to shift stations and provide a better service overall.

¹ *Readiness to Respond*, p 77

- 7.5 The report suggested that the Service needs:
- ...formal links with communities so that it has an early and comprehensive understanding of community expectations and a mechanism for evaluating these. The Service's strategic plans should recognise the needs of different communities and reflect these in its plans for development.²
- 7.6 To this extent the audit report asserted that some other services had a more "outward – looking" approach to community liaison and involvement.
- 7.7 For example at the time of the report, Rural Ambulance Victoria (VAC) had a Community Reference Committee which assisted the Chief Executive in understanding the needs and perceptions of its client communities. The metropolitan Ambulance Service (Victoria) ran 35 workshops with 100 community members (who were prior clients of the Service). The Queensland Ambulance Service had more than 160 local Ambulance Committees.

Action Taken

- 7.8 The immediate response to the recommendations was acknowledgement from the Service that stakeholder and community consultation was important. The Service suggested that this was being achieved through the Government Action Plan for Health (the GAP).
- 7.9 The Service advised in its submission that community members were participating in some committees including the Medical Priority Dispatch System Steering Committee, Clinical Governance Committee, Website Working Party, Consumer and Community Participation Working Party, Integrated Complaints Handling Reference Group and the Health Access Co-ordination Pilot Committee.
- 7.10 The Service also advised that it:
- provided "human interest" stories to the media,
 - used the volunteer ambulance officers to promote attendance at local incidents,
 - provided fact sheets in community languages,
 - was overhauling the website in consultation with community groups to make it more interactive; and
 - was undertaking over 250 child care/school visits.³

Discussion

- 7.11 NSW Health is the main stakeholder of the Service. Chapter Four discussed the expectations of the Service from Health in providing a "whole of health" service to the community.

² *Ibid*, p 77

³ Submission by the Ambulance Service of NSW, p 10

- 7.12 The Service primarily works within the health system in community consultations. The Service's main strategy in community consultation is built into existing structures rather than consultation committees. The 2002/03 Annual Report notes a trial appointment of a community liaison officer in the South Eastern Sydney Sector. The officer's role is to talk to school students and community groups to provide information and receive feedback to improve service delivery.⁴
- 7.13 Other Services have moved further in consulting with the stakeholders and community. Some services have strong community focused awareness and injury prevention programs. The Queensland Service's local ambulance committees (LACs) provide feedback on the Service's work. The LACs liaise between the community and the QAS to promote community participation and an awareness of ambulance services. LACs also carry out fundraising, provide advice and manage money held in trust for the benefit of ambulance services in their community.⁵
- 7.14 The Queensland Ambulance Service (QAS) is also very proactive in community education that focuses on reducing call outs by educating the community in safer activities. It has as a performance indicator in its Annual Report called "Enhance community safety and prevention capability". This indicator shows that the QAS issued 65,836 community education certificates in first aid and 4,842 people were trained in CPR. The QAS also hires out baby capsules and undertakes primary school education programs. Year 1 students are provided with an awareness of what to do in an emergency situation. The program is supported with teacher learning material.
- 7.15 The QAS has an "Adopt an Ambo" officer scheme where primary school students are taught basic first aid, injury prevention and how to use the emergency telephone.
- 7.16 The QAS also runs public awareness campaigns aimed at preventing injury during summer and holiday periods and reducing the demand for ambulances and associated costs to the community.
- 7.17 The 2002/03 Annual Report of the Service includes a chart on types of cases treated. They include such areas as cardiac – 6%, trauma – 16%, respiratory – 6%, general medicine – 9%, neurological – 9% and other 54%.⁶ These figures could be used to plan and design appropriate community programs which target injury prevention and treatment. Such programs would minimise risk to the patient prior to the ambulance arriving and may also alleviate some of the need to use the Ambulance Service. Further data analysis could provide information to design injury prevention programs that target specific communities.

⁴ The Ambulance Service of NSW, *Annual Report 2002/03*, p 20

⁵ Queensland Ambulance Service: Local Ambulance Committees www.ambulance.qld.gov.au/about/lac.asp, accessed on 26/02/2004

⁶ Ambulance Service of NSW, *Annual Report 2002-03*, p 6

- 7.18 The 2002/03 Annual Report noted that overall satisfaction with the clinical care provided by the Service was over 90%.⁷ The Committee encourages the Service to continue to collect and refine these surveys.
- 7.19 Another aspect of providing appropriate services to communities is for recruitment to reflect the culturally diverse community. The Service has been proactive in recruiting trainee Aboriginal and Torres Strait Islanders as well as officers with a first language other than English.
- 7.20 The Annual Report identified several rural and remote areas where recruitment and retention of trainee ambulance officers was targeted. They included Mungindi, Lightning Ridge, Brewarrina, Broken Hill, Collarenebri, Walgett, Nyngan and Cobar. The Committee would suggest that in targeted areas where retained or honorary officers are hard to place then community awareness and education may be a good start in promoting an interest in the Service.
- 7.21 It should be noted that the 2001/02 Annual Report for Queensland's Emergency Services, of which the QAS is part, lists community stakeholders. Identifying stakeholders in the annual report affirms a strong and ongoing commitment to consult with them. It is suggested that the Ambulance Service, particularly in rural and remote areas, identifies and reports in its annual reports on its community stakeholders and the efforts undertaken in building community links.
- 7.22 Community links also help in fundraising. The 2001/02 Annual report for the Queensland Emergency Services states:
- Local Ambulance Committees (LACs) provide invaluable support to QAS by providing the essential interface between QAS staff and the community. There are 175 Committees with more than 1,400 members. They provide advice to the Commissioner and also liaise between QAS and the wider community.
- LACs are active in fund raising with the aim of financially contributing to their local ambulance station. LACs raised \$760,000.00 during 2001/02 to enhance ambulance stations in their communities.⁸
- 7.23 The Committee suggests that, in continuing to implement this recommendation, the Service take Queensland as a guide.

⁷ The Ambulance Service of NSW, *Annual Report 2002/2003*, p 59

⁸ Queensland Department of Emergency Services, *Annual Report 2001/02*, p 59

Chapter Eight - Recommendation 7: Review Recruitment and development strategies

IMPLEMENT ENHANCED MANAGEMENT TRAINING AND DEVELOPMENT

The Audit Report

8.1 The audit report stated that management training and development was needed to:

- meet the increasing complex and intellectually challenging technologically based workplaces;
- manage the clinical aspects related to continuing innovations in treatments, drugs, equipment;
- meet demands placed on the Service by stakeholders such as hospitals and health system; and
- accommodate changing staff profiles such as employment of non-uniformed officers.¹

8.2 The report noted that the Service was committed to implementing a management development program through an external agency.²

8.3 In the initial response to the report, the CEO stated that most senior management positions were filled by external applicants.³

Action Taken

8.4 The Service stated in their submission that they had:

... developed a set of core management competencies for Ambulance managers based on NSW Health Executive Development Centre competencies. All senior managers have now been assessed through an external Management Assessment Centre environment.

The results of these assessments are now forming the basis of development plans, with training and development requirements, for managers.

The Service had also appointed a training and development officer to advance the management training program in accordance with the development plans prepared and to implement a frontline supervisor training program.

At the same time the Service has developed a performance management model that combines individual management goals arising from the Service's new Performance Agreement with NSW Health with personal development targets for individual managers to support and monitor the changes to management approach being disseminated across the Service.

¹ *Readiness to Respond*, pp 77- 78

² *Ibid*, p 78

³ *Ibid*, p 100

Staff appraisals have been developed for staff and are currently the subject of consultation with relevant unions. The appraisals will provide a valuable tool in progressing development programs and succession planning.⁴

- 8.5 In its supplementary submission, the Service further elaborated on the role of managers in the new structure which will impact on the types of training necessary:

The new structure is based on the principles of devolution of responsibility and accountability. Managers will be expected to meet specific targets and teams will report on operational performance and the development of processes that facilitate continual improvement. The new structure, when fully implemented, will facilitate Service growth by developing individuals and improving patient care delivery models.⁵

- 8.6 However, in its submission the HSU expressed concern about the progress in developing senior management:

A significant perception still exists within the Sub-Branch of the HSU representing senior uniformed managers in the Service that little has been done in relation to succession planning, valuing and developing senior staff through training and mentoring programs; and the ad hoc manner that acting opportunities are provided and made available.⁶

Discussion

- 8.7 The new, flatter management structure, implemented as part of the 2000/2001 restructure, requires greater accountability from managers. This in turn requires open communication between managers to staff. It reflects a commitment from the Service to address the recurring communication difficulties identified in the Gleeson Report.
- 8.8 The new training and development officer has the specific role of planning and implementing management programs to best equip managers to undertake their duties. The management programs are based on a consultative approach, with managers invited to identify their training needs to meet competencies. Training is then tailored to their requirements. Considerable work has been undertaken in this area. In discussions with the Service, the Committee was advised that there are a number of short term business courses offered, an annual Senior Manager conference and regular meetings at executive, divisional and operational levels.
- 8.9 The Service also participates in management programs offered through the Department of Health. These include the Health Education Leadership Program (HELP), which is a senior executive orientation program, and the Executive Development Support Centre Program (EDSC), which continues for 12 months and involves the development of individual plans, coaching and learning tasks for managers.

⁴ Submission by the Ambulance Service of NSW, p 11

⁵ Supplementary Submission by the Ambulance Service of NSW, p 6

⁶ Submission by the HSU, p 17

- 8.10 Notwithstanding the recent focus on developing senior managers, the Committee noted in the Annual Report for 2002/2003 that only one of the senior executives had progressed through the Service. Two senior executives were employed from the United Kingdom, three were employed from Health and one senior executive was employed from local government.⁷
- 8.11 However, it should be noted that the restructure of the Service in 2000/2001 was done with an aim of ensuring that internal candidates would be successful in gaining future promotion opportunities. The Service has advised that the new structure should help ensure that this occurs.
- 8.12 As a sign of its commitment to support management training and development the Board should require regular reports from the training development officer. There should also be a specific budget provided to the training development officer to plan and implement programs.
- 8.13 It is also important for the Service that opportunities are provided for officers to practise their management skills through higher duties opportunities with the Service and through secondments with Health and other emergency agencies. This would provide officers with the opportunity to bring new ideas back to the Service. This would also be advantageous in representing the interests of the Service in “whole of health” forums.
- 8.14 The Committee also refers to recommendations in Chapter Four of the audit report that suggested that strategies should be incorporated in management training which promote the study of other Services and which would bring best practice to the Service through middle and senior managers. This may be accomplished by training program, which organises and encourages secondments.

RECOMMENDATION 7.1: The Service organise opportunities for external management secondments.

- 8.15 The Service has also established a Clinical Governance Committee (a Committee of the Board) whose primary function is to:
- ... assist the Board in its responsibilities to give assurances in regard to the clinical quality of care and to establish and monitor clinical quality improvement strategies.⁸
- 8.16 The Committee notes the Service appears to be implementing the recommendations of the audit report in its clinical care training at both an operational level and at the Board Level.
- 8.17 The Committee noted however that there was little information provided in the submission relating to the Audit Office’s discussion of the need for training in new technology, required for analysis of AmbCAD. Recommendation Four discussed the need for developing management

⁷ Ambulance Service of NSW, *Annual Report 2002/03*, p 17

⁸ *Ibid*, p 15

information capabilities to support decision-making. This recommendation involved managers analysing AmbCAD data to support workload, staffing and deployment strategies. This recommendation is significant in addressing response times. It is understood that the bulk of training offered to managers in this area is undertaken by way of on-the-job training at the operations level. As AmbCAD is the main source of information for which decision-making is undertaken, the Committee is of the view that training in the analysis of data generated by AmbCAD should form part of the management training and this training should be documented in the Annual Report.

RECOMMENDATION 7.2: A specific section of the Annual Report be devoted to information about the training of officers in the use of data produced by AmbCAD.

MAXIMISE OPPORTUNITIES FOR WORKPLACE-BASED DISTANCE LEARNING AND TRAINING

The Audit Report

- 8.18 The Audit Office re-iterated recommendations from previous audits regarding the establishment of self-paced workplace-based distance learning methods. The main reference was the Audit Office's 1993 report, *Training and Development for the State's Disciplined Services: Skills Maintenance Training*.
- 8.19 The Audit Office noted that the largest impediment to self-paced workplace-based training was the impediment of limited technological infrastructure such as personal computers where programs were accessible.⁹ The report stated that this program was yet to have a significant impact on operations staff.

Action Taken

- 8.20 The Service reported:
- the establishment of video conferencing in Gilgandra, Macksville, Goulburn and Morisset. These represented the four main rural areas. This was part of NSW Health Telehealth project;
 - Ambulance Education Centres were also developing distance education learning modules and revising the Ambulance Officer Education curriculum to adapt to workplace learning modules; and
 - obtaining funding from the Australian National Training Authority to develop online learning modules.

⁹ *Readiness to Respond*, p 90

Discussion

8.21 On-line learning is an innovative and practical method of supporting the necessary clinical education material to officers in regional areas. The Service appears to be working towards building a strong clinical teaching program through a range of learning experiences, which balances face to face teaching through its Ambulance Educations Centre and the development of distance education strategies. In its 2002/03 Annual Report the Service reported on the delivery of clinical training through its Ambulance Education Centre and distance education programs. Examples are:

- employing four new technical educator positions and associated clinical training officers;
- training teachers in distance learning skills;
- developing interactive CD Rom programs for in-service education;
- success in participating in the 2003 Flexible Learning Leaders project which aims to assist staff in developing flexible education and training initiatives. This also represents a grant of approximately \$20,000;
- successful application to the Australian National Training Association (ANTA) for a grant of approximately \$40,000 - to participate in the “learnscope” project;
- commencement of the Diploma in Paramedical Science for 264 trainee ambulance officers;
- in-house programs in the Diploma of Paramedical Science for 330 existing ambulance officers;
- training provided for 79 paramedics and re-certification of 44 paramedics;
- supervision of 648 distance education students in the Diploma of Paramedical Science;
- provided training to over 1000 staff in a variety of in-service education and focus workshops; and
- employment of four new technical educator positions and associated clinical training officers in regional areas.¹⁰

8.22 To support distance learning, each station needs to have adequate equipment. It is understood that the Service has provided possibly half the stations with computers at this stage. Other stations have raised money themselves, or been provided with computers through community initiatives. This of course leads to problems in quality of computers provided. The Service is currently seeking further funding

¹⁰ Ambulance Service of NSW, *Annual Report 2002/03*, p 34

from NSW Health to roll out substantially more computers in country areas.

- 8.23 With the recent recruitment of some 230 new officers, the majority of whom are destined for country service, adequate distance workplace training provision is a priority for the Service. This was elaborated upon by the HSU in evidence:

Mr RAVLICH: As I said, one of the key discussions yesterday was how we could increase the number of officers trained outside of the metropolitan Sydney area because up until recently because of the level of officers being trained was, in comparison to what we propose to do, fairly limited, or certainly a lesser number, the usual procedure was that there was a residual number of officers trained in rural New South Wales and, keeping in mind that because it is on-the-job training they can only go to certain locations where the workload and the exposure to protocol intervention would be sufficient to be a meaningful training experience. So certainly the default was basically send them to Sydney, there were always vacancies, trainee officers could always be placed in the Sydney environment. That clearly cannot work in Sydney at the moment. I think it is something like a third of all the trainee ambulance officers in Sydney have less than 12 months service. With a combination of having to now train an additional 230, there is a turnover rate of something like 120, 130 on average each year where people leave the service. So during that same period there are almost 500 officers that will have to be trained simply due to attrition.

.... We are now trying to work through appropriate protocols to reduce the reliance on Sydney because it really is at breaking point, but also to recognise that there are a number of major centres where trainees can be distributed. So it is a combination, where, as the additional positions come online we can then use those funded positions to train people and, effectively, regional areas pay a training deposit and contribute towards training the people that will effectively contribute to working in that area potentially at a future point.

Mr WHAN: The new resources that were going to country areas included some training positions in regional centres. Is that something that is improving the capacity to actually increase the skills, particularly of paramedics, in those country areas?

Mr RAVLICH: Certainly one of the first decisions that we made together was that the roll out of the 230—and indeed they were only advertised I think a month or so ago—we clearly identified and agreed with the service that 10 of those positions as a priority should be identified as the various training positions, including one new position that does not even exist in the award, but we said, "Keep talking to us. Do not let that be a barrier", because we want to increase the level of training officer to ambulance officer in the country, which has traditionally been poor, to say the least. I suppose that is an example where both parties have recognised a need and indicated that the first step was a contribution of 10 there and, for example, in the remainder of this year much of the additional staffing that has also been seen as a priority is on the Central Coast basin which is also in a very parlous state for various reasons. The parties again recognise that perhaps the first 16 or so officers next off the rank should be going to the Central Coast, and we are about to start the discussions effectively of what would

happen then about the distribution of staff elsewhere in the subsequent three financial years. There is obviously a question of prioritising those to areas of greatest need and also how they might contribute to training opportunities.¹¹

8.24 The Committee would encourage the HSU and the Service to continue this dialogue to ensure an adequate number of training positions in regional NSW.

8.25 The 2002/03 Annual Report noted:

An Ambulance intranet has been developed and provides a single source of information for staff including a staff directory, policies, procedures, pharmacology, educational material, forms and links to news, weather and job sites.¹²

8.26 It is understood that the provision of the intranet is quite limited at this time probably due to the limited roll-out of computers in stations. The Committee would encourage the Service and the Department to expedite the roll-out of computers to ensure equal access to distance education facilities.

RECOMMENDATION 7.3: A specific section of the Annual Report be devoted to information about the provision of computers and intranet access.

8.27 The bulk of training to officers comes from different sources within the Service. Clinical training is through Ambulance Education Centre, management training is through the training and development officer and on-site technology training is provided for such purposes as using AmbCAD. It appears that there are three strategies for training but no overall structure. At the Board level clinical training is given priority through its own committee. Training in new technology and management are important areas as well which should also be recognised at the Board level. It is the Committee's view that a coordinated approach to training is important. For example in the Annual Report of the QAS:

Ten paramedics graduated from Queensland University of Technology's Bachelor of Health Science program and a further 117 are currently enrolled in the course. The degree is the first of its kind for emergency health care workers in Queensland. It will provide the foundation for QAS staff to develop greater expertise in emergency health care planning, research, clinical potential and management.¹³

8.28 It appears that the QAS has approached a structured learning scheme for their experienced officers that combine different learning areas within the one course.

8.29 The Committee would see it as beneficial for the Service to investigate the strengths of having training facilitators from different areas in the Service working together in advancing integrated and graded courses. It

¹¹ *Readiness to Respond*, p 13

¹² Ambulance Service of NSW, *Annual Report 2002/03*, p 36

¹³ Queensland Department of Emergency Services, *Annual Report 2001/02*, p 39

also requires an expanded view at the governance level of the equal value of clinical, management and technology training.

RECOMMENDATION 7.4: The Board take a greater role in co-ordinating and integrating training and development courses across the organisation.

REVIEW ARRANGEMENTS AND STRATEGIES FOR RETAINED AND HONORARY OFFICERS, PATIENT TRANSPORT OFFICERS AND COMMUNICATIONS STAFF

The Audit Report

- 8.30 The audit report noted that under section 14 of the *Ambulance Service Act 1990* the Service may appoint honorary officers. The Sinclair Report also recommended the appointment of honorary officers as a way of servicing rural and remote areas.
- 8.31 NSW does not use honorary officers to the same extent as volunteers are used in other services. Industrial issues and the Ambulance Act's provision of non-remuneration (meaning that essential equipment and uniforms are provided to undertake the position but there is no provision for wages) limit wider appointment of these officers.
- 8.32 The audit report also considered that the work of communications staff was monetarily undervalued, as evidenced by high departure rates.¹⁴
- 8.33 The report recommended a consultative and inclusive approach with the union to review existing conditions of communications staff, given the importance of communication functions to the Service.¹⁵

Action Taken

- 8.34 A pilot Project in the Murray District of Regional NSW is currently underway which includes developing thresholds for different models of care, eliminating roster redundancy and developing partnerships with Health Services and the Community.¹⁶

Discussion

- 8.35 In evidence the CEO defined and elaborated on the role of the honorary officer.

Mr ROCHFORD: The Auditor-General picked up this issue as well. Honorary officers are in effect ambulance officers who do have some advanced first-aid training but are not qualified to the same level as an ambulance officer or a paramedic ambulance officer. They work for ambulance services in an honorary capacity: they are not remunerated. There are various different formats for that around Australia or around the world, with equipment being provided or money for it being raised by local communities and people

¹⁴ *Readiness to Respond*, p 90

¹⁵ *Ibid*, p 90

¹⁶ Submission from the Ambulance Service of NSW, p 12

being used as first responders. In New South Wales under our Act we have specific provision for engaging and appointing honorary ambulance officers. Historically, we have not made great use of that. Depending on the time of year, between 60 and 80 ambulance officers are honorary ambulance officers in rural places. It has been a fairly ad hoc arrangement historically. In Victoria there are more than 300 honorary ambulance officers—in a much smaller rural State.

CHAIR: How does the honorary officer get to the scene? Do they actually have to come to the station and get in an ambulance or can they drive their own car if the incident is just around the corner?

Mr ROCHFORD: Both of those things. It depends on the nature of the scheme. In some cases our honorary officers have a vehicle supplied by the service to drive. In other cases they will use their own car and simply be paged. Typically, at the same time as the 000 call comes in the operator who is aware of an honorary officer and sees that the honorary officer is closest will activate that officer. But at the same time they will activate a professional crew so the honorary can deliver initial treatment before the professional crew arrives. That is the way most schemes are working around Australia. For us that has been a little more ad hoc. You will find a variety of arrangements depending on local circumstances and the initiative of local communities. More recently we have standardised our approach with a new policy that has been endorsed by the board and has gradually been implemented. It will standardise the way we deploy and organise honoraries. It will standardise the level and quality of the training they receive so that we can be sure that they meet the minimum levels that we would require for an ambulance service response, both in terms of recruiting the individual from the community and also in keeping their skills current over the years as they train. They will be linked with a professional station to provide that. In the Murray area of the State we are developing a pilot with at least two communities which are developing these new schemes that will allow formally recognised and formally responding honoraries to be piloted.

Mr WHAN: Is that the same as the first response teams?

Mr ROCHFORD: Yes. There are effectively three levels. There is the first responder, who might typically be a community initiative. They might raise the funds for a defibrillator. There is a case of that at Branxton in the Hunter. The community has raised the funds for a defibrillator. They place it on the local volunteer fire vehicle and they get responded. It is a community initiative and we are happy to support it: we respond to them. The next level is people that we recruit for ourselves, train them to our honorary ambulance officer standards, which are typically a little higher than a first responder. They have a broader range of skills. They are the projects that we are trialling now in the Murray. Increasingly, in remote hospitals and communities where we do not have a presence the nurses or sometimes the maintenance staff will effectively provide an ambulance service to the community. Examples are Tibooburra and Wilcannia. Recently we have trained those people up to the same standard as well so that there is a consistent level of skill across the organisation. But there are at least

three different models that we will be employing, depending on the needs of the community and the availability of local resources.¹⁷

- 8.36 Providing an ambulance service to rural and remote areas is an important but difficult issue to resolve. As noted in the audit report NSW uses far fewer honorary officers than states such as South Australia and Western Australia.¹⁸

	NSW	Vic MAS	Vic RAV	Qld	WA	SA	Tas	ACT
Ambulance Officers	84	-	346	392	1,687	1,477	432	-

- 8.37 This comparative table, taken from the audit report, must be viewed carefully. The table shows 1,477 volunteer officers in South Australia and only 84 officers in NSW. Each Service provides vastly different services. The large figure of honorary officers in the South Australian Ambulance Service (SAAS) also reflects reliance on volunteer ambulance officers to undertake the majority of ambulance work. These figures also incorporate the temporary officers who share workloads in smaller areas which is a direct result of the voluntary nature of the work, and which can inflate the figures.

- 8.38 The challenges faced by other services in the use of honorary officers can be important knowledge for the NSW Service if it considers moving further down this path. In the Board meeting papers for July a number of concerns have also been raised by staff as a result of the Murray District Project. They include:

- Honorary officers becoming the “norm” across all regional stations;
- deployment practices for honorary officers will mean splitting crews, a reduction in call-outs and a delay in fulltime ambulance officer response times;
- a number of communities may perceive the concept of community first responders as a second rate service; and
- the possibility of introducing retained officers as financial incentive may produce a better service.

- 8.39 Reliance on volunteer officers in the SAAS drives intense community campaigns and regular events such as volunteer’s week that promotes the importance of service to the community. Strong grass roots committees negotiate perceived community needs and expectations with the Service’s ability to deliver a quality service. This leads to a

¹⁷ Transcript of Evidence 5/11/03, p 28

¹⁸ *Readiness to Respond*, p 92

¹⁹ *Ambulance Service Australia Report 1998-99*, The Convention of Ambulance Authorities (Table 3) as taken from the Audit Office of NSW, Performance Audit Report, *Ambulance Service of NSW: Readiness to respond*, p 92

situation as in the SAAS where it attempts to tailor the service to meet individual community needs.

- 8.40 Training honorary officers is an ongoing challenge. The clinical knowledge required of honorary officers in each state varies as does community expectations of training requirements and Service expectations. The SAAS is finding that the level of education that an honorary officer requires varies from community to community, and in accordance with expectations of the SAAS.
- 8.41 Maintaining volunteer numbers for the Service is an ongoing challenge due to the commitment to training that is required. It is understood that honorary officers in NSW receive four weekend training sessions. In comparison a volunteer in South Australia undergoes training in a Certificate IV in Community Studies (Volunteer Ambulance), which is the primary care course run over a 12-month period (one night a week and four weekends). It is undertaken through TAFE. Skills are updated through ongoing training and re-accreditations. Honorary officers are supplied with uniforms, educational texts equipment and child care subsidies.
- 8.42 The volunteer system in South Australia is designed so that volunteer officers undertake similar tasks to those performed by trained officers in NSW. The minimal training provided to NSW honorary officers reflects the level of care they are required to provide. The role of the honorary officer is aimed at rapid first response, basic care and assessment of a situation to report back to the operations centre so that an ambulance or other response such as air ambulance can be provided if required.
- 8.43 The HSU has opposed the further use of honorary officers in NSW mainly on the grounds of the quality of clinical care that can be provided under current training arrangements.
- 8.44 The HSU has also made strong allegations concerning the proposed use of honorary officers in rural and regional NSW. The HSU alleged that the Service had provided inaccurate population statistics that under estimates the identified populations to be serviced and incorrect establishment figures for individual stations. It also alleges there was inadequate data to accurately provide certainty about rescue activity, hospital patient transport figures and seasonal variations in patient numbers.²⁰
- 8.45 The HSU provided the Service with a draft proposal for minimum requirements for the fit out and equipment of proposed honorary appointees.
- 8.46 If the Service wants to pursue the use of honorary officers, as a first step in attracting honorary officers, the Service should foster community enthusiasm to participate in education programs such as

²⁰ Submission by the HSU, Appendix F

the services in Queensland and South Australia do. The Annual Report of QAS stated that one of its objectives for the year is:

continuing to increase the number of people participating in community education programs through targeted marketing campaigns.²¹

8.47 The Committee would encourage community education as a pathway to involvement in the Service and as a means of attracting Honorary Officers in the long term.

8.48 The SAAS also has a volunteer website. The inclusion of a volunteer section on the Service's website would be another way to encourage the community to find out more about the functions of the honorary scheme in NSW.

RECOMMENDATION 8: The Service use the experiences in other States as a model for the recruitment and management of honorary officers.

8.49 The work of communications staff is vital in assessing and advising in the initial response to emergency calls, often in emotionally charged situations. The implementation of AmbCAD further utilises their specialist skills. Communications staff identifies the severity of a situation so that the appropriate team can be deployed to assist. They have an important role to play in increasing response times. The annual report noted that community satisfaction with communications staff was 96.8%.²²

8.50 Some civilians are recruited into the service as communications staff. The development of the team-based approach to staffing through the management restructure should assist in recognising their contribution to the team.

8.51 Further, management training should include a section that redresses perceived hierarchies of importance of uniformed officers compared to civilian employees. The Committee also would agree with the audit report recommendation that specialist communication skill levels should be recognised through appropriate remuneration.

²¹ Queensland Department of Emergency Services, *Annual Report 2001/2002*, p 33

²² Ambulance Service of NSW, *Annual Report 2002/03*, p 59

Chapter Nine - Recommendation 8: Continue to place a high priority on addressing issues relating to culture and ethics

INCREASE ETHICS TRAINING AND AWARENESS ACTIVITIES

REVIEW AND UPDATE PREVIOUS RISK ASSESSMENTS AND CONTROL REVIEWS, INCLUDING APPROVAL OF OVERTIME

The Audit Report

- 9.1 A number of written allegations of corruption were received by the Audit Office, members of Parliament and the ICAC prior to and during the performance audit.¹ Some of the allegations centred around robbing on rosters and planned and unplanned overtime to benefit a small group of officers. As they were pertinent to the issue of response times they were included in the report.
- 9.2 Overtime expenses in 1999-2000 represented 14% of the total employee related expenses. The cost of overtime was attributed to a number of factors including fluctuating and growing demand, limited resources and the effects of being unable to deploy resources adequately to match workload patterns.
- 9.3 The audit found that payroll information about caseload, overtime and call-outs, although accessible, was difficult to obtain. This was coupled with communication difficulties between area and operations management where Operations managers were not making available reports to area management regarding approval for overtime:
- Area management have all the information necessary to organise, verify and approve claims for planned overtime. However, most area Managers interviewed by the Audit Office indicated that they did not receive timely information on the unplanned overtime which has been authorised by the Operations Centres. This relates to issues such as shift extension, late meals or callouts. Area Managers were thus sometimes unable to approve timesheets.²
- 9.4 The Audit Office also found that neither area or operations managers were fully providing timely and accurate authorisation of all overtime. Although there were checking systems in place, they were not followed adequately, nor were either managers accepting accountability for verifying unplanned overtime payments.³
- 9.5 The Audit Office suggested:

¹ *Readiness to respond*, p 16

² *Ibid*, p 84

³ *Ibid*, p 84

- establishing processes to ensure equity in the distribution of overtime,
- investigate the processes in place by other services with regard to overtime; and
- overtime rosters should be openly displayed for all staff to view.

Action Taken

9.6 The Service called the ICAC to carry out a *Corruption Resistance Review*. The review made recommendations to be implemented from 2001 – 2003. They include:

- Corruption risk management
- Corruption prevention strategies
- Internal reporting and investigation
- Complaints handling
- Internal audit
- Code of conduct
- Conflict of interest
- Gifts and benefits
- Secondary employment
- Training and development
- Recruitment and selection

9.7 The Service nominated several activities to manage serious conduct and disciplinary matters in accordance with the Service's internal policies and the ICAC report and working with operational and corporate managers. They include:

- Corruption resistance review
- Training staff in ethical conduct
- Drug and alcohol policy
- Training for managers by the Health Care Complaints Commission
- Anti-Harassment training

9.8 The Professional Standards and Conduct Unit was established in 1999 to oversee the planning, implementation and evaluation of strategies to improve ethics. The submission noted that this unit has minimised the instance of complaints going offsite to the ICAC – a sign that:

Individuals are confident that the Service will itself properly investigate and deal with complaints in a fair, expeditious and professional manner.⁴

⁴ *Ibid*, p 106

9.9 The Service added:

As a measure of the progress made in this area, the Service has been advised by ICAC that routine monitoring of corruption matters will cease and the Service is no longer required to provide regular reports.⁵

9.10 The submission from the Minister for Health stated that Deloitte Touche Tohmatsu was appointed in 2001 to review the Service's internal audit services and to prepare a revised audit plan. This revised plan has been overseen by the Service's Audit Committee. It includes review of overtime authorisation, time sheets, workers compensation claims, revenue and debtors, and general IT controls. Progress in each area is reported to the Audit Committee each quarter.

9.11 Deloitte Touche Tohmatsu then adapted the Treasury and Standards Australia risk management guidelines and undertook a risk assessment review of the Service's activities. The consultants then prepared a risk management plan for the Service.

9.12 The business risk assessment is now the basis for the development of a risk assessment model.

Discussion

9.13 ICAC's decision to cease monitoring the Service indicates that the Service has been active in addressing the concerns of the ICAC and has developed adequate responses to address ethical problems. The Committee also notes the inclusion of the Professional Standards and Conduct Unit in its Annual Reports. The Service has been transparent in publicising the types and numbers of matters resolved by the unit in its 2002/03 Annual Report.⁶ The provision of the table of matters assists the Service in identifying any patterns and deficiencies, which then may be addressed by proactive planning and training. The Committee strongly supports the continued training provision in ethical standards.

9.14 Overtime is still a major expense for the Service. In its report to the Board the Service indicated that:

Overtime expense is \$4.5m (13%) unfavourable to budget, which is an improvement of \$2.6m during June. The overtime budget was enhanced in June by supplementation of \$3.0m for the Financial Framework. The June results also reflect the continued reduction in overtime hours worked, especially in Sydney Division. The May projection for Sydney overtime of \$3.5m was achieved.

9.15 There has been a small reduction in overtime expenses. This may be partly due to the increase in staff numbers particularly in regional centres, where overtime was an issue, and changes to rostering systems to match workload and caseload. (These issues were more fully discussed in chapters five and six). The continued expense incurred in

⁵ Submission by the Ambulance Service of NSW, p 3

⁶ Ambulance Service of NSW, *Annual Report 2002/03*, p 30

overtime identifies this as an area where risk management strategies should be focused.

- 9.16 The Service's Audit Committee is charged with risk management in relation to such matters as authorising overtime. It is also encouraging to note that in evidence that the Auditor-General stated:

The Department of Health is no longer represented on the audit committee because, I understand, it considered that the organisation had reached a sufficient state of maturity and understanding of governance issues that it could operate its own audit committee.⁷

- 9.17 It appears from this statement that the Audit Committee is capable of monitoring rostering and overtime.

- 9.18 In addition, s.18 of the new draft enterprise agreement outlines the proposed conditions in relation to work roster.⁸ It states that rosters should be displayed seven days before the roster commences with the proviso that circumstances outside the control of the Service may alter the displayed roster. Section 18 also states that rosters are to show any allocated days off and shift workers working the same roster are to provide for a fair distribution of weekend work.

- 9.19 This agreement demonstrates that the Service is providing transparent management decisions regarding rostering and, where possible, overtime. The Committee suggests that wherever possible all overtime should also be clearly displayed and should form part of the enterprise agreement.

- 9.20 The Committee acknowledges that the Service is attempting to address overtime problems. However, the budget deficit in overtime indicates that more has to be done. These steps include minimising the substantial reasons for overtime and then limiting the potential for unfair rostering practices.

⁷ Transcript of Evidence 5/11/03, p 3

⁸ Ambulance Service Operational Officers (State) Award Draft 2, 3 December 2003 – without prejudice HSU copy, pp 14-15

Chapter Ten - The value of the audit report, in terms of accountability and in improving the performance of government.

ACCOUNTABILITY

- 10.1 On an examination of the report, the Committee has come to the conclusion that the Audit Office effectively held the Ambulance Service to account. In particular, the Committee notes the thorough analysis of performance indicators in chapter two of the audit report. Another indicator of the effectiveness of the report in holding the Service to account is that the Service generally supported the report's findings and recommendations.
- 10.2 In terms of future reports, the Committee came to the view that there are a number of ways in which the report could have better held the Service and other key players to account. The matters are discussed below for the Audit Office's consideration.

Change in Scope

- 10.3 The original objectives and scope of the audit report were designed to examine the efficiency and effectiveness of staff deployment practices to meet variations in demand. The original objectives and scope of the audit were identified as:
- clarity of accountability within the management structure
 - comprehensiveness and effectiveness of management information reporting and follow-up
 - flexibility of staff deployment and resource allocation practices.¹
- 10.4 During the course of the audit other issues emerged that appeared to the Audit Office to impact on the Service's ability to use its resources effectively and efficiently:
- the health system and hospitals can have a significant effect on the Service's ability to respond. Issues include: the level of access to emergency departments; non-emergency transport; and nurse escorts
 - the Service's clinical structure and relationships have a critical influence on staff deployment practices and performance.²
- 10.5 As a result the Audit Office significantly broadened the scope of the performance audit report to include these extra matters. This widening of scope was discussed in the report.
- 10.6 In the 2003 *Triennial Review of the Audit Office of New South Wales* the independent reviewer, Acumen Alliance, agreed that the Auditor-General could expand the scope of a performance audit. Such changes

¹ *Readiness to Respond*, p 14

² *Ibid*, p 15

however, should be explained in the audit report. The report recommended:

Changes in scope during an audit be clearly identified and explained in the final audit report.³

10.7 The Auditor-General did not accept the recommendation:

Parliament has given the Auditor-General the right to determine the scope of performance audits undertaken without having to justify his decisions. It is therefore illogical to require him to justify any changes to the scope that become necessary during the course of the audit.

However any changes are always discussed with the agency concerned.⁴

10.8 The reviewer, in support of the recommendation responded:

As we state in our report, the issue here is one of effective communication. Whilst recognising that Parliament has given the Auditor-General the right to determine the scope of performance audits undertaken without having to justify his decision, to drive change in government, it is our professional opinion that an Agency needs to have ownership in any audit undertaken within its organisation. As an organisation that sees its role as assisting in improving accountability in government, we find it somewhat interesting that the Audit Office is not prepared to clearly identify and explain in the final audit report, for sake of clarity to the reader, where changes in scope have been made and why.⁵

10.9 The Committee supports the review recommendation. The Committee, as a user of the report, believes this type of context is useful. In most cases, an expansion of scope would suggest that following preliminary work, the Audit Office found considerably more issues in the agency than initially expected. The Committee would generally support a change of scope of these grounds, and is interested to learn when it occurs because it adds detail to understanding of the process of accountability.

10.10 The Audit Office explained the change of scope in the audit report and the Committee would encourage the Audit Office to continue this practice.

<p>RECOMMENDATION 9.1: The Audit Office should clearly identify and explain any changes in the scope of a performance audit in the final audit report.</p>

Supporting Information and Context

10.11 In outlining the structure and methodology of the report it was stated:

the report seeks to serve as a catalyst to provide insights into the nature of existing difficulties and the means by which they might be addressed.⁶

³ Public Accounts Committee, *Review of the Audit Office under section 48A, Public Finance and Audit Act 1983*, November 2003, p 33 – recommendation 22

⁴ *Ibid*, p 33

⁵ *Ibid*, p 34

⁶ *Readiness to respond*, p 15

- 10.12 The report then went on to identify the research avenues it explored to reach its conclusions. These included relevant documentation, site visits and interviews of Service staff, consultation with Health and hospital management as well as interstate visits to ambulance services.⁷
- 10.13 Conclusions from discussions in the report were generally based on well-researched facts and evidence such as in Chapter Two of the audit report, which analysed the performance of the Service. In other cases, such as the discussion of the adequacy of information provided to the Board, information is less detailed.
- 10.14 The Committee believes that clarity of information is fundamental to performance audit reporting. Not only is it a public resource document, the report also serves as a starting point for agency reforms.
- 10.15 Further, performance audits are a less objective process than financial audits, which are backed by a complex and lengthy set of accounting and auditing standards and guidance statements. The performance audit standards are by their nature subjective and must be applied to a wide range of activities in the public and private sector. Hence, the Committee would encourage the Audit Office to maximise the persuasive power of its performance audit reports. This would place greater onus on agencies to implement the recommendations and assist the Committee in follow-up inquiries.

RECOMMENDATION 9.2: The Audit Office ensure the findings and recommendations clearly demonstrate the factual evidence and context, particularly in the absence of agency agreement with a performance audit report.

Communication with External Stakeholders

- 10.16 The Auditor-General identified inflexible work practices as a major issue. The report included a recommendation that the Award be made more flexible. This finding and the Audit Office's lack of communication with the HSU during the audit were elaborated in the evidence:

Mr McLEAY: What discussions did you have with the union about [the audit]?

Mr SENDT: We had discussions with many people within the Ambulance Service, and one of the things that we became aware of was that many of the people in the middle management area of the service were also Health and Research Employees Association [HREA] representatives, so certainly we got the views.

Mr McLEAY: Were you speaking to them as HREA representatives, or as middle managers?

Mr SENDT: We were speaking to them as middle managers. I think part of the problem that the Ambulance Service may have had, though, was that

⁷ *Ibid*, p 15

because this middle management layer had a strong union level of activity, they felt constrained in the extent to which they could discuss options with those managers and the extent to which they could roll out reforms in an open and transparent way. We did not have any discussions formally with the union, as such. That is not a practice that we generally do. Anybody can make a submission to us during the course of the audit. HREA did write to us after the report came out. They took some exception to what we had said but we believe that what we had said was genuine.

Mr PAUL McLEAY: Having said that, though, and the fact that you noted earlier on what you perceived as high union activity, should you not have broadened it out and spoken to that stakeholder?

Mr SENDT: Perhaps we could have, but we took the view that we were getting quite a deal of input from people on the ground who were seeing the issues we were concerned about—response times, flexibility and resource allocation.

Mr HORNE: It was very clear when we were doing the rounds—we went around a lot of the country areas and metropolitan areas and spoke to many, many people, over 80—that we had got in contact with the union people because they were threaded through the organisation very strongly. When they were speaking to us, it was quite apparent that they were telling us what they thought as a person, not necessarily as a manager or as a union representative, but as someone who worked in the place and knew what the issues were. So I think that we got a very clear view of what the position was. We did not get formal representation on behalf of the union but the review was very well known. As you can imagine, in an organisation like that, the audit was very, very well known. The union is well structured and well organised there, and it surprised me somewhat that they did not make a submission to us during the course of the audit, which went for quite some time. But they chose not to.⁸

10.17 In evidence the HSU stated its position in relation to the Auditor-General's findings and recommendations in the report:

Mr WILLIAMSON: I would like first to thank the Committee for the opportunity to speak today in relation to the audit report. This is the first occasion we have had the opportunity to speak to any committee relative to response times in the Ambulance Service. Having said that, I would be remiss if I did not add that in our submission you will note that there would appear to my union to have been a perception by the Auditor-General that we were some form of blockage within the Ambulance Service, that the union was out of step with what was required in terms of delivery of response times within the Ambulance Service, and that the award under which we work is deemed to be inefficient in terms of the Ambulance Service. ...

...When the report was released that was the first occasion that we knew that the Auditor-General was undertaking a review of response times. We were never written to to ask our comments. We are a major stakeholder in the Ambulance Service in terms of our membership. I represent 2,500 ambulance officers in New South Wales and I thought it would have been only fit and proper that we would have been requested to make a

⁸ Transcript of evidence 5/11/03, p 7

submission. Whether the Auditor-General has said that it was advertised or whether it was not I am uncertain; all I know is that based on the membership I have, I am sure one of them would have been able to tell me that something had been advertised somewhere in terms of a review into response times. As I said at the beginning, when we became aware of the report I observed the many recommendations but the one clearly aimed at us was that the award was inefficient, that the union was unwilling to negotiate in terms of the award. To this day we have not had one shred of evidence put before us from either the Auditor-General or the Ambulance Service of New South Wales as to where the award is inefficient. We have appeared before the New South Wales Industrial Commission. We have asked the question of the Ambulance Service where it can identify that the award is inefficient and where we have failed to assist it or to work with it. The evidence in the commission on the transcript is that there is none.⁹

10.18 Under section 38C of the *Public Finance and Audit Act 1983*, the Auditor-General is required to consult with relevant agencies before finalising a performance audit report. Although no such obligations exists in relation to external stakeholders such as unions or businesses, the Committee would encourage the Audit Office to consult at a suitably senior level with these groups where they are directly involved in a report. These communications would allow facts to be double-checked and would be consistent with the principle of natural justice. The National Audit Office in the UK conducts such consultations.

RECOMMENDATION 9.3: The Audit Office consult with organisations to ascertain their point of view prior to making findings or recommendations that directly affect them.

10.19 The report was also written to be available to the general public and as a reference work. With this in mind the report should aim to be easily accessible, which would make it more effective in holding the Service to account. Recommendations were listed in the front of the report, but were not provided in the text. The order in the list did not always reflect the order of discussion in the report. Hence, the Committee found that matching recommendations with discussions on specific topics was time consuming. It is suggested that recommendations be placed at the point where the discussion originates. Recommendations should remain in the front of the report but a page reference to the particular discussion area should be included. This is the practice of the National Audit Office.

RECOMMENDATION 9.4: Recommendations be placed in the body of the report immediately after the discussion of the issues which raise the recommendation. Recommendations should remain at the front of the report but include a page reference to match the relevant discussion in the body of the report.

⁹ *Ibid*, p 10

PERFORMANCE

- 10.20 In evidence, the Audit Office noted that the key indicator for the Service is response times. This follow-up report ascertained that the service has shown commitment to improving response times. For example response times data from 2000-01 to 2001-02 have shown an improvement from 47.6% to 52.8% of meeting responsiveness targets. This was due to roster changes being made for the Sydney region and suggests the audit report had an impact on the ability of the Service to implement change. However, in the 2002-03 Annual Report there was only an improvement of 0.3% to 53.1%. This could indicate that the improvement in response times has plateaued. It may also be that other factors are impacting on the ability of the Service to improve response times such as increases in workload and the continual deterioration in hospital delays.
- 10.21 Although the Service has made significant reforms in some areas the follow-up report has clearly shown that the Service still needs to improve its performance in relation to response times. Another reason that the Service's performance has plateaued may be related to the fact that much of the audit report recommendations still need to be implemented. Direct comparisons of response times are problematic in that other states use different data to that used in NSW. Nevertheless, it should be noted that there is still a significant gap between NSW's performance and that of the leading states.
- 10.22 In conclusion, the Committee notes that the audit report led to a significant initial improvement of the Service's performance. The audit report, however, is still relevant to the Service. The Committee would encourage the Service to continue to address the report and discuss the audit in its Annual Report.

Appendix One - Submissions and documents received by the Committee

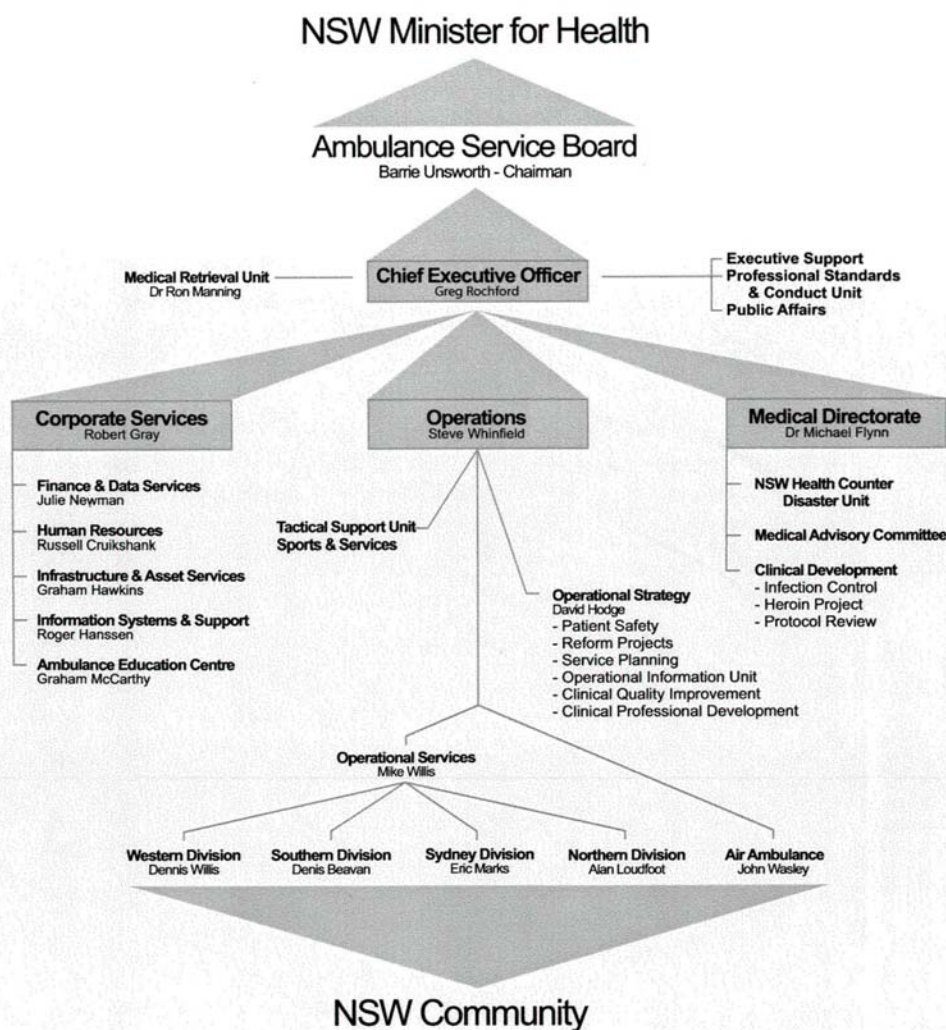
No	Provided by	Subject
1	Mr R J Sendt Auditor-General	Submission in response to Terms of the Inquiry
2	The Hon Frank Sartor, MP Acting Minister for Health	Submission in response to Terms of the Inquiry
3	Mr Michael Williamson General Secretary Health Services Union	Submission in response to Terms of the Inquiry
4	Mr Greg Rochford CEO Ambulance Service of NSW	Submission in response to Terms of the Inquiry
5	Mr Steve Whinfield Acting CEO Ambulance Service of NSW	Supplementary Submission relating to issues raised in the public hearing on 5 November 2003
6	Mr Frank Fitzgerald	Submission in response to Terms of the Inquiry

Appendix Two – List of witnesses at Hearing

Wednesday, 5 November 2003

Organisation	Representative
Audit Office of NSW	Mr Bob Sendt Auditor-General Mr Stephen Horne Director, Performance Audit
Health Services Union	Mr Michael Williamson General Secretary Mr Dennis Ravlich, Manager, Industrial Services Mr Sean O'Connor Councillor, Health Services Union and Advanced Life Support Officer
NSW Health	Mr Gregory Rochford Chief Executive Officer, Ambulance Service of NSW Ms Deborah Green Chief Executive Officer, South Eastern Sydney Area Health Service Mr Steven Whinfield General Manager, Operations, Ambulance Service of NSW

Appendix Three - Organisational Structure for the NSW Ambulance Service



Appendix Four – Hospital diversion verification form



EMSC OGP 115-01, APPENDIX C
January 16, 2003

HOSPITAL DIVERSION VERIFICATION FORM

HOSPITAL INFO:

Hospital Name: _____	Hospital Number: _____
Administrator Name: _____	Title: _____
Administrator on Authorized List? <input type="checkbox"/> YES <input type="checkbox"/> NO	Phone: _____
Diversion Request Type: _____	Date: _____
Time Diversion Requested To: _____	Time: _____ <small>(Time Call Received)</small>
Number of Patients: <i>Awaiting Admission</i> _____ <i>Awaiting Evaluation</i> _____	
Sufficient Staffing in E.D.: <input type="checkbox"/> YES <input type="checkbox"/> NO	If NO, Normal Complement: _____
	Present level: _____
Sufficient Stretchers in E.D.: <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, Number: _____
Sufficient Monitors: <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, Number: _____
Any Other Circumstances: <input type="checkbox"/> YES <input type="checkbox"/> NO	

STATUS OF AREA HOSPITALS IN HOSPITAL GROUPING:

	<u>NAME OF HOSPITAL</u>	<u>NO.</u>	<u>STATUS</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

REQUEST AUTHORIZATION:

Citywide Dispatch Supervisor: _____	Shield #: _____
Chief Officer on Call: _____	
Diversion Status: <input type="checkbox"/> Granted <input type="checkbox"/> Denied <input type="checkbox"/> _____	
Other: _____	
Specify Type Granted: _____	
Diversion Time: _____ (Actual Time Hospital) _____ (Actual Time Hospital) _____ (Total of Time)	
Authorized By: _____ <small>(Citywide Dispatch Supervisor Signature Required)</small>	

Note: Place all comments on rear of sheet

Over

- DIRECTIONS:**
1. **OPERATORS** Will Complete all sections of this form.
 2. Forward Completed form to Citywide Dispatch Supervisor.
 3. **CWDS** Will review and sign form.
 4. Forward original form to the **COMMANDING OFFICER** for distribution.
 5. INCOMPLETE FORM WILL BE RETURNED..

EMSC 115.01.01(01/03)

Appendix Five – Minutes of Proceedings



LEGISLATIVE ASSEMBLY
PUBLIC ACCOUNTS COMMITTEE

Minutes of Proceedings of the Public Accounts Committee

Wednesday 2 July 2003 at 9.30am
Room no 1254 Parliament House
Meeting 4/2003

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian, Mr Turner and Mr Torbay

Apologies

No apologies

Follow ups of Auditor General's Reports

Resolved on the motion of Mr Turner and seconded by Mr McLeay:

“That the Committee commence an inquiry to examine the Auditor General's performance audits into the Ambulance Service: response times (March 2001) and Academics' Paid Outside Work (February 2000) according to the following Terms of Reference:

3. Implementation of the report's recommendations; and
4. The value of the audit report, in terms of accountability and in improving the performance of government.”

The Committee adjourned at 10:00am until 9:00am on Tuesday 15 July 2003.

Chairman

Committee Manager



Minutes of Proceedings of the Public Accounts Committee

Tuesday, 15 July 2003 at 9.00 am

Meeting No 5/2003

Parliament House (Jubilee Room)

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian, Mr Turner and Mr Torbay

Apology

No apologies

Correspondence

To write to the Auditor-General to inform him the Committee are:

- Commencing inquiries into *Universities: Academics' Paid outside work* and *Ambulance Service of NSW: response times*

The Committee adjourned at 3.15pm.

Chairperson

Committee Manager



LEGISLATIVE ASSEMBLY
PUBLIC ACCOUNTS COMMITTEE

Minutes of Proceedings of the Public Accounts Committee

Thursday, 28 August 2003 at 1.15pm

Meeting No 6/2003

Parliament House (Library Meeting Room)

Members Present

Mr Brown, Mr Whan, Ms Berejiklian and Mr Turner

Apologies

Mr Paul McLeay, Mr Richard Torbay

Future hearing dates:

Resolved on the motion of Ms Berejiklian and seconded by Mr Whan:

“That the Committee advise the secretariat of available hearing dates for inquiries in October November and December.”

That the Committee decide at the next meeting on 3 September 2003 to prioritise either the Academics’ Paid Outside Work or Ambulance Response Times follow up inquiries.

The Committee adjourned at 1.55pm.

Chairman

Committee Manager



Minutes of Proceedings of the Public Accounts Committee

Wednesday, 17 September 2003 at 9:00am

Meeting No 8/2003

Parliament House – Room 1254

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian and Mr Turner

Apologies

Mr Torbay

Inquiries

- a. Inquiry into Academics' Paid Outside Work and Ambulance Response Times:
Resolved on the motion of Mr Turner and seconded by Mr Whan:
"That the Committee prioritise the Inquiry into Ambulance Response Times."
- b. Hearing dates
Resolved on the motion of Mr Turner and seconded by Mr McLeay:
"That the confirmed hearing dates for October and November are:
23 – 24 October, 31 October, 5 November, 21 November, 26-27 November 2003."

The Committee adjourned at 10:05am until Wednesday, 15 October 2003 at 9:00am.

Chairman

Committee Manager



LEGISLATIVE ASSEMBLY
PUBLIC ACCOUNTS COMMITTEE

Minutes of Proceedings of the Public Accounts Committee

Wednesday, 15 October 2003 at 9:00am

Meeting No 9/2003

Parliament House – Room 1254

Members Present

Mr Brown, Mr Whan, Ms Berejiklian, Mr Turner and Mr Torbay

Apologies

Mr McLeay

Auditor-General

Mr Bob Sendt, NSW Auditor-General and Mr Stephen Horne, Director Performance Audit were admitted. They discussed with the Committee matters regarding...the follow up of the performance audit on the Ambulance Service.

The discussion completed, Mr Sendt and Mr Horne withdrew.

Upcoming events, Date, Time and Venue

The Committee noted the schedule of hearings, times and dates.

Resolved on the motion of Ms Berejiklian and seconded by Mr Whan:

“That the Committee conduct a site visit in Sydney, of the Ambulance Service, on 31 October 2003.”

The Committee adjourned at 9:50am until Thursday, 23 October 2003 at 9:30am.

Chairman

Committee Manager



Minutes of Proceedings of the Public Accounts Committee

Wednesday, 5 November 2003 at 11.30 am

Meeting No 13/2003

Parliament House – Room 814/815

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian and Mr Torbay

Apology

Mr Turner

Public Hearing

The Committee commenced its hearing of the Inquiry into Ambulance Response Times.

The public was admitted.

Audit Office

Mr Bob Sendt, Auditor-General, was affirmed and examined.

Mr Stephen Horne, Director, Performance Audit, was sworn and examined.

Evidence completed the witnesses withdrew.

Health Services Union

Mr Michael Williamson, General Secretary, was sworn and examined.

Mr Dennis Ravlich, Manager, Industrial Services, was sworn and examined.

Mr Sean O'Connor, Councillor, was sworn and examined.

Evidence completed, witnesses withdrew.

Ambulance Service of NSW and NSW Health

Mr Greg Rochford, Chief Executive Officer, was affirmed and examined.

Mr Steve Whinfield, General Manager, Operations, was affirmed and examined.

Ms Deborah Green, Chief Executive Officer, Eastern Sydney Area Health Service, NSW Health, was affirmed and examined.

Evidence completed, the witnesses withdrew.

Transparency International

Mr Peter Rooke, Director of Projects, was affirmed and examined.

Evidence completed, the witness withdrew.

The Committee adjourned at 3:40pm until Wednesday, 12 November 2003 at 9:00am.

Chairman

Committee Manager



LEGISLATIVE ASSEMBLY
PUBLIC ACCOUNTS COMMITTEE

Minutes of Proceedings of the Public Accounts Committee

Wednesday 12 November 2003 at 9.00 am

Meeting No 14/2003

Parliament House (Room No.1254)

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian, Mr Turner and Mr Torbay

Inquiries

Submissions on the Internet

Resolved, on the motion of Mr Berjiklian, seconded by Mr Whan:

“That the Committee approve the publication of submissions for the:

- Inquiry into Ambulance Response Times;
on the internet.”

The Committee adjourned at 9:50 am until Wednesday, 19 November 2003 at 9:00 am.

Chairman

Committee Manager



Minutes of Proceedings of the Public Accounts Committee

Wednesday, 3 December 2003 at 9:00am

Meeting 19/2003

Room 1254, Parliament House

Members Present

Mr Brown, Mr Whan, Ms Berejiklian and Mr Torbay

Apologies

Mr McLeay and Mr Turner

Inquiry into Ambulance Response Times

Submission received from Mr Frank Fitzpatrick.

Resolved on the motion of Ms Berejiklian and seconded by Mr Whan:

“That the Committee approve the publication of the submission on the Internet once Mr Fitzpatrick has received the letter of acknowledgement.”

The Committee agreed to send a copy of Mr Fitzpatrick’s letter to the CEO of the Ambulance Service, once it had been published.

The meeting adjourned at 9:50am until Wednesday, 18 February 2004.

Chairman

Committee Manager



LEGISLATIVE ASSEMBLY
PUBLIC ACCOUNTS COMMITTEE

Minutes of Proceedings of the Public Accounts Committee

Wednesday, 18 February 2004 at 9:00am

Meeting 1/2004

Room 1254, Parliament House

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian, Mr Turner and Mr Torbay

Inquiry into Ambulance Response Times

Publication of corrected transcript of evidence.

Resolved on the motion of Mr Torbay and seconded by Mr Turner:

“That the Committee approve the publication of the corrected transcript of evidence for the inquiry hearing of 5 November 2003.”

The meeting adjourned at 9:50am until Wednesday, 25 February 2004.

Chairman

Committee Manager



Minutes of Proceedings of the Public Accounts Committee

Wednesday, 25 February 2004

9:00am

Room 1254, Parliament House

Meeting 2/2004

Members Present

Mr Brown, Mr McLeay, Mr Whan, Ms Berejiklian and Mr Turner

Apology

Mr Torbay

Inquiry into Ambulance Response Times

Supplementary submission received from Mr Steve Whinfield, Acting Chief Executive Officer, Ambulance Service of NSW.

Resolved on the motion of Mr McLeay and seconded by Ms Berejiklian:

“That the Committee approve publication of the submission on the Internet, except the Board papers, once Mr Whinfield has received the letter of acknowledgement.”

The meeting adjourned at 10:00am until Wednesday, 10 March 2004.

Chairman

Committee Manager