Submission
No 38

REVIEW OF THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE INQUIRY INTO THE MANAGEMENT AND OPERATIONS OF THE AMBULANCE SERVICE OF NSW

Name: Name suppressed

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NSW Upper House General Purpose Standing Committee Number 2

Subject: **Submission to Review of Ambulance Inquiry Recommendations**

Please accept this abbreviated submission on various aspects of the Ambulance Service following the 2008 Inquiry. The timing of this review, over Christmas and New Year has prevented me from making a more detailed submission and from providing references and attaching evidence before today's deadline.

I would be pleased to expand on any of the following points if desired and can be contacted as above.

I have attempted to align comments to the recommendations however further, unedited comments appear at the end.

I would be grateful for my details to be suppressed.

Ambulance Officer

Recommendation 7 *ASNSW should create and distribute one-page, plain-English fact sheets on grievance management and disciplinary matters.*

This was circulated, and will probably be useful to officers who may wish to engage in this process, however I have not met an officer who hasn't commented that there is no point as nothing seems to be achieved by submitting grievances.

Recommendation 8 *Contact officers should be available within the ASNSW to provide impartial advice to staff on grievance and complaint policies and procedures.*

At January 2010, no one has heard of the existence of such officers.

Recommendation 9 *Review selection processes*

I have no idea what review might have taken place but one outcome seems to have been that the interview 'panel' for new trainee applicants has been reduced from 3 persons to a single officer. An officer who was on such a selection 'panel' complained to me that this is open to abuse on both sides. Having only one person decide on the worthiness of an applicant is not a transparent process, and also leaves the interviewer open to false accusations should an applicant decide to claim that he or she was unfairly treated. There is also a personal safety issue with a one-on-one interview.

Recommendation 11 *Officers who undertake responsibility for training and supervision should receive recognition or incentives.*

The government's response clearly indicates that there is no intention to comply with this recommendation in regard to the on-road training of new officers and, indeed, no positive change has occurred. Ambulance Officers are routinely required to mentor trainees for weeks at a time, without regard to the training ability of the mentor, nor whether the senior officer is interested in undertaking this role.

There is no recognition or reward for those who hold qualifications in training.

For those that carry the significant burden of sole responsibility for all decisions and actions by the two-officer team, there is neither financial incentive nor even recognition by title. In the past, those who trained probationary officers were known as "Training Officers" and, for some years "Inservice Instructors", however these titles are no longer used officially, as the Service likely wishes to avoid any potential claims for an appropriate allowance to be provided.

In the past, the Service provided a 2-day "Instructional Techniques" course to assist officers who were Inservice Instructors to provide the best guidance that we could for our trainees. No such training now exists for those who mentor trainees.

The Service may boast that it has employed Clinical Training Officers and that Station Managers are involved in the training process however the reality is different. S/Ms have little contact with their staff as high workloads mean that officers are rarely on station during the times S/Ms are available, and CTOs are rarely seen unless dealing reactively with a problem.

On-road Officers who are required to train probationers are not reviewed routinely at any regular interval, let alone six-monthly. The Service would be very reluctant to identify poor performance in this area as removing a senior officer from a training role would simply reduce the number of potential supervisors for trainees. There are already insufficient senior officers available to train probationers so it is still common to see a Level 1 trainee partnered with a Level 2 'Intern".

In fact, the Service is very reluctant to identify poor performance by any of the officers who mentor trainees. To do so would highlight that, as one officer put it, "we are not trained, paid or equipped to train probationers, so how can I know if I'm doing it right?"

When it comes to rostering, having a 'bum on a seat' is all the Service aims to achieve.

I know a number of senior officers who now flatly refuse to be rostered with a probationer because they have become burnt out by having carried the extra responsibility and stress of doing so over many years, with not one cent extra in their pay packets, or appreciation for doing so.

In addition to this, many have commented that the quality of trainees has deteriorated in recent years. Once, there were ten applicants for each Trainee Ambulance Officer position. I understand that we now struggle to find sufficient applicants who meet the selection criteria. The job of training probationers has therefore become harder than ever, yet senior officers are less equipped than ever for this role.

Despite the value and trust the community has in our work, it is probably more attractive to anyone interested in a career in the emergency services to apply to the NSW Fire Brigades where they can receive a higher base rate of pay for a fraction of our workload and responsibilities.

Recommendation 12 *Stream 1 (traditional recertification training) should remain available.*

I believe this recommendation *has* been implemented however there are extremely few officers who realize that Stream 1 is still available. Most have been told, verbally, that they are not entitled to go back to Stream 1 for reasons such as their employment date. The Service continues to allow a serious level of misinformation to prevail in order to keep officers in the CTP (Stream 2) process whereby they take responsibility for their own training and have to undertake more studies in their own time.

Recommendation 13 *Regular, paid training times be incorporated into rosters so that paramedics can meet with CTOs for uninterrupted training.*

Apart from the new recertification system that will see officers attend "recert" once every 18 months (Recommendation 14), there is no provision for training within each roster projection. Indeed, the Service now even limits officers providing police statements to 30 minutes, so setting aside time for "uninterrupted training" is out of the question.

Regular training days are still incorporated into Special Operations rosters, as they were for Rescue Officers, however these officers represent a very small minority of ambulance staff.

Recommendation 15 *Annual performance appraisals for all on-road officers*

While this recommendation has not been implemented as yet, it will be interesting to see what elements would be used for appraisals for on-road staff. The recent appearance of a poster of the Service's "Values" might suggest what is to come. The poster is nothing more than a list of expected behaviours and includes a number of direct instructions not to be critical of the Service or managers.

Recommendation 16 *The ASNSW should ensure that CTOs follow up all ambulance officers in an appropriate manner after the distribution of updated protocols in order that officers understand the changes.*

The government's 'response' document accurately describes how this recommendation is being ignored. The Service feels it has fulfilled its obligations simply by issuing protocol updates, yet there is no follow up by anyone to see if officers understand the changes. Most officers have little time to read lengthy updates during work hours and misinterpretation is common as it is up to the individual to interpret correctly the wording.

Even significant matters such as changes to drug packaging and strength are not followed up with any face to face training.

CTOs are certainly provided *after* officers make mistakes but this does not seem to have been the intent of the recommendation.

Recommendation 17 *Explore the option of national registration*

The Government's 'response' sidesteps this issue by using the AHMAC criteria as an excuse not to work towards national registration. Since the Australian Health Ministers' Advisory Council is a government body, there is no reason why Health Ministers could not move towards national registration of paramedics. Since we now take so much more responsibility for our own training, and now that there are so few ambulance crews where both officers are of the same skill level, officers have come to believe strongly that we should be recognized as professionals.

We are expected to behave as professionals yet are not treated as professionals. For instance, there is rigid insistence that we take 2 sets of observations on even the healthiest of routine discharge 'patients' (many of whom don't even require an ambulance) and we are constantly reminded that we have no authority to make interpretive decisions as professionals would.

It clearly suits the Service to avoid having us gain 'professional' status as there would be an associated pay claim.

The lack of recognition and pay as professionals are significant dampeners to morale. Many Officers have given up trying to be 'professional' and try to treat their work simply as a "job" however the irony is that we work virtually autonomously and make life-affecting decisions on a daily basis.

It is incongruous for the Service to expect its employees to be thinking professionals and mindless protocol-following robots at the same time.

Recommendation 18 *Staffing levels*

The Service always responds to criticisms about staffing levels by referring to numbers from 1995. In that year, numbers had become so low that we saw a massive industrial campaign by ambulance officers. It was only through this action that numbers are not worse than they are. Most of the additional "891 paramedics" were added in the late 1990s and the Service should not claim credit for this figure. They were hard fought for by the HSU and were employed through sheer necessity, recognized by the government of the day.

The Service's roster model, which it successfully had endorsed by the IRC in 2008, required at least 100 additional positions. A year and a half later, I understand that none of these have been employed despite repeated commitments. With attrition and increased workload, in real terms, numbers have never been worse.

One only has to look at the number of times officers do not get the "required" breaks during their shifts to see the extent of the shortfall.

Ambulance Officers frequently work full 12-hour shifts, plus overtime, with no break at all. The Award requires that two 30 minute breaks are given. There is a small penalty payment for a 'missed' or 'late' crib break not taken within the relevant 3-hour 'window'. Once this penalty is applied, the Co-ordination centre no longer bothers to attempt to give a break, even though it is still required by the Award. We frequently hear on the radio "No, you got the penalty so you don't get a break now" and the crew is then given routine, non-time-critical cases.

I estimate that, on average, only about half of the "required" breaks are given.

Recommendation 20 *Establish an internal strategic planning unit*

On-road officers are not aware of such a unit having been established "by December 2009" however, whether or not one is created in the future, we have no confidence in the direction of the Ambulance Service in regard to strategic planning. For many years, it has been widely known that additional ambulance stations are required. In the past, there were even plans for stations at Berowra, Dural and Carlingford. The greatest current need is for a station at Bundeena.

Unfortunately, the Service's vaguely worded "Sydney Infrastructure Project" suggests the number of ambulance stations will be *reduced*, rather than increased.

The recent use of external consultants has probably resulted from the fact that so few of the Service's executives are or have been operational Ambulance Officers. The creation of Ambulance Advisory Committees, which include Ambulance Officers, was an excellent system however their advice is often ignored or, if the executive does not like what the AAC is achieving, the committee is simply disbanded, as occurred with the Uniform AAC in April 2008.

Recommendation 21 *Allow Suitable Alternative Duties at injured officers' home stations*

I am not aware of any officer being given the opportunity to do any work at his or her home station. Ambulance Officers are always told that they need to go to Rozelle or to one of the Sector Offices for SAD.

Recommendation 24 *Reinstate Level IV Training*

Many officers believe that Level IV training remains valid and useful as the clinical skills involved are still significantly greater than P1. With recent changes to the Medical Priority Dispatch System resulting more serious cases being allocated to Primary Care (including Level IV), these officers are now quite often using their skills because they are the ones already on scene with the critical patients.

Recommendation 27 *Review uniform to improve identification of paramedics*

This recommendation resulted from submissions about the inadequacy of the current uniform. Apart from the inclusion of a belated short-sleeved shirt in 2008, neither the uniform policy nor the design has changed since December 2007, prior to the Inquiry.

Major issues raised at the Inquiry included the following and most of these remain.

- The single word "Ambulance", rather than "Paramedic", across the back of the shirt implies a transport role rather than clinical skill.
- The wording on epaulettes is relatively very small and the colour differences for various skill levels are too slight.

Three current major skill divisions – Level 3, 3C and P1 – all wear the same coloured epaulette markings as all are "Qualified Ambulance Officers". There are also subdivisions within these levels – 3CF and P1 with or without Morphine – that add to the confusion about who can perform what skill.

In addition to the unresolved issues, the provision of the short sleeved shirt has seen a new issue emerge. Although the uniform policy specifies that the long-sleeved shirt can be worn untucked, officers doing so with the short sleeved shirt have been told to tuck the shirt in. While this approach may be intended to promote a neater appearance, it is inconsistent with the policy that applies for the long-sleeved shirt, which is, after all, the standard upper uniform garment. The short sleeved shirt is only an 'option'.

It is unfathomable that Ambulance Officers are permitted to dress slovenly when in the standard uniform but must be neat when wearing the short sleeved option.

The extremely poor quality lettering has been replaced with much better sewn-on lettering however the Service never acknowledged the original design was faulty. Many officers are still seen wearing their faded original issue as these shirts were never recalled.

Recommendation 28 *OH&S guidelines to maintain health, strength and fitness*

Manual handling training is somewhat lacking outside of induction and recertification courses. In 2009, a new DHS 305 stretcher was introduced yet few officers have received training on its significant design changes. The new stretchers, therefore, sit idle at many stations except some officers are using them unsafely, without training.

The Health and Wellness Program has now been satisfactorily negotiated with the Ambulance Service agreeing to cover all the costs involved, however it does not address strength or fitness. It is only a health and wellness program whereby officers will receive health assessments and, presumably, advice pertaining to any deficiencies found.

We do not know yet what will happen to officers whose health assessment find they have work-related deficits such as hearing impairment from many years of long runs using sirens.

Some ambulance stations still have gymnasiums however the Service's approach is inconsistent with regard to allowing these.

Recommendation 29 *Critical Incident Debriefing and Employee Assistance Programs*

Critical Incident Debriefs are not being provided and the Service has not given any explanation as to why they were ceased. Debriefs are not simply for the benefit of officers' emotional welfare but are valuable feedback tools for improving the management of critical incidents.

While the Service does now advertise its EAP, the lack of group discussion after incidents leaves officers feeling alone and, because counseling is always a private matter, the Service never gets to address performance issues that might be raised.

Referring to the fact that we carry a support brochure for witnesses to incidents does not seem to address the recommendation.

Recommendation 30 *Special leave for traumatic incidents*

The sudden removal of about 120 Rescue Officers' chosen career with 34 hours' notice is fairly high on a scale of emotionally traumatic events. A number of affected Rescue Officers took 'stress leave' and made workers' compensation claims for a small amount of time off work. My understanding is that all claims were rejected and the only leave available to these officers was sick leave.

Sick leave remains the only leave option for any type of stress and we have not heard of any review of staff support services around June 2009 or since.

Recommendation 31 *Database to record traumatic incidents and notification to Peer Support Officers*

We are not aware of the creation of any such database. The intention to reconfigure the IIMS to notify peer support officers would be inadequate, in any case, as not all officers use the IIMS. Many find difficulty navigating the lengthy online document (that does not allow work to be saved for later completion) and there is so little time available in our shifts that a large percentage of reportable incidents simply go unreported via IIMS.

Traumatic situations that would benefit from peer support are not necessarily relevant to the IIMS.

Recommendation 32 *Recognition of Peer Support Officers*

Officers have to look up lists of peer support officers to find them. There was once a PSO's lapel pin however all metal badges were removed with the introduction of the uniform policy in 2007, based upon an inappropriate 'risk assessment'.

There is no financial reward or incentive for officers to take on this important and demanding role.

Recommendation 33 *Rescue*

The removal of Metropolitan Ambulance Rescue has resulted in a significant reduction in the quality and effectiveness of rescue services in NSW. Although State Rescue Policy is that it is the paramedic's role to "guide rescue operators in the manner and timing of the extrication" several major issues continue to exist.

Who controls the rescue?

While most rescue agencies will defer to Ambulance Officers' expertise with patient extrication, many firefighters will say "leave the rescue to us". This may be because firefighters are indoctrinated with the belief that rescue is part of their core business, simply because they have the role of rescuing persons from burning buildings, in the rare event that this is required. They receive a little basic training in simple hydraulic tools. It is only once those firefighters go on to receive further training to become accredited Rescue Unit Operators that they start to appreciate that "rescue" is more than climbing ladders or breaking doors open.

Firefighters are almost always out of their depth when dealing with trapped persons because their training is based upon the fact that they do not have medical knowledge. The Fire Brigade's approach to a rescue is always to "remove the entrapment from the patient" and rarely to "remove the patient from the entrapment". Ambulance Rescue Operators understand the physiological considerations of a rescue and have the choice of either approach.

The result of the decimation of Ambulance Rescue is that Ambulance Officers, who once relied upon Ambulance Rescue Officers to make clinical decisions in relation to rescues, now find themselves having to guide firefighters in rescue procedures – assuming the firefighters involved actually allow that.

At one incident, I saw the rescue policy in action – and fail. In late 2008, like most Ambulance Rescue Officers, I was still wearing my Rescue uniform as no other uniform had been provided to us. I attended a motor vehicle crash in my former rescue area and had to work with the local fire crew that had recently been converted to a combined fire/rescue unit. The ambulance treatment of the patient was being performed by other paramedics so I was in a position to assist with the rescue.

I was initially pleased that the firefighters were prepared to acknowledge they had run out of ideas and defer to me. Initially, I felt the State Rescue Policy might be workable.

I suggested and described a straightforward Ambulance Rescue technique. The firefighters were willing to try it yet they did not seem able to follow the advice and tore the metal in a way that prevented a second attempt. Despite being fully co-operative, the firefighters' training was clearly lacking and we ended up having to manhandle the patient out in a most unsatisfactory way.

It was shortly after this that a colleague encountered a similar situation only, in his case, he was frustrated enough to ask to use the rescue tools himself. The firefighters at that job handed over their tools to the Ambulance Rescue Officer and he effectively completed the extrication. I wished I had felt it appropriate to ask for the tools at the MVA I attended.

Despite the success of the firefighters allowing my colleague to use their tools, this will not be an option in the future as very few Ambulance Officers now receive full rescue training, and none of these officers will be in metropolitan areas.

Reduction in Rescue Equipment Standards

The MVA above occurred at night. The fire brigade could only provide one lighting panel powered by a portable generator. By comparison, Ambulance Rescue trucks had large, truck-mounted generators with an array of halogen lighting options that could provide virtual daylight. Ambulance Rescue units also had portable lighting for additional lighting and as a backup.

It is most frustrating to have gone backwards more than 10 years with inferior fire brigade equipment and we find ourselves once again having to extricate patients by torchlight.

Ambulance Officers not being present when the patient is accessed

The fire brigade now attends a majority of suburban situations where access to dwellings is required before Ambulance Officers can attend a collapsed casualty. At one such situation, firefighters gained access to the unit through a window but delayed opening the front door to allow Ambulance Officers in.

When the door was opened, a firefighter said "It's alright. We've put the (elderly) lady back to bed" and left the address. The Ambulance Officers then entered and found that the patient had a fractured hip. Not only was this patient lifted inappropriately by the firefighter/s (with potentially serious repercussions for an elderly person) the fact that she was now in a bed made the application of the appropriate lifting device more difficult.

From the firefighter's ignorant and arrogant approach, the patient's care was delayed and her injury was worsened. The firefighter/s who did this had left address so they will have no idea that they harmed the patient.

I am very close to the Ambulance Officer involved so I know this story to be true. Unfortunately, it was never reported but, even if it had, reports to the State Rescue Board are always squashed.

Reports to the State Rescue Board are squashed

One of the Ambulance union's efforts to have Ambulance Rescue reinstated was to appeal to the State Rescue Board and point out the many issues of long response times and poor extrication techniques used by firefighters. The SRB said there was "no evidence" so, at the next meeting, several months later, HSU provided all 80 pages of reports that had been submitted.

The SRB still deferred the matters by saying they must be investigated by police before the board could act on them. The Board even went so far as to say publicly that the "new arrangements are working well". That was over a year ago and nothing has been heard of the reports since.

One of the problems with rescue arrangements, anywhere, is that there is no scientific approach involved. It is always political. Ambulance Rescue has always been about the needs of the casualty whereas the fire brigade's seems to be about justifying its existence.

Ambulance Rescue held a database of actual response and extrication times but the State Rescue Board does not use any such data as KPIs. Because there is no cross-agency data collected, it is impossible to tell if the increase in road deaths since 2008 is attributable to changes in rescue arrangements.

Questionable fire brigade rescue figures

One of the arguments the fire brigade has used to increase its stake in rescue is to inflate the number of 'rescue matters' it says it attends. In 2005, during the only recent independent review of NSW rescue arrangements (by the auditor general), the fire brigade's figures were seen to be more than twice the number of actual rescues it attended in the year reviewed.

In 2006/7, the fire brigade's annual report claimed it had attended 11,555 "rescue matters". Clearly, these were not actual rescue incidents as I have been reliably informed (by a rescue co-ordination officer in the police control room) that the total number of all "rescues" in NSW that year was around half that number, and that included rescue responses by *all 5* agencies.

An example of how the fire brigade may be inflating its rescue figures was seen in mid-2009 when a semi-trailer left the F3 freeway in northern Sydney and crashed down an embankment. Only 1 driver and no other vehicles were involved yet the fire brigade sent no less than fourteen (14) crews and supervisors to that incident. Apart from the fact that it was the fire brigade that caused the resultant major traffic delays (to the point that words were said at the next local emergency management committee meeting), it seems highly likely that this one incident became 14 "rescue matters" for the fire brigade to add to its database.

Increased personnel required to perform rescues

Despite the Inquiry's recommendation that paramedics be involved in all rescues, I responded to a rescue of a boy whose fingers were trapped between two sash windows to find the fire brigade had already arrived and extricated the boy's fingers. This action was understandable but the firefighters were then at a loss to know what to do with the injuries.

Had that job been handled by Ambulance Rescue, both extrication and treatment could have been performed by two officers.

Firefighters have been known to claim it is more efficient for the fire brigade to perform rescue because of the notion that it can perform both rescue and fire protection with 4 officers on one truck. For comparison, the Ambulance service performed rescue and treatment/transport with 2 crews (one rescue unit and one ambulance but, ironically, still only 4 personnel).

Since the changes of 2008, however, we now see *two* fire units responding to persons trapped collisions – one unit for fire protection and another for rescue. It still takes 4 firefighters to provide fire protection (as it always did) and it usually takes 4 firefighters to perform a rescue. This means a rescue performed by the NSWFB needs 2 more personnel than one performed by Ambulance Rescue.

"More Paramedics Available to Respond to Medical emergencies"

This was the excuse made by the, then, Health Minister for the decision to hand over Rescue responsibilities. Since the figures used by the Head Review of 2007/8 were known to be misleading, and since Ambulance Rescue was known to have the highest standards of training and equipment and the best response and extrication times, the only reason that could appear to

justify the decision was the suggestion that more ambulance officers would be attending patients, instead of rescuing them. Unfortunately, this claim was false on two counts.

Firstly, even the Head Review identified that 89.1% of Ambulance Rescue work was already providing medical care, so there was very little to be gained by the change.

Secondly, it eventually became apparent that the 88 positions to be 'gained' by converting rescue positions (from dual-crewed rescue trucks) were really to become only 44 positions, all single officer response. The only reason that the Service did not see such a reduction in numbers was that the IRC intervened and insisted that the 44 new rapid responders must be in *addition* to the 8 dual-crewed ambulances that replaced the rescue trucks.

Vertical Rescues

The fire brigade has never seemed interested in putting the necessary resources into vertical rescue training. Firefighters are well known to admit that they are not skilled or confident in this area and rely heavily upon Ambulance SCAT paramedics to undertake the main elements of all vertical rescues.

Even if firefighters were to descend to an injured person on a cliff ledge or rope, there is nothing a firefighter can do to manage the patient's medical condition.

The ASNSW clearly recognized that the loss of metropolitan Ambulance Rescue meant it would need to expand its vertical rescue capability to cover fire brigade inadequacies. The ASNSW has now created Special Operations Teams to perform all manner of rescue-type functions to gain 'access' to trapped or remote patients. Many of these officers are the former Ambulance Rescue Officers who still, in a practical sense, have to perform the actual vertical rescue of their patients while the fire brigade sits at the top of the cliff, in front of the TV cameras and receives the credit for being the "rescue agency" involved.

I am also led to believe that Police Rescue has similarly identified the need to expand its vertical rescue capacity. Police and Ambulance services have been working together to provide NSW's cliff rescue functions since the 1940s.

Funding

I recall it being clearly stated that, in order for the decision to be effected on 3 September 2008, the Ambulance budget was increased by the same amount as it received for its rescue role. This is logical given that Ambulance Rescue was run so cost-effectively that the bulk of rescue finding was used simply for wages.

The result is that the ASNSW now provides only some of the rescue functions it used to perform yet the cost has not reduced. In fact, additional vehicles and equipment have been required for the Special Operations Responders to use so costs for the ASNSW have likely increased since September 2008.

At the same time, it was acknowledged in Parliament, around Oct/Nov 2008, that the fire brigade had to run no less than four extra rescue courses to bring sufficient firefighters up to rescue accreditation standard. Overtime rates were paid to all those firefighters attending the courses and to those firefighters who had to backfill their shifts at fire stations.

Although moving rescue to the fire brigade was no doubt portrayed to the government as a cost-saving measure, the reality is that the community has had to pay more (mostly through insurance

premiums) for the fire brigade to provide a lower standard of rescue service than was provided by Ambulance Rescue.

For those former Rescue Officers who now work on 'general duty' ambulances, the irony is that they now attend fewer patients per shift, on average than they did on a rescue unit. Whereas on Rescue Units, they would respond to several medical cases per shift, in addition to rescue and support roles, they now find themselves attending to perhaps 4 or 5 patients per day, many of those being routine cases requiring no clinical interventions. Instead of treating patients, doing rescue training and maintaining rescue equipment, they now spend many hours out of every shift simply standing in hospital corridors. Ambulance Rescue Officers are far less value for money to the government than they were when we had a rescue function.

False "options" for Ambulance Rescue Officers.

On 2 September 2008, the Ambulance CEO wrote to Rescue Officers to announce the overnight decision to axe metropolitan Ambulance Rescue. In his letter, one of the "options" for affected officers to choose was "transfer to the NSW fire brigades with full recognition of ambulance leave entitlements and superannuation" (subject to entry requirements for firefighter positions).

A small number of Ambulance Rescue Officers were interested to take up this offer however, well over a year later, no one has had any response to any expressions of interest. The Human Resources Departments of both the NSWFB and the ASNSW have told officers that they know nothing of any transfer arrangement.

Members of the public still believe that Ambulance Rescue Officers are now employed by the fire brigade however it is clear that the suggestion that this was an option was simply untrue.

Comments by Non-Rescue Ambulance Officers

There have always been Ambulance Officers who express an opinion that the fire brigade "might as well" have the rescue role, however this comment is almost always followed by a story about an incident where the fire brigade's approach did not work in the best interests of the patient. I have heard, many times, even officers who would support the fire brigade having rescue, say that, despite that opinion, they have never seen rescues go so well as when Ambulance Rescue Officers performed the rescue.

Part of the reason for the decision against Ambulance Rescue in 2008 was that few know just what synergy exists when the rescuer and the clinician have the same basic understanding of the physiological needs of the victim and speak the same language. The CEO of the Ambulance Service certainly has no idea as he has never been an Ambulance Officer.

Comment

There is an urgent need for a proper, independent investigation of collusive practices at State Rescue Board level, that have favoured the aspirations of the NSWFB over better quality, more cost-effective services.

Recommendation 37 - *Provide a dedicated ambulance service in Bundeena*

The Service has chosen to do the opposite of this recommendation. Instead of providing a much-needed ambulance station, it has instead engaged with the fire brigade to have firefighters respond to medical calls and provide limited clinical care. These firefighters are now called "community first responders" and the precedent this sets is alarming for the community.

In addition, the ASNSW no longer uses proper 4WD Landcruiser Ambulances but has purchased a number of cheaper, smaller 4WD non-ambulance vehicles into which a Stokes litter can be strapped. Such vehicles do not have proper stretchers, padding for any patient that might be transported via the access tracks, nor anywhere for an attending paramedic to sit beside the patient. Essentially, the only road-transport capacity for any patients in bushland is now the equivalent of carrying them in the back of a ute.

This is causing an increased reliance on expensive and more risky helicopter transports, however whenever helicopters cannot be used there is no longer an adequate bush extrication service available in metropolitan NSW. Rural areas still retain full 4WD Ambulances.

While the rest of Australia is moving away from volunteers towards increasing use of professional officers, NSW seems to be moving the other way. Not since the 1970s have we seem so many. The number of Honorary officers was very small until 2009 when "Community First Responder" programs were started. A very recent bulletin boasts that we "now have 206 volunteers and CFRs". This is approaching 10% of ambulance staff yet these responders have a fraction of an Ambulance Officer's training and skills.

This is clearly a cost-saving measure intended to avoid putting in place the ambulance services that communities such as Bundeena deserve.

Recommendation 40 *All ambulance vehicles be equipped with satellite navigation units*

The ANSW has indeed provided SatNavs, however it did not install them in ambulances. Instead, it simply issued the devices to all Ambulance Officers. Initially, we were surprised that the Service would purchase twice as many units as were required (because there about 900 ambulances yet 3000 officers) but it seems the devices chosen were so cheap that it could afford to, presumably so that it could simply pass on responsibility for the safe-keeping of the SatNavs to us.

Several issues exist with the use of Sat Navs.

- They often give wrong directions. Officers at my station, all report that when one is approaching the station, with the station visible to the left, the SatNav will curiously instruct the driver to turn *right*, into a street that takes one in exactly the opposite direction! Others have reported being told to turn where no turn is allowed.

- The devices (usually) operate according to the road rules and do not, for instance, recognize that urgent ambulances can make turns not ordinarily allowed. The devices do not recognize any T-ways, which ambulances can use.

- Satellite navigation technology is very new to general ambulance crews in NSW. Not everyone owns or uses a SatNav in their personal life. The ASNSW has provided no training for officers in the use of SatNavs. Some officers are trying to teach themselves. There is an instruction CD in the box however the Service's computers will not allow the software to run.

  This appears to be yet another example of Ambulance Officers being expected to train themselves in their own time.

- The use of SatNavs is already creating a culture whereby officers no longer bother to learn how to get around in their own areas. Instead, they rely on the machine to tell them where to go. Apart from the fact that the devices often give the wrong information, any system failure in the future will leave fewer officers who are skilled at reading the street directory.

- There is a delay in responding to incidents while information is programmed into the SatNav. Ambulances could often have been halfway to a local emergency while the driver is still typing in location information.

I suspect that, at this stage, the issue of cheap SatNavs to officers has had a negative impact on response times.

Recommendation 41 *Provide portable radios for all officers*

This recommendation has not been complied with. The ASNSW has even provided false or misleading figures to the IRC about how many portables it has issued. The reality is that there is, on average, only one portable radio to each *ambulance*, to be shared between 2 officers. This leaves the original safety concerns unaddressed as Ambulance Officers are often separated at scenes.

Recommendation 44 *Reinstate an Ambulance Board*

This has not occurred however it may or may not be a good thing anyway. We had almost as many problems when there was a Board. The important thing would be for the government to appoint the right members to such a panel. Our perception is that the government is only interested in engaging individuals who are prepared to run our service into the ground in order to reduce costs.

Recommendation 45 *Reintroduce an Ambulance Act*

When we operated under the Act of 1990, we had a legislated duty of care to our patients and the community. We have no specific Act and currently operate in a grey area, at the whim of the Health Department.

Other Comments

Unfortunately, I have had no time to construct the additional comments that I felt certain the Inquiry Panel would find insightful. As the deadline for submissions is approaching, I shall simply cut and paste some information that has been provided to me.

Respectful Workplace Training

There has been a strong emphasis on all officers attending this training. While these sessions have been a marvelous opportunity for participants to vent their feelings about how poorly the Service is run, the fact that "nothing leaves the room" means that valuable feedback is wasted. Because so much of the criticism relates to the CEO and policy-makers, the government will never be told how Ambulance Officers are affected by their actions.

Rochford's promise to repay anyone who made less money in 08/09 than 07/08.
Firstly, we all made extra money for more than 6 months (Sept 2008 to Feb 2009) after the Minister's decree that the former penalty rates should continue to be paid, so 08/09 income was artificially inflated.

Secondly, there is no undertaking to compensate anyone comparing 09/10 with 07/08.

Thirdly, the bulletin advising of the promise has no follow-up. There is no contact person, no mention of what process would be used etc. Some officers are keen to have their incomes assessed but have no information on how this can be done.

No one has any better access to flexible work practices.
In fact, the Service has approached part timers to work to a less flexible roster and is putting pressure upon 'reduced hours' officers to do the same.

Annual Graduation Ceremony
This is touted as being a new thing introduced however it simply replaced up to 8 or 10 graduations that happened at the end of each class. The new system is not an improvement. It simply means that a percentage of the graduands, particularly rural officers, will not be able to attend as the separate date will clash with rosters or personal activities. It simply reduced the effort and cost to the ASNSW.

There is a current survey to see if attendance can be increased by hold 2 ceremonies. If this goes ahead, Amb will no doubt call this a significant "increase" in commitment to the graduation process without acknowledging that 2 ceremonies is far fewer than would have been held in the past.

Vehicles only recently becoming less rough to ride in, however engines getting smaller. After ten years of bumping patients along in converted parcel vans, the new Mercedes Ambulances do seem to have smoother suspension. Despite statements of "increased power", however, they seem to have less and less. The newest ambulances are dangerously unresponsive.

Mercedes vans are also less robust than former ambulance vehicle types. A 10yo F250 with 200,000km was heaps better than a 3yo Merc with 140,000km.

Rochford bragged about how vehicles would be replaced after 40,000 km but half the ambulances at my station have in excess of 150,000 km and the doors rattle and are hard to shut.

An officer received the standard, threatening **Sick Leave letter**, despite being well within the allowed number of sick days for the year. This prompted him to go to work the next time he was ill. He was then criticized further my managers for vomiting while on a case and refusing to go home as he feared having a further 'sick leave' letter placed on his file.

"Our Values" poster does <u>not</u> mention that the Service values its employees. It is simply a list of expected behaviour. Sept 09

A **Vehicle Tracking Policy** is about to be implemented, despite earlier promises that it would not be used. While claimed to be a safety measure, it is seen more likely as a method of keeping tabs on whether Ambulance Officers are taking the routes preferred by the Co-ordination centre.

Officers being pressured by managers

- An officer on reduced hours following maternity leave wanted to do one shift per fortnight so that she could attend to her child's needs. She was asked to sign a Contract that she would work 12 hours per week but was told that she would only be expected to work the 12 hours per fortnight that she wanted. After a few months, a new manager insisted that she work the extra shift because she "had signed the contract".

- Another officer was told to sign an 'application' for annual leave that she didn't want. The Award provides for annual leave to be allocated if no agreed block can be negotiated so there was no need for her to sign anything. Her signature was simply wanted to make it look as if she had requested that leave block.

- We all have to sign various sheets acknowledging that we have 'read and understood" certain instructions. No one ever reads the details but we are pressured to sign to keep management in the clear.

- The Service issues a raft of instructions via e-mail every week, almost daily, however many officers don't get a chance to access their e-mails for weeks at a time. Those that do, usually sacrifice their short rest breaks to do so.

Mid 2009 – **Accommodation** no longer offered automatically at the Ambulance Education Centre. Only for "special circumstances". Priority is now given to mangers doing AMQ courses, instead of trainees.

Oct 2009 - **Motorcycles** reduced from BMW to Yamahas and to be reduced in number.

Emergency Response Standards were issued in November 2009 without consultation with the union. These see a raft of reductions including longer expected response times to cases and, most significantly, only sending a minimum of 3 officers to a cardiac arrest!! In the past, a minimum of 4 officers, often more, were sent to any cardiac arrest, as there are many functions to be performed quickly at such incidents.

Three is hopelessly inadequate. When the union protested, senior management of the ASNSW said it had "to refer the matter to a committee" for determination. This was despite that committee having had no input into the decision that needs to be reversed.

Hospital Delays Delays are now so bad that there is a new instruction to record observations every 30 minutes while waiting at hospitals

We also had an instruction to report to Co-ord every 30 minutes with an update of the expected delay however, we are often not even triaged by 30 mins. On 13 January, we waited over an hour and a half just to be triaged! We cannot advise how long the delay will be when we have not even seen a triage nurse by the 30-minute point.

A former Station Officer has recently been reemployed by the Service after a 2-year absence. This officer is known to be incompetent both in clinical and managerial skills. The fact that this officer has been reemployed when other, far more capable former officers are not given an interview caused officers to speculate that she has "something on someone".

This officer is now at a fourth station because officers refuse to work with her.

Swine Flu Vaccinations were offered during the winter of 2009. We all signed forms to indicate whether we wanted vaccinations or objected to being vaccinated. At January 2010, I do not know of any officer who has received a vaccination for Swine Flu.

Uniform Trousers are still issued unhemmed. The Service's expectation is still that officers will have the legs shortened in their own time and then claim reimbursement for the expenses incurred.

Staff Movements occur whenever single officers need to team up with a partner for the shift. Movements are accepted but should be limited to a geographical area that was agreed between the union and the Service in 2003. Since that agreement was made, the Service changed the boundaries of its sectors but has never sought to renegotiate the staff movement agreement.

The Service regularly ignores the agreement and instructs officers to travel unreasonable distances to team up with a partner from another station. Examples include officers being told to move from Blacktown to Narrabeen. These are within the new Sector boundaries but are way beyond the extent of the staff movement agreement. The main issue is that officers have to drive past several other ambulance stations to get to the assigned station and that it often takes well over an hour before the ambulance becomes fully operational with two officers on board. Protests are ignored.