Submission
No 111

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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General Purpose Standing Committee No. 2
Management and operations of the NSW Ambulance Service
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Committee members

Re: Management and operations of the NSW Ambulance Service

I understand that the General Purpose Standing Committee No.2 is holding an inquiry into the management and operations of the NSW Ambulance Service; and specifically into management structure and staff responsibilities, staff recruitment training and retention, staff occupational health and safety issues, operational health and safety issues; and any other related matter.

I have been employed by the NSW Ambulance Service (the Ambulance Service/the Service) for over years. There has been a great deal of organisational change over this time. Unfortunately, I feel that a lot of these changes have not been for the benefit of Ambulance Officers or their patients. I have highlighted specific areas of concern below, and I believe that a lot of areas in the Ambulance Service, including recruitment, education and training, promotion, payroll, and dispatch, should be outsourced to public or private companies that can deliver a fair and consistent service on time and on budget.

Recruitment

The Ambulance Service has recruited university graduates with either Diplomas or Degrees in Pre-Hospital Care. It has then provided 'recognition of prior learning' and allowed them to 'fast track' through the education and training system to become qualified paramedics and sometimes intensive care paramedics. This saves the Service a significant amount of money in education and training, but it is a false economy. The Service places junior staff with a lot of 'classroom' knowledge and not a lot of operational experience directly on the coalface; and it shows.

Regardless of your university qualifications it should take three years of on-road experience to become a 'qualified' paramedic. The uni degree is a 'nice to have' and not a 'need to have', as demonstrated by countless paramedics from trade backgrounds. Often the graduates are young, with little life experience, and need a period of time in the job learning how to put all of their education and training into practice, and most importantly learning how to deal with people. Regardless of your university qualifications, a Paramedic should then have a minimum of five years on-road experience before they can apply for an Intensive Care Paramedic position.

The system should maintain high standards. It should invest time and money into the education and training of staff and it should ensure that Paramedics who have the required knowledge, skills and experience can move through to higher clinical levels.

Education and Training

The Ambulance Service has chosen to move away from direct class-contact education and training to remote or distance education, with an emphasis on 'educational packages'. Likewise the two-yearly re-certification (re-cert) process has moved to a 'points' system (allocated through a range of sanctioned activities), with Ambulance Officers able to do a shortened re-cert and opt out of the extra practical and theoretical tests associated with the longer traditional re-cert. The problem with not testing all Ambulance Officers every two years is that the Service cannot guarantee that all staff in certain essential areas, like paediatric resuscitation, are both competent and abreast of recent changes.

This change appears to be financially driven, with Management complaining that traditional re-cert costs them too much money; as the staff away on re-cert are paid and their on-road position is then back-filled with overtime shifts. Management has gone so far as to roster staff to re-cert on their days off and then denied that there were hours owed. One Officer was rostered to work two day shifts then one night shift and then two days later present for a five day re-cert in Sydney. The next day he then reported for an additional day shift and two night shifts. A total of eight shifts without a break and with no compensation either with hours or money owed!

The bottom line is that Ambulance Officers need more contact with educators; and on a more regular basis i.e. every year, and they shouldn't have to do so in their own time. The class-contact time should cover changes to protocols, procedures and pharmacologist; and should appropriately 'test' Officers in essential areas.

Another big issue in the area of education and training is the introduction of changes to the way that Ambulance Officers do things. Since establishing a staff 'intranet', the Ambulance Service is happy to email updates to staff. When there are changes to protocol or pharmacologist it prints them off and pops them in the post (several amendments may also arrive as the Ambulance Service isn't big on proof-reading). The Service 'broadcasts' these changes, but it doesn't ensure that all staff have 1) received the changes, 2) understood the changes, and 3) are competent to implement the changes. The obvious solution is to time all changes to occur once every year; to disseminate those changes once, and to ensure through yearly re-certification that all staff have the same level of understanding and competency.

Another change in educational focus has been the implementation of 'clinical educators' and 'technical educators' posted in certain geographical areas. I assume that the rationale is that staff have greater 'face to face' contact with Ambulance Service educators. Problem is we never see them, either because they aren't around or because operational staff are busy working on road.

Mental Health Act

The area of mental health is both a sensitive and difficult area to handle in the pre-hospital environment. Mental health patients can be difficult and sometimes violent. The recent changes to the Mental Health Act are interesting. As far as I can tell they divest some of the powers held by the Police and grant them to Paramedics. Now the Police Association should be able to tell you how woeful the current system is, but to make these sweeping changes without consulting operational Paramedics isn't smart. Paramedics don't want to independently disarm, search, restrain, sedate or schedule mental health patients. We are not appropriately trained in any of those areas. We will be putting ourselves in greater danger and there will be a greater chance of patient complaints (and trust me the Ambulance Service has a poor record when it comes to investigating complaints).

We provide pre-hospital care and transport and the Police schedule, disarm, search, and restrain where required. If the patient was happy to be scheduled then they hopped in the ambulance and had a chat to the ambos and if they weren't happy to go then the Police were automatically called to schedule them and to compel them to go. The 'old' system should never have been changed; the Police should retain their powers and use the Ambulance Service in partnership as required.

Operational establishments

The Ambulance Service should automatically increase staff as population centres increase over time. There is enough census data collected Australia-wide to predict the geographical spread of the population and these people should have appropriate access to essential services like an ambulance and a hospital. Instead the Ambulance Service implements 'staffing reviews', which take significant amounts of time and money, and then cry poor when their own review finds staffing shortfalls.

We need to develop an acceptable formula for providing ambulance services to the community and we need to automatically apply that formula at regular intervals AND we need to do so now.

If you don't have enough staff to run the rosters that you have, then you have to rely on staff to do a lot of overtime and on-call duties. If there aren't enough 'extra' staff then this impacts on the ability of staff to take leave when they wish, the ability of senior staff to take long service leave when they wish, and the ability of staff to accrue and use time in lieu. And of course, the bottom line is that if MOLs (minimum operating levels) aren't met then you compromise service delivery to the public.

Organisational restructures

The Ambulance Service appears to be in permanent state of 'restructure'. The core focus of this re-structuring is the carving up of NSW into discrete areas, sectors and divisions, and then assigning those areas a 'management team'. The make-up of these management teams, from the base-line 'station' officers to 'district' officers and then 'sector' managers and 'divisional' managers has tended to reflect the personal focus of those in Rozelle (State Headquarters) and the State Superintendent in particular.

These rolling changes to area demarcations, to management titles and responsibilities, to expansion or contraction of lower or middle management numbers, don't necessarily affect positive changes for front-line paramedics. The changes appear to be focused on upper management retaining lower management teams that will unquestioningly support their agenda. To do so they have to select particular staff and then place them in strategic positions.

It often appears that the primary concern of Ambulance Service management isn't to facilitate the core functions of the Ambulance Service (what I like to call 'two people driving around in an ambulance'), but to protect their positions. This means that they have to be seen to be making changes and that these changes appear to save money.

The majority of managers are, and have traditionally been, Ambulance Officers that have worked their way up the management ladder. Their operational experience is both a 'blessing' and a 'curse'. A blessing because they are personally acquainted with our core business, but also a curse because they themselves are part of a work culture that is inefficient and slow to change; and they then go on to perpetuate the same style of management that they experienced as Ambulance Officers. The 'changing of the guard' creates an illusion of change and 'progress'.

I can see the need for most if not all managers to be recruited externally; and for these people to have both management qualifications and a strong management background in both the public and private sector. Perhaps, to ensure greater productivity and accountability, we need to reduce management and place all managers on performance based contracts; with a strong focus on 'service delivery' and not 'fiscal responsibility'. As one of my colleagues has pointed out the obvious solution to our staffing shortfalls is to take all the managers out of their offices and to put them all on-road.

Interestingly, the issue of operational restructuring highlights another issue. When operational staff transfer to other positions in the Service, for example middle and upper management, education and training, or to CAD, they retain their clinical rank and its corresponding allowance. They effectively get paid the same as a Paramedic driving around treating the public. It has always struck me as peculiar that the Service allows staff to move away from the coal-face but to retain the title and pay of those still working there.

The Ambulance Service should look at how many people receive allowances for work they don't currently perform. It should maintain that clinical titles and pay should only be paid to those in on-road Paramedic positions. When you leave that position you relinquish that title and pay. When you return to the position then you regain that title and pay.

Now we're all 'paramedics'

The majority of 000 emergency calls are not emergency calls. The core duties of a Paramedic is transporting people who would like to go to hospital in an ambulance because 1) they have ambulance cover (either through a pension card or private cover) or 2) because they need to or would prefer to lie on a stretcher or 3) because they believe that they will get a bed and be seen quicker if they present to hospital in an ambulance. The minority of the 000 emergency calls are genuine life-threatening emergencies. Traditionally, the Service has recognised this fact and trained staff to different clinical levels – Patient Transport Officers, Qualified Ambulance Officers, Advanced Life Support (ALS) Officers and Paramedics. They trained more officers at the patient transport and ambulance officer levels and fewer Officers up to ALS and Paramedic level. In addition to this, they controlled the distribution of this ALS/Paramedic staff, and controlled how these officers were responded.

In Newcastle, Sydney and Wollongong they ran 'dedicated' intensive care cars with two Paramedics always rostered on duty. This car was then utilised as a training resource for future intensive care paramedics and as a local resource to respond to more 'serious' incidents and to 'back up' staff requiring greater clinical interventions. The system is tried and tested around the world and works well. But paramedic training is expensive. All that money spent on the dedicated six months training program – classroom time, hospital theatre time, mentoring time on-road with another paramedic. The system produced great Paramedics, but at a cost.

This 'paramedic' system is well established in NSW and well respected by the public. So much so that the Service saw some political advantage in promising to put 'a Paramedic on every car'. Well they did and on a budget too – they changed the name of 'Ambulance Officers' to 'Paramedics'; and then changed the name of 'Paramedics' to 'Intensive Care Paramedics'. They edited the operational guidelines in the 3P's (Procedures, Procedures and Pharmacologies – colloquially known as the 'three P's') and provided some cursory training – hey presto! A 'paramedic' on every car!

The Ambulance Service would argue that they have 'enhanced the base level' of ambulance officers by providing more Officers with more skills and drugs and therefore the qualified ambulance officer level is now a 'paramedic officer', but the truth is that the poor level of training provided by the Service has ensured that this is not the case. They have only managed to erode the strong 'paramedic' system that they had along. By all means, put an Intensive Care Paramedic on every car, but don't cut corners when recruiting or training them. Let's maintain high standards in every endeavour. This will mean keeping dedicated 'paramedic' modules with two intensive care paramedics working together, because this, and not a 'paramedic on every car', represents best practice.

Paramedics – pay and rosters

The greatest single resource held by the Ambulance Service of NSW is its staff. They are consistently voted 'most trusted' profession by Readers Digest poll, but retain an uncomfortable relationship with management. Unfortunately, staff do not always feel that they are valued or trusted by the management team.

The fall-out from the 'promotion' of all qualified Ambulance Officers to Paramedic Officers is that there has been no financial compensation for those Officers. Nor has there been for Intensive Care Paramedics that have take on additional responsibilities under 'P1' training. If anything the Ambulance Service would like those Officers to 'trade off' conditions under new Award negotiations so that any pay 'increases' are effectively 'cost neutral'. This has been the subject of lengthy and on-going negotiations between the Service and the Health Services Union (HSU) in the Industrial Relations Commission.

In addition to this, the Service does not adequately recognise long service. Currently, once an Officer has reached their ten year anniversary the hourly rate between him and an Officer who has been in the job for thirty years is negligible. All that operational experience is essentially unrecognised. Ideally, Officers who have provided an extended period of Service should receive financial compensation in the way of a pension or at the very least a working allowance.

And finally, in negotiations with the HSU the Service consistently targets rosters as a means of minimising staffing shortfalls i.e. keeping current staff on rosters that keep them at work 'more' and on days off 'less', not providing 24/7 roster coverage on some stations, and establishing 'on-call' rosters. I can only emphasise that the most important work condition for an on-road 'ambo' is the roster that they work – this dictates when you have to be at work (or on-call) and who you have to sit next to in the ambulance. Ideally, you are not rostered at work for long periods of time, and are given adequate days off to recuperate.

The ideal roster is four days 'on' and five days 'off'. There has been much talk about changing all shifts to 12 hours maximum, but in a field where Officers must do a 'reasonable amount' of overtime and where emergency calls must be responded to immediately, Officers can still work in excess of 12 hours regardless of their rostered hours (which is why longer days on with shorter shifts actually translates into *longer* shifts over *longer* days, and if you're unlucky with on-call periods in between). It is more tiring to work seven days 'on' and three 'off' than to work four 'on' and five 'off', regardless of the length of the shift. It would be disappointing if the Service used the current debate around shift lengths to either increase the days 'on' or decrease the days 'off'. This would have a detrimental impact on the work/life balance of all operational Officers.

Medical Priority Dispatch System

The Ambulance Service has moved to a medical priority dispatch system in an attempt to improve its response times. The system has been operational for the past few years utilising a ProQA system of call-taking, this system is thought to be an improvement of the old system which made every call an 'emergency', by trying to 'prioritise' the 000 calls into 'hot' and 'cold' responses and to assign a benchmark response time to each category. Strangely enough the Service has introduced this system but not encouraged Paramedics to provide appropriate feedback on how it is performing, particularly where the ProQA has prioritised the call an 'emergency' and the call has been 'non-urgent' and where information provided on the patient's chief problem was plain wrong. The focus has been on reducing response times and not on acquiring accurate information off the caller so that they get the right Paramedic in the right time frame.

From firsthand experience I can tell you that ProQA is not working. The call takers don't gather enough information from the callers. They don't gather accurate information on the patient's chief problem. We read our jobs on our MDT computer terminals and know that in all likelihood the information on the screen is not accurate – the call will not be prioritised correctly, the chief complaint will not be accurate, and sometimes the address is wrong. There is no consistency to the way that it performs – one dispatcher will send two cars to a chest pain, another will send one; one dispatcher will send the on-call car at home because it is closest; another won't. But the greatest problem is the lack of review within the system itself. The ProQA system will not improve when there is no feedback from Paramedics, no review into the system and no implementation of appropriate changes – we may as well go back to every call being a 000 emergency.

Rapid Responders and Extended Care Paramedic Program

The Service has introduced, mainly in Sydney, a 'rapid responder' position. This is effectively one person driving a vehicle (without a stretcher) responding to jobs and other Officers requiring 'back-up'. This raises two issues 1) Paramedics working 'single' and 2) using staff to improve 'response' times but not 'transport' times.

As an organization, we pretty much agreed some time ago to a 'two officer crewing agreement' that meant that every person that called the Ambulance Service got two trained Paramedics in an operational ambulance. This meant that the Service couldn't cut corners by sending only one person to jobs and those Paramedics wouldn't be exposed to potentially violent scenes on their own. It also meant that there would be a baseline standard of care delivered to everyone (i.e. two qualified officers can implement more over a quicker time than just one officer).

The emphasis with this ambulance vehicle is on 'response' times and not 'transport' times. The rapid response car may sit on scene with a patient waiting significant periods of time for a car to become available to transport the patient to hospital. In that time it cannot respond to any other calls.

The bottom line is that we wouldn't need a rapid response vehicle if there was enough staff rostered on duty and this staff wasn't delayed for unreasonable lengths of time at hospitals.

I have similar criticism for the 'extended care paramedic program' which is trying to implement out-patient services through the ambulance service instead of through the hospital system. We have enough trouble using available funding to staff ambulance stations, but now we want to use staff and resources to take the pressure off public hospitals! I think the hospitals should be utilising their funding and their staff to attend and treat patients at home.

Ambulance Rescue

From an operational perspective the presence of qualified ambulance officers on a rescue truck is ideal. Paramedics may be called to a car accident or industrial incident and have rescue support staff that have the same Paramedic training as them, who are operating under the same clinical guidelines, and with whom we routinely work with. As rescue operators would argue it's not 'mechanical' it's 'medical'.

The Ambulance Rescue service also provides training opportunities for Paramedics and provides a more holistic approach to patient care – especially where the logistics of extricating or rescuing a patient are as important if not more important than the clinical treatment that they receive.

Unfortunately, the Ambulance Service of NSW doesn't quite see it that way. They see an opportunity to save money by not providing the service and by redeploying 'extra' staff onto station rosters. Slowly, but surely, Ambulance Rescue is being consumed by the NSW Fire Brigades. Once again I feel that this is a false economy. The money saved and the staff redeployed by dissolving Ambulance Rescue in no way compensates for the impact on the care of our patients.

In addition to this I would question why another publicly funded body, like the NSW Fire Brigades, is given so much funding that over the years it has procured rescue vehicles and equipment, trained staff, and implemented rosters in areas where it did not have a 'primary' role in the provision of rescue services? I would ask whether the use of this public money was fiscally responsible. I would also ask why such 'empire building' should be rewarded.

All public money essentially sits in the one 'pot'. Why is public money diverted away from an agency that has a specific role to one that doesn't? Where are the checks and balances here? The Fire Brigade shouldn't provide pre-hospital care any more than we should fight fires or arrest criminals. The Fire Brigade, shouldn't automatically assume rescue services from agencies (regardless of whether they are ASNSW, NSW Police, or SES) that have traditionally provided that service in that area, and consistently provided it to a high standard.

Helicopter Operations

The Ambulance Service of NSW utilises a number of helicopters across the state for inter-hospital medical retrievals and for 'primary' responses to 000 calls. I suggest that for inter-hospital patient transfers the Service should use a doctor, but for all 'primary' and rescue jobs, that they should utilise two intensive care paramedics.

I have worked with helicopter crews configured with an Intensive Care Paramedic/Doctor and Intensive Care Paramedic/Intensive Care Paramedic and in my experience; Doctors are trained to work in a 'controlled' hospital environment and not in a 'pre-hospital' care environment. Doctors tend to create significant delays when they work on accident scenes.

Paramedics are trained to work outside of hospitals, when they go to accident scenes they take control, they do only what has to be done urgently and then transport without delay. Where there is a real or perceived need for interventions, like emergency intubation under rapid sequence induction (RSI) or the insertion of chest drains, Intensive Care Paramedics are more than capable of being trained to administer this care (as is the case overseas where many Ambulance Paramedics already administer RSI).

I think that there should be greater scrutiny of doctors working in pre-hospital care and I think that they should be working under the same parameters as Paramedics – in pre-hospital care it is called the 'golden hour', the hour immediately following trauma, and it is the benchmark that Paramedics strive for - deliver the patient to definitive care (i.e. a trauma hospital) within that 'golden hour'. Often the patient being treated by a doctor on scene will lose that 'golden hour'. Such delays shouldn't be tolerated – the doctor doesn't represent 'definitive' care, definitive care often means an operating theatre equipped with surgeons and nurses.

The solution is simple, on rescue helicopters (that do 'primary' missions) staff the chopper with two intensive care paramedics operating under protocol, and on medical retrieval helicopters (that do inter-hospital retrievals) staff the chopper with a doctor and an intensive care paramedic. This system would then best utilise the expertise of both the doctor and the paramedic; and would work out cheaper to implement.

Hospital Delays/Bed-block

Ambulances are delayed at hospitals for longer and longer periods of time. This means less ambulances on-road to respond to calls. A lot of the time 'bed block' is created because the Hospital has triaged the patient and decided that he/she requires a bed and needs to be supervised. The hospital then decides that the patient can have the ambulance stretcher and be supervised by paramedics until they find an appropriate hospital bed. It is an ideal solution for the hospital as Paramedics are not paid for by the hospital and are therefore utilised as extra unpaid staff to monitor, move, feed/drink, toilet, the patient for the hospital. Perhaps the hospital should be billed for all of the time that Paramedics spend in the corridor in bed block (the Service can bring in Officers on overtime and bill the hospital). Maybe then there will be some incentive to off-loading patients on ambulance stretchers. Maybe then they will take ownership of the problem.