Submission
No 13

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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Dear Members of the General Purpose Standing Committee,

There are many issues facing the Ambulance Service of New South Wales (ASNSW) and I would like to draw your attention to some of them.

1) Lack of autonomy.

ASNSW has an annual budget of around $300 million.

This comprises ~3% of the annual NSW Health budget.

The area health services (AHS) typically have a budget of around $1 billion PA.

Thus ASNSW comprises around one third of the budget of a typical AHS.

In comparison to these AHS's in particular and health in general, ASNSW is a minnow.

ASNSW senior management can be seen as a subset of the wider health bureaucracy.

We can also compare the ASNSW with the Fire Brigade, which, coming under the Emergency services portfolio, only has to share a minister with largely volunteer organisations such as the SES and RFS.

Likewise, the Police Force has its own minister and a much higher public profile.

In comparison to the Fire Brigade and the Police, ASNSW is the poor, silent cousin.

This lack of autonomy was demonstrated most clearly with the sale of several stations around 5 years ago. Under pressure from the then Minister for Health, ASNSW was forced to balance its budget. The only way to do this in the time frame provided was to sell the stations. This has left a myriad of problems and will cost ASNSW far more in the long term than the sales generated. A closer inspection of the sale, temporary relocation and redevelopment of the Ryde station would no doubt be enlightening. As would the Auburn station debacle.

Suggestions: 1) 1) Increased autonomy. While a close working relationship with the Health department is to be desired there is no reason that ASNSW could not fall under the Emergency Services portfolio with its senior management and medical director loyal to ASNSW rather than the Health department generally. If ASNSW has the ability to make its own decisions than some of the bungles of the past might not be repeated.

2) Improve the public profile of ASNSW by boosting the public relation budget.

2) Increasing and inappropriate ambulance usage.

Public utilisation of ambulance resources increases every year.

The service has 3 current strategies to deal with this:

1) Increased recruitment of Ambulance Officers,
2) The Health Advisory Centre (HAC) – underutilized and experiencing staffing difficulties,
3) The Extended Care Paramedic (ECP) program – currently a 12 Officer pilot.

Experience would suggest that many "000" calls are inappropriate and that strategies 2 & 3 are to be commended in attempting to deal with this. Why more effort is not devoted to this expensive problem in puzzling. More cynical members of staff suggest that "empire building" might be a factor.

Suggestions: 1) A well funded campaign to explain to the public when it is appropriate to call for an ambulance. The London Ambulance Service (LAS) ran a successful program along these lines by placing an ambulance and a taxi next to each other and listing the appropriate use of each. The campaign was clear, humorous and respectful. A business case to cover the cost of this campaign could be put to Health, based on the cost per callout of an ambulance.

2) A full time (or equivalent) school and community visiting Paramedic who would highlight this issue.

3) A five dollar flat fee for all pension card holders (currently fee exempt).

4) Subscribing to the Nurse on call program such as that used in Victoria. Patients and their relatives can call in with any sort of enquiry and the nurse links them to an appropriate resource (including ambulance) or simply provide advice. The HAC could probably be abandoned if this took place. http://www.health.vic.gov.au/nurseoncall/

3) Staff morale.

Corporate culture surveys (2000 – 2003 – 2007)

Theses surveys provide a grim picture of the perceived gulf between senior management and staff.

Some quotes from the 2007 survey:

> "Ambulance employees still feel extremely undervalued when compared to employees in other benchmarked organisations."

> "(The) concern for career development (is)…very low when compared to other organisations in the benchmark group."

> "…staff feel they are not paid or rewarded based on their performance, nor recognised for their achievements."

> "…the organisation continues to be extremely systematised and structured with clear rules and regulations."

> "…staff still perceive a moderately high degree of restriction on how free they are to make decisions regarding the approach they take to work."

> "Ambulance is still regarded as being considerably more reactive and short-term focused than other organisations in the benchmark group."

> "Vertical relations between groups … Ambulance still rates this dimension as considerably lower than most organisations in the benchmark group."

Suggestions: 1) Moving from a machine bureaucracy model to a professional bureaucracy model. This will entail considerable effort in raising the clinical standards across the board – a difficult task given some of the issues listed below.

2) Improved organizational autonomy as listed in item 1.

3) Address staff morale and organisation culture as a priority. If any organisation is in need of a culture overhaul, ASNSW is it. The employment of an Organisational Psychologist skilled in corporate culture change would be a good place to begin. Clearly, they would need significant authority and the backing of senior management.

4) Introduce measures to identify and promote clinically excellent officers.

4) Lack of staff supervision.

The practice of placing Trainee Ambulance Officers (in their first year of training) with "Level 2's" (in their second or third year of training) is widespread. The practice of placing new Paramedics with more junior partners is also commonplace. This is clearly not best practice in any field, let alone one as important as this. This problem is especially severe in rural areas where new Level 2's (after 1 years' experience) are sent to isolated regions, often to work with similarly junior officers.

Case study: J had no medically related background and joined the ASNSW 15 years ago. He spent his probation in a suburban Sydney station and then was posted to a rural NSW town. He worked as a single officer with very little contact with senior or education staff for several years. The station was upgraded and he continued on as Station Manager with a handful of staff. This station has a high staff turnover, J has been documented as being clinically dangerous by several of his staff and dozens of complaints have been received about him. Nothing is done and the situation remains the same.

While it easy to blame J for this situation, surely the ASNSW bears some responsibility for the lack of support, both personally and clinically, towards J.

Unfortunately, this story is not uncommon.

Suggestions: 1) Moving to a point where staff are partnered with a mentor at least 2 levels above them. Eg. Trainee officers are placed with a 3C or P1 level officer who has completed appropriate mentoring training. With the current high staff turnover, this will be a challenge.

2) Better utilisation of Clinical Training Officers (CTO's). The daily experience of these officers is often one of frustration as they struggle to locate busy crews and find time to update, evaluate and educate them. Some CTO's use a "on and off" approach where they join a crew for a case, then changeover to a different crew at the hospital for the next case and so on through the day. This seems to be effective and is to be commended.

3) Placing new Intensive Care Paramedics with a senior IC Paramedic for their first year.

4) Hospital theatre time for P1 level officers. Currently they may administer intravenous midazolam without having adequate "bagging" and airway management practice. This is unsafe.

5) Aggressively targeting and helping underperforming officers.

5) Lack of feedback.

Performance reviews are essentially unknown to Ambulance Officers (A/O's) unless (in some circumstances) there have been severe performance problems. For the bulk of A/O's beyond their first year there is very little feedback. Most A/O's assume that they are "all right" at their job but have nothing concrete to base that upon or any clear strategies for growth. Performance based pay seems a long way off given the current award system and HSU intransigence. Thus there is little or no distinction made between A/O's who are clinically excellent and those who are just getting by. More seriously, under-performing A/O's are often not dealt with appropriately. Some changes to this mentality appear to be happening. In recent years the rescue officers' recertification has been toughened up and several officers have lost their rescue qualifications.

Suggestions: 1) Modifying the Certificate to Practice (CTP) system to include a recertification of some sort.

2) Using CTO's (prior point) to provide feedback. Specifically, using CTO's to ride along for a day with all trainee A/O' and new IC paramedics.

3) Providing ongoing optional, clinical learning modules for P1's and IC Paramedics.

4) Annual or bi-annual performance reviews conducted by well regarded, senior staff.

6) Flawed selection processes.

The ASNSW recruits and promotes ostensibly on a merit basis.

Unfortunately, this principle has been subverted into a "application and interview" process, which does not measure true merit. Expertise, qualifications and experience are overlooked or undervalued in favour of "application and interview" ability. This may be appropriate in other areas of the public service but not in an ambulance context.

Case study: M was a highly regarded and experienced paramedic who was constantly sought out by other staff for advice and mentoring. Many senior staff regarded him as a true pre-hospital "expert". He had excellent clinical and scene management skills and an exceptional bedside manner.

M applied for a position at a popular coastal station.

M lost out to a new "Level 2" (On staff for less than 3 years) with no other qualifications.

When he queried this, he was told that the other applicant had a better application.

This too, is a common story.

Also, standards seem to vary wildly. E.g. for IC paramedic course 42 in 2001, there were approximately 450 suitable applicants' vying for 19 positions. In later courses there have been at times, more positions than applicants.

Suggestions: 1) Alter the selection procedures to give credit to on-road expertise, experience and qualifications.

2) More stringent physical fitness requirements at the recruitment stage and thereafter annually.

7) Inappropriate workload mix.

While difficult to measure, this has a significant impact on the daily working lives of A/O's.

A combination of poor data from the public, the concept of "over-triage" and scarcity of Patient Transport Officers (PTO's) results in:

The majority of primary care crews spend most of their time performing PTO-level work

The majority of paramedic crews spend most of their time performing primary care level work.

While this to an extent is unavoidable, the current mix leads to widespread staff dissatisfaction and skills atrophy. There is a strong sense of under-utilisation of skills and knowledge.

Solutions:

1) Increase PTO numbers markedly. Privatisation or corporatisation of the PTS should be considered. All R3 and below cases should be a PTO response unless there are extenuating circumstances. Skills extension for PTO's to deal with this should be examined.

2) Integrate the use of mobile phone cameras into the call taking process. The market penetration of these devices is high and as every experienced clinician knows, a picture speaks a thousand words. Privacy issues will need to be worked through.

3) An ongoing review of the MPDS system to ensure appropriate dispatch categories.

8) Lack of career path.

Many options exist for paramedics to diversify, however issues of infrequency and randomness affect nearly all of them. Coupled with the "application and interview" selection process detailed in point 6 and the poor work quality (point 7) leave many previously motivated staff in a career limbo. At this point could I note our IC paramedic training falls behind the standards of much of the USA, South Africa, Canada and in particular the MICA paramedics from Melbourne. Yet ASNSW uses mottos such as "Best again" and Clinical excellence" without apparent irony.

Solutions: 1) Increased training standards across the board.

2) An integrated pathway of on-road time, tuition at the AEC, take home packages, CD ROM interactive learning, scenario training, hospital and clinic time, SIM man instruction and examination would culminate in a diploma, degree or masters, depending on the level at which the employee chooses to stop. Certainly a push towards having every A/O at a degree level should continue in order to match other health professions. The ECP program is a welcome move in the direction of professionalism.

3) International exchange programs with other first world, English speaking nations e.g. The USA, Canada, South Africa, the UK and New Zealand. Likewise this could operate on an interstate basis. National registration of Paramedics and Intensive Care Paramedics should be pursued.

4) Introduction of a higher clinical level who would act as a clinical supervisor and mentor with increased skills.

5) Double the number of rescue and co-ordination positions so that officers can work "roster on – roster off".

6) Clear indication of when courses will be run (IC paramedic, rescue, SCAT in particular)

7) Teaching first aid to the public as a career or career break option.

8) Improved flexible workplace practices. These could include a career break or nomination of hours per year to be worked (as in some UK ambulance services).

9) Inadequate Ambulance station coverage.

Many areas in Sydney are inadequately covered by ASNSW due to a deficit of stations. In the areas known to me there are three (Carlingford, Berowra and Galston) that are at best 15 minutes away from an ambulance. For a first world city in the 21st century, this is embarrassing.

Solutions: Smaller, more widely distributed stations. This will require significant a capital outlay, a symptom of chronic past under-funding.

Thankyou for taking the time to review this submission.

Kind regards,