

**INQUIRY INTO 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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Partially Confidential

Dear members of the GPSC,

Thank you for taking the time to review this document.

I made a submission to the committee and had the privilege of appearing before you when the Ambulance Service of New South Wales (ASNSW) was called to account in 2008.

In this paper I have copied my original submission (normal text) and made notes (italics).

### **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.

*This lack of autonomy was demonstrated again when ASNSW divested itself of many of its rescue units, apparently under direction from NSW Health. ASNSW displayed either its lack of organisation or lack of concern for its workers by not notifying rescue operators until 36 hours prior to the units being shut down. This has led to widespread distrust of senior management.*

*Can I add by way of counterpoint that three initiatives in particular are leading the way in Australia: the Special Casualty Access Team, the Ambulance Research Institute and the Extended Care Paramedic program. Each of these (to my knowledge) is unique in Australia and to be commended.*

## **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 is puzzling. More cynical members of staff suggest that “empire building” might be a factor.

*Ambulance usage continues to grow.*

*There has been slight growth in the ECP program in spite of issues with “buy in” from necessary health resources.*

*There has been a massive intake of new ambulance officers (paramedics) in 2009 as a response to the new “4 by 5” rosters that require extra staff. While this will no doubt help in some ways it also exacerbates the “junioriness” problem detailed in point 4.*

*A low budget advertising campaign of “this is a taxi, this is an ambulance” was run. I am unsure of the outcome of this campaign.*

### 3) Staff morale.

Corporate culture surveys (2000 – 2003 – 2007)

These 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.

*Little seems to have changed in this dimension. The staff survey has not been issued again.*

*ASNSW put its entire staff through "Healthy Workplace" training. I am not aware of the outcomes of this training.*

#### **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. E.g. 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.

*Due to changes in the award there are now many more supervisors.*

*Junior staff continue to be rostered with each other routinely.*

*Case studies like “J” remain.*

## **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.

*Performance reviews remain absent for the bulk of staff.*

*Some additional training is available.*



## 6) Flawed selection processes.

The ASNSW recruits and promotes ostensibly on a merit basis.

Unfortunately, this principle has been subverted into an “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.

*“Application and Interview” continues to be the dominant selection paradigm with the notable exception of Intensive Care Paramedic (ICP) and SCAT.*

*No ongoing physical assessment of Paramedics is made. Examples of paramedics who are so overweight that they cannot lift patients, bend over or perform CPR exist. Exercise equipment is banned on station due to fears of injury at work.*

## **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.

*This is unchanged.*

## **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).

*The changes seen here include “Improved workplace flexibility”. Due to the new award, casual work is now available. Also, national registration of paramedics is underway. Otherwise, this is unchanged.*

**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 21<sup>st</sup> century, this is embarrassing.

*This is unchanged.*

Please feel free to call me for any clarification on

Kind regards,