Submission
No 136

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

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NSW Legislative Council

General Purpose Standing Committee No.2

Inquiry into the Management & Operations of the NSW Ambulance Service

NOTE:

This submission is made in the capacity as an individual having considered the terms of reference for the inquiry. The author wishes for the contents contained herein to be kept confidential and be withheld from general public viewing, specifically the management of the Ambulance Service of NSW.

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EXECUTIVE SUMMARY

The author of this submission is currently employed with the Ambulance Service of NSW (the service) In total the author has been associated with the service for a total of years.

No matter how much various levels of management dress things up to please those in health and government, at the frontline of Ambulance, the organisation is still one that places very little value on staff and lacks any ability to tackle the real issues and achieve sustained improvement for staff. Many of the issues around today are not new and have been around along as I have been associated with the service.

The work environment of road paramedics is one of very low morale and an attitude of 'we have tried so many times before to get things improved and ended up with nothing but lip service, so why bother now?' This position is probably best illustrated in the low number of submissions made to this inquiry by frontline staff. Staff feel beaten down and have lost hope that any positive, sustained change will arise from any investigative process into the service.

There is a general feeling that the service will be better off becoming a commissioned service, with a uniformed officer, who knows what it's like at the frontline, as the head of the service. The Police Force, NSW Fire Brigade & Rural Fire Service all have commissioners, so why can't Ambulance? In addition to this there is also consensus that Ambulance would do best being removed from the Health ministry into the Emergency Services ministry. These are sentiments with which I strongly agree.

The pages that follow expand on the following:

1. The services processes involving re-employment of staff are grossly inadequate resulting in substantial wasted time and unnecessary expenditure of tax payer funds.

2. The service continues to prioritise sending staff that are least equipped and experienced to rural and remote locations.

[redacted]

4. Despite assurances from the service to the contrary, the service continues to endorse trainee paramedics supervising other trainee paramedics due to lack of experienced workforce.

5. The service continues to disregard the welfare of clinical mentors who have experienced high supervisory loads and fails to provide adequate relief from these duties until forced to do so through medical certificates for stress related issues, or until staff seek appointment to other positions.

6. The service continues to ignore the need to have on-station training sessions built into roster structures to provide skills currency.

7. There is very little incentive for staff to remain in frontline clinical roles due to lack of staff, excessively high workloads, inflexible annual leave arrangements and poor remuneration

8. When staff do choose to leave the service, the service shows no desire or enthusiasm to retain their services.

1. STAFF RECRUITMENT

1.1 Re-employment Processes

The following summarised account of my experience with ASNSW highlights a business unit that is grossly inefficient, heavily bound in 'red tape' and process. It shows a unit with no ability assess each case on its own merits and act in a manner that gets best value for tax payer money in terms of re-employment of recent former employees.

[Following 2 pages omitted by secretariat to protect identity of author, as requested]

Surely it is appropriate for a level of discretion and common sense to be used in circumstances such as this. It is absurd that someone who has very recently been a Paramedic for a number of years with the organisation they are seeking to be re-employed with should have to undergo aptitude testing. Such circumstances have 'Prima Facie case' written all over them, in other words, it speaks for itself that someone who has done the job for a long time has the aptitude to do it. This is a complete waste of time and money, and does nothing more than delay the delivery of experienced clinical care to the public.

Whilst I do not disagree with the requirement to have assessment of medical fitness, yet again a level of discretion and common sense should prevail. Surely a review of the previous employee's personal file would show all sort of relevant history such as sick leave patterns, lost time due to injury and workers compensation and any staff complaints regarding fitness for duty. In light of this though, the service has a required fitness standard for entry but does not require one to maintain that standard, and neither do they provide incentive or opportunity for one to maintain it.

[Following paragraph omitted by secretariat to protect identity of author, as requested]

The service should implement a specific streamlined re-employment process similar to that utilised by the defence force, and I am led to believe also by the NSW Police Force and NSW Fire Brigades. These programs do have time limits for previous employees to take advantage of them. For example, subject to being a Qualified Paramedic, within 2 years of leaving the service; submit application, attend interview, and subject to medical assessment and conduct and services check of previous personal file, undertake an abridged induction program of 3 weeks including mandatory induction lectures, skills review and assessment at the level of clinical certification upon resignation.

1.2 Post-probationary Posting Processes

It is current policy that following completion of approximately 12 months service i.e. completion of probationary time and in-service 1, the priority use and placement of Level 2 Paramedics is to rural positions that are difficult to fill.

This situation is not ideal to say the least. The reason for this is that these people are still in training, i.e. they are not yet fully Qualified Paramedics however considered safe to work without direct supervision should the need arise. It is unfortunate that someone who is for all intents and purposes an advanced beginner is sent out to a rural or remote setting with limited resources and support after just 12 months to be in charge of situations that seasoned Paramedics in metropolitan settings will never have to deal with.

It is recommended that newly qualified Paramedics become the priority use in placement at rural positions that are difficult to fill. There would be quite a significant benefit to rural and remote communities through this in that they will have fully qualified Paramedics with greater experience and treatment capabilities. At the moment they get advanced beginners with only limited treatment capabilities.

2. STAFF TRAINING

[Following 1 ½ pages omitted by secretariat to protect identity of author, as requested]

2.2 Supervision of Trainee Paramedics

Since I was originally employed by the service in there has been an increasing reliance on using level 2 Paramedics to mentor and supervise Probationary Paramedics. This arrangement is totally inadequate as it essentially consists of a trainee supervising a trainee.

The service has, and will, continue to argue that this is not the case. This could not be any further from the truth and again does not bode well from a patient safety and clinical quality perspective.

The process to become a Qualified Paramedic takes at least 3 years and comprises; an initial trainee school component of 8 weeks, a minimum 30 weeks supervised on road practice (probationary time, i.e. Level 1), In-service 1 school comprising 3 weeks and then back on road for 12 months to 2 years (Level 2), and finally In-service 2 comprising 3 weeks and attainment of Diploma Paramedical Science (Qualified Paramedic).

The level of trainee recruitment is so high that probationary supervisors (clinical mentors) are working for up to 2 years straight or more without working with another fully qualified officer. This is placing unprecedented stress on mentors and causing burnout. Such a system only works to create a negative feedback cycle where there is a gradual deterioration in the quality of supervision and input being provided to the point where in some cases there is virtually no input being provided whatsoever. There is essentially no recognition of the work clinical mentors perform and does not

seem to be valued in any tangible way by the organisation. As a direct result of this situation officers are seeking promotion to other non-operational positions such as co-ordination simply as a means to get away from working with trainees for a period of time.

In order to get any relief I had to see a doctor to get time off work. It was only then that management took any notice and made appropriate changes.

2.3 On Station Training

Around the time Certificate to Practice was introduced, the service introduced a new role of Clinical Training Officer (CTO) as part of the education team to assist with the implementation of CTP. Two of the key roles a CTO performs are on station and on-the-job training.

In reality, in the Sydney area, a CTO performs very little on station training due to the high level of operational activity. When arrangements are made to undertake training on stations, training sessions are inherently interrupted due to cases.

Some CTO's train Paramedics in ambulance parking bays as hospitals when crews are delayed because of hospital block. Again this is far from ideal and certainly would does little in contributing to building public confidence in the service as it generally occurs in public view.

Overall the activities of CTO's are highly inefficient due to limitations in accessing staff on stations for training purposes.

There have been proposals made to the service by Paramedics over the last few years suggesting alternative rostering systems that would allow incorporation of designated on station training components. This training component would be in addition to time allocated for the CTP program.

The service should implement a rostering system that incorporates designated times for on station training that cannot be interrupted for operational purposes. Such a system would markedly improve effectiveness and efficiency of CTO's.

3. STAFF RETENTION

Overall there is very little incentive for staff to remain in the service performing a frontline clinical role. The reasons for this relate to inadequate frontline staffing levels, rigid and inflexible annual leave arrangements, excessive workload and poor remuneration. These are all explained further in the sections that follow.

There is a general feeling amongst Sydney based Paramedics that there is no future in working frontline clinical duties full time in Sydney. Many, including myself are of the opinion that if one wants to stay a full time 'road ambo' then you need to go to a rural/coastal position, or if you want to

stay living and working in Sydney, then your only future is to get a job 'off-road' in a role where you can still maintain some patient contact. In fact to take this further there is other sentiment that says that being an ambo in Sydney would be a fantastic part-time/casual job but is pretty ordinary on a full-time basis.

3.1 Staffing Levels & Workload

Despite record levels of recruitment over recent years there remains a lack of staff at the frontline. Unlike other essential services such as the Fire Brigade, staffing is not indexed according to population growth. For example, western Sydney has undergone a population explosion over the last decade yet Blacktown and Castle Hill stations have not had any staffing enhancements on the frontline in the last 10 years and Parramatta has not had any enhancements for 8 years.

Some years ago an operational review was conducted for Sydney that recommended significant staffing enhancements are made in addition to a 30% relief capacity to cover sick leave, training requirements and annual leave etc... To date we are still yet to see full implementation of these recommendations at the front line.

At the time of the Sydney operational review, a process was in place that ensured a minimum level of staffing was maintained for each shift, these were Minimum Operational Levels (MOL's) and were heavily enforced and failure to maintain them would result in industrial action. With the completion of the operational review, the MOL's were replaced with Effective Deployment Levels (EDL's). EDL's are essentially MOL's rebadged and are not subject to the enforcement that MOL's were. On any given shift in Sydney it is now common for resourcing to be well below established EDL's.

It is a regular occurrence that Sydney operates with over 10 ambulances out of use on a Friday night shift due to sick leave, the same had also occurred on occasions on a Saturday night shift. In

fact because of the workloads at these times, some staff now simply refuse to work consecutive Friday and Saturday night shifts.

Issues relating to staffing and workload are intrinsically linked.

It is now common place in Sydney that on a day shift one may commence work at 8am and be called out on a case straight away leaving no time for checking of vehicle and equipment. Managements approach is that it only takes 5 mins to check a car, in fact that doesn't really matter, just go do the job and cop the flack if something is missing or goes wrong because a car check was not done. Once a crew leaves the station they often do not return until after their shift completion time. It is common place for crews to be doing 2 hours of shift extension without having had a meal break all shift.

On night shift things are no better. Yet again start at 6pm, no time to check vehicle or equipment, go straight out on a case and you might get back to station for the first time at around 4am. You might then be lucky to get some downtime but it is limited. The fatigue levels experienced on night shifts are enormous and nothing else but dangerous. There is no longer much difference between workloads experienced on day or night shifts, except night shift runs with reduced crews.

One positive is the services intention to reduce the length of night shifts from 14 hrs to 12hrs. This is a good start but is not the only solution in ensuring effects of fatigue are minimised.

3.2 Annual Leave Arrangements

Paramedics are currently entitled to six weeks annual leave per year. However one must submit their leave requests about 18 months in advance and must take either two 3 week blocks or one 6 week block and take them within specific allocated leave blocks. The rigid and inflexible nature of

leave arrangements is a big turn off and annoyance for many staff that no doubt has a significant personal impact.

3.3 Remuneration

Whilst the issue of remuneration is currently subject to proceedings before the industrial relations commission, it still nonetheless requires mentioning here.

The general consensus among frontline staff is that they need to work like 'dogs' to make a decent income. This means doing excessive amounts of overtime and relying upon penalties to make ends meet.

This situation gets worse when one gains a position off road with the exception of Paramedic Educators. In general there is very little incentive for people to gain higher positions because the remuneration at management levels is also poor and does not seem to have parity with similar positions outside of health.