Supplementary Submission No 178a

INQUIRY INTO EMERGENCY SERVICES AGENCIES

Name: Name suppressed

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Chairperson
Enquiry into Emergency Services Agencies
NSW Parliament
Macquarie St,
Sydney NSW 2000

Point of Interest, Ambulance aspect of enquiry.

Dear Hon. R. Borsak

My declared interest in this enquiry relates to my employment with the Ambulance Service of NSW. I commenced my employment in and resigned in . I was fortunate to work in both the Sydney region, and in rural NSW with my last posting in what was known as the . I am years old and have previous experience as an . Concurrent with my Ambulance and other paid employment I held membership of a number of volunteer organisations, some of which are providing evidence at this enquiry.

I am providing the following comments without fear or favour, coercion or any other inducement or on behalf of any other individual or organisation.

The Ambulance Service was historically a "Command and Control" based organisation as was the nature of management process across all emergency response agencies in NSW. For the most part this worked, in relation to how individual agencies worked and then how the inter-relational workings developed in multi-agency responses. The predicament for the Ambulance Service is that while it is within the Health Service area of government responsibility, it is an Emergency responder agency. Within the hospital system there is a hierarchy that is medical officer centre driven that is clearly understood. In usual operational terms, regardless of whether in an emergency department, operating theatre, high dependency care or general ward area, the conditions are predictable.

The issue for the Ambulance Service and the paramedics working in often very "Un-Controlled" circumstances, is that not only does there need to be leadership structure within the organisation, but a representation of the Ambulance Aspect of the response with as many as eight other agencies. With on-going multi agency situations such as the "Thredbo Emergency" where there were many agencies involved with the initial and on-going response the Ambulance Commander was part of a team of nearly twenty separate representatives involved with managing that particular incident. There needed to be a cohesive internal singular agency command structure as well as the very well understood inter- agency command relationship structure, the success of this and other major incidents, is partly due to the recognition of persons wearing various rank/position insignia and the associated authority that comes with the particular rank markings or insignia.

In terms of occupational stress and the issue of bullying I see this being synthesised in the following manner.

Organisational, I best explain this in the following manner.

- As an employee you agree to be "posted anywhere within NSW, to meet the needs of the Ambulance Service". Usually Trainees, (probationers) will be allocated a station as close as possible to their home address be that in the Greater Sydney area or in rural NSW.
- That said, in some situations where trainees are allocated their training station two hours of travel prior to and after the completion of the allocated shift has been a "necessity. Typically the roster pattern, in particular the Ambulance Service, is to work a 4 shift on 5 day off sequence.
- The trainee returns to their second cycle of training, some nine months after joining the service, if there are unfilled country vacancies the trainees are then, firstly advised that there are unfilled stations and to consider "volunteering" for one of these placements. These placements used to be for a minimum of two years. The consequences is that the staff member, who may have a family connected to their location of origin then needs to dislocate the family or commute, hoping that someone else may later swap with them. I know of situations where employees after trying to provide a case of extenuating circumstances, have resigned as the "only option" due to the ambivalent attitude of either senior uniformed or civilian management employees.
- In country areas where in smaller stations staff numbers are low and work load is inconsistent, and the performance of the officer in charge as been sub optimal, yet if junior staff complain, the local management either "coerces" them into withdrawing the complaint, or move the junior officer, rather than sanction the officer in charge.
- In the metropolitan and larger centres in Newcastle and Wollongong there was a well-accepted "localised" culture that as everyone before you had been subject to the same "rules" then you as the junior had to also follow that same behaviour. When complaints were made about unfair treatment, the management would normally suggest to the complainant to consider a transfer elsewhere rather than offer any other solution.
- There is plenty mentioned about emergency service workers being "trained" to deal with the various elements of occupational stress. In my experience this training was superficial at best. The sessions were usually presented by education staff that may have themselves been to a short training course and then essentially relaying what had been taught to them.
- Through my employment with Health, Police or Ambulance did I ever have a training session delivered by either social worker or psychologist? I have only ever heard of a few situations where managers when attending various training seminars have received what could be best described as appropriate training by professionals within this qualification skill set. As a in a control centre having to often provide complex medical advice to distressed callers and also dealing with staff both within the call centre and also "Counselling" road staff who had been at the calls that we had handled, I received NO Training. The inference was that my plus years "learnt" experience would get me through. It did not and I left.

Localised management, I best explain in this way.
When I joined, there were still staff members who were third generation predominantly male staff, some who were early intensive care paramedics and while well intentional continued

with "past privilege and practice" methods of management. If you were the junior on the station, you were assigned the relief duties to undesired stations, if rostered to larger country stations. In Sydney you were, in some cases, blatantly assigned the rosters that involved working busy periods or less desirable parts of social activity such as working over the Christmas and New Year holiday period. When staff would ask if consideration could be given to being allocated other roster lines the response was generally, "You joined knowing that this was 24/7 rotating roster job, suck it and see". While perhaps in one sense, not a bullying issue, it is the intent in which the response was offered.

Staff relations at Branch level is explained with in the sphere of:

- one staff member not getting along with another
- one staff member not being considered for additional specialised training against another staff who is nominated for any additional training made available
- Certain leave blocks always being allocated to certain staff and other staff have to just accept the leave blocks offered. In smaller stations, the leave can be organised around a group of stations with little or no acknowledgement of staff with compelling reasons to apply for one particular leave block against another leave block. When application is made to higher levels of management, the response is generally too bad or similar.
- One or two staff being offered higher duties, yet several other staff being eligible regularly over looked. In small stations, often the favoured officer who may be friends of the officer in charge then will treat the other staff members with indifference.

As I moved through from branch level to a control room situation, I noticed that as younger officers were employed, there was less respect for senior staff and a significant increase in compliance to local allocated station duties. Often, in the control room, I would receive complaints from staff about other staff on the same station resulting from disagreement over assigned station duties. In these situations I would contact the relevant operational manager to resolve the issue. In many situations I was not confident that the situation would have been resolved adequately, however my hands were tied when it came to branch station operational management.

In many respects, the attitude of staff while I was employed, and as I understand it from speaking with staff still employed today, it is not what you know, but who you know. This could be at a local level where one officer is given "higher duties" more frequently against other suitable eligible staff, to applications for further clinical or supervisory being denied through to perceived or actual complaints or conflicts not being adequately managed or resolved.

During my years of employment with the Ambulance Service I know of eight fellow staff who committed suicide as a result bullying, complaints or investigations not being resolved or due to long term deliberate inter personal staff conflict. In many circumstances I either had direct knowledge of some of the issues inflected on these staff, or had excellent third party knowledge. In some cases the local managers were clearly not equipped to be managing often complex personal and inter-personal issues. I know one occasion where the senior manager indicated that he could not make a decision to assist as he would be seen as favouring that officer against other staff. Additionally the senior manager could not offer any assistance for the officer in terms of counselling other than to speak to a peer support officer. The irony of this was that the two local peer support officers were themselves seeking additional assistance as a result of being peer support officers and felt that they could not offer any assistance.

The employee assistance counsellors sought, had no appreciation of small town rural ambulance operations, nor had a clear idea of the impact that the roster cycle in place at that time had on the staff concerned. Representations were made to more senior managers and the response simply was inept and ultimately left one particular officer with no other likely option, but to suicide. My understanding is that while some improvements have been made to allow staff to access a wider range of support options, often at 3 am in small remote communities half way through an eight day roster cycle, the idea of perhaps ringing someone many hundreds of kilometres away, is simply not an option.

There are many issues facing operational staff as well as mid line and senior managers, these include:

- Changes to education and training levels and resulting changes in clinical performance.
- Changes in community expectations of emergency service response, in part due to the increase use of mobile phone technology.
- A poor understanding that due to changes in employment opportunities in rural areas the families of employed staff cannot simply move from one location to another at the whim of either a senior uniformed manager who may have come "through the system" when it was a given that you just accepted your posting and "got on with it" or a civilian support worker with no concept of what it means from going from a station where you might do 10 cases a shift to ten cases in a week with no other clinical assistance.
- A perceived indifference from senior managers toward junior staff who raise issues of concern and these officers not being supported. In some cases the union advocates are the people who officers would normally turn to, but these employees (Union representative) are the cause of the complainants' issues.

This was a major issue in my case, where in my role as a , my decisions were often interfered with. Due to the long term relationship between my middle line managers and the road supervisors, my decisions were frequently overturned, changed to suit the whims of these union representatives. The senior management did not want to be seen as "rocking the boat" so would support the overturned decisions, sometimes impacting the outcomes of the patients due to this interference.

One of the other inherent issue with Ambulance Service, but still an issue, but to a lesser degree in other services, is that staff can get to a particular location or position and stay there. One of my managers has been in one area of the Ambulance Service structure for more than twenty five years. While aspects of his corporate knowledge had developed with various change management initiatives, his approach to line management problem solving has not, another reason why I left. He had lost perspective of staff relations and went for the pathway of least resistance in almost every instance of conflict between staff under his command.

In my time in the Operations Centre environment, there was a significant change in managing resources through the implementation of computer aided dispatch technology, there was a change in the skill set of the staff working in these centres and changes to capability and capacity of smaller hospitals to assess and treat patients arriving at these facilities. The integration of these processes was poorly managed by senior management and the communication pathways in some situations non-existent leaving the shift staff employed in the various operations centres to explain often quite complex changes to long held and accepted practice/s to the staff working from the branch stations.

In closing, the Ambulance Service, as an entity, is a unique agency within the responsibility of Government service delivery, along with other response agencies, works within a specialised response framework, that while required, are often seen as inflexible. While the management policy framework needs to be part of the way the organisation is managed, it is not always able to allow staff to work as desired with the uncontrolled nature of the work faced on a daily basis. This work is often the catalyst to conflict between individual staff or groups of staff against each other. Senior Policy level Ambulance Staff and Department of Health staff simply do not always articulate the integration between observing inflexible generic government policies to the fluid nature of emergency response. This is a major failing of senior management across all response agencies and what I witnessed during the tenure of five "State Superintendent/Commissioners" during my employment.

The protocol framework that paramedics work within, in essence works well. Unfortunately the various human relations policy frameworks do not. On this aspect the issue of indifference, bullying, perceived or actual is allowed to progress. While the intent of the professional standards unit maybe honourable, the reality is, that in the attempt to ensure due process is effected, reverse discrimination occurs. The ambulance service has a poor attitude toward ensuring middle level managers are provided with necessary investigations training that will ensure valuable investigation process is not missed, ignored or simply not applied.

I have a training background and the analogy I would use is this. Sometimes an adaptive methodology is required to allow the student to benefit from the skill or knowledge being sought. In essence the principle is taken to the student, not the student being expected to learn by one methodology when another may be more appropriate. Historically, the Ambulance Service has, even in a "Modern" context managed by reaction, not by prevention. The change management process has been lost on this basis with current management, but equally with a younger generation who do not always want to accept that there needs to be a particular structure so that the job is done well the majority of the time, by the majority of the staff providing a high level of care in a very often un-controlled environment dealing with individuals with often complex medical/trauma issues or who are effected by substances of abuse.

The system is not broken, but certainly it is not running at an optimal level. There does need to be included during training, additional information on conflict resolution, positive communication, and team work. There needs to be a "hands on" approach by managers to engage with staff, not manage by phone or "remote control". Staff must have available trained trauma counselling specialists who can appreciate what it is like to resuscitate a person in wet dark conditions and who may make "honest mistakes" due to a range of variables that can contribute to the less than optimal care being delivered.

There needs to be a re-introduction of clinical staff within the control rooms, so that civilian staff have the ability to seek real time advice on complex situations or the clinical staff can provide technical advice to road staff due to the subliminal knowledge developed from being in road based positions. That the dispatch guidelines be further articulated to a NSW context. The system was purchased from an American based software company in 1997 with virtually no localised integration. This system is very suited to American conditions not for a State wide based government service agency such is the case in NSW.

To move forward in reducing harassment and bullying within the Ambulance Service, the following elements must be investigated:

- Employment of health & well-being professionals (Social worker/psychologist skill set) who can be involved with training staff from entry level to attending regional managers meetings and who can be available for 1st line intervention crisis management situations.
- A process to developed where if a station receives either a certain number of complaints within a specified time frame or a particular type of complaint that the station officer is removed, not the other staff.
- That mediation is actually used and coordinated by someone with appropriate training. I know of several situations where the local middle line manager made things worse by trying to resolve historic long term issues, purely due to a lack of insight himself on the situation.
- That the command and control structure actually be reinforced and staff understand that in an unstable environment such as violent patient situation, adverse weather conditions or where there are variable outside the control of the staff or organisation, that the resilience of the command and control structure is what actually assists in dealing with the situation.
- An acknowledgement by sector/zone and senior management that posting staff to a town with no rental accommodation and expecting the staff member, who may have been dislocated from family and other support networks, is not appropriate in the 21st century. To resolve this, the Ambulance Simply needs to supply appropriate accommodation and not expect staff to stay in sub- standard public holiday accommodation, which I witnessed myself only 3 days ago.

Thank you, forwarded for consideration as required.