REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO THE MANAGEMENT AND OPERATIONS OF THE NEW SOUTH WALES AMBULANCE SERVICE

———

At Sydney on Friday 4 July 2008

———

The Committee met at 10.10 a.m.

———

PRESENT

The Hon. R. M. Parker (Chair)

The Hon. C. M. Robertson
The Hon. G. J. Donnelly
The Hon. M. A. Ficarra
Reverend the Hon. G. K. M. Moyes
Ms L. Rhiannon
The Hon. H. Tsang

IAN MICHAEL PETERS, Acting Director, Workforce, Ambulance Service of New South Wales, Locked Bag 105, Rozelle,

MARIAN FRANCES O'CONNELL, Director, Professional Standards and Conduct, Ambulance Service of New South Wales, Locked Bag 105, Rozelle,

DEBORA MARGARET PICONE, Director General, NSW Health, Locked Bag 961, North Sydney, and

MICHAEL DEAN WILLIS, General Manager, Operations, Ambulance Service of New South Wales. Locked Bag 105, Rozelle, sworn and examined:

GREGORY JOHN ROCHFORD, Chief Executive, Ambulance Service of New South Wales, Locked Bag 105, Rozelle, affirmed and examined:

CHAIR: Welcome everybody to the New South Wales Parliament and to the inquiry into the New South Wales Ambulance Service. I have some opening comments to make on this our first day of the inquiry, if you will just bear with me. The inquiry's terms of reference are about examining the operation and management of the Ambulance Service. So we are looking at the systems of the Ambulance Service rather than looking to point the finger at individuals. We do not propose to investigate or conciliate individual complaints, so I ask witnesses to reflect on the terms of reference and to assist the Committee by using your experiences to improve the New South Wales Ambulance Service.

That said, there have been a number of inquiries into the Ambulance Service over the years. This inquiry has come about because of concerns raised with many members of Parliament and in the public arena on behalf of ambulance officers who report concerns specifically regarding bullying, harassment, intimidation, and occupational health and safety. As front-line workers, the ambulance officers we meet have a great regard in the community. It is our responsibility—all of us—to make sure that the service is efficient and operates the best it can while supporting those front-line workers. That is the reason our terms of reference have been established. They go to those issues in particular more than to things such as call-outs and rostering, although they may be raised and considered. That is the difference between this inquiry and many others that have arisen in the past.

This inquiry, however, is not a forum for witnesses to make adverse reflections about others. It should be remembered that privilege applies to parliamentary proceedings, including committee hearings, and that is absolute. It exists so that Parliament can investigate properly matters such as this, and I therefore ask witnesses to minimise their mention of individual colleagues and managers unless it is absolutely essential in order to address the terms of reference. The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines covering the broadcasts are available on the table inside the door. I point out that, in accordance with the Legislative Council guidelines for the broadcast of proceedings, members of the Committee and witnesses may be filmed or recorded but people in the public gallery should not be the primary focus of filming or photographs. In reporting the proceedings of this Committee, the media will take responsibility for what they publish or what interpretation is placed upon anything that is said before the Committee. Witnesses, members and their staff are advised that any messages should be delivered through the Committee clerks. I also ask that everyone please turn off their mobile telephones. I welcome our first witnesses today. Would you like to make a brief opening statement?

Professor PICONE: First of all, thank you for this opportunity to address the Committee, but also, Chair, thank you for your opening remarks. It helps us understand some of the ground rules. I thought, with your permission, that I would give a brief outline of the Ambulance Service and some of the issues that our service is confronting. We have a written submission that, with your permission, we would like to table today in the Committee. The Ambulance Service of New South Wales employs more than 3,700 staff across 291 locations. Those of us who have had the misfortune to need an ambulance will appreciate the enormous reliance we have as a community on the service, particularly on our paramedics. Our ambulance paramedics confront the most difficult situations on a daily basis—the immediate tragedy of a motor vehicle accident or the sudden collapse of a colleague in the workplace. They enter people's homes, often in the most desperate circumstances. Whatever the event, it is an intensely personal and intimate time when we entrust our lives or that of our loved ones to our paramedics. There are more than 2,000 calls each day that can be defined as emergency calls.

Our Ambulance Service is highly trained and a highly skilled workforce. In fact, in the past three years 91 per cent of the workforce has completed enhanced training to enable them to undertake very complex clinical

procedures and front-line treatment. I want to say how proud we are of the New South Wales Ambulance Service. The Ambulance Service in New South Wales has the largest proportion of front-line staff compared with our interstate colleagues. So 89.7 per cent of the total staff are made up of front-line officers. It is worth noting that the attrition rate within the service is one of the lowest across government agencies—in fact, across the total Australian workforce. Our attrition rate has averaged 4.5 per cent over the past eight years.

While we acknowledge that there is always more we can do to support our workforce, it is important to highlight that there has been considerable reform undertaken by the service to build the capacity within the service on both the front line and within management. You will be pleased to know, Chair, that in my homework and preparation for this hearing I went back and looked at the origins of the ambulance service in New South Wales. The first ambulance service was established in 1895 at Railway Parade by two officers under the supervision of a brigadier. So it is one of our most long established health services. The Ambulance Service review released yesterday is the next significant wave of reform for the service. I will not touch on that because I know that Mr Head is to appear before the Committee as a witness. However, I assure you that it is our intention to implement each and every one of those recommendations.

There is no doubt that the demands of the job contribute to staff morale issues. In turn, the morale of staff within an organisation affects the culture of that organisation. In some circumstances it can cause staff to exhibit unprofessional behaviour towards each other and also between the management and the staff. Consistent with the observations of Graeme Head's review, the recommendation is for the Ambulance Service to implement improvements to manage these conflicts. He has basically said that over time the Ambulance Service has addressed these issues, but I assure you that there is a lot more work to do.

New South Wales Health has a zero tolerance to bullying and harassment. Bullying is not tough management; its purpose is to hide inadequacy. The reason I welcome forums like today and these sorts of inquiries is that I believe it allows us to bring into the open and discuss issues around bullying and harassment, because I think that is one of the most important ways of, at the end of the day, defeating bullying and harassment in the workplace.

Before I update the Committee on some of the initiatives we have undertaken in these important areas, it may be instructive to give the Committee some insights into our approach and the theory underpinning our complaints handling. Most large service organisations suffer conflict, as their biggest asset is people. So the Ambulance Service is not unique in that regard. The conflict ranges from personality clashes between staff to bullying and harassment between staff and between management and staff.

A national poll of Australia reported that 35 per cent of Australians had been verbally abused by a co-worker and 31 per cent by a manager. That was a Roy Morgan Research Centre report. When the conflict is not resolved, a grievance may be lodged. The grievance usually involves some concern or personal distress, and usually, though not always, involves other people. In the Ambulance Service, as in other organisations, it is the role of managers to take the lead in resolving grievances raised by their staff. As much as possible we encourage and support the local resolution of the problem.

If you look at our policies, we say that front-line handling is the most important aspect to complaint resolution. To that end, a large amount of training is underway. In fact, training is compulsory. Greg Rochford advises me that over 400 operational managers within the service will be trained. Obviously, there will be some need to escalate that through to the senior regional management teams as well. Grievances that allege behaviour that may constitute misconduct escalate directly to the Professional Standards and Conduct Unit for investigation and management.

Swift resolution is very important, not only for the individuals involved but for the morale of the entire workforce. Grievances are different from complaints of bullying and harassment. Bullying and harassment is defined as unreasonable, undesirable behaviour in the workplace, or in the course of employment, that will generally have characteristics such as: being repeated and unwelcome; the recipient will find the behaviour offensive or threatening, as would any reasonable person. So there is a difference between conflict in the workplace, and bullying and harassment.

A number of international studies report verbal abuse and bullying as common experiences across the industrialised world, with incidences between 10 and 20 per cent. In international health areas, studies report that a significant level of international violence is experienced by these workers. I hope that the Committee will not take my next statements to be sexist, because God forbid that anyone would think that of me. It has been

reported that white males aged 30 to 50 years who have been employed with an organisation for some time may be more common perpetrators of physical violence. Of note, the Ambulance Service staffing profile is predominantly white male. I can say, however, that the proportion of females in the service has increased from 1 per cent in 1980 to 31 per cent in 2008.

New South Wales Health has developed a number of key initiatives to prevent workplace bullying occurring and to effectively and promptly manage this. I want to say that we have absolutely zero tolerance of bullying in the workplace. I think our code of conduct for the New South Wales health system—which every one of our employees signs at the time of employment—sets the tone for our organisation and makes it very clear to people that bullying and harassment is not acceptable. In an organisation leadership is very important to set the culture, but that is done not just from the top; it is done from every person who works within the organisation. Hence our requirement for all our employees to sign that code of conduct.

As I have said, we will have all our 400 managers trained in these issues by the end of 2009. A bullying and harassment task force was established in 2007 to examine current practices. A healthy workforce summit was held in May 2008, and I understand that the summit was well attended and was considered valuable by all who attended. Given the rapid changes in clinical practice, and the demands placed on front-line staff and management, it is increasingly important to remain vigilant to the need to keep our policies current and unambiguous. Working with the staff, the union and management to drive these reforms will be critical to success.

In closing, it is worth reiterating the strength of our Ambulance Service and the strength of our officers who are the service. Mr Head, who is the author of the review, expressed the view that the Ambulance Service maintains a high standard of service against a backdrop of increasing demand. Let us not forget that those in the community who utilise the service rate it very highly. I am very happy to take any questions.

CHAIR: Professor Picone, a large part of your opening statement related to bullying. I can tell you that we have over 150 submissions to this inquiry, and almost every one of those submissions responds to issues of bullying and harassment. To say that things are happening is clearly not evident from the ambulance officers who are working out in the field. They are very concerned. You talk about a culture. What we are getting in submission after submission is that it is the management that has the culture of bullying and harassment, and that it is coming from upper management down. Do you have confidence in your management of the New South Wales Ambulance Service?

Professor PICONE: I am not suggesting for one moment that there are not issues of bullying and harassment in the workplace, and I think I was very frank in my opening statements about the levels that one would expect in an organisation of this size. My view is that the vast majority of people who work in the New South Wales Ambulance Service, from the top management to the paramedic, are decent and honourable people. However, I do believe that there are pockets of bullying and harassment in that organisation, and I believe that we have to work diligently to stamp that out. It is not accepted, under any circumstances.

CHAIR: Have you had complaints made to you about your chief executive officer, Mr Greg Rochford?

Professor PICONE: No, I have not had complaints about bullying and harassment by my chief executive officer, whom I have every confidence in and who is a very decent and honourable man. I have never seen that sort of behaviour in relation to Mr Rochford—in fact, the exact opposite.

CHAIR: And you have not had complaints about upper management in terms of bullying and harassment?

Professor PICONE: By "upper management", are you referring to the corporate executive team?

CHAIR: Yes.

Professor PICONE: In this inquiry these matters have been apparent. The statements you have just made are that there are staff who believe that there is bullying occurring with the upper management team and middle management. Is "middle management" the station officer level? Is that the level you are talking about?

CHAIR: I am talking currently about upper management.

Professor PICONE: I have not had any formal advice until recent days that this is an issue.

CHAIR: Clearly, if 150 submissions are saying it is an issue, there is something wrong with—

The Hon. GREG DONNELLY: Point of order: Madam Chair, you are making a statement on your behalf, not the Committee's behalf. On a fair reading of the submissions, it is not true to say that the 150 submissions overwhelmingly basically completely deal with bullying. A range of issues are dealt with in the submissions, and you ought not characterise—certainly on my behalf as a Committee member—the position you have just asserted.

CHAIR: I did say a large number of them. What I am getting to is that there are complaints about every part of the management, but specifically there have been complaints about upper management made to this Committee through the submissions we have received—a number of them. I am asking you whether those complaints are filtering through to you, and if not why not, and what sort of performance indicators you put on your chief executive officer and your upper management to address those issues.

Professor PICONE: In the Ambulance Service there is a professional standards unit that is established to deal with, what I would call, gross misconduct and then within the Ambulance Service itself the complaints handling, grievance procedures, and bullying and harassment policies are present. In my view the best way to deal with a complaint is at the front line. That is why I was asking you earlier whether it was at what I call the front line, which is at the station officer level, that some of these complaints are coming from. Experience in organisations shows that often the person that workers have the greatest difficulty with is actually their immediate boss.

CHAIR: There are those sorts of complaints as well.

Professor PICONE: Now if there is a perception within the organisation and if there is evidence—which you are telling me there is but I have yet to see—from our staff within the organisation that bullying and harassment occurs at the most senior level then I need to see that. My other answer to that is that we need to deal with that in the way that we deal with these issues within our organisations. But I repeat this; the senior executive team of the New South Wales Ambulance Service are decent and honourable people. I have not seen any evidence, until I heard what you have said here today, of bullying or harassment by any members of that team. I really do need to understand what is sitting in there. It is very difficult for me at the moment because I do not have the material that you have in front of you.

CHAIR: Have you responded to the comments of the Health Services Union from the meeting it held on 1 September last year where the union unanimously endorsed, and I quote:

> That the mass meeting has absolutely no confidence in the senior management of the Ambulance Service and, in particular, the current Chief Executive Officer. That crisis in management is demonstrated on a daily basis in a variety of ways, as is the lack of regard it has for its employees and the services they deliver to the community. Why is it that the most trusted profession is so singularly insulted by its CEO?

Professor Picone, with a report card like that from ambulance officers—

The Hon. CHRISTINE ROBERTSON: From the union.

CHAIR: From the union—which is made up of ambulance officers—at the meeting, do you think a review of your Chief Executive Officer and upper management is worthy?

Professor PICONE: It was that resolution passed by the Health Services Union—which is not the Ambulance Service, or the men and women of the Ambulance Service, but they are certainly members of that union—that led the Minister to take the action that she did it in relation to the review that was undertaken by Mr Head. So action has been taken. I do have regular discussions with the General Secretary of the Health Services Union in relation to these matters. The general agreement at that time was that we would undertake the review and my understanding is that the Minister released that review publicly yesterday.

CHAIR: Mr Rochford, there have been a number of issues raised with the Committee about bullying and harassment leading towards suicide. In your view, is that an occurrence that is more prevalent in this service than others?

Mr ROCHFORD: Madam Chair, may I clarify your question?

CHAIR: I am wondering whether you have done any work on employees within the ambulance service and the prevalence of those workers taking their own lives in comparison with other organisations of similar numbers?

Mr ROCHFORD: Thank you. I was not sure whether you were referring to bullying and harassment as the issue or the tragedy of suicide. Naturally we hold the view that any human being who reaches a state of mind where they see they have no option open to them other than to take their own life is a real tragedy. There have been suicides in the Ambulance Service. Health professionals, as we all are in the service, deal with mental illness and human distress on a daily basis. When such a tragedy occurs in the Ambulance Service it hits us very hard.

We have looked at the rate in which these tragedies occur and, of course, each suicide occurs in the context of a person's own complex social situation. Paramedics, like the rest of the community, have their own private lives and human frailties and are subject to the same human stresses as every one of us. The rate of suicide that we have been able to detect in recent years does not appear to us to be any different than the rate of suicide that is prevalent in the general community in Australia. I am advised that rate is approximately one in 10,000 people—

Professor PICONE: 100,000.

Mr ROCHFORD: Excuse me I am getting some instruction.

Professor PICONE: If I could make a general comment about this issue. It is very difficult statistically, which in itself must illustrate that the rates probably are not higher, to answer that. I am happy to take that on notice and provide some further advice to the Committee. But we have had I think eight or nine of our staff commit suicide tragically over the last decade. The question is how many of those were related to work-related circumstances or not? We know of one person where it was. Are the rates any higher than in the general community? The answer to that is: I would like some more time to look at it. But the early advice I have is that the rates are not any higher. I would appreciate the ability to take that on notice and provide better advice.

CHAIR: Mr Rochford, over the past 10 years it has been mentioned that there have been a number of reviews and corporate surveys have been done, we understand, on a regular basis. Why, after all of those reviews, are ambulance officers still complaining about bullying, intimidation, lack of planning from upper management, staff shortages, single-officer crews, overtime and recruitment issues? Why are those complaints continuing with the number of reviews that have been undertaken?

Mr ROCHFORD: Like all organisations, we welcome reviews. They are an excellent opportunity to chart a way forward, to analyse the current situation and to get a range of views that may not be open in the normal busy working lives that we all occupy. Those reviews include external reviews and internal reviews that we undertake ourselves in the normal course of our planning functions. Over the past 10 years the staff of the Ambulance Service have embraced substantial changes in technology, management changes, fleet and equipment changes, and changes in the clinical skills that paramedics apply to their patients every day. The men and women of the Ambulance Service have driven the changes and also a new executive team during that period has brought diverse experience in paramedic practice and technical skills. This has led to a strengthening of the relationship between paramedics in their clinical role and their interaction with the rest of the New South Wales health system.

This has been a time of significant reform and change to work practices and the work environment. The reforms have focused very much during this period on the clinical and technical aspects of the ambulance service. Madam Chair, during your visit to the ambulance service earlier this week you were able to see some of the differences even in our operations centre from only 10 years ago until today. With all changes in a workplace, reforms do bring different points of view and perspectives on priorities. What is clear to us from the feedback we are getting from ambulance officers is that there is a need now to focus our reform agenda on the arrangements we have in place to support paramedics in their workplace.

CHAIR: Your corporate survey states that 75 per cent of ambulance officers say they are over worked and four out of five ambulance officers say the service does not effectively deal with stress. These are the very

people that are delivering your service. Does that not demonstrate that those frontline officers are not getting the support they need from you, in particular, and your leadership down?

Mr ROCHFORD: Those surveys are a valuable guide but they are not the only source of information. We have a range of ways of communicating with staff that have proved very effective. They range from my executive and me travelling the State every year to meet with managers and staff directly, and typically we encounter discussions with more than 700 of our staff on a typical pattern, and we do that each year. We have regular management forums where we discuss issues and aspirations of staff and also the need to make particular changes.

In the clinical area we have a system of administrative bulletins and clinical papers that we issue to staff for discussion. We receive feedback often numbering 300 to 400 responses at a time that allows staff to comment on proposed changes, their application in the workplace, the issues they may see arising from them, and that also occurs in relation to a range of management initiatives as well, such as the recent changes to the front-line management structure, the operational managers who are out there in the field supporting ambulance officers on a daily basis.

The composite effect of all this feedback we get from ambulance officers through those processes is that they embrace these reforms, that they are very happy with the extra clinical skills, that they accept and have responded tremendously to the additional accountability and responsibility that those clinical interventions have come with in terms of reporting and the opening reporting of clinical issues and clinical performance throughout the organisation.

CHAIR: Mr Rochford, can I suggest that your bedtime reading tonight is the submissions we have received, because that is not—

The Hon. GREG DONNELLY: Point of order: With the greatest respect, there are two things. First of all, Mr Rochford is entitled to complete the answer to the question that you posed to him. Secondly, I think to suggest that it be his bedtime reading is a bit below the comment I would expect the chair of a Committee to make. I ask you to withdraw that statement.

CHAIR: Perhaps it is not bedtime reading, but I would like you to be familiarised with these submissions that have been presented to us, because the evidence and the submissions presented to us is in contrast to the comments you have made. I did mention your corporate survey, which also said that 75 per cent of ambulance officers are unhappy. Are you happy with your grievance processes at work through the Ambulance Service?

The Hon. GREG DONNELLY: Point of order: I would like the opportunity to hear Mr Rochford complete his answer to the question that you asked. You have gone on to another question. I was listening intently to his answer and I want to hear him complete his answer.

Mr ROCHFORD: With your permission, Madam Chair, may I continue?

CHAIR: Certainly.

Mr ROCHFORD: We know from the submissions that have been published on the website and also from the 2008 review of the Ambulance Service that was published yesterday, there are staff who are dissatisfied with the level of the communication and support they receive in the workplace. It is apparent that they are also dissatisfied with the way the organisation responds to unacceptable workplace behaviours. As the director general as outlined, workplace conflict, bullying and harassment is present in all large organisations. It is present in the Ambulance Service of New South Wales. Let me say, that the failure to treat colleagues with respect, dignity, and compassion in the Ambulance Service of New South Wales is unacceptable and it is unacceptable to the vast majority of loyal and dedicated staff in our service. We know, from the communications I was describing earlier, from the survey that was conducted some 18 months ago and also from the recent information, that there is a need to improve the way the organisation responds to these events.

I want to emphasise that we are taking these issues very seriously. While our priorities over the past 10 years have been to modernise the clinical, technical and operational aspects of our service delivery to the community, there is no doubt in my mind that over the next period, while we must continue those other reforms, our priorities need to be focused more on the way we provide, as an organisation, support to paramedics and

other staff in their workplace, and to improve clarity and simplicity with which they may raise issues of concern about the behaviour of their colleagues.

We are approaching this in three ways. If I may just broadly outline the three strategies we are pursuing in this area at the moment. The first is to ensure that the service identifies and responds swiftly to serious occasions of unacceptable behaviour whenever they occur. I can advise that through the Professional Standards and Conduct Unit, when behaviours are reported of a serious nature they are formally investigated and, where warranted, formal disciplinary action flows and, on occasions, that has led to the dismissal of people from the service. However, the Professional Standards and Conduct Unit has also, over recent times, taken on a broader role in dealing with grievances and other workplace conflict matters that perhaps are not to the same level of severity as are serious misconduct matters. During this period, the timeliness of the way in which the unit has been able to process many of these matters has been criticised, and in some cases—not all—that criticism is appropriate.

As a result, we have moved to clarify the role of the Professional Standards and Conduct Unit to orient it to be a place where serious misconduct issues are managed, investigated and dealt with. At the same time we are reinforcing the human resources section of headquarters to add additional staff there, expert in management of grievances and workplace conflict, so that expertise can be applied directly to line managers to assist them to deal with issues at the workplace as they arise.

The second way we are responding to these issues is to provide more appropriate numbers and more appropriate structures for front-line operational managers so they can work more effectively with staff in the field. As the Committee will appreciate from its visit, the ambulance workplace is the community. Officers are frequently in close contact with a single partner for many shifts at a time and, on busy occasions, it can be quite difficult for the normal management supervision and support that we take for granted in our workplace to be delivered simply to ambulance officers. As a result, we are proposing to change the way the front-line management structure operates so that operational managers have more time available to them to work directly with their staff and have more flexible work arrangements so they can more easily contact staff during a roster cycle. We are also proposing to increase the numbers of operational managers at the front line so their span of control, the numbers of staff they are required to supervise and support, is maintained at a more manageable level than is possibly the case at some of our busier stations at the moment.

The third area where we are taking action at the moment is to improve the way we provide information to staff at all levels in the organisation about how to deal with and respond to incidents of unsatisfactory workplace behaviour. That involves a number of steps. Firstly, we are completing an external review of all our policies, procedures and guidelines on workplace behaviour, from bullying and harassment to grievances to more serious conduct. The preliminary results of that review confirm that our guidelines are comprehensive and clear, but they are also telling us that they are complex, and for many of our front-line managers and many of our staff it is not an easy task to find your way through those procedures, if you are looking for a way to get something addressed.

So, as a matter of urgency we are having those procedures rewritten, redesigned, and the process simplified and clarified so that someone anywhere in the organisation can find easier ways of dealing with their concern. The underpinning philosophy that is in the current procedures will be very clear in the new, recast procedures and it will be the responsibility for each and every one of us in the Ambulance Service to address workplace behaviour at an early stage when we see it occur, and it is the responsibility of each of us to seek assistance from our managers or from the other supports available in the organisation if we do not feel we are in a position to deal with that. This is a message we have been very clear about as Mike Willis and I and the other executive team have moved through the organisation over the past two years talking to our managers, that we must take responsibility to identify early, to recognise the early signs of unsatisfactory workplace dynamics, and to respond to behaviours as they occur and to address them at an early stage.

We still have a lot of work to do before we will be comfortable with the arrangements in place. I would suggest, particularly in the light of the director general's remarks about the incidence of these sorts of behaviours in any complex and busy organisation, that no organisation can afford to be complacent at any time about the way these behaviours are addressed. It will be a constant challenge and we need to be constantly vigilant in order to address them as they occur at an early stage and, for serious misconduct, to address that swiftly and comprehensively.

Ms LEE RHIANNON: I am interested in how you respond to triple-0 calls. In some instances have directions been given to officers not to answer triple-0 calls and to allow them to go through to other centres?

Mr ROCHFORD: In response to your question, Ms Rhiannon, I might first get Mike Willis, General Manager of Operations, to explain the way the triple-0 call taking system works.

Mr WILLIS: Ms Rhiannon, the triple-0 system operated by Telstra diverts calls to one of four operational centres operated by the Ambulance Service—one in Sydney and the three others spread throughout the rural divisions. Those calls then enter a triaging system by the call taker, which is designed to identify the call priority. What I mean by call priority is what level of response should the Ambulance Service have in regards to the often limited information that members of the public will pass through to our call takers. We utilise a recognised triaging system, an electronic system, called medical priority despatching. It is certainly used throughout the ambulance services in this country but largely throughout the world. That call is then transferred electronically, even while the caller is on the phone with our call taker, to the despatchers who are trained, highly trained, in the ability to recognise the priority that has been assigned to that case and allocate the most appropriate resource in accordance with those standards. I am certainly not aware of any instruction, and it does not naturally follow that a triple-0 system in an ambulance service would have an instruction that calls are not to be said and be allowed to divert. I am aware, of course, that we have a backup system, and we need to have that system, that if the load of calls going to a particular centre is high—and there are peaks and troughs in calls, as would be understood—that those calls automatically divert to the next available operation centre and call taker. That system is built into the process.

Ms LEE RHIANNON: Mr Rochford, are you aware of any officers being directed not to answer triple-0 calls?

Mr ROCHFORD: Ms Rhiannon, that would be an inappropriate direction to be issued to any officer who has as part of their duties responsibility for answering triple-0 calls. I might say that some of the recent changes that have been introduced into our four operation centres where calls are answered involve a move to multiskilling of the functions in the centre so that at very busy times all suitably qualified and trained personnel who work in the centres can be called upon to assist in answering the triple-0 calls. That has been a progressive reform that has been introduced over the last couple of years. As Mr Willis has indicated, there can be quite significant peaks in triple-0 call demand. These days with mobile phones in everyone's pocket it takes just one motor vehicle or pedestrian accident in the central business district for there to be a large surge of calls to occur in the Sydney operation centre, for example, from everyone who sees the accident. So there does need to be a method of responding to those surges quickly and also of backing up the overflow of those calls which in each of the four centres works together with each other to back up each other's local surges and demand. That is an important part of maintaining our operation.

Ms LEE RHIANNON: How do you deal with protected disclosure? How is it followed through? Does it end up effectively that the Ambulance Service is investigating the Ambulance Service?

Professor PICONE: No, that does not happen. Who would like to do the protected disclosure processes in the organisation?

Ms O'CONNELL: I can answer, to a certain extent. Protected disclosures are made internally. They are internal disclosures by their nature. They are, on occasions, investigated by the Professional Standards and Conduct Unit or investigators engaged by us, external investigators. They do have to be notified to the Department of Health and to the Independent Commission Against Corruption if they raise issues of corruption.

Ms LEE RHIANNON: It is always external?

Ms O'CONNELL: Not always external. There are some occasions when the matters raised can be investigated by officers of the service outside of the area or not connected with the disclosure made. The decision about that may be made on the basis of the seriousness of the disclosure. But they are always notified to the Department of Health, that is a requirement, and they are notified to the Independent Commission Against Corruption. So those bodies can intervene if they choose to.

Ms LEE RHIANNON: I want to ask a question about the supervision of paramedics. It has been raised with us that once training is completed they are largely left to their own devices and supervision is minimal. Is that the case? Do you see that this is an area that needs to be improved?

Mr ROCHFORD: Ms Rhiannon, no, that is not the case. I might give an answer and then hand over to Mr Willis for a more detailed outline. I would like to note that some years ago, approximately five years ago, we identified the need to provide better supervision to trainees as they go through what is usually a three-year program, although graduate entrants can complete the course in 12 months if they have a suitable background with clinical qualifications. We have moved from the arrangement of clinical training officers where we had approximately one clinical training officer, who is a qualified experience paramedic who does not have line duties in terms of responding to triple-0 emergency but is available to provide on-road/on-scene support and educational assistance to trainees and also to attend stations to help assist them with their distance learning packages, which is part of their training. Those clinical training officers were previously a ratio of approximately 1 per 300 staff in the Ambulance Service. Over the last five years we have been able to increase that to a ratio of 1 per 75 staff, which has provided a lot of extra support for staff, particularly in rural areas where obviously logistical challenges are greater.

We have recently identified in Sydney, where the majority of trainees undertake their on-road training, that with the significant increase in numbers in the Ambulance Service and enhancements over the last few years there has been an additional concentration of trainees in Sydney. We plan in the coming year, as a result, to further upgrade the number of clinical training officers in the Sydney area to help provide additional support. In terms of the experience trainees go through on the road and how they are supervised and the range of training obligations they must discharge during the course of the training period, I will hand over to Mr Willis.

Mr WILLIS: One of the most trying times—I am coming from direct experience, I guess—for a young paramedic is that first initial period where you take up duties on the road and in the community. The world of the training school suddenly changes to the reality of life working in the community. As Mr Rochford has mentioned, there are two key elements that you look for in those early days. The first thing is how do you align yourself to your colleagues on the station, and how do you fit into station life. To do that you look to the guidance of the station manager and the senior officers of the station. And, of course, more importantly, how do you align yourself and how do you become an active operational member of the ambulance team in the field. To that point, having the ability of having senior paramedics as clinical training officers, as clinical mentors, in that case is the step forward for doing that. That certainly is improving the ability for new paramedics to ease into that workforce and to pick up the operational duties.

There are some steps we need to take in regards to the station management side and, I think, some of the management training. But, more importantly, we are looking currently within our service at increasing that front-line supervision, both in numbers and in skill. If I can take a moment to elaborate on that, what I am saying there is given our shift patterns and the way in which paramedics work 24/7 across the community, it has been identified, and we have responded to that now, that it is important that each paramedic has the opportunity of seeing their boss no matter what shift they are on. The steps that we are taking to increase the management of front-line supervision deals with the second issue I have spoken about. We have dealt with the clinical training officers and the mentoring of our officers in their operations. But, likewise, it is about now supporting those officers in the field with front-line supervision, in a sense, a peer that they can go to, and have that easing into the service and the general supervision as we go about it.

Ms LEE RHIANNON: Have investigations been carried out into possible bullying at the southern operations? Were there two investigations in 2001 to 2002? If so, what happened to the recommendations? Were they acted on?

Mr ROCHFORD: Yes, there were investigations into that workplace on several occasions. The recommendations that arose from those reports have largely been implemented, but some are subject at present to a further review that is relating to further complaints that have been received about the management arrangements at that centre. I am awaiting the outcome of the latest review, which is one that is independent of the service, to consider what, if any, further requirements are required at the southern operations centre. At present we have installed some interim management arrangements to support the staff at the centre to ensure that business is carried out as normal pending the outcome of those inquiries and my advice is that, as a result of those interim workplace arrangements, the atmosphere and the issues of the majority of staff there have begun to improve during this period, although we are monitoring that workplace closely until a permanent solution is found for some of the management difficulties that have been experienced there over a number of years now.

The Hon. CHRISTINE ROBERTSON: Mr Peters, my first question is directed to you. Many of these submissions on first reading appear to be in relation to grievances and, despite the fact that Mr Rochford has

outlined some of the processes, for the inquiry to be upfront on the current processes and complaint handling procedures, we really need to get a good handle on exactly how they work and how they apply to the New South Wales Ambulance Service.

Mr PETERS: Thank you very much, Ms Robertson. From my own experience with the ambulance service, I suppose we need a bit more traction and that is what you are on about here. How do we get the policies in place? How do we get traction with those policies and get them implemented? That is what you are hearing about here today. When people raise a matter, they want it to be dealt with in a short period of time, they want it to be dealt with, if possible, by the person they are raising it with—and that is the frontline supervisor—and they want the outcome documented so that it can be monitored and tracked so they know it is going to happen.

We do have the policies in place and we can review those, simplify and streamline them so that people understand them better, but we do need to get more traction around them. I suppose some ways of getting more traction around them have been talked about here today. You can make it a clear statement in a position description, but that can just rest as a statement in a position description unless you go a bit further. Some statements that we have written in the frontline supervisor position descriptions in recent times are to take a lead role in establishing a positive workplace culture, so their responsibility not just to sit back and let things happen, but to take a lead role. You have to undertake timely assessment, effective resolution and monitoring of staff grievance, which I have talked about. That is one building block.

Another building block is through the performance management system because, if I take station officers, their performance would be reviewed by the district officer and if you review the performance of how the station officer is going you can identify their needs. You can say, "Well, that wasn't handled so well", there could be a learning and development opportunity for you, and we identify a suitable program. It is an important point I am making because at the present time the performance management system applies to the district officer and above level and so it does not at present apply to the station officer level, so we need to roll it down because they are the frontline supervisors and we need to work out what their training needs are so that we can offer those to them.

Professor PICONE: If I can, with your permission Madam Chair, interject here, this is one of the slight differences I have noticed between our ambulance service and, say, our hospitals: We have spent a great deal of time in our hospitals concentrating on the development of the first-line manager, so that could be the nursing unit manager, the medical department head, the head of physio, head of occupational therapy [OT], and my observation is that in the ambulance service at this stage—and it might be a part of its history—it has tended to operate in the past on a command and control type structure from the military. I could also say that about some of our public hospitals because our antecedents in medicine and in nursing, as you know, are either military or religious. So the transformation in culture in the ambulance service, in my view, in the last ten years has been about going away from the command and control environment to a more professional clinical service, and I think that it is an absolute credit to the current leadership of the ambulance service that 91 per cent or 95 per cent of paramedics, I think it is, have actually had advanced clinical training. So that culture change is absolutely critical to allow those advanced clinical skills and new way of operating to come to bear. I think the next major piece of work for the ambulance service is what we have done in our hospitals and our other health services, community health and other places—the development of that first-line manager, the head of department position, if you like—and I think that is critical to culture change as well. I am sorry to have interrupted.

The Hon. CHRISTINE ROBERTSON: Are you planning on introducing performance appraisal processes for frontline ambulance officers themselves?

Mr PETERS: That is what we would be seeking to do in consultation obviously with the Health Services Union. We would need to roll it out in consultation with the union who represent the staff. We are seeking to do that, but I suppose one of the key things—and it has been mentioned here today—is that we have actually engaged the Australian Institute of Management to work with us in coming up with a program for the frontline supervisors and it will cover the things we have been talking about here today.

There are basically four components to the package that we will run out. There is the positive workplace culture, the leadership, the things around your people skills like managing these grievances; it is your audit and compliance so that things actually get done; and it is your operational management. The whole business is about patient safety and quality, so we need all of that to happen. The program is well and truly

underway and, as you heard from the chief executive, you cannot do this without resourcing and in part resourcing is at that front line, to increase the number of supervisors at the front line, and also back in the workforce, so people have somewhere to go to have that expert capability there.

The Hon. CHRISTINE ROBERTSON: Could I ask on notice for a copy of the grievance and complaint handling process please, so that we can get a real handle on what we are dealing with in the submissions? I would also like to ask particularly because of the submissions, and some of them are from very disturbed people, is there a process within the service for access to psychiatric or psychological care that is totally confidential, and is there psych testing on the recruitment process?

Mr ROCHFORD: Yes, there is access to professional, confidential, external counselling for all members of staff of the ambulance service and their families. In fact, as supported by all the modern research in this area, it is really important that we make available a range of opportunities for staff to seek support and assistance whenever they come across distressing events either in their work or in their private lives. We have set up a number of options, including the very honourable tradition of ambulance chaplains that goes with many of the emergency services, having a chaplain see them, so multi-denominational and available to all staff and their families at any time for all sorts of support reasons.

We also have 111 peer support officers trained from within the paramedic ranks and these are experienced paramedics, many of whom will have gone through the same sort of stresses that their colleagues experience on a regular basis. They are formally trained to support and assist all members of staff of the ambulance service and their families. They are available at any time, 24 hours a day, and they do provide their services like the chaplains voluntarily, and I think that provides tremendous support to colleagues.

The third level of service is our employee assistance program through which the service contracts a company of professional workplace psychologists to provide 24 hour on-line—telephone line—service to any member of staff and also more formal face-to-face counselling if that is required. That service, which is available to anyone, is free of charge. The latter professional service is confidential. If anyone uses that service—and I know that many of my colleagues have—it is not known to management. That service, which is available, is a useful support service. I might just add to the comments that were made about the cultural dynamic in the service. I would hate anyone listening to these proceedings to think that we are being critical of middle and front-line managers. Many of them have been in the job for 10, 20 or 30 years and they are highly committed, highly professional and highly experienced and trained to perform their role.

When I travel through the service and talk to the younger and newer generation of highly qualified staff and I talk to the older experienced management work force they both recognise that there is a generational dynamic change in people's attitude and approach to their working lives—their approach to supervision and their approach to direction. The young and the experienced alike in the Ambulance Service talk openly about the difficulties that those changes and interactions present. I suspect that they present difficulties for all of us in many aspects of our lives.

We really want people in the service to have these conversations out in the open. It is not a place to criticise, categorise or discriminate against any staff group in our service. These difficulties are human ones and they are real, and we manage them every day of our lives. Many of the experienced staff that have taken on management roles have done so at time when promotion was not on a merit basis and when the selection and the identification of management skills was not as precise as it is today. There are real challenges to deal with an organisation that is changing so rapidly and where its complexity, in particular in the clinical area, is growing so quickly.

I believe that some of the symptoms that are present in these proceedings and in our previous reviews result from staff not being adequately addressed by these systems inside the service. We have to listen to them very seriously and respond to them. For many cases the solution will not be a generic management program or management training—it will be dealing with individuals as sensitively and as passionately as we can. That is why those counselling services are most important. Any individuals who believe that they need more are always welcome to raise their concerns and we will do whatever we can to support them.

The Hon. CHRISTINE ROBERTSON: Do you think that front-line members of staff understand where they can access the employees assistance program?

Mr ROCHFORD: It is published regularly. Mr Willis might have had some more direct experience of how it is accessed.

Mr WILLIS: There is notification of how to contact that service on the station and it is part of the workplace. Mr Rochford mentioned the peer support officers. Given the nature of our work, health professionals are often reluctant to step forward and to highlight that they need a bit of a hand. That is where the peer support officers and the chaplaincy program come into play. They almost seek out those officers who are perhaps a little shy in coming forward. Through the peer support and the chaplaincy program that is another avenue of the promotion of the professional services—taking an officer and engaging in those professional services. There is the formal process of notification at each station and workplace. I would argue that probably the more sensitive approach is using our peer support officers and the chaplaincy program to help these officers.

Professor PICONE: I have some statistics that might be helpful for the Committee. This is via the invoices that we receive from the company but it should be remembered that these are totally confidential services. Face-to-face counselling was used on 544 occasions in the last 12 months. The 24-hour telephone counselling line was used on 124 occasions in the last 12 months and the manager assist 24-hour phone service was used on 24 occasions in the last 12 months. Post-traumatic support—this was known in the old days as critical incident debriefing support—was provided by an employee assistance program [EAP] psychologist in the Ambulance Service workplace on four occasions in the last two years, with one occasion in the last 12 months. Mr Willis talked about the peer support and the chaplaincy service but I do not have any statistics for them.

The Hon. GREG DONNELLY: I direct my question to Mr Rochford but he might wish to defer either to Mr Peters or to Mr Willis. My question relates to the grievance procedure and grievance handling issue. I acknowledge the detailed response that Mr Peters has already given, but I want to clarify the issue. Internal procedures will be provided to us to outline the ways in which you deal with grievances. Does the award that covers employees in the service contain its own grievance procedure? Does a separate grievance procedure operate by virtue of the industrial instrument?

Mr PETERS: The answer to that question is yes: it is in clause 41, it is called "Issues Resolution" and it contains the process that I talked about earlier.

The Hon. GREG DONNELLY: Just so that we are clear, we have a provision within the award?

Mr PETERS: That is right.

The Hon. GREG DONNELLY: That is the procedure that everyone understands they are to follow to elevate an issue through a series of steps to resolve a grievance. Is that right?

Mr PETERS: There is the provision within the award. There is also a policy framework that specifically relates to grievances within the workplace. While the award has certain provisions, more detail is available in a policy framework.

The Hon. GREG DONNELLY: Are these provisions that the union understands and to which it has agreed?

Mr PETERS: That is right. Because it is in the award we also specify what role they would play at various levels as the matter is escalated.

The Hon. GREG DONNELLY: That relates to representation if any union member wants to be represented in the grievance procedure?

Mr PETERS: The support that they can offer to people, yes.

The Hon. GREG DONNELLY: I am not an expert on the provision within the instrument or the other procedures, but can you tell me whether there is any inconsistency between the two? Do they marry together?

Mr PETERS: I have not checked that out to see whether they do. Broadly, there is consistency because they all talk about the lowest level possible with your front-line supervisor in the shortest period of time and documenting outcomes.

The Hon. GREG DONNELLY: I do not want you to guess the answer. I am keen to ensure that there is a marrying together of those issues and for you to analyse them. If there is not a marrying together, or a seamlessness between the two, therein might lie some of the bases upon which there could be issues. I ask you to take that question on notice, to analyse it and to provide us with some insights as to whether they are consistent and there is seamlessness between the two, or whether there are differences and the extent to which there are differences. It would be useful to know what are those differences.

The Hon. CHRISTINE ROBERTSON: While it is being reviewed it would be a good time to look at that.

Mr ROCHFORD: I wish to clarify an issue. We find, both within our staff and often within the union representation as well, that there is not always a clear understanding of the difference between the definition of a grievance and what constitutes bullying and harassment. In fact, the two areas have different pathways for dealing with them. It is described in a bit more detail in our submission, but I will provide a description to provide clarity for this discussion. A grievance, in the Health construct of how that works, is a written or oral statement made by an employee regarding a concern arising in the workplace. Examples might include interpersonal conflict, the way work is allocated or managed, interpretation of policies or people management policies, or a perceived unfairness in the workplace.

Usually, but not always, the grievance involves some personal distress and, by definition, will always involve more than one person. But grievances are usually relatively minor matters and are most amenable to strong encouragement to have them dealt with in the workplace, perhaps with some external assistance on occasions, but by a local procedure that will allow the person grieving to work out his or her issues to maintain a lasting and durable relationship in the future. Bullying and harassment is a more serious form of workplace conflict and I believe that we have an obligation to deal with it in a more precise and objective way to ensure that the solution that is derived is a fair and appropriate one, both for the individuals involved and for the future of the organisation as a whole.

The Hon. GREG DONNELLY: That is precisely where I was taking this discussion and line of questioning. I am familiar with some industrial instruments that actually have a grievance procedure, which deals with, shall I say, the traditional industrial-related matters that might go to award or agreement entitlements. That stream of issues is dealt with in that procedure and there are separate procedures that deal with matters of bullying and harassment. I am not suggesting that I agree with having two separate procedures but, rather, to the extent that there are not separate procedures and things get all bowled into one or some get bowled into one and others are left to be dealt with through some other stream, that is where you can end up with some degree of conflict over the resolution of issues?

Mr ROCHFORD: Indeed. It is only a short definition but I think just going through the definition we use for bullying and harassment helps illustrate that point and why it would be inappropriate to use the grievance philosophy to attempt to resolve many of these matters. Bullying and harassment is unwelcome and unsolicited if the recipient considers the behaviour to be offensive, intimidating, humiliating or threatening, and a reasonable person would consider that behaviour to be offensive, intimidating, humiliating or threatening. That sort of behaviour is not acceptable in our workplace; it is not acceptable in anyone's workplace. If it is thought to be occurring, it needs to be properly and formally followed through to either exclude the possibility of it occurring or, if it is occurring, to correct it in a way that ensures all workplaces are safe and all people are protected from that sort of behaviour. It is certainly not something that would be amenable to a local unsupervised method of resolution.

Professor PICONE: Could I add one comment at this point. These confusions around definitions are not just an issue in the health system.

The Hon. GREG DONNELLY: No.

Professor PICONE: Often you will hear a person say, "I've been bullied by somebody" when, in fact, they have not met the technical definition of bullying. What has happened is that someone has been absolutely rude or acted like a pig. This education on conflict resolution from the lowest form, which is just two people not getting on, right up to the worst misconduct, is an ongoing exercise in all of our organisations. So, I think it is actually a very pertinent point that you raise.

The Hon. GREG DONNELLY: Indeed. Just following on from that, I want to clarify one point. Let us take a hypothetical situation of someone wanting a roster change and having in their mind good argument for that roster change. They keep putting it to their immediate supervisor or ambulance station manager and arguing it but, perhaps for operational reasons, it would not be possible to do it for a period of time. So the answer given is, "No, that's not possible." It could be construed perhaps in that person's mind—in this hypothetical situation—that there is a bit of bullying going on in that their request is not being met. So, the fact that they are being told firmly "No, that is not possible" could be argued that in that person's mind they are being bullied about this roster issue. I am just using that distinction between conflict and bullying.

Professor PICONE: Yes, that is right, but what is in that person's mind ultimately is extremely important.

The Hon. GREG DONNELLY: Yes.

Professor PICONE: So at that stage they have a perception that they are being treated unfairly or perhaps even being bullied, which is where the conflict resolution comes in. But, as you well know, and it certainly has been my experience, very deep conflict actually does not involve bullying. Sometimes conflicts are never resolved between the two parties. The feelings are so deeply held that these conflicts go on for a very long time, but there may not have been any bullying in that.

The Hon. CHRISTINE ROBERTSON: Madam Chair, part of my question was not answered. I would ask that it remain a question on notice. It relates to psychological testing for initial recruitment. Also, what the service may think about the pros and cons of such a process. It cannot be answered now because we have run out of time.

The Hon. MARIE FICARRA: Looking at the end of the financial year to 30 June 2008 how do ambulance officer numbers compare with those in 2007, 2006 and 2005?

Mr ROCHFORD: I will wait for the numbers to be handed to me perhaps, but I can say that they have increased significantly over those years. Also, the 2008 numbers may not be available as yet as that financial year ended only some days ago.

The Hon. MARIE FICARRA: Would you be able to supply that information to the Committee, if you do not have it now?

Mr ROCHFORD: I certainly will do that. Would you like me to supply the previous years now or provide them altogether?

CHAIR: Perhaps if you would take that question on notice.

The Hon. MARIE FICARRA: If you could take the question on notice and provide the accurate statistical situation.

Mr ROCHFORD: I certainly could give you the previous years up until now.

The Hon. MARIE FICARRA: I would like to know also the number of officers who have quit in the past financial year?

Mr ROCHFORD: Yes, certainly.

The Hon. MARIE FICARRA: Could you provide us with a trend over that similar period of time from 2005 to the current year ended 30 June 2008? So, what I am asking you to provide is the number of ambulance officers, the number who have quit and the proportion?

Mr ROCHFORD: Certainly. I can indicate at this stage that the attrition rate for paramedics in our organisation is in fact lower than the attrition rate for other staff. Over the last period, the period you are describing, it has averaged at 4.5 per cent. In the last year there has been a very slight increase in that rate to approximately 5 per cent, but still we regard that as very low for any organisation. Currently, we are analysing, and I will endeavour to provide it in our answer to you, whether that increase is associated with the age profile of our workforce. We know from our workforce planning that come 2017 we will reach a demographic hump

where quite a large number of our senior and experienced staff will be looking to retire. We have just completed a survey of the entire workforce to start to prepare strategies for 2017 so that we can adjust the workplace to encourage a number of those very experienced people to stay on in different forms through part-time and flexible work, perhaps a break from shift work or into duties that perhaps are not as arduous as those a frontline paramedic must be ready for every day. So, there is quite a bit of work going on in this area.

The Hon. MARIE FICARRA: I preface my next question by stating that I understand the level of training in the ambulance service is very high. The standard is very high. We saw some of your operational management schemes: it was very impressive. My question is addressed to you, Professor Picone, and possibly could touch on human resources, as well as you, Mr Rochford. How have we allowed the ambulance service to get to the point where so many officers are placing their complaints in the public arena? Why is it that the culture in New South Wales Health or the New South Wales Police Force has not filtered into the New South Wales Ambulance Service? It might have started with a military-type organisation, but there has been a change in value of the management of our human resources within the Ambulance Service—not just training but also in looking after individuals. There was a culture that may have been there with the older, experienced officers and now there are newer recruits who are used to a different type of workplace. Why was this not picked up earlier by middle management or senior management rather than have the service at this point now?

Professor PICONE: It is an excellent question. My view is that cultural change does not occur overnight. Sometimes organisations can take decades—people talk of batches of five years—for quite serious change. I mentioned to you earlier that the difference I have noticed between perhaps what happens in a hospital environment, which is what I am most familiar with, and the Ambulance Service is that we develop the first-line manager: the nursing unit manager [NUM], the medical head, the head physio far more. I have noticed that development in the Ambulance Service. In my view that is the next step we have to take. Do I think there has been a delay in those cultural changes? No, I do not believe there has been and I hope we will convince you with the evidence, with your permission, we provide you in our submission. There has been a decision to concentrate on modernising the service—the plant and equipment, the infrastructure, the ambulance services and upgrading the clinical skills of the paramedics. Sometimes organisations can only take so much change. I firmly believe that there is still a great deal of work we need to do in these areas that you have raised, but I believe also that there have already been substantial steps undertaken. It is very interesting that the first service within New South Wales Health to set up a professional practice unit, which became the exemplar for the rest of the State, actually was the New South Wales Ambulance Service.

Ms LEE RHIANNON: Mr Rochford, in answer to my earlier question about investigations into bullying in the Southern Operations Centre—I mentioned that there had been two investigations—you said that there had been several investigations and you were still waiting on the recommendations to come forward. Does that mean that the recommendations from those earlier reports were not successful or were not implemented? Were they implemented and, if so, were they unsuccessful? I was surprised to hear you give the clear impression in your answer that the bullying in this area has been ongoing since 2001-02.

Mr ROCHFORD: I thank you for the opportunity to clarify my answer. The issues in the Southern Operations Centre are many and multifaceted. Within them are some complaints about bullying. There are also concerns about the overall performance and management of that workplace environment and general capacity issues in that area. We have taken a number of steps to improve those. I think it is fair to say that not all the people involved in that change and improvement process are satisfied with the results. There is a need to await the findings of this latest inquiry to determine whether that dissatisfaction is merely a consequence of the change that has occurred or whether it is a concern that needs to be addressed more properly and dealt with by the service. Until those inquiry results are available to me, I cannot really comment on the validity of a number of those matters.

But I emphasise that there were a range of issues in that workplace environment going back a number of years—perhaps from when the major change occurred in 1999 and the workplace was computerised. A number of work practices had to change and a number of staff needed to acquire new skills both in the core delivery of services and also in managing the more technologically advanced environment. Three other operations centres adapted to those changes very well, and in fact have progressed remarkably from that period. In the Southern Operations Centre the change was not as successful. We have spent some time trying to understand why that occurred and to take the appropriate action. Much of the action that we have taken has been successful in that the centre is now performing adequately. I am confident about the quality of service there, and the vast majority of staff are discharging their duties to the standards that any of us would expect of the

Ambulance Service. But a number of issues remain outstanding, and some people feel that those issues are not resolved. So we are still working through the process of doing that in the best and fairest way we possibly can.

Ms LEE RHIANNON: It must be a worry that this type of behaviour has gone on for six or seven years. Is it impacting on the delivery of services from that centre?

Mr ROCHFORD: I have on occasion had concerns about the quality of the service, or at least the performance standards out of that centre. I believe they have been addressed—and Mr Willis may wish to comment further—during the course of that time. However, I emphasise that the behaviour—I think you mentioned bullying, Ms Rhiannon—has not been going on unfettered for all that time. There have been successful strategies to address individual incidents of that behaviour. But, as I mentioned earlier, some of the people involved in those activities are not satisfied with the outcome, and that is what we are still pursuing. But certainly the bulk of the strategies that have been applied over that time had been successful and achieved a beneficial result. I would not suggest that there is not more work to do; there most certainly is. But the improvement is apparent in the way the centre is performing, in reports of staff attitudes to those changes and in how the workplace is functioning at the moment.

Professor PICONE: May I add a comment because you are touching on a very important point about long-term conflict in workplaces, which is not at all unique to the New South Wales Ambulance Service or indeed to NSW Health? The issue is: When do you say enough is enough? You have taken it through every procedure, and there are always two sides to every story. As you well know, the most important thing is procedural fairness to all the parties involved. So you start off with the initial complaint and you work it through, you take it through mediation and you still cannot get a resolution and the behaviours do not change. If it requires disciplinary action, it goes off in that circuit. If it involves a larger group of workers, you bring in external people. My view is—because I am getting old and crusty, being an early baby boomer—that sometimes enough is enough and you have just got to move on.

I have been involved in conflict resolutions with very senior staff that have gone on for two or three years. I remember one case in particular at a major teaching hospital where I said to the two people involved—who were both individually the most capable and professional people—"You have to stop this; this has now been going on for too long". They would bring their lawyers to meetings. I think this is an issue around procedural and administration law. As I have said before in other forums, when do you have to say for everybody's sake, "We've done everything we can to resolve these conflicts"? This is not bullying and harassment; this is conflict resolution. I think it is an excellent question and it goes to administrative and procedural law, in my view.

Ms LEE RHIANNON: Perhaps you can take this question on notice. The Minister for Health announced this week the decision, in line with one of the review recommendations, to withdraw the Ambulance Service from the direct provision of rescue services and pass those responsibilities to NSW Fire Brigades. Will you take that question on notice if you do not have time to answer now? Alternatively, if you can give a quick answer now it would be useful. I am interested to know why the decision was made. Do you see it as a reflection on the level of service, and are the people who have delivered that service within the Ambulance Service concerned about it?

Professor PICONE: I think that they will be concerned. I think they are absolutely outstanding, and each one of us would want them there. The question from my understanding is around a critical mass issue—the service would be better co-located with NSW Fire Brigades. I also understand this issue has been under discussion for four or five years, or even longer. I know that the chair of the State Rescue Board supports it. The Minister expressed to me on Wednesday that she would like to have further discussions within the service and also across the emergency services just to understand that recommendation a little more.

Mr ROCHFORD: Madam Chair, do you mind if I make a very brief comment because, as the Director General mentioned, this is an emotional issue? I would like to make it clear for the record that, as the Chief Executive Officer of the Ambulance Service, I highly value the work of our rescue operators. They are professional and very skilled, and passionate and committed about their job. I met with the manager of rescue yesterday to discuss the recommendation and the action the Minister is considering at the moment. I asked him to pass on my appreciation to all the staff. All the rescue operators around the State and all organisations are highly skilled, passionate and committed. Our staff, in particular, have taken enormous steps over the past two to three years to upgrade their training skills and equipment and also to take on the dual role of being professional paramedics and to be available for rescue jobs when they come along. They have done a fantastic

job and I would like to formally acknowledge my appreciation of what they have done. If they do continue in rescue, I am sure they will continue with the same professionalism that they have displayed in recent years.

The Hon. CHRISTINE ROBERTSON: I recognise that there is no time for an answer, so I will put this question on notice. Several submissions, including the submission from the Health Services Union, have registered difficulty with the Ambulance Service being an integral component of Health. Will you please list the advantages and disadvantages of that arrangement?

Professor PICONE: If I may make a general comment on this—simply because I studied up on it last night—the word "commissioner" means a person who is given authority by the Government to exercise a public office position. It also can be a person who sits on a commission. There has been this longstanding argument that our service should be headed by a commissioner, similar to the fire department and the police department. My view is that the New South Wales Ambulance Service is an integral part of the New South Wales health system; it provides pre-hospital care. Some of the evidence we have given you today concerns the training of paramedics. It is all medical training. My view is that from a patients' point of view, patients want a professionally trained clinician providing that care. That is my view about it, but I will also send it to you in writing.

CHAIR: I also have a question on notice. I am not sure to whom I should address this question. With regard to the drugs that go out with ambulance officers that they have access to—such as morphine, et cetera, some of the necessary but quite dangerous drugs—could you provide us with details about protocols concerning how the drugs are recorded; information on the distribution of the drugs; where there have been instances of the drugs going missing, information about that and about what action has been taken; how often that has occurred; and whether ambulance officers have needed to be disciplined or provided with rehabilitation as a result of drug taking, and whether they return to work afterwards.

Professor PICONE: Yes, we will provide that information. We keep records of that.

CHAIR: I am aware that you would like to table your submission, which we would like to make public. Thank you for that. With regard to questions you have decided to take on notice, would two weeks be enough time for you to provide answers to those questions?

Professor PICONE: Yes.

Motion by the Hon. Christine Robertson agreed to:

That the Ambulance Service submission be tabled.

CHAIR: Thank you for appearing before the Committee today. We look forward to reading your submission, together with your answers to questions on notice.

(The witnesses withdrew)

(Short adjournment)

GRAEME HEAD, Deputy Director General, Performance Review Unit, Department of Premier and Cabinet, affirmed and examined:

CHAIR: Thank you for appearing before the Committee. You have an opportunity to make a brief opening statement if you would like to do so. The Committee members have been issued with a copy of your report, which we received either last night or early this morning. Some of us may not have read the entire report, so please excuse us for that.

Mr HEAD: Given that the report sets out fairly comprehensively the terms of reference and the process for the review, that it summarises the findings, and that there is a fairly lengthy description of those findings in each of the chapters and how the 27 recommendations relate to those findings, I do not think there is much I would want to say by way of introduction. I think it is a comprehensive examination of the terms of reference that we were set for the review, and I am happy to take questions from the Committee regarding the report.

CHAIR: In your report you say, "There should be a review of all management and supervisory positions and their current capabilities". What concerns do you have about the NSW Ambulance Service management?

Mr HEAD: If I can just explain, by way of introduction, a little bit about the process. We established an e- mail hotline for the review where officers from the service could contact us. In addition we held a number of randomly selected workshops with staff: two in Sydney and one in each of the three non-Sydney regions, to talk to people about what was on their minds regarding the service. We received about 50 e-mail submissions from people and we had very lengthy workshops with staff in the regions. Indeed, at the end of the review process we brought some people back—a sample of people from each of those workshops—to talk through the directions.

CHAIR: May I interrupt to ask when you started that process?

Mr HEAD: That process started I think in February—round about that period after the summer break but I would have to check the dates to be sure. One of the issues that came up in the discussions was around the first line of response when operational ambulance officers have a problem, particularly a sensitive problem around some of the issues that I know have been raised with the inquiry around bullying et cetera, there was a feeling that having managers better equipped to respond to those issues at the coalface would assist.

It is my experience, and I have experience working in the health system and in a number of other operational environments, that it is quite a transition moving from an operational role into a management role. People are often very confident with what they are doing in the clinical role and often there is quite an adjustment when they are doing things that are very different than the things they were used to performing in an operational role. That recommendation is about really being clear to the organisation about what is expected of managers, what skill sets are required and making sure that managers are supported to properly exercise those skills. There was a second recommendation related to that, which is really about identifying people who are interested in moving to management and making sure they are properly prepared before they enter into those roles. Some of what we discuss in the report about length of time in handling certain complaints may well have been lesser issues if there was a more confident response in the first instance by the manager to whom things were reported.

CHAIR: You talked about the grievance process in your report, which has certainly been discussed today and is within a number of our submissions. Do you think that the time it takes to manage a grievance is a large area of change that needs to happen within the service?

Mr HEAD: Yes, I think we are clear about that in the report. People need to understand how these processes apply. All staff and managers in the organisation need to understand how different types of complaints are handled, when it is appropriate to resolve them at the coalface, when it is appropriate to escalate them, and what will happen when they are escalated. I think there ought to be reasonable expectations across the organisation about what the timeframes are for resolving those issues. Our recommendations on that issue are coupled to our recommendations about policies around the prevention of harassment and bullying. We think it is extremely important that these behaviours are properly defined, that there is a clear set of expectations, that there is a requirement on staff to abide by the way those expectations are framed in the code of conduct, and that

if managers are trained about their obligations and staff are aware then where there are substantiated complaints of this kind of behaviour then a more rapid and appropriate response is available.

As I said before, we had about 50 contacts to the e-mail address we set up out of a staff of 3,500—so not huge proportionally—and we talked to probably somewhere between 60 and 70 people in the staff workshops. This was a theme that came up in those discussions.

CHAIR: In your review you say that the increase in demand for the Ambulance Service is above the rate of demographic change. What do you mean by that?

Mr HEAD: The numbers are outlined in the report. I think essentially what we are saying there is that there is an expected rate of growth that you can predict based on how the population is ageing and the prevalence of chronic disease within that profile et cetera. You would expect that level of growth naturally to occur. One of the things that is very clear not just in our review but in the recent review of the Queensland Ambulance Service—which I think came out about six months ago or perhaps a little less—and some work done in Victoria, is that all of the eastern seaboard States are experiencing a rate of growth above that. While you can map as we have done what those trends are, we feel that the drivers for that disparity are not well understood and we have made a recommendation about further work there. There is quite strong anecdotal evidence, that ambulance officers came forward with during our consultations, about some of the things they believe are driving some of these demands and it is clear that we need some quite rigorous investigation of these things. Understanding the drivers for demand is important in terms of developing the right responses and we have recommended a piece of work to be conducted nationally around that issue.

The Hon. MARIE FICARRA: The recommendations in your report concurred with a lot of the complaints we are getting. You got 50 email responses. So far we have had 150 written submissions with more coming in every day. I am surprised. You think because ambulance officers saw you as almost a representative of the Government that they perhaps were reluctant to complain to you at the same level that they seem to be complaining to us?

Mr HEAD: I could not comment authoritatively at all on what was in the minds of people about that. I am a longstanding public servant. I have worked in the health system. I was a registered nurse who worked in accident and emergency environments. Ambulance officers understood that. They understood I had a personal familiarity with some of their work environments. I have to say, in some of the staff consultation sessions that we did, we made it clear they were sessions where we would not attribute views to any individuals and people were very open. There was no sense at all that people felt inhibited in saying things. We were talking directly to staff as well as their email submissions. We also had a very lengthy workshop with statewide delegates from the Health Services Union specifically around many of those issues to do with grievance handling, et cetera. So, I think there was a level of confidence that the issues that were being raised were being heard by the team.

The Hon. MARIE FICARRA: Why did it take so long for the report to be released?

Mr HEAD: The report was only finished early last week and it was released as soon as it was printed. Why it took longer than the original terms of reference to complete—this is well known—there were some objections raised by delegates early in the process about the breath of the terms of reference and some challenges in organising the original consultations, while we resolved those issues. They were resolved. We also undertook some consultancy work as part of this brief, where we engaged an international consultant and we had a lot of data to go through. This was the first review my unit has done since it was re-established in a different form last year, and it took roughly eight weeks longer than anticipated.

The Hon. MARIE FICARRA: Do you think you can blame some of the officers for being cynical that your report was released yesterday, the day before this inquiry began? Do they have a right to be cynical?

The Hon. CHRISTINE ROBERTSON: I have not heard of any cynicism.

The Hon. MARIE FICARRA: Read the media reports.

Mr HEAD: I have read the media reports this morning. The point I would make is that I received a set of terms of reference. We responded comprehensively to those terms of reference and I think provided very detailed recommendations based on our findings—commonsense changes that will assist the organisation. The report was released as quickly as practical after it was completed. So, people may form whatever view this may

want but the report came out as quickly as it could, and I think comments on all of the issues that were raised. In terms of the thrust of recommendations and comments made in some of the media today, the review report responds substantively to almost all of the recommendations that the HSU formally raised with the review team during the course of the review.

The Hon. MARIE FICARRA: The Director General of Health this morning seemed to make a lot of saying bullying was a problem but they had a code of conduct in place to deal with this bullying. Do you think this to be sufficient from your review?

Mr HEAD: My views on this are clear through the recommendations. I think, based on my past experience as a chief executive officer, this is a difficult issue to manage and it is one that is commented on in a wide range of workplaces these days. Why we have specified the elements of the program areas, I think it is extremely important that all staff in an organisation have an understanding of what the behaviour is; that the behaviour therefore is properly defined; that managers in particular understand what is expected of them, are required to comply with the code of conduct as part of their position description; and are given the proper training and support to identify these behaviours, respond appropriately where they can or escalate the problem where it is beyond what they can manage in the local workplace. We have been very clear about our requirements and it requires some updating of the current arrangements.

The Hon. MARIE FICARRA: Do you think the response issued by the health Minister addresses the concerns raised by ambulance officers?

Mr HEAD: What response are you referring to?

The Hon. MARIE FICARRA: The response by the Minister to date to the issues of concern raised by ambulance officers.

Mr HEAD: My understanding is that the media communication indicates that 26 of the 27 recommendations have been adopted and there will be further consultation on one recommendation. Even on that recommendation we had made some comment on the need for further consultation and implementation. So, my recommendations in full, with that exception, have been accepted.

The Hon. MARIE FICARRA: I am reading from your executive summary where you recommend a review of all management and supervisory positions and current capabilities. You also include that other challenges need to be addressed, such as improving the systems for resolving complaints and grievances, prevention and management of bullying, issues relating to staff transfers—which we have had many complaints about—and management processes and staff consultations to improve the relationship between staff, unions and management. When you discussed these issues with senior management of the New South Wales Ambulance Service, did you feel that there was an agreement that these issues were areas of concern and areas that needed improvement? What do you believe the culture is from the people you discussed these issues with?

Mr HEAD: I would have to say in conducting this review that every level of the organisation was cooperative and very forthcoming with information. My sense is that in the discussion with management some of the things that we have recommended, as we have acknowledged in the report, are processes that have been begun in the Ambulance Service. I think that speaks for itself and the fact that there is some recognition of the need to continuously improve these things. My sense is that we have provided a structured way forward on all those key issues. Certainly when we tested the general directions that we were thinking of framing in our recommendations in the follow-up staff workshop, there was some enthusiasm from staff around seeing these problems clearly stated and a clear set of recommendations about how to address them.

Ms LEE RHIANNON: I seek further information about some of the points you have made in your report. You talk about how the Ambulance Service is not adequately integrated in the New South Wales Health financial resource plan. Do you mean just the actual plan or does it flow on that it is missing out on resources?

Mr HEAD: No, in fact, our report indicates that the level of increased resources that have been provided has tracked slightly above activity level. This really goes to the issue that Professor Picone, I think, referred to at the end of the comments when I was coming in that the Ambulance Service is a critical component of how health and allied services are provided to the community. We believe that there are opportunities for a more structured dialogue between the Ambulance Service and other parts of the health system about the interactions between those services. We have made some specific recommendations about improved capabilities

on modelling demand and a major recommendation about looking at tiering the service. All of those things have flow-on effects around the system. So there needs to be a well-structured process within which the strategic issues around that are considered.

Ms LEE RHIANNON: When you say that recurrent funding has increased at a rate higher than activity, you are not suggesting that is unwarranted?

Mr HEAD: No. I think the rate of funding increase has been consistent with that elsewhere in the system. But we do have this theme, which is very strongly articulated through the report, that demand is continuing to grow, and it is continuing to grow above the rate of demographic change. There may be a range of things that are available to reduce some of that demand to make sure that those resource allocations are applied to where they are most needed. That is why we have made specific recommendations around non-emergency patient transport.

Ms LEE RHIANNON: I note that you talk about the inappropriate use of ambulances. Could you elaborate on that? That issue has come before us already.

Mr HEAD: This was a very strong theme that came up in our discussions with operational ambulance staff. This is why we have recommended some more work be done on the drivers of demand. Certainly the anecdotal evidence from officers is that many people call ambulances essentially to take them to an emergency department for what is essentially a primary health care interaction. So they are going to emergency departments for GP-related services and they are using ambulances to attend. We have also made some comments about the extent to which there is an expectation of what skills ambulance officers had to assist people on the scene and sometimes avoid transports for what are not really required transports to hospital. Paramedics are highly trained people. This is really about making sure that they are able to use those skills and that the public understands when it is appropriate to use an ambulance and when it is appropriate to use alternatives. It is clear that some of the growth in demand above the rate of demographic change is essentially around the inappropriate use of ambulances.

Ms LEE RHIANNON: Does that mean you concluded it is more an issue of education and providing community health buses to get people to appointments?

Mr HEAD: We certainly think that education has a role to play and we have made some comments about that, not just in terms of the appropriate use of ambulances but making sure that people understand what the service is there for, what it can provide and how to use it effectively given the important role it plays. We have also recognised that it is more efficient for some forms of non-emergency patient transport not to be delivered through ambulances. Why we have been very specific in setting out terms of reference for a supplementary piece of work is because that is potentially a very significant finding in terms of redirecting resources and making the best use of the Ambulance Service and, therefore, freeing up resources to respond to increased demand. In an operational sense the recommendation to adopt the principle of tiering and the recommendation to undertake a very detailed piece of work about how to operationalise that are very significant in terms of the issue of demand management and resource allocation.

Ms LEE RHIANNON: In relation to staffing, you did some work on the issue of overtime. Information that has come to us relates to complaints about the inappropriate or unfair allocation of overtime. Did you come across such problems and, generally, how do you suggest overtime should be managed?

Mr HEAD: It is clear to me through the consultation we had with staff that there are quite a range of views among staff themselves about the issue of overtime. We all know that in workplaces people want increased flexibility these days. There are some work practices that probably were more common 10, 15, 20 years ago and the younger people coming into the workforce want to see some change on. In the issues that were raised with us directly, overtime was not focused on significantly by the staff. In fact, the work process, beyond the things I have already discussed, that was of most interest in the staff consultation was around how transfers were managed. So, while it may be an issue that surfaces in this inquiry, and we did make some comment on it and we made some comment on the processes for pursuing reform around those issues, of much more note to the staff was the issue about how transfers are managed. Again, we have made some very specific commentary on what we think could improve that so that there are clear expectations and a greater degree of transparency.

The Hon. CHRISTINE ROBERTSON: Thank you very much, Mr Head, for coming today. We had some debate about your report coming out. We found out not long after we called our inquiry. The terms of

reference of your review process are quite different to our terms of reference. I want to know what you think about your recommendations in relation to our terms of reference because it would seem that although your terms are reference are quite different to ours your recommendations have addressed many of the issues we are looking at.

Mr HEAD: Some elements of the terms of reference that I received were very broad and allowed us to look at some of the issues, which I know this inquiry is examining, around workplace practices, around bullying and harassment, et cetera, around grievance handling. What we have tried to do really is critique the existing systems and make suggestions about sensible commonsense changes that would improve the experience of staff where there is a problem and would also go a long way to preventing the preventable components of those problems.

It should not be a mystery for any of us, if somebody makes a complaint about our conduct in the workplace, how that complaint will be handled and it is reasonable for staff to have expectations about the timeliness of that process. It is also very important that organisations set clear expectations around acceptable behaviour, and not just in a clinical sense but how we behave towards our colleagues. I have implemented these programs in other agencies I think effectively. I think the steps we have set out are a sensible way of responding to those issues, but of course in your deliberations and consideration of advice from others you may take a different view. I think what we have set out essentially reflects good practice in those areas and sensible improvements for the service.

The Hon. CHRISTINE ROBERTSON: Many of our submissions relate specifically to grievance issues. I am wondering if the submissions that came to your inquiry were heavily loaded on grievance issues? Are you allowed to say that?

Mr HEAD: Yes, we gave an undertaking to staff that we would treat the submissions from individual officers confidentially, but as I indicated in response to the first question, issues around grievance handling, particularly around timeliness, et cetera, were raised by staff in their emails to us, in the staff consultation sessions and also in the meeting we had with delegates from the Health Services Union. There were lots of positive comments too about more general improvements that people thought would help. We have made some commentary on structured performance management in the organisation and that is I think really about making sure that when staff get feedback they are not only getting feedback when something goes awry but they are getting feedback when they are doing a good job and where they are showing the qualities that we expect of people in these roles.

The Hon. CHRISTINE ROBERTSON: During your review process did you get a handle on whether the trial programs currently being undertaken—and I think the Care Program has extended, but the extended paramedic program and also the intensive paramedic program—appear to be addressing the issues, or have they been structured to address the issues in relation to changing demands? Did you get an impression where they came from?

Mr HEAD: Yes, and we have described the programs and commented on them in the report.

The Hon. CHRISTINE ROBERTSON: We have only had time to read your recommendations.

Mr HEAD: Yes, sorry, I cannot give you a page reference off the top of my head, but they are part of a suite of solutions to the issue of managing demand. Again, one of the reasons we have been so explicit in our recommendations about non-emergency patient transport is that we really need to understand all of the options available to the service so that we can really I guess optimise that suite of responses, and certainly developing these trials looks very promising at this stage.

The Hon. CHRISTINE ROBERTSON: I have a conflict of interest that I should declare: I am a member of the Health Services Union. You tell us that the Health Services Union got a very good hearing in relation to this process and I understand that almost all of their recommendations have been adopted in your process. Why do you think they are wanting to say it is no good now?

Mr HEAD: I cannot comment on that. I feel that we had a very open door and certainly responded to some of the issues that delegates raised and the desire for some direct, focused discussion with them around some of the issues that they wanted the review to consider, and I believe that the review does consider those. The Health Services Union made 13 recommendations to the review. Ten of those are substantially

accommodated and indeed expanded on in the way we have framed some of our recommendations. One of them is really contingent in part upon what comes out of the further piece of work on non-emergency patient transport. The two recommendations that we did not adopt were related recommendations about the institutional model for the ambulance service, bringing it back out of the health system and creating it as a separate organisation with a direct report and with a uniformed commissioner. I do not think there was a compelling argument put forward for that model and I also think—and we have commented on this in the review—there are a range of potential improvements for the ambulance service from its location within the health system around that coordinated planning, et cetera. These arrangements are relatively new and I believe that they ought to be given a chance to work.

The Hon. GREG DONNELLY: I posed this question to witnesses earlier, specifically Mr Peters from the ambulance service, about the grievance mechanism—and forgive me, I have not had a chance to fully read your report and perhaps you have dealt with it. There is obviously a formal grievance procedure within the award structure and it was explained to us that that is vented by some additional protocols and the two are read in conjunction with each other. The issue that arises is whether or not that is seamless and people can readily understand it and how it works together with the protocols and award provisions, and also whether the combination of those is the way in which matters associated with bullying are to be dealt with, or they are to be dealt with in some other fashion, and if so how that is done. Would you be able to generally comment on the formal structure, protocols, procedures and grievance handling within the service?

Mr HEAD: I think the general thrust of our commentary and recommendations is that, while there are arrangements in place, the impression we formed is that they could be clearer; that an absolute fundamental of making this stuff work is that people are clear about what is expected of them and they are clear about what happens when those expectations are not being met. We believe that, while there are certainly some good things in place, one of the strong messages we took out of the consultation and which was confirmed in our own review of things was that these things need clarifying and the expectations need to be clear, but also people do not just need documentation, I think particularly in a service like the ambulance service where many of the managers come out of an operational role, they need some good structured guidance on how they manage these situations once they are managers. To be able to take effective and appropriately timely action when there is a substantiated complaint you need to know that the whole organisation does have a clear policy, that the right people have been trained on it, and therefore you can take the right action when there is a complaint that is upheld. Certainly some of the elements of that system are there. What we have suggested is I think a set of improvements that make the framework more complete, more coherent, more easily able to be understood by staff.

The Hon. GREG DONNELLY: Once again without knowing what you have put in the report in detail, does that involve provisions of timelines to deal with issues?

Mr HEAD: We do believe that, in the review of the way the Private Sector Casemix Unit [PSCU] conducts its investigations, being clear about how long things take is an important element of how those procedures are reviewed.

The Hon. GREG DONNELLY: Finally, do you also believe that clear definitions of bullying and harassment verses industrial grievances are important to facilitate the processing of those issues?

Mr HEAD: Absolutely. One might assume that everybody has an understanding of those things, but having been in workshops with staff in other organisations, often there are lively discussions about these different behaviours. It is important to state clearly what are these problematic behaviours and to ensure that everybody—whether they are in a supervisory role or an operational role—has a clear understanding of the behaviours and the organisation's attitude to those behaviours.

The Hon. HENRY TSANG: We heard in an earlier submission that the Ambulance Service was formed as a result of a religious and regimental beginning. In your report you recommended that there should be an improvement in its work force and in its capital planning in order to modernise its corporate and business system. Could you expand on your recommendation and advise the Committee how that will result in a more modern practice?

Mr HEAD: Our communities have changed a lot in the time that the Ambulance Service has been operating—physically as well as in relation to what people expect from the service. The thrust of our report is about the need for good, strong planning processes so that the right capital investments are made at the right

time and in the right place. Generally, business systems is an area where we made some critical comment about the level of manual processes still used in the organisation. There are a couple of benefits. We believe that the reforms we have set out in the review will provide for a more efficient corporate service function within the organisation.

We also think that those improvements will assist some of the staff issues, such as payroll inquiries, et cetera. There are some benefits for staff from having good tools, not just in the clinical environment but also in the corporate environment. There are benefits to the community from having strong capital planning processes for investment decisions, and there are benefits to staff from having more user-friendly systems available to them. We have suggested a sensible reform program to improve and modernise the corporate systems of the organisation.

The Hon. HENRY TSANG: In a way you are giving staff at all levels an understanding of your corporate planning—whether you will have more ambulance stations, or whether you will be selling some?

Mr HEAD: There are two elements to your question. Dealing with performance management, we said that we think the organisation would benefit from a tiered system that has high-level statements and corporate objectives for planning at the next level down. Those things should translate into individual performance management processes for every staff member in the organisation so that people know what is expected of them and so that they get regular feedback on how they are going. But we have also recommended a set of improvements to business systems which are really just about making them more efficient—making sure that the right people in the right parts of the organisation are having conversations about things like capital planning. In response to an earlier question, the outputs of those discussions must be properly fed into consideration of these issues within the rest of the health system framework.

The Hon. GREG DONNELLY: I give as a personal example a conversation that Ms Lee Rhiannon and I had last Tuesday at Penrith when we were waiting for something. We were chatting with an employee who was doing the forthcoming roster cycle and we were watching her working on a huge magnetic whiteboard. She used magnets to identify people and to work out how the roster should work. When we questioned her about it she made the obvious comment that we needed to move from a magnetic whiteboard to a computerised rostering system.

Ms LEE RHIANNON: She also said that software was available but that they did not have it.

Mr HEAD: We noted in the report that one of the outstanding issues in an earlier review that was done involved automation processes for rostering. What we have set out there I think is a sensible set of business process reforms.

CHAIR: I cannot remember whether the issue of rostering arose in your submission. A number of complaints that we have received relate to people's ability to take appropriate leave and to communicate with whoever is authorising that leave. It seems that there are frequently grievances about that issue. Did you also establish the qualifications of ambulance crews and whether or not there were single ambulance officers, as occurred in the Hunter region?

Mr HEAD: In response to the first part of your question, staff raised with us the issue of leave and decisions about leave, although I have to say that the frequency of comments about particular problems was dwarfed by the comments on transfers. Once the issue of transfers had been raised there was generally a substantial discussion about that. We have made quite a detailed commentary in the report on clinical and training issues, which I think speaks for itself in relation to qualifications, et cetera, and I do not have anything to add to that. It was required by the terms of reference but I think we have described it quite comprehensively in the report.

CHAIR: You also talked about career paths and you made some comments about career progression. In your review you state that there are limited incentives for staff to apply for management positions and that a culture exists where managers are pitted against front-line paramedics. Could you explain those comments to us?

Mr HEAD: Yes. I think that the sort of structure of the system probably encourages people not necessarily to pursue a career path in management for the best reasons. We want people in management roles who are good at the things that managers need to be good at. That means you need a structure of identifying

those skill sets and supporting them, but you also have to recognise that it is equally legitimate for people to decide that their preferred role in the organisation is to continue in a clinical operational role. What we are really saying there—and this comes up in many organisations that have a strong technical orientation—is that going forward we must look at the career structure for ambulance officers, make sure that the right support is given to people who want a management role, and ensure that people are supported in staying in clinical roles. That is important, in particular, when we look at things like the age profile of the work force.

Ms LEE RHIANNON: I wish to ask you about triple-000 calls. Were any officers asked to let them go through the loop system, or to let them go through to another centre?

Mr HEAD: I do not recall that being specifically raised with me, but I am happy to take that question on notice.

Ms LEE RHIANNON: Thank you.

CHAIR: Thank you very much for appearing before the Committee today. Given the short time that we had available to us to ask questions, would you mind if Committee staff discussed additional issues with you in the future?

Mr HEAD: That would be fine.

CHAIR: Further questions might arise once we have thoroughly absorbed your report. Thank you very much for your evidence today. It will help us considerably with our deliberations.

Mr HEAD: Thank you.

(**The witness withdrew**)

(**Luncheon adjournment**)

PHILIP MARK ROXBURGH, Station Officer, New South Wales Ambulance Service, 64 Gundagai Road, Cootamundra, sworn and examined:

CHAIR: Mr Roxburgh, in your submission you raised a number of issues about the country ambulance service: isolation, recruitment to country areas and proper training for ambulance officers as opposed to those in the metropolitan area. Do you think the service in country areas suffers as a result?

Mr ROXBURGH: I think the service suffers as a whole through different areas, whether they are in the city or in the country. In my experience, which has mostly been country orientated, they have a very hard time from the base level. In other words, we get these bright-eyed and bushy people who join the Ambulance Service full of enthusiasm. We take them to the training school and we then send them out with a senior officer, who, contrary to what we have heard, is not always a senior officer. I had occasion to have an officer who approached me in regards to a job position. She had been in the job for 14 months, which meant she was 2 months out of her probation, and was almost apologetic because she was now training a probationary officer herself. She was far too junior, and I am not being disparaging of the officer; she was a good officer from all accounts. But we take these people, we put them into the system, they do their 12 months and then we send them out to the country.

They are basically left on their own. When they go out there, accommodation is a huge issue, even whether these people can get accommodation. We look at retaining these people. That is usually a bad step because it is difficult to get someone to go. Following that, these people want to advance their careers. The Ambulance Service to its credit, albeit terribly slowly, is starting to evolve the training to be more inclusive of country officers, but the people in the country in this State are being treated differently to those in the city by virtue of the fact that it is so much harder to become qualified as a full paramedic out in the country. These people get frustrated because often they get trapped out in the country where many of them do not wish to be—there are no incentives for them, there is no accommodation, there is no points system they can accumulate that will get them back to a better spot. They get very dispirited very quickly.

Also, as far as the people who got into the job to help others: their clinical progression comes to a halt. All these issues I am talking about we have been speaking about changing for years, but nothing ever happens. We have five tiers: probation level one; then levels two, three and four, which are all known as ambulance officers; and level five, which is paramedics. It is everyone's goal, who gets into this job, to aspire to offer the best that we can for our patients. We have the ability to do this because when I started my training I started as a probationer and I did what was level three, which was intermediate life support, which then became advanced life support. I picked that up at a school: that was giving some more drugs. From that stage I have progressed with my clinical skills by distance education and by education with clinical training officers. What we are looking at is that there is no reason that over a five-year period we cannot have these young people who come into the job and want to advance their career patient treatment progress as a natural progression up to level five. Then they can think no matter where I am stuck, at least I have this clinical interest. I can do things for people instead of being stuck, isolated and not progressing.

CHAIR: You have raised issues about bullying and harassment, and other specific issues. However, I note in your submission that you went along to the Healthy Workplace Summit on 28 May. How effective did you think that summit was in talking about and combating abuse, intimidation and harassment in the workplace?

Mr ROXBURGH: No, I was not invited to that.

CHAIR: You did not go along to that?

Mr ROXBURGH: No, sorry. I was making reference to it in the letter that was sent to staff.

CHAIR: Do you think it was effective?

Mr ROXBURGH: As a propaganda tool, quite possibly, but the staff in the Ambulance Service are too fatigued with submissions and people jumping up and down saying we are going to do things, we are going to change things. You may have noticed that I termed my first letter that I sent to the service as facta, non verba—deeds not words. We have heard so much for so many years under our current executive about what we are going to do and how they are going to change things in all sorts of realms but especially in bullying, harassment and intimidation. But people are so fatigued they do not take a great deal of notice, and they

certainly have no confidence that the executive will do anything. In fact, we have seen the service be more proactive very recently but, at the risk of sounding part politician, I suspect it has far more to do with politics than anything else.

May I add that, having sent the initial email to everyone in the State in the Ambulance Service, I received in excess of 100 emails from people, which discounts far more telephone calls. I have heard some absolutely horrific stories from my colleagues but they are very reluctant to put their head above the parapet. That even includes people to whom I have said, "Look, you have parliamentary privilege here". People are too afraid to speak out because of what has happened when we have spoken out. In my own specific case, I, as a manager, would not tolerate harassment, bullying and intimidation in my station. I stood up, not for the first time, but I had the grass cut from under my feet by management and then was removed from the situation in circumstances that were so patently going to go wrong for the other officer who was left there, knowing that I had run up the flag and said, "You have to go to the Professional Standards and Conduct Unit and let them know now". But nothing happened, and it took its inevitable toll. No-one did anything, and I am hearing this story time and time and time again. People say, "I've done the right thing; I've looked at our policies and the law of the land but I then become the victim of those above me, who wish to do nothing further than just cast me adrift".

CHAIR: When you say that there will be repercussions from management, which level of management are you talking about?

Mr ROXBURGH: The top; the very top.

CHAIR: Have you voiced concerns further than that about these issues?

Mr ROXBURGH: I tried to make contact with Ms Reba Meagher. I got as far as her private secretary. I spoke to him at length and he said that he would pass it on, but I did not hear anything. May I add that I made representations not for me or my colleague because I could achieve nothing but because I was still getting calls from people who were going through their own very nasty circumstances. This case is from 2004, but nothing was changing and no-one was doing anything. These people were still being ignored. I am sorry, I have a brain injury; I have lost it.

CHAIR: That is okay. In terms of the complaints handling process, we have heard today that there is a grievance procedure and that there is support for officers who are suffering by way of chaplaincy, psychologist support or peer support. You are on the ground, is it your experience that there is adequate support for ambulance officers who are suffering either from perceived intimidation or because of some of the cases they have had to deal with?

Mr ROXBURGH: Absolutely not. In my own particular case that can be demonstrated by what happened in 2004, which led to the unfortunate circumstances in April 2005. I was not contacted from the lower part of the briefing system, which is a peer debriefer. I was not contacted by any peer debriefer until a couple of days after my colleague's suicide. There was no chaplaincy support—but, in their defence, neither did I ask for it. The only person who offered any support to me and my colleague was our rehabilitation worker, and she ended up being on the wrong end of the stick herself, and left the service. She helped keep the both of us sane, but every time she went to the professional standards and conduct unit she was rebuffed. It was an utterly hopeless situation. Everything they said they would do, not one thing was honoured.

The Hon. CHRISTINE ROBERTSON: The performance review report was released today. It contains quite a lengthy section on, and recommendations about, dealing with issues in relation to grievance and bullying, harassment and complaints handling. We heard today that plans are underway to increase the training for station managers and to improve the information processes—for example, where to go to get help—for staff on the ground. Can you give us any idea of how this could best be implemented on the ground? It sounded like a positive step, but I would like to hear from you.

Mr ROXBURGH: First of all, there are parts of the service where we need competence in our managers for the people on the ground. It is interesting to note that I have received more submissions than the Head inquiry has received because of its perceived politicisation. I am sorry, could you repeat the question?

The Hon. CHRISTINE ROBERTSON: We have heard about a proposal to go forward on this issue, which is obviously real. On-the-ground officers and station managers do not necessarily have enough support

processes to deal with complaints and grievances and, as a separate issue, bullying and harassment issues. The deal is to increase training for station managers so that there is more front-line information, and also to work hard to try to get more information to each individual officer so that they have a good handle on the process, which are simple not complicated. What do you think of that idea? What do you think would be the best way to move forward with that?

Mr ROXBURGH: For it to work on the front line you must have competence in the managers above you. If you do not, especially as related to my circumstance, you lose it from that point on. Once you get up, the service politics come into play. Not just with my case but with others. We have the laws enacted by Parliament and we have our own policies. We do not need them rewritten. I have got a brain injury that puts me behind other people, but they are plainly written and most of our other staff do not need them spelt out. We just need people who are going to act on it. How can we change things? For a start, any change has got to start at the top. It is wonderful to talk about everything. Management can come in here and say, "Look, we're building this wonderful superstructure", but if the foundation that superstructure is being built on is not solid it will fall.

For that to work, we have to have confidence in our executive. We do not have confidence in our executive to bring this about because the executive has had year after year to be able to do something about this. I have in my possession, for example, the inquiry they held after my colleague's death, with changes to management practice which, albeit in brief form, was delivered to me in May 2005, which were the same things alluded to here this morning. I am quite happy to give you a copy. None of these have been acted on, and we do not have the confidence that they will be acted on in the future.

I will use this analogy. I have five kids. When they were born, and as they grow up, I draw a line in the sand. I say to them, "If you step beyond this point, you are going to get your backside smacked." You can push it from time to time. I might have better days; sometimes you can go a bit further. Those of you who have kids probably know where I am going. You do not have to discipline your kids, because it is set there. We have the same line drawn in the sand with our policies, with the laws of the land, all ready to be acted upon. We are now teenagers; we have grown up. But now our parents, the executive, in the last couple of months want to change things again. It is too late. Once your kids have grown up, once the culture is embedded, it is too late for those who have overlooked it to then turn around and say, "We are now going to change it", and be taken seriously.

Where do I look at change coming from? We must have people who are going to be exhibiting leadership qualities, who are going to be decisive but fair, who are going to work collaboratively with those on the ground. I would like to see that this change is more driven from—We talk about the military aspect of things. I would like to see this change more driven from a ground level. Management needs to be part of this change, the HSU needs to be part of this change, but we need to have the people on the ground floor having the biggest say in where this is going. If that does not happen, there is not going to be much weight given to it.

The Hon. CHRISTINE ROBERTSON: You work as a station manager?

Mr ROXBURGH: Yes, I do.

The Hon. CHRISTINE ROBERTSON: What sort of processes do you use in relation to bullying and harassment in your workplace, if you happen to see it? What sort of processes have you structured into your workplace?

Mr ROXBURGH: I will go back to the one you have in my submission, just as an example. If there is a problem, you identify the problem. When you move to a new station, you identify what problems you have there. When I moved to the new station there were problems that were unresolved; they had been totally woefully and inadequately handled. I got there, I spoke to the officers, and tried to find out where they were coming from. I tried to sort out the situation because, as a station officer, I have learnt through past experience, even before then, that you must try to manage as much as you can yourself because once it goes above you—the questionability of some of the confidence of some of our managers has for a long time left a lot to be desired. So I tried to handle as much of it in-house as possible.

Then, if something raises its head that someone is not happy with and we want to take it further, we will then give them the option. We will sit down and talk about it, and say, "We have a grievance process that we can use." In this case, this is the way I approached it, and, yes, there was harassment and bullying with this. But I needed to take it to the next level. The person was very reluctant. I said to her, "Look, we have a grievance policy which is sacrosanct; you cannot violate the confidentiality." I took it, and it was just blown right out of

the water at that point. It was proven to be blown out of the water at that point, and there was never any disciplinary action taken against the person in higher authority—none whatsoever.

I then had people ring me and say, "Phil, what do I do?" Some of these people are in dire straits. It is no use my telling them that you cannot take it to the Ambulance Service, because they know that already. They have seen what has happened to me; they have seen what has happened to other people when they take it to the Ambulance Service. You have to wait. No-one treats it seriously. It takes an interminable amount of time for anyone to do anything. No-one returns your calls. You have raised concerns of harassment or intimidation, and then you feel like you have been harassed or intimidated by the service as well, and you are to go away because no-one will face it or do anything about it.

That takes the option away from these people. I then say to them, "Look, you've got ICAC or the Ombudsman." They say, "We can't. We are only such a small organisation. You can do it anonymously, but the moment it gets investigated, it then goes back into the Ambulance Service's hands. Once again confidentiality is blown, and we are too small a gene pool. They will soon identify who has said what." We have had exactly the same thing come up—it is not to cast any aspersions on Mr Graeme Head, but it is seen as being a political exercise and people would not come forward. Which explains why I got many more responses to my email than Mr Graeme Head did.

The Hon. CHRISTINE ROBERTSON: What you are discussing now is about issues that go beyond what can be dealt with at the local station? Normally, complaints and grievances can be dealt with at the local station level, can they not?

Mr ROXBURGH: Most of my grievances have been dealt with at a station level. It is just that when they escalate to a stage where you need higher management, especially in light of mine where there has been a grievance laid before the investigations, which have not been adequately handled, it had to go higher. When it went higher, from that point when it left the station it all fell in a huge heap. I am talking about it going all the way up to the Professional Standards and Conduct Unit, who were notified on the first working day of my grave concerns about where this was going to go in light of previous occurrences. Nothing happened.

The Hon. MARIE FICARRA: How have you maintained your motivation to stay in the system, given its history of management not listening, management not acting, colleagues suiciding, and your colleagues telling you that they are extremely frustrated? How have you managed to stay in the system?

Mr ROXBURGH: I love my job, I love getting out there and doing what my job will allow me to do, and that is to go out and make a difference in people's lives. I also said to my colleagues when I first arrived at any station that my first and foremost thing to do here is to look after patients; my second is to look after my staff. And that is exactly what I believe I tried to do. It is too easy for people to sit back and complain and decry what is happening around us and not do something. But I hear stories from so many people who have come so close to attempting suicide, or have gone through some really horrific experiences. Someone needs to be a voice for these people; someone needs to care for these people and lend something more to them than rhetoric. I will do my best for whoever approaches me and asks for help.

The Hon. MARIE FICARRA: You are pretty fearless, I have to say.

Mr ROXBURGH: Some may say, stupid.

The Hon. MARIE FICARRA: I think it is better that you come out in public, because you are now so public that you are noticeable and anything that happens to you is noticeable. We have been told that the suicide rate in the Ambulance Service is no higher than in any other major front-line organisation. We are to be supplied with some statistics to back that up. For how long have you been with the Ambulance Service?

Mr ROXBURGH: Over 30 years.

The Hon. MARIE FICARRA: Do you feel objectively that you are seeing an increase in untended stress and fatigue that leads to suicide? Do you believe this to be the case?

Mr ROXBURGH: Absolutely. I have had a few dealings with suicides. Let me also add, I have also had dealings with colleagues who have suicided after they have got out of the job because they can handle it no more. These are the statistics that you will not see. But what scared me with the people who were phoning me

and the people who were sending the emails is that we have a lot of people out there who are on the edge. I have had quite a number of people say, "I have been that far from doing it." A couple of people whom I have referred on but who still speak to me, who I term as being on suicide watch, are really that close. I refer these people to professional counselling but we need the system to be looked at to work better than it is because our system usually works by our colleagues talking to each other and that is where any change to the system is going to have to come from.

Ms LEE RHIANNON: From your years of work have you ever been aware of instances where the sale of Ambulance Service resources and infrastructure occurred to fill short-term gaps in the budget? Are you aware of pressure ever having been put on or are you are aware of instances where that may have happened?

Mr ROXBURGH: All the evidence I have heard, because I am only small management, would only be anecdotal.

The Hon. GREG DONNELLY: I understand that the union that covers ambulance workers is the Health Services Union?

Mr ROXBURGH: That is correct.

The Hon. GREG DONNELLY: Are you a member of the Health Services Union?

Mr ROXBURGH: I am but may be not for long.

The Hon. GREG DONNELLY: In terms of having an issue as a union member most union members would understand that they take it forward to someone inside the union, for example, a union official or a full-time—I think most unions call them—organiser. Would the Health Services Union have union organisers?

Mr ROXBURGH: Yes.

The Hon. GREG DONNELLY: Have you had occasion in the past to take your concerns to a union organiser in the Health Services Union?

Mr ROXBURGH: Yes, I have.

The Hon. GREG DONNELLY: It terms of taking the issue up with the union organiser, what has the union organiser done in regard to dealing with the issue that you raised?

Mr ROXBURGH: Let me preface my remarks by saying I am not anti-unionist: I believe there is a place for unions in the workforce. However, I am greatly disappointed in the Helped Services Union. As per the submission with my own case, I was on a station that had a union organiser on it and he basically sought his own good. That was okay. I then went to the actual area organiser when I took the grievance forward—

The Hon. GREG DONNELLY: Sorry to interrupt. There was a person working at the station who was—

CHAIR: We are running short of time.

The Hon. GREG DONNELLY: We will just be clear about this. There was a person working full-time for the Ambulance Service on the site—

Mr ROXBURGH: He was just an ambulance officer.

The Hon. GREG DONNELLY:—and he was an elected union—

Mr ROXBURGH: He created his own position as an assistant president.

The Hon. GREG DONNELLY: The issue then was elevated to a full-time union organiser, is that what you have just said?

Mr ROXBURGH: At that particular stage I could not go to my sub-branch president because my next boss did not like her boss above her—every decision he was making she was giving to the union sub-branch president, which was making the total area unworkable and could not be managed. So now we get to the union organisers. I am removed from a station through my perceived disability.

The Hon. GREG DONNELLY: Through what?

Mr ROXBURGH: Through a disability—I am actually a disabled ambulance officer. I did not want to go to my area union organiser out of respect because she was involved with that area's sub-branch and I did not want to compromise that position so I went to an area organiser in the southern area. I related my story to them and told them the incompetence. The very next day one of the officers at the station took the other officer outside and was saying, "You can't go to management. You can't go to the union. We know what is going on. You can't move anywhere. You're stuffed." Now, I had just had confidentiality breached by the Ambulance Service, I have now got confidentiality breached by the Health Services Union with minimal support to me whatsoever.

Now in the recent occurrences where we had the inquiry brought up by Mr Head and then they tried to change it and then the Health Services Union went in and said, "No, this isn't right". When I put my submission in and we had this Committee formed, I then wrote to Mr Michael Williamson saying I needed his urgent and immediate assistance. I have heard as much from Mr Michael Williamson as I have from Ms Reba Meagher at this stage, which is absolutely nothing except for, what I would call, a rather disparaging letter from the Health Services Union sent out to all stations with another inquiry into the Ambulance Service—with another underlined—going on to say it must be a rare event that we get two inquiries et cetera.

The Hon. GREG DONNELLY: So the position is that no one is supporting you?

Mr ROXBURGH: From the union, no.

CHAIR: I know this is fascinating but we are out of time. Thank you so much for presenting your evidence today and for your submission. On behalf of the Committee I can say we are very committed to making this not just another inquiry but an inquiry that gets results on behalf of those people who are out there on the front line.

Mr ROXBURGH: Can I ask one thing very quickly?

CHAIR: Yes.

Mr ROXBURGH: It should be a recommendation of this Committee, if I may be so bold, that within 12 months time of the submission being sent down that we actually review where the Ambulance Service has got to with this. It is my fervent hope that this is not just put under the carpet and ignored over the process of time.

CHAIR: We will take that on board and hope that every recommendation is acted on.

(The witnesses withdrew)

WAYNE STANLEY POWER, Paramedic, Ambulance Service of New South Wales, sworn and examined:

CHAIR: Mr Power your submission was presented to us as partially confidential. It is my understanding that you now wish to change the status of that submission, is that correct?

Mr POWER: That is correct. I discussed it with Therese this morning and that is fine.

CHAIR: You are happy for it to be a public submission now?

Mr POWER: Absolutely, yes.

CHAIR: You are also a country ambulance officer, is that correct?

Mr POWER: Yes, I am stationed in the country on the south coast.

CHAIR: What is your current title?

Mr POWER: I was an ambulance officer converted to paramedic in the last month or so when we have changed our title.

CHAIR: We have had a lot of submissions that comment on fatigue amongst ambulance officers, particularly so in country areas where they take an ambulance home sometimes, they are on call and not able to have a social life because in the community in which they work they are it, so to speak. Sometimes ambulance officers are on very long shifts. Has that been your experience?

Mr POWER: Yes, while I will acknowledge that the service has made advances in modified-hours rosters, which has assisted us socially and professionally, we still have the problem of fatigue in the country. Basically the ambulance service in the country is an emergency service for whatever duration of the shift is that we are appointed to. On my station it is a nine and a half hour shift, so we are an emergency service then, and we provide an after hours emergency service only—24 hours backed up by on-call. I have noticed in the last few years particularly, maybe it is due to the ageing process with me and that may have something to do with it, but fatigue is definitely on the increase. I am hearing more officers complain and we are seeing the results of fatigue more and more in the workplace.

CHAIR: It is an age-old question in terms of the rates of pay of ambulance officers, but is it your view that ambulance officers are taking overtime as a way of supplementing their wages and therefore working longer hours than is safe?

Mr POWER: Absolutely. I think one of the things that has been concerning me for quite a period of time is the huge disparity in pays across the Ambulance Service from the metropolitan to the country areas. I noticed when I had a quick flick through that report that came down on the Internet yesterday that it is mentioned. There is definitely an overtime culture that is exists out there. Perhaps our base rate of pay could be a little better than it is. I can fully understand and empathise with the metropolitan officers for the amount of work they actually do that they are pretty well underpaid.

In our situation, what I have struggled to come to terms with in the past few years and it seems bizarre that I am complaining about it, but I find it quite obscene that I can more than double my base pay rate with overtime. It has caused me real concern. We are developing this culture where people—especially in the metropolitan areas—are actively seeking out the overtime to supplement a wage purely to survive. In the country I think it is more a case of officers becoming accustomed to earning the bigger wages with the overtime. A lot of the staff are committed to earning those bigger wages and if we had a reduction in pay it would cause some hardship among staff.

CHAIR: In the briefings after critical incidents and if someone has issues that they need to seek some chaplaincy or psychological support, in your experience is that available, freely available on a confidential basis?

Mr POWER: Yes, it is freely available. I have availed myself of the service before. There is a bit of a culture or a mindset in the Ambulance Service that we tend to debrief amongst ourselves at station level before we go on to other methods of debriefing. I have noticed in the past couple of years, though, that our peer debrief system appears to have either fallen over or it is not as well promoted as it was. I was only commenting to the chaplain earlier today that a lot of the staff out there at the moment could not name the peer debriefers that we have, whereas that was not the case years ago when the system came in. It was actively promoted. It is not so much promoted now. We do not see the chaplaincy service out and about as much as it was. Whether it is a divisional thing or a whole of service thing I cannot comment on. We are aware the service is available but it is not actively promoted. They are more inclined to try to promote you to debrief amongst yourselves, leave it in-house, get over it and get on with it, which is pretty unhealthy.

CHAIR: You have noted in your submission, "Violence against us is on the increase and grievances, harassment and bullying in the workplace is also on the rise." Could you comment on that?

Mr POWER: Yes. Definitely violence in the workplace is escalating. It is just the nature of the business these days. We are dealing with more violent people or more violent situations, where we are first response to the scene without the services of police on occasions, or most of the time, when we unwittingly put ourselves in a situation where there is violence against us. It may seem a fairly insignificant thing to some but I have noticed since we changed uniform, going from a white shirt and blue pants to a dark blue uniform, the number of people have commented in public that we look a lot like police. That perception can lead to violence against us in a volatile situation where we are not actively recognised. That does happen.

In the workplace, yes, I have seen violence, intimidation, bullying increase in the workplace. It probably gets more of a profile now with incidents such as Phil's being out there and about. More people are aware of it, more people know about it, and you tend to notice these things more. People in the service these days are more inclined to go down the line of grievance, bullying and harassment than they were years ago, when it was let's sort it out amongst ourselves and get on with it.

CHAIR: Do you feel that the various levels of management support paramedics and ambulance officers out there on the front line?

Mr POWER: I think management has let us down to a fair degree, particularly middle management, where the middle managers we had, the district officers and assistant operation managers at that level now, seem to be tied up far too much with administrative work and they do not get out and about as they used to. There is not the front line supervision and contact that there was. That is a definite concern and I highlighted that in my submission, and it is pretty well across the service.

The Hon. MARIE FICARRA: The problem with placements out in the rural community—you have just recently become qualified as a paramedic. How difficult was it for you to achieve that?

Mr POWER: I am country born and bred and always had the desire to go back to the country from the time that I was appointed to the service. When my probation period ended I was asked if I would volunteer to go to the country. I did. Since then I have progressed, since my initial transfer, through two places based on merit and I honestly did not have any difficulty, and maybe I have it on paper where others do not. I can understand the frustration out there. There are people being sent out to the country who are finding it difficult to get to where they want to be. That is a real concern, but personally, from my point, I have not had that problem.

The Hon. MARIE FICARRA: Have you had encouragement from the service in your training, career path?

Mr POWER: Yes. Probably to go to the top clinical level the encouragement has not been there as much as it should or the offer has not been there as it should. That may concern some people. I can see that can be quite frustrating, to be stuck at a lower level of training and not being able to progress. It is probably one of the things the service needs to actively address, the promotion of people through the clinical ranks.

The Hon. MARIE FICARRA: We heard there is a lack of comprehensive performance assessment, which may tie in with what you are saying now, that those clinical attitudes do not get the same significance attached to them as the ability, say, of presenting yourself well in an interview. Is that something that you feel that limits your progression to those senior levels?

Mr POWER: Yes, definitely. It has been a good while since I have been through the process. My last merit transfer was to the coast 10 years ago now. I am aware the situation has changed a fair bit but I know very little emphasis is placed on clinical ability, clinical skill level. It is more to do with service and conduct. These days you can have two or three more sickies than you are allowed and miss out on a transfer ahead of your clinical ability, which does not really help with a profile of trying to give the best level of care we can to the community.

The Hon. MARIE FICARRA: You are quite happy that this is being looked at and addressed, perhaps, with more consultation with the front-line service?

Mr POWER: As with everything in the Ambulance Service, I am sceptical when I hear that something is being progressed, because with 23 years of service I have heard that things are being progressed on a number of occasions—too many occasions to count—so I am naturally sceptical, as probably 90 per cent of the staff are on anything the Ambulance Service puts out, unfortunately. It is put up as it going to be done or going to be looked at and then we have to, once more, into the breach to give them the benefit of the doubt.

The Hon. MARIE FICARRA: You are happy being in a rural area. Do you know whether the status in other areas is that they are suffering from experienced officers wanting to work out there and remain out there? Are you unusual in the service?

The Hon. CHRISTINE ROBERTSON: Is it strange that you want to live in the country?

The Hon. MARIE FICARRA: Are other areas suffering?

Mr POWER: I do not find it strange that I want to live in the country. I chose to live in the country and come back to a metropolitan area to train. I can see the opportunities to get to the country, or where you want to go in the country, are fairly limited. It has always been the way that the prime positions are very competitive on merit. You almost always have to kill somebody to get to the coast. That is an old adage within the service, yet there always seems to be a position at the Boorowas and the Hardens and the more remote places. I think it is causing us a big problem with retention, to get people to these places, they cannot get to where they come from, and it is causing a problem, definitely.

Ms LEE RHIANNON: I was interested in your comments about overtime. You have a recommendation there, so thank you for setting that out clearly. I was wondering what you see as the solution here? At the end of the day, it seems that the solution is that there is extra staff so people are not forced, even if they wish, to work overtime, particularly with the fatigue factor coming in and the obvious implications for occupational health and safety and patient wellbeing.

Mr POWER: This has been one of my biggest concerns for a long time. The overtime payment—the service in the country survives on overtime.

Ms LEE RHIANNON: Is it only in the country or is it that you do not have experience of the city?

Mr POWER: No, I do have metropolitan experience. I started up here.

Ms LEE RHIANNON: Sorry, so you did. So, is it a problem in the city too?

Mr POWER: Overtime in the city always seems to be available. In the city it seems the main reason for the overtime is for maintenance of rosters, when we have people sick, to put enough bottoms on seats each day to perform a service. In the country, overtime is just the nature of the beast. Because the hours of duty have been contracted and we have to provide a 24-hour service, then it becomes a problem. I think we have to look, not so much at the amount we are paid, the hourly rate we are paid, but the structure of the way we are paid. It seems wrong to me that we have officers who work in the city with their high rents, their travel and their higher cost of living, and that they are working an inordinate amount of cases a day and receiving not much more than base pay rate, whereas in the country—and I should be protecting this and keeping it quiet, because I benefit from it—we can be sitting out in the country not doing a lot through the duty hours but then work after hours and, as I say, double the pay rate with overtime, which is quite wrong. Perhaps we need to look at a composite wage where we even out the overtime. The easy solution would be extra officers but we all know it is practically difficult to do. We need to expand the on duty hours that we provide in the country. At the moment the duty

hours at the station where I work are purely nine and a half hours from 8.00 until 5.30 and then it is an after-hours service with all the inherent overtime that goes with it.

Ms LEE RHIANNON: Are you suggesting that the base of nine and a half hours should be extended?

The Hon. CHRISTINE ROBERTSON: The time for which an officer is appointed rather than the human work hours.

Mr POWER: I do not think we should extend the working hours of the officers that are currently appointed. Longer shifts are not the answer. We need to appoint more officers so that we can extend the duty hours of the station as a whole. That is probably the solution. I know it is not easy.

The Hon. CHRISTINE ROBERTSON: Two shifts instead of one?

Mr POWER: Yes, or overlap shifts, so we have extended duty coverage, which takes the emphasis off overtime and lets officers get their rest. In my situation, as I have stated, it is conceivable and does happen quite often that we can work from 9.00 to 5.30, not do a whole lot through the day but still be there, go home, then half an hour later be sent on a long-distance transfer for six hours and then front up again the next morning at eight o'clock. It is fatiguing; it is cumulative fatigue. It is a huge problem, and it is going to end in disaster.

Ms LEE RHIANNON: You spoke about the dilapidated state of many of the places where you work. Can you elaborate on that? Are there any differences that you see between the work of officers in country areas compared with people in the city and larger regional areas?

Mr POWER: If I was a tenant and the Ambulance Service was my landlord, I would be taking them to the tribunal over some of the maintenance on the properties.

Ms LEE RHIANNON: Can you outline those?

Mr POWER: Buildings in a poor state. As I stated in my submission, a lot of the buildings were constructed in the 1960s and 1970s and very little capital works have been carried out since. A lot of the work that has been done around the stations has been done purely for pride by the staff who have to be there every day, just to make it comfortable. Basic amenities such as floor coverings, heating and cooling and vehicle parking spaces have not kept pace with the times from the 1960s and the 1970s. At our particular station we have three ambulance vehicles assigned to the station and we have undercover parking for two. The service put out a request not so long ago that all vehicles be parked under cover for the maintenance of drugs that are kept in the vehicles because of temperature variance and what have you. We physically have not got parking available. That is the same at many stations. Time has progressed and it has gone ahead of the maintenance issues. When we have approached management over maintenance issues it has been brushed off financially as not possible at the time.

Ms LEE RHIANNON: Do you have to take the drugs inside or do they sit in the ambulance and deteriorate?

Mr POWER: They sit in the vehicle basically or we rotate the vehicles around under cover to try to maintain them.

Ms LEE RHIANNON: Still, it would have an impact?

Mr POWER: Yes.

The Hon. CHRISTINE ROBERTSON: How did you progress through your paramedic training, because you were country based? Did you choose to do it because you were enthusiastic? Could you talk about how that happened, how you accessed it, the process?

Mr POWER: My level of training at the moment is level 4, advanced life support, which is one level under level 5, intensive care paramedic. I obtained that level of training in 1988. As it was known back in 1988, it was called intermediate life support, which was the stepping stone from basic ambulance officer to paramedic. Since then there have been a couple of tiers brought in. I was keen and energetic in those days and it was actively promoted to go ahead and get these positions. There were a number of positions that were offered at

each individual station, and I was keen enough to go ahead and do that. Since those days the clinical pathway has probably contracted a fair bit. The service now is looking at each station or each area individually and appointing advanced level based on merit and on need and based on population, as far as we can figure. It was not really difficult back then, but I have not advanced my level of training since 1988. I have recertified, as I am required to do, a number of times and they have made additions to my skill level, but the level remains the same that I was certified at in 1988.

The Hon. CHRISTINE ROBERTSON: If you should choose to increase your training level clinically, is there a process?

Mr POWER: There is a process. Perhaps 12, 18 months ago all level 4 officers were asked who wished to go on and be promoted to level 5 or advance to level 5. A lot of the officers did, the keener and younger ones. In my case honestly I did not. At my stage of career, advancement, my social and family setting does not allow me that extra time. It is just one of those things. They did offer it to other level 4 officers who indicated that they would like to go on to advanced. Then the service has come back and replied, "We will look at each individual case based on where the officer is stationed and the need for that clinical level." They have to be able to justify it. I do not know what their measures or parameters are to justify appointment to that level. But it was offered and then it has stagnated a little bit since then.

The Hon. CHRISTINE ROBERTSON: Recognising your cynicism in this process—

Mr POWER: Healthy.

The Hon. CHRISTINE ROBERTSON: —we have heard today about proposals to ensure that on-ground managers, the station managers themselves, are upskilled in order to deal with, in particular, grievance complaints and bullying issues. What do you think about that?

Mr POWER: I would quite welcome that. That will encourage more people to actively seek promotion. The way I see it at the moment there is not a lot of incentive for people to go from ambulance officer level up through to the lines of middle management. I think the service figures would back that up if they were asked that when they call for applicants for these positions they are getting less and less applicants these days. I think a lot of it has to do with the role they put on the middle managers. There is too much administrative work. Pay scale wise it is certainly not lucrative to go from an ambulance officer up to middle management and again get out of that overtime culture with a drop in pay rate for the responsibility. As far as station level goes, there is only a limited amount of station officer positions that become available obviously. The pathway for career advancement has probably shrunk a little bit if you take out the desire to go on to middle management. We would certainly welcome any improvement to the training or provision of training to the managers that we already have. That would certainly help from our level. We are missing out on that front-line management from the middle managers.

The Hon. CHRISTINE ROBERTSON: If the skill level were higher at the front line, which is what would happen, surely that process would give more skills to the people on the ground.

Mr POWER: Yes.

The Hon. CHRISTINE ROBERTSON: Would that resolve many of the issues that we are hearing about through this inquiry, for example, the multiple unresolved grievance issues that are bubbling away? I am just asking for your ideas.

Mr POWER: From what I have seen, as Phil stated in his submission, probably a lot of the grievances could have been managed or could be better managed at station level and do not have to progress any further. The grievance issues or the harassment and bullying issues that you are hearing about or are going to hear about are issues that have progressed beyond being managed at a station level, unfortunately.

The Hon. CHRISTINE ROBERTSON: A lot of them look like they were never managed at station level.

Mr POWER: No. There is only so much you can do at station level. There is a policy put in place, a grievance resolution policy, which the station manager follows. Once it goes beyond that it goes on to middle management and upper management. Unfortunately, that is much the case. Probably the policy we had in place

may have been a little bit inadequate to allow the station officer to deal with it at station level. So any change to that would most likely be welcome, definitely.

The Hon. CHRISTINE ROBERTSON: Do you think more training and support at that level would improve that situation?

Mr POWER: Yes, I do.

The Hon. GREG DONNELLY: Thank you, Mr Power, for the frankness of your submission. You come across as a straightforward witness who says it the way it is. We are all appreciative of that fact. I will refer to a couple of points in your submission. On the issue of clinical training, we heard evidence earlier today that between 90 per cent and 95 per cent of the Ambulance Service people at the base level are clinically trained. Does that sound right? That seems to be a figure much higher than you suggested earlier when you commented on people being clinically trained.

Mr POWER: Clinically trained to what level?

The Hon. GREG DONNELLY: That was not specified earlier today. The generalisation was that 90 per cent to 95 per cent are clinically trained.

Mr POWER: Bearing in mind we have tiered levels of training, qualified ambulance officer is the basic level. I would imagine the service is referring to that, that we are each qualified ambulance officer status and the other 5 per cent would be probations or trainees.

The Hon. GREG DONNELLY: As to the issues you have identified, clearly they are issues that emerge in relation to ambulance stations outside the Sydney metropolitan area in regional areas. Given you have worked both in the city and outside the city, is there generally a greater problem with morale outside the city compared with the cities and bigger country towns, or is the morale issue generally flat across the board?

Mr POWER: I think morale is fairly poor across all levels of the service, but for different reasons. In the country it is fatigue.

The Hon. GREG DONNELLY: Fatigue?

Mr POWER: Yes, and there are essentially fatigue rosters. Obviously not a lot of the staff are going to complain about remuneration out there, whereas in the city it is those issues—it is the amount of work that the officers are doing for poor financial reward, and the stress and strain that they are facing to survive daily.

The Hon. GREG DONNELLY: With fatigue, whilst the people in the city may be working overtime, they do not have such long runs. The example you gave of a six-hour drive would not be the same issue in the city, would it?

Mr POWER: Not necessarily. The overtime that is generated in the city—most of the overtime is by the officers choosing. They choose to do overtime shifts on days when it is offered. They do occasionally get extended shifts at the end of their shift, day or night, that is granted. That is usually in the order of—when I was here it was one or two hours at max, but the overtime that they are submitted to here is at their own choosing. The overtime that we are submitted to in the country is not of our choosing. We have an on call system forced upon us where we are required to do X number of nights on call a month, and whatever comes up comes up and we handle it.

The Hon. GREG DONNELLY: Is it prescribed in your award that you have to be available for those?

Mr POWER: Yes.

The Hon. GREG DONNELLY: So it really becomes a staffing issue then, does it not?

Mr POWER: It does, yes. If we could extend the actual hours covered on duty by additional staff it would definitely help a fair bit and the service also needs to have a better coping mechanism put in place for officers for fatigue. At the moment fatigue is a grey area within the service. If an officer was to go off, unable to front back to duty because he was tired, it does not classify as a worker's compensation case, it falls back on the

officer's sick leave, so officers are reluctant to do that. There are wishy-washy agreements in place where an officer can go home and sleep-in the next morning, not front up to work at 8 o'clock but be contacted when a case comes in, which is a token effort. It is not combating the fatigue.

CHAIR: Thank you for your submission and your contribution today, and for coming such a long distance. I should have said the same to Mr Roxburgh. We appreciate it very much.

(The witness withdrew)

(Public hearing concluded)