LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Auditor-General's report No 4 of 2009:
***Delivery of ambulance services to the ACT community*)**

Members:

MS C LE COUTEUR (The Chair)
MR B SMYTH (The Deputy Chair)
MR J HARGREAVES

TRANSCRIPT OF EVIDENCE

CANBERRA

MONDAY, 29 MARCH 2010

Secretary to the committee:
Ms A Cullen (Ph: 6205 0142)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Committee Office of the Legislative Assembly (Ph: 6205 0127).

WITNESSES

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Amended 21 January 2009

The committee met at 10.31 am.

PHAM, MS TU, Auditor-General, ACT Auditor-General's Office

THE CHAIR: I would like to welcome everyone to this public hearing of the Standing Committee on Public Accounts inquiry into Auditor-General's report No 4 of 2009: *Delivery of ambulance services to the ACT community*. I imagine you are familiar with the privilege card and that you do not actually want me to read it to you.

Ms Pham: Yes, thank you.

THE CHAIR: Thank you, Auditor-General and staff, for attending. Do you have an opening comment that you would like to make?

Ms Pham: Thank you, Madam Chair, for the opportunity to appear before the committee to assist the committee in its inquiry into ambulance services. We have done an audit of ACT ambulance services which is now the subject of this inquiry. This is a very comprehensive audit covering many key aspects of ambulance services in the ACT. Like all performance audits, the objective of the audit is for us to assess the performance of the agency—in this case the ACT Ambulance Service. We want to identify areas that need improvements.

The audit found deficiencies in planning, policy and guidelines to support ambulance officers. We also found shortcomings in operational areas, including clinical supervision and the review of cases—lessons to be learnt. This all combined to create quite a poor response rate or response time by the Ambulance Service. This is fully outlined in our audit report.

I trust that during this public hearing I will have the opportunity to address any issues of concern raised about our audit—in particular, in relation to any statements made about the audit and the approach or the methodologies used in the audit. I have no doubt whatsoever that our findings are supported by sufficient evidence. I am confident that our analysis of data and information used to support the findings is robust and valid. More importantly, I believe that our analysis actually helps the ACT Ambulance Service to understand the risk areas. I believe that type of analysis is necessary for ACTAS to make informed decisions about deploying their available resources to provide the best possible ambulance services to the community.

All of us in the community acknowledge the difficulty and the high-pressure working environment that our Ambulance Service has to face on a daily basis. I sincerely believe that the government should take seriously the significant findings in the audit, take action and put in place strategies so that the ACT community can get the best possible ambulance services. I have a team here today with me. I am happy to take any questions that the committee may have.

THE CHAIR: Thank you. First off—I think I know the answer to this—can you confirm that all of the conclusions you drew were on the basis of factual information that the Ambulance Service gave you?

Ms Pham: Yes. I have no doubt whatsoever that, when we have reached a finding in the report, that finding is supported by evidence.

THE CHAIR: But the figures that you have given in terms of response times were simply a different reworking of data that they gave you. All I am saying—and correct me if I am wrong—

Ms Pham: Definitely.

THE CHAIR: is that all you are doing is presenting, in a form that is more easily understandable for lay people, the data that the government gave you.

Ms Pham: Definitely. All of our analysis is based on the data kept within the ACT Ambulance Service system. As you know, the ACT Ambulance Service has a very comprehensive data set for every emergency call—information about the time of the call, the nature of the incident, what kind of incident, the location, when the ambulance is dispatched, when the ambulance crew has arrived, what decision they make to transport or not to transport the patient. All of that information is already available within the Ambulance Service.

We found that they did not analyse the demand information to inform the decision. So we conducted our analysis based on the information available from the Ambulance Service itself. All of the information is reliable, robust and based on factual data. There is nothing simplistic about it and nothing unreliable about it. It is a whole database that we can rely on when we do the analysis.

MR SMYTH: It is normally your practice when you get data from the department that you give it back to them. Did ACTAS agree with what you had looked at and tabulated?

Ms Pham: There is nothing to agree or not agree with because it is factual data. They may not like the result shown to them and they may say that it is something that no other agency has done. In reality, it is a very fundamental, basic analysis that you would expect an ambulance service to analyse, especially when the Ambulance Service did not meet the government's own target of 50 per cent reached within eight minutes. The target that they achieved was only 37 per cent. Reasonably, you could ask: you did not achieve the government's performance target; what did you do about it? Did you analyse the statistics to know where the high demand comes from and where the risks are? How do you make decisions about the ambulance crew, where and at what time?

The service, quite recently, in March 2009, analysed some statistics but it was limited to the time of day of the incident. So they know when the peak period of demand is for ambulance services, and that is from 8 o'clock in the morning to 9 o'clock at night. That is when they put more ambulance crews on the road and at the ambulance stations. But the analysis of time of incident alone would not give you any information about the location. It is a pity, because the information is there in the system for them to analyse and they did not do so. And that is what we did.

That is why I could not understand at all this statement about the methodology being

invented, unreliable or simplistic. I just could not understand that at all because that is the type of data you would expect any good service to analyse to inform their decision.

MR SMYTH: On page 1 of the letter that you sent to the committee, you made a number of statements about what the minister said. No 1, you quote the minister as saying:

> The Auditor invented her methodology, which is not used by anybody except her and which is not recognised as a credible way of managing risks and delivering emergency services in an urban environment.

Did you invent your own methodology?

Ms Pham: I think what the minister referred to as an audit methodology being invented is a simple analysis of demand data in the system by location, by time, by response time and by type of incident. We did that analysis. As I said, the system contains very good data on emergencies and we analysed it.

I am not so sure about the comment that no other ambulance services analyse such data. That type of analysis is usually internal work that is done, and it may not have been an external performance indicator. We never said that performance by each suburb is an external performance indicator. We are talking about internal analysis of information and maybe an internal target. We would not know what other ambulance services are doing with their internal analysis of information. By the way, the Melbourne ambulance services analyse by suburbs and that information is provided to the media under freedom of information and has been published in a Melbourne newspaper. So it is not really accurate for the minister or the Chief Minister to say that no-one else has done it. For the information of the committee, this is the information provided in the *Herald Sun* which indicates response times, together with the database in the case of response times by suburbs.

THE CHAIR: Can we get the date off you so that the secretary can look that up? That would be quite useful, I think, in terms of the report.

Ms Pham: As I said, given that type of data allows it, I would assume the analysis happens normally.

THE CHAIR: As you in fact quoted, he says:

> We are doing a detailed analysis of all emergency incidents for the 2009 calendar year by time of day and location …

I would have thought it was the sort of thing that every ambulance service must look at—

Ms Pham: It is very basic information.

THE CHAIR: That is, what actually happens. That is all you did.

MR HARGEAVES: We are getting a little excited, Madam Chair.

THE CHAIR: I can see that Mr Hargreaves has a—

MR HARGREAVES: We are getting a little gesticular at the moment and I was just going to put a dose of calm around. We are not here to indicate this morning whether we agree or disagree with witnesses before the committee. We can do that later. Mr Smyth has got some questions. I am happy to defer—

MR SMYTH: Following through the logic of what you have presented, the third paragraph on page 2 reads:

> The analysis performed by Audit was comprehensive, and was based on the full set of 2007-08 ambulance incidents data as recorded in ACTAS systems.

You go on to say that the analysis should have been performed by ACTAS as part of a sound management plan. Just for clarity for the committee, the data that you looked at was data provided by ACTAS?

Ms Pham: Definitely.

MR SMYTH: It was not manipulated in any way?

Ms Pham: Definitely.

MR SMYTH: It was simply a suburb-by-suburb analysis of the service as was delivered for that calendar year?

Ms Pham: We analysed the number of incidents by location, by suburb and by response time, and we ranked suburbs by response time. We gave that information to the ACTAS management to discuss between the management and Audit. The information contained in that analysis was totally based on ACTAS information. There is no manipulation, no change, no methodology invented. It is the simple analysis of—

MR SMYTH: A couple of paragraphs down you quote the minister again as saying, "The auditor invented her own methodology." In the next paragraph, you start with the sentence:

> This statement is of particular concern …

Could you outline those concerns for the committee?

Ms Pham: I take very seriously the confidence of the community in our work as an independent auditor. We conduct our work to the highest quality and with the highest integrity. When we indicate a significant finding in services, we hope that the government will take notice and implement some action to improve the services. A very valid and robust analysis by the Audit Office was misrepresented by statements such as we invented it, or when ACTAS commented on things we did not say or which we did not include in the report. It is a misrepresentation of our finding. It calls into question the robustness of our work. It raises doubt as to whether or not our work is valid or based on factual information.

I felt disappointed about it because I could not understand the reason for such a statement, especially as the department should have advised the minister as to the information that was used and how we analysed it. If they do not like the information that is provided, it does not mean that the methodology used is wrong. It has happened that we have had disagreements because the emphasis of our audit may have been different from the agency's perspective. We may emphasise things that the agency does not think are important.

So there is a difference in opinion and there is a difference in emphasis, but we do not expect a comment about the methodology when there is nothing wrong with the methodology whatsoever. There is nothing simplistic about the work that we have done. Indeed, it is such an important area of service to the community that we tried to cover as many aspects as we could which influence the delivery of ambulance services. The report looks at the governance arrangement, the process, the policy, the procedure, the time when the call is first made, how the dispatchers are making decisions about dispatching an ambulance, who reviews that decision, how the ambulance gets there, what kind of care is provided when the ambulance gets there and what decision do they make if they decide not to transport a patient to a hospital.

Is there a systematic review of the decision? The dispatcher, for example, makes a very difficult decision at the time of the emergency. When there are limited resources, they make decisions—for example, to downgrade from priority 1 to priority 2. When you downgrade a priority 1 to a priority 2, it is not reported in the system or in the performance indicator. There are, at times, good reasons for you to downgrade the emergency from 1 to 2. But you have got to have a review system in place to see whether or not such decisions are made based on good information.

There are so many areas where we believe the ambulance services agency can improve. They had to improve the support system to help the people on the front line. We are talking about giving the right support for the ambulance officer, the right support for the dispatcher—the people who took the phone call at the communications centre. We covered all of that and made it a very comprehensive audit. I think it is sad when we feel that, to some degree, there is a dismissive attitude to quite a significant issue raised. If you are being dismissive about the finding then you will not recognise the problem exists, and you will not do anything about it. That is what I am concerned about.

MR SMYTH: A couple of paragraphs down you note that evidence presented by the minister and ACTAS was contradicted by the minister about the analysis. In fact, he has used your methodology to do exactly what it is that you did.

Ms Pham: Yes. I believe that in evidence given at the hearing that the minister and also the senior management of ambulance services indicated that they had started to do further analysis by location, by geographical distribution. That is exactly what we did. There was some inconsistency there about the evidence. If they believe what we have done was simplistic, invalid and unreliable, why have they started doing it now? I think it is an important part of analysing the demand data to help inform decisions.

There are many sources of information to help you to make the right decision with the

limited resources. I believe that is one key source of information. They got other information as well that the agency may decide to analyse.

MR SMYTH: Going on to page 3, dot point 2, there is the statement:

> The Auditor-General seemed to take the view that we had to be 100 per cent confident in every situation that we could to ensure a response to each and every suburb in Canberra. This is not the way an emergency service goes about its business.

You respond by saying:

> The Minister's statement is misleading as it seeks to attribute views not expressed or inferred in the audit report.

Can you elaborate on how it was that the minister misled the committee?

Ms Pham: Whether or not the minister misled the committee is for the committee to decide. I never said anywhere that we had to be 100 per cent confident in every situation. Indeed, we recognise that it is very difficult to achieve that 100 per cent coverage. Given the unpredictable nature of an emergency call and given our limited resources, it is nearly impossible to get that 100 per cent coverage. But I do say very clearly in the report that ACTAS should further analyse demand data by call time and by geographical distribution of incidents. ACTAS should then use this data to guide both ambulance resourcing and the geographical positioning of the ambulance closer to high call demand locations. I am just talking about using existing resources, but having the reliable information to make decisions.

I also state very clearly in the report that Audit acknowledged that it is difficult to achieve the overall target of 50 per cent for each individual suburb. However, we are concerned about the poor response time for many suburbs because getting only 16 suburbs out of 100 covered by target response times is not good enough. That is an indication that the agency may not be managing the risk area very well. It is a concern because some suburbs have a high number of incidents, not just like a suburb with one or two incidents a year. When we look at the data for 2007-08, which is suburb by suburb, we certainly found that incidents occur in some suburbs in a large number. That is based on a full data set for 2007-08. In one suburb, for example, the number of incidents was 157 and only 12 per cent of them were reached within the government's target time.

So we were after more analysis of that. Can the location of the ambulance crews be improved or designed so that it helps the response time in certain suburbs? That is why I am not talking anywhere of 100 per cent coverage, although in 2006-07 the government itself had 100 per cent coverage of suburbs for emergency service as a performance indicator. They found it difficult to achieve. They dropped that performance indicator or the performance report in the annual report. Coverage by suburb is nothing new. You try to cover as many suburbs as you can within the target response time. That is what it is on about here.

MR SMYTH: In the third dot point, the minister again makes the comment:

> There are a number of assertions which are not followed through in recommendations and with any real substantive evidence to back them up.

Your comment is that it is difficult to understand this because the minister has not supported his statement. Is there anything in the report that is not backed up by substantial evidence?

Ms Pham: I do not believe so. As I said, I am very confident that when we make a finding we have appropriate and sufficient evidence to support it. When the minister makes a statement that we make assertions which are not followed through in recommendations or with any real substantive evidence to back them up, I do not think it is a fair statement. During any audit we examine a large number of documents. Not every single evidence was in the report, otherwise that report would be 1,000 pages long. We examine dates and certain incidents. We examine policy and procedure and we look into ambulance incident cases. But it is not always possible to provide evidence in a report in individual cases—for obvious reasons, such as privacy reasons. It may not be in the public interest to include the information. It could be subject to a coronial inquiry.

The information is there. The department or the agency should know that we have evidence. They have every opportunity to question any finding if they believe that we do not have evidence. It is not a quick audit. It is an audit over six to seven months. When we were discussing evidence with auditees, they had every opportunity to raise a concern, if they had one. Again, I do not understand why this statement is made and made now. If there is any concern and any specific example, it is easy for the agency to come back and say that for a particular finding there is no evidence. But I think for a general statement like that it is very unreasonable and we do not know how to respond to that type of statement.

MR SMYTH: So in your process when you would come to a conclusion, you would go back and speak to ACTAS and they never once questioned the validity of the decision?

Ms Pham: The discussions often happened at different levels and included my discussion with the commissioner at the time. They disagreed with the suburb-by-suburb analysis because they do not like the information that is provided by such analysis. They say that no-one else has done this analysis. But it is irrelevant whether or not someone else does it or not. This is one we believe should be done.

MR SMYTH: But subsequently it is also untrue because it is published.

Ms Pham: Exactly right. We now know other people doing it. We did not go and audit other ambulance services to know what they did and how they analysed their data.

That is one of the main disagreements with the agency. They provide very detailed comments about every single finding that we had, and we responded to every single finding that they may have problem with and showed them why we reached that conclusion.

It is a very robust process. It provides an opportunity for the agency to talk to us if there is disagreement. If we finally agree to disagree, then of course the agency has the opportunity to respond formally to the report and we then incorporate the comment or the response by the agency in the report. So it is a very fair process. It is a process we follow to be fair to the agency and to provide a fair and balanced report. Indeed, following any audit report, we send out a questionnaire to the agency asking them if they are happy with the process and whether there is any part of the audit process we could improve. I think the agency responds that it is generally satisfactory.

THE CHAIR: Mr Hargreaves?

MR HARGREAVES: No, keep going.

THE CHAIR: I would like to come back to the data in question about the analysis by suburb. You said the data for Victoria was published in Victoria. What sort of reaction was there when that was published?

Ms Pham: Actually, we did not follow it up. We happened to see it published and we thought it would be of interest to the committee. To be honest, I am not really worried about whether any other ambulance service has done it or not; it just so happened that we saw the article and we thought it would be of interest. So we really do not know how the community in Victoria responded.

THE CHAIR: I guess what I am coming to is the question of whether you think it would be appropriate to publish that data for the ACT. It clearly was not part of the report. It clearly is of interest. Can you foresee any problems if data like this is published?

Ms Pham: Given that there were questions raised by the department and by the government about the analysis done by Audit, and given the impression that our analysis is either simplistic or unreliable, I think I am prepared to provide that information to the committee so that the committee can make its own judgement and decision about the validity of our work and how useful and valuable our work is in improving the Ambulance Service, and maybe starting a process for the service to actually think about such analysis for location. I am, however, mindful that the information by suburb is sensitive information because it can identify the wide difference between response times from suburb to suburb, from location to location.

It is kind of sensitive because it could raise concern that because you live in a certain location you are disadvantaged. There are issues of equity of services. But at the same time we realise the constraints faced by the service with limited resources and so on. If the information is selectively used or sensationalised, or if the information is published without a full understanding of how the information is collected, how it is analysed, then it could be not in the public interest.

Being mindful of that sensitive information and how the information, publicly available, would be or would not be in the public interest, I would like to leave that decision for the committee to decide. But I am happy to provide the result of the analysis, suburb by suburb, to the committee, and for the committee to decide.

MR HARGREAVES: Before you do, could I remind everybody that we are here actually to look into the Auditor-General's report on the delivery of ambulance services to the community. We are not here to examine whether or not the Auditor-General has done a good or a bad job with respect to this. This is about delivery of services; it is about the content of the Auditor-General's report. It is not about the methodology of it; it is about the result of that. I need to make that very clear.

I would also like to ask: is it the usual process that information given to them by an agency is then passed on to a third party? I would have thought that the ownership of the information, and therefore the approval and authority to release the information anywhere, would be with the agency from which the data originated. In fact, if agencies believe that audit will pass information on to a third party, am I not right in thinking that confidence by the agencies in confidentiality by the Auditor-General's Office will be compromised? In this particular instance, I would have thought that the committee should approach the Ambulance Service for that information and not the Auditor-General.

Now that we are aware that the information exists, I am going to suggest, Madam Chair, that we do not ask the Auditor-General to provide that information. It puts the Auditor-General, in my view, in an invidious position, because she could be compromising the confidentiality with which other agencies may regard her office. I think we should think very carefully about this. Do you see a problem there, Auditor-General?

Ms Pham: I can see where you are coming from, and thank you for that view. I want to make two quick comments. The first one is: do we have a mandate to release the information? The answer, clearly, is yes. The information is analysed by our audit. The information is used to support our audit findings. We do have ownership of that information. Even without ownership of any documents, the Auditor-General, under ACT legislation, has the power to disclose information, to provide information to the PAC, whether it is on a confidential basis or a non-confidential basis, to assist the PAC to consider the audit report.

Perhaps the only limitation on the Auditor-General releasing the information is when the information relates to a cabinet matter and an executive decision, and when the Chief Minister may believe that the release of it is against the public interest. The Chief Minister will write to us and give us a certificate or some document to indicate that that information should not be released.

This information is a summary of the results of ambulance data, so it is only suburb by suburb, response time, the number of incidents, the time, the median time for the ambulance to get there. It does not involve individual cases. It does not have anything to do with privacy. So the information is quite within the reasonableness of public disclosure.

As I stated before, this type of information often is internal working information. It is the type of analysis that management do to inform their decisions, but it is not necessarily for public consumption because it can be selectively reported and it can be sensationalised. That is why I am mindful about that information, and that it is why I

did not include it in my audit report. The circumstances at the moment are quite different. I now feel the need to provide it to the PAC because we had statements made about our analysis, and that is the reason I feel the need to provide the information to the PAC—

MR HARGREAVES: I understand—

Ms Pham: and let the PAC make the decision as to whether or not it is in the public interest to—

MR HARGREAVES: I understand, Auditor-General, that you are feeling aggrieved at statements which you do not believe actually to be a true reflection of what you have been doing; therefore there is a need to provide further substantiation that your methodology is robust enough for proper management decisions to be made. I just caution the motives in that we need to make sure we are addressing the Ambulance Service and not the hurt feelings of the Auditor-General. We need to be a bit careful about that and about how it is put forward. The other thing you mentioned—

MR SMYTH: The question was—

MR HARGREAVES: Hang on a second. I want to go on now to clarify something that the Auditor-General said because I think this is a very good point. I was not aware of this, and I thank you for the information—

MR SYMTH: Before you continue, just as a point of interest, we had this discussion before you joined the committee—

MR HARGREAVES: I know.

MR SMYTH: so there are records of this previously.

MR HARGREAVES: I am just providing cautions. You said that, with the release of information, if the Chief Minister felt that it is not in the public interest to do that, he can advise the relevant minister, who will then issue a certificate to have that information withheld and there would be a communication with your office along those lines.

Ms Pham: Only relating to cabinet matters.

MR HARGREAVES: Notwithstanding that, if you have already provided the information it is a bit late to get a certificate to withhold something, isn't it? Do you automatically seek the advice of the ministries to say whether or not this should happen, or do you just put stuff out there and then they can run along behind?

Ms Pham: We do not need to seek permission from the auditees to disclose information because we are independent and that is our role: we release what information serves the public and serves the community. As you said, I do have some reservation about how the information will be selectively or sensationally reported. If the information is provided in a fair manner, that is good.

I am also very mindful that it is more important to work with the service, to support the ambulance officers to do a good job, and this very much is not about really protecting our reputation. We feel disappointed about that, but it is not the main reason for us to raise it and to respond to the committee at the moment. The committee have asked for the information before and we—

MR HARGREAVES: They did not ask for this information now, though, did they, Auditor-General? You have actually discovered something and thought, "Ooh, this might be of interest to the committee; I'll come along and say, 'Here's your Easter egg, committee'."

MR SMYTH: No. That is a dramatic misrepresentation, Mr Hargreaves—very unjust and very unfair. You were not here for the previous discussions when this matter was treated very seriously by the committee. It is in fact the minister who has not taken it seriously. It is the minister who has cast the slur. And if the auditor needs to validate her data she should be free to do so.

THE CHAIR: I guess I feel that, if the Auditor-General wishes to provide the data to the committee, we should accept it and then obviously we have to consider what, if anything, is appropriate to do with it. I certainly would not be suggesting, Mr Hargreaves, that we would be authorising it at this point in time.

MR HARGREAVES: That is good. One of the things I was concerned more about was not so much that the information itself would be withheld from the committee. As you will recall, I said that I thought perhaps we should write to the commissioner and seek that information anyway, if necessary under the call for papers powers. Notwithstanding that, what I am concerned about is, of course, the reputation of the Auditor-General. I was just curious about the withholding certificate, how that actually works and whether it is effective at all if information has been provided to a third party and then somebody says, "Here's a certificate. I don't think it's a good idea." I just do not know how the communication system works between the Auditor-General's independent office and the Chief Minister and cabinet. How does that work?

Ms Pham: It has not happened in the past. That certificate has never been used by any Chief Minister, even during the time when such a report could have perhaps contributed to a serious impact on the government of the day, like the Bruce Stadium report. For the Chief Minister at the time, Kate Carnell, the opportunity was there for the Chief Minister to issue that certificate, but it was never used. The reason was that, for that certificate to be given, the Chief Minister has to be 100 per cent confident that it is against the public interest to do so—not to avoid accountability or to somehow influence the ability of the Auditor-General to report fully and frankly to the Assembly. So no Chief Minister of the day—and I am talking about across a number of governments now—has used that.

The process would be that the department itself would see the kind of information in a draft report, a version of a draft report. If they had a concern about a cabinet decision, they would raise it with us and the first decision would be with me—to decide whether or not it is in the public interest to include the information. If I decide so and I decide to put it in, the agency would then presumably, if they feel strongly enough,

advise the Chief Minister about the likelihood that such a cabinet decision would be included in the report, and of course then the Chief Minister can give a certificate.

But we still have the option of having two reports: one report tabled in the Assembly for public consumption without that confidential information and another with confidential information, including cabinet information, to the PAC. That is how the legislation was designed—to provide the PAC with the opportunity to receive full information, including confidential information that would normally be included in the report but for whatever reason is not included in the report to be tabled in the Assembly.

So the PAC has every right to seek full information. But again I do request the committee to take into consideration public interest and any unintended adverse outcome for the public before you decide to publish information. But it is here and I am happy to table it.

THE CHAIR: Thank you. In terms of exploring all the issues, the obvious difference that I can see here is that that information is not part of the report and presumably was never part of the report and so there was no chance for the government to say, "No, we do not believe this is appropriate." That having been said, if you wish to give us the information, we obviously would be happy to receive it. Well, I assume we would be happy to receive it; I should not say "obviously".

MR SMYTH: More than happy to receive it; I asked for it last time.

THE CHAIR: Yes. We will have to decide as a committee how we wish to approach it.

Ms Pham: As with any audit, what we are on about is for the agency to improve its services, especially such an important service to the community; it is a matter of life and death that we are talking about.

Seriously, that is all we would like to see the agency do—to take our findings seriously. And to some extent that was happening; the evidence given by the minister and the agency was that they do take some findings seriously. They do work on them. They started to analyse data in more detail to inform their decision. So I am very pleased with that; I am happy with that. And there is no need whatsoever to disclose sensitive information that usually will come out during the audit, but the circumstances of this one were a little bit difficult, and different from others.

THE CHAIR: Thank you, Auditor-General. We will receive the information and decide what to do with it. Are there any other areas that you want to discuss?

MR SMYTH: No.

THE CHAIR: In that case, I think we have finished the public hearing. Thank you very much, Auditor-General, Ms Nguyen and Mr Nicholas, for your attendance.

Short adjournment.

MITCHELL, MR STEVE, Intensive Care Paramedic and TWU Delegate, ACT Ambulance Service
NEVILLE, MR DARREN, Intensive Care Paramedic and TWU Delegate, ACT Ambulance Service
SWEANEY, MR BENJAMIN, Official, Transport Workers Union

THE CHAIR: We will resume our public hearing into the Auditor General's report No 4 of 2009: *Delivery of ambulance services to the ACT community*. Have all of you gentlemen seen the privilege card?

Mr Sweaney: We have.

THE CHAIR: You are happy to abide by it and you do not want me to read it to you?

Mr Sweaney: No, that is fine, thanks.

THE CHAIR: Before we proceed to questions, do you have an opening statement?

Mr Sweaney: We do. Thank you, Madam Chair, for the opportunity to appear before you and your colleagues on the committee this morning.

The critical 2009 ACT Auditor-General's report on the ACT Ambulance Service confirmed the need to increase resources to the ACTAS. The report verified what TWU members have said for many years—that is, supply has simply not kept pace with demand. Ambulance officers have lobbied successive governments over many years about the need to increase resources across the service to better meet community demand for ambulance services.

While the population and the demographics of the ACT have changed significantly over the past decade, the Ambulance Service has failed to keep pace. The 2009 Auditor-General's report highlighted the fact that the service lacks adequate resources to manage the pressures associated with running an ambulance service, concluding that the ACTAS delivers a complex range of services against growing demand and limited capacity. The ACTAS regularly runs at between 90 and 95 per cent of its operational capacity, meaning that there is no surge capacity in the system. When a large-scale incident occurs, such as the recent very well publicised quadruple fatality, there are simply no resources to attend other calls for emergency assistance.

The Auditor-General's report made significant recommendations, including the strengthening of quality assurance procedures and the need for transparent reporting of clinical governance management. Our members are pleased that since the 2009 report, the department has commenced addressing many of the issues raised by the auditor. While the minister and the department have taken a hands-on approach in implementing strategies to address the report's recommendations, more work is required. The 2009 report acknowledged the complex and high-pressure work environment of ambulance officers and observed that our members conduct themselves in a professional and dedicated manner—something the minister has long recognised, illustrated by his department's participation in the professional officer case. The report, in combination with efforts undertaken by TWU delegates, has informed considerable work in the service to improve administrative capability and

communications. However, more work still needs to be done.

Following the release of the Auditor-General's report and extensive lobbying by TWU members, the minister committed to an independent and external review into the current and future structure of the ACTAS. The draft Lennox report is currently with the minister for review and it is to be released to the ACTAS and the TWU. As the report is to be released concurrently to the two major stakeholders, we are unable to comment on its contents, only to say that we anticipate and expect the report to make significant comments on the pressures affecting the structure of the service and recommend measures and strategies to be put in place to alleviate some of those pressures.

The Lennox review will not be the silver bullet in terms of providing all the answers. However, our members are hopeful that the information from the Lennox review will provide the department and the minister with greater direction and assist the positioning of the service as an ambulance service with a reputation for excellence. It should be noted that representatives of the Department of Justice and Community Safety have been instrumental in addressing the significant challenges being faced by the ACTAS. Their tremendous dedication and expertise have been vital to the successful introduction of strategies designed to combat issues affecting the management of the service. Nevertheless, there is still a great deal of work that remains to be done.

Our members believe that more needs to be done to address concerns regarding the clinical governance system and the ACTAS. Agreeing with the 2009 report, officers believe that the clinical governance system currently in place is not sufficiently robust to provide assurance or consistent outcomes. Although some minor changes have been made to the clinical governance regime, we submit that these changes have been a knee-jerk reaction to the Auditor-General's report and lack the hallmarks of genuine effective policy change. Officers believe that the new arrangements were born in a vacuum of arrogance, void of any consultation or input from on-road intensive care paramedics.

Our members are concerned that because the system lacks transparency and clearly documented processes, the outcomes are arbitrary and capricious and depend entirely on which way the wind might blow any given day. Until there are clearly documented processes detailing the arrangements for recording procedures in investigations, officers cannot have confidence in the clinical governance framework. Paramedics are frustrated that other health professionals such as registered nurses enjoy a system that protects and balances rights and professional judgement against the safety and assurance of a quality service for patient care, yet ACTAS officers are subject to an ad hoc and often shambolic scheme.

We expect the Lennox review to make recommendations on improving the clinical governance arrangements and very much look forward to contributing to a revitalised and invigorated regime.

I would like to take this opportunity to detail for the committee areas that require additional work in respect of the Auditor-General's recommendations that the ACTAS address key priorities and activities for each key service delivery function

and that the ACTAS develop a comprehensive performance management framework.

It is well accepted that we enjoy the very best level of pre-hospital care of any jurisdiction in Australia. Our intensive care paramedics are without equal. Their level of skill and autonomy mean residents of the territory enjoy above-average clinical outcomes. One of the challenges identified by the Auditor-General is the transferability of those skills from a clinical setting to a role in management. Just because an officer makes an excellent practitioner does not necessarily mean they will make an excellent manager.

ACTAS suffers from management fatigue to the point where a structure has been built around individual preferences and not around accepted, established and legitimate management practices. While the Lennox review will hopefully address many of the issues associated with the management structure, immediate change is required in the area of workforce planning. The Auditor-General's report highlighted that there are no operational plans to support ACTAS's business plan for each of its service areas. ACTAS has to date ignored the Auditor-General's recommendation that a plan be put in place to address key priorities and activities for each key service delivery function in the context of workforce planning. When it comes to workforce planning in the ACTAS, the portfolio is better known as "work farce planning". While our members support the efforts made by the department and the minister to date, we call upon the service to act on the recommendations contained in the Auditor-General's report and implement a strategic plan for workforce planning in the ACTAS. Until senior management realise the impact that mishandling of the portfolio is having on morale, workforce planning will be a carcase swinging in the breeze, waiting for someone to cut it down.

In conclusion, I note that much has been made of recent statements by the Auditor-General and members of the ACT government. While our members support the minister's comments regarding the credibility of the methodology used by the Auditor-General, they believe the political debate is distracting from the need to invest in the service. Canberrans are fortunate to enjoy the most highly skilled ambulance service of any jurisdiction in Australia. However, as our population ages and the demand for ambulance services increases, we need to be ensuring we are doing everything possible to equip our service with the resources they need to carry out their important work.

The Auditor-General's report confirmed what officers have known for some time—that the service lacks sufficient resources and a strategic plan to meet the growing demand for ambulance services. Stakeholders are now well underway in developing a plan for the future of the ACTAS. However, for success, the plan will need the cooperation and support of government, Treasury, the Assembly and the community. The term "ambulance" comes from the Latin "ambulare" meaning to walk or move about. The word originally meant a moving hospital. As more and more of our ambulances are used as moving hospitals, we need to guarantee they are resourced to do so. Thank you, Madam Chair.

THE CHAIR: Thank you. There are a lot of points I could bring from that. I will start where you started—that you think an increase in resources is needed. Do you have any idea of what sort of quantum we are talking about? Is it a minor increase?

Mr Sweaney: We suspect it will be a significant increase. The Lennox review, we suggest, would inform a quantum. We are hopeful but we are unable to comment because we have not received a copy of the report yet. However, our submissions to the Lennox review were based upon best practice and what level of service you expect to provide the community. And that is from the front line, so from intensive care paramedics that are carrying out pre-hospital work, right up to the administrative support at an HQ level.

THE CHAIR: You said that changing demographics was one of the things that have influenced your requirements. Can you talk a bit more about that? I suppose I am particularly aware of it, having ageing parents who have been transported in your facilities more than once.

Mr Sweaney: I might let one of the delegates talk about how much it has changed over the years.

Mr Mitchell: I am here today as a staff delegate. I am vice-president of the Transport Workers Union Canberra sub-branch, and I also serve as vice-president on the executive of the National Council of Ambulance Unions. So I have a national perspective as well.

On the question about demographics, I am about to enter my third decade next year as a serving officer of the service, and when I started we had four cars working 24 hours a day. Today, we have not kept pace with growth in demand. Demand has been acknowledged as somewhere between eight per cent and 16 per cent per year every year. So if we take a figure of 10 per cent, you can do the math and you can see that we are grossly under-resourced. We have a situation now where we have seven cars 24 hours a day, for eight hours we have eight cars and for eight hours we have nine cars, to address acknowledged areas of high demand. But what we do now is vastly different from what we did in 1991. In 1991, our skill level was far lower than what we can do today. We make a significant difference to people's lives daily with the advanced care we can provide to them. So we are doing more, and we are doing more when we get to patients.

A complication of a number of factors influence the amount of time we spend on scene, and more importantly the amount of time we do not transport someone to hospital, and that has ongoing savings to the hospital system. About 30 per cent of the people we go to on a daily basis we leave at home, and we use alternative pathways for their clinical care.

The time on scene that you might spend with a patient in making those referrals could be up to an hour. So when you only have a few cars in the system, you are taking a car out of the system to treat people on scene, you are doing more on scene, we are seeing more people because people cannot get in to the local doctor, or people do not want to go and wait in emergency. It is a multiple-faceted drain on resources which are under-funded.

Mr Neville: I am also an operational intensive care paramedic. I am also here as a staff-elected representative TWU delegate, and I sit on the National Council of

Ambulance Unions, so I also look at it from a national perspective.

To highlight one example that Ben mentioned in his speech, we all know about the fairly high profile accident that happened as a result of a police chase the other night. During that shift there were seven cars on shift at that point in time. One car was actually out attending SouthCare, as often happens. At certain hours of the day now, one crew often disappears if the helicopter goes out. So there were three and sometimes four cars at that particular incident. That leaves us with two, three, maybe four at most, ambulances covering the rest of the community while those cars were tied up in that high-profile job for up for two or three hours. There is no surge capacity. This is where we are really struggling. Not only are we not meeting our demand on a day-to-day basis; if something big happens our ability to meet a sudden surge, which is our core business, to meet an emergency, is severely diminished.

MR SMYTH: How often are you confronted with this inability, whether it be all of your cars out or a major accident that leaves you with no surge capacity?

Mr Neville: It is highly variable, of course, because how often does an emergency happen? This is what we need to be ready for—the big emergencies. Take one example: looking at it from a risk management point of view, we are just about to hit wintertime again. How many buses do we have travelling down Majura Road, down the Monaro Highway? If there is one big bus crash, we are in a lot of trouble, and that will create a huge surge capacity. And who says when it is going to happen? It is highly variable. That is the nature of the business. But it does happen reasonably frequently, and it is a concern.

THE CHAIR: To what extent can that be addressed by using the firies and the police? We talked about this in the briefing with the Auditor-General. She talked about what happens in these circumstances. How does that work?

Mr Mitchell: We currently use the Fire Brigade as a first responder, if they are the closest resource to an emergency. If my house is burning down, I want a fire truck to turn up. If I am sick, I want a paramedic, not a fireman. So if we can send out a fireman as a first-aid option only, they have the automatic defibrillators, which is great, but again it is a band-aid approach.

Mr Sweaney: Just to add to what the delegates have said regarding the utilisation rates, we have got two issues that you cannot separate—the utilisation issue, which means there is no surge capacity, and the understaffing. This is contributing to lower morale, increase in workplace absenteeism and a culture of asking when are we ever going to get across the line to realise that demand is only ever increasing, and we need to address and implement a strategy to meet that demand.

MR SMYTH: Is the call on sending the Fire Brigade getting worse? Are we sending them more often or not to answer what should be an ambulance call?

Mr Sweaney: I do not have the figures but for our membership, whenever we have to task someone that is not in an ambulance to an emergency response, that is one too many times. If I was suffering a heart attack, I would like, of course, anybody there to assist me, but for our members, who are health professionals, who deliver pre-hospital

care, any instance where you have to task a non-ambulance to a response is too many. But we do not have the figures.

MR SMYTH: I asked the minister a question and in 2008-09 it happened 241 times where the ACT Fire Brigade responded. Do people have a feeling as to whether or not that is getting worse?

Mr Sweaney: I am afraid for this purpose it would be anecdotal until we actually obtained the figures from the service.

MR HARGREAVES: I would be interested in your instincts, though, Steve and Darren, on this. I go back with the Ambulance Service almost as far—

Mr Mitchell: What we can say is that more and more there is greater pressure put on the communications staff to queue jobs. So we appropriately triage jobs in the communications centre to their priority, and we are stacking jobs until an ambulance becomes available. So it is not every time that someone dials 000 that they need an ambulance within eight minutes. But what is happening is that because of utilisations we do not have an ambulance to send to that 000 call when they need an ambulance inside that eight minutes on every occurrence. And that is happening more and more frequently.

MR HARGREAVES: You know when you make a decision not to send one at all?

Mr Mitchell: Absolutely, yes.

MR HARGREAVES: Are those incidents on the rise or are they about the—

Mr Mitchell: Absolutely. So the amount of times when we are choosing not to send an ambulance immediately and we will send one in due course is increasing.

Mr Neville: The biggest concern there is that if we are not making a decision, we are not reviewing that ability to make the decision properly. There has been some movement, post the Auditor-General's report and even before, to look at changing how we do communications. But the big issue we are not doing there is reviewing it. What we need to do, and we need to do it very quickly because it is becoming a risk for us, is look at a secondary-type triage by trained clinicians in comms to make sure we are reviewing those decisions. We are not doing that. We are not reviewing what we do on a day-to-day basis, which then cuts down our ability to plan what we do so that we are making the right decisions on an emergency decision. Obviously, when we make it we need to make it very quickly. So we need to plan so that we have got all the information we need to be able to make the right decision most times in an emergency situation.

MR HARGREAVES: With the 000 calls that you get, I can recall there was a certain percentage of them which are not, and never will be, a job for the ambos. Is that percentage of the calls that you are getting rising, static, lessening, is it about the same proportionately?

Mr Sweaney: Part of the Lennox review will hopefully make recommendations about

how to improve the clinical governance arrangements in comm cen and part of that will be a comm cen clinician that can triage those calls and establish a database for where there is a frequent flyer, if you will, and be able to refer those to alternative pathways. But that work has not been undertaken. It has in other jurisdictions but we are still behind the eight ball with respect to how we better triage calls from a communications centre point of view, and better task ambulances.

Mr Neville: From a national perspective, I think every service is facing that challenge. The call for our services is increasing because we are there. When there is stress on the rest of the health system and the doctors are unavailable, we are a government agency and we answer. They call us, we answer and we come. So everyone is facing that situation.

The reason why you need to review it is that the grey area jobs are the ones that have bones in them. The guy that is having the cardiac arrest or the emergency, that is cut and dried. Everyone knows you need to send a resource to that. With the one that is a little bit sick and has a temperature, that might be a precursor to some emergency or it might just be that they have got a minor temperature. That is why you need to review them and need to show whether it is an emergency, a potential emergency, or whether it is just a matter of saying, "Take a Panadol, relax and see your doctor tomorrow." The only way to do that is to have proper clinicians there reviewing it, and reviewing what you are doing and how you are making those decisions.

MR SMYTH: I was intrigued that the comment was made that we are running at 90 to 95 per cent of capacity; therefore we do not have the surge ability. What is the standard? What should we be aiming at?

Mr Sweaney: From my understanding as a lay person, it is around the 50 per cent mark in respect of the best practice.

MR SMYTH: Is that 50 per cent what they work towards around the country or is no-one checking that?

Mr Neville: Yes, 50 per cent is probably the mark around the country that people look at. You have to be careful when you are looking at your different figures in different ways and what it shows. We were talking about this earlier. If you have an accountant looking at 95 per cent, you would say you were doing well, but as you start to drop the percentage mark, your response times start to blow out dramatically. So when you chew out one car, you are chewing out 15 per cent straightaway. If you drop two or three cars out of the system, a la the example I gave before, all of a sudden there are three or four cars not there, and another 50 per cent of that is gone. What does that do to your response times? It has a major effect on them.

MR SMYTH: There was always the issue in that, once you got to the hospital, you guys cannot leave a patient until there has been a proper handover. Are the arrangements at the hospital working better?

Mr Sweaney: There is now a policy in place between ACTAS and ACT Health regarding ramping, and a 20-minute offload.

Mr Mitchell: By and large, that policy is working well, although it is not uncommon, even with a 20-minute offload, to physically have nowhere to put a patient. There is no spare bed, the stretchers are used up, so there is that demand on accident and emergency, and sometimes you cannot meet that objective.

MR SMYTH: Clearly, at the heart of your concerns as professionals, there is the clinical governance system. What is going wrong? What aren't we doing and what do we need to do? I noted in the government's response that recommendation 11 looks at clinical governance, and it is "agreed in principle"; recommendation 12 looks at governance, and it is "agreed in part"; 13 talks about the procedures, and it is "agreed in principle". What is the fundamental problem in you guys not having the same protection, for instance, as a nurse does?

Mr Sweaney: I will start off before Mr Neville answers this one. The point here is that we have a service that has been built around individual practices as opposed to a service built on best practice when it comes to clinical governance. We have some people that are incredibly well-skilled practitioners, but that has not been able to be transferred to the role in management. So we have a system that, for all intentional purposes, is very ad hoc. There are no clearly defined or documented processes or procedures about reporting and investigations. There has been some minor tinkering around the edges, but as we have alluded to, we believe that has been very much a knee-jerk reaction to the A-G's report. Mr Neville might like to add to that.

Mr Neville: To be fair, and I will try to be as precise as I can, some of this is a bit of an industry problem. Steve and I are on the national council, and these are challenges that we face as an industry, and obviously the ACT as a jurisdiction does. To make that point as well, part of our professional claim is that we have come out of the dark ages in a very short period of time. The increase in what paramedics have done in the last 10 or 15 years has been exponential, and that has allowed us to declare that we are professionals, and working professionals. We are not just picking people up and driving them quickly to hospital.

What comes with that is that we have to then look at what we do. So we have got people that were there during that phase when we were just picking people up and taking them to hospital, and still making decisions about how we govern ourselves on a day-to-day basis. What we are calling for is what all professionals have. Some of the knee-jerk reaction that has happened since the Auditor-General's report is that they want to just put more recommendations through what the Auditor-General referred to in there as the clinical advisory committee. That clinical advisory has not been refreshed or changed for 10 or 11 years. They are not looking at best practice standards like root cause analysis and that type of thing in what we do. We need to take personalities out of it, look at how other professions, not just health professionals, actually review themselves, how those reviews show where weak areas are, and then how we plan to actually create best practice.

One of the interesting points that the Auditor-General made, and there has been no change there, is that in what we do on a day-to-day basis we are not run by protocols anymore, which is a huge clinical step forward. We are now run by clinical management guidelines. So that gives us the autonomy to make greater decisions, not bound by strict orders. But there has been no change in the way that we review those,

or how that is run through the clinical advisory committee and then passed up to senior management to dictate how we change those. We need to be reviewing that and looking at what is best practice. The whole industry needs to look at evidence-based practice as well, and we need to get on board with that. Because we are small and dynamic, this is a change that we can make, and we can be at the forefront very quickly.

MR SMYTH: The comment was made that paramedics feel a sense of frustration in that nurses are covered, but in effect they are more exposed. What is the disconnect? How are nurses protected but paramedics are not?

Mr Sweaney: The nurses board have a very clear and systematic process when complaints are lodged and it is balanced against the need for patient safety and professional judgement. Unfortunately, ICPs as health professionals do not enjoy anywhere near that level of confidence or transparency in the system and it is very much on a case-by-case basis depending, as we have alluded to, on which way the wind blows. What we are calling for, and what our members are calling for, is a system to be put in place that provides exactly that—a balance of professional judgement against safety and patient outcomes. In our system, as Mr Neville alluded to, there is a clinical advisory committee. The tenure and membership of that committee is documented nowhere. It has been in place now for how many years, Mr Mitchell?

Mr Mitchell: It is at least a decade.

Mr Sweaney: At least a decade. There has been no renewal there. We are uncertain of how you access membership for that or how matters are then referred back to our members. So we would like the arrangements that are in place for other health professionals such as registered nurses and health professionals working in ACT Health.

Mr Neville: I will give you one example. In most professions, and I certainly know nurses do it, if there is a landmark case that needs to be clinically reviewed—that is, something may have gone wrong—then you have the right to be judged by your peers. So it is a matter of what other professionals, given those circumstances, with names and personalities taken out of it, would have done in that situation. We do not have that opportunity. It is purely a management-based decision. Why can't we convene a panel of paramedics and say, "This guy we believe did the wrong thing," or "There was an adverse outcome; what went wrong? What would other paramedics do in that situation?"

THE CHAIR: This is all news to me. As a member of the public, I thought the situation with ambulance officers was because the time constraints et cetera were so clear and great that there basically was not any complaints process. So what happened happened and it was the best that could have happened at the time. Do you get many complaints? I am really surprised about this, actually.

Mr Sweaney: There are probably two points here. As health professionals, ICPs need to be constantly reviewing decisions that they make (1) for their own clinical practice and (2) for patient outcomes. We enjoy and expect the most highly skilled level of any

service in Australia. To obtain that level of skill it is a constant process of ongoing review and learning. What is not there is the framework to support that. So when complaints do come in, and they do come in frequently, or questions or queries, how do those complaints and questions relate to a particular case? Mr Neville might want to elaborate on that.

Mr Neville: What you are talking about is true. I think it is often given recognition that we are in a difficult situation, we are handling an emergency and we do the best we can. It is really nice; I think the public perception of us—and it is a little bit humbling at times—is that they trust us and they understand that we are in a difficult situation.

But that does not give us carte blanche to just do what we like. We are health professionals; we are performing invasive and sometimes potentially nasty procedures that can go wrong. We need to be scrutinised, and we want to be scrutinised. We want to learn from what we do so that we do it better. Most paramedics have an element of perfectionism about them. They are always trying to achieve the best that they can do. That is the type of personality that comes into the job, and the only way to achieve it is to constantly review what we do so that we know that we can do it better next time.

MR HARGREAVES: I think what we need to do, though, too, is to put it into a little bit of perspective. Darren put his finger on it just a couple of minutes ago—that we have come out of the dark ages rather recently. Moving from what is essentially a technical officer position, which was a glorified van driver with a first aid certificate, through the advanced life support and leading to intensive care paramedics has happened at a dramatically fast pace. Going from what is essentially a tech officer into a professional officer has happened so fast that the support arrangements have not come into place as quickly as the others.

The point that was made here, which I think is a particularly valid one, is that the services of peer review within the doctors, nurses, dentists, pharmacists and all the rest of them have been in place for decades. I can remember back in the mid-70s that already the process was an old one. It is a case of bringing it into someone's consciousness, and I think the guys have raised the issue with us. I think it goes to the quality of the service, which is the subject of this particular audit report. When we say X is wrong, we need to work out what is wrong but also—without casting blame here, there and everywhere—what can be introduced to change that.

I think the quality assurance bit, which is so essential, is not about management taking a decision. And I must admit and put on the record that my understanding of the qualifications of the management of the Ambulance Service is that it is beyond par. I believe it is as good as, if not better than, anywhere else in the country. That does not mean to say, though, that the sort of organisational structure that surrounds the other health professionals ought not to apply to the Ambulance Service.

This is a battle, for the record, that the Ambulance Service has been fighting for decades, to my knowledge, and I know that the current management in the Ambulance Service has fought that battle on behalf of the members of the service for decades as well. Let us hope that this sort of report will be the catalyst to get that sort of thing for you.

Mr Sweaney: Absolutely. Just touching on that, Mr Hargreaves, before Mr Mitchell makes a further comment, we enjoyed an ESA training day, held by the newly appointed Commissioner ESA, Mr Crosweller. Greg Sassella, the CEO of Ambulance Victoria, came and was a keynote speaker on one of the mornings, and he made that exact same point that you are making. I might be drawing it out a little here, but he said that in terms of management they have a clearly defined role in Victoria as do clinical, and never should the two cross over; that managers manage and clinical operators look after clinical and there should be a clear line of demarcation in the middle. Because of economies of scale and the nature and the size of the service we have, we have combined these roles and we have not been able to move forward. Mr Mitchell is going to make some comment there.

Mr Mitchell: Just to follow on from Mr Neville's and Mr Sweaney's comments, and also Mr Hargreaves's comments, what we do not have for ambulance paramedics nationally is registration. Other health professionals had state-based registration and I know through COAG are now moving to national registration. So it is part of the evolution of ambulance service and paramedics that registration for ambulance paramedics would bring in an independent, autonomous view of any clinical issues and discipline issues.

You might be aware of the recent review of the Western Australian ambulance service. The health minister has come out publicly and strongly endorsed the concept of registration for paramedics.

MR SMYTH: Yes. But in WA the ambulance service is under the health department.

Mr Mitchell: Exactly.

MR SMYTH: Should we follow that model here or is it better located where it is, inside the Emergency Services Agency?

MR HARGREAVES: Or, to put it another way, do you want to go back, Steve?

Mr Mitchell: Yes. Mr Neville might like to—

Mr Neville: It is funny you say that. In the actual recent discussion, the minister asked me the same question, and when he actually led to where he was going it was very intelligent. I had spoken to several members about this just before he spoke to me. It is our industry debate: are we health workers that perform an emergency role or are we emergency workers that perform a health role? I think the key is that you find your turf and you stick with it, and the catch is how you then plug into the other side.

I think we have done very well under the ESA and being as part of that role, and it has worked well for us in this jurisdiction. The key is how we plug into the health system and how we support that. When Mr Corbell was asking us about that—and it was very intelligent—what he was looking for was some funding rules. I think that is something to look at. We are helping prop up the health system, so therefore we should be funded. When they get an increase in funding, we should try and help us get a bit of funding as well, because we are helping that system. We take a lot of pressure

off there.

MR HARGREAVES: Just on that point, we notice that in a budgetary sense the health budget has a built-in growth factor and it was up as high as 10 per cent and now it has gone down to six per cent. What is the growth factor in the Ambulance Service?

Mr Sweaney: Since 2001 it has averaged 10 per cent; those were agreed facts from a joint submission to Commissioner Deegan in a professional rates case. We are hopeful that in coming budgets we can secure a model that has an inbuilt component for demand, because as the delegates—

MR HARGREAVES: So it is not formulaic.

Mr Sweaney: No.

MR HARGREAVES: It is not formulaic at all, so you have got no guarantee. Every year you go in there, fit your steel caps on and go for it.

Mr Sweaney: That is it.

MR HARGREAVES: And am I correct in assuming that it would not be too bad an idea actually to have—

Mr Sweaney: One of the best you ever had, Mr Hargreaves.

MR HARGREAVES: Oh, that was Mr Smyth, actually, who just mentioned it to me and I said, "I'll ask the question if you don't."

MR SMYTH: That's very generous, John.

MR HARGREAVES: I know. I am like that.

MR SMYTH: Gentlemen, before we move off clinical governance, you mentioned that the way forward was being conducted in a knee-jerk manner and you mentioned a vacuum of arrogance. What is the vacuum of arrogance?

Mr Sweaney: Consultation. Again, it picks up on what Mr Sassella, the CEO of Ambulance Victoria, discussed recently, in that clinical is clinical and management is management. Management consult very well in the ACTAS. They regularly meet with delegates and workplace representatives to talk about change and talk about how things can be done better. They may not always listen, but they at least meet regularly to discuss the issues.

Clinical in the ACTAS suffer from, as I have described it, a vacuum of arrogance in that they believe—and this is only purely through their actions—that there is no requirement to consult with the people that are carrying out these workplace changes. It is something that frustrates our members immensely. Consultation, discussing issues, is very healthy and very productive and normally results in very good outcomes. But in a clinical setting in the ACTAS, to date, there has been zero

consultation on very important workplace changes, including what we submit are the knee-jerk reactions to the Auditor-General's report about strengthening reporting arrangements in the ACTAS. Mr Neville might like to take that further.

Mr Neville: Yes. It is a shame. I do not want to highlight individuals here at all, but Mr Hargreaves hit the nail on the head when he talked about the change in growth. The first paramedic course only started in 1984 and the first people coming out of the ACT jurisdiction to actually call themselves paramedics, which has now morphed into intensive care paramedic, only hit the road in 1987 and have evolved rapidly since.

The person in charge of clinical comes from that era. He is a brilliant clinical mind, an absolutely brilliant clinical mind, but in the last seven or eight years, with the framework trying to catch up with the level of skill that we have been having, he has morphed into a manager—and he is not a good manager. He is a brilliant clinical mind, but he has become arrogant because he feels as though he is being questioned on a clinical matter, but we are asking him to do a job that he is not best at. He is best at being a great clinical mind—he has got the ability to challenge doctors clinically and that is what he does well too—but he does not manage or look at frameworks and overarch it, because that is not what he is best at. We have got to keep pace with that. We need to put a framework in where we have got someone there that can overarch a proper governance system—not someone who—

Mr Sweaney: And this really does highlight the resourcing issue. As the service has grown exponentially, the management structure and the clinical governance arrangements have not kept pace. So we have got the very best practitioners out there doing the very best work; however, the service, managerial and clinical, has just not kept pace.

MR HARGREAVES: And is it the case from your perspective that the issues are largely systemic, that it is organisational and structural? As a casual observer of the history of the occupation of the top seat of the ESA, you do not get your bum terribly warm in that seat, do you? Personalities sort of come and go, but it seems to me that there is a structural issue, organisational structure, and within those structures themselves there are systemic issues where it would not matter if you put Uncle Tom Cobley in there, it would work, so long as they had got the right background, right training. Is that really where we are at?

Mr Sweaney: If I may comment as external and someone who has never worn the green or practised as an intensive care paramedic: ICPs make fantastic critical incident managers. If you were to suffer a heart attack, Mr Hargreaves, they would know—

MR HARGREAVES: Funny you should say that.

Mr Sweaney: what to do in a flash.

MR HARGREAVES: I only had that because I had not ridden in the back of a van; you know that.

Mr Sweaney: And they will do it in a timely manner, they will do it in a professional

manner and they will ensure that you get the very best outcome. But, once they have finished with you, they might move on to the next patient. And the problem is that that process is then taken to management, so it is a cultural issue. We have got critical incident managers who have worked as ICPs on the road that are used to working, treating a patient, dropping the patient and moving on to the next patient. So they are not looking at the issues of how we get to these incidents or why we should be looking at preventative medicine perhaps. They are just addressing the issues there and then and moving on to the next ones.

Part of it will require a cultural shift, and I think this is across the ESA as a whole, because our comrades in the Fire Brigade have similar challenges when they are addressing fires. So, until there is a cultural shift—and there should be discussions from all stakeholders about what roles civilians can play in management, about how we can better put in place accepted and established practices in management—

Mr Mitchell: To add to that, it is as simple as urgent always trumps important.

THE CHAIR: Yes, everywhere, not just in your line of work.

MR SMYTH: The minister is quoted in the paper this morning as saying that he thinks ACTAS should have a 10-year plan.

Mr Sweaney: Sorry, that was me; I have not actually become a minister yet, so thanks for the—

MR SMYTH: It is a better leader than I thought, and you are dead right: Minister Corbell is mentioned in the paragraph above. During your opening comments you mentioned that workforce planning is a farce. You called it "work farce" and you said workforce planning is a carcase swinging in the breeze.

Mr Sweaney: Yes.

MR SMYTH: What is wrong?

Mr Sweaney: To give you an idea, for the past three years the portfolio has been occupied by a series of inept, incompetent, recalcitrant, moronic, dim-witted fools—

MR HARGREAVES: How do you really feel about this? Stop holding yourself back.

Mr Sweaney: each of whom sought to ignore best practice in workplace relations and industrial relations. So again it is going to require a plan. We would like a 10-year plan. We would like a 10-day plan. With issues for workforce planning—access to leave, approval for short-notice leave and all of those issues—we should not be reinventing the wheel. They are well established in other departments and other industries. There has just been a lack of realisation from senior management as to the neglect of workforce planning and the impact that is having on our officers.

I will let Mr Mitchell actually explain further on this because it is an issue close to his heart.

Mr Mitchell: Currently there is no general manager operating in the position which would oversee workforce planning, and that has been the case for several months. The issue we have with running a 24-hour-a-day, seven-day-a-week service is that we have no management structure to currently cope with that. We have a structure where we have part-time operational managers overseeing workforce planning, and the reason they are part-time operational managers—and this will probably be highlighted in the Lennox review—is because part of their responsibility is to run the day-to-day duty manager shifts, so they are in charge of operations on a day-to-day basis, so for one-fifth or one-third of their time they can only do their portfolio work. So when someone wants to go on leave there is no-one there to sign off on it. We have some ASO5 and ASO6 clerical assistants running the roster, with no delegation or authority to approve leave. We have staff who are not able to take their entitlement of leave allocation this year because there is no-one there to sign off on the leave.

So it is no point having a government policy that you take your leave in the year that it accrues when there is no-one there to approve the leave, and I suppose there is no-one there to approve the leave because we do not have enough resources to cover either the person wanting to take the leave or the person signing off on that.

Mr Sweaney: So it is a resourcing issue once again. We have got officers that have been in the service for 30 years but cannot plan their life. Believe it or not, they actually do have a life outside of the service, they do have things to attend, but are unable to do so, which is leading to a culture now—which is unfortunate but we provided the service with sufficient warning that this culture would happen—where it is all too easy now just to chuck a sickie, book off: "Why should I bother doing the right thing, putting my leave in well in advance, only for it to be ignored, or to be given an inclination that it might be approved and then have it declined close to the date?" So the culture is now building where officers feel: why should I do the right thing and put my application in when all I am going to get is a no?

MR SMYTH: You did lead from some of those comments about the workforce to the effects on morale. What are the effects on morale and what is morale like currently in the service?

Mr Sweaney: Again, I might ask Mr Mitchell, who has been with the service for 30 years, to talk about it.

Mr Mitchell: Under-resourcing cuts right across the board. We have a management structure which is mostly filled by people on higher duties. They are taken from the road to fill those positions. Those positions are valid and warranted because they have a tremendous workload. We have a resourcing issue then by not having sufficient staff to run the roster to accommodate programmed leave and programmed training. The first thing you are going to cut is some training and then you are going to cut leave back. You are going to have people not getting leave approved. Then you have the situation where you have a fatigued workforce, because they are not able to take sufficient leave breaks, not turning up for their rostered shift due to sick leave. So you have a system which is continually running at minimum.

MR SMYTH: Is the number of staff that you currently have inadequate to fill the roster or is it that the full FTE is not being accommodated?

Mr Neville: The FTE is full but we have got the situation where the framework is not there to provide it. We are robbing Peter to pay Paul. At the moment there would be something like eight or nine FTE front-line positions—there are others, but eight or nine front-line operational paramedics—operating just in management. That is one car per shift, 24 hours, off the road working at a higher level. It is not front-line operational anymore.

MR SMYTH: In your estimation, at current service levels, to have those eight or nine positions filled and every position required to run the workforce, the management and the comm centre, how many staff are you short?

Mr Mitchell: It is not just as simple as that. It goes back on the fact that we are increasing our workload by 10 per cent per year every year. Even though we have had some additional demand shifts introduced, we are still running behind the eight ball.

Mr Sweaney: In terms of numbers, the other things you have to work in there include professional development, the in-service which paramedics attend every year. There is also, obviously, a changing demographic. When paramedics are getting the jobs they are not only doing more jobs, they are doing more at the jobs. It is very difficult to pick a figure that would be a full quota for the service, but in my estimation we are behind somewhere to 40 to 50 FTE staff.

Mr Neville: Natural attrition alone hurts us. In the service we are only looking at our front-line paramedic numbers. At the moment I think there are about 90. If you have one person go off with a workplace injury, another person on long-term sick leave and one person getting pregnant, you add up four or five people very quickly. That is five per cent of your workforce gone almost overnight. That has happened to us on several occasions. We are facing it at the moment. When a couple of people are on leave, one or two get sick and one female member gets pregnant the next thing you know you are faced with an eight, nine, 10 per cent decrease in your workforce in a matter of weeks. There is no fat to cover that.

MR SMYTH: Just for the record, though, for those listening or those who might read this later, what is the full staffing level of ACTAS at the moment? What is the full complement?

Mr Sweaney: Our full FTE, I believe, is 150, 160—

Mr Mitchell: I am not sure of the exact number. It is somewhere between 150 and 160.

Mr Sweaney: We would have to double-check.

MR SMYTH: That is okay. It is 150, 160. Those 90 are on the front line?

Mr Sweaney: Those are ICPs.

MR SMYTH: Those are ICPs.

Mr Sweaney: Yes. Then we have 17, or 16 at the moment, ambulance support officers. Then there are administrative and managerial staff and comms staff.

MR SMYTH: To be able to cover in-service training, the other training—

Mr Sweaney: Yes, professional development.

MR SMYTH: leave and professional development and accommodate, let us call it, natural sickness, you would estimate you are 40 to 50 FTEs short?

Mr Sweaney: I am suggesting 40 to 50 additional staff would be a starting point—for increasing a quota, yes.

MR SMYTH: At current usage levels. Again, as you said earlier, if it increases eight to 16 per cent every year then you build in a factor to accommodate that as well.

Mr Sweaney: That is correct.

THE CHAIR: Are you being asked to find an efficiency dividend as part of the government's budget issues?

Mr Sweaney: As part of an ACT government department, yes, the request was made.

THE CHAIR: You have a request—

MR SMYTH: Let *Hansard* record that that statement was made with a wry smile.

Mr Sweaney: If there are efficiencies to be found in the ACTAS I will be very surprised. It runs to full capacity every day. To give you an idea, there was a great discussion today about Tony Abbott's efforts yesterday running a 14-hour triathlon or marathon. Our officers do that day in and day out. When they do a 14-hour night shift they go from start to finish.

Mr Neville: We had a recent incident where I think an officer broke the record on a Friday night at Dickson. He did something like 15 or 16 jobs, going into town, obviously. It is a high demand workload on a Friday with our nice nightclub little jurisdiction. I think he broke the record of about 16 jobs in a 14-hour shift. That is less than one job an hour. It was just go, go, go. It was quite a big effort.

MR SMYTH: Is this pressure affecting clinical outcomes?

Mr Neville: Potentially. I think that is where the officers themselves are concerned. The potential is there. The cracks are starting or could potentially be starting to appear. Not yet but—

Mr Sweaney: It is very much a resourcing issue as well. Our officers can see that there is potential there to have adverse outcomes. They want to prevent that at all costs. What they are saying is that we need to have a system in place, like Mr Hargreaves touched on, that they enjoy in South Australia where there is a better peer review system for jobs so that there is zero potential—they remove or diminish

that potential.

THE CHAIR: Are you having a problem with staff leaving and going to other jurisdictions? Is it worse here than in other places?

Mr Sweaney: Anecdotally—and I do not know if any work is being done by the service to track and measure this—it is very easy to come to the ACT, get the very best quals and then shoot south or across the border to another service, for different reasons. There are a lot of officers that come to the ACT because it is the very best and most highly skilled badge that you can achieve and it is easy to get a job in other jurisdictions. Mr Neville, you might want to—

Mr Neville: I think there are pressures. The contract work dried up for a little while there when post 11 September the big security scare happened. But the contract work is coming back. We have had a few members leave recently to do some contract work in places like the Solomon Islands and East Timor. Registration has cut that down because it is very hard to cross portability skills into other states. If you look at it from a morale point of view, there have been a few who have left that probably should not have.

One of the biggest things we do not do, when you look at it in terms of the framework of planning our staff, is exit interviews. We do not know whether staff leave because they are disgruntled or whatever. It is just a case of the management being so overworked in trying to keep the framework together, which we have talked about, that exit interviews are low down on the priority list. We do not do it, but maybe we should.

MR SMYTH: Just before we run out of time—additional cars on the road: what number of cars would be required to alleviate the pressure?

Mr Sweaney: The membership have—

MR SMYTH: Properly staffed and backed up.

Mr Sweaney: We should be looking at starting nine cars, plus a crew at SouthCare, before we even look at building demand crews on top of that. You are looking at a baseline of nine ambulances on the road.

MR HARGREAVES: As opposed to seven now.

Mr Sweaney: Yes.

MR HARGREAVES: So it is an increase of two straight up.

Mr Sweaney: Two straight up, with a crew at the base of SouthCare, and then we look at implementing demand shifts on top of that nine.

MR HARGREAVES: For the record, how many FTEs does it take to crew one car 24/7?

Mr Sweaney: About 18, I believe—18 FTEs to crew one full vehicle.

MR HARGREAVES: So that is 36 out of your 50.

Mr Sweaney: Out of our 50, just to get us there before we start looking at demand. Our members understand the importance of demand shifts, but we believe that there is better placement of resources before we get to that.

MR SMYTH: In terms of location of the stations, is there a requirement for more stations—

Mr Sweaney: Absolutely.

MR SMYTH: Are the current stations adequate or should some of them potentially be shut and moved to different locations?

Mr Mitchell: In 2000 it was identified that west Belconnen was an area and that still has not been addressed. There was a proposal at one stage to renovate Charnwood station, but there was the 2001 bushfire and then the 2003 fire and it got put on hold. The area of west Belconnen in particular is a black hole. There is a station feasibility study being done, subject to some review through the UFU, which has got some very solid recommendations. Most of the current stations quite old and are in need of either significant refurbishment or tearing down and rebuilding.

THE CHAIR: What about the newer suburbs like Gungahlin, and then there will be Molonglo? Will they need stations?

Mr Mitchell: We have the JES facility at Gungahlin. It is a combined fire, ambulance and police facility which adequately serves that demographic at the moment. Where we are critically short of resources is in west Belconnen. As was alluded to earlier, you cannot just look at the picture seven days a week, 24 hours a day. We have a high demand for resources on Thursday, Friday and Saturday nights in the city. It was picked up by the feasibility study that we need perhaps two stations in north Canberra, for the north Canberra region, to accommodate that.

MR SMYTH: So if Ainslie stays where it is, where would the other one be?

Mr Mitchell: There was a recommendation in the report that the station be built around the Aranda area, which has close access to the city as well.

Mr Neville: The station feasibility study that was done recently was done as an ESA-wide thing. It did not look at anything specifically, which is interesting. So we are looking at incorporating fire crews. Some of the emergency response crews only operate on a very low level. We do something like 60 to 70 per cent of the ESA's work on a day-to-day basis so it needs to be looked at separately. The minister has asked us to put some submissions in based on that, which is good.

I met one of the managers the other day and they have just started to finally do what we have been calling for and that is to look at some area type work. Maybe we need to change our philosophy. Maybe we could look at the hub and spoke a little bit as well.

So there would be a couple of crews at Dickson on a Friday night. You would have one crew at your outlying areas during the demand periods and that sort of thing.

As Steve alluded to, when you look at some of the figures in the Auditor-General's report, some of them were a 24/7 average. You cannot do that. You cannot treat a Tuesday lunch time the same as a Friday night, at midnight. They are totally different. We need to start doing that and managing our station locations. So it is the time and the location and incorporating them together.

THE CHAIR: Any more questions, gentlemen?

MR HARGREAVES: No, but sadly, I have heard it all before.

Mr Sweaney: Let us hope that with the increase in resources we can develop a plan. As I said earlier, once we have got a plan, we can get the support from the Assembly, the Treasury and the community to put it in place and we will see some change.

MR SMYTH: Thank you.

Mr Sweaney: Thank you.

THE CHAIR: Gentlemen, thank you very much. It has been a very interesting session of evidence. The hearing is now adjourned.

The committee adjourned at 12.26 pm.