**THE PARLIAMENTARY STANDING COMMITTEE OF PUBLIC ACCOUNTS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON FRIDAY, 24 SEPTEMBER 2021.**

**REVIEW OF AUDITOR-GENERAL'S REPORT NO. 1 OF 2016-17 AMBULANCE EMERGENCY SERVICES**

**Hon JEREMY ROCKLIFF**, MP, MINISTER FOR HEALTH, WAS CALLED AND EXAMINED.

**Ms KATHERINE MORGAN-WICKS**, SECRETARY, **Mr TONY LAWLER**, **Mr JOE ACKER**, and **Ms MICHELLE SEARLE**, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

**CHAIR** - … If there is nothing else to add then we will move to Ambulance, the Auditor-General's Report into Ambulance and Emergency Services. We will go through the same process. The first recommendation was:

> Ambulance Tasmania collects data aligned with the RoGS data to allow regular medical comparison with clinical outcomes at a regional level, to better allocate resources and rapidly identify problems.

This recommendation was specifically about data at a regional level. Has that been done?

**Mr ROCKLIFF** - As we have stated in the answer, since the review was completed, Ambulance Tasmania now completes annual reviews on report and government services data collected and monthly data reports, which align with the RoGS reporting requirement. In terms of the regional data?

**CHAIR** - Yes, it specifically mentioned regional.

**Mr ACKER** - We report monthly on our performance of the ambulance service, based on the RoGS data but also on other indicators that help us manage our performance. We break that down by the region. For example, we have north, north west and south response times, call volumes, event volumes, multiple resourcing and all of that data available. In addition to the RoGS progress our clinical services group looks at clinical indicators by region to ensure we are being consistent across the state and addressing the regional issues.

**CHAIR** - Do you report the regional breakdown of data publicly, or is that internal reporting?

**Mr ACKER** - We do the regional breakdown internally. We don't report that through to RoGS, as RoGS is an aggregate reporting of the whole system.

**CHAIR** - In terms of the meaningfulness of that data, has it identified particular issues in relation to any of the indicators and clinical outcomes of patients across the three different regions, or is it fairly consistent?

**Mr ACKER** - That is a difficult question to answer, because a number of things have been identified prior to my time - and in addition, since I have been here for the last six months. Inconsistencies in clinical practice have been identified during these reviews, and also opportunities to improve performance.

One example was the need, in the north-west, to add additional solo-response vehicles to improve response capabilities - particularly when the COVID-19 outbreak happened. Now, we have single paramedic critical response units in the north and north-west that help us improve our response times. That was identified through the regional reporting structures.

**CHAIR** - It is an internal process, but you do respond to findings such as that?

**Mr ACKER** - Yes. When I took over as chief executive, I changed the clinical governance to have four executive meetings a month - one per week. One of those is completely dedicated to performance. Our data analyst presents the performance reports to us and talks through them. He has the expertise to draw attention to certain areas, and our executive team immediately creates interventions to address the issues raised.

**CHAIR** - I assume there are more examples of change, such as the single paramedic responses in the north and north-west. Is there anything else you could point to that has come from those findings?

**Mr ACKER** - Yes. A recent one was complex, but I will try to paint the picture. Imagine a room, which is our State Operations Centre. Half of the desks are 000 emergency call-takers, with maybe five people per shift, for example. The other half are the dispatchers. We have a dispatcher for each region: north, north-west and south, and one for air medical. Through these monthly performance reports, we identified that our self-dispatch times were increasing. The time the 000 call was received to the time it was dispatched to ambulance was getting longer. We identified that this was a result of an increase in 000 calls.

We are now processing about 275 of these 000 calls a day, which is about a 10 per cent increase this quarter over the same quarter last year. When a 000 call comes in, we try to answer it within 10 seconds. That is our performance target, and we do so 98 per cent of the time.

When all the call-takers are on the line, those calls go over to those three dispatch desks. But we found that the self-dispatcher was often taking 000 calls and wasn't able to dispatch the ambulance. Our immediate intervention there - particularly in the south, which has about 50 per cent of the state's call volume - was that we stopped having them answer 000 calls, and instead had the other people in the room do that. We were able to immediately impact the response times.

**CHAIR** - That is good, so it worked well.

**Mr WILLIE** - This is not about the data, but how many paramedics are working on their own? I imagine that would be a tough job.

**Mr ROCKLIFF** - We covered some of this in Estimates, Mr Willie.

**Mr ACKER** - We have a number of different roles for paramedics working on their own. We have clinical support officers, which provide an education and clinical support role. They go to a variety of different calls to support paramedics, particularly our new employees.

We also have those critical response units. We have five in the north and north-west, and we are also looking at adding them in Hobart, with some of the new investment.

We also have branch station officers. Across the state, in smaller communities, we have either a single-branch station, which would be one paramedic working on a station over four days, and they work with volunteers. When there is no volunteer available, they will respond by themselves and we will send the next closest ambulance to back them up. It is a fairly regular occurrence in Tasmania, and we have a number of safety mechanisms - as we discussed in Estimates - to ensure those single responders are doing their job safely.

**CHAIR** - We will move to recommendation 2, that the regional summary reports of clinical reviews be standardised to facilitate review and comparison across regions.

One example was that Tasmania supports processes and facilitates dissemination of clinical review findings across the organisation to contribute to improvement of clinical care and patient outcomes, rather than provide comparison across regions. This is data collection versus comparison of data, which means you have not really adopted the recommendation, minister, but this is the explanation. Do you see any value in comparison of data, or is it your view that the collection is the important part? Comparison is not helpful. The Auditor-General obviously has a view, but Ambulance Tasmania had a different take.

**Mr ROCKLIFF** - Data is very important if it is going to point to areas that we can continuously improve our service. Operationally, Mr Acker, can you answer Ms Forrest's question?

**Mr ACKER** - Through you, minister, I do not know the thinking of the Auditor-General at the time, but since then we have created the Ambulance Tasmania clinical governance committee, which is under the direction of our Director of Clinical Services, and brings all the regions together. Clinical support officers and clinical support managers - including aeromedical and retrieval - meet on a monthly basis to discuss their findings from their independent audits. Each region and aeromedical do their audits, and they bring all those results together to identify if there are common issues to address.

I would not suggest that it is necessarily a comparison of region to region, but more looking at trends across the state.

**CHAIR** - So it is a more standardised approach, though.

**Mr ACKER** - Exactly.

**CHAIR** - Yes, which is part of the recommendation that it be standardised.

**Mr ACKER** - That's correct. My understanding is that prior to my arrival, the regions operated very independently of each other. I think a result of this report was bringing it together as a monthly clinical governance committee.

**CHAIR** - The Auditor-General's report talks about different measures of reporting. Patient satisfaction and cardiac survival are some of the ones he has identified as not being consistently collected across all regions. I am not sure why you would not collect that same sort of data across the regions - or do you now?

**Mr ACKER** - Through you, minister. We do collect RoGS data, which are those indicators - cardiac arrest, pain management and patient satisfaction. We do that statewide, broken down by region.

The clinical governance committee has also identified six strategic clinical priorities that we are implementing now and measuring into the future, by region - which will be cardiac arrests, cardiac conditions, airway management, trauma management, mental health patients - particularly those who have sedation involved - and patient assessment standards. These were identified through the clinical quality reviews.

**CHAIR** - How do you report those?

**Mr ACKER** - These are reported to the clinical governance committee and will come out monthly to the clinical executive, who will make changes to the clinical practice guidelines for strategic changes that are needed.

**CHAIR** - We will go to recommendations 3 and 4, which are listed together - Developing strategies to improve response times to those of other jurisdictions, and undertake cost-benefit analysis of those strategies.

There are two aspects to that: develop the strategies, and then do a cost-benefit analysis to investigate whether additional resources in the north and north-west were effective in reducing average response times. This is going back before your time, Mr Acker. This is 2016, so things may well have changed significantly since then. In your response that was provided, you said -

> There is some evidence that response times have decreased in rural and remote communities that previously did not have a paramedic presence, or have moved to a double-branch station model, where a paramedic is rostered on in the day and at night. However, overall it was considered that despite increased resourcing, the increase for demand of services has negated any decrease in response time.

Can you talk a little about the strategies you have used to address this, to try to get fairly consistent response times across the state, acknowledging our challenges?

**Mr ROCKLIFF** - Thank you, Chair. Before I ask Mr Acker to comment, we have committed to investing in 48 additional paramedics across the state. We hope to have those out in the next two years. We will review service demand after that time, which will also inform further investment. However, we are expecting rural and regional areas to benefit - Sheffield, Dodges Ferry, Campbell Town, New Norfolk, St Helens, west coast, north-east, Swansea, Miena and Bruny Island. We spoke at length about the secondary triage program, which aims to improve the integration connectivity of Ambulance Tasmania with other health and social service providers to appropriately divert patients away from emergency ambulance

response when their medical care could be better met by another provider. We heard that quite extensively in Estimates.

Joe will probably speak on the expanding role of the extended care paramedics. In areas of greatest need an ECP is an advanced practice paramedic with additional education and comprehensive patient assessment and primary care skills. Their focus is to provide safe care for patients in their homes so they do not require transport to an emergency department. We have established a helicopter emergency medical service that can be deployed to all areas of the state.

State-wide demand reflected in the dashboard released today shows demand for the ambulance service remained very high, with attendance at 7506 incidents to August 2021. There was a median response time of 14.5 minutes, which is below the high that we had in March this year of 15 minutes. That is a positive direction, albeit further improvement to go. We are continuing to roll-out the secondary triage in which trained paramedics and nurses provide clinical advice to 000 callers and connecting them with other health services, where appropriate, so they can receive their care.

Demand has increased by 9.6 per cent in the last financial year, with the total number of ambulance call-outs of 102 986 compared to 93 165 the previous year. Some of the data within the report is a little old. Joe, would you like to provide some more currency to Ms Forrest's question?

**CHAIR** - Minister, I might ask for the tables in this report to be updated too, if that is possible. We will send a letter in that regard.

**Mr ROCKLIFF** - Send the correspondence through and we will see if we can support that and are still collecting the data in the same way. I assume we would be. We can present that back to the committee at that time. Do you have anything further to add, Joe?

**Mr ACKER -** The issue of response time is very complex. One of the two biggest challenges right now is the increase in demand. As the minister said, year-to-year we are increasing significantly and in quarter-to-quarter. This last quarter was a 10 per cent increase over the last quarter. The other significant impact is off-load delay and ramping at the hospitals. When the ambulances are at hospitals with patients they are not able to respond in the normal matrix that we would have. Our leadership team needs to be very nimble to maintain response times.

The first thing we need to do is to identify which patients are most urgent. That is work that is happening now. Our clinical services team is looking at the almost 2000 different call-types that a 000 operator would take, to compare to Queensland and Victoria matrixes to identify the most critical of those to make sure that we are getting an ambulance to the most acute patients.

As the minister suggested, the other big impact to improve our response times is to ensure that we are sending ambulances to the right patients. That is where the secondary triage is really starting to happen. Since it started on 22 February we have done about 1700 triages of 000 calls. Almost 700 of those did not get an ambulance. That means there were 700 ambulances available to go to the high-acuity calls.

**CHAIR** - It continues to be a problem. I think public education is part of that, for people to know when an ambulance is needed. Do you have a question, Josh?

**Mr WILLIE** - I am interested in this statement. The first sentence in the answer is:

> Ambulance services across Australia operate under different service delivery models. Due to this reason, it is difficult to make direct comparisons between services based on RoGS data -

**CHAIR** - That is because we do not have to pay for it.

**Mr WILLIE** - There are agreed measurements. Isn't that the point? If other jurisdictions have different service delivery models that are more efficient?

**Mr ROCKLIFF** - Is your question about describing the difference in service delivery models?

**Mr WILLIE** - Well, it is comparable, isn't it? They are agreed measurements that are used by the Productivity Commission. If other jurisdictions have more efficient service delivery models shouldn't we be looking at that?

**Mr ROCKLIFF** - Joe, would you like to answer Mr Willie's question on those service delivery models?

**Mr ACKER** - The indicators are exactly the same and report the same indicators but the design of the systems is quite different. Ambulance Tasmania uses a lot of volunteers, about 450 volunteers across the state, which means that our service delivery reflects the time that volunteers are able to respond. Because we are a statewide service with a lot less density than places like Victoria and New South Wales, our response times are different from what it would be for Sydney or Melbourne.

**Mr WILLIE** - But their regional areas would be in a similar situation in Tasmania?

**Mr ACKERS** - Some of those states also use volunteers and they would have some of the similar impacts.

**CHAIR** - We will move to number 5. Meg, are you right? Yes. This is recommendations with regard to the high proportion of volunteers impacting on mobilisation times in the north. This data is a little bit old, but what change has there been in volunteer numbers? How has that impacted on timeliness of responses particularly where you only have volunteers some times. Volunteers by their very nature mean they are not always available.

**Mr ROCKLIFF** - The figure here is approximately 500 volunteer ambulance officers. Joe's mentioned, and we mentioned in Estimates, the 450 figure so. Has that decreased marginally, Joe?

**Mr ACKER** - The number of volunteers changes regularly. We constantly recruit volunteers. We have dedicated teams across the state doing that with a dedicated per cent in each region and a manager centrally that oversee the recruitment and retention of volunteers. COVID-19 reduced our numbers. The demographic of our volunteers is older, many of who

had medical comorbidity so they were not able to respond. At the beginning of COVID-19 and even now, we have lost a number of those previous volunteers.

Regarding the impact volunteers have on service delivery, as the minister indicated when we move a station from a single branch to a double branch, a single branch has a paramedic that is on the station for four days supported by volunteers who often come from home. A double branch has two paramedics, one working the day shift and one working night shift, supported by volunteers who largely stay at the stations. That response time improves. As the response indicates, where we have increased funding to stations to move them from single to double branch, we see an improved response time in those communities, particularly the north and the north west where we have made those changes.

**Mr ROCKLIFF** - We are providing $50 000 in funding to the Volunteer Ambulance Officers Association of Tasmania which is working with Ambulance Tasmania on a memorandum of understanding focusing on the key areas for our volunteers, including attraction, retention, training and support.

**Mr WILLIE** - How is the decision made about single branches and double branches? Is it just the capacity of the volunteers in the area?

**Mr ACKER** - It is very scientific. We have engaged a consultant company called Operational Research and Health from the UK. It does a five-year retrospective review of our call data and the severity of the calls looking at each community. It then predicts for us where we will need to move from a single to a double branch based on the demographics and the health of the patients in that community. We recently did the five-year review. Once we get the census figures next year we will do the 10-year predication so we can look at where we need stations and at which stations we need to change the service delivery, whether it's from a single to a double branch or from a double branch to a career station. Some stations are only volunteers so they may need to become single branch stations. That is the work done by our performance team.

**CHAIR** - We will move to Recommendation 6 - Ambulance Tasmania reinforce the requirement to record factors contributing to response time outliers and remedial action undertaken to address contributing factors.

On page 36 of his report, back in 2016, the Auditor-General reported that 'we were advised the duty managers for all regions prepared daily shift reports, which included a response to outliers'. Is it still the process that the duty managers respond to any case that is considered an outlier, and what about in single paramedic stations and volunteer stations?

**Mr ACKER** - We do two things now. The first thing is in our State Operations Centre, which is our dispatch centre. If there is a long response time, the duty manager puts it into our SRLA system. The SRLA system tracks these and we monitor them on a daily basis for trends.

The second thing is the duty managers, who are the 24-hour operational supervisors, also monitor for these, and identify what mitigating strategies they implemented.

The third thing is that every single day, our executive team and I get a report of our long response times. That is, any P0, who are our most critical patients, and P1, our next urgent critical patients. If the response time was greater than eight minutes, I get a report every

morning. That report is broken down by every portion of the response time: the call answer time, the call dispatch time, the shoe time -the time it takes for the paramedics to respond - and the response time.

**CHAIR** - With their shoes on?

**Mr ACKER** - Put their shoes on and get out the door so they can do the call. Then we look through that for trends. We use those reports to identify trends or severe outliers.

Lately, a lot of the outliers have been long response times where the ambulances have come in from communities outside of the capital city, in the hospital handing over patients, and then they have to respond from the RHH to New Norfolk or other places.

**CHAIR** - You are confident we are not seeing these outliers not considered? It is almost an automatic process here?

**Mr ACKER** - I am confident.

**CHAIR** - Recommendation 7 - Ambulance Tasmania regularly review its emergency and urgent determinants methodology to ensure that it continues to be best practice in accordance with the requirements of the National Academy of Emergency Dispatch. You provided some information there. Have there been any observable outcomes from that approach, and what actions have been taken based on the recommendations?

**Mr ACKER** - As the response indicates, we created a governance committee called the medical dispatch review committee. They meet on a regular basis and review the calls that we are evaluating. As I mentioned earlier, this committee has started a review of the Queensland and Victoria response models, to compare them to Tasmania. Both Victoria and Queensland have recently invested significantly into updating theirs, based on the evidence of those systems. We are going to compare them to ours, instead of reinventing the wheel, and identify best practice.

Through this process as well, this is the same committee that identified the low acuity calls that are being looked at by our secondary triage clinicians. That is an important job. It is not only identifying the most critical patients in our system, but also those callers we can refer to other health resources, instead of sending an ambulance.

This committee is very active, very important. It has a physician as well as our dispatch representatives and paramedic clinicians evaluating those calls.

**CHAIR** - Recommendation 8 - Ambulance Tasmania investigate why the level of multiple responses has increased. There is commentary in the Auditor General's report about the reasons for that, and it has been addressed in the response here. I note your comment that -

> Since the review, Ambulance Tasmania has continued to experience high levels of multi-response dispatch to cases. An examination of cases indicated that the deployment approach is reflective primarily of skill sets, requirements in response to patient acuity, and complexity of medical conditions.

You can't change some of those things. They are outside anybody's control. Minister, are you satisfied that all issues have been addressed to avoid multiple responses, wherever it is possible?

**Mr ROCKLIFF -** Yes, I am satisfied. Mr Acker, would you like to talk more about that?

**Mr ACKER** - This is another complicated situation. Multiple vehicle responses come from a variety of reasons and the organisation is constantly look at opportunities to be more efficient, but also effective. In many cases a multiple vehicle resource response is highly effective and highly efficient.

For example, we don't just have one type of paramedic in the state. We have extended care paramedics who provide primary care. We have intensive care paramedics who provide intensive care skills. We have critical care paramedics and physicians who are critical consultants who respond to cases. So, when we identify patients who can benefit from a different resource, we will send that resource as well. So, we send always a closest resource for higher priority calls, and then we will supplement that by another resource that can better manage those patient conditions.

Where we are putting a lot of investment in, is looking at our clinical response category to ensure we are sending only the appropriate resources and not over depleting our resources. So that is happening as a part of our call review.

**CHAIR** - The Auditor-General observed that Tasmania had the lowest cost per emergency response, 7 per cent less than the Australian average. I thought that's very efficient and effective. Is that still the case?

**Ms WEBB** - A lot of volunteers.

**CHAIR** - Yes, that's right, a lot of volunteers.

Minister, you may not have the answer to this now. If you provide an updated figure at 13, it will show us that, but is that is still the case? It is an interesting statistic, but it probably relates to the significant use of volunteers.

**Mr ROCKLIFF** - For example the last two years 2018-19, $148.30; 2019-20 financial year, $212.06. We are waiting on the 2020-21 figures. It would appear if I start from 2016-17 which was $146.87, it seems to be trending up.

**CHAIR** - The Auditor-General notes on page 40:

> We found the real cost per has increased 26 per cent from $101 to $127 over a nine-year period this represents a compound annual growth rate of 2.7 per cent.

So, I think that was the trend. I would be interested in how it compares. We will send that as a question on notice.

**Mr ROCKLIFF** - Send that as a question. The extra costs of COVID-19 and cleaning have been pointed out to me by the secretary.

**CHAIR** - Yes, that will make a difference, but if you look at the numbers from 2016 to now, surely that will be an aberration, hopefully. Financial investment, and during COVID-19, yes.

We will move to recommendation No. 9: AMS Tasmania KPIs, what KPIs are measured and provide targets and benchmarks for what is good or poor performance. We did talk a little about the progression of this earlier. AMS Tasmania strategy and planning documents will facilitate the further development of appropriate KPIs and performance targets for the organisation.

I assume we are looking at some outcome measures as opposed to just output measures. It is easy to look at output - the number of ambulance calls and the times to respond. But looking at patient outcomes is always a bit fraught because some things are outside the control of any ambulance paramedic. What sort of measures and KPIs are we looking at?

**Mr ROCKLIFF** - In addition, to response times, public satisfaction and the number of service response times statewide by region and expenditure per person.

**CHAIR** - Particularly outcomes-focused KPIs.

**Mr ACKER** - This is a really exciting opportunity to share a vision for the future. We have talked about secondary triage. Instead of reporting what we have done traditionally in the ambulance service which is response time and cardiac arrest, we are looking at whether we can do different for lower acute patients as well as the mental health patients. So, we have an investment in our mental health co-response team starting at Christmas time this year. We hope that the outcome and measures from that will be that we can deal with our mental health patients in the community more efficiently than we have in the past and also prevent them from going to the emergency department and instead finding other more appropriate services.

The other important one is providing more definitive care in the community. That is with our extended care paramedics being able to take care of patients in their homes without transporting them. The next one that is really exciting is our regular paramedics. We have implemented pre-hospital thrombolysis, which is for a patient with a heart attack. The paramedics will administer the clot-busting drugs in their home instead of the delay that it sometimes takes to get them to the hospital or to the cath lab and so far, we introduced this this month, and we have already had two cases that were very successful.

**CHAIR** - They have the patient monitored obviously but do they have that connected to a central monitor somewhere?

**Mr ACKER** - The paramedics monitor the patient directly and are in direct consultation with a physician. It is a clinical partnership and the paramedics take on the responsibility for treating the patient in consultation with the physician. Again the outcomes here are much improved cardiac function because the delays in care are significantly reduced. And we are really excited about some of these definitive care approaches that Ambulance is taking now, in addition to the response times and getting patients to the hospital quickly.

**CHAIR** - I have a bit of a fascination with outcomes-focus KPIs as those across the table would know. Will this performance information be reported in annual reports and our Budget papers and so on? I think they are at least as relevant, if not more so, when you are talking about patient outcomes, than even expenditure per person matters. It is important and interesting.

**Mr ROCKLIFF** - Absolutely. It is all about again transparency, accountability and continuous improvement. I would imagine that we will be able to support that information in annual reports.

**CHAIR** - I will ask you about that next year in Budget Estimates.

**Mr ROCKLIFF** - Look forward to that.

**Mr ROCKLIFF** - Thank you, Chair. I thank Mr Searle, our Acting Deputy Secretary but also Professor Lawler our Chief Medical Officer and Deputy Secretary (Clinical Quality Regulation Accreditation), also our Chief Executive at Ambulance Tasmania, Mr Acker, and Ms Morgan-Wicks as well, our Secretary and State Health Commander for their time and the answers they provided today. We await your further correspondence and we will answer accordingly.

**CHAIR** - We appreciate you coming in and providing evidence, minister. The PAC has not normally called witnesses in. We have looked at desk top-type things as much more effective. But this enables us to get much more thorough information about the responses that you have made. We appreciate that you are all busy, so thank you.

**Mr ROCKLIFF** - Thank you very much.

**THE WITNESSES WITHDREW.**