

**THE JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET
IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON TUESDAY
13 MAY 2003.**

AMBULANCE SERVICES

Mr GRANT LENNOX, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND
Dr TONY BELL, CLINICAL COUNCIL WERE CALLED, MADE THE STATUTORY
DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorpe) - Thank you very much for coming today. As you may understand, this committee has gone through several metamorphoses over the past couple of years. I think, apart from myself, none of us have been present at previous ambulance hearings under these terms of reference. What we thought might be useful would be if you could bring us up to date with the current state of play with the ambulance service, particularly since the last State election because I understand there have been some changes in management structure. Then, if any of the members have questions, they could ask them of you after that.

Mr LENNOX - I did not have the privilege of coming along to your first hearing because I had glandular fever at the time, so this is my first attendance here.

Just to give a summary at the last ten years, the Tasmanian Ambulance Service was a service that was envied by the other States and envied internationally, for several reasons. One is that it had a level of excellence in the training of its staff at paramedic level. To put that in perspective, Perth in Western Australia and the whole of Western Australia still does not have paramedic level as we know it. Queensland and South Australia have only gone to paramedic level in the last four or five years. So Tasmania had a historical level of excellence and a wide spread of the paramedic level - in rural locations from Smithton through to Scamander on the east coast - a wide spread which gave us in this State a very high proportion of cases that were responded to at paramedic level and the highest proportion of cases responded to at that level in any State. We had a high level of government support financially and we were the only State that ran a free service to the public.

Mr FINCH - Excuse me, Grant. Could you just elaborate on what you mean by paramedic level?

Mr LENNOX - In the skill levels, if you imagine a ladder, at the bottom level are people who do first aid - people who have a St Johns first aid certificate or a Red Cross first aid certificate. The people who work in the Ambulance Service as volunteers are trained to a much higher level. We call them volunteer ambulance officer levels 1, 2 and 3. A level 2 has a wider range of knowledge and skills and a set range of protocols. An ambulance officer does a qualification through a university - that is a three-year course - and they

get an advanced diploma or a diploma. Our educational arrangements are with Charles Sturt University. So a person who has completed that three-year training course is an ambulance officer. The term 'paramedic' is used loosely in some other States. What we call a 'paramedic' is a person who has done further training so that they have a wider range of invasive skills and a higher level use of scheduled substances and drugs to give life-saving treatment. An ambulance officer, if you like, is a basic life support; a paramedic is an advanced skilled practitioner and their skills go right up to intubation, cannulation, administering morphine and adrenalin and a range of other drugs that Dr Bell can explain. Internationally we have been at that level of service delivery since the late 1970s. As I said, the whole of Western Australia still does not have anyone operating at that advanced life-support level.

We went through a period historically where we had some very significant resource problems in the ambulance service and some of those are well publicised. They included fleet problems. We had a radio system that was ageing and malfunctioning with no parts. We had a lack of funding for equipment. We were not giving enough support to the 430 volunteers who were delivering services right around Tasmania in rural areas. We had staffing not keeping up with demand growth and some of our stations were in the wrong locations to give a good service to the public.

I will give you an encapsulation of the things that have happened. Over the last four years our fleet has been upgraded with \$7.5 million spent getting us from probably one of the worst fleets in Australia to the best fleet - predominantly Mercedes ambulances. We have completely upgraded the radio system, which cost in the order of \$1 million, which gave us better radio coverage not only in the urban areas but right throughout rural Tasmania. We introduced a paging dispatch system which enables the communications officer at a key stroke to download onto the pager of a crew, whether they are sitting on King Island or Nubeena or in Hobart, the location of the case and the basic details without having to call them up. That has added in our response capability.

We put in a new computer-aided dispatch system. There is one that has been put in only during the last two years in Sydney. We have had one since about 1990-91. I think, Madam Chairman you are the only person who has seen it. It is inter-faced with mapping right down to every town, every street being cross-referenced and rid referenced to the one-in-2000 series maps of Tasmania available on the computer. The communications officer can keep zoning in.

We also have an interface with Telstra which is about four years old. When someone calls in 000 on a landline, not a mobile phone, the computer gives us a separate feed telling us the billing address of that phone. When the communications officer takes the call they go through a set of procedures. I think there are 36 of The Esplanades in Tasmania, 28 George Streets, a lot of streets named after kings and queens. When they type George, 28 George Street is dropped down on a panel and they click on the George Street in Wynyard or the George Street in Ulverstone - there is one in every town - and it links it to a reference in the Tas Map series. If it is in a rural location the experienced communications officer can look through and start working out how many creeks crossed and roughly this is where they are et cetera.

That system has substantially improved our communications capability and our communications officers are well-trained for their task. We are only just in the final

stage of implementing an advanced medical priority dispatch system which is a piece of software considered the world-best practice and which is medically tested, if you like, to give you the most rapid and accurate classification of a case. You have to understand that a lot of people who call for an ambulance do not need an ambulance; they do not even need to see a GP. We get quite extreme cases of people thinking, 'Well, it doesn't cost me anything; I'll get them to come and have a look at me', right up to something that is immediately life threatening. This computer software system is integrated with their other dispatch system. It gives not only the rapid set of questions to get to the medical categorisation but it is also inbuilt to the computer system to give the right pre-arrival advice because care starts, in some cases, from the minute the phone is answered. Everything we do in ambulance communications is recorded to the 100ths of a second of when we receive the call, dispatch an ambulance, when the ambulance crew get into the vehicle and touch a button which sends a radio signal through to the computer to when they arrive at the scene, leave the scene and arrive at hospitals. All of those things are time-stamped.

The Government has allocated 27 new positions over the last four years. The initial batch was to handle issues of fatigue that were linked to the growth in demand. We have some positions linked to the instruction of the 38-hour week and we also increased jobs for volunteer training. We have increased our support to ambulance volunteers who collectively are involved in about 20 units that are wholly volunteer staff. There are another 13 locations where volunteers work alongside paramedics and collectively there are now some 530 volunteers. We were not giving them sufficient resource support from training to reimbursement of expenses to uniform, so we've strengthened all those.

We set up a strategic plan to manage our volunteer resource and we won an award in 2001 from the National Health and Medical Research Council for our management of volunteers. We developed a strategic plan where the president of the union and the president of the volunteers were part of the development of that plan. We're about to go through a revisiting of that. That plan was up to 2005. We did a statewide survey of volunteers to set that blueprint for the things that were the most important to them and the number one issue for them was training and number two was uniforms, so we substantially improved both of those. Other States looked at what we'd done and they took part with us in replicating that survey across all States except New South Wales and throughout New Zealand and that won an award last year nationally for emergency management.

We have also substantially upgraded the emergency medical equipment right across the State from the latest in cardiac monitors to equipping every volunteer ambulance with a semi-automatic defibrillator and putting into place new stretchers and resuscitation equipment. Over that time period, one of the ways we have coped with the extra demand, and demand is probably the dominant issue for the ambulance service, going back into 1994 we started new ambulance services at Bridgewater, Kingston and Wynyard. We started one a couple of years later at Scamander which was servicing St Helens, St Marys and the Bicheno area, all of which have volunteer units. There was an upgrade of the air ambulance and we are in the final stages of commercial-in-confidence negotiations for the next air ambulance contract. The Government upgraded the rescue helicopter to a twin-engine night-flying capacity aircraft. The interfaces between the ambulance service and the health system were systematically strengthened. Dr Bell was medical director of the ambulance service and chairman of the Ambulance

Clinical Council, which is the expert statutory body that sets our clinical standards, monitors our performance and reviews the protocols. The ambulance service became part of the Hospitals and Ambulance Division of the department and we have in every region a sessional ambulance service medical officer who reviews our cases to see that everything has been done correctly.

We have also strengthened our interfaces with the Fire Service. The paging dispatch system is something we share with them and a lot of the radio infrastructure. We have co-located in a number of stations. Some of the stations we had we moved so on the eastern shore of Hobart we are near the Clarence Health Centre in Bayfield Street and we probably get to some places on the eastern shore better from the western shore through traffic, et cetera. Our northern suburbs sole station was at Claremont. We opened a new one at Bridgewater but brought the Claremont one back to Glenorchy and all up we have about six co-located stations and all of them are in a better location for us to respond so it has enabled us to keep our response times on the right side of the ledger when demand significantly increases.

We did a public satisfaction survey last year where we surveyed over 551 cases statewide and we had a 98 per cent level of public satisfaction, a 100 per cent level of satisfaction in the volunteer and branch stations and one of the only areas where the public was not satisfied was that some non-urgent cases felt they were given the impression that the crew would have rather been out on an emergency and that they may not have warranted an ambulance. So as a symptom, if you like, the public believe we have a very good ambulance service.

Mr FINCH - Through you, Mr Chairman - Grant, these 551 in the survey, were they people who had used the service?

Mr LENNOX - Yes, wholly used the service. With some it may not have been them who answered the form, because the relative might not have been in a condition to answer the survey form, and in a couple of cases the person had passed away. And we actually cover in the survey that that is equally important to us, to get feedback on a case where the patient has died either at the scene or later in hospital, so we have just repeated that survey, and I only have the preliminary results, the first cut of that. We increased the sample size to over 1 500 and that is showing a 97 per cent satisfaction level.

Ms RITCHIE - Sorry, what was the first level of satisfaction?

Mr LENNOX - There were 551 cases, with a 98 per cent satisfaction rate, and a 48 per cent response rate, which for surveys of that kind is very high. We have maintained that level of response rate and we have surveyed 1 500 cases. I do not have the detailed breakdown yet by every location, but we also ensured that we did a survey mix of emergency cases, urgent cases which were not immediately life-threatening, and non-urgent cases. And cases where we decided not to take the patient to hospital, which is a sensitive issue in that some patients feel they might need to go.

Mr WILKINSON - And that was a statewide survey?

Mr LENNOX - A statewide survey, every station.

Mr WILKINSON - And you actually surveyed, as I understand it, 551 people last year and around about 200-odd replied. Is that right?

Mr LENNOX - Yes, 48 per cent of 551, and this year 48 per cent of 1 500, and that is the size of the sample that is being surveyed in every State, so for us to survey 1 500 and the whole of Victoria to survey 1 500, Victoria for example is ten times our size, so for them to survey 1 500 is equivalent to our surveying an extra 15 000.

Mr WILKINSON - How many calls do you get a week?

Mr LENNOX - We get over 40 000 calls a year, so if you want to do the maths.

CHAIR - That is 872.

Mr LENNOX - In terms of some of the challenges ahead, a key challenge we have is to maintain that resource base. We cannot afford to have our fleet be ageing and unreliable. The public have a clear expectation that when they call for an ambulance we are able to go there in a vehicle that is safe and reliable. We have a key issue to deal with the issues about the growth in ambulance demand, and that growth is not unique to Tasmania. Every State and Territory has an issue with ambulance demand. We are looking at some issues nationally and some of the factors that influence demand are obvious, such as an ageing population, but a Victorian study recently indicates that ageing only represents 20 per cent of the growth of demand. So some of the other features are the decline in bulk billing, which means a lot of people will call an ambulance rather than go to a doctor where they pay, and 24-hour access to GPs. But there are other issues that are all linked to demand. The only State that is not experiencing a strong growth in demand is Western Australia. In Western Australia the only thing that is different is that they also pay to be in an insurance scheme and then they pay again when they call an ambulance, so that co-payment issue was brought in by the insurance company. That is the only State where the demand is not experiencing strong growth. We are all averaging about 7 per cent growth in demand a year, so we have some challenges in coping with that demand.

Mr MORRIS - Can you just outline briefly how much less work Western Australia has overall, how many less calls they get because of that co-payment situation?

Mr LENNOX - It is not so much that they get less calls. They get less growth in calls. In terms of public utilisation of ambulance service, the highest level of utilisation in Australia is Queensland, and there are some historical reasons for that. In some country towns the ambulance station is it, there is no district hospital et cetera and they have operated for years to go to the ambulance station to get bandaids and bandages. They also do baby capsule hire and a few other peripheral things.

We are about mid range in the level of utilisation of ambulance per head of population. To differentiate the things that are unique about Tasmania compared to other States, Tasmania and Queensland like in any other area of government, we have the most distributed populations so that gives us a range of factors that are unique. In South Australia, for example, over 90 per cent live in the capital city and 10 per cent are spread through a huge area. We have a wide spread. While we have a high reliance on volunteers, collectively the volunteers probably only attend to 5 per cent of the cases but

because of that spread, we have a network and we are the only State that has maintained a free service to the public and that would be an issue at the margin, about utilisation, but when you consider that we have been running a free service since 1982, it is not something that you can demonstrably pinpoint and say, 'This is the actual impact'.

Mr STURGES - Grant, just a couple of questions. You made reference before to the communications system, the 000 calls. Can I clarify, the initial 000 call, does that go through to Telstra or go through your communications?

Mr LENNOX - No, it goes to Telstra. The Telstra caller asks which State you are calling from and then which service you are after - police, fire or ambulance. Then, by one key stroke, it is onto our communications system.

Mr STURGES - My understanding is that the 000 service is no longer based in Tasmania and that Telstra have exported the 000 service to some mainland site and I am also aware that there has been instances, not recent I will concede, where ambulances have been dispatched to mainland sites when in fact they should have been dispatched to Tasmanian sites. You made mention before about 30 Esplanades or whatever.

Mr LENNOX - Thirty-six.

Mr STURGES - Thirty-six, thank you. I did not take note of that but there are a number of like towns in Tasmania and mainland States. What sort of checks and balances does the ambulance service have in place to ensure that firstly Telstra are properly conforming to the required process and that ambulances are not being misdirected to mainland sites?

Mr LENNOX - I will answer that in a series of steps. At the national level there is an emergency call-taking working group that covers police, fire and ambulance meeting with Telstra to look at the issues around the 000 system, or they prefer to call it the triple zero system. It is only relatively new - I say 'new'; in four years or so - that we have had the direct feed electronically onto a separate computer screen which interfaces straight over on a keystroke for the billing address of every landline call.

The only problems that have occurred in the last four or five years were over mobile phone calls where they could not tell in Telstra where the caller was calling from, but for a landline call we get the billing address of the phone. I would say that is about 98 to 99 per cent accurate. The areas where it is not accurate is with people who have several houses. They might have a house and a shack in the Tasmanian situation, they get the bills sent to one and the billing address will come up but our first question in communications is, 'What town or suburb are you calling from?', that is the first question in ambulance, not about what has happened.

Mr STURGES - So once Telstra establishes that it is an ambulance service required in Tasmania -

Mr LENNOX - The first thing Telstra establishes is which State and then what service.

Mr STURGES - And then it comes to your communications centre.

Mr LENNOX - And then by a keystroke, and they keep a monitoring standard, they can tell electronically, to the hundredth of a second, when they gave that call to us and they can also tell when we answer it. So if we take 27 seconds to answer it, when we go back to them on a call we can say, 'We took 27 seconds to answer that'. You do get situations, particularly with mobile phones - some members of the public think they are a blessing to us - in some cases you might have someone going along the Brooker Highway in peak hour traffic and there is an accident near Risdon Road. We might get a dozen mobile phone calls for that one accident and until we answer them we do not know that they are not the same call. You don't know what it is until you have answered the call. So in that way it is not a blessing but in other cases it absolutely is.

For the mobile calls, Telstra strengthened their technology so they could identify the location base for the mobile. Until yesterday I had not had a complaint about a misdirected call in probably 18 months. The call yesterday came through a member - the honourable Speaker - and it was a three-call situation: the person made a call from a hardware shop when they saw a person fall outside the shop - and that was in Exeter in Tasmania. When they made the call, they could not answer the questions about what was wrong with the patient because they hadn't actually gone outside. They were asked to go outside and assess the condition of the patient and were given the option to stay on the line or call back; they said they would call back. When they called back they went through Telstra again. We are currently checking with Telstra whether they gave the State. The person said, 'I called a few minutes ago about Exeter' and there is an Exeter in New South Wales - but we had already sent the ambulance from the first call. Then they made a third call asking, 'Where is it?' and as they were calling we were arriving. So what we are checking with Telstra is: on their second call, did they say the State or did Telstra make a hiccup. That is the first case I have had in 18 months of a query location.

Mr STURGES - So just on that, apart from this committee, with the 000 committee, or whatever it is called -

Mr LENNOX - Emergency call.

Mr STURGES - there is nothing within the Tasmanian Ambulance Service where you interface with Telstra to check that there aren't misdirected calls; it is all through this committee?

Mr LENNOX - I can assure you that if there is a misdirected call either I will know or a member of parliament will know or the media will know.

Mr STURGES - But there is nothing in place?

Mr LENNOX - We deal with Telstra on a regular basis; we deal with Telstra probably daily on technical issues. We have an interface person at the local level that we deal with. They go back and give us a report, generally within half a day of a case we refer to them.

Mr STURGES - I hear what you are saying but there is nothing ongoing where you monitor the number of calls and whether or not the initial call through to Telstra is in fact being -

Mr LENNOX - We don't take the initial call through to Telstra.

Mr STURGES - That's right; that is what I am saying.

Mr WILL HODGMAN - Can I just jump in on that one, if I may. From what you say then, Grant, it couldn't be, for want of a better word, ordinarily the fault of Telstra because they would, firstly, ascertain the State in the initial conversation and then direct it to ambulance services.

Mr LENNOX - The original complaints that received some media attention - and there were probably about half a dozen of them nationally and they got a lot of prominence - were predominantly Telstra mistakes, where the Telstra caller skipped the first question about which State they were calling from. Quite often what was happening was that when a person calls 000 a lot of them are in a state of panic and in some cases they are giving information before you ask and they might give information like, 'I'm calling from Campbell Town', which is a suburb of Sydney of 180 000 people, whereas we have a Campbell Town here of 900 people. So the person might think, 'Oh, it's Campbell Town, New South Wales'. That was one of the problems that happened - so then they brought in more rigorous training and system checking where they go back and audit their call takers who do the emergency calls. It is not every call taker who takes emergency calls. They have a tripping system, where if the 000 call is not answered in one 000 call-taking centre within so many seconds it trips to another one. Generally speaking - and I don't have the statistics right in front of me - their call-taking receipt time internationally would be superb.

The mistakes initially were Telstra's and they tended to be over mobile phones and they tended to be on mobile phones for locations that were multiplied by suburb, if you like, or town name or similar name. So Telstra changed their systems because that is where the problems lay. In the last 10 years we have probably had two or three cases where we have gone to the wrong location. The last one I took of those was a person who had worked in the Health department and when they went through the case with me, when we went back to the call they were wrong because they were in a panic and it was Roaring Beach Road, Dover, and this was Roaring Beach and the person didn't say they were calling from Dover, they said they were calling from Roaring Beach.

Mr STURGES - Just a couple more questions, if I may, Grant, while you are here. My understanding is that the ambulance service has a reaccreditation program or policy for driver training, for rescue and for paramedics. Is that ongoing?

Mr LENNOX - Yes.

Mr STURGES - Are all staff currently accredited within the service?

Mr LENNOX - We have gone through a period over the last 18 months where we have been at our absolute peak in the services history for training and that came about through the Government being generous in giving us extra staff so at one stage we had 32 student ambulance officers in the service and probably our previous peak had been around about 20. We have done a major impetus on volunteer training in the various facets of our training from paramedic refreshers, volunteer training, road accident rescue training, helicopter training and driver training. We had to make priority decisions as to what got the priority in that period of time and our education resources were stretched to the max so I'd have to go back and look for every individual but we deliberately delayed and

reprioritised southern training because our training resources were stretched because of a new intake plus the deficiencies in volunteer training.

Mr STURGES - Chairman, could I then request that the department provide the percentages for staff by specific area that are currently accredited, and those areas are driver training, rescue and paramedic?

CHAIR - Yes.

Mr STURGES - Thank you.

Mr WILKINSON - Can I come in on that point of paramedic training. Are paramedics still required in their own time to deliver training to volunteers?

Mr LENNOX - We have a mixture of systems: some paramedics volunteer their time; some volunteer their time and get time off in lieu; some are required to do it as part of their job, particularly branch station officers who work with volunteers every day. It is part of their duties to train the volunteers that work with them and we have two full-time permanent positions that are doing volunteer training. What we have done is we have upgraded volunteer training. Some of our past methods of training don't meet modern standards in a technical sense in that now to determine someone is at a particular skill level the person who is assessing them has to have a particular training credential in training small groups and assessing people at a skill level and that is a set of skills that are not ambulance, they are I suppose, if you like, national training industry standards, so in the past some of the people who have delivered the training effectively didn't hold that extra credential; they were a trained paramedic but they weren't a trained trainer. We never had any positions whatsoever that were volunteer training but we now have two permanent full-time positions.

Mr WILKINSON - There were going to be three, weren't there?

Mr LENNOX - No. Our target is to get to three.

Mr WILKINSON - I see. Was that a recommendation at one stage that there should be three pretty well full-time trainers, I suppose - medical trainers?

Mr LENNOX - That's certainly the goal of the Volunteer Ambulance Officers Association. When we did our strategic plan, which I said involved the president of the union and the president of the volunteer association, one of our highest priorities was to strengthen volunteer training and our goal is to have three trainers exclusively working on volunteer training.

Mr WILKINSON - And those trainers therefore, as I understand it, would take over from your paramedics doing the training. Is that right or would they work in concert with them?

Mr LENNOX - You have 11 locations in the State where branch station officers work with volunteers and it is part of the person's job to do the training. We have another three locations where paramedics work with volunteers but there's a paramedic on duty 24 hours a day at Kingston, Bridgewater and Ulverstone. We've brought in a system

which is listed for discussion with the union later where we were expecting a person in what we call a double-branch station to train on duty. In those locations they are double branches because they have a higher case load. We changed the system because the training was being disrupted because the person who was on duty was training a group of 10 or 12 or 8 volunteers, then they would get a call and they went. So we changed the system so that we paid one of the colleagues. In a double-branch station there are four paramedics rostered permanently to the station, of whom one is on at any one time. We changed the system so that the one on duty is not the one doing the training. We paid them an overtime call-out and that has raised an industrial issue about the guys who work in the 11 rural branch stations. The technical aspect of the job is that they work four days in a row on day-shift paid time. They have four nights where they are paid on-call and they are paid overtime when they are called out. We give latitude on their duty hours, and in return historically the custom and practice arrangement is that they have done the volunteer training. You can ask Tim and Peter Hampton later. When a branch station increases in case load, how often does it occur that a person doing the training is then impacted. Is the training disrupted by the person -

Mr WILKINSON - No continuity of training; that is one of the arguments.

Mr LENNOX - Yes, and so what we are doing and part of our strength in volunteer training is to work out what is our highest priority, and our highest priority in volunteer training is the units that are wholly volunteer and at greatest distance. So if you are a crew responding to a case and you have a paramedic on board, then the level of training of the person with them is not as important 30 kilometres up the road where both the people attending are volunteers. So our number one priority was to strengthen the training of the most isolated communities: King Island, Flinders Island, Dover, Nubeena, Triabunna, Swansea. So they were our target highest priority, and then stepping back through those who work in branch stations. Historically several of the branch stations have trained the nearest volunteer stations, so some of our branch stations are basically a single-town branch station, but others form a sort of hub and spoke where they cover an area. So on the west coast we have a paramedic based at Zeehan. That is the lowest case load of any paramedic station in the State, but there is a hospital-based ambulance at Queenstown, a volunteer ambulance at Strahan, a volunteer ambulance at Rosebery, a volunteer ambulance at Tullah, a volunteer ambulance at Waratah, and there are also volunteers at Zeehan with the paramedic. When a call comes in on a west coast town, depending on the severity of it, we send the nearest crew and then we back the crew up with a paramedic who is going to that area. We have a similar model in the northern end of the east coast where we have a roving paramedic who is based at Scamander, but on any given day they might be at St Marys or Bicheno or St Helens, but each of those towns is a volunteer unit. So historically those groups have trained a wider group than their own, and we have been progressively taking them off them and training them externally.

CHAIR - I am mindful of the time. We have gone 15 minutes over, so if people could think of their final questions, please.

Mr WILKINSON - Helicopters bringing in people. What are the protocols for calling a helicopter? I say that because I was listening to an incident down at Bruny Island. I was on a boat and there was a call where a fellow got speared down at Bruny Island three or four years ago. The helicopter took an hour and a half or so to get there. A fellow down

at Simpsons Bay was speared by a branch off a tree, and it took ages for the helicopter to get there, and I heard all the people calling, 'When's it going to get here? What's happening?' In the end it would have been far quicker really to take a boat and have an ambulance waiting at Kettering and put him on that boat and get the ambulance to pick him up at Kettering. So can I ask you what are the protocols for calling in helicopters?

Mr LENNOX - Well, it depends. If we have a case in a rural area - in some cases we instantly put the helicopter on standby. If we have a multi-casualty incident then naturally we put the helicopter on standby. For Port Arthur we actually used three helicopters, two that weren't contracted to us because they were available and we were working with police. We have gone from doing about 25 cases a year by helicopter to doing 90 cases a year and part of that growth in utilisation is the availability of a better aircraft, one that can fly at night. Previously you couldn't send a helicopter if you couldn't get back in daylight hours.

Mr WILKINSON - What are the protocols, though? When you do you say, 'Yes, a helicopter has got to be there'?

Mr LENNOX - I'll send them to you, if you like. Off the top of my head, it is a scaled down situation. If the information is very clear cut from the scene that it is needed then we dispatch it, so we immediately alert the helicopter operator and a helicopter trained paramedic, and you have one sitting over here so he can answer that. One of the helicopter paramedics, the nearest available, is despatched to go and crew that. A police winchman crews it and they go. Sometimes we have them on standby while we are waiting for reliable information from the scene because the greater the distance then issues come into play of what is going to get there quicker.

Mr WILKINSON - Would you mind if we got those protocols, please?

Mr LENNOX - No.

Mr WILKINSON - The other thing is, is it ever governed by money; in other words, if you send a helicopter to a road accident MAIB no doubt would pay for that, whereas if you send -

Mr LENNOX - Not all of them. MAIB won't pay for a case where a person has been driving unregistered off road so we send to a lot of vehicle accidents, for example on the Strahan beaches -

Mr WILKINSON - Yes, but in a number of them MAIB picks up the tab, whereas sending it down to Bruny Island in this instance to pick up a fellow who was speared in the stomach, MAIB wouldn't have paid for that, the ambulance service would have had to pick up the tab. What I am therefore asking is, is where you send them ever governed by who is paying?

Mr LENNOX - It has been an issue in the past but it's not only just a simple issue of cost, it is an issue about timing of response and appropriateness of the response clinically and so on. One of the things about the helicopter is they are excellent for some functions and not as good for others. There are some patient types, for example, who are clinically inappropriate to send by helicopter because the helicopter is not pressurised so any

trapped air in a patient they are at risk of death to go up. For divers with the bends they fly all the way back to Hobart at sea level. Clinically sometimes - I can think of one case with a diver with the bends at St Helens - the communications staff are talking to the State's expert on that area of medicine, Dr Smart, about what's the right thing to do for that patient in that situation.

Mr WILKINSON - Am I right in saying that - and I am wary of the time but I don't want to cut you short - it was an issue in the past in relation to cost but that is not the case now in your belief.

Mr LENNOX - Well, partly an issue because some of the cases are not paid for by the ambulance service. We are using the helicopter by a factor of about five times more frequently than we used it before but the police pay for a range of cases - the helicopter contract is with police and they pay for cases. A person might have a broken ankle and they are in a wilderness area and the police pay. It is a health case and it is because of their role delineation; they are responsible for paying for cases where we can't get a road ambulance close effectively. That is the simple analysis, so the police pay and sometimes they might have a helicopter out for a whole day or two days searching and we've got a paramedic with them.

The grey area is where the money shifts - MAIB - but if it is a motor accident and the person is not covered by reason of drink driving, unregistered vehicle, unregistered driver, unlicensed driver or off-road vehicle, et cetera, then the ambulance service pay. Then there are others. If it is a workplace injury the workers compensation insurance pays and then there are some anomalies, if you like, so the fishing industry don't pay because of the way they are structured under the Workers Compensation Act.

Mr WILKINSON - Is it ever a case because of the costs involved with helicopters where there might be a volunteer on the scene, as far as the volunteers are concerned it is obvious that it is serious that you say, 'Hey look we can't do anything until we send out a paramedic to see whether it requires a helicopter or not?'

Mr LENNOX - We have a stepped-up process, as I said. You do not send your most expensive high-cost resource when it is not needed. What we have had in process over the last year was to finetune those protocols which I will send through to the committee. Going back in time there was definitely an issue about cost and clinical need and timeliness and some of the other factors where we might want to send it but you could not send it because of weather, you could not send it because of daylight, so no decision on deployment of the helicopter ever comes to me or to a finance person. The decisions about the tactical use of the helicopter are made by the communications officers with the supervisor of technical operations for that area.

Sometimes you have a debate particularly at range, say up around Scottsdale, of what is going to get there in time so the helicopter takes basically a hour to go from Hobart to Launceston. If you have your nearest ambulance within 10 minutes and it takes that ambulance an hour to drive to Launceston General, in that hour the helicopter is going to Scottsdale - it depends on your scene time. I will get you the protocols.

Mr WILKINSON - Finally, if I might, the Shugg and Fitzgerald Report, and I have not read it for ages -

Mr LENNOX - 1994.

Mr WILKINSON - Yes, set out a number of recommendations. Have they all been implemented?

Mr LENNOX - I have not got all of them at my fingertips but the key ones were to have an independence in the clinical review process which is achieved by the Clinical Council, the Ambulance Service medical officers. There was an issue that we delayed in implementing for a while with the clinical instructors having some off-road time to perform that function. They did not recommend extra staffing but the Government gave us extra staffing - some people thought they did but look through their report - so we started the stations at Wynyard, Kingston and Bridgewater.

Clinical audit - we needed to strengthen our communications - there was a concern that a couple of our communications officers were deficient in their skills and training, that has been addressed and all the systems in communications have been dramatically upgraded and I would certainly encourage the committee - Madam Chair is the only person here who has been there. It would certainly allay some of your potential concerns if you saw how the system worked in practice and I would encourage you to visit.

CHAIR - We might organise that.

Mr FINCH - In respect to the Royal Flying Doctor Service - you talked about the increase in the air ambulance being used, the helicopter. Where does this leave the Royal Flying Doctor Service? Where would they fit into the scheme of things?

Mr LENNOX - I will put an order of magnitude on it first. Last year we moved 90 patients by helicopter and 850 by air ambulance. They are not interchangeable modalities for a lot of cases. The helicopter is not an option to service the Bass Strait islands, the helicopter is not an option to take the critically ill interstate, so we are talking about critically ill patients with anything from spinal injuries to one last week to Sydney with a brain stem injury where there are only two locations in the State.

So the air ambulance is categorically always needed. We tend to move the longest distance by air, we service the outlying areas by air and we do the majority of the interhospital critical care transfers by air, that is 125 cases a year where there is a doctor as well as the flight paramedic.

Mr FINCH - Why wouldn't the helicopter do the islands, King and Flinders Island?

Mr LENNOX - Time. The aircraft flies at twice the speed, it is located closer to them and it is pressurised. The helicopter is not pressurised so there are some things clinically you simply cannot transfer by helicopter other than being at risk to the patient.

Dr BELL - If I can just add, you cannot look after a patient in a helicopter. It is too noisy, too small, too confined and it is a very dangerous place to put anyone who is seriously ill. So if you have a short distance flight for a helicopter to pick a patient up and get back to a hospital then that is a use for it. If you have an interhospital transfer of a

patient on a ventilator you are much safer in a plane and therefore the helicopter has a very limited role in medical retrieval.

Mr LENNOX - Where they are used internationally for retrievals is where you have small distances but huge traffic, like from one area of Los Angeles to another, or the huge cities, where we do not have that sort of traffic volume and traffic gridlocks where the road ambulance simply cannot do the distance et cetera.

Mr FINCH - So there is always going to be the need for that fixed-wing aircraft.

Mr LENNOX - Yes, and it is used at about nine or ten times the rate of use of the helicopter, and it is moving the people interstate as well, which is something that will always happen for the most super-specialised services.

Mr STURGES - If I could just come back a couple of steps. You were answering a question from Jim Wilkinson. I would appreciate it if I could get some figures. I think I heard you clearly that MAIB pick up some of the cases and workers compensation picks up some of the other cases, but for those who chose to break the law the ambulance service picks up the cost. That is what I have heard.

Mr LENNOX - They break the law in a vehicle.

Mr STURGES - Okay. I am not suggesting, by the way, that they do not deserve service. I am not going there, okay. But I would appreciate it - I do not know how long you keep your figures for - if for over the last, say, three or four years we could have a look at the figures of those occasions where through drink driving, unlicensed driving, unregistered vehicles, those cases that you cited, the number of cases that you dealt with and the costs associated with that. Would you be able to provide those figures?

Mr LENNOX - I don't know if I would be able to provide them. I certainly would get an indication. I don't know if our database would pick them up in that way, but certainly between us and the MAIB we will look at it.

Mr STURGES - I do not want to put you to too much trouble, but I think it is an area that -

Mr LENNOX - Knowing the way our financing system works, I do know that I will be able to easily pick them up, but at worst I can get you some anecdotal information.

Mr STURGES - I would appreciate that. Thank you.

Mr LENNOX - At best I might get some figures, but I will see what I can do.

Mr MORRIS - So you would be billing MAIB?

Mr LENNOX - We bill the patients with a form telling them to bill MAIB. We give them an MAIB claim form - this is for a motor vehicle accident - and a cover letter that tells them that they do not actually pay it themselves, they lodge their bill. We also do not get paid if they do not lodge their claim with MAIB. So that is another issue.

Mr MORRIS - Okay, so that warrants looking into further.

Mr LENNOX - Yes.

Mr STURGES - I would really appreciate those figures, anecdotal though they may be.

Mr LENNOX - Yes, they would be anecdotal at worst.

Mr MORRIS - Okay. We will probably come back to that once we have that bit of information.

CHAIR - Do you feel that you have had an opportunity to cover the main points you wanted to cover?

Mr LENNOX - Yes, and I am more than willing to take further questions when you have had an opportunity to talk to other witnesses.

CHAIR - Sure. Does anyone have a question they would like to ask at the moment?

Mr MORRIS - Just one quickly. Progress on the Sorell station.

Mr LENNOX - I expect you will have a government announcement.

CHAIR - I will have a word to you later, Tim.

Mr MORRIS - We have already had some government announcements.

Mr WILKINSON - In relation to staffing, a number of years ago - and I do not know whether it is still the same - there was a problem in relation to overtime and the amount of work that the volunteers were performing. In short they were tired, they were being called out over and above perhaps the normal hour week that they should have to be called out. Has that been remedied at all? I notice you said there were 27 extra people.

Mr LENNOX - Yes, talking about volunteer services, we have gone from having 430 volunteers to having 530. In the last two years we have had a growth. We have people who volunteer who realistically do not want to volunteer. They volunteered because they know that if they do not their town does not have a service, or a reliable service. So when we surveyed all the volunteers in this State and nationally, one of the features about ambulance volunteering nationally is that some of the people who volunteer do not want to volunteer. They do it because of service to the community. We had an issue in the last few months on Flinders Island because of the Flinders Island fires, and we said to the community, 'As a community you are putting too much pressure on this small number of ambulance volunteers, currently dealing with 13 new volunteers who have sought to join us'. So some people desire to do it, and some people - I think the longest-serving volunteer in the State has done about 39 years.

Mr WILKINSON - They have increased by 100. What about the paramedics? Do they suffer from the same problem, that is, over-work because, I suppose, of endeavouring to keep -

Mr LENNOX - We certainly had an issue going back a couple of years that was quite severe in which the Government gave us 13 additional jobs. We had a very strong issue at Kingston and Bridgewater and a strong issue for the paramedics who worked on the air ambulance. They were definitely getting severely fatigued, so staffing resources were increased there. We have an issue from time to time about meal breaks being missed for the duty crews and so on. You can get another perspective on that from the union. When I try to monitor the demand by station, certainly our busiest stations are not as busy as the busier stations interstate. Then to try to correlate that you have to understand the distance they are travelling to get to a hospital and how long a case takes because of the geography of our State. In Sydney you might be going to an outer city hospital whereas here we are bringing them into the city. I think our busiest station is around 4 000 cases a year; the busier stations in Sydney and Victoria are 6 500 cases.

Mr WILKINSON - Do you believe there are any deficiencies in the service?

Mr LENNOX - In the areas I would like to see strengthened, volunteer training is number one. The Government is looking at the issue with Sorell, which would cope with the growth on the eastern shore. Another area where I am looking at trying to improve service provision is an area not of large case load but a gap and that is the Cradle Mountain-Sheffield area. They would be the areas: volunteer training because you are trying to sustain 550 people across a range of locations; Sorell, which the Government is looking at in the budget context; that Cradle Mountain area, which does not have a large case load but volunteers are not there for those cases, they are there for the first response to the occasional life-threatening case. The other thing we are looking at is semiautomatic defibrillators in some towns.

Dr BELL - Grant, from a clinical point of view, if I could have access to more clinical outcome data from the ambulance service, which hasn't been possible in the last decade.

Mr WILKINSON - Why's that, Tony?

Dr BELL - I think it's just a matter of funding to computerise the clinical records of the patients so that we can determine how we do for people who have cardiac arrests and so forth.

Mr WILKINSON - Is that important as far as you are concerned?

Dr BELL - It is from my point of view. We do review cases and all cases do go to emergency departments as such and we have a good relationship with all the emergency doctors so we have some idea of what happens.

Mr WILKINSON - Do you believe that is a top priority?

Dr BELL - I think more the provision of services is a higher priority.

Mr WILKINSON - Grant, as to the training of volunteers, can you just clarify for me that the two qualified trainers are not permanently assigned to training.

Mr LENNOX - No. There are two permanent positions exclusively for volunteer training. There are 22 branch station officers in 11 locations, so two in each who have training as

part of their responsibilities. We also have some clinical instructors who do operational roles plus training roles and who supplement volunteer training and we have some paramedics who assist in volunteer training, some on a time-in-lieu basis and others on a cost-reimbursement basis or an overtime basis.

Mr WILL HODGMAN - Do the trainers travel all over the State?

Mr LENNOX - We run some courses centrally. So, if we have two new volunteers at Dunalley, one at Oatlands, one at Maydena and one at Dover and some scattered around, we might run one course where they are all doing the same thing rather than one person in a town needing training. But if we have a whole group, like say Flinders Island, we take the trainer to them and we train them when they want to be trained. So the first thing you ask a group of volunteers is, 'How do you want to be trained? Do you want to be trained in large lumps on full days like Sundays, or do you want to get it regularly once a week?' So they sit down and think about it and then we deliver what the majority want. We do some centrally, but it is best always done locally. We are about to put a computer in every volunteer station so that there is some web-based training, but that can never replace face-to-face training.

Mr WILL HODGMAN - The two that you have, is that satisfactory or do you need the third?

Mr LENNOX - As I answered to Mr Wilkinson, our desire in terms of the challenges ahead is to further strengthen volunteer training.

Mr MORRIS - Can you tell us a little bit about the decision making regarding the split between volunteers and professionals? What are the protocols associated around the decision making whether a station will be entirely volunteer or there will be mix of volunteers or professionals or it will be entirely professionally staffed?

Mr LENNOX - I suppose in the simplest terms it is population being served and case load. You would say for nine of the 11 branch stations they are there because of case load; at the bottom end, two are there because of where it is. So, for example, Campbell Town has a very low ambulance case load, Zeehan has a very low case load for a paramedic, but it is distance and risk factors. So the risk factors of high-speed collisions on the Tasman Highway, risk factors for mining, fishing, forestry and wilderness adventure activities on the west coast. No-one internationally has a standard of what to have, but effectively we use a rule of thumb where we have looked at double branches, say, at Kingston and Bridgewater where we have had 1 500 cases a year; we have some volunteer stations that do 40 cases a year. You look at the population case load, throughput of visitors and other risk factors and then the distance to the next ambulance resource. So if you've got another ambulance resource 10 minutes away it is no different to having an ambulance in Glenorchy and not one at Claremont. Whereas, when you have some towns literally competing against each other, we look at the risk assessment and the case load.

I think I have given the committee the case loads levels of every station. It shows they fall out into a system where the highest case load stations are all two-person salaried crews. There are three stations that are mid range, about 1 500 cases a year, and they have a paramedic on duty 24 hours a day with volunteers. The union might want to see

them progress through to being two-person salaried crews 24 hours a day. Then there are 11 locations stepping down, and the bottom ones are not much higher than some volunteer stations. Certainly in Western Australia, for example, they don't put salaried people if there are less than 25 000 people in a town. We have a much higher standard of service delivery in Tasmania. There are no clear-cut rules.

CHAIR - Thank you very for coming. It was very informative. We will be in touch about organising a visit to the communications centre. There is some information that you have undertaken to provide to the committee. Could you please provide that to the secretary.

THE WITNESSES WITHDREW.

Mr TIM JACOBSON AND Mr PETER HAMPTON, HEALTH AND COMMUNITY SERVICES UNION, WERE JOINTLY CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorp) - Thank you for coming along. You may have heard the comments I made to Mr Lennox and Dr Bell. Basically we are revisiting a reference that we received some time ago, so if you could give us an overview of where you see the ambulance service as it is today with reference to our terms of reference that would be really useful and then perhaps people could ask questions when you have had a chance to speak for a while.

Mr JACOBSON - Thank you, Madam Chair. I did go into some preparation beforehand and I have actually written up a bit of a spiel to go through. It was August 2001 when we in fact put in our initial paper. There have been some things which have occurred subsequent to that date, the provision of some new initiatives into the ambulance service, some changes to management, staffing et cetera, but it would be fair to say that we still see that there is a fair way to go in the provision of ambulance services in Tasmania. There are some critical issues that need to be dealt with both in the short term and in the medium term as well.

Just in terms of history - and Mr Lennox gave some history in terms of the ambulance service - in the 1980s the Tasmanian ambulance service was seen as the leader in the provision of ambulance services across Australia. We had a paramedic program that was certainly the world best practice, if you like, and certainly better than any service provision anywhere else in Australia. There was a real sense of leadership and achievement within the ambulance service both at the ambulance officer, volunteer, paramedic and management level, and it was certainly seen as a service on the move, if you like.

At the time the case load, not surprisingly, was about half of what it is today, and staff had plenty of time to work on basically their own personal development, the development of the ambulance service and the development of volunteering within the ambulance services. Night shifts particularly were not as busy, so the meal breaks, for instance, were not such an issue. There were not as many both nuisance and social factors as well impacting on the provision of ambulance services, and I will go into that in a little more detail. There is some anecdotal evidence in terms of the social factors now impacting on the provision of ambulance services as well, certainly information that is coming through from our members, that is of concern.

Not surprisingly in the 1990s, as I think happened to all government departments, the Tasmanian Ambulance Service suffered severe cuts in staffing and finances provided to the service. The ambulance service lost a number of supervisory staff, which limited career paths. Budgetary pressures seemed to change and we got less money and were certainly less certain about the future allocation and the future of the ambulance services and expenditure. In the short-term those financial policies and pressures were accepted by members, given that there was debate about the state of the funding to the Tasmanian community, but there were still frustrations around the way that funding was provided. As time went on it became the norm to accept what we believe were inefficiencies, the lack of research and development, watching other agencies in fact take the lion's share of funding rather than the ambulance service getting adequate funding, watching the fire

service in particular expand, having major projects delayed indefinitely, such as infection control measures and others, watching the fleet and radio network deteriorate, which has only recently been resolved, to the point where neither the fleet nor the radio network were reliable or functional. And I could go on and on with a number of the pressures, financial and physical pressures, that were provided on the ambulance service.

It has got to be understood that staff actually became cynical and morale plummeted during that period. Students who were enthusiastic about joining the ambulance service were given, by the rest of the ambulance service staff, about six months to have that edge taken away from them. It did not take long for that degree of cynicism that existed within the ambulance service to permeate through new staff that joined the services.

At the level of the senior officers - the senior officers of the ambulance service are regional superintendents and supervisors within the regions - all those people are long-term employees. The majority of the superintendents have over 20 years' service. They certainly know the job inside-out, but seem unable to impress to the Government about the dire needs of the service and the need to in fact progress a number of the major projects and, whilst there has been a fleet replacement program and a new radio system put in place recently, there had been an expressed concern in the ambulance service for many years prior to the implementation of those initiatives around the adequacy of both the fleet and the radio network. There were, for a long period of time, certain areas of Tasmania which could not be contacted by way of the two-way communication system. That is common knowledge but it was certainly a professional concern of our members.

Mr WILKINSON - It is remedied now.

Mr JACOBSON - It is remedied now to a large degree.

One of the concerns expressed by members as well is the fact that the CEO of the Ambulance Service is not a professional ambulance officer. It is perceived that on the basis of the appointment of the CEO that in fact the priorities of government were more economic than professional and focused more on finances rather than the professional development of the ambulance service.

Mr BEST - That is an issue of concern that you raise. It is interesting though because a lot of the comments or complaints that you have made are in relation to the financials, so would not that be something that might address some of your concerns on the financials, that you would have someone that might start to put things together in that direction.

Mr JACOBSON - Well, at the risk of sounding controversial, the CEO has been there for some time and the financial pressures have been there for some time. Largely speaking they have been unresolved for a long period of time. The major issues for our members are professional. There aren't, in terms of my paper, a lot of industrial issues that actually come out. They are focused on the provision of services to the Tasmanian community and the dire need to in fact address those particular services but in fact a significant number of our members believe that it would be beneficial to have a professional ambulance officer at the helm, someone who understands the pressures that occur on a day-to-day basis for those people on the road in order to pursue those more vigorously in fact with whatever government is in power at the time.

Mr BEST - So when you say long-term, how long are you saying this person, the CEO, has been in that position?

Mr JACOBSON - I can't answer that exactly. Around about 10 years.

Mr WILKINSON - Is there any professional ambulance officer in the higher echelons of management?

Mr JACOBSON - The superintendents of the regions are all ambulance officers, all paramedics, so in the senior officers' groups there are paramedics. There is a distinction between the CEO and the decision making that relates to the way that the CEO makes decisions and the senior officers of the ambulance service. The dichotomy, if you like, is that the CEO sits separate from what is an internal structure in the ambulance service - that is the senior officers group - and can make decisions autonomously from the senior officers group. Concern has been expressed that the senior officers group tends to get caught up in debate rather than decision making. At the end of the day it is the CEO that needs to make the ultimate decisions in terms of what the priorities are for the ambulance service and how the funding is in fact distributed when it comes through.

Mr BEST - What about other States?

Mr JACOBSON - There are a number of other States and I could not exactly tell you where there are professional ambulance officers who administer the service. I am not seeking to make a comparison. One of the concerns that we have about making comparisons with mainland States - comparing Tasmania with other States, New South Wales, Victoria et cetera - is that you are not comparing apples with apples. What we are saying is that there is a concern of our members about the person that is at the helm. There is a concern that more advocacy is required in terms of the day-to-day dilemmas that affect ambulance staff. In terms of response times, for instance, often mainland comparisons are made around against the response times in Tasmania, when in fact Tasmania is a more rural community. There are more difficulties in terms of access to outlying areas and a one-size-fits-all comparison with other States is not adequate because we are a different type of community for response times.

We have concerns that response times in Tasmania are extremely high, that it takes a long time in general for an ambulance to get to cases, that is affected by the remoteness of the Tasmanian community. We have been seeking to have a debate for some time with the ambulance service about what the protocols are with the ambulance stations that are currently there. There isn't a policy in place that states at what point you review a station in terms of its staffing needs or you review a particular community in terms of their needs around the provision of ambulance services - that is, what case load do you need to have in a community to require an ambulance service? When should that ambulance station be a branch station, a double-branch station et cetera? The majority of the discussions that we have with the ambulance service around the establishment of ambulance services in some areas, for instance Sorell, are based on pressure that comes through from our members about the amount of cases that they attend in those particular areas. The other difficulty we have is, when you get an ambulance station established, at what point do you have a review, and on what data do you determine, whether that station should be upgraded et cetera.

One of the issues that was raised earlier was the use of volunteers within the ambulance service. It would be fair to say that we accept the use of volunteers. We are extremely supportive of volunteers. In fact it is the union's members who train and work with volunteers on a daily basis and there is certainly no concern about the use of volunteers in Tasmania. What is of concern is that the community really has no understanding of the difference in the type of training that volunteers have and the level of care provided by volunteers as opposed to paramedics. It is our view that the service exploits this by placing volunteer ambulances in areas where they may well be of little value and therefore appeases the community concerns about the lack of an ambulance service in their area. Unfortunately there is this perception that a white truck with a red light on the top signifies that help is on its way, but people don't understand that the people who are in that truck may well be either highly skilled or less skilled. There is a degree of comfort, as I have said, merely in having an ambulance, rather than getting in underneath and having a look at the type of training and the support that is given to those people.

Mr WILKINSON - So what are you saying, Tim? There needs to be more training or better training or a bit of both?

Mr JACOBSON - There are issues that relate to training. We have concerns in terms of accreditation and reaccreditation of a number of staff and the provision of training programs to the professional ambulance staff. We also have concerns about the increasing reliance on volunteers to provide services to the Tasmanian community. Volunteers on some occasions are in fact moving into metropolitan areas because of staffing problems we have. There are concerns around the fact that there isn't a staffing model, if you like, for the ambulance service that would indicate in a proactive way what the staffing needs are into the future. In our view the ambulance service operates on the basis of a minimum staffing establishment. There have been occasions of late where in fact there has not been a paramedic rostered on a shift on the north-west coast, which is of concern to us. As I said, there is that increasing reliance on volunteers to back up services. In fact, whilst there have been additional staff put in place over the last few years, it is important to understand that those staff in the first instance were put on to address fatigue, but since those staff were put on there has been an increase in the cases that the ambulance service attends. The additional positions that were put in place more recently were well overdue, to implement a 38-hour week for ambulance officers. They are some of the last public servants in Tasmania to receive the 38-hour week. So those resources haven't necessarily gone into addressing fatigue issues. We know that there is still a significant level of overtime; there are still difficulties in terms of filling rosters. We believe the only way that that can be really addressed in the medium to long term is to develop a proactive way of determining and seeking to determine what the minimum and the future need of the ambulance service is bearing in mind that it takes some time to train an ambulance officer up to the required level, certainly to get them on road.

Mr STURGES - I am not sure whether Tim wants to give his submission and then we ask questions.

CHAIR - Well, it might be easier if we wait until the end. Are you happy to wait until he has concluded?

Mr STURGES - Yes, I am.

CHAIR - Is everyone else happy to do that?

Members - Yes.

Mr JACOBSON - If I just touch on some of the issues and without boring you -

CHAIR - We are going to get a copy of this, aren't we?

Mr JACOBSON - I can provide a copy of this.

There are some major issues. As I said, the lack of forward planning in terms of requirements in recruitment of staff. There have been historically major delays in terms of the implementation of important projects of fleet, the new computerised dispatch system, the new radio system, et cetera. There has been and is some secrecy around the volunteer budget and the budget provided to volunteers and to the training and development of volunteerism within the ambulance service.

There is obvious and has been obvious concern for many years about the fact that the ambulance service is run on more economics than service delivery and the frustration around the fact that what we come down to often are discussions about service delivery and about the services that the Tasmanian community require but what sort of dollars there are and how those dollars should be distributed equitably, and unfortunately service delivery and our expectations are comprised from time to time based on the funding for the service.

There are, as I said, problems with training and the lack of training courses are certainly concerns around reaccreditation of ambulance staff. There are, since the eighties, certainly a double in the callouts required in the ambulance service without a contingent increase in staffing and there is no doubt that ambulance staff are working harder and certainly working smarter than they ever did before and that is to their credit.

There is a major issue now coming through in terms of the social factors that are impacting on the provision of the ambulance services. There has historically been a level of nuisance calls, if you like, and the ambulance service has found it difficult to deal with those nuisance calls but more recently there are a range of social factors, particularly in some of the lower socioeconomic communities, that are having an impact on the provision of ambulance services. Unfortunately some members of the community do call an ambulance because it is the only way of one seeing a doctor, not having to pay the doctor's costs which will become an issue in the future but also an impact in terms of transport and the fact that unfortunately some people cannot get to a doctor and use the ambulance as the next best way of getting to a doctor.

The deinstitutionalisation of mental health and disability services, community integration has had an effect, anecdotal I can only say, there has not been any major research into it but certainly information is coming back to us in terms of the level of effect that those types of projects are having on the provision of ambulance services and the level of unhelpful calls that come through and cases that are attended which may not necessarily have required an ambulance.

Over the time the ambulance service has changed in terms of where it fits within specific departments. Most recently the ambulance services fitted within the confines of the Department of Health and Human Services. There has been very poor integration between the ambulance service and the Department of Health and Human Services. Unfortunately the ambulance service is seen as an adjunct to the department rather than an integral part of it and in fact the concerns have come down to simple issues like the provision or the swapping of equipment. If a piece of equipment is used in an ambulance and in fact a similar piece of equipment exists at a hospital the ambulance service cannot access that or has not been given access to that equipment over time simply because there is not a sharing of resources in that respect. There has been some attempt to resolve those simple things over time. It has taken quite some time to resolve some of the sharing of resources and greater integration. There have been some issues over time that we have raised in relation to major outbreaks and information that has come back to the ambulance service around some communicable diseases in the community, the fact that some of our members have attended cases and it is only through either reading the paper or second-hand information that they have become aware that they have handled or that they have operated in an ambulance where someone has had a communicable disease. In one particular case where there was a meningococcal case, our member was not aware that they had transported that case and that they may well need some medical intervention following it until they read it in the paper. There has been very poor integration of information flowing backwards and forwards from hospitals to the ambulance service over time. We would have thought when the ambulance service was integrated proper into the Department of Health that those things would have been resolved.

There are concerns around the senior officers group and the decision-making capacity of that group within the ambulance service. There are historic problems in terms of, unfortunately, personality problems between some of the players in the senior officers group, which has led to problems with making decisions. That is of concern to us. There are problems with equipment and the lack of suitable equipment and that as a back-up we are still using 1985 defibrillators, for instance, that whilst they might be a back-up they can be used from time to time. They are very old equipment and we don't believe it is acceptable. It did take some time, for instance, to get some equipment in place - simple equipment, spine boards, for instance, which are the boards which slide in under a patient; they become soiled and in some areas there weren't adequate facilities to wash those spine boards until very recently.

The other issue that is of concern - and it has been raised - is the helicopter and the budget that is allocated to the helicopter. We do know there is funding for the provision of helicopters externally to the ambulance service. We also know that there are financial pressures on the ambulance service and we wouldn't want to see a situation where financial pressures impact on the utilisation of the best and quickest form of first response to a patient. There are concerns, based on financial considerations, that the helicopter particularly isn't used to its greatest extent. A budget that is set aside specifically for the provision of helicopter rescue would certainly be welcome so that there aren't pressures put elsewhere in the system where the helicopter is used.

In terms of what we see as the major impacting factors, there hasn't been a specific strategic plan put in place for the ambulance service or review of a strategic plan for some time. There doesn't appear to be any proactive stance taken by the Government or

the management of the Tasmanian Ambulance Service and the ambulance service's future direction. There doesn't appear to be a desire to do things better and smarter, to have a look at what exists elsewhere, to adopt best practice and put it in place in Tasmania. We are continually frustrated by the level of funding and the capacity for the ambulance service to deliver on what are, we see, the major factors impacting on ambulance service provision in Tasmania. There are major issues that take too long to fund, which I have already touched on. There are problems in terms of the internal management and the way that decisions are made within the ambulance service and the lack of constructive and effective debate around issues that affect the service. Unfortunately what we get down to often are discussions that really lead nowhere. I guess the best word I could use is sophistry, if you like, where we engage in discussions but really we go nowhere. We have these circular discussions around particular issues but no real action. I have to say that in fact the budget has an impact on that and there is frustration across the ambulance service about the capacity to put in place certain initiatives based on budget.

As I have already said there are problems or concerns about the use of volunteers and the over-reliance of volunteers to provide services to the Tasmanian community. There must be a model put in place in terms of service delivery and how services are distributed in the Tasmanian community, how ambulance services are determined, how ambulance stations are established and how they are reviewed over time. That is certainly something that we see as critically important and will certainly put in place some transparency in terms of the way that ambulance services are provided in Tasmania and that those services will be provided on evidence rather than political imperatives.

There are, and it has already been stated, some concerns around the capacity for the ambulance service to do specific research on particular projects, to have a look back, to have a look at what was good and what was bad and what we could do better. There is a need for more funding to look at the development of skills, drugs and procedures to keep pace with technologies and with other ambulance services in Australia and overseas. There was a patient-satisfaction survey that went out that Mr Lennox referred to. I guess from our members' perspective that was flattering but one of the issues that we certainly would have liked to see come out of that was some hard data, if you like, in terms of what the realities are in the ambulance service and a review or a survey of the ambulance staff in terms of what they believe were the major imperatives. But there is no doubt that patients would be, in our view, satisfied with the level of services that are provided. We believe that our members provide the best possible quality service under the circumstances, but there is a problem with morale, efficiency, progressiveness and effectiveness within the service that needs to be addressed as a matter of urgency and importance. Perhaps I will leave it there.

CHAIR - You have raised numerous matters here and I don't think we've allocated sufficient time to deal with all the issues that you have raised. I am wondering whether you would both be willing to come back. In that case, could I ask members to keep their questions now pretty concise with the understanding that we will have Mr Jacobson and Mr Hampton back as soon as possible.

Mr STURGES - Chairman, given the fact that Mr Hampton and Mr Jacobson are coming back I will ask one question and it is in line with the terms of reference given to the committee. Either one of you can answer this. I have heard a lot of comments about

training, allocation of money, budget constraints and what have you - and I also heard comments made about the CEO, that wasn't missed - or what is HACSU's opinion of the general administration of the ambulance service in Tasmania? That will be my question for today and I will have a few more next time.

Mr HAMPTON - I suppose that being a paramedic for 20 years and listening to what Tim has said, a fair amount of the 1980s work time was quite enjoyable and we had a real sense of achievement through that time when the paramedic course was invented and brought into Tasmania. There were other services doing paramedic work but we came in on it fairly quickly and of course we were in front of some other States and still are today. The sense of achievement was quite good. During the 1990s we got a lot of cut backs. We accepted, from the union's point of view, the Government's dilemma with its funding but we took it fairly hard. I suppose at some stage we expected, as a union, as employees, that things would get better if we took the nasty medicine. So when things are still difficult and funds are not there, we wonder what is going on, what is this smokescreen? We are not particularly interested in debating where the smokescreen is coming from, because surely people must know about some of these major projects - such as fleet, which was falling over on a daily basis about three or four years ago. But, still, the time-frame in getting these projects done and fixed was just too long, and if it was not for the goodwill of the staff things could have been a lot worse. There was so much cooperation needed. When a vehicle breaks down we do not have any spare gear, so one truck has to be stripped and the components put in another truck, usually an older one, at least one that goes, and so on, and that process was going on daily for two or three years. So I am mindful of the fact that I have my boss sitting here behind me, and I do not wish to be too controversial or derogatory, but you would see what I mean. There is a smokescreen here. Either our managers are asking for money and politicians are not giving it to us, or someone is saying everything is fine there. So that is my opening comment about what I think of the general administration.

Mr JACOBSON - Can I just add to that? There is no doubt that when you have a look at the management structure within the ambulance service and the duties that are assigned to each of those managers, there is far too much work, at a managerial level and simple managerial practices, budgeting, clinical service provision, monitoring et cetera, required of all those people. At the top there are essentially four people that provide that leadership to the ambulance service. It is inadequate and there needs to be a more robust system put in place to deal with those issues. You have the CEO having to get involved in issues in relation to the development of a tender for the fleet, radio, having to negotiate an enterprise bargaining agreement, having to deal with staffing issues on the ground. It is not a big service but there is just too much work for those people who are in fact charged with those duties. The regional superintendents are charged with developing and providing leadership in their regions, but are also getting sucked back into some of the central issues and some of the central work that is required for the provision of ambulance services in Tasmania. There are simply not enough staff to provide the type of support that is required in the ambulance service.

Mr STURGES - Is there any formal consultative process with staff and/or the union on an ongoing basis to discuss these concerns that you have raised about the administrative issues?

Mr HAMPTON - Yes, there has been, and Tim and I have both participated in a number of committees, and I feel that these committees are set up with a lot of enthusiasm. We do a lot of hours, we do a lot of work in conjunction with management on those committees, but we never seem to be able to kick the goal. It is just not possible for me to know why that is.

Mr WILKINSON - Number of possessions to goals - sounds very much like footy stats.

Mr HAMPTON - Once we come up with a policy, and we design what we want, it has to be funded. Once we start talking about funding, the committee doesn't meet and it just fades away, similar to what we were talking about before with volunteer training. My first job and my first responsibility is to be a paramedic and that involves shift work and training. I am probably not doing as much training these days as I used to, when you have a young family and have to put your priorities into their education. It is not convenient for me and anyone else working shift work to actually start going to day-time meetings. We have done hundreds of them, and we still do not feel satisfied that we have been able to finish off a number of projects. I can give you examples of those.

CHAIR - Perhaps that information could be brought to our next meeting.

Mr JACOBSON - I would probably be a little bit mindful that I have sworn an oath. I haven't actually done that before and I am probably a bit unprepared for that exact information, if that is what you want.

Mr STURGES - Well, you are coming back again so we can get some examples then.

Mr WILKINSON - I have a raft of questions; I will not ask them all now. But what I would ask is if it is okay if it write all the questions out and then send them to you?

CHAIR - Could we do that formally through the committee, to bring that information back?

Mr WILKINSON - Yes, sure. Just one question, without asking the raft of others, there was the Fitzgerald and Shugg report no. 1 1994, as I understand it, then after that there was the Targett report in 1999. Has that report been made public?

Mr HAMPTON - I am not aware if it was made public. I would have to say I cannot remember whether in fact I got a copy of it. I can't answer that question.

Mr JACOBSON - But bear in mind the Targett report didn't set the world on fire. There weren't any really major changes to the way that the ambulance service operated coming out of that. There were some changes. There have been some good things that have happened in recent times. The unfortunate issue for us is that they are long overdue. The provision of fleet, some equipment, the radio transmitter, the new configured despatch system are all great but unfortunately our members who advocate in those areas and who want those types of systems implemented are very cynical about when they are implemented because it has taken so long and is well overdue. With the fleet replacement, unfortunately we are in a situation, as Peter said, where on a daily basis we have ambulances - trucks we call them - breaking down. On one particular day I think about 10 ambulances broken down in the very hour we were sitting in a room with the ambulance service debating the fleet and the fact that there needed to be funding put into

it as quickly as possible. And unfortunately when they are implemented it is seen with some cynicism. It is long overdue; it took the ambulance service too long.

Mr HAMPTON - We understand that some of these issues we are bringing up have been fixed but we are not confident that the processes and how they were fixed are satisfactory or reliable to continue fixing them in the future. There seems to be a lot of pressure put back through to the union to make noise to get the funding, which is difficult. It is not what I would like to be doing; I have other things to do, being a paramedic.

Mr WILKINSON - I can see the stresses with you there. Are there any officers out on stress leave? If so, do you know how many?

Mr HAMPTON - I don't believe there are any, certainly not in the southern region that I work in.

Mr MORRIS - There are two things I would like to ask. One is regarding the funding: at the moment there is a very heavy reliance on the annual Budget from the State Government. Would the union like to see a move to have a situation whereby the annual funding or at least a significant part of the funding came from a source that had a little bit more reliability? Now that there are a number of stations co-located with the TFS, how do you see the comparison between the two services? I have seen a situation where the TFS has managed to have ongoing, apparently significant, funding available to it. It has benefited from the so-called insurance crisis. A significant part of its funding comes through the collection of the fire service levy at rating. Would the union like to see perhaps that fire services levy be changed over to an emergency and services levy so that the ambulance service was guaranteed a certain amount of funding from there or some other type of system that did that, or would co-payment or a patient payment system be preferred?

Mr JACOBSON - It's an interesting question you ask and it's one that we're right in the middle of debating internally so I can't give you a yes or a no in terms of whether in fact we'd be happy to see a levy. In terms of co-payment or systems that exist interstate, I certainly wouldn't be advocating any of those systems because some of them have failed and don't deliver outcomes. We would like to see a secure funding source come into the ambulance service. As I said, the way that funding comes in is something that is open to debate amongst our membership at the moment. There is no doubt, because of the co-location with fire, some envy expressed at the level of funding that the fire service has, the level of support, the level of facilities and equipment, training et cetera that goes into the fire service, which our members do envy -

Mr BEST - What are the priority issues, without going into them in detail because I know you are coming back a bit later, that you say you need fixing or you need funding for?

Mr JACOBSON - There are a number of priority issues. We see the internal management structure of the ambulance service being reviewed for additional resources et cetera as an urgent priority.

Mr BEST - So internal management review, you are saying.

Mr JACOBSON - Yes. But, having said that, that's not just a review of management, that's a review of the level of resources provided against what's actually required of the service.

Mr STURGES - And would that go to look at the policies and practices of the service?

Mr JACOBSON - Yes.

Mr BEST - So review of resources, policies and practices?

Mr JACOBSON - Yes. I guess second to that is the need to plan proactively the way that services are provided within Tasmania and tackle head on, rather than in a reactionary way, the crises that exist. We don't want to end up with the crisis that we had with the fleet, for instance, but we need to have a look at where the future services should be provided from. We had a major debate with the ambulance service over 12 months ago in relation to the ambulance station at Sorell. Those sorts of debates shouldn't happen in a public forum. There should be a system put in place that will ensure that, where there is the caseload and the demand, it is addressed in a proper way without having to have an argument in the public forum about where ambulance services should be provided. Those arguments, in my view, whilst they had to be had, unfortunately, don't do anything to boost confidence.

Mr BEST - It's not that I want to cut you short, I just want to know that those are the two priority areas that you have. Are there any others?

Mr JACOBSON - On-road staffing.

Mr BEST - So there are three major areas that you have?

Mr JACOBSON - There are a number of other areas but these are the major ones.

Mr WILL HODGMAN - Have you got a current audit or appraisal of your fleet and its status? I may have missed if you mentioned that.

Mr JACOBSON - There is a fleet manager that has been put in place. The fleet is being moved around for the first time. We didn't have a fleet manager for many years and that's why the fleet ran down. That position was lost in the early 1990s. There is a fleet manager and the fleet is being reviewed. There needs to be not only a one-off capital expenditure on fleet, which is our concern. There has been a lot of money put into the fleet and there needs to be ongoing funding to ensure that that fleet over the years is maintained at a high level and that we are not run down to the point that we were run down to a few years ago.

Mr WILL HODGMAN - Will you be able to quantify that and, just out of interest, have you made a submission to the Government with a view to this year's budget?

Mr JACOBSON - No.

Mr WILL HODGMAN - Would you be able to quantify these sorts of funding constraints that you have?

Mr JACOBSON - Well, unfortunately, we don't have access to the data that the ambulance service has access to. We operate on the basis of anecdotal information and the pressures that come out on the job. What needs to be noted I guess is that we are an industrial organisation and nine times out of ten the arguments that we have in the ambulance service aren't industrial; they are professional and they are based on the types of services that the ambulance service provides, the frustration of our members in terms of their capacity to provide patient care rather than their industrial needs; pay rises, workers compensation issues, et cetera, which is the union's bread and butter. Unfortunately we do not have access to a lot of the data so we cannot put a major submission in but certainly they are issues that are minor.

CHAIR - Thank you very much. I am very sorry - I feel like we are cutting you off and I do not want that to be the case. Our secretary will get in touch very soon and arrange a time that is agreeable to you. There seem to be quite a lot of questions that members want further information on so we will compile those and pass them on to you, if that is agreeable.

Mr JACOBSON - Sure, that's fine.

CHAIR - Thank you.

THE WITNESSES WITHDREW.