**THE PARLIAMENTARY STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON TUESDAY 14 JUNE, 2003**

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**Mr PETER BERRY**, ACTING PRESIDENT, AMBULANCE EMPLOYEES SUB-BRANCH WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED AND **Mr TIM JACOBSON,** HACSU, WAS RECALLED AND EXAMINED.

**CHAIR** (Ms Thorp) - Thank you very much for coming back to us and I do apologise that we needed to cut you short last time but we had a busy timetable.

We aim to be finished by about 2 p.m. today and then we have a couple of other agenda items to deal with but, as I said, it's not set in concrete.

**Mr MORRIS** - Just remind us exactly where we left off, because we have a number of questions that we want to ask.

**Mr JACOBSON** - I know that there are a number of issues outstanding from our last meeting. What we did following that meeting was to put together some detailed information, so it might be better if I go through that first. I may well answer some questions as we move through.

**CHAIR** - That sounds good.

**Mr JACOBSON** - There is some information that we would like to tender to the committee in camera. In that context, it might be better to bring on the in-camera issues first and briefly discuss those, then perhaps move on to the formal process.

**CHAIR** - Okay, fine. We will go in camera.

**Mr STURGES** - Sorry, Peter, I do not want to take your line of thought away, but are you suggesting that the supervisors do not have a clinical background? I hear that?

**Mr BERRY** - No, they do. All of the people currently in supervisory positions have come from a paramedic background - usually. But I know supervisors who have been in those jobs for a number of years and my view, and a view of a lot of the members, is that the management line, if you like, is weighing up clinical need against cost.

**Mr STURGES** - Without sort of dragging this on too much - I think that it is appropriate to ask this question - are the supervisors regularly retrained and updated with current procedures and requirements in order that they can make the best-judged decision at the time.

**Mr BERRY** - Formal training, no, but the supervisors regularly work shifts on road to keep their skills updated. They do not work as paramedics on the road; when they go on road they are working as qualified ambulance officers because they have been out of the paramedic program for a number of years.

I am not saying that they don't understand the clinical need but they are weighing the information - 'Well, let's get someone at the scene and have a look first before we actually fly the helicopter'. We go to prangs in remote areas and put the helicopter on what we call stand-by, which is activating the police crew and our officer. They go to the airport and they are ready to fly.

**Mr STURGES** - Thanks, I understand now.

**Mr BEST** - Can I just follow on that because I heard during the Estimates about the air ambulance services and I seem to recall - I do not have the exact details in front of me - that there was some mention about the suitability of a helicopter sometimes because of the equipment. The helicopter may not always be suitable because of the equipment, the noise and vibration and other factors -

**Mr FINCH** - Pressurised cabins.

**Mr BERRY** - Yes, pressurisation and the fact that generally the helicopter is geared primarily for one patient and is used for areas where we need to have a quick response and a quick retrieval. The RFDS does, as you heard from Mr Lennox in the previous hearing, by far the greatest amount and that will continue. The helicopter is used in a different way in that if it is a trauma or whatever in a remote area that is going to take the long road response, to and back, then it is probably appropriate that a helicopter be used. In some - probably all - of the mainland States they have set zones of where they respond with road vehicles only, to and from, and where they will respond with flight retrieval solely - whether it is fixed or rotary wing. The Illawarra region in New South Wales - I visited there a few years ago - is a long, narrow corridor and they have three zones. Zone A is just road response/road retrieval, zone B is road response/air retrieval and zone C is air response and retrieval. It is purely on transport time.

**Mr WILKINSON** - Do you believe that there is any forwarding planning in the service? That is where technology be in 10 years' time, what new skills should we be equipped with and what are other States doing? My information says - and I could be totally wrong - that there is no real planning from management other than, 'Well, when are you going to retire?' - that is the forward planning. But there is not that forward planning in relation to upskilling yourself. Is that right?

**Mr BERRY** - We have no research and development at all.

**Mr WILKINSON** - Can I just finish then by saying do you believe that there should be forward planning and if so what should that forward planning be?

**Mr JACOBSON** - There isn't. There should be. The Ambulance Service operates in reactionary mode but even in terms of the recruitment of student ambulance officers the only snapshot that is taken is really a gut feeling of what we need right now and what the foreseeable need will be in the next 12 months or two years - up to three years because of the training. Now invariably positions become vacant and that causes a problem. I have a specific statement to make in relation to that, particularly because of the implications that has on overwork, workload, overtime, et cetera.

You cannot just fill a position on a roster, it has to be filled. You can't run a crew out of an area without the crew running and the crew needs to be there. The service has been established, the base for minimum staffing levels are there right now and if we fall below that someone has to work from that particular catchment area and the only way that that can happen is through the use of overtime. There is an extraordinary and unacceptable amount of overtime in the Ambulance Service.

**Mr WILKINSON** - Okay.

**CHAIR** - Are you right? Do you want to do a quick synopsis of the questions that you are going to ask and then perhaps -

**Mr MORRIS** - There is only one question and it is actually a very general question and that is just briefly what is the union's general opinion in relation to the administration and so forth in the Ambulance Service? We heard from you last time that there was a problem potentially in discussing some things in front of the boss. Here is your chance.

**Mr JACOBSON** - Certainly it is helpful to be frank on that particular issue and there are a number of areas and perhaps the best one to focus on is the dispute that we had in relation to the Sorell Ambulance Service and the way that the decision was made. We touched on that in the hearing last time. The Ambulance Service has this view that the service and the union work closely on a number of issues - and it is fair to say that we do sit across the table from the Ambulance Service on a regular basis and we talk through issues. But the fundamental problem is that when we get to the point of outcome, the point of decision, it does not occur. There are a number of areas where that has happened. When we ended up at the Industrial Commission as a result of the Sorell dispute, there were a number of factors that came out of that. One significant issue was a recommendation that we took back to our membership, and was endorsed by our membership, that we would lift the bans and agree to a number of things. Not all those things were things that we were particularly happy with but we agreed to enter into them.

One of the issues that we were happy with was to talk about the resource allocation within the Ambulance Service. The Ambulance Service set up a committee - and if you ask any ambulance officer or paramedic what they think of committees, they will laugh. There was a mountain of information that was provided to us - statistics and so on, in terms of case load. Our position was that what we needed to do was basically have a look at it on a scientific basis, not on a partisan basis, not on the basis of whether we felt something or the Ambulance Service had a gut feeling about something else or what the community thought. We set up a process where there would be some analysis of what the needs were, in terms of where the resources go. Then, once that is conducted, that we sit down and talk about the implications of that. There has been resistance to that and in fact, as a result of the resistance, that committee just ceased to meet.

**CHAIR** - What was the name of it?

**Mr JACOBSON** - It was called the Resource Allocation Group and it is a bit of a joke. That committee took off, we thought, as an excellent opportunity for us to sit down and look at the forward development of the Ambulance Service and the community. A number of issues were discussed in that committee, particularly around some of the benchmarks that have been established through the Tasmania Together process. One of the issues that we talked about was, for instance, having appropriate schools in those regional areas, having proper paramedic schools and having paramedics in particular branch stations. We talked about a staff rotation policy. But we actually got to the point where we were almost at lift-off and it died. It is fair to say that occurred even on the simplest issues. For instance, we spent two years talking about two uniforms. But committees die; they lose their impetus, they lose their meaning, but we are constantly in this committee process where we regurgitate the issues. We have the arguments. The same issues are raised and the same arguments and it is not surprising that members get extremely cynical about it.

The other issue in relation to that as well is that, in terms of the union, and its capacity to participate in those consultative committees - and we do it regularly, we do it all the time - is that any time our members spend on those committees - and, frankly, our members are the experts; me, as the Assistant Secretary of the union and the industrial officer for the area, I am not the expert - requires a significant commitment. They do it in their own time. They resource it in their own time. They meet with the union in their own time. There is not any paid time in the Ambulance Service for union representatives or delegates - what we call ambulance employee sub-branch executive members - to conduct any of their duties during paid time. The only time that they can is when management calls a committee. So what does that mean? We go to the committees in paid time that management want us to sit on but it is extremely difficult to get members to committees that we want to establish, simply because of the cost to the employee of that. In terms of our executive members, it is not only the financial cost. You should bear in mind that on particular days, because of the overtime, they may well knock back an overtime shift if they are on a day off. So it costs them $250 or $300 to attend a committee meeting that goes nowhere that day. Also, that has a burden on their time with their families. These issues are being raise din a number of forums at the moment. That is specifically and significantly in the Ambulance Service, particularly when you look at the high incidence of overtime. We went through a process about two and a half years ago -

**Mr BERRY** - Just to expand on what Tim was saying with the committee work and the involvement that the union executive has, most of what we deal with is not to benefit the members, effectively. A lot of our work is trying to improve the quality of the service that we provide, improve the service delivery to rural and metropolitan communities. There was very little of the time that I spent - and Peter Hampton who is having a well deserved break now, after banging his head on a brick wall for years - that benefits our members in the pocket or in any other direct way. A lot of our efforts are to benefit service provision. It is as frustrating as you would not imagine; to spend time and time on these committees and Resource Allocation Group, uniform committees and our wilderness committees. All of these exercises that we get drafted off to, to come up with draft policies or guidelines that go nowhere.

One of the things close to my interest is driver training. I have been a driving instructor with the southern region for five years. Four years ago, a group of eight of us instructors from around the State went away to a workshop with the task of providing policy and guidelines as to the driving standard. The service has adopted and paid for a driving model, provided by one of the States - the leading driving experts, if you like. We train that model and it is in-built within that package as an effort to change the driving culture of our staff - both career and volunteer. We went away for a week to provide this guideline and draft policy. It came back to the senior officers group and sat on the table for two years. No action was taken on that at all until there was some political pressure brought to bear by the volunteer association group, who run some driver training. The response to that was, 'Go out there and train the volunteers. It doesn't matter what you give them, just get out there and do it'. So we put together a compromised package of an eight-hour day to deliver to a group of eight volunteers on each day, compared with two weeks in school and four weeks one-to-one training for a career officer. You can imagine what level of training you are going to get on an eight-hour day. So we did that I think about two years ago and in the southern region we trained about 130 volunteers. But we could never go back and test to see whether what we had taught them was beneficial, so it went nowhere. Two years ago we had another driving instructors' workshop to provide more policy and further guidelines as to how the service wanted to have their driving going, as far as matters like acceptable upper limits of speed, blood alcohol levels and so on. We, as a group of instructors, said zero-zero.

How often do the officers get trained? At the moment we do not have any refresher training or review so if you come in as a student - which will happen in September when we take a new group on - you will receive driving instructions and that is it at this point in time in your career. So we worked our bums off really for a week, again, and provided more policy, guidelines and input to what we felt was the best way to go with a driving policy for the service. It sat with the senior officers group again until early this month. A new group has been formed called the Driving Review Group, which is made up of 10 people around the State, from superintendents to users to driving instructors - we have a union rep on that program. Fifty per cent of the tasks that they have been given have already been done. This group has been budgeted about $15 000 to go and rehash a lot of what is already in place that has not been acted on. This is the sort of thing we were saying - that these groups just go on and on and either die a natural death or, when the answers get too hard, the recommendations are not acted on.

**Mr MORRIS** - I would just like to follow up on that a little bit. How many committees or groups are there that you are actively involved with, that you are actually a member of? I am talking about committees that have not come to a conclusion, either ones that are active currently or ones that are in abeyance. You may not have the answer now, you might have to go away and think about it a bit, but could you provide the committee with perhaps a list of those groups or committees, what their references were, whether they are active, how long since they last met and what the outcomes are?

**Mr JACOBSON** - Perhaps I can go back and get some more information. I am probably cutting it a bit short here because there are a couple more, but there are committees that we have been involved in that have not reached any major outcomes. There is an ambulance consultative committee that is supposed to meet on a regular basis but meets on an irregular basis as a response, usually, to issues or the need to meet for whatever reason. There is a wilderness committee that has been meeting for some significant time now but still has not reached any outcomes in relation to certain things. There is the Resource Allocation Group which, as we said, has pretty well died a natural death. There are some issues that have come out of that which are still being worked on but the significant issues have not really progressed any further. There was the uniform committee, which went on for about two years. It did reach an outcome but after two years it was a bit of a low point. The outcome was not significant in terms of those matters that we wanted to revise.

Just by way of example, one of the issues that we wanted to deal with on the uniform committee was the issue of outer garments. Currently, when you are employed in the Ambulance Service, for the length of your employment you are issued with a fibre pile jacket, which is like a wilderness wear jacket. That is the only outer garment you could have so if that soiled you really do not have another outer garment to put on. One of the issues that we wanted to be certain to work through was issuing a further outer garment because obviously there were occupational health and safety issues in relation to that. We got nowhere. Obviously, it is not an issue that you would go out and have a major dispute about but it is certainly an issue of principle and of common sense that really was not progressed. The costings were done; it was not a significant cost. The compromise was that the Ambulance Service agreed on a type of jumper to wear but the jumper could only be purchased at the employee's own expense. So that was really the only significant change. The badges changed. We did some things with the headwear. We used to have akubras. Obviously akubras are now not fashionable and they are not practical in terms of wearing. We looked at a more broad-rimmed hat and a cap, I think.

**Mr BERRY** - The uniform basically didn't change in issue. Some material type and identification things changed but predominantly the main issue still remains. If I'm working on night shift tonight, I have one jacket to wear. If somebody bleeds or other body fluids get on to that jacket I've got nothing to wear. That's not my fault but I've got nothing else to put on over the top of that. As a membership, we see that as negligent really. As I said before, we are not after issues to line our pockets or whatever; we are out for our membership to be working safe and to have appropriate equipment. This issue with the uniform committee - Peter Hampton was union delegate on that and it used to drive him crazy. He was on it for two years and got nowhere. This is the frustration that we feel.

We are quite happy to put our time into committees to try to develop the service and help provide better services but we just don't see the outcome from it.

**Mr BEST** - My question follows on a bit along those lines because it appears from what's being said that there's obviously fairly extensive involvement in discussion et cetera. Comments have been made that there is no strategic plan, but it seems though there is some involvement with the union in relation to that. Am I reading that incorrectly?

**Mr JACOBSON** - No. The only point in recent times where we had the potential to look at the Ambulance Service in a strategic sense was following the dispute in relation to Sorell and the recommendations made by the Industrial Commission.

**Mr BEST** - So you're saying up until that stage the union had no involvement at all in the strategic plan?

**Mr JACOBSON** - There was a strategic plan developed and it was of some interest. Mr Lennox said at the last hearing that that is about to be reviewed but certainly you might find involvement in the Ambulance Service. We don't come back to that plan, that plan hasn't been looked at as a blueprint.

**Mr BEST** - I'm not trying to cut you off, but I'm just trying to get the detail.

So in relation to that and pretty much as a follow-on from the questions that Tim's asked, I assume there are a number of things in the strategic plan possibly that you have agreed to and there are probably other things that you haven't. Is there some way you could identify them or we could know what they are? What has been agreed to and what hasn't happened? I guess we would also like to know, in the committee sense, about other issues outside the strategic plan that may fit that category of what has been agreed to but not acted upon?

**Mr JACOBSON** - In answer to that, the strategic plan is a bit of a non-event for us. It was developed but the actions and activities that are undertaken in the Ambulance Service aren't referred back to the strategic plan. To say whether we agree or disagree with what's in the strategic plan really doesn't come as any significance because the Ambulance Service pretty well operates autonomously from the strategic plan that exists.

Similarly, we don't refer back to the strategic plan because obviously, as I said, the strategic plan isn't a blueprint for the Ambulance Service. So whether we agree or disagree really isn't so much -

**Mr BEST** - No, but I think we need to know as a committee though what your grievance is. I don't really understand that because to me it's unclear. I don't know, maybe these other people are aware. I understand some of your grievance in the sense that what you're saying is that things have been agreed upon or things aren't agreed upon but you assume that they will happen and they don't and there's an expectation or there's a lot of time wasting. I guess what I am trying to ask is: what do you want? I need to know. What are these things that you want done that aren't actually happening? Some of them may relate to the strategic plan or the point about the uniform that has been raised. It would be nice to know and I think, as a committee, we are about identifying these issues that you raise because, from my point of view, it just seems a bit vague.

**CHAIR** - A good point.

**Mr BEST** - I am not necessarily asking for them right now, but perhaps we could come back and you could tell us what they are. That would be great.

**Mr JACOBSON** - I will have to find it and dust off the dust and the cobwebs.

*Laughter*.

**CHAIR** - That would be really useful to us, I think. I am mindful of the time and I am sure members have things they need to do before going back into Parliament, are there any specific questions that members would like to ask at this point?

**Mr MORRIS** - I have one left, but it is quite a different tack. What is your view of the vehicle replacement program and how that has been going?

**Mr BERRY** - I went through the Ambulance Consultative Committee - I cannot remember what date it was now, it was either earlier this year or last year - and we asked what plan was in place for recurrent funding and the answer was noncommittal really. I am not sure what the service management had been lobbying or trying to get funding for as a recurrent funding. Vehicles per annum that need to be replaced are going to be somewhere about, from my limited knowledge of the vehicle group, 15 vehicles per year, so you are looking at about $1.5 million to turn the vehicles over on a regular basis and retire them out.

**Mr STURGES** - Metaphorically speaking!

**Mr BERRY** - Yes, but with the Mercedes vehicles that we have at the moment they are a bit untested in that we do not know whether we are going to take them out at 150 000 or 200 000. There are some issues with the Victorian service at the moment about that particular type of vehicle that may determine which way they go. On our fleet it has enabled us to replace them totally over the last three years or so and we have a good fleet at the moment but we are not sure the recurrent funding is in place with ongoing budgets to make sure that we don't go back to where we were three or four years ago where the breakdowns were compromising patient care. But, again, it's one of those issues that we would push for service delivery and if the vehicles need to be replaced because they get a relatively hard time when they do their 100 000, 150 000 or 200 000 kilometres. It is like a lot of our equipment, if it doesn't get replaced on a regular basis, we run it out for a long period of time and then put budget submissions and try to get new gear in. It is not a regular influx every year of new spine boards or resuscitators.

**Mr STURGES** - Just a quick one, Chair, thanks. There has been some talk previously about the establishment of ambulance stations and growth in metropolitan areas and regional areas of the State, I am just interested to know are there agreed criteria or formulae by which stations are upgraded or established and, if not, how does it come about?

**Mr JACOBSON** - In short, really the only indicator that is used is case load in a particular area: what sort of cases in any particular areas. That was our concern in relation to

Sorell with the case loads because it indicated with a professional ambulance service, a paramedic service is required there. Case load is one thing but I think the -

**Mr STURGES** - Response time?

**Mr JACOBSON** - That would be another issue. Community pressure would be another issue that has an effect on it. There are difficult issues in there to grapple with as well. For instance, there may well be ambulance stations that currently exist in communities where in fact because of contemporary practices may not be of significant value in those communities. Obviously there are difficulties if you are looking at moving resources around to take a full-time ambulance service out of a particular community. So there are difficulties with that.

**Mr STURGES** - I am not suggesting that. I think you have answered my question. I was basically trying to ascertain whether there was an internal process that involved the union and management sitting down periodically and using a benchmark to determine it.

**Mr BERRY** - No. That was going to be part of the Resource Allocation Group.

**Mr STURGES** - Thanks.

**Mr BEST** - Can I just put some questions on notice so it gives you plenty of time to answer them. Hypothetically, if the Government was to write a cheque for expansion of ambulance services, what would be the union's priorities? I would just be interested to know. Just in relation to the fact that there is a free service largely for the general public, for argument's sake would you have a view about Ambulance being part of any Medicare arrangements, if that was ever possible? Also, what is your view in relation to the personal use of semi-automatic defibrillators.

**Mr JACOBSON** - The personal use?

**Mr BEST** - Yes. I understand that in some places sometimes the police have used them. I do not expect you to answer it now, you can come back to it.

**CHAIR** - I just have one quick one, if I may, too. That is, in the case of a non-response from a volunteer station, are there consequences of that? I mean are there questions asked as to why there was no-one responding at a volunteer station?

**Mr BERRY** - Anecdotally, there are frequent occasions where a response group cannot respond and Maydena currently have reduced their number of volunteers to about six or seven at the moment. There are days during the week where they cannot get people to go on call. So they will notify headquarters that they cannot respond or they are off-line for a day or two days and the nearest response to Maydena will be the New Norfolk paramedic if he is in. If he is out on a case, which is frequently the case now, it would be Bridgewater.

**CHAIR** - Is there ever a situation whereby people expect there to be someone at, say, to use Dodges Ferry purely as an example, they expect someone to be there but there is not anybody there?

**Mr BERRY** - Frequently.

**CHAIR** - Frequently. So part of the planning would be to be able to use someone at Dodges Ferry to attend an incident and in fact there is nobody there - even though they have not notified that they are going to be off-line?

**Mr BERRY** - With Dodges, I am familiar with that, I am not sure about the rest of the State. But quite often communications will activate the volunteer's pagers and they will then wait to see if they get a response. Generally the volunteers within those rural areas will notify COMs of their availability, be on call or not.

**CHAIR** - Can that compromise patient outcomes?

**Mr BERRY** - Of course it can. The reality is that if that volunteer group, wherever they are, do not respond to somebody who is haemorrhaging or having a cardiac arrest is that the haemorrhage control or CPR will not be initiated until the next response group which will generally be from a branch station or a metropolitan station.

**CHAIR** - From an organisational point of view, what consequences are there to that? Is there a review or hearing or questions asked as to where people were and what happened?

**Mr BERRY** - I am not sure of the particular practice but there would probably be a review through the operational side of management and communications as to a delayed response to the case. Communications, I know, will put through a document. They call it 'delayed response case'. So if there is a long response time they document the details and forward that to their superintendent, which may then go to the regional supervisor to find out why.

**CHAIR** - So the presence of a volunteer brigade with equipment, with vehicles in a specific area, does not necessarily mean that service is going to be able to get to incidents that occur in its immediate radius?

**Mr BERRY** - Not 24 hours a day, no. The volunteer issue is long and involved and retention of volunteers is a big issue for this service and others because of the support from the service regarding the training and helping them through the progress of their training. Case load is an issue because generally the volunteer groups do not respond to a lot of cases and for a lay person to have, as I said, 40 hours of training and then go and have to try to diagnose a certain condition is fairly intimidating. When they might only go to one or two cases a month their skill level drops off, their self confidence drops off and a lot of people just bail out.

I suppose it is not peculiar to this State but ways around that would be to give more support to volunteers and have career staff designated to train them and see them more often. The case loads are just not there. Maydena, for example - I used to go and train there when I was at New Norfolk - would do about 50 cases a year, which is pretty low to maintain your skill and exposure.

**CHAIR** - Thank you. Are there any other questions?

**Mr MORRIS** - I could go on for a while but I think that I might leave it there. Perhaps if we could have the ability to maybe put some questions to you in writing.

**CHAIR** - Yes. Through the secretary.

**Mr JACOBSON** - That would be good then we could perhaps answer them all at once.

**CHAIR** - Thank you very much for your time. We really appreciate it.

**THE WITNESSES WITHDREW**.