CORRECTED VERSION

STANDING COMMITTEE ON FINANCE AND PUBLIC ADMINISTRATION

Inquiry into public hospital performance data

Melbourne — 17 August 2009

Members

Mr G. Barber
Ms C. Broad
Mr M. Guy
Mr P. Hall
Mr P. Kavanagh
Mr G. Rich-Phillips
Mr M. Viney

Chair: Mr G. Rich-Phillips
Deputy Chair: Mr M. Viney

Substituted members

Mr D. Davis for Mr M. Guy
Ms C. Hartland for Mr G. Barber
Mr B. Tee for Mr M. Viney

Staff

Secretary: Mr R. Willis
Research Assistant: Mr A. Walsh

Witness

Mr S. McGhie, general secretary, Ambulance Employees Australia.

The CHAIR — I declare open the Legislative Council Standing Committee on Finance and Public Administration hearing. Today's hearing is in relation to the inquiry into Victorian public hospital performance data. Specifically the committee is examining the capacity of hospitals to meet demand, standards and quality of care, resourcing and access levels and the accuracy and completeness of performance data for Victorian public hospitals.

I welcome Mr Steve McGhie, the general secretary of Ambulance Employees Australia. For the information of witnesses and the committee, I point out that the following substitutions will apply for today: Mr David Davis for Mr Matthew Guy, Ms Colleen Hartland for Mr Greg Barber, and Mr Brian Tee for Mr Matt Viney.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Any comments made outside the precincts of the hearing are not afforded parliamentary privilege. All evidence is being recorded by Hansard, and witnesses will be provided with a proof version of the transcript in the next couple of days for any corrections.

I now invite you to make an opening statement if you would like, Mr McGhie, and then the committee will proceed to questions.

Mr McGHIE — The reason for Ambulance Employees Australia putting in a submission was that we felt that ambulance paramedics, and in particular the ambulance service, were indirectly affected by the performance of public hospitals. Our main reason for this submission is that over the last few years we have seen an increasing problem with what we in the ambulance service call the ramping up of ambulances at accident and emergency departments. The concern for paramedics and patients is that there is a delay in offloading patients at many of the major hospitals in metropolitan Melbourne and in some of the major regional hospitals around the state. We have seen evidence of patients having to wait between 1 and 3 hours before they have been offloaded from an ambulance stretcher within an A and E department. That causes my members a lot of concern and frustration.

We have continually raised this over the last few years with the Department of Human Services. Obviously they have tried to address it in some ways by introducing what they call an escalation process where a senior manager from the ambulance service is to communicate with a senior person within the hospital to try to alleviate the problem, but we have seen no change. If anything, it has probably got worse.

The concern for my members is that their unavailability to respond to emergency cases is increasing, and that means you have less ambulances available to respond to emergency cases. That has an indirect effect on response times for ambulances. We are seeing current response times that are in the 90th percentile of signal 1 response times. Signal 1 means a lights and sirens response. That is out to around 17 minutes at the moment, and the government benchmark is 15 minutes. That is not a trend we want to see blow-out any further. It increases the frustration for my members because the situation is that they are standing around in a hospital unable to do the role they are trained and paid to do. They are wasting a lot of time within a hospital to some degree babysitting a patient whom the hospital should be dealing with at that time.

That is our reason for putting in the submission. It is really about trying to address the front end of the hospital problem — that is, when ambulance paramedics deliver patients to A and E departments.

The CHAIR — Thank you. Can you give the committee an idea of how prevalent the ramping up issue is, how widespread it is across hospitals, metropolitan versus regional?

Mr McGHIE — We hear reports of most of the major public hospitals in Melbourne having issues of ramping up at various times. Some of it is around either being on bypass or not on bypass or hospital early warning systems. There are a lot of occasions when ambulance paramedics arrive at hospitals where they are not on bypass or even a hospital early warning system and there are a number of ambulance crews ramped up there at that particular time. I received a document over the weekend which is data that the ambulance service has been collecting over the last three months. I have handed out a summary sheet that makes reference to that data; we have done a bit of a summary of it. Over the last three months there have been 997 cases in metropolitan Melbourne alone where a patient has had to wait on an ambulance trolley for greater than 1 hour, and in 145 of those cases it was greater than 2 hours. It is fairly prevalent right across most of the major hospitals. Obviously some hospitals are worse than others, and that may be due to their geographical location

within the metropolitan area, in particular down south in the Frankston area. It is the only major receiving hospital down that way, so that might be an issue for them — receiving all the patients from the peninsula and places like that. But we see it regularly, if not daily. I am getting reports from my members.

The CHAIR — In this table you have circulated, the last column was the worst example within the sample.

Mr McGHIE — That is exactly right.

The CHAIR — You have times up to almost 3 hours in the case of Frankston.

Mr McGHIE — Exactly.

The CHAIR — Monash, Dandenong et cetera.

Mr McGHIE — Yes.

Ms HARTLAND — Does this mean that people are actually still in the ambulance, or on the trolley?

Mr McGHIE — No. What happens is they are actually on the trolley. It depends on how many ambulance crews and patients are waiting — and we have had examples of up to 11 on any one occasion — and on the type of day. If it is a very warm day, it could be possible that the ambulance crew might put their patient back into an ambulance. That would happen only irregularly; generally they are on the ambulance trolley in the passageway of the accident and emergency department.

The CHAIR — And the problem is there are no staff to receive that patient so your members cannot leave them to get another.

Mr McGHIE — That is right. There are a couple of questions here in regard to that. What happens is that you have a situation where the ambulance crew will take the patient into the hospital. They will wait in line. They may get initially triaged by the triage nurse. That can take some time, and in the larger document that I have handed up today you will see that there is reference to triage times. We have seen quite lengthy triage times on some occasions, too. It can take a while before the triage nurse will actually assess and triage the patient for their acuteness and what sort of area they should be placed in anyway. It does take some time, and they can be triaged or not triaged in an appropriate time frame. Again, that is obviously due to the busyness of staff in the hospital.

I should say that at no stage in our submission are we criticising any staff; they are doing the best they possibly can. We believe this is a systemic issue. We would argue from an ambulance point of view, on behalf of my members, that if it is not addressed at the hospital level, then we have to address it at the ambulance level, and that means we have to find more ambulance resources. If we are going to have a percentage of ambulance crews just waiting at a hospital unable to respond to emergencies, then we need more ambulance resources on the road to respond to those emergencies that are waiting.

The CHAIR — Why is the hospital bypass and hospital early warning system not addressing this problem? Are they not supposed to prevent the sort of problems you are talking about?

Mr McGHIE — They are, and to some degree they will. But we are seeing on many occasions that the hospital bypass system is fairly widespread. What you find is that once one hospital goes onto bypass then you have an overflow to the next closest hospital, and quite quickly it is one of those days where it is a very busy day, a lot of patients are coming in, and you see that it becomes very widespread. So the hospital bypass probably cannot address it to some degree because the volume is greater than what the system can cope with.

The CHAIR — And the early warning system, how does that work? How should that work?

Mr McGHIE — That is just a pre-hospital bypass situation where the ambulance service is warned that a particular hospital is starting to fill up fairly rapidly and there are only a few beds left. They try to divert ambulances to other hospitals depending on the condition of the patient. If the patient is seriously ill, all of the hospitals will receive that patient at that particular time, even if they are on bypass. If the ambulance paramedics think they cannot go on to another hospital, then they will still take that critically ill patient to the hospital that is either on a hospital early warning system or on bypass.

Ms BROAD — Thank you, Mr McGhie, for your submission and for the work your members do in taking care of Victorians. Because I represent the northern part of Victoria I want to particularly focus on what is happening in rural and regional Victoria, so I would like to ask you some questions about that. My understanding is that in terms of recent history there are some 100 extra paramedics being recruited in country Victoria by Ambulance Victoria — I think over 80 have already been recruited — and there has been more than a doubling of funding for ambulance services, and that is without the 77 new and upgraded ambulance stations. Quite a few of those are in the region I represent, and I am keeping in close touch with those developments.

Notwithstanding those very substantial investments, I am certainly aware of some of the pressures that paramedics talk to me about. One of the reasons that has been advanced to me for some of those pressures is to do with people calling for ambulances in circumstances where essentially they are seeking primary health care services and they are not able to access those out of hours when they need them. I notice that in your submission you have a proposal around paramedic practitioners which is designed to reduce the need to transport people to accident and emergency departments and in that way take pressure off hospitals. I invite you to talk some more about that proposal and particularly that issue that I am aware of in country areas.

Mr McGHIE — Sure. The reason for that suggestion by us is that to us, as I say, it is a systemic issue. The patient volume going into hospitals is increasing and it appears that trend will continue. I think the projections are that that will continue and is likely to get much worse. From an ambulance perspective, what we have felt is there are a number of patients who ambulance paramedics will transport to a hospital who do not need to be in a hospital and who could be treated in other ways. If they do not have the primary health care within their own local communities, if there are not enough GPs or whatever it is within their own local communities, and I know they have nurse practitioners and things like that, there have been suggestions that other allied health services could expand their roles.

We have raised, both with the ambulance service and government, that we really should be looking at an extension of scope of practice for paramedics. Maybe they can treat some of these people at home, even if that means prescribing medication or even if it means suturing wounds or even if it means — I do not know — some minor types of treatment in the home to stop the volume of people being transported into hospital. Anecdotally I could say to you that ambulance paramedics respond to a very high percentage of code 1 cases — emergency cases — and probably 60 or 70 per cent of those code 1 cases are not real emergencies. But you do not know that until you get there; you can only go on the evidence that you have. Out of that 60 to 70 per cent, probably about half of those do not really need transporting to hospital and could be dealt with at the location — whether that be referring them off to another agency, whether it be some minor treatments at the home, whether it be the prescription of a drug or something like that. That is what we are talking about.

My members are open to looking at all of that to see whether it can avoid or reduce the volume of people who they respond to in regard to an emergency but also in transporting that volume of patients into hospitals. Because if a patient wants to go, an ambulance paramedic cannot refuse transport. Quite often people use the ambulance system to get a trip into the hospital because they know that they will be seen, if they do not have the services in their local community. I will not call it an abuse — it is the only way that people can get treatment to some degree. They use the service as an avenue to get into the hospital, and you hear it quite often: ‘Oh, if I go in by ambulance I will be seen quicker’. It is not true but that is how sometimes it is used. So, yes, we would like to see at least a discussion about whether there can be an extension of practice that be can delivered at home rather than those people utilising the service to go into the hospital and then clogging up the hospital.

Ms BROAD — Chair, can I follow up on that? I am certainly aware that paramedics are very highly trained health professionals. What steps do you think would be necessary in order for what you are proposing to happen?

Mr McGHIE — There are courses around, I think even interstate. There are some ambulance services overseas that have already extended their practices to paramedic practitioners. I think Queensland is trialling something. It is through the universities, because it is all university training now. I think you can get an extension of the training and qualifications in regard to that. Again, I think firstly what needs to happen is the debate around that and how that fits in with the rest of the health system. Obviously there will be issues about demarcation and things like that, and we want to avoid all that sort of stuff. It is really about at the minor end and trying to stop the volume and just dealing with people at home more than transporting them to the hospital.

But there are some courses around through some of the universities within Australia already, and I think we should talk about that at some point in time and look at what options are around.

Ms BROAD — Again anecdotally, I am certainly aware of paramedics talking about the number of occasions when they are called out and visit the home of someone who might be very anxious — they might have a breathing condition and there might be good reasons why they are anxious — but the end result of the visit is that they are not transported to hospital because that is not necessary and the paramedics do everything that needs to be done.

Mr McGHIE — Yes, that is true. I will use the breathing situation where someone is short of breath. It might be an asthmatic or someone like that. The ambulance paramedics would commence treatment and give them the appropriate drugs — salbutamol and nebulised salbutamol and things like that — and that patient's condition settles down. Once the patient settles down, through discussion with the ambulance paramedic they might be comfortable to not be transported to hospital. That can happen quite often, even with patients who have chest pain and things like that. It might be that their Anginine tablets are not fresh but the ambulance paramedics have the fresh tablets and their patient takes an Anginine and their pain subsides. There is no need to take them to hospital if their pain subsides and everything checks out okay.

A lot of situations like that occur. That is a normal practice now. But we are probably looking at other types of ailments that really draw on the services of the hospital system. It is a question of whether they really need to. That is what we are looking at; that is what we are thinking about.

Ms BROAD — Thank you, Chair. Can I just underline that in country Victoria the issues of distances to hospitals and access to GPs, particularly out of hours, are more significant than they are in the metropolitan area.

Mr McGHIE — Sure.

Mr HALL — Thank you, Steve, for your comments this morning. Does Ambulance Victoria have a single dispatch system operating right across the state now?

Mr McGHIE — No, it does not. There is a dispatch system in Melbourne based at Tally Ho, and that is run by ESTA. In about 12 months to 18 months the five rural op centres — based at Wangaratta, Bendigo, Ballarat, Geelong and Morwell — will be closing and that work will be transferred to ESTA based at Ballarat. So there will be two dispatch centres in about 18 months time.

Mr HALL — And the ambulance employees unions — do you think that would be a more effective dispatch system? Or are we currently well served with our dispersed dispatch systems in country areas?

Mr McGHIE — I think we have been reasonably well served with the five dispatch centres in rural Victoria. There has been a gradual reduction of dispatch centres for many, many years now. There were many more dispatch centres when it was regional ambulances services. There will be some hiccups with the transfer into the rural dispatch centre in Ballarat. There are a lot of local things done out of the local dispatch centres through local knowledge and local services and things like that, and in the transition to the new dispatch centre there may be some initial hiccups. Hopefully that can be worked through fairly quickly.

Mr HALL — Are you aware of any plans to move some of the rural administration to Melbourne, or indeed to Ballarat?

Mr McGHIE — With the merger of the ambulance service there has already been a merger of various departments within the ambulance service and a number of people have either left the rural headquarters or moved to Melbourne to take up a new position or a similar position within metropolitan Melbourne, but I am not aware that there is a plan to either close down offices or close down any other departments within the ambulance service.

Mr HALL — Do you think the coming together of the rural ambulance and metro ambulance services into one has enabled you to use your resources better? Has it been more certain?

Mr McGHIE — I do not think that has happened yet. I think it may, but I do not think it has happened yet.

Mr HALL — In terms of ambulance hotspots around the state, you mention on your website that there are some areas of the state that are described as crisis points. Do you have what I would describe as ambulance hotspots around the state?

Mr McGHIE — There is always ambulance hotspots, and that may vary depending on resourcing and things like that. Over time there have been additional resources placed into some of those hotspots. But we have seen a growth in caseload of about 22 to 24 per cent over the last three years. Staffing increases have been about 9 to 10 per cent.

As I referred to before, it depends where health services are. Ambulances are an easy port of call: you pick up the phone and you dial 000. If you want an ambulance, you will get one; no matter how long it takes, you will get one. A lot of rural people in particular seem to be, in my words, a bit tougher than us city folk, because they tend to hang on for a lot longer than the city people do, but where you have got, again my words, an inappropriate level of health services, you will always have a drain on the ambulance service because it will always get there.

Mr HALL — What about response times right across Victoria? Again, the difference between metro and country. Like Ms Broad I am representing a country electorate, mine being Eastern Victoria Region, so therefore I am interested in terms of your response times in the country and compared to Melbourne.

Mr McGHIE — We would say, obviously, in the major centres the response time should be the same where you have got high population, high caseload. At the moment the benchmark is 90 percentile in 15 minutes. I believe that response time right now in Melbourne is about 17 minutes; in rural Victoria it is probably worse than that. I think it is even out to about 25 minutes in the lower populated areas, but the benchmark is for a population greater than 7000 it should be 90 per cent in 15 minutes. I do not accept 90 per cent in 15 minutes, I think it is too long. I think response times are of the utmost importance.

Mr HALL — Thank you.

Ms HARTLAND — Over the last few weeks I have been contacted by a number of rural ambulance officers who have talked to me about issues of fatigue and the incredible shifts that they have had to work. With the new agreement, do you think that is going to change at all, or is there still a real need to place more officers in the rural system?

Mr McGHIE — Rural has been underresourced for many years, and we still have a situation in rural Victoria, or parts of rural Victoria, where we still have officers working on their own in a very fatiguing state. They work 10-hour days with 14-hours of on-call attached to the 10-hour day shifts. They work eight shifts in a row and seven nights of on-call and then have six days off. It is demanding enough when there are two of you working together, let alone working on your own.

That situation has to be addressed over time. We would love to see a timetable to address those sorts of situations and phase out that single-officer crewing arrangement. The new agreement that has been reached will assist in addressing some of the fatigue issues. Obviously the full implementation of a 10-hour rest break will not happen until two years into the agreement, but in the interim ambulance paramedics, if they feel that they are fatigued, only have to inform their employer and they are entitled to have a 10-hour break, so I think it can help.

Ms HARTLAND — I am thinking more of the actual numbers.

Mr McGHIE — About resources, yes.

Ms HARTLAND — The problem, in speaking to those people, is the sheer lack of numbers in the service in rural areas.

Mr McGHIE — That is true. I will give you an example of what would happen on a daily basis in a lot of rural centres where there are, in particular, single officers or even two officers in a smaller branch. They have a situation, as I said before, in their roster pattern of eight 10-hour shifts to which the 14 hours on-call are attached. They might work all day, respond to two or three emergency cases during the course of their on-call period, be entitled to a, currently, 8-hour rest break, go on their rest break and still have to respond to work from

their 8-hour rest break; to the point where they may become so fatigued that they have to say, 'I cannot do any more', and that is not a thing that would only happen irregularly. It happens regularly around the state.

Clearly that is an issue that there are just not enough resources, because one would make the assumption that if you have worked so much that you are entitled to a rest break, then the ambulance service would replace you or at least provide some level of coverage. It is a risk management game at the moment — that is, depending on the location, whether they will cover those officers or not, and in some cases they choose not to. Of course, if an emergency comes in in that township, the first person who gets called is the person who is on the rest break. So it is clearly a resourcing issue when you get down to those types of examples.

Ms HARTLAND — A follow-up question: I was interested in the extended ambulance transfer time but there are no hospitals listed here in the western suburbs.

Mr McGHIE — No. And I do not know why because I have not been through the full document. I was of the understanding that western Footscray also had some issues but it is not in the documentation that has been provided to me, and again this is only the last three months.

Mr TEE — It must get a great service.

Ms HARTLAND — No, we do not. We absolutely do not get a great service in the western suburbs.

Mr McGHIE — I do not know why western is not there.

Ms HARTLAND — Maybe they are disguising it because it is really, really bad.

Mr McGHIE — I have had anecdotal evidence out of the western suburbs, both the Footscray and Sunshine campuses.

Ms HARTLAND — Thank you.

Mr DAVIS — Thank you, first of all, for this helpful chart which lays out a number of important statistics. It is quite striking. Nearly 1000 cases are greater than an hour, and 145 greater than 2 hours. I want to get some understanding of what that 15-minute threshold, as opposed to the 17 minutes that is being achieved now, means in terms of patients, what does it mean in terms of outcomes and safety, what does it mean in terms of lives?

Mr McGHIE — Obviously 15 minutes is a benchmark that the government has set, and obviously they hope to achieve that benchmark in 90 per cent of all the cases that they respond to in a code 1 capacity, which is the lights-and-sirens capacity, life-threatening capacity. To wait an extra 2 minutes for a patient who potentially is non-breathing with no pulse, really has one of two outcomes to some degree. If the patient survives, potentially the risks are greater. The potential for their survival is reduced and the damage — brain damage or whatever — can be a lot higher. If they do not survive, it can potentially be because of that extra 2-minute delay. Again, I am not a fan of the 15-minute benchmark — that is also far too long — but to add another 2 minutes to it, to me, will cost lives.

Mr DAVIS — Just to understand this sequence from when a call goes out to an ambulance until the point where the patient is dealt with in full at the hospital, there is either an ambulance bypass and the ambulance will head somewhere else or a hospital early warning system might go out; equally the ambulance could get to the hospital and find, as you are describing, this ramping up.

Mr McGHIE — That is right

Mr DAVIS — With quite a number of people waiting. With the ambulance bypass figures and the hospital early-warning figures, we do not see the publication of early-warning system figures. Do you think they should be published?

Mr McGHIE — Yes, I do. I do think they should be published, yes.

Mr DAVIS — What percentage of cases would the hospital be on bypass as opposed to the warning system?

Mr McGHIE — I think you would find there would be a lot more hospital early warning systems than bypass, because it is obviously a pre-bypass situation.

Mr DAVIS — Three or four times? You are not sure?

Mr McGHIE — I do not know. I would be guessing, but one would assume almost double, I would think, because the whole purpose of the hospital early warning system is to avoid bypass and to not get to bypass. Hospitals are trying to manage their throughput a lot better and trying to prevent getting to the bypass situation. I would think it would be at least double. But, I mean, it would be great I think if that data was published.

Mr DAVIS — Then the ambulance in these kinds of cases, the almost 1000 cases here, would get to the hospital and then the patient would be offloaded onto a trolley?

Mr McGHIE — Eventually, yes.

Mr DAVIS — Or they would simply wait?

Mr McGHIE — They wait.

Mr DAVIS — They would wait in the ambulance, would they, until — —

Mr McGHIE — Well, not necessarily in the ambulance. These figures would be reflecting that the patient would be, in most cases, on the ambulance trolley, probably awaiting in the passageway of the accident and emergency department.

Mr DAVIS — Or sort of in the foyer or something?

Mr McGHIE — Wherever they can find a space.

Mr DAVIS — Right. Is there an impact of that kind of wait on their outcomes, do you think?

Mr McGHIE — Well, there can be, because obviously if there is a delay in hospital intervention, in clinical intervention from the hospital, I suppose that can have an impact on the longer-term outcomes for some patients, depending on their conditions. There are also legal issues there. We have raised the question and cannot seem to get the answer to who is actually legally responsible for the patient? Is it still the ambulance service and the paramedics, or is it the hospital?

Mr DAVIS — Because you will have in effect delivered them?

Mr McGHIE — You have delivered them, particularly once you have handed them to triage; who is responsible? Again, I am aware of a case where a patient had a cardiac arrest on an ambulance trolley after being triaged by the hospital. I am of the understanding that happened last year at the Austin hospital. It will be interesting to see. Given it was an elderly patient, I do not know whether it will go to a coroner's inquest, but it would be interesting to see who was legally responsible for that patient at that time.

Mr TEE — I suppose there has been some discussion around resourcing for ambulances and for the service. You need to, I suppose, acknowledge that since the election of the Bracks and Brumby Labor governments there has been a lot of rebuilding done, in particular I think the budget has gone up by 140 per cent. There are 800 extra paramedics and 131 extra ambulances. I understand what you are saying, that there is tremendous demand, but would you acknowledge, too, there has been a considerable allocation of resources?

Mr McGHIE — Definitely. There has been a considerable allocation of resources. I think it has been well warranted and accepted by us that there has been. But I suppose I would say it has been patching up some very black holes we have had in this state for a number of years.

Mr TEE — I saw the submission from DHS, which talks about, I suppose, the growth in demand which has gone up by 43 per cent. When I look at this table, which is obviously about having people waiting, whether the 997 were waiting for a period of time, but again I suppose that is in a context where we have had that sort of demand where our 38 public hospitals are seeing 1.3 million patients each year. So it is, I suppose, a very difficult balancing exercise in terms of getting that number of patients — 1.3 million — through our 38 public

hospitals. Really the question is: what does government do about it? My question goes to some of the initiatives that have been put in place. Will they go towards addressing some of these issues? In particular there is a new package of beds — the $300 million, which will provide 100 acute and 170 subacute beds, so we are looking at 300 new beds coming through. I assume that will make a difference in terms of the capacity of emergency hospitals to put patients through.

Mr McGHIE — In my solutions I think I referred to the fact of either providing more facilities, such as more beds and, in particular, more staff. The problem for ambulance paramedics is they take their patients in and they get ramped up. There is nowhere to place their patient. That is the issue for them. There is the delay in ambulances; because of that very reason there is a delay in treatment. So no doubt any more beds and any more trained hospital staff should help the system, but I suppose the fundamental issue is: can we continue with the trend of so many people coming into a hospital using the services? Is that what we really need, or should we be dealing with a lot of these people out there in the community at the community level rather than having just this massive trend of people coming into hospitals when potentially a lot of them do not need to be in a hospital for treatment? They should be able to get treatment in other ways. I suppose from our perspective, from the ambulance perspective, and from the union's perspective and its members, they feel there is a lot of people they go to who could and should be provided with services in other ways. It will not clog up or should have a reduction in the clogging up of the system.

Mr TEE — I suppose an obvious example of that is the co-location of GPs at hospitals and emergency hospitals. Again, you get people going to the GP rather than using the ambulance, because they think that is going to get them into the emergency hospital.

Mr McGHIE — Yes, I think that can work in certain locations. I am not so sure that is a great answer for rural Victoria, because people still have to travel to those major regional centres. I think certainly in regard to certain locations, in particular some of the major Melbourne hospitals, if you can have some general practice services, whether it be aligned to the hospital or not, that can deal with the more minor end of the scale of issues for patients, I think that can help.

Mr TEE — I suppose again, in terms of managing that surge in demand, the other bit that helps — and I do not know whether you have heard of it — is the winter demand strategy, where there is an extra allocation of 100 beds. I suppose my question concerns the fact it makes a contribution and it is helping. Is that what you are seeing in terms of meeting your members' needs to get people through the system as quickly as possible?

Mr McGHIE — The extra 100 beds obviously helps. Again, I know the winter demand is always raised about it having been a poor winter and a bad winter in regard to coughs, colds and things like that. But I have to say from ambulance's perspective, we do not see the trend changing in the winter or the summer. The spreadsheet I have done, or the fact sheet I have done, is really only a reflection of three months collection of data. We would find that trend probably similar right across the year for various reasons, whether it be coughs, colds or other reasons. That has been going on for a number of years, as I said in my submissions. I just see it is the use of the hospital system by our community. The question is: is there a percentage of the community that does not really need to use it in that way?

Mr TEE — Just finally, I suppose it is the experience of other jurisdictions, but my understanding is that Victoria's median wait time in an emergency department is 22 minutes, which is 2 minutes faster than the national average. We have a demand; we are meeting it. There are the issues that you raise, but we are doing better than the rest of the country. Would that be your experience or sense of it?

Mr McGHIE — I have not seen data from other states. But I know from talking to paramedics and other ambulance unions around the country that they have very similar problems to what we have in this state in regard to the ramping up. I am meeting with the other unions very shortly. This will be one of the things on our agenda in regard to what we call ramping up at hospitals. It is a problem for all states; there is no question about it.

Mr KAVANAGH — Could I ask you a little bit more about the increase in demand for services. Why do you think that is happening, apart from people knowing they will get treated?

Mr McGHIE — I think I referred to it before, that people know they can get a service from the ambulance service, no matter how long it takes. They also get to talk to someone at the end of the phone, so that eases their

pain immediately to some degree. I think it is a reflection on some services not being immediately available to them within their own local communities, and in particular in some of the rural communities. I think there is an element of distance for some of the rural communities that to get to a major hospital there is, you know, quite some travel time.

Mr KAVANAGH — Mr Hall asked you about hot spots and you said they exist. Could you tell us where they are and why they are hot spots?

Mr McGHIE — Funnily enough, I do not have the list with me, but we see hot spots throughout metropolitan Melbourne — generally the western and northern suburbs. There are corridors in that area that are very busy corridors, and in rural Victoria you have places like Geelong, Ballarat, Bendigo. I know they are pretty broad areas, but these areas are pretty common, and then you have places down in the Gippsland area, the Morwells, the south Gippsland type area.

Mr KAVANAGH — Why do these areas have this demand that other areas do not?

Mr McGHIE — Population; ageing population in some of these towns; tourism. Geelong is a very busy city. There is a large volume of tourists and traffic that goes through the Geelong area. There is the spread of the community and the drain on the resourcing; greater travel times. There is a range of reasons why some of these areas are hot spot areas.

Mr KAVANAGH — And the northern and western suburbs, why might they be hot spots?

Mr McGHIE — The type of cases that are responded to; there are a lot of social and domestic issues; drugs and alcohol; domestic violence issues; industrial areas. So there are a lot of incidences that fall into those sorts of categories.

Mr KAVANAGH — Getting to the main point that you have been making today, which is the problems at hospitals, you have given three reasons for that, or three possible solutions to the problem: better treatment at home, or a wider range of treatments at home; increasing ambulance resources; perhaps co-locating GPs at hospitals. Is there something that could be done administratively at the hospital level, such as the appointment of a receiving officer, or somebody like that, who is responsible for looking after patients as soon as they are brought in by ambulances?

Mr McGHIE — I suppose that could be done, but I think they do have those sorts of people within the hospital. They may not be called a receiving officer, but from arrival of an ambulance patient, you have the triage nurse who deals with where that patient should be directed to, and obviously you have the medical staff, the doctors who are responsible for their respective departments. Of course there are senior executive staff which, it is my understanding, under this escalation process the Department of Human Services created where there was communication between the senior manager of the ambulance service and the senior person in the hospital to escalate the system and move people along quicker, so I think they have some sort of internal processes available for that. But I do not know whether someone specifically has been appointed for that. That may be an option, but there are people within the system now that have the right to direct patients to move on into various areas of where they should require their treatment. It is a question, I would think from my view, of are those people too busy to cope with it all? Do you know what I mean? It is a matter of the volume against whether they have the time to deal with it all.

Mr KAVANAGH — Besides increasing the resources of hospitals by 40 per cent or something, do you see any other way of avoiding this problem in the future?

Mr McGHIE — Again, I do not know the exact projections of what the throughput in hospitals will be, but I am assuming it is going to be an increasing projection, given our population is growing and expanding and, as I say, depending on the level of services that are out there in communities. From the ambulance perspective or from the union's perspective, we would again say: do we need to have that volume coming into a hospital? I think the bigger question has to be: should everyone who wants to be, be treated in a hospital, or should we look at other levels of service within the community, and I am not so sure that everyone that goes into a hospital really needs to be in a hospital.

Mr KAVANAGH — In practice, what sort of system could you envisage as an alternative?

Mr McGHIE — It is a good question. It is not an easy one to answer. An example that I might give may not fit every sort of community, because you may not be able to fund a particular concept within a more remote community because of the lack of volume of throughput, but I would think just broader health services within particular regional areas. I think the outer areas of metropolitan Melbourne require some of that, because what you see is this influx of people swarming into the cities with their ailments, for want of a better term, and if our population is moving out and we are not putting the services out there, then they have got no choice but to come in.

Mr KAVANAGH — Could a bigger role for district nursing, for example, be a partial solution?

Mr McGHIE — I think that is obviously one of the things that could be dealt with and increased. I think even the nurse practitioner role is fantastic. Nurse-on-Call is a great service, and the ambulance service has a referral service where they refer about 30 000 to 40 000 cases per annum to other agencies. That may be able to be expanded. I think the Metropolitan Ambulance Service did over 300 000 emergency cases last year, and 30 000 to 40 000 of those cases were referred to other agencies. I think there probably should be some sort of consideration for improvements in mental health in regard to after-hours service and things like that, but a lot of the drain on the ambulance service in certain parts of the state is to do with mental health issues, and unless we provide services for them, both within hours and outside of business hours, it takes up a lot of resources, both from ambulance and from the hospital service to deal with mental health issues, let alone the police. You are sort of draining all of those resources in combination, where if we probably had, depending on the part of the state, improved mental health services in some areas of the state — —

Mr KAVANAGH — What could be the alternative services offered, do you think?

Mr McGHIE — For mental health?

Mr KAVANAGH — Yes.

Mr McGHIE — This is a broad response. I think they need general support. I do not know that the support structures are there. I think the people who work in mental health are absolutely stretched to the bone, and the demand is so high. They are demanding issues at the best of times — demanding and sometimes very dangerous issues — and that is why the police become involved. It not only takes up mental health services, it takes up police and ambulance; and then you get them to a hospital, and it is the hospital staff and security staff in a lot of cases. It is just such a demanding area of health that we have to try to deal with in some way. Again — as I say, it is just a generalisation — there needs to be some level of improved support structures. I think a lot of it is about mental health patients not regularly taking their medication, and once they fluctuate with their medication, they fluctuate in the way that they deal with their issues. We have to start to take control of the overseeing of that — and how you do that, I do not know, because obviously there are privacy issues.

Mr KAVANAGH — Is that often related to drugs and alcohol as well?

Mr McGHIE — Some mental health is, but I would not think it is a high percentage. I think drugs and alcohol are another avenue we have to address in regard to problems within our society with drugs and alcohol and violence related to that, but I think mental health is out there on its own. There will be an element of mental health that is related to the drugs and alcohol, because they can be in combination to some degree if people are trying to deal with their issues. I think drugs and alcohol are a separate issue again.

The CHAIR — We have a couple of follow-up questions from the committee. Just following on from Mr Kavanagh's question about the hot spots, are you able to provide the committee, on notice, with the list you have got that you said you did not bring with you?

Mr McGHIE — Sure. I do not know that we have got a more recent list, but there is the one that I think we have had on our website for some time, and I certainly can provide that to you.

The CHAIR — I just want to ask you about the single responder issue. What is the current status of the plan to introduce single responder units? Are there any implications arising from your EBA negotiations to that single responder issue?

Mr McGHIE — Just to explain what the single responder issue is, it is a mobile intensive care unit. Currently there are 16 mobile intensive care units in metropolitan Melbourne. A plan has been announced by Ambulance Victoria and funded by the government to convert 8 of those 16 intensive care units to 16 single response units. A single response unit is one intensive care paramedic in a sedan type vehicle with all of the intensive care equipment, and they will spread them out throughout Melbourne to try to provide a greater spread of intensive care paramedics to respond to the patients that require them.

The concern is, can one intensive care paramedic deliver the same outcomes as two working concurrently together? We believe that the evidence is that they cannot. They can still deliver the same level of service in regard to all of the clinical interventions, but it takes longer in performing that on your own rather than working in tandem with another experienced intensive care paramedic. In delaying all of those treatments, does that mean there are the same outcomes for the patients? In some cases it would mean that there are not the same outcomes for the patients. But that is the plan. In the current enterprise bargaining negotiations there has been an in-principle agreement to the outcome, and the ambulance service has offered intensive care paramedics an allowance to operate on a single-response unit.

I should say that the intensive care paramedics are a not very happy bunch of people at the moment, and there have been a number of resignations from intensive care services. It is something that the ambulance service will have to address very quickly because my understanding is that those resignations will take effect from around about 8 or 9 September. We are probably talking about two-thirds of intensive care paramedics throughout the state have tendered their resignation from the intensive care services. It is something that hopefully we will be able to work through with Ambulance Victoria and obviously the government, and hopefully we can get the issue addressed. But when it comes to the concept of the single-response unit — just putting one person in a vehicle and responding and trying to improve response times — while it is fantastic from that point of view and it will reduce response times, the question is: will it deliver the same clinical outcomes? And there is a question mark about whether it can.

Mr DAVIS — Just to follow up, is there a document that lays out the government's decision to move in that direction? Why is it, in effect, downgrading some of the MICAs to the lesser standard with only one trained to the full level?

Mr McGHIE — My understanding is that it comes off the back of some discussions between Ambulance Victoria and the government. The government announced it in the budget last year. Ambulance Victoria has obviously provided the government with an operations plan, and in that operations plan was this issue of restructuring the MICA services in Melbourne. They are also introducing four single-response units into rural Victoria: Bendigo, Ballarat, Geelong and Morwell. They are additional intensive care services to those areas but again they are single-response units. Our concern in regard to that is that, while they are additional services, it is still a single person responding on their own in some areas of remoteness to some degree. Here you have a single operator with no bed-carrying capacity who may have a time-critical patient. They can commence the treatment but they cannot load the patient and transport the patient if they need to be brought into hospital very quickly. And there is no guarantee that they will have backup resources, because we are talking about rural and regional Victoria — long distances, and long distances to hospitals in some cases — so we have some issues around that in rural Victoria.

Mr DAVIS — Is it a budgetary issue that has driven them in that direction?

Mr McGHIE — I think it is a response time issue. From an ambulance service point of view, I think it is the response time issue.

Mr DAVIS — It is about the quality of the response too.

Mr McGHIE — Yes. I think it is the only model that the ambulance service has been able to come up with that will actually have some serious effect on response times.

Ms HARTLAND — At the start of the year when there was the heat wave that preceded Black Saturday I am aware that there were a number of heat-related deaths, and this is likely to become a common summer phenomenon. We have talked about the winter problems, especially with older people. How did the service cope during that period, and is there anything the government should be looking at to address those hot periods?

Mr McGHIE — I would say definitely they should be looking at it, and we should be preparing for it. I have been critical of all governments for a number of years in regard to the fact that we seem to provide services at the base level rather than looking at periods of peak workload and extreme situations. I know we cannot fund and run services based on peak loads all the time, but obviously through the heatwave and into the bushfires it was a serious situation and on a number of those days I would say that the ambulance service did not cope. They coped as best they could but probably did not cope as well as we would have expected them to.

I am aware of a situation on one particular evening in the week before the bushfires when there were something like — I cannot think of the exact figure but it was well in excess of 50 cases still waiting on the books to be responded to on the Thursday night. That is just unheard of in an ambulance service. You cannot have 50 emergency cases waiting. Do you know what I mean? We need to put things in place to address that.

The ambulance service tried — calling people back from annual leave and things like that. There are some mechanisms that can be implemented, and there are obviously procedures under the state health emergency response plan. Knowing that the weather forecast was so predictable, I do not know that we put enough preplanning into it at that particular time. I think it is something we have quickly got to address coming into this summer and any subsequent summers.

Mr HALL — I wanted to ask one further question about the extent of ambulance transfer times, which you talked about earlier today, so ambulance ramping up. Do you see the large amount of time incurred in the cases documented here as being a result of or caused by the capacity of emergency departments at hospitals only, or is it a cumulative effect where people are staying too long in emergency departments and not being able to get an acute bed in a hospital when required?

Mr McGHIE — I think it is probably a combination of all of those things. There is the situation where they cannot move on to get a bed in a hospital. It is obviously the volume of people coming into the hospital and not being able to be seen in an appropriate time because there is just not the staff to be able to do that, let alone the facilities to do that: there is nowhere to put them. Once all the cubicles are filled up, if a patient's condition is not deemed to be serious, they are shuffled into the waiting room and then the waiting room is full and things like that. I think it is a combination of all of those things. It is the bed capacity within the hospital, the bed capacity within the A and E department; and then of course there is the waiting room situation of just not being able to move people through, and you still have volumes of people coming in either by ambulance or off the street. My understanding is that only about 40 per cent of the people who come into an A and E department are transported by ambulance; the rest of them come in off the street. So you can see what the problem is.

Mr HALL — I suppose in relation to those figures it is a simple assumption that when you have got nearly 1000 cases waiting for more than 1 hour there would be times when you would have a number of ambulances lined up together.

Mr McGHIE — That it right. Quite commonly when I am contacted by my members they are ringing me from a hospital saying, 'We have three or four lined up here, they have been waiting an hour'. And, as I said, in the worst-case scenario there were up to 11. Quite often members will ring up in frustration saying, 'We just can't move'. Once you get that backlog of patients you have a number of ambulances lined up.

Ms BROAD — My follow-up is on the single-officer stations and the pressures on those officers in rural areas that was referred to earlier. My understanding is that, following the merger with Rural Ambulance Victoria and the freeing up of resources for both additional stations like Wodonga and additional positions, arrangements have been made for those single-officer stations where officers can come in and spend some time in stations. They can be relieved of that position so that they can get the benefit of spending time in a team environment, which can produce benefits in terms of getting away from that pressure of being 'the' person in that small rural town. They also get the benefit of team approaches and training while they are there. My understanding is that those sorts of arrangements are increasingly being utilised. Can you comment on those sorts of changes following that merger and those additional resources?

Mr McGHIE — I am not aware of it. It is news to me. I hope that does occur; I have not seen it occur and not heard of it occurring. We have a situation where in a lot of rural branches Ambulance Victoria is drawing on the services of what are called ambulance community officers, who are people from the general community who are trained up in first aid. Technically they volunteer their time to assist the ambulance service in

responding to cases. We see a lot of situations in a lot of the single-officer branches where it is an ambulance paramedic who may respond with a community officer. There are some issues around that. It is fantastic that people from the community do that, and they are trained up to a first aid level. They do receive some payment from the ambulance service when they are actually utilised, but I am not aware that there are circumstances where officers can be relieved by other people coming in to allow them to have some breaks or training or some head space in regard to having a bit of a break from the particular workload at that time. I would welcome that. If that is what is on the agenda, I think it would be a great idea.

I think the bottom line is that a number of ambulance stations out there are yet to have an appropriate level of resources to be able to cope with the workload they have. The problem is that we have competing issues where other, busier areas need more resources. You might have an area that is not as busy but it is a rural area that needs additional resources, so who do you give it to first? Do you give it to the one that has the higher volume of cases that have a greater potential of risk or do you give it to the single officer who does not do as many cases but when they do cases they are lengthy cases — they might be 4 or 5-hour jobs, long transports to hospitals et cetera, and they are working considerable numbers of hours and are highly fatigued. That is the balance we have to try to find.

For years now we have been saying that it would be fantastic to have some sort of timetable. I know we shy away from those things because we do not want to be locked in concrete about having said that on this particular date this is what was going to happen at that particular branch. But there has to be some sort of criteria for a phasing-in of resources whether it is to deal with workload, whether it is to deal with fatigue, whether it is to deal with appropriate working conditions or whatever. The ultimate is to get a better service. If we can provide resourcing levels that does not make it easier but makes it more workable for people out there, the ultimate outcome has got to be a better service. How do you do that? It is difficult and it is costly. But I will keep an eye out for that because I am very interested in whether resources have been made available.

Ms BROAD — Can I just say that my understanding in the north-east from paramedics is that following the recruitment of additional paramedics as a result of the merger and additional resources being available, some of those arrangements have been put in place. Certainly the feedback I have had has been very positive.

Mr McGHIE — What that probably is is before the merger Rural Ambulance Victoria had announced that they were going to employ 100 additional paramedics and they were going to utilise them in some sort of relieving capacity. That is possibly what it is. But what you will find is that some of those people have taken up roles in a more permanent capacity. There are some of them who certainly do go and relieve at branches, but they relieve because the officer there is on their rostered day off and there is no other officer there so they put those people in for the rest of the shift. If you have a fortnightly roster, you will have one officer who might work the eight days straight and then have six days off and the reliever will go in and work for the six days that the other person is off. I am not aware that they are there as an additional resource to relieve on any particular day, but they are there to fulfil the complement of the roster. They might move around and move to different locations but they are relieving vacant shifts. And that will help, for sure.

Ms BROAD — This was not vacant shifts.

Mr McGHIE — Okay. I will check that out.

The CHAIR — Thank you, Mr McGhie. The committee appreciate your appearance here this morning and your written submission. This is the first hearing we have had, so we may have some follow-up questions for you. We will have the transcript to you in the next couple of days for any corrections you wish to make. Thank you very much for your time this morning.

Witness withdrew.