Chapter 5 – Organisational Effectiveness and Service Delivery Model

This section considers a range of issues which are relevant to the QAS' approach to service delivery and its organisational effectiveness. Specifically it considers the QAS' functions, service delivery model, legislative framework, bodies that advise the QAS, and the functions of the QAS – emergency patient treatment and transport, non-emergency transport and ancillary services.

Operating framework

With 3,197 full-time equivalent employees, the QAS is the second largest ambulance service in Australia and, it is claimed, the fourth largest in the world. Its structure and functions have changed considerably since the 96 Ambulance Transport Brigades were amalgamated into a single, state-wide service in 1991.

The Queensland Ambulance Services (QAS) is one of five divisions of the Department of Emergency Services. The Department's other divisions are: the Queensland Fire and Rescue Service, Emergency Management Queensland, Business Support Services and Strategic Policy and Executive Services. The QAS reports through its Commissioner to the Director-General, Department of Emergency Services, through the Director-General to the Minister for Emergency Services and, through the Minister, to the Queensland Parliament and the community as a whole.

Having the QAS as part of the emergency services portfolio in Queensland recognises the synergies between ambulance, fire and emergency management, particularly in providing services to the community in emergency situations. There are also potential cost sharing and efficiencies to be gained by sharing emergency dispatch and communications infrastructure across the three entities.

The QAS' mission is to improve the health, safety and well being of the community and its vision is excellence and innovation in emergency medical services.

The QAS divides its activities into two categories: ambulance response services and community and business services. Ambulance response services include:

- emergency response to patients with sudden illness and injury;
- pre-hospital patient care;
- specialised transport services;
- stand-by at special events;
- coordination of aero-medical services;
- inter-hospital transfers;
- casualty room services; and
- in conjunction with other agencies, planning for and coordination of multi-casualty events and disasters.

Its community and business service activities include:

- community education, including first aid training and injury prevention;
- commercial activities, such as industry contracts;
- training and education of ambulance professionals;
- pre-hospital care research; and
- provision of a baby capsule hire service.

The QAS has established its own customer service standards and it is committed to:

- providing the highest possible quality care and service to the community;
- providing patient care in accordance with accepted clinical standards and the needs of the patient;
- ensuring that all services are delivered in a professional and courteous manner;
- ensuring response times for both emergency and non-emergency transport are within national standards;
- ensuring that patient's and customer's rights to privacy are respected; and
- honest and effective communication with patients and customers.

The emergency and non-emergency response functions of ambulance services in other Australian states and territories are relatively similar to that provided in Queensland. However, the Audit notes the QAS provides substantially more ancillary services than ambulance services elsewhere.

Structurally, placing the ambulance service in an agency which is responsible for other emergency responses is in contrast with the situation in most other Australian states and territories, where the ambulance service is part of, or attached to, a health portfolio. In New South Wales, Victoria, SA and Tasmania the ambulance service is part of the Department of Health, as a division, statutory government owned corporation, incorporated association and division, respectively. The Governments in Western Australia and the Northern Territory both contract for ambulance services. Only Queensland and the Australian Capital Territory (ACT) separate ambulance response and other health functions. (The ACT Ambulance Service is a statutory body and one of four operational agencies of the Emergency Services Authority, reporting directly to the ACT Minister for Police and Emergency Services.)

The placement of an ambulance service within a health portfolio recognises that paramedic services are provided as a response to a personal, and immediate, health need, rather than as a crisis response to a fire or natural disaster. Recognising this functional alignment, the Audit considers that in the longer term, the QAS would be more appropriately located within the health portfolio. This issue is considered in detail in Chapter 6 – Interface with the Health System.

Service delivery model

The QAS operates a regional-based service delivery model, with many administrative and other corporate functions centralised at its head office in Brisbane. There are 284 separate QAS service locations around Queensland comprising:

- 224 ambulance stations serviced by permanent employees;
- 49 ambulance stations and locations staffed by volunteers;
- 7 communications centres; and
- 4 field offices.

The Audit notes that the number of communication centres will reduce to six when the Brisbane and South Eastern centres merge. The Audit understands the QAS intention is to reduce the number of communications centres further.

In addition to this, there are:

- 3 Emergency Management Queensland Helicopter Rescue air bases;
- 5 community helicopter providers;
- 1 Special Operations Centre;
- 18 administration offices;

- 7 educational centres; and
- 7 fleet management centres.

The QAS also provides services at 14 mine sites around the state. These services are provided on a contractual basis and generally provide for 24 hour, on-site paramedic services. The QAS is also providing services at a construction site.

Stations are divided into five categories depending on their size and workload. Category 5 stations are the 24 hour stations. There are 77 Category 5 stations around the state. Category 4 stations run both day and afternoon shifts and provide on-call support after hours. There are 15 Category 4 stations. Category 3 stations have two paramedics working day shifts and provide on-call support after hours. There are 34 Category 3 stations. There are two types of Category 2 stations – Catergory 2A has one paramedic working an eight hour day shift who works on call after hours (46 stations) and Category 2B has one paramedic working a ten hour day shift who works on call after hours (52 stations). Catergory 1 are the Honorary stations. There are 29 Honorary stations, of which 14 are hospital based ambulance services.

Organisational Structure

The QAS' structure is hierarchical. The Commissioner is supported by a Deputy Commissioner, Assistant Commissioners for Strategic Development and Service Planning and Resourcing and the Medical Director. There are Assistant Commissioners for each of the QAS' seven regions – Far Northern, Northern, Central, South Western, North Coast, Brisbane and South Eastern. These Assistant Commissioners report through the Deputy Commissioner.

Other responsibilities of the Deputy Commissioner include: patient services (operations and communications); special operations and mass casualty planning; industrial relations; workplace health and safety; and the Queensland Emergency Medical Coordination Centre.

The Assistant Commissioners for Strategic Development and Service Planning and Resourcing and the QAS' Medical Director also report directly to the Commissioner.

The Assistant Commissioner Strategic Development is responsible for strategic planning, budgeting and projects; the community services unit, education and training, pre-hospital research, the Queensland Emergency Medical System Secretariat, Volunteer and Community Development Services and Risk and Management Services.

The Medical Director is responsible for Priority One, staff health, clinical governance and standards and medico legal.

The Assistant Commissioner Service Planning and Resourcing is responsible for operational service planning and strategy, information support and performance reporting, capital works (including fleet and equipment), information and communications technology and recruitment and workforce planning.

Within the regions, the Assistant Commissioner will have reporting to them, Area Directors, an Executive Officer and managers for the communications centre, community services, operational support, quality assurance and regional staff development. Depending on the region's size or attributes, there may be managers for patient transport (in South Eastern, Brisbane, South Western and North Coast regions), mine sites (in Central region) and mass casualty (in Brisbane region).

Each of the QAS' regions is divided into between two and four areas, each with an area director, and paramedics work from stations situated in these areas.

The QAS is also assisted by volunteers – honorary ambulance officers – and advisory bodies – such as the state-wide Queensland Local Ambulance Advisory Council, Local Ambulance Committees in many areas and the Queensland Emergency Medical System Advisory Committee.

Department of Emergency Services
Queensland Ambulance Service
Region by location of ambulance station

In brief, the Audit's analysis of these regions has found:

- while the majority of ambulance stations are outside the south east corner, the majority of services are provided and staff are located within the south east corner;
- there is a shortage of paramedics in some regional and rural areas although many regions are above their establishment;
- when employees take leave, it is easier to replace administrative support personnel than operational support or ambulance operatives;
- all regions, though not all areas, have experienced an increase in demand for services;
- by establishing Patient Transport Services, the QAS has sought to reduce the number of paramedics and acute ambulances that respond to non-emergency work.

For further information on the QAS' regions, see Appendix 4.

This regional approach provides a network of ambulance stations around the state. It also means investment has tended to focus on the facility (that is the station) rather than the function (that is the skills and mobile resource that a paramedic represents). This station-based approach to service delivery is, in many locations, inefficient. For example, over half of the QAS' response locations performed two or fewer responses a day in the 2006-07 financial year. The QAS seeks to deal with these inefficiencies through the number of paramedics it has at a station or the number of hours in a roster. The Audit has been advised of situations in some communities where nurses and paramedics effectively compete for work.

The Audit recognises that paramedics provide an essential service. However, decisions need to be made which ensure the best use is being made of scarce health resources.

Progress has been made through, for example, developments such as Isolated Practice Paramedics. These are paramedics who will have additional skills in basic health care management and will work in close alliance with the existing and visiting health care services in rural and isolated communities. This has the dual affect of ensuring communities have access to health services given increasing health workforce shortages and making effective use of an increasingly highly trained resource. Other models which may be appropriate include the development of mobile ambulance response units.

Another approach, evident since the QAS and the Queensland Fire and Rescue Service became part of the one organisation, is joint emergency service facilities and, in some locations, the QAS is located with a Queensland Health facility. There is significant potential for paramedics to play an important role in the delivery of other health services in many communities. It is the Audit's view this is most easily achieved by collocation of facilities.

While this is not a measure to reduce demand for ambulance services, it does seek to ensure that the most efficient use is being made of scarce health resources across the state. Any review would need to be undertaken jointly by the QAS and Queensland Health and would need to account for the varying health needs of communities and be informed by local consultation.

While the QAS' structure is regional, its decision making is centralised. A particular example of this is that a decision to establish a Patient Transport Service is made centrally rather than by that Region's Assistant Commissioner. The Head Office function is separate to the operations of the Brisbane Region. It functions include: strategic and operational service planning; performance reporting; education and training; volunteer and community development services; special operations and mass casualty planning; recruitment and workforce planning; capital works (including fleet, facilities and information and

communication technology); clinical governance and standards; medico legal and other organisational functions (such as workplace health and safety and industrial relations).

At June 2007, Head Office had 161.55 FTE personnel, of these 55% were corporate support personnel and a further 22% provide clinical support. Head Office accounts for around 21% of the total QAS budget.

The Audit appreciates there are economies of scale in consolidating these functions these types of functions within one area, there would appear to be scope to reduce the level of overheads within the QAS. This issue has been discussed in detail in Chapter 3 – Budget and Resourcing.

Legislative framework

The functions of the Queensland Ambulance Service are set out in a wide ranging piece of legislation – the *Ambulance Service Act 1991.*

The Act enables the QAS to provide services such as emergency treatment and pre-hospital care and transporting sick or injured people, as well as first aid and cardiopulmonary resuscitation education and identifying and marketing products and services.

Ambulance Service Act 1991
3D Service's Functions
The functions of the service are –
(a) to provide, operate and maintain ambulance services; and
(b) for ambulance services provided during rescue and other related activities – to protect persons from injury or death, whether or not the persons are sick or injured; and
(c) to provide transport for persons requiring attention at medical or health care facilities; and
(d) to participate with other emergency services in counter-disaster planning; and
(e) to coordinate all volunteer first aid groups for major emergencies or disasters; and
(f) to adopt and put into effect all necessary measures (including systems of planning, management and quality control) to best ensure the efficient and economic operation and use of its resources in providing ambulance services; and
(g) to provide casualty room services; and
(h) to provide community and workplace education in first aid, cardiopulmonary resuscitation and other related matters; and
(j) to identify and market products and services incidental to its other functions; and
(k) to perform other functions given to the service under this Act or another Act; and
(l) to perform functions incidental to its other functions.

The Act outlines the role and governance arrangements for Local Ambulance Committees. Under Part 6 Offences, sections 43 and 48 prohibit the establishment of a service or the use of the term ambulance without the written authority of the Minister. Other offences include making a false calls and failing to give way to an ambulance.

The *Ambulance Service Act 1991* has been amended over time to reflect, for example, Community Ambulance Cover being introduced and the QAS and the Queensland Fire and Rescue Service becoming divisions of the Department of Emergency Services, rather than separate statutory authorities.

The Public Benefit Test Report of the National Competition Policy Review of the Queensland Ambulance Service Act 1991 and Ambulance Service Regulation 1991 noted that the Act "is essentially an Act for the Queensland Ambulance Service rather than for the provision of

Ambulance Services in Queensland" (Department of Emergency Services 2002-3). The Audit agrees with this assessment of the Act.

Advisory Bodies

Queensland Emergency Medical System Advisory Council
Queensland Emergency Medical System (QEMS) is the approach taken to planning for and delivering emergency health care services such as community preparedness and pre- and at hospital patient care. This encompasses health promotion and injury prevention measures, self-aid and community response capability, pre-hospital response coordination and patient care, inter-facility and retrieval services, and the interface with hospital based care through hospital emergency departments.

QEMS is designed to be an integrated and coordinated system of care for the acutely ill and injured. As its parties are all separate organisations, it focuses on the system, rather than an organisational approach to patient care services. (These organisations are public and private health care providers and emergency service agencies.)

The Queensland Emergency Medical System Advisory Council (QEMSAC) links the Department of Emergency Services and Queensland Health. QEMSAC has focused on improving the emergency medical response system by understanding and using data. It aims to streamline data collection, management, sharing and reporting and systems monitoring and reporting and develop emergency medical system service benchmarks. Specifically, QEMSAC is required to review and evaluate health indicators regarding measured quality, sentinel events and clinical audit. It recommended and is overseeing the introduction of Root Cause Analysis (RCA). RCA is a quality improvement technique that explores the chain of events responsible for adverse events in order to identify the factors which caused or contributed to the event, as well as measures that may be implemented to reduce or prevent recurrences of the same type of event.

As the next phase of its activity, QEMSAC will oversee the first detailed review of patient data in the EMS environment which will result in a comprehensive report on the quality of the Queensland Emergency Medical System. This is a strong indicator of the commitment of stakeholders to improving patient outcomes. As part of the Government's ongoing commitment to making information about the quality of the health care system publicly available, the Audit would recommend the results of this report be published.

Medical Advisory Council

The Medical Advisory Committee supports the Commissioner in efforts to enhance pre-hospital patient care. It has four aims:

- to provide a forum for the two-way flow of information between the QAS and the medical profession about the medical aspects of pre-hospital care.
- to monitor and advise on the co-ordination, investigation and interpretation of the medical practices within the QAS.
- to make recommendations to the QAS on matters relating to the development and maintenance of pre-hospital patient care and first aid services.
- to obtain the services of representatives from all relevant medical specialities and other organisations to assist the MAC in its deliberations relating to the provision of pre-hospital care and first aid, including the equipment used.

Meetings are held quarterly and membership comprises four ambulance representatives (including a union representative), plus medical representatives from a range of specialties

including a representative from the Australian Medical Association and a nominee of the Director-General Queensland Health.

Queensland Local Ambulance Committee Advisory Council (QLAC)
QLAC is a high level, community-based, advisory committee which reports to the QAS Commissioner and plays four key roles. It assists the QAS to obtain community views about its standards, policy and strategies. It advocates to the QAS on behalf of the community. It seeks to ensure that equity of access to ambulance services exists across Queensland. And, it aims to build stronger partnerships between the QAS and the community to seek innovative solutions to service delivery issues. QLAC also acts as a conduit between Local Ambulance Committees and the QAS, as well as providing advice and support to Local Ambulance Committees.

QLAC comprises 14 Local Ambulance Committee members (which is two members from each Queensland Ambulance Service region). Committee members are nominated by their peers. The council meets with the QAS Commissioner and the QAS executive at least three times per year.

QLAC was established in 2002, following a review of the Commissioner's Local Ambulance Committee Reference Group. The Reference Group was established in 1995 to provide advice on QAS policy, standards and strategies.

Local Ambulance Committees
At October 2007, there were 183 Local Ambulance Committees, involving 1544 volunteers across the State.

Local Ambulance Committees were established on 1 July 1991 with the commencement of the *Ambulance Service Act 1991* and under this Act their functions are:

- to liaise between the community it represents and the QAS.
- to promote community participation in and awareness of ambulance services.
- to provide advice to the Commissioner in respect of ambulance services in the community it represents.
- to undertake fundraising activities for the benefit of ambulance services in the community it represents.
- to manage money held in trust for the benefit of ambulance services in the community it represents.
- such other functions, as the Minister agrees to.

Every Local Ambulance Committee is held accountable by the provisions of the Local Ambulance Committee Constitution and Part 4 of the *Ambulance Service Act 1991*. They are established as statutory bodies under the *Statutory Bodies Financial Arrangements Act 1982*.

The Local Ambulance Committees provide feedback and advice to the QAS about emergency medical service delivery in their community. In addition, they promote community safety initiatives (such as stinger awareness in the Far Northern Region), contribute to the delivery of quality services and to implement effective ways in which their community can promote injury prevention and preparedness.

The Local Ambulance Committees also raise funds within their communities and apply for grants through programs such as the Community Gambling Benefit Fund. These funds are used to enhance local services and have contributed to additional equipment, training

materials, resources for the station, training manikins, the purchase of vehicles, station enhancements and contributions towards further education for paramedics.

The QAS has a long history in engaging local communities in the delivery of its services. The Audit does not consider there is any need to alter this approach to engaging local communities.

Functions of the QAS

The functions of the QAS that are seen by the community can be divided into three basic categories: emergency patient treatment and transport; non-emergency patient transport and community education and support (including casualty room services, community and workplace education and marketing of products and services, such as the baby capsule hire service).

Emergency patient treatment and transport
Emergency patient treatment and transport are the services provided as the result of a call to Triple 0 – Ambulance (000). The QAS is the monopoly provider of ambulance services in Queensland. However, it is still possible for other providers to operate in Queensland with the approval of the Minister for Emergency Services. Under s43 of the *Ambulance Service Act 1991*, the Minister may licence an operator to run an ambulance service and under s48, the Minister can approve the operation calling itself an ambulance service. The Queensland Government committed to ambulance services tasked through “000” (Code 1 and 2 responses) being provided by the QAS when responding to the National Competition Policy Review of the *Ambulance Service Act 1991* and *Ambulance Service Regulation 1991* in June 2003 stating:

> In considering the recommendations of the Public Benefit Test Report, the Government is strongly convinced of the need to maintain quality of, and access to, essential ambulance services and, in accordance with recommendations contained within the Public Benefit Test (PBT) Report, ambulance services tasked through the triple zero “000” facility will continue to be provided by the QAS. Consistent with the intent of the PBT Report, this will retain a single provider with the capacity to successfully deliver a State-wide response. This was a key outcome that was identified and unanimously supported throughout the targeted consultation process. (Queensland Government, 2003: p2.)

The Audit has proposed a range of alternatives for responding to “000” calls including referring to alternative providers, such as general practitioners, community health and other transport providers. The Act should be reviewed to ensure there are no impediments to this occurring. Further information on the alternative service delivery model for emergency ambulance is contained in Chapter 2 – Demand Management Strategies.

Non-emergency transport
In relation to non-emergency patient transport (Codes 3 and 4), there have been a range of developments over the last years. Non-emergency patient transport is a lessening proportion of QAS activity, but the number of non-emergency patients transported has been increasing. Members of the community cannot organise a non-emergency transport – they are authorised by general practitioners or hospitals calling 13 12 33. This call is directed to a Communications Centre and transports are provided an MPDS Code 3 or 4, (see Figure 5.1 for a breakdown of the MPDS – Medically Authorised Transport – categories).

Figure 5.1: Medical Priority Dispatch System Code 3 and 4 responses

MPDS Code 3 and 4 – Medically Authorised Transport	
3	**Pre-booked on time**
3A	Time critical non-emergency response, paramedic required – eg all transports to hospitals and medical facilities with a defined appointment time requested at time of booking
3B	Time critical non-emergency response, Patient Transport Officer required – eg all transports to hospitals and medical facilities with a defined appointment time requested at time of booking
4	**Pre-booked clinic**
4A	Routine transport – not time critical – paramedic required – eg all post treatment transports, negotiated hospital discharges (excluding aerial) etc
4B	Routine transport - not time critical – Patient Transport Officer required – eg all post treatment transports, negotiated hospital discharges (excluding aerial) etc

The National Competition Policy Review of the Queensland *Ambulance Service Act 1991* and *Ambulance Service Regulation 1991* Public Benefit Test Report made a range of recommendations which supported greater contestability in non-emergency patient transport. By implication, the Queensland Government's response (June 2003) acknowledged the interest of other parties in delivering non-emergency patient transport, and strongly supported the recommendation to retain a non-delegable authority of the Minister to approve alternative ambulance providers.

At that time, the Queensland Government did not consider it viable to develop a Regulation stating that "While a Regulation may enhance transparency of market entry, it also places a considerable compliance impost on supplier organisations, particularly those that have already gained Ministerial approval to operate in the Queensland ambulance transport market" (2003: p3).

Currently, there are fewer than 10 single operator services in Queensland who have been approved by the Minister to provide ambulance transport services. These include community helicopter providers, contracted private ambulance providers at mining and industrial sites and private hospital based non-emergency ambulance transport vehicles.

The absence of agreed criteria has acted as a further barrier to entry to the market for non-emergency patient transport. Recently the Minister for Emergency Services has been asked to approve an assessment process and assessment criteria to assist in assessing applications to provide ambulance transport services in Queensland. This follows applications from several businesses (some dating back to January 2005) to operate wider scale patient transport services. These applications have fallen into two categories – mine based work and transferring individuals between hospitals and diagnostic centres. In addition to these formal applications, taxi companies have expressed interest in providing dedicated non-emergency patient transport services.

While the QAS has not taken any steps to make non-emergency patient transport contestable, the Patient Transport Service (PTS) was introduced in the 2004-05 financial year. PTSs have succeeded in reducing the non-emergency patient transport load for paramedics. At a minimum, PTS officers have a Certificate III (Non-Emergency Patient Transport). PTS officers may respond to Code 1 and 2 responses; however, they are not authorised to undertake acute care, only advanced first aid in an emergency.

These dedicated, non-urgent services provide coverage from during daylight hours, Monday to Friday. After hours non-urgent services are generally provided by two paramedics in an acute vehicle.

Patient transport services have been established in many jurisdictions in response to increasing demand for acute ambulances. They generally use the same approach but, for example, hours of operation may differ. For example, the New South Wales Patient Transport Service operates from 6am to 10pm, Monday to Friday. In Victoria, non-emergency patient transport is a privatised industry regulated by the Department of Human Services.

From the data that has been provided to the Audit there appears to be potential to establish more PTSs, alter the operating hours of the PTSs, or to open the market to greater contestability through either contracting out of non-emergency services or outsourcing.

In South East region (headquartered at Beenleigh and also covering the Gold Coast and Ipswich) the QAS has worked with community organisations that provide community transport. Staff in these community organisations have undergone additional training to meet QAS requirements as part of a pilot project that provides Medical Practitioners with an additional transport option. Community Transport Operators in South East Region provided 31,249 transports in 2006-07 at a direct cost per transport of $13.09. This compares with the South East Region PTS providing 25,040 stretcher vehicle transports at a direct cost per transport of $103.77. This is an average cost of service delivery and includes overhead costs associated with the QAS administration and communications centre costs.

A reasonable argument can be made that non-emergency transport is not core business of the QAS, particularly in an environment where there is increasing demand for emergency transport and treatment options. With paramedics being an increasingly skilled profession, it can also be argued that using a paramedic for non-emergency transport, which can happen, is a waste of finite resources.

There is insufficient total demand in all areas of Queensland to contest all non-emergency patient transport. Therefore, any approach needs to recognise that existing models of service delivery will continue in some parts of the state. This includes using the Royal Flying Doctor Service and other similar services, using acute vehicles and crews for long-distance trips in isolated communities, and arrangements for handover of patients between regions for long-distance transports.

The Audit suggests focussing on the PTS and Code 3B and 4B responses – work which does not require paramedic support. Already PTS' undertake over 65% of Code 3 and close to 75% of Code 4 responses. There are two options to make these services contestable: either the QAS and / or Queensland Health contracts for non-emergency transport services on behalf of clients or outsources non-emergency transport services.

The positives and negatives of both models are relatively similar. Alternative transport providers are likely to be able to provide a more cost effective service by using different vehicles and having a lower overhead cost structure. However, clients may have to pay for a service that is currently free and this may require a reduction in the CAC levy. The interest of community operators and businesses is likely to be high, but their capacity is unknown. Both options free up financial resources to transfer to emergency support and transport options. And both options have industrial implications.

Contracting out of services could be done at the regional level, based on a needs analysis and through the running of a competitive tender process, with a focus on quality, timeliness and cost.

Outsourcing would devolve decisions about what the most appropriate transport option is to the individual and their general practitioner or the individual and their hospital and would lead

to multiple transport operators marketing themselves to hospitals and general practitioners. Outsourcing of services is likely to require legislation to establish a licensing system to ensure private providers have the clinical skills and equipment required to protect the patient's health and safety.

Clearly there are industrial implications as the QAS is committed through its latest Enterprise Partnership Agreement to maximum employment security for its employees. Further, at 2.3 Employment Security, the 2005 Enterprise Partnership Agreement, states:

(c) Any organisational change undertaken by the Queensland Ambulance Service will demonstrate clear benefits and enhanced service delivery to the community. Such organisational change will not result in unemployment for permanent Queensland Ambulance Service employees other than in exceptional circumstances. Where changes to employment arrangements are necessary, there will be active pursuit of retraining and deployment opportunities. The Queensland Ambulance Service will advise the LHMU of any intention to implement changes that may affect the employment security of Queensland Ambulance Service employees prior to commencement of any planned changes.

This was a scaling back of the commitment in the 2002 Enterprise Partnership Agreement which stated that:

(1) The QAS is committed to maximum employment security for its employees by remaining as the preferred provider of existing services to Government and the community.
(2) It is the QAS intention that future organisational change and restructuring will be limited in scale. All organisational change will need to demonstrate clear benefits and enhanced service delivery to the community.
(3) The QAS is also committed to providing stability to the QAS by limiting organisational restructuring and contracting out of services.

The aim of this process is to ensure cost effective non-emergency transport services and manage the effects of increasing demand for non-emergency services. There would need to be a review of the criteria on which general practitioners and hospitals determine the need for paramedic support for a non-emergency transport (that is the patient's mobility and clinical characteristics). Any process would need to ensure there is a thorough understanding of existing costs and what costs would be retained under a purchaser / provider model. The process should also seek to maximise the use of existing resources and have a clear understanding of the role of communication centres. To test the approach, outsourcing or contracting out could be piloted in a region.

Ancillary Services

The QAS provides a range of services which are specifically provided for or implied in the *Ambulance Service Act 1991*, which can be regarded as ancillary services. The include community education and community safety services, pre-hospital research and history and heritage services. In other Australian states and territories these services are generally provided by the non-government sector.

Community Education

The QAS delivers first aid instruction and other community health awareness programs.

<u>First aid</u>

The QAS offers a variety of first aid courses, from introductory first aid through to advanced resuscitation and automatic external defibrillation techniques. The QAS' approach to and

delivery of first aid training has changed over time. The QAS became a Registered Training Organisation in July 2001 and the most recent review of first aid training resulted in an upgrade of delivery and assessment resources and the transition, in July 2007, of first aid courses to a new Health Training Package. This training is delivered under the national first aid training standards which ensure consistency in competency standards, assessment guidelines and Australian Qualifications Framework qualifications for specific industry sectors or enterprises requiring first aid or emergency response training. The Audit understands the QAS intends t o to further develop these programs to provide online learning facilities.

In 2006-07, ran over 8,000 courses and issued over 65,000 first aid certificates. However, the QAS has a decreasing market share in this community education sector. The Audit recognises the role that education plays in assisting people to provide basic first aid or first aid before a paramedic arrives on a scene and recommends community education services remain full cost recovery.

CPR for Life

CPR for Life is a free program which seeks to increase the number of people trained in cardio-pulmonary resuscitation. This is done by training people to recognise the early signs and symptoms of heart attack, the importance of calling "000" quickly and also how and when to perform the single operator adult CPR. Over 40,000 people have been trained under the CPR for Life program since its inception.

Following a 2004 Queensland Government election commitment to ensure all state Year 12 school leavers had access to CPR training, a partnership with Education Queensland was developed under the CPR for Life in Schools initiative. In 2005 and 2006 over 42,000 Year 12 state high school students were trained in CPR awareness as part of the CPR for Life in Schools initiative.

Given the positive effect a bystander providing CPR can play in surviving a cardiac arrest, the Audit supports the continued provision of free CPR training.

Community Safety

Baby Capsule Hire Service

One of the most visible community safety services the QAS provides is the Baby Capsule Hire Service. The aim of the Baby Capsule Hire Service is to provide a low cost, affordable and accessible alternative to the purchase of capsules and there are three components to the program:

- capsule hire services (which is supported through revenue generation);
- private restraint fitting services (where there is no fee for service); and
- private restraint checking services (where there is no fee for service).

Clients access the hire and fitting services through Smart Services Queensland and the services are delivered across 29 dedicated fitting locations, mobile and emergency fittings by 249 trained fitters (239 of which are paramedics).

While the QAS is not the only organisation to hire baby capsules, other providers will advise clients to access the QAS' restraint fitting and checking services.

Given the contribution of road accidents to childhood injury and fatality each year, the Audit does not question the importance of having affordable access for child car restraints. Prior to 2003, restraint fitting and checking services were provided on fee for service basis and the

Audit recommends the QAS seeks to recover the costs of fitting and checking services, and consider a subsidised rate for pension and concession card holders for equity reasons.

Injury and illness prevention
QAS delivers a number of targeted community safety programs by itself or in partnership with other government or non-government agencies.

PrimeSafe - developed to teach primary school students (Prep to Year Three) how to identify, prevent and respond to a medical emergency. The key PrimeSafe messages are in a medical emergency seek the assistance of an adult, and always call 000.

Prevent Heat Related Illness initiative – due to deaths resulting from the 2003-04 heatwave, the whole-of-government Queensland Heatwave Response Plan was developed. QAS's Prevent Heat Related Illness initiative provides targeted advice for babies and infants, outdoor workers, the elderly, and sports people with strategies for recognising and preventing heat related illness. The key priority is to ensure community members are educated and prepared to respond appropriately during a heatwave.

Childhood injury prevention programs - Queensland has one of the highest rates of injury in Australia and children in the 0-4 age group are particularly vulnerable to injuries, such as drowning, poisoning, burns and falls. The incidence of injury in young children is particularly high in rural and regional areas of Queensland and as such QAS has developed the One Step Ahead short course which aims to familiarise carers of children from 0-4 years with basic strategies to reduce the risk of injury occurring in and around residential settings.

Project DOV (Drug Overdose Visitation) - Project DOV is a collaborative project between QAS and Teen Challenge Queensland. Project DOV utilises a brief window of opportunity to assist those with a drug problem or those who have attempted suicide, make the steps forward in recovering their lives. A Project DOV Coordinator from Teen Challenge contacts the person within 48 hours of a paramedic referral to provide follow up support, arrange for counselling, drug detoxification, drug rehabilitation and or referral to other agencies as required.

The Audit recognises the QAS can improve health and safety outcomes in rural and remote communities where there is limited access by other providers due to high costs of program delivery in these locations. However, the Audit considers there is value in a more structured approach across the health services to delivering injury and illness prevention programs, a wider range of providers being involved and rigorous evaluation of the effectiveness of programs.

The Audit recommends a review of injury and illness prevention programs delivered across all agencies. The Audit recommends that programs be based on an analysis of regional priorities and needs and that every effort is made to work in partnership with non-government agencies and that formal evaluation occurs to ensure programs are having the anticipated effect.

The Australian Centre for Pre-hospital Research
The Australian Centre for Pre-hospital Research is a collaboration between the Queensland Ambulance Service and the School of Population Health, University of Queensland. It was established to provide a focal point for pre-hospital research and facilitate interaction between the profession and researchers to develop the evidence base for pre-hospital care. It manages a longitudinal research project which generates data for Key Performance Indicator reporting on survival from out-of-hospital cardiac arrest.

Since 2003-04, the Centre's clinical research program has focused on three priorities:

- cardiac outcomes;
- respiratory management; and
- trauma and injury.

The Centre is sustained by Queensland Ambulance Service funds (on average $450,000 per annum) and secures grants for specific projects. The Centre has generated an additional research budget of $2.5 million since 2003.

On 1 July 2007 new governance arrangements were established, with the stated aim of providing a stronger base for growth of the Centre, both in terms of its academic associations and the extent of its public sector / operational capacity. The Centre is now contained within the Queensland Ambulance Service, which has an academic partnership with the Faculty of Health Sciences, University of Queensland. The position of Director was established as a public sector position, with 20% of this person's salary contributed by the School of Population Health.

The Audit is supportive of the concept of the Australian Centre for Pre-hospital Research. It can provide independent analysis of efficacy of emergency treatment, analyse and develop new modes of practice and research improvements into the delivery of pre-hospital emergency medicine. However, the decision to house the Centre within the Queensland Ambulance Service is not supported. While not objecting to the Queensland Ambulance Service contributing funding to the Centre, the Audit would recommend the Centre be housed within a university, following a public tender.

The Audit notes the Centre has recently won an Australian Research Council Linkage Grant to consider factors driving demand for ambulance services. The Audit considers this will be a valuable contribution to the work in this area.

History and Heritage
Unlike many organisations, the QAS has had a strong focus on recording the contribution it has made to Queensland's social history. The QAS collection consists of two period buildings (the old Wynnum and Charters Towers Ambulance Stations), a part of the whole-of-Department of Emergency Services site established at the Australian Workers Heritage Centre in Barcaldine, 11 historic ambulance vehicles (the oldest is from 1926), over 6000 photographs, records, documents (including the minutes of the first Committee meeting in 1892), equipment and training artefacts and period uniforms.

Volunteers conduct tours of the Museum sites as well as prepare and maintain the museums for public visits. Ambulance vehicles and equipment are loaned by specific requests to film and theatrical interests.

Managing public access and supporting the ongoing preservation of these items has required an investment in resources, security and registration. Supporting the Heritage and History Committee, a QAS Manager, History and Heritage position was established to manage the collection and its supporting resources. An Honorary QAS Historian has been appointed to assist with the historical enquiries. The Historian also assists the History and Heritage Manager with requests for research services.

While clearly not a core service, the existence of the history and heritage function reflects the strong commitment that local communities have had to their ambulance services. The Audit recommends that responsibility for History and Heritage be transferred to the

Queensland Local Ambulance Committee Advisory Council and that it seek to become self-funding over time.

While all these services have merit, the Audit is concerned that they are not core business for the QAS. Savings that could be realised be reducing ancillary services have been outlined in Chapter 3 – Budget and Resourcing.

Chapter 5 – Organisational Effectiveness and Service Delivery Model Recommendations

Recommendation 5.1

QAS move towards deploying additional resources via mobile resource units rather than establishing additional ambulance stations across the State and that QAS work with Queensland Health to facilitate the co-location of ambulance with Queensland Health facilities in rural and remote areas.

Recommendation 5.2

Non-emergency services to be made contestable in Queensland recognising that a certain level of service will need to continue to be provided by the QAS.

Recommendation 5.3

Government amend the *Ambulance Service Act 1991* and associated legislation/regulations to ensure there are no barriers to establishing alternative referral paths and an expanded scope of practice for paramedics to deal with "000" callers, or barriers to introducing greater contestability in the provision of non-emergency ambulance services.