C O R R E C T E D T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Subcommittee

Inquiry into the Victorian Rural Ambulance Service – Fulfilling a vital community need

Melbourne – 10 November 2003

Members

Ms C. Campbell
Mr W. Baxter
Mr J. Merlino
Ms G. Romanes

Chair: Ms C. Campbell

Staff

Executive Officer: Michele Cornwell

Witnesses

C. Brook, Executive Director, Rural and Regional Health and Aged Care Services, Department of Human Services; and

D. Kimberley, Chief Executive Officer, Rural Ambulance Victoria.

The CHAIR – I declare open the Public Accounts and Estimates subcommittee hearing on the follow-up review of the Auditor-General's report on *The Rural Ambulance Service – fulfilling a vital community need.*

I welcome Dr Chris Brook, Executive Director, Rural and Regional Health and Aged Care Services, Department of Human Services; and Mr Doug Kimberley, Chief Executive Officer, Rural Ambulance Victoria.

All evidence taken by this subcommittee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript early next week.

Thank you very much, gentlemen, for your attendance. To go to the first of the questions that I would like to pose: What commitment does the Department of Human Services have towards providing for RAV beyond what is included in 2003 Rural Health Service, particularly in relation to the fact that there have been discussions under way and an enterprise bargaining period occurring at the moment?

Dr BROOK – Sorry, I am not quite sure – are we talking about –?

The CHAIR – Yes.

Dr BROOK – The department's increased budget for Rural Ambulance Victoria this year was $3.8 million. That money is allocated, as is normally the case, for specific outcomes, so that includes increases in professional staffing at Kangaroo Flat, two-man crewing in a total of five rural branches, some upgrading of some other branches, some expansion of new models of care – the community emergency response teams, and a new service model in Omeo and Mallacoota. That is on top of the moneys that have been provided to RAV over the past several years – which have been substantial. The service finished last year with a surplus of $3.8 million, which just happens to be the same figure as the increase in budget this year, but that is purely coincidental.

Any funding that would result from the outcome of enterprise bargaining would be funded at that time, so there is no specific allowance made in that $3.8 million for enterprise bargaining outcomes. Should there be a change to the way that arrangement occurs, it will be in the future, but at the moment funding increases, CPI and growth are given to the service and if there are specific EBA outcomes they are funded separately.

The CHAIR – Thank you.

Mr BAXTER – I feel myself at somewhat of a disadvantage in having just got the documentation earlier today, so I haven't come along with any great questions to ask. I say at the commencement, though, that I take offence at the overview statement that prior to 1997 there were five small unprofessional services in country Victoria. I represent many of those people. I don't think that takes account of the tremendous amount of input and volunteer work and fundraising that has been undertaken over many, many years by a lot of people. The fact that those five services got into difficulty was not entirely of their making; if it were not for the accreditation of the ambulance union and increasing expectations and requirement by government, I think those services would have continued. So I don't want to make a big issue of this, but I do really feel affronted that the work of those people is thus described five years later. So I will pass for the time being. Thank you, Madam Chair.

Mr MERLINO – My question is related to performance measurement. My understanding is that the annual report provides a great level of statistical information but not a lot of information in terms of setting performance targets or goals in terms of operational performance, of judging operational performance. Can you tell me what steps are being undertaken to develop meaningful performance measures and benchmarks for the economy efficiency effectiveness and the cost of the operations?

Dr BROOK – Yes. There is a range of different ways in which the information regarding Rural Ambulance Victoria is reported. Some is reported in its annual report; others are reported through national data collection to the Conventions of Ambulance Authorities, others are reported in BP3. I think it is fair to say that to date there has not been as comprehensive a series of data on performance for RAV as has been the case, for example, for the Metropolitan Ambulance Service. A great deal of work has been done, and this in some sense traverses not just the development of performance measures for quality purposes but the funding model which has been progressively developed and is still being developed; that looks at the concept of what is the nature of Rural Ambulance Service, and how does one make sense of this complex beast over a large range of quite various demographies.

The work that has been done on the funding model and on the development of very good human resource systems and analytic systems within RAV since its formation has meant now that it is quite possible to look at the costs of ambulance services in two ways: to look at availability costs – a very important concept in ambulance as opposed to other kinds of human service delivery, because like other emergency services it has to be there, whether used or not; and activities. So that is the general split that is available.

Within availability are the fixed costs – what comprises the efficient configuration of various types of ambulance stations: if it is a fully professional two-man crewed station, what are the input configurations that are appropriate for that kind of service, and so on, through single-officer stations through to community stations and the like.

We would expect that whether in BP3 or through other publications that we would be able to release information about those kinds of appropriate levels of configuration – EFT and the like.

There are lots of other measures of performance, though. The most common is response time; and the most common quoted is response time. In this year's BP3 statement we have published for the first time a state-wide response time in addition to the response times for just metropolitan ambulance services, which to date has been the most common.

The difficulty for us in relation to rural ambulance response times is that there are no standards, while there are standards for particular types of response in the metropolitan area where you have a reasonably compact area. I mean, it may be congested but international response times don't apply when you are talking about things that are as various as Warracknabeal and Hopetoun as opposed to Melbourne. So there is a great deal of consideration being given both at our own level and nationally through the Conventions of Ambulance Authorities – if I have the name right – to look at what is an appropriate set of standards that can take account of the fact that clearly response timing in a regional city is going to be different from response time in a dispersed broad area.

But if you look at BP3, the inclusion of figures this year and the targets there indicate that we do expect to have 50th percentile response times of nine minutes statewide, so that that is one minute more than the expected response time for metropolitan areas, which is a pretty good target, a pretty stretched target; and likewise a 16-minute target for the 90th percentile as opposed to 15 minutes for metropolitan only.

In reality of course, the response times for the 90th percentile in rural areas is longer than 15 minutes, but again that is because you are looking at the whole of the state. There are also such things as the percentage of audited cases that meet clinical protocols. That is information that is published in BP3, but only at this stage for metropolitan ambulances. There is no particular reason why that can't be reported for RAV as well. In fact, it will be reported in next year's BP3, subject to the usual change of BP3 reported information. The clinical audits are conducted; the number of complying cases in RAV is similar if not identical to that in MAS, and that will also be reported. So those two things will continue in BP3 for next year. If it were possible to get nationally agreed response times, then they would be put in as appropriate for rural Victoria. Certainly, for clinical audits that will be put in. And certainly there will be better information published in RAV's annual report and other publications in relation to what is the appropriate configuration of ambulance services, what is happening with EFT and where.

There is then a further body of work being conducted clinically. Again, not just in this state, but nationally, looking in conjunction with a range of medical and other advisers to see if it is possible to develop a suite of clinical indicators – such things as survival after cardiac arrest, and so on and so forth, that may be useful to give a broader feel for the quality of service provided. Those things in the first instance will be internal, partly because there will be probably a number of them and they will need to be very vigorously tested, and partly just to the make sure they are appropriate. But in due course one would hope such things do become within the public domain. I am not sure if that answers your question.

Mr MERLINO – That's fine, thank you.

Mr CLARK – Just following up on Mr Merlino's question: I understand that in a press release dated 14 October 2003 the minister referred to a response time for the 90 per cent of emergency cases at 28 minutes in Ballarat, and 28 minutes again in Mildura. I would have thought that the Ballarat and Mildura areas – particularly Ballarat – would have been among the better performing areas. Do you have an explanation for what the minister has said in the media release, and what you have told us about response times?

Dr BROOK – I might ask Mr Kimberley to add to this. However, I will make a couple of comments. Overall response – 90th percentile response in Rural Ambulance Victoria is 24 minutes, so across the state outside of the metropolitan area the 90th percentile is 24 minutes. Ballarat, of course, refers to the Ballarat dispatch area; it is one of the five dispatch areas, so it is not Ballarat city, and I will pass over on that one.

Mr KIMBERLEY – I will say a couple of things in support of what I am about to say. In RAV now we do 50 per cent of our cases in 5 per cent of the postcodes in the state. So it is an important one to add in mind, and 90 per cent of our cases are in 27 per cent of postcodes. So there, I guess, a high proportion of our work is done in a few of the postcodes, and then you have very significant outliers that stretch times out – well, sometimes over two and a half, three hours – so that is an important thing to look at.

The other thing that I need to say is that 50 per cent of all cases are responded to in nine minutes, so in the larger provincial and rural towns where we are operating we either have very quick response times, which you would expect and I would expect, but it is the actual catchment areas of some of these others such as Ballarat and the other one you mentioned, that we travel significant distances. In fact one of the initiatives this year in the Ballarat area is that we have a community officer branch at Ballan that will go to a professional branch, recognising the need for those response times to improve; and we are looking at that right around the state. Mildura is another one where there is a commitment for an additional branch at a Mildura south location.

The CHAIR – I would like to look at your progress towards developing clinical service assist performance measures, and Dr Brook has flagged that briefly in an earlier response. You also flagged that you are looking at putting that in the annual report. What progress has been made to enable that to actually occur? Or I will use the phrase 'clinical audits'; are they different to clinical services performances?

Dr BROOK – They are a specific version of clinical measures. The clinical measures that are directly being built on at the moment are the number and type of clinical audits, the number of branches, staffing profile, number and types of vehicles, utilisation to vary ambulance and EFT numbers, and that is to what I was referring earlier.

There as been a great deal of work in clinical audits, which now is believed to be at a level equivalent to MAS. That information is reported to the department quarterly. As I said before, previously that information had not been published in BP3 or anywhere else, but it certainly will be.

In relation to clinical standards: Since 1999 there has been a tiered approach to statewide clinical structures to support a range of clinical activities, only some of which are suited to regular reporting, but they sustain the clinical quality with the service. There is a centralised clinical standards committee that comprises four RAV medical advisers and the department's senior medical advisers. That group meets in conjunction with operations managers and others from RAV to look at not just clinical standards but their application and implementation.

I think it is very important that RAV has developed an educational services department that has its own dedicated manager, and has been very active in ensuring that there is ongoing education with two dedicated clinical training days per year for each operational officer. Those two days are highly focused on clinical review and the introduction, where appropriate, of clinical competencies. That initiative has been in conjunction with the introduction of a statewide process of clinical review looking through retrospective patient care review.

Now some of the output of that goes into the simple measure of the number of audited cases, which is the single one. There is always a compromise as to what one reports not just what one does, and what one measures and how one reports it. Clearly, as I alluded to earlier, there is not much value in the public domain having 15 or 20 quite complex indicators when people are really interested in something else. That activity is proceeding appropriately, and hence the clinical audit report has been the one people are focused on – and what percentage of cases.

The CHAIR – But my question goes to the annual report, which is the particular focus of the work of VEAC (to be verified).

Dr BROOK – Correct. As I said earlier, that is not reported in the annual report, but the measures that I previously discussed will be. This is work that is being conducted with the Conventions of Ambulance Authorities. But that goes to more than just clinical. It will also be reported in BP3 as of next year, as it is for MAS.

Mr KIMBERLEY – Our clinical audit is greater than 92 per cent on all cases. We are also involved at any one time in about 10 research projects with various research bodies around Victoria and Australia to underpin pre-hospital care service delivery. That all goes through our medical standards committee, so in that way we are very focused on clinical outcomes and measurement of how we are going.

The CHAIR – Can we look forward to some of that being in annual reports at some time?

Dr BROOK – As of next year you will get the clinical audit material in annual reports.

Mr BAXTER – Looking at the financial summary for the protected zone 304, on the face of it bad and doubtful debts are very minor, but of the transport fees taken into account, I suppose a lot of those transport fees are guaranteed because they are paid by TAC or the Commonwealth; can you give us some idea of what the collection is like for fees that are incurred that are the responsibility of the patient and no other one in terms of how we are going on that, please?

Mr KIMBERLEY – We have a reasonably low bad debt record. We work very hard on that activity and have in fact made it our business to ensure that we do get as much revenue as possible through that without recognising the sort of business we are in and the service delivery we provide. To say that TAC and others always pay is not quite right. As an example, a significant number of our bad debts do come as a result of motor vehicle accidents where people don't make a claim through TAC, and if there is a statutory period – I think it is 12 months, but I am not quite sure – but there certainly is a statutory period. If a person doesn't make a claim, then TAC won't pay, obviously. We can tell them that this person should be TAC, but not the individual – and we try to encourage the individual to do so.

The number of bad debts for those who are not even subscribers, or that are not through TAC or through the Commonwealth, is fairly small. And in fact the majority of those are people who either give us a false address, or some other issue arises whereby we just can't contact them.

Mr BAXTER – So there is some indication of fraud, perhaps, by people? That might be too strong a word, but you have been given a bum steer?

Mr KIMBERLEY – Yes, or they shift very regularly – or whatever it might be – but it is not a large number.

Mr BAXTER – Where you can identify a recalcitrant, do you eventually engage debt collectors?

Mr KIMBERLEY – We do. However, recognising the cost to do that and the level of those debts and the amount of those debts generally, there are not too many that are pursued by debt collection.

Mr MERLINO – My question is about the effectiveness of the communication system of RAV compared to Metropolitan Ambulance Service. I note that $5 million has been provided to upgrade the communication system this year. Can you tell me what further improvements will be needed to get it up to a comparative level with the Metropolitan Ambulance Service?

Dr BROOK – The whole strategy in relation to future communications is being managed through the Bureau of Emergency Services Telecommunications. SIPSACS is the strategy being developed – the Statewide Integrated Public Safety and Communications Strategy.

I think it is fair to say that RAV has, with the department's support, had to develop a transitional strategy in anticipation of SIPSACS because it will be some time before SIPSACS will be rolled out in regional and rural Victoria. What has happened as a result of that, because of the nature of the underlying telecommunications infrastructure, is that RAV with DHS has identified a strategy of $11.8 million which will provide it with modern telecommunication equipment and computed-aided dispatch and the like, and in due course vehicle location and all the other attributes within that.

Just this year the government was able to announce the $5 million funding boost for that. There is, in addition to that, a $4.6 million commitment as part of Labor's financial statement, too, so that in total there is $9.6 million of the $11.8 million available. It is our hope and expectation that we will be able to in time – in whichever budget cycle – fulfill the rest of that. Work is under way to replace radio equipment and the refurbishment of operation centres. And in due course, when the LFS funds flow, that will enable the development of computed-aided dispatch, a further upgrading of the radio network and some mobile messaging. That will all proceed in the course of the next. Some of it is proceeding now, the radio network update and the refurbishment of operation centres. And we expect with the LFS funding as of next budget cycle, there will be further development there. Now that will put RAV in a position where it is really on a very sound footing, and it will then be a matter of how that integrates in due course with the SIPSACS function, but I will hand over to Mr Kimberley for further comments.

Mr KIMBERLEY – I am on the ministerial steering committee for SIPSACS, as are heads of other agencies involved. RAV at the moment is involved with CFA and SES on one of those projects, the emergency alerting system, because Telstra will be going out of emergency alerting within about 18 months time. Although we have our own emergency alerting system, it is, together with our radio system, aged, so we are working through that. I understand that the metropolitan mobile radio and metropolitan data network are obviously critical to the state, and they will obviously get up first. But we recognise with our ageing system that there is a need for us to move forward and not wait for the five or so years that it is reckoned it will take for rural radio systems, et cetera, to come through.

What we have put forward is a bridging strategy, or a transition strategy, that will enable us, we believe, to upgrade our current radio system. Certainly we are purchasing new radios, and the tender has recently closed for those – in such a way that it will integrate with a new system – and I guess you would call that a whole-of-state system once it moves out from the metropolitan area; it will have all of the components that we are working on at the moment. In developing up that strategy we have done that in close concert with BEST and with the other emergency services so we ensure we are going forward to develop a statewide activity.

Mr CLARK – Following on from that, if I could clarify the situation. I understand that part of the bridging strategy is to extend to the whole of Victoria the CAD system developed by Intergraph. Is that still part of your bridging strategy? Perhaps you could answer that, and I will follow through with the second part of my question.

Mr KIMBERLEY – Whether it is the Intergraph system – and that is what we have based our strategy on – or whether it is another CAD system, it really in my mind does not matter; it is a CAD system that rural needs. When it becomes whole-of-state, whatever proprietary system you have in it would be aged anyway and you would move on to what the state was operating. So yes, we have based it on the Intergraph system, but I am not wedded to the Intergraph system, if there were to be a period of time. But it is the CAD system that is really required to be able to control calltaking and dispatch; measurement is the other major issue with the CAD system.

Mr CLARK – The second part of my question goes to timing. I am not sure if you covered this in what you said earlier. But do you have a time identified for when you plan to get a CAD system up and running for RAV; and also in relation to the funding needs – I think Dr Brook mentioned around about $1 million plus – I understand around $12 million cost for the bridging strategy of which the government has now provided $5 million definitely. And I gather from what Dr Brook said, upwards of $4 million additional was in Labor's financial statement 2002, which leaves something in the order of $2 million unallocated at all. What is the expectation for timing on the $4 million balance from LFS, and what is your expectation about the remaining $2 plus million?

Dr BROOK – It is difficult for me the answer that other than to say that obviously all of the Labor financial statement funding will flow during the course of this term of government, and clearly we are in the business of bidding along with everybody else for that to flow in the shortest possible time frame, but I can't pre-empt the government's decision in relation to the precise time of that. The bridging moneys – the amount of money that is left – is in the order of money that we routinely need to find for various things, be it vehicle replacement or other things, and I would anticipate us finding the balance between the $9.6 and the $11.8 in due course.

Mr CLARK – And the timing for the implementation of a CAD system?

Mr KIMBERLEY – Again, that will depend again upon that funding. From the $5 million that we have, we will be building or rebuilding our radio network and purchasing new radios and we will be refurbishing our operation centres. That really takes up the $5 million. The next step is to look at CAD and the other activities.

Mr CLARK – As and when the money becomes available, do you have a priority order for the other settlements, and what is that order?

The CHAIR – That is a fairly long question. Have you got that information here with you?

Mr KIMBERLEY – Yes, I have. The steps that we planned for are radio network upgrade, refurb of the Operations Centres computer-aided dispatch, radio network upgrade 2 – which will have to do with the computer-aided stats – and mobile messaging. They are the five main elements in the strategy.

Ms ROMANES – Dr Brook and Mr Kimberley, I am sure there are always new and changing pressures on RAV. Can you tell us what action has been taken to identify emerging needs and strategies developed to meet those new and emerging needs into the future?

Dr BROOK – It is certainly the case that things never quite stay the same, and in fact consistent with the metropolitan ambulance, and indeed with a whole range of health services, the demand on RAV has been pretty dramatic. Indeed, since its formation there has been almost a 25 per cent increase in demand for Rural Ambulance Victoria services, and in so far as we are able on judge, that is a real and justified demand. It is not some unnecessary utilisation of service.

The very formation of RAV has meant that the data that they and we with them are able to assemble is much greater than was ever the case before. And I indicated earlier that these things all tend to crowd in on each other. So better information about what is happening out there, about the kinds of cases that are being received – emergency and non-emergency and vehicle-based as opposed to aircraft-based – can also blend in with information that we now have available to us about the kinds of funding models and facilities that we need to be able to provide. And as I said earlier, that work is based on the concept of availability – that is the relatively fixed costs of services on the ground including an appropriate level of EFT, and the activity costs. In addition to that, I indicated earlier that we are also looking at different service models – community emergency response teams, if you like, or all first-responder teams and some novel approaches for some very isolated communities. There is a whole range of different things happening.

Some of those lead us to the need to built up to two-officer crewing, and we have seen quite a lot of increase in two-officer crewing in a number of stations around rural Victoria to increase the professionalism and professional support, including for those community-based teams, and to a much greater emphasis on training.

I will pass over to Mr Kimberley to further respond, but the point I make is the very creation of RAV and the nature of the systems and staff that we now have in place ensures that we are much better able to determine what is happening in terms of the totality of the service across the state, and to respond better to those issues as they arise.

Mr KIMBERLEY – A couple of issues I think are fairly important in that are that we see the delivery of Rural Ambulance Services as a continuum in the health sector rather than stand-alone. We have been working very hard to ensure that we are part of the continuum of health provision and the pre-hospital service. In looking at that there are a number of things we balance out: the caseload, when the caseload is and the volume of that caseload. As an example, we are now in a position where we keep very close tabs on growth in particular areas so that we can look at it and ask should we be putting on an afternoon shift as well as our normal day and call, rather than do just day shift and call; and we are on the cusp in a couple of areas of that, so we get breakeven on that. So for every branch that we have – all 118 of them – we are looking at those issues.

We also have some themes around community in ambulance and ambulance in community in that we have to be responsive to particular communities rather than say, "This is what we can provide for you and this is what you need". In that way we have been able to increase the number of ambulance community officers, which is, if you like, the retained volunteer-type officer, group. We have introduced a couple of community emergency response teams, which are purely volunteer, but we equip and train and keep them up to speed at a fairly high level of first-aid and pre-hospital service delivery. We are now looking at two places – Omeo and Mallacoota – where we are putting in a very senior ambulance paramedic who will have skills to fill the gaps in what are the community health responses. In Mallacoota, for example, they have GPs but no doctor, so we are working around a GP and community health centre.

The CHAIR – They have GPs?

Mr KIMBERLEY – GPs and no hospital-type facility, but they have a community health centre. We will be working in closely with them there – and it is isolated, a fairly large community but isolated. In Omeo, on the other hand, they have a hospital and have difficulties at times with doctors, so we are working in closely there. In that way we have taken a proactive role in looking at the requirements of rural Victoria and rural Victorian communities.

The CHAIR – I referred earlier to enterprise bargaining, one of the fairly complex IR issues in anyone's books. I am curious to know what involvement the department has in relation to RAV when industrial issues arise.

Dr BROOK – I will take the liberty of commenting that the industrial environment has been – from the perspective of somebody who has sat through many industrial environments – particularly positive in the past several years. There have been very few issues and disputes notwithstanding that from time to time there are some differences between parties. Certainly the whole creation of RAV and all that is around it has occurred in a very positive industrial environment.

The department has an industrial relations branch, which is not part of my division, but its role is essentially providing central coordination and advice rather than anything to do with hands-on management of day-to-day industrial issues, or indeed the carriage of direct negotiations. Both RAV and MAS as employers are responsible for everything to do with the day-to-day management of industrial relations. And indeed, as we are aware, at the moment there is such a matter before the AIRC, but that is a good example of an exception that proves the rule. They will be the people who will respond to the claim in the forthcoming EBA.

The nature of their response is to be determined. The nature of any employer position is to be determined, but the department's role is essentially not to run things but to provide advice and to coordinate, obviously, across government to ensure that whatever positions that are taken are consistent with government's positions, and to engage in the negotiation process from the point of view of consistency but not as the employer.

Mr BAXTER – Can I explore the WorkCover experience and get some idea of the way it is trending, bearing in mind some areas of mixed activity are higher than we have in the private sector. Looking at the figures there – I can't actually make an assumption on what the levy percentage is with any degree of accuracy – so could you give me and idea, a snapshot on the way it is going, trending, please.

Mr KIMBERLEY – When RAV was formed, it is true to say the overall levy and application of return to work was fairly ordinary. We have taken a very active role to reduce our levy, number one – which you would expect. Secondly, we want to return people to work much more quickly. Just to give you an example. The average cost of claims in the past three years has come down from somewhere around $20,000 to somewhere around $6,000.

Mr BAXTER – That is fairly dramatic.

Mr KIMBERLEY – It is fairly dramatic. In fact, we got an $80,000 rebate last year on our levy. Our levy in fact – well, it is more complex than that. Our levy has gone up because we have opened up more sites. When RAV was formed the levy on the smaller services was not just transferred to RAV; it actually grew, because we became a larger organisation. I don't know the exact formulas they use, but it is not only the number of locations but also the size of the organisation. So in that way we were at a bit of a penalty when we first started. But we have been able to claw that back quite significantly.

Our target is to reduce the number of lost-time injuries. And we are actually working close with Metropolitan Ambulance Service, Ambulance Employees Union and WorkCover at the moment to do that, particularly for people with musculoskeletal injuries. I would expect to see some good results from that next year.

Mr BAXTER – What is the major claim category?

Mr KIMBERLEY – Strains and sprains, musculoskeletal claims, yes.

Mr BAXTER – And your decrease in claim cost is basically because you have improved in that area, or is it in some other area?

Mr KIMBERLEY – It is basically that, but also we are working with people to return them to work more quickly than previously was the case. I think it is an established case that if you work with people to return them to work more quickly – and you may need to transition them through light duties or whatever it might be – they effectively come back to work more quickly.

Mr MERLINO – Following on from your discussion about WorkCover, two questions: has that impacted on reducing overtime costs, the improvements in WorkCover? And secondly, the savings you have achieved – is that within the department, the savings that are shared within the department – or within RAV?

Dr BROOK – Let me answer the latter question one first. Any savings that RAV makes in terms of better management stay with RAV. We don't reap a reward from that. I will make some preliminary comments about overtime and Mr Kimberley may answer further.

Overtime was a significant issue as part of the audit report, and it is one of the key areas that addressed in the consultancy a couple of years ago now. Overtime remains a significant issue for RAV, and there are a range of reasons why that is the case. When trying to manage any human service, obviously there are things that are within management control and thing that are to some extent not within management control. The emphasis RAV has taken is on the attempt to either maintain or reduce overtime hours. They have been successful in so doing, but the cost of the overtime has continued to rise for a number of reasons. Obviously salaries and wages have increased; therefore the literal cost must increase even if the number of hours doesn't. But there have also been the very positive changes themselves. The introduction of two-man crewing has meant the implementation of an eight-hour break rule – and by that I mean that in a quite normal sphere of operations, if there is a daily crew and that day crew is then on call overnight and are called out, they are entitled to an eight-hour break before they are then put back on duty. Unfortunately, that means that the period of the eight-hour break for which they are not on ordinary duty is paid at overtime.

Those work conditions are something that we work within. So those sorts of things mean that you can actually get an increase in overtime costs through nothing more than two-man crewing. There are a range of other reasons why overtime is a difficult one to manage.

I suppose the department's overall view, however, is that notwithstanding, this is a key area where we want to see the very best work possible being done – and indeed a lot of work is being done. Mr Kimberley referred earlier to the fact that he is now able to look at a glance at what is happening in each and every one of the 118 or so ambulance stations and determine precisely what is going on in terms of ordinary staffing and overtime. For example, it might not be better to put an additional afternoon crew on in some of those situations, because that then means there is no need for an eight-hour break, so that the officers on call can achieve an eight-hour break by different means. And that work is, I believe, very close to being implemented in some instances.

To go back to what I was saying: we are very concerned about and strongly support the work being done in this area; the fact is that RAV did actually achieve an operating surplus of $3.8 million last year. So notwithstanding, there are always going to be some areas of budget pressure, it is living within its resources and achieving respectable outcomes.

The CHAIR – You must be positively glowing at that point, Mr Kimberley.

Mr CLARK – Coming back the question of response times, I understand at the moment a lot of the data is collected manually at point of dispatch and then correlated with patient records. How accurate and reliable to you think the current figures are given this manual recording and data entry method; and at what stage of the bridging strategy do you expect data to be recorded by a more automated basis that will give you figures of a reliability with which you are satisfied?

Mr KIMBERLEY – It is very difficult to estimate what reliability there is at the moment, given it is a manual system, it is a manual-use and radio system. So that when a call comes in, somebody records that on a card and that is passed on to a dispatcher and it is recorded when they dispatch. You are then reliant on the officer in the car saying, " We are at the scene" and to put the next time on it, if you like, and then so on and back to base. Wherever you are doing those sorts of things manually, if you are using a clock in a centre, it could be different by one minute to one somewhere else. That's an issue that I think has been recognised all around the world.

There is no thought of anybody intentionally being misleading but there are obviously errors; there have to be, because it is manual, and particularly if you have a high workload for a short period of time, that can impact. So the real answer to automated systems is a CAD system. And that would be the time you would expect that you will have built-in clocks into that system, which will be statewide – or in our case RAV-wide – and the vehicle recording information will be automated as well within that system.

Ms ROMANES – The government overall has adopted an accrual output-based budgeting system with departments funded for their outputs on an accrual and accrued basis inclusive of depreciation. RAV's financial statements, I understand, are prepared on than accrual basis. However, the funding is on a cash basis. Can you explain that to us; why that is the case?

Dr BROOK – All funding of all Human Services is essentially cash-based. There are some exceptions to that, but they are minor. In fact, RAV is one of them, in a perverse sense. I guess the question goes does government provide funding for depreciation? And the answer is that no generally it does not, at least not within the standard output-based funding process. I am actually not the right person to ask that question; it is simply a statement of fact that government does not in general provide funding within its output groups for depreciation. The story is slightly more complex than that, however, that in most instances there is some contribution from within government prices, or from within agencies' own activities for certain parts of the equipment replacement and/or maintenance. So, for example, in the hospital sector there is some contribution from within its own resources for equipment replacement and maintenance.

In general, government makes decisions in relation to large components of infrastructure separately from that relating to prices. I said earlier that RAV is a slightly special case. RAV does receive an amount of money which is now recurrent, for example, for vehicle replacement, and it does receive an amount of money within its current budget where a great deal of work is being done on availability and activity for maintenance. So essentially government does provide for RAV to, for example, replace biomedical equipment – which it has done comprehensively in the past few years; and it provides a recurrent sum of money that meets its obligations in relation to vehicle replacement. What government does not do is provide RAV with depreciation against fixed assets, and that is dependent upon the standard cycle of bidding for capital infrastructure, as has happened in recent years, in RAV's case. But I again emphasise it is not a matter of departmental discretion, it is simply the way the funding works; and while there are some variations on a theme it is generally the case that we don't fund depreciation.

The CHAIR – Just picking up on that point, what is the current basis for negotiating operating capital grants with RAV?

Dr BROOK – The work in progress, what comprises precisely the components of the availability funding, which includes station maintenance costs, for example, and the vehicle replacement costs, is still in place. But we do provide of the order of $3.4 million or $3.6 million per annum recurrently for vehicle replacement. While that might or might not be adequate in any particular year, RAV maintains those funds in reserve, and it currently has substantial sums in reserve in order for it to meet vehicle replacement costs.

A component of the availability fund – and I am sorry I can't offer that level of detail – is therefore the maintenance costs of the ambulance stations. However, for other components, the basis of negotiation, for example, for the rebuilding of Ararat, Bairnsdale, Colac, Hopetoun and Kyneton – the five stations that have recently been rebuilt – is a matter of going through the standard asset replacement bidding cycle through the economic review committee of Cabinet. And likewise, we talked earlier about the communication platform changes. That is a matter of bidding through the standard economic review committee of Cabinet asset replacement processes. However, in that case it is modified with there being an LFS commitment. So there is a more robust basis for it in RAV's case than in many, but there is no automatic access to capital funds for building.

Mr BAXTER – Can I ask a supplementary question. I am not an accountant, so I perhaps don't grasp these things too readily. But in the financial summary you have both a cash column and an accrual column. Who uses which?

Dr BROOK – I think you might in due course need to seek the services of your advisor in relation to that. There are no less than five different ways, I think, at the moment these figures are construed. All figures, of course, are absolutely accurate and audited; but it is the way they are assembled that is viewed differently by different parties. The department traditionally looks at operating results, both on a cash basis and on an accrual basis, taking into account capital injections and accrual, and taking into account capital injections and depreciation. The difficulty for us in that is balance sheet adjustments, for example, evaluation. What does that actually mean?

The RAV approach is very similar to that of the department's. It looks at both operating results on a purely cash basis and results on a partial accrual basis. And of the $3.8 million, it is important to say, that that result is in fact after taking account of equipment depreciation. So from a partial accrual perspective it is a fairly true figure of RAV's financial performance.

The Auditor-General has taken a different view of this position in the past, and has for a number of reasons looked at operating results plus all depreciation but without capital. From the DHS perspective that is a little difficult, because it looks at depreciation against capital but not the input of capital. So that is something different from pure accrual accounting. I am sorry to say that there are also differences in the way these are looked at at the national level, which makes it all the more confusing. But I think the RAV results give you a pretty clear picture, because you do get the cash picture and you do get the result after both injection of capital and depreciation for equipment, which is an important way of looking at it, as that is the way accrual should work.

Mr CLARK – A point of clarification, I might not have picked it up from your previous answers. In *Budget Paper* number 0203 at page 65 there is reference to a performance measure requiring 92 per cent of audited cases to meet clinical practice and standards. I gather that has not been covered yet in RAV's annual report. Does that measure in the *Budget Paper* include RAV's performance on that score, or does that measure in the *Budget Paper* relate only to the Metropolitan Ambulance Service?

Dr BROOK – No. I think as we mentioned earlier, at the moment that relates only to Metropolitan Ambulance Service. There is no reason why that shouldn't apply to RAV, and it will as of next year, subject to changes being made to BP3, which we do not think are problematic. It is the case that RAV does have the same process and the same standard of clinical audits as MAS. And I can confidently say to you that it exceeds 92 per cent of audited cases meeting clinical standards, but for more historic than any other reasons it has not been reported in BP3, more in the agency's annual report.

The CHAIR – Thank you very much. I draw your attention to our estimates report that was tabled in the Parliament in September, and for some light bedtime reading I will direct you perhaps to chapters 15 and 16 rather than to the entire document, because that might give you some indication of why we were asking the kinds of questions we were. It goes to performance management and reporting, and our particular interest in annual reports, so I draw that to your attention on top of the Auditor-General's reports to those other things.

Thank you again for your attendance. It has been an extremely useful session. There may be a couple of issues that we will follow up through the secretariat, so thank you again, and good afternoon.

Witnesses withdrew.