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| Non-Emergency Patient Transport Amendment Regulations 2021  Regulatory Impact Statement |
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Department of Health

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| Non-Emergency Patient Transport Amendment Regulations 2021Regulatory Impact Statement |
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# Executive Summary

Non-emergency patient transport (NEPT) is regulated in Victoria under the Non-Emergency Patient Transport Act 2003 (the Act) and the Non-Emergency Patient Transport Regulations 2016 (the Regulations).

This regulatory framework mandates requirements to establish a licencing system for private non-emergency patient transport (NEPT) operators and prescribes standards and requirements for the provision of NEPT including patient acuity, transport of patients, staffing of vehicles, stand-by accreditation, quality assurance, vehicles and equipment, and infection control.

The current regulations are being amended to support amendments to the Act. The Act is being amended to implement a 2018 Government election commitment, in particular the commitment to improve safety for NEPT staff and patients. The changes are part of a package that will see the introduction of licencing and regulation of the commercial first aid sector, and amendments to the Drugs, Poisons and Controlled Substances Regulations 2017 to allow certain classes of licenced first aid providers to store and administer a restricted range of scheduled medicines.

These amending Regulations are intended to come into effect at the same time as the amendments to the Act which is currently expected to be 30 September 2021. The Regulations, including these amendments, will sunset on 19 April 2026.

The Amendments to the Act will introduce patient safety and quality of service as an objective which in turn leads to a number of further changes to the Act and Regulations. Further changes to the Act include:

* clinical governance processes to be assessed prior to the granting of a licence,
* a minimum number of transports to be undertaken each year
* amendments to the power for the Secretary to suspend or cancel a licence to provide for flexibility and a proportionate application of the power where there is a serious risk to patient safety
* the repeal of stand-by accreditation to provide services at public events
* the introduction of licencing requirements for commercial first aid providers, and
* increasing the penalties for breaches of the Act

In accordance with the requirements of the Subordinate Legislation Act 1994 and the Victorian Guide to Regulation, this regulatory impact statement (RIS) is required to assess the proposed Regulations in terms of their objectives and their effects, alternative approaches to achieving those objectives, and an assessment of the costs and benefits of the regulations and the alternatives.

The majority of the changes to the Regulations relate to patient safety and quality of service and the Government’s 2018 election commitment.

## Objectives

The primary objective of the amending Regulations is to strengthen the requirements for the safety and quality of care of patients receiving treatment and transport from NEPT operators. The proposed amending Regulations set minimum requirements, with the aim of minimising the risk of harm to patients, while not imposing onerous or unjustified costs on those being regulated.

A further objective that is not articulated in the proposed Regulations to is provide for improved efficiency and flexibility of licenced NEPT fleets and to improve the efficiency of Ambulance Victoria by reducing the use of the AV emergency vehicle fleet for NEPT transports.

The major changes the amending Regulations will require are that:

* All medium and high acuity NEPT patients are single loaded and not transported with any other patient.
* A maximum of two patients may be carried in a stretcher vehicle at any time.
* All stretcher vehicles must be fitted with power lift stretchers only. A three-year transition period will be provided.
* All vehicles collecting patients from their home must carry lifting cushions. A twelve-month transition period will be provided.
* All drivers of NEPT vehicles must hold a full Victorian licence or equivalent.
* A 400,000km life limit on NEPT vehicles.
* Clinical governance arrangements to ensure patient safety and quality of care is maintained are to be in place to the satisfaction of the Secretary of the Department of Health and Human Services (the department). This will include a requirement that every licencee must have a clinical oversight committee.
* All new Patient Transport Officers must undergo 100 hours of clinical supervision before they can work without a higher qualified staff member.
* 50% of medium and high acuity patient case sheets must be reviewed.
* All licenced NEPT businesses must have, and work to, an accredited occupational health and safety plan.
* Strengthened training requirements for NEPT crews be undertaken to ensure maintenance of skills and competencies.

### Nature and extent of the problem being addressed

Non-emergency patient transport (NEPT) exists to transport patients who require clinical monitoring or who are unable to be transported in a standard domestic vehicle, but who do not require time critical emergency transport, to and from hospitals, aged and disability care facilities, or home.

The NEPT service is allocated to the patient by either the Emergency Services Telecommunications Authority (ESTA), Ambulance Victoria (AV) or the sending hospital. Patients cannot choose the service provider. NEPT offers a range of transport platforms to meet the various clinical needs of patients ranging from low acuity to high acuity. These transports may be planned or unplanned. It is necessary to ensure that right transport platform is provided to meet the clinical needs of the patient being transported.

The Act was introduced in 2003 to licence private providers of NEPT services. The Act was not written with patient safety and suitability of service as a prime consideration. The Non-Emergency Patient Transport Amendment Bill 2020 (the Bill) will address this issue by including patient safety as an objective of the Act and introducing requirements to provide for patient safety and quality of care. The amending Regulations are designed to support the amendments to the Act by strengthening existing patient safety and quality of care requirements in the Regulations.

More than half of the NEPT services in Victoria are provided by twenty licenced private businesses. The remainder are provided by AV primarily utilising contracted licenced private providers. Seven of the licenced private businesses currently provide NEPT services under contract to AV.

Approximately 85% of the NEPT workforce is casual. It is reported by the Victorian Ambulance Union that this is creating a disincentive for staff to report problems to management as there is concern the staff member will be seen as difficult and lose shifts and income as a result. This makes the existence and application of appropriate regulation even more important than if the workforce was largely permanent.

The Government acknowledges that:

* patients are more vulnerable when requiring treatment and transport, and hence their interests need to be protected
* safety-related incidents or issues that produce adverse patient outcomes do occur
* there are benefits to the community in ensuring high quality health care
* there are market failures that warrant intervention.

Common types of ‘market failure’, where there is a case for the government to intervene, relevant to the private non-emergency patient transport sector include:

* Addressing information and power asymmetries in the health care system:
  + - Patients cannot choose the transport provider for non-emergency patient transport (NEPT). Most patients do not have the knowledge to determine which transport platform would best suit their needs. Some patients are not well enough to be aware of their transport arrangements.
    - The choice is made for them by ESTA, AV, hospitals, or their medical practitioner. It is important to note that the asymmetries are partially mitigated as the choice is made on the patient’s behalf by medical professionals who are expected to have the relevant information and act in the best interests of the patients.
    - Unless otherwise advised many patients would not be aware they were being transported by a private business.
* Addressing public health and safety:
  + - There is an expectation in the community that the government has a role in ensuring minimum standards of safety and quality in health care for patient transport. Not all private NEPT businesses would be subject to oversight in the absence of Regulations although the majority of the larger private NEPT providers (including all the largest providers) are either contracted to AV, hospitals, or other businesses to deliver NEPT services.
      * Without adequate oversight (and sanctions) there is a risk that some NEPT services would not meet the necessary standards to ensure the safety and quality of care of patients during transport. There is a risk that some NEPT services may not employ suitably qualified staff, may not equip vehicles suitably, or may not allocate appropriate staff and vehicles with the necessary skills, competence, and equipment to manage the clinical needs of the patients. The consequences of a failure to meet the clinical need of patients may be a worse patient outcome than would otherwise have occurred, or death.

The Government has an interest in high quality, efficient patient transport services to complement the Ambulance Victoria service and to ensure emergency vehicles are available for their primary function. Without it, we would see increased demands continuing to be placed on Ambulance Victoria leading to increased funding requirements and further deterioration in emergency response times.

Quantifying the extent of a ‘quality problem’ in patient transport is difficult, both due to differing definitions and perceptions of what may constitute ‘quality’ as well as a lack of quality performance data for NEPT services. Quality in health systems is defined by the World Health Organisation[[1]](#footnote-2) as:

* “effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
* efficient, delivering health care in a manner which maximizes resource use and avoids waste;
* accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
* acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
* equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
* safe, delivering health care which minimizes risks and harm to service users.”

Government intervention is intended to reduce the risks associated with NEPT and the number of negative consequences with social and economic costs that may arise, affecting individuals, the community, and the sector, including:

* loss of life
* decreased quality of life
* longer-term or additional treatment
* longer-term care and rehabilitation
* financial impact on patients, family, and carers
* cost of investigations and inquiries
* cost of legal action and negligence claims.

The data provided in this RIS supports a role for government intervention in the NEPT sector, to ensure minimum standards of patient safety and quality are met.

#### Why is the Government considering action?

#### The Government recognises the current *Non-Emergency Patient Transport Act 2003* is not fit for purpose. It does not address patient safety and quality of care. The Non-Emergency Patient Transport Amendment Bill currently before Parliament addresses this issue by inserting provisions to ensure the Act’s purpose and objectives are about patient safety and quality of care. The Bill also replaces stand by accreditation (to provide first aid services at events) with licencing and regulation of the First aid sector.

#### These changes to the Act necessitate amending the Regulations to give effect to, and support, the new provisions in the Act.

#### What outcomes is the Government aiming to achieve? (objectives for action)

The Government seeks to improve safety and ensure a suitable quality of care for patients who are transported by licenced NEPT providers. The Government also seeks to improve safety for crews of NEPT vehicles to reduce injuries acquired on the job. The amendments to the regulations will specify what measures are to be taken to achieve these aims. The major amendments are the introduction of:

* power lift stretchers,
* limits on vehicle life,
* requirements for clinical governance,
* increased training requirements for NEPT crews
* accreditation of occupational health and safety plans

#### What are the possible different courses of action that could be taken?

The Government could leave the legislation as it is (base case) and accept that any improvements in patient safety and quality of care, or occupational health and safety, will be at the discretion of licence holders. The market operates to the extent that staff can choose who they work for based on their record of patient and staff safety.

There is no peak NEPT body and operators are generally small, not organised collectively, and there is a history of antagonism by some licence holders towards others. It is therefore most unlikely the industry would collectively develop industry wide standards. It is more likely that the AV contracts would increase standards for the contracted element of the NEPT sector over time. This may then lead to those improvements slowly being rolled out across the rest of the fleets operated by AV contractors but may not impact on non AV contracted NEPT licence holders. Uneven safety and quality standards across the sector is the likely outcome. So, the only other feasible option to ensure equal minimum standards across the sector would be for Government to empower Ambulance Victoria to take over responsibility for all NEPT services and set the standards for those services. However, the Government has no plans to do so. The Government wants AV to be an emergency service focused organisation and does not wish AV to be the sole provider of NEPT services. It considers the NEPT sector is a legitimate space for the private sector to operate in and provide support to AV.

#### What are the expected impacts (benefits and costs) of options and what is the preferred option? (impact analysis)

It is expected that patients will receive improved care, in newer and safer vehicles, by better trained staff using better equipment once the proposed amendments (as explained in chapters 4-8) to the Regulations are fully implemented. The changes are expected to improve the professionalism and accountability of the industry as well.

It is also expected there will be fewer injuries to patients and staff due the required upgraded equipment and the reduction in age of the vehicle fleet meaning safety features in vehicles in use are modern and up to date.

The total discounted cost over the 5 years remaining life of the Regulations is estimated at $62,183,595. This represents approximately a 15% increase over current costs which will need to be largely funded by increased government funding to hospitals who pay for any NEPT transport they organise, and AV whose patients are either concession card holders or have ambulance insurance.

This RIS is divided into a number of specific chapters. Option A in each of Chapters 4–8 is the preferred option.

#### What are the characteristics of the preferred option, including small business and competition impacts? (summarise the preferred option)

The preferred options will increase the cost of providing NEPT services overall but this will be balanced or outweighed by improved patient safety and care and improved occupational health and safety overall.

The changes will increase the barriers to entry to the sector due to the need to have more expensive equipment and newer vehicles however this is seen as a positive step and it will require businesses to be properly capitalised before they enter the industry.

The amendments to the Act are expected to result in seven small NEPT licence holders (out of 20) exiting the industry and replacing their NEPT licence with a First Aid licence which more accurately reflects their activity. The changes to the Act require the department to:

* cancel the licence where the licence holder has not transported any patients in the preceding 12 months, and
* cancel the licence where the licence holder transports fewer than 250 patients per year unless the licence holder can demonstrate that its staff can maintain minimum competencies to transport patients safely.

Three of these licence holders do not transport any patients and the other four transport very few patients. As a result staff of these licence holders are unlikely to be able to maintain the necessary competencies required to transport patients safely. The provision of first aid is the primary service these businesses provide and the department expects these companies will move to a first aid licence. The change of licence will remove the need for them to have and maintain a NEPT vehicle and so will result in savings for those businesses. First aid licences are cheaper and less onerous than NEPT licences, so these seven licensees will benefit from the package of changes to the Act and Regulations.

In the 2019 calendar year these 7 licence holders transported fewer than 100 patients in total so their exit from the industry will not have any impact on overall service provision.

The overall impact will be that there are less NEPT companies but they will be the larger and better capitalised businesses.

#### How will the preferred option be put into place?

For the more expensive changes there will be a transition time allowed. A three year transition period will be allowed for power lift stretchers to be introduced. A five year transition period will be allowed for vehicle replacement.

Forums will be held with the sector to inform and explain the changes. Guidance material will be developed to assist the sector.

#### When (and how) will the Government evaluate the effectiveness of the preferred option in meeting the objectives?

The Regulations are due to sunset in 2026. The development of new Regulations will commence in 2024 at which time an evaluation of the changes will be undertaken.

The department maintains dialogue with the sector at all times so feedback will be reviewed as it is provided and if there are parts of the Regulations that are proving unworkable or ineffective, they may be amended prior to 2026.

### Options Analysis

In the development of these amendments the department explored a range of options with licence holders and other stakeholders, noting that the changes are the result, in full or in part, of the Government’s 2018 election commitment.

The introduction of powerlift stretchers to replace manual stretchers is the preferred option to reduce manual handling injuries for NEPT crews. To supplement this requirement, all vehicles collecting patients from their home must also carry lifting cushions to allow vehicle crews to assist patients who have fallen in their homes to be safely lifted either to standing or onto a stretcher to reduce the risk of injury to the patient or staff member.

The introduction of a 400,000km vehicle life limit is the preferred option based on feedback from the NEPT sector. This is to ensure the fleet is relatively modern and has up to date safety equipment.

The introduction of clinical governance requirements will specify the minimum requirements expected of each licenced NEPT business to maintain patient safety and quality of care. Clinical governance is the process by which the business assures itself that it is operating to the required standard to ensure clinical care of patients is appropriate at all times. This measure supports the new provision in the Bill that requires licence holders to provide a safe service and ensure quality of care at all times.

Additional training requirements will be introduced to improve standards of care and assist with maintenance of staff skills and competencies.

The Regulations will require that each NEPT service operates to an accredited Occupational Health and Safety Plan. The Regulations will prescribe a list of minimum inclusions that must be in the Plan however the licencee will determine the content of each of the prescribed inclusions.

Each of these options is considered by the Department as preferable to the base case.

**Impacts**

It is anticipated that as a result of the changes to the Act and the Regulations, 7 currently licenced businesses will exit the Victorian NEPT sector. These businesses are expected to transition to a First Aid Licence as the provision of first aid is their main business. Each of these businesses have one to five vehicles licenced for NEPT use. At least three of these businesses did not transport any patients last calendar year.

### Analysis and Cost of the Preferred Options

Based on the assumptions outlined in this RIS, the real costs of the Regulations, relative to a hypothetical base of the existing regulations, is $15.91 million in year 1 and $69,055,360 over the remaining 5-year life of the Regulations in net present value terms. The discounted cost is $62,183,595.The majority of costs incurred are attributable to measures aimed at ensuring minimum levels of safety and ensuring quality care (that is, suitable mode of transport, appropriate equipment, competent staff, quality assurance, etc.).

The major cost for NEPT businesses will be the power lift stretcher requirement. Each stretcher costs approximately $40,000 and has a life of 5-7 years. This requirement is about 60% of the total cost of the new Regulations.

Across the sector, the cost of introducing this requirement is significant. It is partly mitigated due to Ambulance Victoria (AV) introducing the same requirement into their NEPT contracts from I July 2019. From that date all private NEPT providers who contract to AV were required to use power lift stretchers (with a three year transition period), so introducing the requirement into Regulation will affect only those vehicles not utilised through the AV contract.

The Department considers that the cost of compliance with the amending Regulations is reasonable over the remaining life of the Regulations given the Regulations have been developed primarily to protect patient safety in NEPT and will regulate at least 1.75 million patient transports in that time (as an estimated 350,000 NEPTs transports occur per year). At a total discounted cost of $ 62,183,595 over the remaining life of the Regulations this works out to an additional cost of $35.82 per NEPT transport.

Because of the difficulty in estimating all potential costs and benefits of the Regulations, the RIS relies on a multi-criteria analysis (MCA) as the decision rule in assessing the costs and benefits of options for specific components of the Regulations. MCA involves four key steps:

1. specifying a number of assessment criteria
2. assigning a ‘weighting’ to each criterion
3. assigning scores for each option in relation to each criterion; and
4. calculating a weighted score for each option

The option with the highest weighted score is the preferred option.

The MCA analysis represents the Department’s judgements about the likely costs of various options and the extent to which they would provide for safety and appropriate clinical care to be provided to NEPT patients.

As outlined in the RIS, the proposed Regulations are expected to generate a number of direct and indirect benefits, many of which the Department has not been able to quantify. Direct benefits to NEPT patients include prevention of adverse events due to delays in patient transfers and prevention of injuries. The Department has tried to capture these benefits in the MCA.

The MCA scores for each of the options considered for the major components of the proposed Regulations in the RIS are noted in the tables below. A differential scoring system has been used due to the disparity in costs of the various measures. For the power lift stretcher MCA a score of 1 point is allocated for every $4 million. For the remainder of the measures MCAs a score of 1 point per $1 million has been allocated.

The scores attributed to the patient care and staff safety component of the MCA have been given precedence over costs in weightings as these are the fundamental reasons for the changes and are considered by the Government and Department to be of paramount importance. For each MCA patient safety and quality of care and staff safety have been weighted at 70% and costs weighted at 30% to reflect the emphasis on patient and staff welfare.

Some of the consideration is necessarily subjective due to the lack of available data. Where this is the case it is identified.

The proposed Regulations were assessed against identified feasible alternatives in each of the main areas. In each case, the proposed Regulations were considered to be superior, because they received a higher overall score when assessed against an MCA, which assists comparing options where costs and benefits are not able to be fully calculated.

Voluntary approaches for such as Codes of Practice were considered for some proposals but were assessed to be effectively the same as the base case.

**Summary of the MCAs for the different regulatory amendments**

Note that scoring for preferred options are presented here and scores for alternative options are in the chapters.

Table I: Power Lift Stretchers

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient and staff safety and care | 70% | +6 | **+4.2** |
| Costs to NEPT licencees | 30% | -10 | **-3.0** |
| **TOTAL** | **100%** |  | **+1.2** |

The introduction of power lift stretchers is a Government election commitment, and this reflects the priority the Government has assigned to protecting patient and staff wellbeing.

Powerlift stretchers are proposed to be introduced to protect NEPT workers from manual handling injuries and to protect patients from injuries when manual stretchers collapse. Ambulance Victoria, reported that manual handling was the cause of 66.9% of illness or injury in paramedics.[[2]](#footnote-3) Considering that paramedics also use stretchers to transport patients, albeit in emergency situations that may not be in controlled environments and that the patients they collect are not stable, it is still a reasonable reflection of what happens in the NEPT sector. It can be deduced that in the controlled circumstances in which NEPT staff usually work in, there is less occupational violence, exposure to chemical or biological substances and infectious diseases, and so the NEPT sector’s rate of manual handling injuries would be expected to be lower than AV’s 66.9%.

While the cost of powerlift stretchers is by far the greatest cost resulting from these new regulations the safety benefit is significant. It is estimated, based on the AV experience, that manual handling injuries will reduce by 30% per annum across the sector compounding over at least 5 years. This will result in significantly reduced injury, trauma, cost, and impact on families over time.

The introduction of powerlift stretchers also aligns the sector with AV, who commenced the introduction of powerlift stretchers in 2019.

The discounted cost of this regulation is $45,063,544 over the five year life of the Regulations.

Table II: Vehicle Life Limits

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient care and staff safety | 70% | +2 | **+1.4** |
| Costs to NEPT licencees | 30% | -1 | **-0.3** |
| **TOTAL** | **100%** |  | **+1.1** |

The proposed Regulations requires all NEPT vehicles to be replaced when they reach 400,000km. By comparison AV change their vehicles at 200,000km.

The purpose of the requirement is to ensure vehicles are fit for purpose and have modern safety equipment, to minimise the risk of injury to patients and staff during transport from faulty vehicles or in collisions. It is also to ensure that the vehicle is kept in good repair. Patients and vehicle staff rely in part of the safety of the vehicle to ensure their personal safety during transport.

As has been seen repeatedly in the trucking industry, unsafe vehicles, old vehicles, and poorly maintained vehicles have led to many avoidable accidents and loss of life.

It is a requirement that at least one clinical staff member must travel with the patient in the patient compartment at all times. Caring for the patient may entail the staff member moving around the patient compartment to attend to the patient while the vehicle is in transit, so the staff member is not always restrained in case of an accident. In addition, there is limited outside visibility so the staff member cannot see and prepare for a looming accident. These factors combined significantly increase the risk of injury to the staff member in the case of an accident.

AV data shows that from 2015-2016 21 staff (1.3% of total WorkCover claims) were staff injured in vehicle accidents[[3]](#footnote-4). There is no data on whether patients were also injured in these accidents. As of 2019 there were 1770 clinical staff working in the private NEPT sector. If we assume the same accident injury rate as experienced by AV, the number of NEPT clinical staff injured in vehicle accidents would be 12 per annum.

Injuries received in road accidents can impose significant trauma on the individuals affected and their families. A motor vehicle injury can have lifelong implications and reduce the quality of life and the earning capacity of affected individuals, which in turn impacts on their families. In addition, there is the ongoing medical treatment and associated expenditure incurred as a result of these injuries that may continue for the rest of the life of an affected patient or staff member.

The cost of this measure will only apply to those companies not currently changing their vehicles over at 400,000km and who will continue with a NEPT licence. For the rest of the sector it is already an accepted cost of doing business.

The discounted cost of this regulation is $1,329,456 over the five year life of the Regulations.

Table III: Clinical Governance Options

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +8 | **+5.7** |
| Costs to NEPT licencees | 30% | -3 | **-0.9** |
| **TOTAL** | **100%** |  | **+4.8** |

Clinical governance requirements are proposed to be introduced to specify minimum requirements expected of each licenced NEPT business to maintain patient safety and quality of care. Clinical governance is the process by which the business assures itself that it is operating to the required standard to ensure clinical care of patients is appropriate at all times.

The introduction of clinical governance requirements supports the new requirement in the Act for a licence holder to provide a safe service and a suitable quality of care to patients at all times. Patient safety and care is central to an NEPT business. Having robust clinical governance systems in place drives continuous review of patient care and this results in continuous improvement in patient care. Clinical governance provides a system for checking patients are being treated appropriately, for ensuring staff know the limits of their competencies and work within those limits, for ensuring the business knows the limits of its expertise and works within those limits, and for reviewing every incident of sub optimal patient care.

It is only by recognising where patient care is not delivered to the required standard, and by reviewing what happened, can improvements be made and repetitions be prevented. This approach is standard practice in hospitals and AV, and should also be standard practice in all NEPT services as they are part of the same continuum of patient care.

Effective clinical governance systems have been shown to result in improved patient outcomes[[4]](#footnote-5). “From the literature review it was identified that organisations with functioning and thriving clinical governance are also likely to be organisations in which professionalism is high”[[5]](#footnote-6). The converse is also true[[6]](#footnote-7).

All NEPT licenced businesses will be required to have a clinical oversight committee (COC) that has at least one health practitioner as a member.

The COC will be responsible for:

* reviewing every sentinel event,
* reviewing every 000 call out
* auditing of patient care records (PCR)
* reviewing patient care records
* processes to set the scope of clinical practice of all clinical staff (whether employees, contractors, staff of contractors or volunteers)
* processes to set the scope of practice of the business to ensure it does not provide services beyond its competencies and ability
* credentialing and three-yearly re-credentialing of all registered medical practitioners engaged by the business in any capacity
* reviewing all matters of clinical concern including each critical incident and each sentinel event
* maintaining records
* reviewing staff safety survey data
* reviewing all complaints that relate to patient experience
* reviewing clinical practice protocols and guidelines of the licenced NEPT business
  + processes to continually assess the ability of the business to provide safe, patient centred care.

Written policies and procedures will be required to support each of the above matters.

The discounted cost of this regulation is $2,584,310 over the five year life of the Regulations.

Table IV: Staff Training options

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +6 | **4.2** |
| Costs to NEPT licencees | 30% | -10 | **-3.0** |
| **TOTAL** | **100%** |  | **+1.2** |

The new Regulations, will require:

* Specified clinical training to be delivered face to face
* A new requirement for mental health training
* 100 hours of supervised on road training for new Patient Transport Officers (PTOs)

The setting of uniform training standards for NEPT vehicle crews is intended to ensure that irrespective of which company transports the patient, all staff have up to date minimum competencies to ensure the safety of the patient and an appropriate level of care.

In order to address the reported situation where some training providers are delivering clinical training online instead of face to face the Regulations will prescribe a number of clinical matters that must be delivered in face to face training (see Chapter 7).

It is the advice of reputable registered training organisations the department has consulted with, and the Victorian Chief Paramedic, that this clinical training cannot be effectively delivered or effectively assessed online. Online training of clinical matters caries the risk that staff will be certified as competent when they are not, and this then creates a liability risk for the staff member and the licence holder, and a safety risk for the patient.

The introduction of mandatory mental health training and annual refresher training recognises the changing nature of patients. Mental health issues also intersect with drug and alcohol addiction, making responding to these patients more challenging. Licencees report that the number of patients with mental health issues being transported is increasing. Most of these patients are being transported for other medical reasons but still need to have their mental health issues managed appropriately during transport to ensure they reach hospital or their medical appointment in a suitable frame of mind and are not unnecessarily distressed. AV advise that mental health training is already a requirement for their paramedics.

It is necessary that new PTOs are clinically competent to work without an Ambulance Transport Attendant (ATA) being present on the vehicle. In order for that to occur it is necessary that new PTO graduates undergo a period of clinical supervision to ensure the that PTO is clinically competent to attend to patients within their scope of practice. This measure will enhance patient safety and quality of care. This replicates the current regulatory requirement applied to graduate ATAs.

The discounted cost of this regulation is $12,490,624 over the five year life of the Regulations.

Table V Occupational Health and Safety Plan options

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +4 | **+2.8** |
| Costs to NEPT licencees | 30% | -1.0 | **-0.3** |
| **TOTAL** | **100%** |  | **+2.4** |

The proposed Regulations require that each NEPT service operates to an accredited Occupational Health and Safety (OH&S) Plan. The benefit of an accredited OH&S Plan is that it functions as a continuous improvement tool to assist a licencee to continually improve OH&S for staff and patients. Because of the variable size, structure, and complexity of NEPT licencees, a degree of flexibility is required in the development of the OH&S plans so that the plan is tailored for the business. Therefore, the Regulations will prescribe a list of minimum inclusions that must be in the Plan however the licencee will determine the content of each of the prescribed inclusions.

Continuous improvement is the purpose of accreditation to a quality standard such as the International Standards Organisation (ISO) or Australian Standards (AS) occupational health and safety systems. The idea is that workplace systems, protocols, and processes are constantly reviewed and updated in order to improve and prevent opportunity of injury or illness to staff. These plans are written by the business and tailored for its specific needs. Identification of potential for injury or illness and reports of injuries or illness are seen as opportunities to systematically improve the business.

In the long run, companies that embrace a culture of continuous improvement save money due to a lower rate of accidents, non-compliances, or deviation from standard procedures.[[7]](#footnote-8) A review of processes and procedures is triggered every time a required element is not met, rather than waiting for an accident to occur, and systems are updated to prevent a recurrence. The business is continually learning and improving its operations.

Accreditation to external third party audited standards is commonplace in many industries and is currently required for quality assurance in the NEPT sector.

The department considers that the proposed Regulations will provide for greater staff safety over the life of the Regulations. It is a higher initial cost option than the base case. However, the proposal is potentially a lower cost option than the base case in the long term due to reduced injuries, illness, and lower workers compensation premiums. The Department also expects a number of indirect benefits to result from the proposed Regulations such as less trauma and improved mental health of families of patients and staff.

The discounted cost of this regulation is $715,661 over the five year life of the Regulations.

**Other Patient Safety and Quality of Care Regulations**

The Regulations will require that all medium and high acuity NEPT patients are single loaded and not transported with any other patient. Currently only high acuity patients are required to be single loaded. It is proposed to extend this requirement to medium acuity patient in recognition of the fact that they may be quite unwell and may require significant monitoring and possibly treatment while being transported. It is essential that vehicle crews have sufficient room to access the patient to monitor and treat them at all times. The department considers that dual stretcher vehicles do not provide sufficient room for the effective monitoring and treatment of medium acuity patients at all times. It is noted that single loading of all patients is also an AV requirement for their NEPT contractors.

A maximum of two low acuity patients may be carried in a vehicle at any time. This is to ensure that staff are never in a position of having more patients on board than they can safely monitor. A 1:1 staff to patient ratio for stretcher patients is considered the minimum acceptable noting that one of the staff must also drive the vehicle. The department considers that any more than 2 patients in a stretcher vehicle is potentially unsafe for patients.

All drivers of NEPT vehicles must hold a full Victorian licence or equivalent. As patients cannot choose who drives the vehicle they are transported, do not have right of refusal, are medically incapacitated in some way and are therefore not independent the department considers that it is appropriate that only fully licenced drivers should drive NEPT vehicles A full licence provides for a level of experience and presumable increased safety. The requirement is consistent with the requirements of the taxi directorate for taxi drivers. The taxi directorate is also responsible for licencing and regulating a private transport industry and so is the most direct parallel.

50% of medium and high acuity patient case sheets will be required to be reviewed by the licenced NEPT provider. Again, this is for patient safety reasons. The purpose behind the requirement is to provide a mechanism by which NEPT licences can look for systemic patient safety issues or clinically underperforming staff who may need additional training. Identifying deficiencies leads to improved patient safety and quality of care.

The proposed Regulations also require that for all patients the person who is providing the clinical monitoring and/or medical supervision will be required to travel in the compartment with the patient to ensure immediate care is provided should it be required.

**Impacts**

It is anticipated that as a result of the changes to the Act and the Regulations, a consolidation of the NEPT industry will occur. It is expected that 7 currently licenced businesses will exit the Victorian NEPT sector and transition to a First Aid Licence as the provision of first aid is their main business. Each of these businesses have from one to five vehicles licenced for NEPT use. At least three of these businesses did not transport any patients in 2019, the last reported calendar year. While overall vehicle numbers may reduce slightly it is not expected to have any impact on patient transport numbers as the companies that will exit the sector transport very few patients in total.

The Government expects significant improvements in patient safety and staff welfare as a result of the changes to the Regulations and the imposition of minimum standards in a number of areas as described in this RIS.

## Consultation – the Department is seeking your feedback on this RIS

A primary function of the regulatory impact statement (RIS) process is to allow stakeholders and members of the public to comment on the proposed Regulations before they are finalised. Public input provides valuable information and perspectives and improves the overall quality of regulations. Accordingly, feedback on the proposed amending Regulations is welcomed and encouraged.

All interested parties are invited to provide comment on this RIS. Parties may wish to respond to any part of this RIS or the draft Regulations, although particular comment is invited on whether there are any specific unforeseen impacts of the proposed amending Regulations; and if the assumptions used in calculating costs and benefits of the proposed amending Regulations are reasonable.

Initial consultation was undertaken with NEPT licencees, Ambulance Victoria, United Voice, Victorian Ambulance Union, and hospitals to inform the drafting of the amending Regulations. Chapter 11 includes a list of those involved in initial consultations and a summary of the views presented.

**Submissions will be received until close of business Friday 6 August 2021.**

# Introduction

## 1.1 The non-emergency patient transport sector

Specific regulation of the NEPT sector in Victoria by the Department of Health commenced in 2003 to meet a community need and to ensure the more efficient use of emergency ambulance services. The sector had previously been regulated by the Taxi Directorate.

The 2013 ACIL Allens review of the NEPT sector described the sector as follows: “The NEPT sector in Victoria was established in 1993 with the separation of the emergency and non-emergency transport services of Victoria’s ambulance services. Originally, private providers of NEPT services had to comply with the Transport Act 1983 and be licensed by the Taxi Directorate. The Non-Emergency Patient Transport Act 2003 (the NEPT Act) recognised the industry’s unique characteristics and established a regulatory framework for NEPT.

NEPT is defined by the NEPT Act as transport of persons to, or from medical services:

* By road:
  + - ‘using a stretcher carrying vehicle; or
    - ‘where the persons being transported are provided with specialist clinical care or monitoring

while being transported.’

* By air:
  + - ‘where the persons being transported are transported on stretchers; and
    - are provided with specialist clinical care or monitoring by the person operating the transport service’.

This definition establishes that NEPT road services include those using a stretcher-carrying vehicle and those in a non-stretcher carrying vehicle, where specialist clinical care or monitoring is provided. NEPT air services on the other hand, cover only instances where both the patient is in a stretcher, and the patient is provided with specialist clinical care or monitoring.

There are currently 20 private NEPT operators who are licenced to operate 428 vehicles and 6 aircraft. The Regulations oversight the provision of both on-road and air transport. Of the 20 licenced operators, seven are currently contracted to AV and supply approximately 55% of the AV NEPT services. In 2018-19 licenced NEPT operators undertook 250,000 non-emergency patient transports independently and a further 155,000 transports for Ambulance Victoria. It is reported by the sector (2018/19 annual reports to the department) that there are about 1700 clinical staff employed in full time, part time and casual positions in the sector.

The NEPT sector has both for profit and not for profit providers. There are some tensions that exist as some for profit providers take the view the not for profit providers have a cost advantage due to the federal tax arrangements that apply to not for profit organisations. This is potentially an impediment to achieving a common approach to patient safety in the sector without the imposition of regulations.

The NEPT sector is estimated to turnover around $120 million per annum currently.

In managing the patient journey through the health system, NEPT services are a crucial player.

The Victorian Government provides funding for non-emergency patient transport services through:

* Funding to Ambulance Victoria to provide free transports to pension and health care card holders (Community Service Obligations) for eligible transports.
* Funding of health services that is incorporated into activity price for the purchasing of non-emergency transport for public hospital patients where the hospital is responsible for payment (primarily inter-hospital transports).

Non-emergency patient transports are also funded through patients’ private health insurance policies, Ambulance Victoria membership fees, third-party patient fees from WorkSafe, Transport Accident Commission and Department of Veterans Affairs, and from full fee paying patients.

The Ambulance Services Act 1986 contains a range of mechanisms by which the government and the department can oversee, monitor, and set standards in the emergency ambulance services to ensure patients receive high quality care. These powers do not extend to directly regulating the standard of care provided by private providers in the non-emergency sector.

The NEPT Act and Regulations set the standards for patient care in the NEPT sector however they need updating to reflect community expectations in managing patient safety and care.

In metropolitan Melbourne, private businesses undertake the majority of non-emergency transports through either direct arrangement with purchasers, such as hospitals or through contractual arrangements with AV. Outside metropolitan Melbourne, both AV and private providers provide non-emergency transports. Currently seven private NEPT businesses are contracted to AV.

AV typically provides NEPT transport in rural areas where there is no private NEPT provider available. AV is also the provider of last resort and will provide the transports using emergency vehicles where there is no market for private providers. This will typically be remote rural areas. Given the broad range of patients currently transported by private providers of non-emergency transport services, the term ‘non-emergency’ should not be taken to mean ‘not seriously ill’ nor to mean ‘no clinical skills are required’ to transport these patients. Rather, patients transported by the NEPT sector are those who do not require and are not likely to require a time critical ambulance response. The users of NEPT services are patients with clinical needs that require monitoring who are travelling from home to health services, between health services and from health services to home.

Without the private NEPT services the provision of all NEPT in Victoria would revert to AV. AV are not resourced to undertake the entire NEPT service for Victoria. As a result, the Department considers that NEPT transport services would be substantially reduced and would be far less timely and reliable than currently provided by private NEPT services. Hospitals would face greater difficulties in discharging patients and turning over beds which would lead to greater delays for those patients requiring admission through the emergency departments. Some patients requiring clinical transport may not be able to access the service due to demand constraints. The Department also considers that, as Ambulance Victoria would be required to transport all non-emergency patients there would be a detrimental impact on their emergency service capability.

NEPT transports are organised according to the acuity of the patient. Patient acuity is divided in to 3 levels of low, medium, and high acuity. The higher the acuity, the worse the health of the patient. All NEPT patients must be stable and not require time critical transport. No NEPT patient transports are considered to be time critical and that is why lights and sirens are not used for usual NEPT transport.

A low acuity patient is a person who has one or more of impaired cognitive function requiring supervision, chronic diagnosed shortness of breath, an inability to walk more than a few steps unaided. A low acuity patient may or may not need a stretcher for the transport.

A medium acuity patient is a person who may require active management or intervention, or specialised equipment requiring monitoring, or observation or monitoring of some types of intravenous infusions.

A high acuity patient is a person who requires a higher level of care than a medium acuity patient, or cardio respiratory support and can include neonatal patients.

Victoria is unique within Australia in having a significant, growing, and competitive non-emergency patient transport sector. Victoria is one of three States that licences and regulates private NEPT providers, the other States being Tasmania, and South Australia. The NSW Ministry of Health and the Queensland Department of Health may accredit private providers to provide NEPT services. In both States there are limited numbers of businesses that are accredited, and they usually work at public events. There is no contracting of NEPT services by the respective ambulance services in those States to supplement their services as happens in Victoria. The Western Australian and Northern Territory governments contract private companies to provide all emergency and non-emergency patient transport services. The Australian Capital Territory (ACT) ambulance service provides all NEPT services in the ACT.

Victorian NEPT operators are regulated under the Non-Emergency Patient Transport Act 2003 (the Act). Under the Act private NEPT operators are required to be licenced by the Department before they can provide NEPT services. AV and public and denominational hospitals are not required to be licenced to provide NEPT services, however the remainder of the regulations apply to these NEPT services.

The regulation of the NEPT sector and the associated licencing requirements were originally introduced in 2005[[8]](#footnote-9), to provide assurance to users of the service that minimum standards were in place.

The 2018 election commitment by the Government stated, “Minister for Ambulance Services Jill Hennessy today announced a re-elected Andrews Labor Government will review the Non-Emergency Patient Transport Act to strengthen compliance and enforcement and ensure the highest quality of care for patients.” A number of amendments are being made to the Act to implement the Government’s election commitment.

A Bill to amend and update the Act is currently being developed to come into effect at the same time as these Regulations. The Bill will make patient safety an objective of the Act, strengthen patient safety requirements and increase the penalties for noncompliance.

The Bill will modernise the Act to reflect current thinking and approaches to patient safety.

The patient transfer by NEPT providers is part of the bigger patient journey through the health system. Patients may be very unwell but not in a time critical situation and therefore are transported by a NEPT service rather than Ambulance Victoria (AV). AV contract 7 private NEPT providers to transport patients on behalf of AV. Likewise, HealthShare Victoria currently contracts 8 private NEPT providers to provide services directly to public hospitals. In addition, some public and private hospitals contract directly with NEPT providers. These non-AV services allow hospitals to book and schedule transports at times that suit them to admit patients, discharge patients and send them home, move patients to another hospital, or to access outpatient services.

All hospitals and AV have robust clinical governance systems in place with the aim of ensuring patient safety and quality of service and, through continual review, improving those services over time. Some, but not all, NEPT providers have clinical governance systems of varying quality.

Given NEPT providers part of the patient journey to and from the hospital system they should also have robust clinical governance systems, of a minimum standard, in place with the aim of ensuring patient safety and quality of service and continually improving those services. To ensure this occurs the Act will be amended to require the Secretary (or delegate) to assess the clinical governance processes of applicants prior to the granting, renewal, or transfer of a NEPT licence.

A key to ensuring safe patient transport is staff competence. To that end it is intended to amend the Act to require a minimum number of patient transports be undertaken annually. Undertake too few transports and staff are at risk of not being able to maintain competencies, and organisational systems and processes can get forgotten through lack of familiarity.

##### Licence suspension or cancellation

The Bill will increase the flexibility of the power for the Secretary to suspend or cancel a licence. where there is a serious risk to patient safety. Currently the Secretary can suspend a licence where he or she forms the view that there are grounds for cancelling the licence. The suspension is a precursor to cancelling the licence after inviting submissions from the licencee.

The Bill provides that the Secretary may suspend a licence or a class of a licence (low, medium, or high acuity) if he or she forms the view there is a serious risk to patient safety or there is a breach of the Act. Suspension of the licence will be an enforcement measure in its own right and will not automatically lead to a cancellation of a licence. The licencee will be provided with the reasons for the suspension in writing with a deadline to rectify the matters. If the patient safety risk and subsequent suspension only concerned one class of patients such as high acuity, the licencee would still be able to operate their medium and low acuity patient transfer services. The flexibility this measure introduces allows the specific patient safety risk to be immediately mitigated without jeopardising the entire business and so is proportionate.

While rectification is occurring the suspension will stand. Once the rectification matters have been completed to the satisfaction of the Secretary the suspension will be lifted and the full licence reinstated. The Secretary would only cancel a licencee circumstances where the licencee refused to carry out the rectification measures.

The Government election commitment also promised to “investigate the extent that penalties need to be increased”. As a result, the current penalties in the Act are being reviewed and increased penalties are expected to be introduced.

In considering whether or not to licence a NEPT operator, the Secretary of the Department of Health and Human Services (DHHS) is required by the Act to take a number of factors into account. These include:

* whether the proprietor is a fit and proper person to carry on the service,
* the suitability of the equipment and vehicles to be used,
* whether the proposed operating arrangements for the management and staffing are suitable and comply with the regulations,
* whether there are arrangements for maintaining the quality of the service are appropriate, and
* whether there are arrangements for evaluating, monitoring, and improving the quality of the service.[[9]](#footnote-10)

Proposed licencees may also be approved in principle prior to purchase of vehicles, in which case licencing is subsequently granted on terms that are consistent with the approval in principle.

The Act is supported by the Non-Emergency Patient Transport Regulations 2016 (the 2016 Regulations), which are intended to provide for the safety and quality of care of patients being treated or transported by NEPT operators.

The 2016 Regulations:

* set minimum standards of requirements relating to staffing, suitability of equipment and vehicles and equipment, and infection control.
* require accreditation to a quality assurance plan
* specify consumer protection arrangements, including consumer information and complaints resolution requirements.
* detail a range of requirements to support the secretary’s regulatory functions in the Act, such as licencing, application forms, licence fees and annual fees.

The Act and Regulations, while imposing minimum standards for the sector, are not considered to impose a significant barrier to entry to the market. Licence fees are minimal, in comparison to non-legislated businesses costs, and accreditation costs are in line with costs across all industries that are accredited by third parties. In many cases businesses would undertake accreditation even without a regulatory requirement to do so. For those operators, accreditation costs are not an additional cost imposed by regulation.

Costs associated with purchasing and fitting out vehicles, and employing suitable staff are the commercial barrier to entry to the sector and apply whether or not regulations exist. As the regulations impose minimum standards for both these elements additional costs are imposed on the participants of the sector that would otherwise operate to a lower standard. To that extent these costs have been included in the RIS.

There are a range of participants in the NEPT sector including the Victorian Government as regulator and part-funder, service providers, purchasers and requestors of services, and end-users. There is a complex series of interrelationships between market participants. Ambulance Victoria (AV) has multiple roles as a transport provider, purchaser of services, and for some services, a booking and dispatch role.

AV has the monopoly role for the provision of Community Service Obligations (CSOs). Eligible services are provided free to pensioners and health care card holders. In metropolitan areas, AV contracts out its CSO road services, while in regional areas, AV contracts out some of its services and meets others through its internal resources. Health services (public and private) may have their own fleets, contractual arrangements or use AV or a mix of all three.

Call taking and dispatching arrangements are currently organised in two major ways: (i) centrally through the Emergency Services Telecommunications Authority (ESTA) – with NEPT services dispatched after either: (a) ‘000’ calls triaged through RefCom; or (b) through the ‘1300’ number for planned services known in advance – with AV’s CSO market organised through this arrangement; and (ii) through devolved arrangements, involving private providers, which have their own call-taking and dispatching arrangements, used to service the inter-hospital transfer market.[[10]](#footnote-11)

## 1.2 Purpose of this regulatory impact statement

The 2016 Regulations are due to sunset in 2026. The proposed Regulations are assessed against the base case of the existing 2016 Regulations.

In accordance with the requirements of the Subordinate Legislation Act 1994 and the Victorian Guide to Regulation, an RIS is required to assess the proposed Regulations in terms of their objectives and their effects, alternative approaches to achieving those objectives, and an assessment of the costs and benefits of the regulations and the alternatives. An assessment should also be undertaken of the implications of the proposed Regulations on competition.

In assessing the most effective option to achieve the identified objectives, the RIS must determine decision criteria to assess each option. These criteria must relate directly to the objectives of the proposed Regulations and the Act.

By virtue of the framing of the Act, the 2016 Regulations and the proposed Regulations respond specifically to particular provisions of the Act rather than being self-contained. Therefore, the assessment of the costs and benefits of the proposed Regulations is only on the ‘incremental’ costs and benefits arising from the proposed Regulations and not the impacts that are attributable to the provisions of the Act.

# 2 The reasons for regulation

## 2.1 Background

Private NEPT services are integral to the transport of patients in the Victorian health system. Therefore patient safety and quality of care must be the paramount aim of the legislation and the sector.

In managing the patient journey through the health system, NEPT services are a crucial player. The Department therefore considers it appropriate that they should be considered as part of the patient continuum of care. In that light it is appropriate that the NEPT providers should be required have a similar approach to patient safety and care as is expected from the hospital sector as a similar level of care is expected. This does not mean they require the same level of expertise and specialisation as do hospitals. It means that NEPT providers must have a similar approach to systems of patient safety and care to ensure the patient can be maintained in a stable condition and receive appropriate care, on their journey to, between, or from a health service facility.

Patients, as a result of age, illness, and frailty, rely on health services and health professionals to make decisions regarding patient transport service providers on their behalf. Patients do not have the ability to elect to travel with a NEPT provider other than that organised by the AV, the health service, or the health practitioner. Therefore, minimum standards of patient safety and care are required to be set to give the patient confidence that suitable care will be provided irrespective of which NEPT provider is used.

The NEPT Act and Regulations set the standards for patient care in the NEPT sector however they need updating to reflect community expectations in managing patient safety and care.

The private NEPT sector provides approximately 350,000 patient transports per annum including the AV contracted transports. Transport may be provided from home to a health care facility, between health care facilities and from a health care facility to home (Home may include an aged care or disability care service). Transports enable patients to attend medical appointments, attend emergency departments, attend hospitals for admission, transfer between health care facilities and return to home. All NEPT trips must be clinically required as NEPT is not an alternative to the taxi service. People who do not require clinical monitoring are expected to organise alternative transport such as taxis.

Of the 20 licenced NEPT providers in Victoria, 13 also have stand-by accreditation to provide NEPT services at public events. Of these 13 providers, 7 do not usually transport patients and their main business is the provision of first aid at public events. The Bill to amend the Act will remove stand-by accreditation and replace it with first aid licencing. So in future, any company wanting to provide first aid at events and not transport patients will require a first aid licence and not a NEPT licence. There will be separate regulatory schemes for NEPT and First Aid tailored to the specific requirements of each sector.

All hospitals and AV have robust clinical governance systems in place with the aim of ensuring patient safety and quality of service and, through continual review, improving those services over time. Some, but not all, NEPT providers have clinical governance systems of varying quality.

Given NEPT provides part of the patient journey to and from the hospital system they should also have robust clinical governance systems, of a minimum standard, in place with the aim of ensuring patient safety and quality of service and continually improving those services. To ensure this occurs the Act will be amended to require the Secretary (or delegate) to assess the clinical governance processes of applicants prior to the granting, renewal, or transfer of a NEPT licence.

A key to ensuring safe patient transport is staff competence. To that end the Act will be amended to require a minimum number of patient transports be undertaken annually. Undertake too few transports and staff are at risk of not being able to maintain competencies, and organisational systems and processes can get forgotten through lack of familiarity.

The Bill will repeal the current stand-by accreditation provisions and replace them with a licencing and regulation scheme for commercial first aid providers.

Stand-by accreditation currently allows a NEPT licencee to provide first aid services at public events using the scheduled medicines that are approved for use by NEPT licencees. A number of NEPT licencees have subverted the intent of this provision to obtain a NEPT licence without ever intending to transport patients, purely in order to access the approved scheduled medicines to give them a competitive advantage over other first aid providers. This potentially creates a risk for attendees at events because the NEPT regulations only set out requirements for the transport of patients and do not set out any requirements for first aid treatment with scheduled medicines.

The Bill will address this patient risk by requiring anyone wishing to provide a commercial first aid service to be licenced with the department. Separate First Aid Regulations are being developed to support this requirement and will have separate and different scheduled medicines permissions to the NEPT licencees.

If a person wishes to provide a NEPT service and a First aid service two licences will be required. If any NEPT service does not transport the minimum number of patients required annually they may have their licence cancelled and be invited to take out a first aid licence. It is anticipated that as a result of this change 7(of 20) current NEPT licencees will exit the NEPT sector and take out a First Aid licence instead as they do not transport sufficient numbers of patients.

A new requirement will be introduced into the Act to require the Secretary to consider whether the applicant can provide a safe service with suitable quality of care at all times before a licence can be approved.

The proposed Regulations will therefore affect a fewer number of providers than are currently registered and these will be the larger providers generally, with more sophisticated patient and staff safety arrangements in place

Victoria is unique in having a contestable and substantial private NEPT sector. Victoria is also unique in having a long standing Act and Regulations specific to NEPT. The legislation was considered to be necessary by the Government of the day as a significant amount of NEPT services were being delivered by arrangements outside the control of emergency ambulance services.

In NSW, NEPT is provided by the Patient Transport Services of NSW (PTS). The NSW Ministry of Health also accredit provide NEPT providers. Mandatory service specifications for NEPT services operating for the NSW Health department are set by NSW Health. This includes the crewing specification and crew qualification requirements. There is also one private air NEPT provider and one private road NEPT provider.

In Queensland the Queensland Ambulance Service (QAS) is the primary provider of NEPT in Queensland as part of their overall patient transport services. As NEPT is a QAS service the training and staffing arrangements are determined by QAS. There are two accredited private NEPT operators.

In South Australia the bulk of NEPT services are provided by the South Australian Ambulance Service (SAAS). The Health Care Act 2008 and supporting Regulations require licencing of private NEPT providers, and prescribe NEPT staff qualifications and staffing arrangements. There are six private providers who are licenced under the Act as NEPT services that can transport a range of patient acuities.

In Western Australia, most NEPT is provided by St John Ambulance under contract with the Department of Health. There are at least 3 contracted private NEPT providers servicing hospitals and the mines. Licencing is not required. All services are managed by contracts.

Ambulance Tasmania is responsible for most NEPT transports in Tasmania and sets the criteria for staffing and qualifications for its own services. Private NEPT providers are licenced and regulated. There are 5 private licenced NEPT providers in Tasmania.

The Northern Territory also contracts a private provider for emergency ambulance and NEPT services.

NEPT services in the ACT are provided by the ACT ambulance service.

Given the various and divergent arrangements employed by other States and Territories for their NEPT services, there is little point in comparing Victoria’s current and proposed arrangements with them for the purposes of this RIS as no useful conclusions can be drawn from doing so.

## 2.2 Rationale for government intervention

Governments generally intervene in markets and regulate if there is a risk, actual or potential, to consumers.

Typical patient safety risks in NEPT transfers are:

* The patient falling while under the care or supervision of the NEPT staff member
* Extravasation of a peripheral intravenous cannula during an infusion
* The occlusion of an infusion that goes unnoticed, for example with a Baxter pump, ceasing the infusion of a medication, or an IV pump being on hold or off and going unnoticed
* The injury of a patient who is unable to communicate that the injury is actively occurring
* Dislodgment of a tracheotomy
* One patient injuring another
* Causing trauma to a patient from an insitu device such as an indwelling urinary catheter
* Traffic accident
* Incorrect administration of medication

The existence of risk factors requires the protection of the patient in the form of regulation, education and training, occupational health and safety and codes of practice.

Governments also intervene in markets if there is an information asymmetry as there is in the NEPT market. Users of NEPT do not have sufficient information to make informed decisions about the type, quality, and price of the service they will receive. They have no choice in the provider of the service. That choice is made by AV, the health service or ESTA. As the price of the service is fixed by other entities who may also select the provider the patient has no control over pricing and cannot exercise choice on that basis.

Even if a service used was to provide full information, patients cannot act on this information, and must rely on others to make appropriate decisions for them. Patients cannot negotiate the cost of transport or choose a provider based on cost - the costs of AV provided NEPT services are fixed by the Government, and the costs of NEPT services that are contracted directly by the health service are agreed between the health service and the NEPT operator. Depending on the destination of the NEPT transport the costs may be recoverable by the patient if they have private health insurance or have taken out membership with AV.

In this situation, the potential sources of risk to the patients are the expertise and incentives of those making the decisions for, and transporting, the patients. However, those who request the services on behalf of patients are expected to have relevant information to make NEPT decisions on patients’ behalf.

If the patient rings triple zero AV allocate a transport from one of their contracted private providers or provide the service using an emergency vehicle. The same process occurs for transports booked directly with AV. For transports organised by health services the service will either access the AV service or use their own contracted private NEPT provider. In the latter case the hospital chooses who provides the transport. Many patients would not be aware that the NEPT service they are using is a private service and not AV.

In either case, if staff with insufficient expertise make the assessments about the patient’s medical condition and the level of care they require during transport there is risk to patient health and safety. Risks may also arise if there is not a common understanding of different levels of patient acuity in the sector.

Another potential source of risk to patients occurs during transport if NEPT operators do not provide an appropriate vehicle with staff who are competent to manage the patient’s clinical needs. NEPT operators have commercial incentives (reputation, contracts, etc.) to manage appropriately the clinical needs of the patients at all times, including hiring competent staff. Other potential influences on provider behaviour that would reduce the potential for adverse consequences include liability laws, and occupational health and safety requirements. Private providers may, however, also face pressures to reduce costs. It has been informally reported to the department in the recent past that the need to provide a competitive price to win contracts with health services has led to some licenced NEPT providers failing to maintain training of staff as required by the current Regulations, keeping older (and potentially no longer suitable) vehicles on the road, and not abiding by OH&S legislative requirements, in order to keep costs down.

Further some licensed NEPT providers do not have adequate clinical governance arrangements in place. Clinical governance is the process by which a business ensures it is providing appropriate clinical care within its capability. This should include:

* setting the scope of practice of clinical staff
* setting the clinical scope of practice of the business
* credentialing medical practitioners
* setting up a medical advisory committee to review all clinical activities of their business
* establishing procedures for clinical matters.

Where a NEPT provider competes for an AV contract it can be argued that there is a type of a market as the NEPT provider must meet the minimum standards designated by AV in order to be considered for a contract. There is a risk however, that the AV contracting process may have a perverse outcome of forcing a NEPT providers to cut corners in order to maintain a contract. We have seen a number of examples over the years that when a NEPT provider does not retain a contract to provide AV services they exit the industry. As there may be significant financial detriment in losing a contract there is an incentive to cut corners where possible to keep costs down.

For those NEPT providers who do not seek an AV or hospital contract it can be argued there is market failure as there is no market driver, apart from the legislation, to encourage the providers to meet minimum standards in vehicle condition and age, occupational health and safety, clinical governance and staff training. Users of the service have no market power for reasons described earlier.

The NEPT sector is not a fully functioning market and patients in particular have no power make choices about their transport provider. The only way to ensure patient safety and quality of care in this environment is to set minimum standards across the NEPT industry and to raise standards over time, by the making of legislation.

The proposed Regulations strengthen requirements around patient safety and quality of care, staff training, equipment, and OH&S. The Department considers that a market-driven scenario does not enable government to meet its primary objective of safety and quality of health care for all Victorians using the NEPT service.

As discussed later in the RIS the proposed Regulations attempt to address these issues by setting minimum standards to deal with the potential recalcitrants, by providing an appropriate framework for the maintenance of patient safety and quality of care, minimum standards for clinical governance, additional requirements for suitability of equipment, and active OH&S management by all licenced NEPT operators. In this way strong guidance about Government and community expectations for standards of care are conveyed to the sector while also protecting the interests of the service users and responsible service providers.

## 2.3 Nature and extent of the problem

Approximately 350,000 patient transports are undertaken by private NEPT businesses annually. The Government considers it essential to ensure the safety and quality of the services provided by these businesses.

With the Act being amended to include patient safety as an ongoing requirement to hold a NEPT licence it is necessary to review the patient safety requirements in the Regulations to ensure the Regulations give proper effect to the Act, and to ensure consistency with the Act. In considering the nature and extent of the problem it is helpful to look at the following two components.

1. What minimum patient safety and quality of care measures should be introduced to support the Act?
2. What elements of the current Regulations are inadequate and why?

### Rationale for government intervention

The private sector was involved in NEPT prior to the introduction of the NEPT Act in 2003. In introducing the Act to Parliament, the then Government was explicit in seeing a role for the private sector in NEPT delivery and further, it endorsed contestability of the sector. Given the private sector was to have a central role in patient transport the Government considered it necessary to regulate to ensure patient safety and care in order to provide public confidence in the system. The rationale continues to be relevant today.

The second reading speech for the original Act stated “Non-emergency patient transport services primarily involve work such as transporting patients between hospitals and from hospital to home. Patients transported by private providers are often frail requiring transport via stretcher.”

The objective of the draft Regulations is to strengthen the requirements for the safety and quality of care patients being transported by NEPT providers to reflect the forthcoming changes in the Act. In considering the rationale for the proposed Regulations it is appropriate to consider:

* *To what extent is it the role of government to address residual safety risks, given the high level of voluntary compliance with the existing Regulations?*
* *In the absence of the Regulations, would other incentives be sufficient to minimise the incidence of adverse events and achieve appropriate safety outcomes? To what extent do Regulations contribute to safety outcomes?*

Consideration of these questions form part of the examination of the draft regulations in this RIS. Therefore, in the development of the proposed (amending) Regulations, the RIS needs to examine the costs to providers of compliance, to ensure the costs are not at a level that would create an insurmountable barrier to entry to the market. The RIS also needs to examine whether the Regulations have struck an appropriate balance between the costs of compliance and provision of minimum requirements for patient safety and care.

The Department has enforced the current Regulations using a mix of inspections prior to initial licencing or the two yearly licence renewal (i.e. and inspection every 2 years), review of the documentation submitted for licencing or licence renewal, verification of accreditation of the quality assurance plan and complaint investigation. Inspections involve a visual check of one or more vehicles but never the entire fleet, apart from single vehicle operators. It is largely a point in time approach and does not necessarily provide the department with information about licencee processes, or emerging risks either at a single licencee or across the sector. This is the base case from which we compare the proposed Regulations.

Note: Currently there are no on-going spot checks of vehicles. Part of the Government election commitment was to address this deficiency and it is expected that spot checks will commence soon after the introduction of these amendments. Inspections and audits are operational policy of the department and do not typically sit in Regulations.

The current regulations are primarily a licencing scheme with a secondary focus on patient care, albeit a significantly increased focus since the introduction of the 2016 Regulations. As the Act is now being amended to prioritise patient safety and quality of care so the proposed regulations also seek to prioritise and strengthen the requirements for the safety and care of patients. These changes will ensure the Regulations are more aligned to their objective which is:

“to prescribe standards and requirements for the provision of non-emergency patient transport services under the No-Emergency Patient Transport Act 2003, including standards for the safety and quality of care of patients using the services.”

Currently in the NEPT industry there are variable levels of patient care, vehicle and equipment maintenance, clinical governance, occupational health and safety, and staff training. The consumer of the service (the patient) does not have information or power to enable them to choose a provider based on the patient’s priorities. The service is allocated to the patient by a third party without patient input into the choice. In these circumstances the only way to ensure minimum standards that meet community expectations is to regulate.

# 3. Identification of options

## 3.1 Objective

The primary objective of the proposed regulations is to strengthen the requirements for the safety and quality of care of patients being treated and transported by NEPT services.

The 2016 Regulations went some way down this path but were constrained to an extent because there are no requirements under the Act for licencees to provide a safe service. This is a substantial gap in the Act which is now being addressed and which will permit regulations aimed specifically at patient safety to be introduced.

The secondary objective of the proposed regulations is to improve OH&S protections and outcomes for patients and staff without encroaching on the OH&S Act, and to remove stand-by accreditation of licencees as this service is not patient transport. Stand by accreditation permits NEPT licencees to provide first aid at public events. Stand-by accreditation is being replaced with the licencing and regulation of the commercial first aid sector.

## 3.2 Base case

The ‘base case’ scenario is the 2016 Regulations as they do not expire until 2026. This RIS estimates the costs against the base case up until to 2016 Regulations sunset, that is, for 5 years. The Victorian Guide to Regulation requires the base case to be defined for the purposes of comparison (that is, what are the potential costs and benefits compared to the situation where the proposed approach is not adopted).

The base case has a number of gaps when considering the effectiveness of the current Regulations in regulating the safety and quality of care provided to patients. The base case also does not address OH&S matters sufficiently, leaving that to the OH&S legislation. In some cases patient safety and staff OH&S intersect and one regulatory requirement can address issues with both. An example is the proposed requirement to use power lift stretchers.

In the absence of the proposed Regulations there would still be drivers for a number of NEPT operators to provide for patient safety and quality to the level envisaged by the proposed Regulations. Those companies that have, or seek, a contract with AV or Health Purchasing Victoria (HPV), will meet most of the proposed new requirements. All businesses have a need to uphold business reputation to a greater or lesser degree, as a business that did not provide appropriate care to patients during transport would soon lose contracts with hospitals and AV. While these drivers promote safety and quality, under the base case there is limited power for government to act or intervene in circumstances where it is found that adequate patient safety and quality standards are not being met.

As stated earlier there is market failure to the extent that the user of the service cannot select their preferred provider and even if they could, has no information to allow them to make an informed choice. The proposed options for the Regulations do not address this issue directly, instead focussing on setting minimum standards across all providers.

## 3.3 Options to achieve the objectives

In considering options it is noted that:

The Subordinate Legislation Act 1994 Guidelines (the guidelines) state:

“In most cases, when a responsible Minister is considering making a statutory rule or legislative instrument, the authorising Act or statutory rule will dictate what kind of instrument may be created. For example, where the authorising legislation provides for fees to be prescribed in statutory rules, there may be no discretion to set those fees by another method.”

The authorising Act in this case, the *Non-Emergency Patient Transport Act 2003* sets down a regulatory framework requiring licencing of NEPT operators.

A number of provisions in the Act allow for forms, fees, or registers to be prescribed in regulations.

In addition, Section 64 provides that the governor-in-council may make regulations to prescribe matters relating to: safety, cleanliness and hygiene; standards and requirements for the welfare of persons being transported, staffing; for vehicles and equipment; communication devices, and records. The Amendments to the Act will include a power to make regulations for patient safety.

In accordance with the Act and guidelines, making regulations for these provisions is the only viable option to give effect to the Act. Therefore, alternative “stand-alone” regulatory or non-regulatory options (for example, negative licensing instead of licencing or guidance notes to proprietors in place of Regulations) are not considered in this RIS.

The Act does not constrain the final form of the Regulations for matters prescribed for the purpose of addressing patient safety and care. It is noted that the current Regulations have imposed a range of requirements on NEPT licencees that have impacted on their business models. Similarly, NEPT businesses that have sought or been awarded contracts with AV or HPV to transport NEPT patients have been required to meet a range of contractually imposed requirements to ensure patient safety and care in addition to the regulatory requirements.

Options involving information, such as league tables or benchmarking, while arguably addressing information asymmetries, are not viable, because this type of performance information is not available and even if it was, as patients do not have the right to chooses their NEPT provider, it would be of little benefit.

As a result, options to be considered and assessed for the purposes of the RIS focus on those regulations that are either required by the Act or that directly regulate patient safety and care. These matters represent an incremental cost on the sector. For the proposed Regulations these have been identified as:

* The type of stretchers to be used and use of lifting cushions
* Age of vehicles
* Clinical Governance
* Staff training
* OH&S accreditation

Specifying the type of stretchers that may be used and the maximum age of vehicles to transport patients, and mandating use of lifting cushions directly impacts on patient safety and staff OH&S. Similarly introducing additional minimum staff training requirements will directly impact on patient safety.

Introducing clinical governance requirements recognises that the patient transport is part of an overall journey through the health system and merits similar considerations and oversight as other parts of the health system such as hospitals. Clinical governance is a system whereby clinical operations and associated matters are continually scrutinised, challenged, and improved and it contributes to improved patient safety and quality of care over time.

Each of the above requirements increases the cost of doing businesses. However, failing to introduce the requirements means there is a greater overall risk to patients of unsafe transport or poorer quality of care than would otherwise be the case. However, the actual risk is that there would be an uneven provision of safety and quality of care as some providers already meet most of the proposed requirements while some providers don’t.

OH&S is important both in protecting the workforce and patients and potentially reducing costs.

These aspects of the proposed Regulations are examined in chapters 4 - 8 where the nature and extent of the problems particular to those areas, as well as the arrangements in other jurisdictions, are discussed.

In addition, the Regulation’s objectives and options will be examined. The cost-benefit for each option will be assessed using multi-criteria analysis, resulting in a preferred approach.

The rationale for other regulations that are either of a low impact to the sector or where the cost is attributable to the Act and not the Regulations is set out in chapter 9.

# 4. Power Lift Stretchers & Lifting Cushions

## 4.1 The nature and extent of the problem to be addressed

Prior to the 2018 State election the Government made a commitment to review the NEPT Act. A specific commitment was to require all NEPT licence holders to use power lift stretchers and lifting cushions in all NEPT vehicles.

The intent behind the commitment was to improve occupational health and safety for NEPT vehicle crews by making it easier to move patients onto stretchers, and to load the stretchers into vehicles. The Department is of the view that the new requirement should reduce workplace injuries and hence Workcover claims. If this outcome is achieved it follows that Worksafe premiums for the sector overall would be reduced

Existing licencees were surveyed in 2019 to see who was using power lift stretchers. 12 of the 20 licencees responded:

5 licencees have power lift stretchers

4 licencees do not have power lift stretchers

2 licencees have both power lift and manual stretchers

1 licencee did not say

8 licencees did not respond

See table 1 below.

**Table 4.1**

NB: Both means a NEPT business operated both power lift and manual stretchers.

Of the licencees that responded to the survey only 2 reported that they had had manual handling injuries since 2016, whereas 4 licencees had not and 6 licencees did not respond. The figures are not considered to be reliable as the comparable AV data shows higher manual handling injury rates[[11]](#footnote-12). In terms of manoeuvring patients onto, and on stretchers, the risks for AV and NEPT staff are much the same and therefore the injury rates would be expected to be similar.

There is no uniformity among NEPT businesses as demonstrated by the survey results. As a result, the company a NEPT staff member works for can increase or decrease risk of injury depending on whether or not power lift stretchers are in use. This creates inequality that is not necessarily within the power of the staff member to rectify. While a prospective employee may prefer to work with a company that uses power lift stretchers there may not be any positions available and they are then forced to work with a company using manual stretchers or not work at all. There is a power asymmetry between the staff member and the employer.

A further consideration of workplace injuries is the burden these injuries impose on the individuals affected and their families. A back injury can have lifelong implications and reduce the quality of life and the earning capacity of affected individuals, which in turn impacts on their families. In addition, there is the medical and associated expenditure incurred as a result of these injuries that may continue for the rest of the life of an affected staff member.

The department was unable to obtain Worksafe data on manual handling injuries for NEPT staff. Therefore, based on data from Ambulance Victoria (AV) and NSW Ambulance (see below) we can predict that in the NEPT sector there will be reductions in manual handling injuries of staff over time once power lift stretchers are introduced. This should, in turn, reduce Workcover premiums.

There is no data to show injuries that may have been incurred by patients as a result of not having power lift stretchers and lifting cushions available.

Power lift stretchers are designed to raise and lower electronically rather than manually. They are easier and safer to use than manual stretchers and can be lowered to allow for easier loading of patients. Lifting cushions are used to raise patients who have fallen in their own homes to allow them to be transferred to a stretcher. Both pieces of equipment are expected to prevent staff injuries and reduce Worksafe claims potentially leading to a reduction in Worksafe premiums for NEPT providers.

Historically, sixty per cent of paramedic injuries (in Ambulance Victoria) have been manual handling injuries[[12]](#footnote-13).

Based on the NSW Ambulance experience the introduction of power-lift stretchers is expected to result in a significant decrease in manual handling injuries for NEPT crews. NSW has used power lift stretchers since 2014 in both their emergency and non-emergency fleets resulting in a significant (80%) decrease in manual handling injuries since then.

There is a significant cost associated with this requirement. The cost is mitigated to some extent by the fact that it is expected manual handling injuries will reduce as a result.

It is noted that AV have introduced a requirement for their NEPT contractors to use power lift stretchers. This requirement commenced on 1 July 2019 and is being phased in over three years. In addition, two larger NEPT businesses have already independently begun to transition to power lift stretchers having made the assessment that it is a good business decision and is worth the cost.

Lifting cushions are used to raise a fallen patient from the floor to a height where they can be transferred to a stretcher. In the absence of lifting cushions staff are required to manually lift the patient from the floor to transfer them to a stretcher. Lifting cushions operate by being placed under the patient when uninflated and they are then inflated lifting the patient to a standing position as the inflate. The use of lifting cushions removes the need for staff to bend to lift patients thereby removing an injury risk.

## 4.2 Objectives

The objective of the regulations requiring the use of power lift stretcher and lifting cushions is to:

* minimise the risk to health and safety of staff who move patients onto stretchers and manoeuvre stretchers, and
* reduce the risk to patients of being dropped or having a stretcher collapse. (If a staff member is injured moving a patient onto a stretcher the patient may be dropped.)

The secondary objective is to ensure the health and safety risk to patients and staff are managed without risking the viability of NEPT businesses.

## 4.3 Interstate Arrangements

Around Australia, Tasmania and South Australia do not have any Regulations specifying the type of stretchers to be used in NEPT services. South Australia emergency ambulances do use power lift stretchers and have done so since 2017. Ambulance Tasmania is currently transitioning to power lift stretchers.

The Northern Territory contracted St John Ambulance NEPT fleet are transitioning to power lift stretchers.

NSW has used power lift stretchers since 2014.

Queensland advises that all emergency and non-emergency vehicles use power lift stretchers.

Apart from Tasmania and South Australia all NEPT services are provided by the Government. As a result, those Governments can set out requirements for the NEPT services through the funding arrangements and not need to use legislation.

As mentioned earlier because States and Territories have different approaches to the delivery of NEPT services it is not possible to make a direct comparison with the Victorian NEPT system. As a result NEPT systems operated by other States and Territories are not feasible options for Victoria.

## 4.4 Identification of options

|  |
| --- |
| Base case: Not require the use of power lift stretchers – the current regulations |
| NEPT business owners are free to choose what types of stretchers they use to transport patients in their NEPT vehicles within the constraints of the *Occupational Health and Safety Act 2004*. The base case is a continuation of the current Regulations. NEPT businesses owners are also free to use lifting cushions or not as they see fit. |
| Option A: Require the use of power lift stretchers – the proposed regulations |
| All stretchers used in NEPT vehicles to transport patients must be power lift stretchers. Lifting cushions must be carried by NEPT vehicles attending patient’s homes. |

Each stretcher costs approximately $40,000 and has a five to seven year lifespan. Some providers have raised concerns that putting a power-lift stretcher in every vehicle would be too expensive to be able to financially accommodate within a reasonable amount of time. It is therefore proposed that this measure would have a transition period of three years.

Ambulance Victoria has introduced a contractual requirement that all of their contracted NEPT providers must introduce power-lift stretchers within the three-year life of the current contract that commenced on 1 July 2019. The regulatory requirements will therefore only impact on licencees and vehicles not subject to an Ambulance Victoria NEPT contract.

The base case and Option A simply reflect whether the Government’s election commitment is introduced or not. The options outlined below are therefore limited to those two alternatives.

The base case is a continuation of the current regulatory approach which does not require power lift stretchers or lifting cushions to be used and leaves it to the NEPT business owner to decide which type of stretcher to use.

Option A is the implementation of the Government’s election commitment which requires all NEPT vehicles to operate power lift stretchers and lifting cushions.

Additional mandatory training in the use of manual stretchers was considered however the department is of the opinion that it will not make a material difference. The Regulations already mandate annual training in manual handling, which while preventing additional injuries to the current level have not reduced injuries to the level that the use of power lift stretchers is likely to achieve. Therefore, additional mandatory training is not put forward as an alternative option.

No other option was identified.

## 4.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 4.2 below.

**Table 4.2 Multi-criteria analysis criteria and weightings**

|  |  |
| --- | --- |
| Criterion | Weighting |
| Patient care and staff safety | 70% |
| Costs to NEPT licencees | 30% |

These criteria reflect the objectives of the Regulations as they relate to the identified problem in this RIS about ensuring patient and staff safety and care by having appropriate equipment in use to collect and transport patients.

Because providing for patient and staff safety and quality of care is the primary objective of the Regulations, the effective assessment of using power lift stretchers and lifting cushions is accorded a criterion weighting of 70 per cent. The overall costs imposed by the Regulations on NEPT licencees are therefore weighted at 30 per cent.

### The Base Case - the current Regulations

The base case is one of lower patient and staff safety and lower cost. It allows NEPT licencees to choose to use manual stretchers or power lift stretchers and whether or not to use lifting cushions.

The base case continues the current requirements which permit the licence holder to determine what types of stretchers are used in the transport of patients.

As stated in **4.1**, in response to our survey 7 licencees reported using power lift stretchers. At the time 5 of those licences were contracted to AV. As the use of power lift stretchers is an AV contractual requirement, we therefore conclude that there are 9 licencees currently using power lift stretchers for all or part of their fleet. The 9 licencees comprise the seven licencees contracted to AV plus 2 other uncontracted licencees who responded to the survey. These 9 licencees operate 356 vehicles currently

Under the base case, there are no restrictions imposed by regulations so any type of stretcher could continue to be used. Lifting cushions are not required to be used. The existing patient and staff safety risks of injury associated with the use of manual stretchers would continue to the extent that manual stretchers continued to be used. A similar situation would exist for those licencees not using lifting cushions for fallen patients.

The department has been advised by two larger NEPT licence holders that the average cost of a worker’s compensation claim in the NEPT industry is about $60,000. This is the best estimate the Department has and in addition, the AV 2018/19 Annual Report confirms these costs.[[13]](#footnote-14) The report states AV have 4.2 claims per 100 equivalent full-time staff (EFT). The NEPT sector employs about 1700 people, not all of whom are full time. If we assume 1200 full time positions and similar injury claims to AV then the number of injury claims per annum is about 50 claims per year across the sector. At $60,000 per injury the total cost per annum is $3,000,000. Not all of these claims will be manual handling injuries but the vast majority are likely to be. The department has no data to enable a further breakdown of the injuries so for the purposes of discussion we will assume the annual cost of $3 million. There is also no data on injuries sustained by patients so no cost has been attributed as any figures would be unreliable.

The cost of the base case is zero as it is a continuance of current arrangements.

**Table 4.3 Multi-criteria analysis scores for the base case**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient and staff safety and care | 70% | 0 | 0 |
| Costs to NEPT licencees | 30% | 0 | 0 |
| **TOTAL** | **100%** |  | **0** |

### Option A – The proposed Regulations

Option A, the new Regulations, will require all stretchers used in NEPT vehicles to be power assisted lift stretchers and will require all vehicles attending patient’s homes to carry lifting cushions.

The purpose of this requirement is to reduce manual handling injuries for staff, reduce the risk of injuries to patients from being dropped or from manual stretchers collapsing, and to provide for dignity and reduce embarrassment for those patients who had fallen prior to arrival by the NEPT service and were unable to get up by themselves.

In 2018/19 350,000 patients were moved by NEPT vehicles, the vast majority of whom required stretchers.

There is more than one type of power lift stretcher available on the market and there is no intention to mandate any particular brand. Whatever brand is selected by the NEPT provider staff training in its safe use will be required. However, this additional training will be offset by the removal of the need to train staff to use manual stretchers and is therefore considered cost neutral.

The department considers the introduction of power lift stretchers and lifting cushions will significantly reduce the opportunity for injury of patients and staff. NSW Ambulance has experienced an annual reduction of 16% in manual handling injuries each year since the introduction of the power lift stretchers up until 2019. AV experienced a 32% reduction in the first year after the introduction of power lift stretchers in 2016 (AV unpublished data provided to the department). In the three years prior to 2017 manual handling injuries from stretcher use made up 60% of AV WorkCover claims.

The Victorian Health Building Authority website published a press release from the Office of the Premier that reported that in 2017, one year later, that the number of manual handling injuries actually fell by 60% (from 30 per annum to 12 per annum)[[14]](#footnote-15).

The two sets of data referred to above are different presumably because one set of data had been updated after the other set was released. For the purposes of this RIS we will use the more conservative 30% reduction as the proxy for NEPT.

If we use the 30% reduction as a proxy for the Victorian NEPT sector, then the reduction in the number of manual handling injuries attributable to stretchers will fall by 30% at a saving of $1 million in year 1. We have also assumed 30% reductions in subsequent years until the Regulations sunset. We think this is a fair and conservative assumption.

In the response to a department survey, responses from two NEPT licencees confirmed a reduction in manual handling injuries after the introduction of power lift stretchers. It is noted the numbers are small and therefore unreliable, however the trend is consistent with that of AV and the NSW ambulance service

The data provided by the two NEPT respondents who have introduced power lift stretchers showed a significant fall in manual handling injuries after the power lift stretchers were introduced albeit with very small numbers.

**Figure 4.4 Victorian NEPT staff manual handling injuries from stretcher use[[15]](#footnote-16)**

There is no data on injuries sustained by patients as a result of the absence of lifting cushions. Therefore, it is not possible to say how many injuries will be prevented by this requirement, nor what the cost saving will be as a result of prevented injuries due to this requirement. Even so it is reasonable to assume there will a reduction in injuries to patients and NEPT staff once lifting cushions are introduced as patients will no longer need to be manually lifted from the floor prior to transferring them onto a stretcher.

The use of lifting cushions protects the dignity of patients to a degree and preserves their independence, as the patients can be gently raised to a standing position (if not injured) which allows them to then to move onto a stretcher. It is far preferable to being picked up by NEPT staff and placed onto a stretcher, which can induce feelings of helplessness and embarrassment in the patient. Lifting cushions assist in patients preserving a positive frame of mind which is linked with improved patient outcomes. Without the use of lifting cushions, the current risk of injuries to staff and of the patient being dropped, and the risk of incurring additional injury remains.

Lifting cushions are not required for transfer out of a hospital as the patient will not be on the floor at the time of pick up so the requirement will only apply to those vehicle collecting patients from their own homes.

The Department assumes that reduction in workplace injuries will lead to a reduction in WorkCover premiums, however as the department was unable to obtain specific NEPT injury data from Workcover (they may not hold such specific data) we are unable to quantify any potential savings resulting from the new Regulations.

It must also be considered whether or not there is a workable design solution to allow two power lift stretchers to be fitted to a NEPT vehicle while achieving the 350 mm separation between them that is also to be required by these Regulations. One licencee has advised there is such a design solution available and the department considers this design is workable. In the current AV contract providers are required to use single stretcher vehicles only and this has resulted in a number of providers purchasing new vehicles which was a consequential cost of the contract requirements. AV have provided a three year transition process to power lift stretchers.

The department also proposes a transition period of three years for the introduction of power lift stretchers to spread the cost impact.

#### Costs

There will be a significant cost impact from introducing the power lift stretcher requirement. The methodology by which the costings were calculated is summarised below. Submitters are invited to identify any errors in the costings and underpinning assumptions.

Total number of NEPT stretcher vehicles operated by licencees – **428[[16]](#footnote-17)**

Total number of NEPT stretcher vehicles contracted to AV – **72**

No. of vehicles to exit the market = **44** (moving to a first aid licence).

It is assumed that all NEPT providers contracted to AV have some powerlift stretchers and will have all AV contracted vehicles fitted with power lift stretchers by 2023. It is unclear how many vehicles operated by NEPT providers outside the AV contracts and by those not contracted to AV have powerlift stretchers. A minimum number of vehicles affected has been calculated by assuming that all AV contracted providers and the providers identified as having powerlift stretchers use powerlift stretchers in all of their vehicles. A maximum number of vehicles affected has been calculated by assuming that all vehicles outside the AV contract do not use powerlift stretchers their vehicles.

Maximum number of non AV contracted stretcher vehicles affected by the proposal is 428 – 72 – 44 = **312**

Minimum number of non AV contracted stretcher vehicles affected by the proposal is 428 – 356 (see base case) – 44 = 28

The number of actual vehicles to be affected by the requirement is between 28 and 312. We have taken the midpoint of **170 vehicles** for the costing calculations below.

The cost per power lift stretcher is $40,000 and each stretcher has a 7 year life under normal operating conditions.

Many NEPT vehicles are dual stretcher vehicles so additional stretchers will be required to replace existing manual stretchers and these will either be placed in modified dual stretcher vehicles or additional single stretcher vehicles will need to be purchased. The department anticipates the final outcome will be a mix of these 2 scenarios.

If we assume 70% of the vehicles are double stretcher vehicles, then the total number of stretchers required is 170 + 119 = 289.

For comparative purposes (sensitivity analysis), if we take the best case scenario of 28 vehicles and assume 70% of the vehicles are double stretcher vehicles then the total number of stretchers required is 28 + 19 = 47. If we take the worst case scenario of 312 vehicles and assume 70% of the vehicles are double stretcher vehicles then the total number of stretchers required is 308 + 218 = 526.

The potential cost range for supply of the stretchers therefore is from $1,880,000 to $21,040,000.

For the purposes of this RIS we are taking the midpoint for the cost calculations. There is every chance the cost will be lower due to some companies already transitioning to power lift stretchers ahead of the Regulations. However using the midpoint, the cost is:

289 x $40,000 = **$11,560,000**

With a 3 year transition period and then replacement in years 8-10 the cost profile (assuming a linear transition) is:

Year 1 (2021) = **$3,853,333**

Year 2 (2022) = **$3,853,333**

Year 3 (2023) = **$3,853,333**

Year 4 (2024) = **0**

Year 5 (2025) = **0**

**NB:** Years 6-10 are not included as the life of the current Regulations is 5 years.

While the Regulations will not specify that only single stretcher vehicles must be used it is anticipated that 30% of dual stretcher vehicles will be moved to a single stretcher over time. In order to maintain capacity in the sector this will require approximately **50 additional vehicles** at an estimated cost of $130,000 per vehicle. In addition, there are fit out costs of another $30,000 per vehicle. While some of the shift to single stretcher vehicles will be to satisfy the AV contract it is anticipated that some providers will preference single stretcher vehicles for reasons other than the AV contract. For example, single stretcher vehicles are easier for staff to work in due to the extra space.

It is important this RIS does not underestimate costs imposed on the sector. It is essential the cost of the new regulations is made clear to the sector as this may influence their submissions to the draft Regulations. In particular it will provide sufficient information for licence holders to decide if the proposed changes are financially viable for them, and if not, allow them to alert the department through their submissions. If this were the case the department would need to revisit the draft regulations or plan for the impacts caused by the loss of one or more businesses. For these reasons the cost of all additional vehicles is being attributed to the Regulations.

The cost of additional vehicles is 160,000 x 50 = $8,000,000. Companies would be expected to spread the cost over the life of the vehicle. It is estimated this is a 6 year period so the cost per annum is **$1,333,000**

50 additional crews will also be required to operate the vehicles. The cost of the extra crews is 50 x 2 x $60,000 (salary + oncosts (including training)) = **$6,000,000 p.a. ongoing**

The total cost therefore is:

Year 1: **$11,186,000** ($3,853,000 + $1,333,000 + $6,000,000)

Year 2: **$11,186,000**

Year 3: **$11,186,000**

Year 4: **$ 7,333,000 (**$1,333,000 + $6,000,000)

Year 5: **$ 7,333,000**

**Total $48,224,000**

AV data has been used to estimate how much manual handling injuries in the NEPT sector will reduce. As explained earlier while the AV figures show a 60% reduction in injuries in year 1 for this RIS, but we will use a more conservative figure of 30% per year.

If these figures were replicated in the NEPT sector, at a cost of $60,000 per injury, the saving would be $1,000,000 in year 1, and increasing thereafter (see above for explanation) once all vehicles were equipped with power lift stretchers.

For comparison, we can also use the NSW figure as a proxy, noting NSW Ambulance Service has been using power lift stretcher for 2 years longer that AV.

If the same trend is replicated in Victoria after power lift stretchers are introduced a reduction in manual handling injuries of 16.8% annually (84%/5) for the first years can be expected.

We have used the AV figures as the basis for the costings below.

The number of manual handling injuries in the NEPT sector resulting in workers compensation claims is estimated at 50 per annum currently. If there is a reduction of 17 cases in year 1 at $60,000 per claim this amounts to $ 1,020,000. Additional savings are assumed to reduce by one-third each year. Year 2 savings would be $1,020,000 + (50-17)/3 x $60,000 = $1,860,000. Total year 3 savings would be $2,280,000, year 4 - $2,580,000, and Year 5 $2,760,000. For the purposes of this RIS the reduction in injuries contributes to the MCA score for patient and staff safety.

Option A will provide greater patient and staff safety but at a significantly higher cost than the base case.

For the reasons outlined above, the department considers that the merits of introducing power lift stretchers and lifting cushions outweigh the costs overall.

##### Lifting Cushions

The Mangar Elk Lifting Cushion costs $3,495. It is a common cushion used to lift patients from the floor, so has been used to estimate costs for this RIS. A maximum of 305 vehicles will be required to carry a cushion. Assuming none do so currently: -

305 x $3,495 = **$1,065,975.**

The lifting cushions are to be introduced in the first 12 months or by 30 September 2022.$1,065,975

The total cost in year 1 is $11,186,000 + $1,065,975 = $12,251,975, $11,186,000 for years 2 and 3, and $7,333,000 for years 4 and 5.**The total cost of Option A** over the remaining life of the Regulations is **$49,289,975. The discounted cost of Option A** over the remaining life of the Regulations is **$45,063544** which gives an MCA score of 10.

NB: $4 million = 1 point due to the high cost of this specific regulation. It is necessary to ensure the total cost fits within the scoring, i.e. $40 million = 10 points

An MCA score of +6 has been attributed to the change due to the significant reduction in manual handling injuries expected to result from adopting option A. Patient and staff safety has been given a weighting of 70 per cent because the Government has amended the Act and it reflects the priority the Government places on patient and staff safety and care. The benefit in reduced injuries is not only in medical and WorkCover costs but also in reduction in staff turnover or replacement (on going or temporary). There will also be a commensurate reduction in mental health impacts on both the staff member and their families and the prevention of life long medical impacts.

Option A will provide greater patient and staff safety but at a significantly higher cost than the base case.

**Table 4.5 Multi-criteria analysis scores for option A**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient and staff safety and care | 70% | +6 | **+4.2** |
| Costs to NEPT licencees | 30% | -10 | **-3** |
| **TOTAL** | **100%** |  | **+1.2** |

The two options put forward in this assessment (base case and Option A) are considered to be the only two workable regulatory options. Either stretchers are power assisted and lifting cushions are provided, or they are not.

Option A, the proposed Regulations are considered justified due to the material difference in injury rates that are expected to result and this is considered to be a higher priority than cost. Option A delivers a Government election commitment.

# 5. Vehicle Life Limits

## 5.1 The nature and extent of the problem to be addressed

Prior to the 2018 State election the Government made a commitment to review the NEPT Act. A specific commitment was to ensure all NEPT vehicles were fit for use.

The intent behind the commitment was to improve occupational health and safety for NEPT vehicle crews by ensuring that all vehicles were roadworthy at all times and were not being used to the point where they become difficult to maintain in good working order.

In discussion with the larger NEPT businesses the Department was advised that vehicle changeover at 400,000km is the point at which it makes financial sense. The department was advised that the maintenance costs on vehicles beyond that mileage outweigh the costs of replacing them with a new vehicle. There is a risk that beyond the 400,000 km mark the financial incentive to keep running the vehicles without investing in the necessary maintenance may be such as to tempt some business operators to keep old vehicles on the road without sufficient maintenance to maintain roadworthiness.

Patients cannot choose whether they are transported by a NEPT licencee who uses modern vehicles and changes them over by 400,000km or not. Apart from the vehicles contracted to AV there is therefore little market incentive for NEPT licencees to change their vehicles at 400,000km or at any particular mileage or age. In this instance arguably there is market failure. It is expected that if patients could, they would choose a modern vehicle rather than an older vehicle in which to be transported.

If the Regulations do mandate vehicle changeover at 400,000km it is not expected to result in any expansion of the NEPT fleet as while the frequency of replacement would increase for some providers, the vehicle numbers required overall won’t change as a result of the requirement. Patient demand drives vehicle numbers.

For comparison AV change over their emergency vehicles every 200,000km.

The department surveyed licenced NEPT providers to find out when vehicles are normally replaced. The chart below shows the variation in vehicle replacement criteria among the providers.

**Table 5.1 – Vehicle Replacement Mileage**

## 5.2 Objectives

The objective of this regulation is to ensure patients transported in NEPT vehicles, and staff whose working environment is the vehicle, are protected from unnecessary risk of injury or death from the use of unsuitable vehicles.

The safety and staff and patients is best assured if the vehicles in use are modern, safe, and properly maintained.

The secondary objective is to introduce the requirement without creating cost pressures that put the viability of NEPT businesses at risk. Therefore, the department proposes to provide a five year transition period from the date of the introduction of the regulations for NEPT businesses to achieve compliance.

## 5.3 Interstate arrangements

Interstate arrangements do not provide examples of feasible options for amending the Victorian Regulations. No other State or Territory mandates vehicle replacement criteria for private NEPT providers. Tasmania and South Australia do not have any Regulations mandating a maximum mileage before NEPT vehicles must be replaced. Remaining States and Territories implement vehicle life limits through their funding and contractual arrangements with the State and Territory ambulance services.

## 5.4 Identification of options

|  |
| --- |
| The base case: Not mandate a maximum vehicle mileage – the current regulations |
| NEPT business owners are free to choose at what point they replace their vehicles within the constraints of the *Occupational Health and Safety Act 2004* and the *Road Safety Act 1986*. The base case is a continuation of the current Regulations. |
| Option A: Mandate a maximum mileage of 400,000 km for all NEPT vehicles – the proposed regulations |
| All NEPT vehicles to be replaced when they reach 400,000km. |
| Option B: Mandate a maximum 7 year age limit for all NEPT vehicles |
| All NEPT vehicles to be replaced at 7 years of age. |

The base case is the current situation where there are no regulatory controls under NEPT legislation over vehicle life and it is the decision of the NEPT licencee when a vehicle should be replaced. Criteria for vehicle replacement differs between licencees, ranging from 300,000km up to 1 million km.

Option A proposes requiring all NEPT vehicles to be replaced once they reach 400,000km. The vast majority of NEPT vehicles are already changed over at the 400,000km mark (or lower) as licencees advise that beyond this point the vehicles become uneconomic to operate.

Not changing vehicles over at reasonably frequent intervals delays the introduction of more recent safety innovations in vehicle manufacture thus delaying the opportunity to reduce safety risk to patients and staff. This creates the potential for avoidable on-going risk of injury to staff and patients compared with newer vehicles that have updated crash avoidance and crash minimisation equipment installed. This must be measured against the cost of introducing minimum vehicle life to determine whether there is a benefit.

If proceeded with, it is proposed that this measure would have a transition period of 5 years to allow for those companies that would have budgeted to amortise the costs of existing vehicles over an extended time. A shorter transition period may create financial stress particularly for smaller companies. A replacement vehicle costs approximately $130,000 at current prices. In addition, there is a further $30,000 required in fit out costs.

Option A implements the Governments election commitment and reflects consultation feedback from a number of larger NEPT providers. The point was made that a mileage limit is more appropriate than age limit as vehicles do varying mileage according to whether they operate in the metropolitan or rural areas, and according to what type of patient they carry. For example, bariatric vehicles do a much lower mileage than standard stretcher vehicles. Apart from those providers who did not want any limit on vehicle life the general consensus (not universal) was that 400,000km was the point at which vehicles become more costly to maintain than purchasing a new vehicle so therefore 400,000km was a logical life limit to mandate. However, there is heavier wear and tear on a vehicle if it is predominantly driven in the city compared to if it is mainly driven in rural areas.

Option B is the alternative proposal to limit vehicle life to 7 years. Option B is an alternative way of implementing the Government’s election commitment. A vehicle that has travelled 400,000km in city traffic may be far more worn than a vehicle that has travelled 400,000km in rural areas due to the longer time taken to travel distances in the city and the stop start nature of traffic. Some NEPT providers report keeping vehicles on the road for up to 10 years. A time limit rather than a mileage limit addresses these issues.

However, vehicle mileage is not uniform and at 7 years some vehicles may be high mileage and potentially unsafe while other vehicles may still be low mileage and fit for use.

If option B is proceeded with a 5 year transition period is proposed for the same reasons as option A.

## 5.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 5.2 below.

**Table 5.2 Multi-criteria analysis criteria and weightings**

|  |  |
| --- | --- |
| Criterion | Weighting |
| Patient and staff safety and care | 70% |
| Costs to NEPT licencees | 30% |

These criteria reflect the objectives of the Regulations as they relate to the identified problem in this RIS about ensuring patient and staff safety by having safe, fit for use vehicles in operation to collect and transport patients.

Because providing for patient and staff safety and quality of care is the primary objective of the Regulations, the effective assessment of limiting vehicle life is accorded a criterion weighting of 70 per cent. The overall costs imposed by the Regulations are therefore weighted at 30 per cent.

The base case is one of potentially lower patient and staff safety and lower cost. Option A will provide greater patient and staff safety but will be a significantly higher cost than the base case. Option B also provides increased patient and staff safety at a significantly higher cost than the base case. It should be noted that the NEPT sector transported 350,000 patient transports in the 2018/19 year.

### The base case (current Regulations)

The base case continues the current requirements which do not set limits of vehicle life.

Under the base case, as there would be no restrictions imposed by regulations, vehicles can be used for as long as the business chooses irrespective of age and condition provided it complies with the existing requirements under the Regulations to ensure the vehicle is maintained in good working order.

As previously stated, the majority of NEPT sector vehicles are changed over at 400,000km currently, however the changeover point ranges from 300,000 km to 1 million km. Some smaller providers have reported using vehicles for 10 years before replacement, typically these vehicles can reach 600,000 – 700,000 kms.

Under the base case the existing requirements of the *Occupational Health and Safety Act 2004,* and the *Road Safety Act 1986* apply. Under these Acts it is largely the responsibility of the licencee to comply as enforcement is generally reactive.

As we have seen in the transport industry self-assessment of compliance with the above Acts does not always work. There is a small proportion of operators who cut corners to save money thus endangering their drivers and other road users. This risk applies to any privately operated transport industry including NEPT.

The cost of the base case is zero as it is the existing case.

**Table 5.3 Multi-criteria analysis scores for the base case**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | 0 | 0 |
| Costs to NEPT licencees | 30% | 0 | 0 |
| **TOTAL** | **100%** |  | **0** |

### Option A – the proposed Regulations – Limit vehicle life to 400,000kms

Option A, the proposed Regulations, requires all NEPT vehicles to be replaced when they reach 400,000km. Each trip is a potential for injury if vehicles are too old and no longer fit for purpose. By comparison AV change their vehicles at 200,000km.

The purpose of the requirement is to ensure vehicles are fit for purpose and have modern safety equipment, to minimise the risk of injury to patients and staff during transport from faulty vehicles or in collisions. It is also to ensure that the vehicle is kept in good repair. For example, making sure shock absorbers are kept in good condition to minimise the discomfort of travel for the patient. Patients and vehicle staff rely in part on the safety of the vehicle to ensure their personal safety during transport.

There is no data available to allow any measurement of the safety benefits of limiting vehicle life of NEPT vehicles. However, we know vehicle safety is constantly being upgraded by manufacturers with a view to saving life and preventing and minimising injury to occupants. The sector advises that 400,000km is usually reached by year 6 in normal use and may be quicker for rural vehicles that cover large distances. For those reasons it is highly desirable to have a modern patient transport fleet to utilise the most recent manufacturer built in safety equipment to maximise patient and staff safety. Option A would therefore be expected to result in vehicle replacement earlier than option B.

Option A supports the new requirement in the Act for the licence holder to ensure a safe service and an appropriate quality of patient care is provided at all times.

As has been seen repeatedly in the trucking industry, unsafe vehicles, old vehicles, and poorly maintained vehicles have led to many avoidable accidents and loss of life.

It is a requirement that at least one clinical staff member must travel with the patient in the patient compartment at all times. Caring for the patient may entail the staff member moving around the patient compartment to attend to the patient while the vehicle is in transit, so the staff member is not always restrained in case of an accident. In addition, there is limited outside visibility so the staff member cannot see and prepare for a looming accident. These factors combined significantly increase the risk of injury to the staff member in the case of an accident.

More frequent vehicle replacement allows vehicle safety innovations to be deployed in the NEPT fleet earlier and more often than under the base case to the benefit of patients and vehicle crews. Crash avoidance technology is particularly important in reducing the risk of injury to the patient and the NEPT staff member who travels in the patient compartment with them.

Any measure that could reduce patient and workplace injuries arising from the use of an unsuitable or unroadworthy vehicle that is involved in an accident is worth considering. AV data shows that from 2013 to 2015, 21 staff (1.3% of total WorkCover claims) were injured in vehicle accidents[[17]](#footnote-18). This would equate to 10 NEPT staff members over the same time frame because NEPT employ just under half the numbers of clinical staff as AV[[18]](#footnote-19) [[19]](#footnote-20).

Worksafe Victoria data available online shows that in 2019, excluding medical practitioners and nurses, there were 189 Worksafe claims by other health professionals. It is assumed the majority of these claims are from paramedics and clinical NEPT staff. The data also shows that in 2019, 742 claims were the result of vehicle accidents. The data does not differentiate between industries but it does show the risks involved in work that is primarily on road in vehicles.

Injuries received in road accidents can impose significant trauma on the individuals affected and their families. A motor vehicle injury can have lifelong implications and reduce the quality of life and the earning capacity of affected individuals, which in turn impacts on their families. In addition, there is the ongoing medical treatment and associated expenditure incurred as a result of these injuries that may continue for the rest of the life of an affected patient or staff member.

As NEPT services transport patients who are often restrained on stretchers is imperative that as far as possible accidents involving unsafe vehicles are avoided. As stated earlier, patients cannot choose who their NEPT provider is, and staff must work where the jobs are. That being so, it is unreasonable for there to be a potential variation of safety standards across the sector as it puts some patients and staff more at risk than others, depending on whether the particular NEPT service operates a modern, well maintained fleet or not.

In its 2006 paper, “Quality of Care A process for making strategic choices in health systems”, the World Health Organisation uses the following definition:

It suggests that a health system should seek to make improvements in six areas or dimensions of quality, which are named and described below. These dimensions require that health care be:

effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;

efficient, delivering health care in a manner which maximizes resource use and avoids waste;

accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;

acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;

equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;

safe, delivering health care which minimizes risks and harm to service users.

Old vehicles lacking in safety equipment would not meet most of the above objectives. It would mean patient care may not be effective, would not be efficient, acceptable/patient centred, equitable, or safe.

The contracting environment where AV, HealthShare Victoria (HSV), and hospitals contract NEPT services drives contract prices to the absolute minimum and works against improvements to safety and quality of care as these come at a cost. Therefore, legislation is needed to put a floor under, and articulate, the minimum safety required. In order to increase the levels of patient and staff safety in the private sector it is often necessary to legislate and is the original basis of WorkCover legislation. To improve safety standards over time it is often necessary to increase the minimum standards in legislation. Option A is an example of this.

Anecdotal feedback from some NEPT licencees is that the current contracting arrangements incentivise lengthening the operational life of vehicles to recover costs for those companies who may tender for the contracts with too low a price. If so, this is a perverse outcome of the contract process as AV, HPV and hospitals would also be seeking the safest possible service for patients.

The introduction of vehicle life limits will prevent vehicles getting too old, reduces the likelihood of vehicles not being fit for purpose, reduce the opportunity for injury of patients and staff, and removes the current financial incentive to operate vehicles beyond the point where they may be considered fit for purpose.

The Government proposes to address the issue of excessive age or use of NEPT vehicles by mandating a 400,000km changeover, and by introducing a requirement for annual roadworthy checks. Certification of each vehicle annual by a VicRoads approved motor mechanic will be required and this is discussed further in Chapter 9.

It is expected the 400,000km limit will only impact 35 vehicles. There is a sizeable additional cost associated with Option A for those businesses not currently changing their vehicles at 400,000km.

NEPT licencees were asked at what point they currently change over their vehicles. Ten responses were received. The responses are below:

**Change vehicles at 400,000km**

6 licencees currently replace vehicles at around 400,000km. These licencees operate 349 vehicles

**Change Vehicles at more than 400,000km**

4 licencees currently replace vehicles at more than 400,000 km ranging from mechanics advice, to 600,000km to 1,000,000 km. These licencees operate 46 vehicles

The cost of this measure will therefore only apply to those companies not currently changing their vehicles over at 400,000km and who will continue with a NEPT licence. For the rest of the sector it is already an accepted cost of doing business.

A number of the licencees who operate vehicles beyond 400,000km are expected to exit the NEPT market as a result of the changes to the Regulations. The actual number of vehicles affected is a small proportion of the total NEPT fleet.

Total number of NEPT vehicles operated by licencees – **428**

No. of vehicles to exit the market = **44** All these vehicles are owned by licence holders expected to move to a first aid licence. They may choose to dispose of their vehicles.

Number of NEPT vehicles already changed over at 400,000km = **349**

Total no. of NEPT vehicles affected is 428 – 349 – 44 = **35.** These are vehicles do not belong to those licence holders who will exit the market.

For this Chapter and the remaining chapters, $1 million is assigned one point in the MCA. This is because the scale of costs is significantly lower to the costs in Chapter 4. Benefits scores also use a different scale where a four points in this chapter and remaining chapters is equivalent to one point in chapter 4.

**The cost of option A is $308,000 per annum** (see appendix A3 for calculations) **or $1,540,000** over the life of the Regulations(5 years). **The discounted cost of option A** over the life of the Regulations is **$1,329,456** which gives an MCA score of -1**.**

The patient care and staff safety benefit attributable to option A is considered to be positive due to the elimination of old vehicles and the more rapid introduction of new vehicle safety features to the fleet which will have a preventative effect in accidents and potentially provide safer patient journeys. An MCA score of +2 is therefore attributed.

**Table 5.4 Multi-criteria analysis scores for option A**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient care and staff safety | 70% | +2 | **+1.4** |
| Costs to NEPT licencees | 30% | -1 | **-0.3** |
| **TOTAL** | **100%** |  | **+1.1** |

### Option B – Limit Vehicle Life to 7 years

Option B considers whether a 7 year life limit on NEPT vehicles would be a more suitable option. A small number of stakeholders suggested 7 years is a better changeover point as metropolitan vehicles tend to do a lower mileage than rural vehicles over a given amount of time. It is argued by some NEPT licence holders that a rural vehicle that has done 400,000 km may still be quite new and in good condition as the trips are longer than those in metro areas with little stop start traffic. One provider reported that one of their vehicles does 38,000km per month in rural patient transport. Generally, rural mileage accrues more quickly and does not create the same wear and tear as suburban mileage. It was suggested that the actual age of the vehicle is a better indicator of wear and tear within the NEPT industry.

This argument assumes the vehicles are in fairly constant use, which is not always the case. Rural vehicles may not be utilised continuously due to the lower population but when used the trips are much longer. In addition, specialist bariatric vehicles do a much lower mileage than normal vehicles (less trips) and may not have done many kms at the 7 year age limit and would not need replacement at that point (apart from the issue of upgraded safety technology).

Unless a NEPT business is solely a rural transporter of patients they can rotate their vehicles between rural and metropolitan work to even up wear and tear.

The sector advises that the 400,000km limit proposed in option A is generally reached at 6 years of vehicle age. So, option B allows an additional year of useable life for NEPT vehicles overall.

The same supporting arguments for mandating vehicle life apply to option B as apply to option A. The decision about which limit is better able to achieve the aim of ensuring the fleet is relatively modern, has recent safety innovations, and is fit for use, comes down to which of the options is the most effective in achieving vehicle changeover of the majority of vehicles within a reasonable timeframe. Option B is considered to be relatively less effective in achieving these outcomes and therefore relatively less effective in ensuring patient and staff safety while on road.

The patient care and staff safety benefit attributable to option B is also considered to be positive due to same reasons as option A. As vehicles are changed over one year later than option A the MCA score for patient care and staff safety is scored at +1

The department considers option B would not be as effective as option A overall and therefore option B is not supported.

**The cost of a 7 year vehicle limit is $176,000 per annum** to the sector **or $880,000 over the life of the Regulations.** A score of -1 is therefore allocated. See Appendix A3 for calculations.

**Table 5.5 Multi-criteria analysis scores for option B**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient care and staff safety | 70% | +1 | **+0.7** |
| Costs to NEPT licencees | 30% | -1 | **-0.3** |
| **TOTAL** | **100%** |  | **+0.4** |

# 6. Clinical Governance

## 6.1 The nature and extent of the problem to be addressed

Clinical Governance is the process by which an organisation providing medical services establishes procedures and protocols to manage, review and improve its clinical activities over time. This includes:

* setting the scope of clinical practice of clinical staff
* setting the scope of clinical practice of the business
* credentialing of medical practitioners
* setting up a medical advisory committee to review all clinical activities of the business
* establishing procedures for all clinical matters.

Clinical Governance systems are designed to ensure the right people are providing the right medical care at the right time with the right equipment and that when errors are identified the processes are upgraded to prevent a repetition.

Patient safety and care is central to an NEPT business. Having robust clinical governance systems in place drives continuous review of patient care and this results in continuous improvement in patient care. Clinical governance provides a system for checking patients are being treated appropriately, for ensuring staff know the limits of their competencies and work within those limits, for ensuring the business knows the limits of its expertise and works within those limits, and for reviewing every incident of sub optimal patient care.

It is only by recognising where patient care is not delivered to the required standard, and reviewing what happened, can improvements be made and repetitions be prevented. This approach is standard practice in hospitals and AV and should also be standard practice in all NEPT services as they are part of the same continuum of patient care.

When patients use a NEPT service they are entrusting their care to that service for the duration of the journey. Given patients cannot choose their preferred NEPT service they have a right to expect that their care is of a similar high standard whatever NEPT service they are allocated. The only way to ensure this happens is to require minimum standards of clinical governance across all NEPT services.

Effective clinical governance systems have been shown to result in improved patient outcomes[[20]](#footnote-21). “From the literature review it was identified that organisations with functioning and thriving clinical governance are also likely to be organisations in which professionalism is high”[[21]](#footnote-22). The converse is also true[[22]](#footnote-23).

For comparison the 2016 report to the Victorian Government: *Targeting zero, Supporting the Victorian Hospital System to eliminate avoidable harm and strengthen quality of care, Report of the Review of Hospital Safety and Quality Assurance in Victoria, by Professor Stephen Duckett, et al,* made a number of recommendations about strengthening clinical governance in Victorian hospitals. The report described clinical governance as central to patient safety and the avoidance of unnecessary harm. All recommendations were accepted by the Government and in the case of private hospitals made into law.

The same principles should apply in all parts of the health system. As patient transport is part of the patient journey through the hospital system is makes senses that patient safety and quality of care systems should be aligned.

All hospitals and AV have, and operate to, clinical governance processes to ensure clinical errors are reviewed, clinical practice is as good as it can be, and the clinical practice continually improves over time. Clinical Governance is a requirement of the funding agreements the department has with AV and public hospitals. The *Health Services Act 1988* mandates that suitable clinical governance arrangements must be in place in order for a private hospital to be granted and to maintain a registration to operate.

NEPT is the only link in the patient journey chain not required to have clinical governance systems in place. A number of NEPT businesses do have clinical governance arrangements in place however there is no uniformity in what is encompassed. Some NEPT businesses have sophisticated clinical governance arrangements in place while others only have rudimentary arrangements.

As consumers cannot choose which NEPT provider they use (it is allocated by AV or is a company contracted to a hospital) they must accept whatever clinical governance arrangements are in place by the NEPT provider they are allocated. Consumers may have different preferences for which companies they would choose if they placed a priority on clinical governance. It is more likely consumers are not aware of what clinical governance is or the role it plays in protecting their safety. There is a significant information asymmetry as a result.

There is no data to determine where inadequate clinical governance has resulted in poorer patient outcomes in the NEPT sector however, there have been a number of case studies in Australia and overseas that have demonstrated improved patient outcomes when robust clinical governance systems are introduced. One such study is the Understanding corporate governance of healthcare quality: a comparative case study of eight Australian public hospitals[[23]](#footnote-24).

Given this the department considers it to be important to have minimum clinical governance standards to reduce the safety risk to consumers who may be allocated transport by less sophisticated NEPT businesses.

It is proposed to require that all NEPT licenced businesses must have a Clinical Oversight Committee (COC). The committee must have at least one registered health practitioner[[24]](#footnote-25) as a member. The committee must meet every 3 months at a minimum.

The committee will be responsible for:

* reviewing every sentinel event,
* reviewing every 000 call out,
* oversighting the auditing of patient care records (PCR) and reviewing all measures taken

as a result of PCR reviews and staff safety reviews.

* oversighting processes to set the scope of clinical practice of all clinical staff (whether employees, contractors, or volunteers)
* oversighting processes to set the scope of practice of the business to ensure it does not provide services beyond its competencies and ability
* oversighting the credentialing and three-yearly re-credentialing of all registered medical practitioners engaged by the business in any capacity
* reviewing all matters of clinical concern including each critical incident
* maintaining records of its meetings including decisions taken and the rationale for those decisions
* reviewing staff safety survey data
* reviewing all complaints that relate to patient experience
* reviewing clinical practice protocols and guidelines of the licenced NEPT business
  + oversighting processes to continually assess the capacity of the business to provide safe, patient centred care.

It is proposed that the COC should keep written minutes that can be made available to the department on request.

It is also proposed that every NEPT licencee must nominate a person (e.g. Clinical Manager) who is responsible for all clinical matters for the business and the name of this person and business contact details (phone, email) be provided to the department within 28 days of appointment.

## 6.2 Objectives

NEPT is part of the patient journey through the hospital system and therefore the same principles of delivering clinical care should apply whether the patient is in hospital, in an emergency ambulance or is being transported by NEPT.

The primary objective of clinical governance arrangements is to ensure safe patient care and a suitable quality of care for every patient transport. Clinical Governance does this by setting minimum standards for the deliverance of clinical care by the business in a way that is appropriate for that business. The setting of minimum standards and consistent principles across the NEPT sector is intended to ensure that all NEPT businesses are delivering safe care within their identified competence, and to ensure all serious (sentinel and critical) incidents are reviewed to establish the cause and where possible to prevent a recurrence. This process will lead to improved standards of care over time.

Effective clinical governance should also ensure that clinical staff are competent to carry out their designated roles. It should also ensure all staff and businesses do not become overconfident in their abilities and try to deliver care that is beyond their capability to do safely, which would be to the detriment of patients .

## 6.3 Interstate arrangements

The Tasmanian Ambulance Service (NEPT) Regulations 2019 contain regulatory requirements for clinical governance for licenced NEPT providers. Regulation 15 states:

**“’Clinical governance committee**

(1)  The licensee of an NEPT Service must establish a clinical governance committee in respect of the Service to review and make recommendations in respect of the following:

(a) the administration requirements for the Service, including any registers and plans to be implemented and maintained in relation to the clinical and non-clinical operation of the Service;

(b) the quality assurance plan, and the patient care functions, of the Service in relation to the clinical and non-clinical operation of the Service;

(c) the procedures for determining the scope of practice of the crew members of the Service;

(d) the safety and quality requirements for the provision of non-emergency patient transport services;

(e) the procedures within the Service for the prevention, and control, of infections;

(f) the procedures for the management of incidents and complaints in respect of the Service;

(g) improvements to the quality and safety of non-emergency patient transport services offered and provided by the Service;

(h) improvements to the Service generally.

(2)  If requested to do so by the Secretary, the licensee of an NEPT Service must provide a copy of the reviews and recommendations of the clinical governance committee of the Service in accordance with that request.”

Tasmania also requires NEPT providers to set the scope of clinical practice of clinical staff.

South Australia does not have any clinical governance requirements in their legislation governing private NEPT providers.

All emergency and ambulance services and NEPT services provided directly by the remaining State and Territories operate to clinical governance frameworks, standards, or protocols.

Can you make point here about interstate arrangements not being applicable so they cannot be used as feasible options?

## 6.4 Identification of options

|  |
| --- |
| Base Case: Not mandate clinical governance requirements – the current regulations |
| NEPT business owners are free to decide what, if any, clinical governance arrangements they have in place to manage the delivery of clinical services and patient safety. |
| Option A: Mandate clinical governance requirements – the proposed regulations |
| All NEPT licencees be required to introduce minimum clinical governance arrangements to manage patient safety – see option A assessment |
| Option B: Industry develop a Code of Practice |
| The NEPT industry develop a voluntary Code of Practice to set minimum standards to manage patient safety – see option B assessment |

### The Base Case - the current Regulations

At the moment there are no mandated clinical governance requirements in the Regulations. In part this is because the objective of the Act has not included patient safety. The Act is now being amended to include patient safety as an objective.

The department understands that seven licenced NEPT providers already have clinical governance arrangements in place for their businesses in full or in part. The clinical governance arrangements differ between the businesses in part, to reflect their different operations, and in part to reflect the individual priorities of the businesses. Then there are some licenced NEPT providers that do not have clinical governance arrangements in place.

The base case is simply a continuance of current arrangements.

### Option A – The Proposed Regulations

Option A proposes to require all NEPT licenced businesses to have minimum clinical governance arrangements in place.

### Option B – A Voluntary Code of Practice

Option B proposes an industry developed Code of Practice to manage clinical governance by setting minimum standards that are voluntarily adhered to by licencees.

The Department does not consider that it should develop a voluntary Code as it is the regulator. While some regulators have developed Codes of Practice for business sectors they tend to be quasi regulations rather than purely voluntary. The Department considers that voluntary Codes of Practice are best designed by industry sectors or peak bodies as they have the best understanding of their sectors.

Note: The Department has already developed mandatory clinical practice protocols for the sector and will be developing guidelines to assist the sector to comply with the Regulations.

## 6.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 6.1 below.

**Table 6.1 Multi-criteria analysis criteria and weightings**

|  |  |
| --- | --- |
| Criterion | Weighting |
| Patient safety and care | 70% |
| Costs to NEPT licencees | 30% |

These criteria reflect the objectives of the Regulations as they relate to the identified problem in this RIS of ensuring patient safety and care by requiring all licenced NEPT business to have minimum clinical governance arrangements in place.

Because providing for patient and staff safety and quality of care is the primary objective of the Regulations, the effective assessment of mandating minimum clinical governance requirements is accorded a weighting of 70 per cent. The overall costs imposed by the Regulations to NEPT licencees are therefore weighted at 30 per cent.

### The Base Case (current Regulations)

The base case continues the current requirements which do not set any clinical governance requirements.

Under the base case, there are no requirements imposed by regulations which leaves the licencees free to decide if they wish to have clinical governance policies and processes within their individual business and to what level.

There is significant variation in standards of clinical governance across the sector. In part this is due to whether or not a business has an AV contract and for those licencees who do not, it is dependent on the philosophy of the business owner in relation to patient safety and continuous improvement. As there is a cost associated with robust Clinical Governance systems most of the smaller operators do not have a formal clinical governance system in place. In some cases there is a lack of understanding of what clinical governance is and what it is designed to achieve. However, the prime cause of the variation in standards is the lack regulations that set minimum requirements for clinical governance.

As a result there is potential for avoidable on-going risk of substandard clinical treatment of patients under the base case. For a business with robust clinical governance arrangements the risk is lower and the risk of repetition of sub-standard care is substantially lower due to the continuous review and reporting required by effective clinical governance arrangements. However, for those businesses with rudimentary or no clinical governance arrangements there is a risk of repetition of sub-standard care as there is no business process to review errors in the provision of care. Currently the degree to which this may occur is unknown as patients would need to complain to the department if they were unhappy with their care. To do so they would need to be aware they had been subject to inadequate care, noting this would not be information that was provided to them by them by the NEPT service provider. Very few patients do complain to the department.

The department does not consider the lack of complaints an indicator that all NEPT services are operating to a high standard. Rather as patients are not generally experienced in the use of NEPT, may not be fully aware of the care they are receiving, or know what a normal standard of care is, they lack the necessary knowledge to determine if their care was of a suitable standard or not. In addition when people are unwell they may find it is more difficult to complain.

Examples of substandard care allegations that have been brought to the department’s attention over the past few years are:

* a person was to be delivered back to their home and was unloaded in the middle of their street and not accompanied to their door to ensure they got into their home safely,
* a patient was resuscitated on the way to a palliative care facility.
* unqualified staff dispensing medications

Each of these reports was substantiated. While not common these are not one-off reports. There have been a number of complaints about inappropriate pick-up and delivery by patients. The issue of resuscitation of patients being transported to palliative care has been an on-going issue due to difficulties with the Do Not Resuscitate (Patient Care) directives. Inappropriate dispensing of medications is unusual however misuse of medications by staff has been an issue from time to time.

As the base case is the continuance of current arrangements there is no additional cost to the NEPT providers associated with it.

The department considers the base case will have potentially lower patient safety than if the amendments are put in place.

The cost of the base case is zero.

**Table 6.2 Multi-criteria analysis scores for the base case**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | 0 | 0 |
| Costs to NEPT licencees | 30% | 0 | 0 |
| **TOTAL** | **100%** |  | **0** |

### Option A - the proposed Regulations

Option A, the proposed Regulations, will require all NEPT licencees to meet minimum standards for clinical governance. Each NEPT trip is a potential for poor treatment if the clinical governance is not robust and suited to the business. The introduction of clinical governance requirements to set minimum standards should improve overall patient safety and quality of care in the NEPT sector over time.

Good clinical governance is a critical element of patient safety in all healthcare systems. A robust clinical governance system would be expected to improve standards of patient care and safety over time. A clinical governance system would provide a NEPT business with the tools to identify poor care or performance, allow for review of each case, and put in place rectification measures. Each time an error or underperformance is identified, and rectified, patient care and safety is improved.

Staff would be empowered to refuse to take patients outside their competence thus driving more appropriate patient care, and better triaging by ESTA, AV, and hospitals. Staff would no longer need to be concerned about being punished (by losing shifts), for reporting problems.

A clinical governance system that is supported by management encourages reporting of problems and over time such systems and cultures become embedded leading to continuous improvement.

All NEPT licenced businesses will be required to have a clinical oversight committee (COC) that has a minimum of one health practitioner as a member and meets every 3 months at a minimum. The department invites comments on whether 3 months is an appropriate meeting schedule.

NB: The 3 month meeting requirement is consistent with what is required of private hospitals and day procedure centres under the *Health Services Act 1988*.

The COC will be responsible for:

* reviewing every sentinel event,
* reviewing every 000 call out
* auditing of patient care records (PCR)
* reviewing patient care records
* processes to set the scope of clinical practice of all clinical staff (whether employees, contractors, staff of contractors or volunteers)
* processes to set the scope of practice of the business to ensure it does not provide services beyond its competencies and ability
* credentialing and three-yearly re-credentialing of all registered medical practitioners engaged by the business in any capacity
* reviewing all matters of clinical concern including each critical incident
* maintaining records
* reviewing staff safety survey data
* reviewing all complaints that relate to patient experience
* reviewing clinical practice protocols and guidelines of the licenced NEPT business
  + processes to continually assess the ability of the business to provide safe, patient centred care.

Written policies and procedures will be required to support each of the above matters.

It will be the responsibility of each licenced NEPT provider to develop their own clinical governance processes to suit the activity of that businesses.

The department will review and oversight the clinical governance procedures of licenced NEPT businesses to ensure they are sufficiently robust and meet the requirements set out in the Regulations.

The costing of the proposed Regulations is based on the assumption that there will be 13 remaining providers of NEPT services after the changes to the Act are implemented.

The department understands that 4 licenced NEPT businesses currently meet these requirements in full. Therefore, the costs associated with this requirement will be incurred by 9 licenced businesses in full or in part.

The cost of the requirement includes the time taken to prepare the policies, implement them, and maintain them. The cost also includes all costs associated with the COC and all actions resulting from their meetings.

The COC responsibilities dictate that each licenced business must have procedures to address each issue. It is the development, implementation and ongoing review of these procedures that will incur cost if they do not already exist.

Against this can be subtracted the savings to NEPT providers resulting from improved patient outcomes (noting this cannot be measured as there is no available data).

##### Cost of a Health Practitioner on the Clinical Governance Committee –

Indicative sitting fees for an independent medical practitioner range between $297 to $547 per day, guided by State Government’s Appointment and Remuneration Guidelines (effective from 1 July 2017). These are detailed in Schedule B of the guide (Classification criteria and remuneration schedule - Group B organisations). Costs would be less if a nurse or paramedic was the registered health practitioner sitting on the COC.

For the purposes of this costing we assume one registered medical practitioner would provide 4 days of time per annum for clinical governance committee meetings (meet every 3 months). Based on three monthly meetings of the COC, **the cost would be up to $2200 per business per year.** Where a business used a registered health practitioner instead of a registered medical practitioner the cost would be lower. For the purposes of this costing we will assume the higher cost.

**Cost for 9 businesses x $2200 = $19,800 per annum**

##### General clinical governance costs

Advice from the NEPT sector indicates the median cost of the clinical governance requirements is about $65,000 per annum. Large businesses would incur greater costs and small businesses would incur lesser costs but the cost differential may not be linear. The 4 companies excluded from this costing are the 4 largest companies. Therefore the $65,000 figure is used in the expectation that none of the 9 companies who will incur costs will exceed this figure.

The table below lists the clinical governance matters required to be addressed by the new Regulations

|  |
| --- |
| **Clinical governance activities** |
| Credential a registered medical practitioner every three years |
| Set the scope of the NEPT business and review annually |
| Set the scope of each clinical staff member and review annually |
| Review of each sentinel event |
| Review of each 000 call out |
| Review of each matter of clinical concern |
| Review of staff safety survey data |
| Review of each complaint |
| Review of the business clinical practice protocols annually |
| Review of capacity of business to provide safe patient centred care |

The department is not able to determine which of the proposed clinical governance requirements are being met by which businesses. Advice received is that all NEPT businesses expected to continue to currently meet or partially meet some or all of the proposed requirements.

For this reason, the cost of $65,000 has been assumed to apply as a new cost to the 9 businesses described above. As this is likely to be an over-estimate given the levels of partial compliance with the proposed regulations, the figure has been discounted by 20%, on the assumption that most of the licence holders are currently partially meeting the requirements, to provide an annual cost of $52,000 per business.

So, the total assumed cost to fully implement clinical governance requirements is $52,000 x 9 NEPT businesses = **$468,000 per annum**

##### Patient care records/case sheets

Auditing of patient case sheets is estimated to take 5 minutes at a cost of $5 per case sheet

The regulations propose to require auditing of 50% of case sheets for patients of medium and high acuity. In 2019 80,684 medium and high acuity patients were transported.

The cost is $5 x 80,684 patients / 2 = $201,710 per annum

Some NEPT licencees already audit a percentage of patient case sheets and all AV transports require medium and high acuity patient case sheets to be audited. The 7 licenced NEPT businesses contracted to AV are already required to do this as part of their contract. So the portion of patients being transported under the AV contract would already be audited in accordance with this new regulation.

As 44% of all NEPT transport are done for AV it is assumed this is an equal proportion across all patient types. Therefore, the AV transports are not included in the total cost as it is already required by AV contract and is therefore not a cost attributable to the proposed Regulations. The costing is calculated on non AV transports only.

Costs excluding AV transports: (80,684 – (80,864 x 44/100)) x $5 x 50% = **$ 113,408 per annum**

The 5 remaining businesses transported 345 medium and high acuity patients in 2019. Each review costs $5.

The cost is $5 x 345 x 50% of patients = $863 p.a.

The total cost is $113,408 + $863 **= $114,207 p.a.**

The estimated total clinical governance costs for the sector is $ 19,800 + $468,000 + $114,207 **= $602,007 per annum.**

**The cost of option A is $602,007 per annum or $3,010,035. The discounted cost of option A is $2,584,310** over the life of the Regulations. Costing is allocated one point per million dollars therefore an MCA score of -3 is therefore allocated.

The introduction of clinical governance is considered a very important addition in protecting patient safety and providing suitable quality of care. Clinical Governance is a requirement in the public and private hospitals sectors nationally for both day and overnight hospitals. In the hospital sector clinical governance is considered an indispensable part of providing safe patient care. Properly functioning clinical governance is proactive in reducing patient injuries, deaths and improving quality of care. Therefore an MCA score of +8 has been allocated.

**Table 6.3 Multi-criteria analysis scores for option A**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +8 | **+5.6** |
| Costs to NEPT licencees | 30% | -3 | **-0.9** |
| **TOTAL** | **100%** |  | **+4.7** |

### Option B – an industry Code of Practice

Option B is a voluntary Code of Practice (the Code) to be developed by the NEPT sector to provide guidance on minimum standards of clinical governance for NEPT businesses. The Code would set out what matters clinical governance must encompass. The NEPT licencees would choose whether or not to adopt the Code.

If adopted by the sector the Code would achieve the same purpose as option A and address the same safety risks identified in option A.

A number of issues arise with this approach. Ambulance Victoria, public hospitals, and private hospitals would be strongly encouraged by the department to only contract with NEPT licencees who had adopted the Code. However, the Department considers that those NEPT licencees who did not wish to contract to AV or hospitals would have limited incentive to adopt the Code. It is estimated that up to 5 licencees would be in this situation, mostly those who do not contract to AV. Therefore, a Code that required minimum standards of clinical governance may be seen by those licencees as onerous unless all users of NEPT services required the adoption of the Code through their contracting arrangements. The risk with option B is that it is possible that licence holders who did not see the value in clinical governance would not adopt the Code. Should that be the case we still would have variable standards across the sector and would only have partially achieved the outcome sought.

As there is no peak industry body to take ownership of and responsibility for the development, updating and implementation of the Code it would fall to the current licencees to collaborate to develop the Code. There are only expected to be 13 NEPT licencees following the amendments to the Act. Due to tensions between the for profit and not for profit sectors it is considered unlikely that all licencees would be willing to collaborate to develop or implement a voluntary Code of Practice. Being a regulator, the Department does not consider it has a responsibility to write a voluntary Code of Practice for the sector. Therefore, it is unlikely a Code will be written.

The Department considers that a voluntary Code of Practice would add very little to existing arrangements and would have the drawback of being unenforceable. In practice it has the potential to be the same as the base case (the current Regulations).

Note: The Department would have the option of placing a condition on the licences of NEPT providers to require compliance with the Code. Such an approach would not be preferred as the Department would be effectively mandating a Code over which they had no control or authority. It is not standard practice for Government to mandate such documents through conditions on licences however it is noted that in some policy areas industry developed Codes of Practice are mandated through legislation or regulation.

For patients Option B is unlikely to significantly improve outcomes relative to the base case . Therefore, patient safety and care has been scored at 0, that is, the same as the base case.

The cost of option B if fully adopted is estimated to be the same as Option A so is $602,007.However because it considered only 3 additional providers would adopt the Code the costs are as follows.

3 x $22000 = $6,600 to engage a medical practitioner.

3 x $52,000 = $156,000 for general clinical governance development and implementation

$113,408 for patient case reviews which is the same as for Option A as no providers routinely do this for non AV patients.

**Therefore the total cost per annum is $276,008 or $1,380,040 over the life of the Regulations.**

As a result Option B is scored at -1 for the MCA.

The impacts on patient safety would also be the same as for Option A if adopted across the industry. However, this is considered to be unlikely in a voluntary approach. Therefore, the MCA score allocated is +4.

**Table 6.4 Multi-criteria analysis scores for option B**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | 0 | **0** |
| Costs to NEPT licencees | 30% | -1 | **-0.3** |
| **TOTAL** | **100%** |  | **-0.3** |

# 7. Staff Training

## 7.1 The nature and extent of the problem to be addressed

One of the critical elements in delivering a safe NEPT service is a competent workforce. To ensure the workforce is competent, annual refresher training for a number of elements of managing a patient is required. The Regulations currently set out minimum training requirements for staff that crew NEPT vehicles.

The department is concerned that not all licencees are ensuring their staff are maintaining the necessary competencies. While a number of staff are full time or also work for AV as paramedics, many staff (85%) are part time or casual. Part time or casual staff may not face life threatening situations regularly and therefore require annual refresher training to maintain their competencies.

It is particularly important that staff maintain their clinical skills to protect patient safety and because NEPT is now available to be used as deemed necessary under the State Health Emergency Response Plan (SHERP). Under SHERP, NEPT vehicles may be used as first responders (emergency ambulances).

The department has received a number of reports from some NEPT providers, NEPT staff, and the Victorian Ambulance Union, that since the introduction of the 2016 Regulations some licenced providers are not ensuring staff are maintaining their skills in critical areas such as basic life support, advanced life support, airway management, manual handling, etc. It is reported that these are cost cutting measures that are due to the downward cost pressures on the industry. During the initial direct consultation phase with the sector for the development of these regulations about 50% of NEPT licencees consulted raised this issue (naming competitor businesses) as a concern. The department notes that any NEPT licencees who operate in this manner are increasing risks to patient safety.

The reports about the downward pressures on costs related to the need to tender at the lowest possible price in order to obtain a contract with AV or HPV. This is a particular issue for the for profit sector of the industry as they are directly competing with not for profit providers who have tax advantages that potentially enable them to tender at a lower cost for the same work. The for profit providers continually point out that the sector does not operate on a level playing field as the for profit providers cannot access the tax advantages available for not for profit providers. In order for them to compete they must find other ways of lowering costs. It would appear, from some of the reports, that one way some companies have lowered costs is by not providing the necessary training to staff to maintain competencies.

Annual refresher training in the above mentioned skills is required by AV of their workforce (including contractors) and is considered essential in ensuring staff maintain skills are and are up to date with the latest clinical practice. Many staff in the NEPT sector are part time or casual. They may not have to deal with life threatening situations very often, if at all given the patient transport is non-emergency, but they must be competent to do so when it is required. The Regulations already require annual training must be provided to staff for basic life support, occupational health and safety, and current evidence based clinical practice.

Failure by a licencee to provide annual refresher training for staff has the potential to place patients at significant risk of death or injury if staff are unable to maintain their competencies in their life saving skills.

Reports have also been received from stakeholders that some refresher training for hands on clinical matters is being conducted online only. Online training is not an appropriate or effective delivery method for:

* Advanced life support
* Basic life support
* Use of bag valve mask
* Airway management
* Defibrillation
* Manual handling, and
* Stretcher handling

as competencies must be assessed in a live action scenario and this cannot be done effectively on-line. It is not possible for the assessor to get a full view of what the trainee is doing nor provide effective demonstrations of what is required. The same is also true for driver training.

If this type of training is not conducted face to face and the student competencies not assessed or not assessed effectively, there is no way for a NEPT employer to be satisfied that staff have achieved the required competencies. This has the potential to place patients at risk and put the business in breach of occupational health and safety laws.

The current Regulations require Ambulance Transport Attendants to undergo 400 hours of clinical training within the first 2 years of employment before they can work unsupervised. This is to ensure they are, and have been assessed as, competent to carry out their duties.

Patient Transport Officers (PTOs) do not have similar requirements placed upon them. Although PTOs work with patients of lower acuity (and hence less complex medical conditions) they work often in pairs without a higher qualified person on the truck. The Department is concerned there is no process to ensure PTOs are competent before they can work without supervision and considers this increases risks to patients. The new Regulations therefore will require 100 hours of clinical supervision before PTOs can work without supervision.

## 7.2 Objectives

The principal objective of strengthening training requirements for clinical staff is to ensure the provision of training to assist staff to deliver best practice clinical care to patients. Best practice can only be delivered by ensuring all staff are competent and up to date in their training.

This includes ensuring training and assessment is provided in the most effective manner for critical matters such as manual handling and life support.

## 7.3 Interstate arrangements

Tasmania and South Australia are the only other States or Territories that regulate private NEPT services. Therefore, they are the only other jurisdictions to have made regulations for training and competence of NEPT staff. It is worthwhile looking at their approach for comparison.

The Tasmanian Ambulance Service (NEPT) Regulations 2019 requires that  “…the licencee of an NEPT Service must ensure that, at least once in every 12-month period, each crew member of the Service is provided, at a minimum, with training in the training areas that are relevant to the scope of practice of the crew member.”

South Australia has set a minimum competence for NEPT clinical staff, albeit at a lower level than in Victoria, and training is provided by the SA Ambulance Service Clinical Education unit.

All non-emergency ambulance services provided by State and Territories have their own clinical staff competency protocols. These addressed are employment matters given they are not in Regulations and are therefore not subject to independent or regulatory oversight.

Can you make point here about interstate arrangements not being applicable so they cannot be used as feasible options?

## 7.4 Identification of options

|  |
| --- |
| Base Case: Maintain current clinical staff training requirements – the current regulations |
| NEPT licencees must meet the current training requirements for clinical staff in the Regulations. |
| Option A: Strengthen clinical staff training requirements – the proposed regulations |
| NEPT licencees will be required to introduce additional minimum clinical staff training requirements to ensure patient safety |
| Option B: Develop an industry based Code of Practice to govern clinical staff training and competence |
| The NEPT licencees will develop a Code of Practice to govern clinical staff training and competence |

### The Base Case – The current Regulations

At the moment there are a number of mandated clinical staff training requirements in the Regulations. Currently the training requirements in the Regulations are:

* Staff who crew NEPT vehicles must be provided with annual training that is appropriate having regard to the nature of their work and in the following areas:
  + - Basic life support;
    - Occupational health and safety
    - Current evidence based clinical practice.
* Ambulance Transport Attendants must undergo a minimum of 400 hours supervised on road supervision (within two years) by a clinical instructor before they can work independently.

However, it has been reported that due to cost pressures in the NEPT industry a number of providers are not fully complying with the requirements. In particular it is reported that ongoing training is not being provided in some cases or, is being inappropriately being provided as on-line training only. These approaches have the potential to undermine patient safety.

The base case (current Regulations) is the status quo and is one of potentially lower patient and staff safety and lower cost.

### Option A – The proposed Regulations

Option A proposes to strengthen the training requirements for NEPT clinical staff to provide greater assurance for patients by ensuring clinically appropriate ongoing training is provided. The list of mandatory annual training requirements currently in the Regulations will be expanded by adding mental health training for NEPT staff to assist them to manage appropriately the increasing number of patients transported who have mental health conditions.

Option A also proposes to require newly employed PTOs to undergo 100 hours of supervised clinical training is to ensure that when PTOs work independently, they are competent to do so.

Option A provides increased patient and staff safety by requiring all licenced NEPT business to have clinically appropriate ongoing training in place, and by requiring PTOs receive clinical supervision before they can work independently.

These requirements are expected to improve patient safety and quality of care by ensuring NEPT staff maintain critical competencies and skills. The Department will be able to review records to verify the mandated training is being provided.

Option A is a higher cost option than the base case.

### Option B – A Voluntary Code of Practice

Option B would allow the NEPT sector to develop a Code of practice to address ongoing training and maintenance of skills. Codes of practice can be more responsive to changing circumstances.

Option B is an industry code of practice, noting there is no peak body for the NEPT industry so licence holders would need to collaborate to develop a Code.

The risk with a voluntary Code of Practice is that not all NEPT licence holders would comply with it. This is more likely to be the case where a licence holder is in financial difficulty or is undercapitalised.

The Department does not consider that it should develop a voluntary Code as it is the regulator. The reasons for this are explained in Chapter 6.4.

Option B is a higher cost than the base case.

## 7.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 7.1 below.

**Table 7.1 Multi-criteria analysis criteria and weightings**

|  |  |
| --- | --- |
| Criterion | Weighting |
| Patient safety and care | 70% |
| Costs to NEPT licencees | 30% |

Because providing for patient safety and quality of care will be the new primary objective of the Act, the Regulations must reflect this. These criteria reflect the objective, as they relate to the identified problem in this RIS of ensuring patient and staff safety and patient quality of care. So, the assessment of mandating additional ongoing training requirements and additional clinical supervision requirements is accorded a weighting of 70 per cent. The overall costs imposed by the Regulations are therefore weighted at 30 per cent.

### The base case – current Regulations

The base case continues the current requirements which set a number of ongoing training requirements.

There is no data available on the costs associated with substandard patient care that are due to insufficient training of NEPT staff.

**Risk of the base case situation:** Potential risks that could occur in the case of PTO’s without clinical supervision time include, but are not limited to:

* + troubleshooting NEPT equipment without a more experienced colleague present. This could take up valuable time, result in the malfunction of the equipment, or injure the staff member;
  + troubleshooting administrative issues with healthcare providers without a more experienced colleague present. This could take up valuable time or cause administrative mistakes that could take up resources and even more time;
  + taking a long time to figure out how to utilise sources, such as where and how to look up what to do if a patient becomes hypoglycaemic — this could be a risk to the patient and cause permanent impairment.
  + inability to resolve issues with the patient or their family in the community in a timely and professional manner — if not done in such a manner, this could place the organisation’s reputation at risk
  + not knowing how to administer medication properly or how to ensure that treatment is being administered (properly). For example, if tubing is accidentally disconnected from the oxygen and the patient is not receiving the oxygen intended.

The drafting of the Regulations allows training that must be delivered face to face to be effective, to be delivered as online training as on-line clinical training was not anticipated when the Regulations were written.

The cost of the base case is zero.

**Table 7.2 Multi-criteria analysis scores for the base case**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | 0 | 0 |
| Costs | 30% | 0 | 0 |
| **TOTAL** | **100%** |  | **0** |

### Option A – proposed Regulations

The department proposes to strengthen the training requirements for training of staff.

Option A, the new Regulations, will require:

* Specified clinical training to be delivered face to face
* A new requirement for mental health training
* 100 hours of supervised on road training for new PTOs

Without appropriate ongoing clinical training patients and the department cannot be assured that staff skills and competence are being maintained at a suitable level. The setting of minimum training standards for NEPT vehicle crews is intended to ensure that irrespective of which company transports the patient, the staff all have up to date minimum competencies to ensure the safety of the patient and an appropriate level of care. It is also intended to prevent licence holders from cutting corners on staff training to reduce costs to allow them to put in lower tender prices for contracts.

It is also proposed to introduce a requirement for ongoing training in mental health so that staff are equipped to properly manage patients exhibiting mental health symptoms, even if the call out was for another condition. Mental health is a significant issue in society today and patients are reported as frequently exhibiting symptoms when collected by a NEPT transport. Inappropriate management of the patient can exacerbate the mental health symptoms potentially impacting on a patient’s health and recovery time.

A new requirement for 100 hours of clinical supervision for new Patient Transport Officers (PTO) will be introduced to ensure PTOs are demonstrably competent before they can work independently. The training must be completed within the first 12 months of employment. Clinical supervision would be able to be provided by an ATA (who had completed his or her own clinical supervision) or by a clinical instructor.

The Amendments to the Act will contain powers to suspend a licence. It is anticipated that where a licence holder was not meeting minimum training standards for staff the power to suspend would be exercised, as failure to maintain staff competencies creates a serious patient safety risk. As a result it is expected that licencees will comply with the new requirements.

##### Face to Face training

In order to address the reported situation where some training providers are delivering clinical training online instead of face to face Option A will prescribe a number of clinical matters that must be delivered in face to face training (see below). It is assumed that most of these elements will be delivered annually to all clinical NEPT staff under the requirements of the current Regulations. Some elements may only be delivered to ATAs and Nurses however, for the purposed of costing, we have assumed that each element is delivered to each clinical staff member annually.

It is the advice of reputable registered training organisations the department has consulted with, and the Victorian Chief Paramedic, that this clinical training cannot be effectively delivered or effectively assessed online. Online training of clinical matters carries the risk that staff will be certified as competent when they are not, and this then creates a liability risk for the staff member and the licence holder, and a safety risk for the patient.

For comparison, training of hospital staff in advanced life support, basic life support, airway management and defibrillation is always carried out face to face.

Critical refresher training that requires a hands-on assessment will be required to be delivered face to face. Online training for some clinical competencies and driving components is not considered suitable as the on-line trainer has no ability to determine the physical competence of the person being trained.

The clinical training to be required to be carried out face to face and assessed for competency achievement is:

* Advanced life support,
* Basic life support
* Use of bag valve mask,
* Airway management
* Defibrillation
* Manual handling, and
* Stretcher handling

While this regulation is being proposed to address current gaps, the department considers that these are matters that should already be trained face to face as standard industry practice. It is expected this will result in increased costs for those licence holders not already providing this training face to face. The department estimates this could be as high as 30% of licence holders (based on discussions with the sector). The cost is estimated at $2,000 per staff member to provide face to face training for those licence holders not already doing so. 30% of the staff of the sector is about 600 staff so the cost would be $1,200,000 per annum or **$6,000,000 over the life of the Regulations**.

##### Mental health training

The addition of mandatory mental health training to the annual refresher training requirements recognises the changing nature of patients. Mental health includes drug and alcohol addiction. Licencees report that the number of patients with mental health issues being transported is increasing. Most of these patients are being transported for other medical reasons but still need to have their mental health issues managed appropriately during transport to ensure they reach hospital or their medical appointment in a suitable frame of mind and are not unnecessarily distressed. Five NEPT licence holders and AV were supportive of this requirement in their submissions to the department and no licence holders opposed the proposed requirement. AV noted mental health training is already requirement for their paramedics.

St John Ambulance run a mental health training course designed to assist people to recognise and support people with mental health issues. This is the type of training that will be required in the NEPT setting by these Regulations. The cost of the course is $255 and is used as the proxy to cost this requirement.

So $255 x 1770 clinical staff = $451,350. We have assumed this is a year 1 cost with ongoing costs as part of employing new staff.

The department has estimated 200 new staff per year will require the mental health training across the NEPT sector from year 2 onwards.

$255 x 200 = $51,000 per annum ongoing from years 2-5.

The total cost will therefore be:

$451,300 + (4 x $51,000) = **$655,300** over the life of the Regulations.

##### 100 hours of clinical supervision for Patient Transport Officers (PTO)

It is considered necessary that NEPT licencees are assured that new PTOs are clinically competent to work without an ATA being present on the vehicle. In order for that to occur it is necessary that new PTO graduates undergo a period of clinical supervision so the licencee can be assured, and verify, the that PTO is clinically competent to attend to patients within their scope of practice. This measure will enhance patient safety and quality of care. This replicates the current regulatory requirement applied to graduate ATAs.

The requirements for PTOs undergoing the 100 hours of clinically supervised training over 12 months, will be:

* The PTO qualification must be obtained before clinically supervised training commences
* All clinically supervised training must be hands on. Observational shifts will not count towards the 100 hours.
* All clinical supervision must be provided by a clinical instructor (as defined by the Regulations) or an Ambulance Transport Attendant (ATA).

The purpose of clinically supervised training is to ensure that PTO’s are competent to make clinical decisions within their scope of practice independently of any other advice or assistance.

It is also intended to strengthen the requirements around the 400 hours of clinically supervised training over two years for ATAs to require:

* The ATA qualification must be obtained before clinically supervised training commences
* All clinically supervised training must be hands on. Observational shifts will not count towards the 400 hours.
* All clinical supervision of ATAs must be provided by a clinical instructor (as defined by the Regulations).

Clinical supervision of healthcare practitioners has shown that “there is an increasing focus on improving healthcare in order to ensure higher quality, greater access and better value for money. In recent years, training programs have been developed to teach health professionals and students formal quality improvement methods”[[25]](#footnote-26).

Clinical supervision is used in the educational development of doctors, nurses, paramedics, and allied health staff. Clinical supervision can be defined as “oversight — either direct or indirect — by a clinical supervisor(s) of professional procedures and/or processes performed by a learner or group of learners within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each learner’s experience of providing safe, appropriate and high quality patient-client care”[[26]](#footnote-27). It “aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development.”[[27]](#footnote-28)

The benefits of clinical supervision can include:

* A process for establishing standards of care in practice
* Becoming aware of lifelong learning in practice
* The development of individual responsibilities under clinical governance
* The recognition that one can contribute to the improvement of healthcare delivery through regular reflection of practice with colleagues
* Practice-based learning that contributes to the continuing professional development of the NEPT staff member[[28]](#footnote-29)

Clinical supervision “has been found to be associated with improved medical resident adherence to guidelines in the inpatient setting. Our results not only support this association but, through the analysis of a further 13 studies, support the use of clinical supervision to improve process measures in nursing, allied health and medical professionals across both inpatient and community settings.”[[29]](#footnote-30)

As well as the clinical-based patient care benefits of clinical supervision, clinical supervision also teaches the supervisee the valuable practice of self-reflection. “When reflection is mandated and evaluated…[it can] reveal emotional difficult[ies], clinical uncertainty or professional vulnerability.”[[30]](#footnote-31) Identification of these issues is a first step to improvement. Self-reflection and questioning in the clinical setting opens an environment of discussing how best to approach the care of a patient and presents portals for colleagues to discuss previous similar experiences and the results of their decisions and actions. This can lead to an open decision-making process which could increase the options for staff to make — thus increasing the chances of staff making — the best decision for the patient and their care. Self-reflection is standard practice in hospital settings. It promotes a culture of improvement without blame.

The department has been advised by NEPT licence holders that it will cost businesses $8000 - $10,000 to meet the 100 hours clinical training requirement for each new PTO depending on whether the clinical supervision is provided by an ATA or a clinical supervisor.

It is estimated that there will be 155 new PTOs each year and all will require clinical supervision. While ATAs will be able to supervise PTOs we have used the high estimate of 10,000 to ensure costs are not underestimated.

Therefore, the estimated cost is $10,000 x 155 PTOs = **$1,550,000** annually

The cost of option A is **$1,550,000** annually or **$7,750,000** over the life of the Regulations.

##### Total impacts

The total cost of staff training is $6,000,000 + $655,300 + $7,750,000 = $14,405,300. The discounted cost is **$12,490,624** over the life of the Regulations.

A MCA score of -10 is therefore allocated as the cost exceeds $10 million.

The benefits to patient safety and care from having a well trained workforce with up to date skills and competencies is considered significant. An MCA score of +6 is therefore allocated.

**Table 7.3 Multi-criteria analysis scores for option A**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +6 | **4.2** |
| Costs to NEPT licencees | 30% | -10 | **-3.0** |
| **TOTAL** | **100%** |  | **+1.2** |

### Option B – Voluntary Code of Practice

Option B, a voluntary Code of Practice is another potential option. The industry would develop the Code and would encourage all licencees to adopt it.

However, as there is no peak industry body it would fall to the current licencees to collaborate to develop the Code. There are only expected to be 13 NEPT licencees following the amendments to the Act. Due to tensions between the for profit and not for profit sectors it is considered unlikely that all licencees would be willing to collaborate to develop a Code of Practice. Further as there has been reported non-compliance with existing staff training requirements there is a risk that businesses that operate in such a manner may not adopt a voluntary Code.

There would be a cost to the industry as a whole to develop the code. If the Code was fully adopted there would be similar costs to option A in the implementation of the Code. However it is likely a voluntary Code would not be adopted by all licence holders for the same reasons as in Chapter 6. I.e. the risk with option B is that it is possible that licence holders who did not see the value in staff training would not adopt the Code. Should that be the case we still would have variable standards across the sector and would only have partially achieved the outcome sought. Therefore the cost would likely be lower than option A.

The cost of Option B is therefore estimated to be less option A. It is considered only 8 of the licence holders would be likely to adopt the Code. These are the companies contracted to AV plus one other company that undertakes overflow AV work as it would be expected that AV would include compliance with the Code as a requirement in their contracts. The companies not likely to adopt the Code are the small companies not contracted to AV.

The department estimates about 20% of clinical staff may not be trained as desired under the Code of Practice for face to face and mental health training. Staff include PTOs, ATAs and Nurses. For PTO training we have used PTO numbers employed reported to us in the annual report.[[31]](#footnote-32)

##### Face to Face

For option B the cost of face to face training is estimated at $2,000 per staff member to provide face to face training for those licence holders not already doing so. For option A 30% of the staff of the sector was costed which was 600 staff, and for Option B it is 80% of that number which is 480 staff

The cost would be $2,000 x 480 staff per annum or **$960,000 p.a. or $4,800,000** over the life of the Regulations.

##### Mental Health Training

At 80% of Option A the cost is $255 x (1770 x 80%) clinical staff = $361,080. We have assumed this is a year 1 cost with ongoing costs as part of employing new staff.

The department has estimated 160 new staff per year (80% of the number of staff trained under Option A) will require the mental health training across the NEPT sector from year 2 onwards for option B.

$255 x 160 = $40,800 per annum ongoing from years 2-5.

This gives a total of $524,280 for mental health training over the five years. The department estimates about 20% of clinical staff may not be trained as desired under the Code of Practice.

##### 100 hours of clinical supervision for Patient Transport Officers (PTO)

The number of new PTOs employed annually by these 8 licensees is estimated to be about 130, so it assumed that 130 PTOs would be supervised in accordance with the Code (NB: more than 80% of all PTOs). For the purposes of this costing it is assumed the remaining 25 PTOs (16%) would not be supervised in accordance with the code. Therefore there would be an annual cost of the **$1,300,000 (130 staff at $10,000 each)** or a 5 year cost of $6,500,000 plus the cost of developing and oversighting the Code.

##### Total costs

The total cost would be $4,800,000 + $524,280 + $6,500,000 = $11,824,280.

The discounted cost is $10,581,705 (See appendix A).

While this is slightly lower than option A an MCA score of -10 is still allocated as the total costs exceed $10,000,000.

The benefits of a fully taken up voluntary Code of Practice would be the same as option A. However a full take up is considered unlikely and so an MCA score of +4 has been allocated.

**Table 7.4 Multi-criteria analysis scores for option B**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +4 | **+2.8** |
| Costs to NEPT licencees | 30% | -10 | **-3.0** |
| **TOTAL** | **100%** |  | **-0.2** |

# 8. Occupational Health and Safety

## 8.1 The nature and extent of the problem to be addressed

NEPT vehicle crew occupational health and safety is generally covered under the *Occupational Health and Safety Act 2004*. This Act provides general protections across all sectors of the workforce.

NEPT has particular staff safety risks due to the nature of the work which involves lifting and manoeuvring patients. This include both manually lifting and manoeuvring patients onto stretchers and manoeuvring the patient stretchers. These risks are similar to those encountered by nurses in hospitals when patient have to be moved or manoeuvred on beds. Back and shoulder injuries can occur.

There have been many studies into the effect of preventing lifting of patients (manual handling) and the associated reduction in staff injuries[[32]](#footnote-33). However, this research does not appear to have been applied to the NEPT industry in a systematic way.

The Victorian Government made election commitments to introduce power lift stretchers and lifting cushions as mandatory equipment to be carried by all NEPT vehicles in an attempt to reduce manual handling risks. This is being addressed in amendments to the Regulations.

Worksafe does not have publicly available data on the prevalence of workplace injuries in the NEPT sector. However, claims by nurses have ranged between 800-900 over annum over the last decade.[[33]](#footnote-34) It is reasonable to assume a significant proportion of those claims relate to manual handling injuries.

AV staff made about 50 manual handling injury WorkSafe claims per annum prior to the introduction of powerlift stretchers. As a proxy that would equate to about 25 claims per year by NEPT staff as the NEPT workforce is about half the AV workforce. While this number is expected to drop as powerlift stretchers are introduced, they will not be eliminated. Any measure to reduce the incidence of injuries is worth considering.

There are also risks associated with attending and transporting patients who are mentally unwell (unforeseen events that may be a potential threat to staff safety), including patients with Alzheimer’s or dementia or who are drug affected (occupational violence). While the department has not received any reports of attacks on staff, AV staff have reported assaults by drug affected patients and patients with dementia, so there is certainly potential for it to occur.

Further the recent legislation mandating minimum jail sentences for assaults on emergency workers does not extend to the NEPT sector.

The other common risk associated with the sector is the risk of staff exposure to infectious disease from patients being transported. Prevention of transmission of infectious disease will be particularly important in a COVID-19 world.

Over the past five years there have been several complaints to the department from staff within the NEPT sector alleging unsafe work practices creating potential for staff injury or illness transmission. These have generally related to use of stretchers, access to vehicles and the inability for staff to easily move around the patient compartment when two patients are loaded.

The department understands from the sector that WorkSafe does not carry out routine or unannounced inspections in the sector. Rather investigations are carried out on receipt of a complaint.

### Occupational Health and Safety Plans

There is a current Australian Standard for Health and Safety (AS 4801) and International Standards Organisation standard (ISO 45001) available for use by companies who wish to improve their staff health and safety outcomes and potentially reduce their Workcover premiums.

In the NEPT industry, injuries and illness acquired by vehicle transport staff, apart from the distress caused to the individual staff member and their family can interfere with crew rostering, and increase Worksafe premiums.

The Standards above are suitable for any organization that wishes to:

(a) implement, maintain, and improve an Occupational Health and Safety Management System (OHSMS)

(b) assure itself of its conformance with its stated Occupational Health and Safety (OHS) policy

(c) demonstrate such conformance to others

(d) seek certification/registration of its OHSMS by an external organization

(e) make a self-determination and declaration of conformance with the Standard, and

(f) demonstrate compliance with the law.

The standards cover matters such as a safety plan, policies, processes and procedures, training and induction, monitoring, supervision, record keeping and reporting.

## 8.2 Objectives

The main objective of introducing the requirement is to reduce manual handling injuries of staff and reduce other injury and infection risks to staff and patients. It will be the responsibility of each licenced NEPT provider to develop their Occupational Health and Safety Plan (if they do not already have one) to suit the activity of that businesses.

A secondary objective is to reduce costs for the sector over time by reducing workplace injuries and thus reduce WorkCover premiums.

## 8.3 Interstate arrangements

Victoria has the longest duration and most comprehensive legislative framework for the NEPT sector. Victoria is one of only three States or Territories to regulate the NEPT sector. The Regulations have evolved over the past 17 years in response to observed activity in the NEPT sector.

Victoria will be the only State or Territory to have Occupational Health and Safety requirements in NEPT legislation.

Those States and Territories that provide all or nearly all of their NEPT service through State ambulance organisations are able to include occupational health and safety measure through internal policy and directives. This is not an option open to Victoria as the NEPT space is populated by private providers and therefore any new requirements must be set out in legislation.

SafeWork Australia data that is publicly available is not specific enough to enable any work related injury comparisons to be drawn with other States and Territories. And as the Occupational Health and Safety arrangements for NEPT services in other States and Territories are fundamentally different to the arrangements in Victoria direct comparisons cannot made.

## 8.4 Identification of options

|  |
| --- |
| Base case: No requirement for accredited occupational health and safety plans – the current regulations |
| NEPT licencees must meet the current requirements under the *Occupational Health and Safety Act 2004.* |
| Option A: Require all NEPT licencees to maintain an accredited occupational health and safety plans – the proposed regulations |
| NEPT licencees will be required to introduce and maintain accredited occupational health and safety plans |

The types of occupational health and safety risks the department is aware of within the sector are:

* Movement of patients
* Safety and maintenance of vehicles
* Safe ingress and exiting of vehicle patient compartments
* Motor vehicle accidents
* Out of date equipment and materials
* Maintenance of on-board machines and equipment
* Lack of shade/shelter while waiting for job allocation when away from depots
* Long road journeys
* Correct storage of medications
* More recently, risk of COVID-19 infections

Essentially whether or not to adopt option A depends on whether the current *Occupational Health and Safety Act 2004* and its inspectorial and compliance regime is adequate to deal with the specific staff and patient safety risks of the NEPT sector.

The department has been advised by two NEPT providers that when Worksafe investigates complaints about NEPT businesses the officers do not ride the NEPT vehicles when they are engaged in picking, transporting, and setting down patients. Further the investigation is limited to the matter alleged and is not a comprehensive assessment of all occupational health and safety matters in the first instance, noting this may occur if Worksafe is sufficiently concerned about their findings from the complaint investigation. As a result, it is argued that it cannot be relied on that a comprehensive assessment is carried out at all NEPT businesses on a regular basis.

In order to address this concern it is proposed that all NEPT licencees must develop and maintain a third party accredited occupational health and safety plan. Accreditation would be to the Australian Standard or International Organisations Standards (ISO) and the accreditors would themselves be required to be accredited to either JAS-ANZ or an ISO accreditation body. The plan would be required to be re-accredited annually or in accordance with the accreditation regime of the accreditor. The plan would be developed by the NEPT licencee and would therefore be tailored to the individual business. The Plan would be required to incorporate the Worksafe legislative requirements in order to be consistent with OH&S legislation. It is a principle of law that regulations made under another Act must not contradict or be inconsistent with the provisions in the principal Act, in this case the *Occupational Health and Safety Act 2004*.

One currently licenced NEPT businesses already operates to their own accredited occupational health and safety plan. This business arguably provides a safer working environment for staff than those businesses without a Plan. Due to the lack of a consistent approach to occupational health and safety, staff who work in the industry are currently faced with differing levels of workplace safety depending on which NEPT provider they work for.

It is arguable that the existing occupational health and safety legislative requirements under the *Occupational Health and Safety Act 2004* are sufficient and no further legislative obligations should be imposed on the sector. If so, any further measures to address occupational health and safety should therefore be at the discretion of the business. This is the base case.

The base case is the current situation where the existing occupational health and safety legislation applies.

Option A is the proposal to mandate third party accredited occupational health and safety plans in the NEPT sector.

No other option is considered feasible.

## 8.5 Assessing the options

A multi-criteria analysis was used to assess the costs and benefits of the identified options. The criteria and their weightings are shown in Table 8.1 below.

**Table 8.1 Multi-criteria analysis criteria and weightings**

|  |  |
| --- | --- |
| Criterion | Weighting |
| Staff safety | 70% |
| Costs to NEPT licencees | 30% |

These criteria reflect the objectives of the Regulations as they relate to the staff and patient safety and the priority given to staff safety by the Government’s election commitment.

Therefore, the staff safety requirement is accorded a weighting of 70 per cent. The overall costs imposed by the Regulations are therefore weighted at 30 per cent.

### The base case – current Regulations

The base case is the status quo and is one of lower initial lower cost but potentially long-term higher costs.

Under the base case the NEPT licencee is responsible for compliance with the *Occupational Health & Safety Act 2004* and for determining how that Act will be complied with and what matters require attention. This approach tends to rely on staff reports of hazards or injuries. .

The degree to which a NEPT company works to prevent injury and illness transmission to staff will vary according to the emphasis placed on occupation al health and safety. As a result, staff may be subject to greater or lesser risk depending on who their employer is.

To the department’s knowledge there is one licenced NEPT provider that currently operates an accredited occupational health and safety plan.

The cost of the base case is assigned a score of zero for the MCA as continuing with the current arrangements would not impose any additional costs on the NEPT licence holders. Similarly, there are no additional benefits to patient safety and care.

**Table 8.2 Multi-criteria analysis scores for the base case**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Staff safety | 70% | 0 | 0 |
| Costs to NEPT licencees | 30% | 0 | 0 |
| **TOTAL** | **100%** |  | **0** |

### Option A – proposed Regulations

With its election commitment to introduce power lift stretchers to reduce the potential for NEPT staff injury the Government has made its priority clear. However, a single measure, while helpful, is a point in time solution. To embed the Government priority of staff safety into the culture of the NEPT sector it is considered appropriate to introduce a requirement for continuous improvement.

Continuous improvement is the purpose of accreditation to a quality standard such as the International Standards Organisation (ISO) or Australian Standards (AS) occupational health and safety systems. The idea is that workplace systems, protocols, and processes are constantly reviewed and updated in order to improve and prevent opportunity of injury or illness to staff. These plans are written by the business and tailored for its specific needs. Identification of potential for injury or illness and reports of injuries or illness are seen as opportunities to systematically improve the business.

In the long run, companies that embrace a culture of continuous improvement save money due to a lower rate of accidents, non-compliances, or deviation from standard procedures. A review of processes and procedures is triggered every time a required element is not met, rather than waiting for an accident to occur, and systems are updated to prevent a recurrence. The business is continually learning and improving its operations.

At the moment, a company with the mindset of compliance with the *Occupational Health and Safety Act 2004* will review accidents causing injuries but not necessarily situations where there is potential for accidents to occur. As a result, there may be more accidents resulting in more lost work days and in higher Worksafe premiums over time compared with companies that are continually reviewing the potential for accidents. Such an approach may also not place sufficient weight on infection control and prevention of illness. Staff contracting illness from patients would utilise sick leave rather than WorkCover and so a review of the circumstances that led to the illness may not occur.

As stated earlier 85% of the NEPT workforce is casual. Where a company is not committed to OH&S there may be a disincentive for these staff to make complaints about work safety as they risk being seen as troublemakers and they may find their number of shifts reduced as a result.

Accreditation to external third party audited standards is commonplace in the food industry, the manufacturing industry, the hospital sector, and the financial sector to name a few, and is currently required for quality assurance in the NEPT sector.

It is proposed to introduce a regulation to require all NEPT licences to have an occupational health and safety plan that is audited and accredited by a JAS-ANZ accredited third party annually (see <https://www.jas-anz.org/>). It is intended to mirror the current requirements of the Regulations for Quality Assurance Plans.

At this stage, the department does not propose mandating which standard should be used. Businesses will be able to choose either the ISO or the AS standard.

The Regulations will specify the minimum elements that must be included in the occupational health and safety plan. Proposed inclusions are:

* maintenance of a hazard register
* incident reporting and management
* data sheets
* risk evaluation
* risk management
* staff qualifications and training
* recording of incidents and resulting actions.

Adherence to an accredited occupational health and safety plan will encourage a health and safety culture for employers and employees and potentially reduce the number of WorkSafe claims and therefore premiums over time.

External oversight of the occupational health and safety plan, which includes verification that the plan is appropriate and is being followed, will provide the department, users of the service, and staff, with confidence that staff safety, and by extension patient safety, is being appropriately managed.

As Worksafe is limited to responding to complaints in the NEPT sector, accreditation to a recognised occupational health and safety standard provides for the setting of a level playing field, for the adherence to minimum standards by all licencees, and for increased compliance with the *Occupational Health and Safety Act 2004.*

The department considers that the proposed Regulations will provide for greater staff safety over the life of the Regulations. It is a higher initial cost option than the base case. However, the proposal is potentially a lower cost option than the base case in the long term due to reduced injuries, illness, and lower workers compensation premiums.

The department is advised that any reductions in premiums due to improved OH&S outcomes takes about three years to be reflected in the premiums charged by Worksafe. In addition, the department does not know what reduction on workplace injuries may occur as a result of this change. Therefore, no savings have been costed.

There are costs to develop the plan, maintain the plan and have the plan audited and accredited by an accredited third party.

The department has been advised that certification of the Plan is $8,000 with annual surveillance audits costing approximately $3,500. There are ongoing costs to support the certification and standards in the business as a person must be responsible for ensuring the plan is being adhered to in order for it to be effective. The amount of time required varies according to the size of the businesses and whether or not these activities were already embedded in their routine business practices.

All NEPT companies are required to comply with the *Occupational Health and Safety Act 2004*. In addition, all companies contracted by Health Purchasing Victoria to provide NEPT to Victorian public hospitals or contracted by AV are required by the contract to comply with the Act. The contracts do not require accreditation to AS4801.

It is expected 13 businesses will remain as licenced NEPT providers.

1 NEPT business is already accredited to AS4801.

8 NEPT businesses are currently contracted to HPV and/or AV. For these companies the only additional cost should be the annual cost of accreditation and audits. They should already have most of the policies and procedures in place that are required by AS4801.

This leaves 4 companies who may have to develop an OH&S plan with suitable policies and procedures to get accreditation

The additional costs to the businesses not already accredited are the cost of annual accreditation ($8,000) and annual audits ($3,500) and costs associated with the formalisation of their occupational health and safety policies and procedures.

The cost of annual accreditation and auditing is 12 x ($3,500 + $ 8,000) = **$138,000 p.a.**

As the plan simply documents how the business is complying with the *Occupational Health and Safety Act 2004* the supporting policies and procedures should already be in place to a significant degree as it is a cost of doing business. However, the degree of sophistication of these policies and the degree to which they have been documented varies between NEPT providers.

Therefore, only the cost of developing the remaining documentation required by AS4801 for the plan is considered an additional cost for these businesses. This is a one-off cost. The Department has consulted with the sector and has been advised that a cost of $10,000 per business is a reasonable estimate to develop the plan. So the cost for this is 12 x $10,000 = **$120,000 in the first year only**.

**The cost of option A is $258,000 in year one reducing to $138,000 in the following years** or **$810,000** over the life of the Regulations. The discounted cost is **$715,664** over the life of the Regulations. Therefore the MCA score is -1.

The benefits to staff from reduced injuries and illness and to the licencees from reduced Worksafe premiums over time may be substantial. In terms of staff injuries, prevention also has a benefit for their families. Therefore an MCA score of +4 is allocated.

In the opinion of the department Option A is likely to lead to less injuries and illnesses over time than in the base case.

**Table 8.3 Multi-criteria analysis scores for option A**

|  |  |  |  |
| --- | --- | --- | --- |
| Criterion | Weighting | Score | Weighted score |
| Patient safety and care | 70% | +4 | **+2.8** |
| Costs to NEPT licencees | 30% | -1 | **-0.3** |
| **TOTAL** | **100%** |  | **+2.5** |

# 9 Other Regulations

There are a number of other Regulations that are proposed which are not expected to have a significant cost impact on NEPT licenced businesses. These Regulations that have not been analysed for alternative options.

This section details these Regulations and provides a rationale for their exclusion and seeks to quantify the cost (if any).

## 9.1 The nature and extent of the problem to be addressed

The analysis in this RIS has focused on those Regulations that result in an incremental cost to private NEPT licencees. The reasons why these Regulations have not been considered for further analysis include:

* the regulation gives practical effect to the Act
* the cost of the regulation or requirement is of low impact to the sector because it represents ‘business as usual’
* the cost of the requirement is more accurately attributed to other frameworks

## 9.2 Regulations that give practical effect to the Act

The Act requires all NEPT services to be licenced. Once the Act is amended it will require, in order for a NEPT service to be licenced, the Secretary of the Department to be satisfied that:

* the applicant is a fit and proper person,
* That the licencee can deliver a safe service with a suitable quality of care,
* the vehicles and equipment to be used are suitable,
* the operating arrangements for the management and staff of the service are suitable,
* the arrangements for maintaining the quality of the service are appropriate,
* the arrangements for evaluating, monitoring, and improving the quality of the service are appropriate,

If the Secretary is not satisfied as to one or more of the above requirements he or she may, refuse a licence application, suspend an existing licence or part of a licence, or cancel a licence. Regulations are required to prescribe certain matters required by the Act, and to set the minimum standards required to meet the Act’s requirements. In order to do this certain terms need to be defined to provide clarity to the NEPT sector, the Regulator, and the Courts.

The proposed regulations described in this section go to one or more of the requirements of the Act

Regulation 5 is a range of definitions that are required to provide scope and give effect to the Act. Defining “active management” provides clarity to the sector and the regulator about what is meant when this term is used in the Regulations.

Defining a “Nurse” will ensure consistency with the National Law.

Regulations 12-15 prescribe minimum crewing numbers (which reflects general industry practice) and makes clear that a crew member must travel in the patient compartment when low acuity patients are being transported. This will mean a minimum of 2 crew as one staff member must drive the vehicle. The current regulations already require a crew member to travel in the passenger compartment with medium and high acuity patients.

It has been reported by NEPT staff and the Victorian Ambulance Union, and the Ambulance Employees Association of Victoria over the years that only one staff member is used to transport low acuity patients in some cases. The department has also received numerous reports, and department staff have observed, both crew members travelling in the drivers compartment of vehicles.

It is a current requirement of the Regulations that all patients must be monitored during transport. A single crew member driving the vehicle cannot also effectively monitor a patient in the rear compartment. Similarly, if both crew members are in the driving compartment and no-one is directly monitoring the patient then the patient is not being effectively monitored. This compromises the safety of the patient as the crew may not notice immediately if the patient is having an unexpected (or potentially expected) medical episode.

This regulation is intended to make explicit, that one crew member must travel in the patient compartment with the patient for the purposes of monitoring that patient throughout the journey regardless of the level of patient acuity. Regulations 12 and 13 in the current Regulations are already explicit, however, regulation 11 which applies to low acuity patients is not as clear as it only requires a low acuity patient must be visually monitored during the transport. When the Regulation was written it was assumed one crew member would travel in the compartment with the patient as this is good (minimum standard) clinical practice. However the department has received many reports since this regulation was introduced in 2016 of both crew members travelling in the drivers compartment and no-one directly monitoring the patient. So for the avoidance of doubt and for absolute clarity it will now be a requirement that a crew member must travel in the compartment with the patient at all times. This will not result in additional crew members being on board as two crew members (a driver and another crew member) already need to be in the vehicle so that patient monitoring requirements can be met (Regulations 11,12 and 13).

While this may be seen a cost imposed the Regulations most NEPT licence holders already have this practice in place. The Department also considers that no reputable NEPT operator would crew a stretcher vehicle carrying any patient with one staff member only due to the safety risks to the patient.

Regulations 19-21 will be amended to strengthen staff training and competency requirements. All staff who drive vehicles will be required to hold a full Victorian drivers licence. P plate drivers will no longer be permitted to drive NEPT vehicles. While NEPT vehicle drivers must undergo a driver training component the Department does not consider that compensates for the experience, and road and traffic awareness, gained over the 3 years prior to becoming fully licenced. It is additional training specifically related to handling the NEPT vehicles. Regulation 19 will be amended to clarify that clinical supervision is active patient care under supervision and does not include observational shifts. This is to ensure hands-on practical experience is gained from these shifts. These Regulations are required to give effect to the new requirement in the Act for patient safety and quality of care to be maintained at all times

Regulation 29 already requires the development of a Quality Assurance Plan. The regulation will be clarified to correct an error in the Regulations and will specify the Plan must be accredited by a recognised third party accreditation body. Accreditation bodies issue Certificates of Accreditation. There is no cost to licence holders associated with this change.

It is proposed to insert a new regulation to require licencees to conduct annual (at a minimum) staff safety surveys. The purpose it to ensure formal staff feedback occurs that is fed into the clinical governance arrangements. Evidence in the hospital sector is that these surveys can identify patient safety and occupational health and safety matters that might otherwise not be brought to the attention of management.

During earlier consultations with the NEPT sector the Department was provided with a list of hourly wage rates for NEPT staff under a range of Enterprise Bargaining Agreements. The highest hourly rate was $30 per hour. Applying the multiplier of 1.75 to account for on costs and overhead costs gives a final hourly rate of $52.50.

There are about 1700 NEPT employees across the sector. Allowing 15 minutes per survey once per year at a cost per employee of $13.12 which gives a total cost across the sector for staff time of $22,304. The size of NEPT companies varies significantly so the time taken to assess the survey results will also vary. The assessment will be by 13 companies and the department estimates the time taken will vary from one hour to two days. A midpoint of one day (8 hours has therefore been chosen to cost the assessments. 13 x 8 x $ 52.50 = $5,408.

Therefore, the total cost of this regulation is estimated at $22,304 + $5,408 = $27,712 p.a.

Regulations 47-51 set out the requirements for the use and condition of an NEPT vehicle. It is proposed to add specific requirements to require every NEPT vehicle to undergo annual roadworthy checks and be certified as roadworthy by a motor mechanic approved by VicRoads. It is also proposed to require a minimum separation of 350 mm between stretchers where a vehicle carries 2 stretchers to allow staff to move between the stretchers while in transit to attend to patients without having to lean over their heads as currently occurs. This requirement will apply to all new vehicles introduced into service after the Regulations come into effect. These changes support patient safety and quality of care.

The cost of an annual roadworthy check is estimated at $200 per vehicle. The total cost of this requirement will be 436 x 200 = $87,200 p.a. to the NEPT licencees. Any repairs arising from the roadworthy check are not included in the costing as this is considered part of normal maintenance.

No costs are attributed to the requirement to have a 350 mm space between stretchers as this requirement will be phased in as vehicles are replaced and forms part of the vehicle replacement cost calculated in Chapter 5.

## 9.3 Low-impact regulations

The proposed Regulations will require all medium acuity patients to be transported single loaded (not double loaded). This requirement already applies to high acuity patients. This is to ensure appropriate patient care can be provided, particularly if a patient deteriorates during transport. This is also a requirement for the transport of medium acuity patients under the AV contract.

The discussion paper raised a proposal to require all patients to be single loaded. The majority response was that this was unnecessary and that low acuity patients could be single loaded provided they were not suffering from conditions already specified in the Regulations as requiring single load transport.

Non-emergency patient transports in all states allow for the transfer of 2 stretcher patients in one vehicle. The ability to continue to transport 2 low acuity patients is appropriate from a cost/benefit position.

However medium acuity patients will be required to be single loaded under the new Regulations. Data provided to the department in the annual reports from the NEPT licence holders indicated this will only impact on about 150 transports (out of 74,000 medium acuity transports) annually as the vast majority of medium acuity transfers are undertaken for AV.

In 2019 the annual reports from NEPT licencees showed that 74,000 medium acuity patients were transported. Of those, it is expected that the vast majority would have been undertaken for AV who already require medium acuity patients to be transported singly. The AV annual reports do not breakdown NEPT transports into acuity levels.

As NEPT vehicles will all be required to move to power lift stretchers, which as discussed in Chapter 4, will lead to a significant increase in single stretcher vehicles, it is anticipated that the net costs associated with this requirement will be zero as the single stretcher vehicles will be deployed for medium acuity transports. Increasing the number of single stretcher vehicles will allow licence holders to respond more flexibly to AV demands and also allow better rotation of their fleets.

NB: AV require all patients to be single loaded under their contracts.

The proposed Regulations will also limit the maximum number of patients that may be carried at any one time to two patients. This is to ensure there are sufficient staff to deal with any patient care matter and staff are not at risk of being overwhelmed. Over the past four years there have been a number of complaints about three patients being transported at one time with one being carried in the driver’s compartment. This is clearly not appropriate from a patient safety perspective. It is already the expectation of the department that a maximum of two patients be carried in a stretcher vehicle and this has been communicated to the sector. As medium acuity patients will now be required to be single loaded (as well as high acuity patients) this change will only apply to low acuity patients. The change is being made for clarity and the avoidance of doubt as the current Regulations are not explicit.

As the NEPT Regulations are being amended only, the majority of the existing Regulations continue as is and are therefore not considered as part of this RIS.

Regulation 53 will be amended to increase the amount of public and professional liability insurance to $20 million each. The industry has been consulted about this change and is supportive. Increasing coverage from $10 to $20 million would not increase premiums significantly. In addition, having $20 million in coverage is common practice in both the NEPT and first aid sectors. With the sector expected to reduce in numbers to 13, and the fact that many companies already have this level of insurance, the department does not expect any net cost increase to the sector.

# 10 Impacts on competition

## 10.1 Groups affected

Groups affected by the proposed Regulations or their alternatives; include NEPT providers and their staff, patients, commercial first aid providers and their staff, hospitals, Ambulance Victoria, event organisers, sporting organisations, and other users of commercial first aid providers.

## 10.2 Impact on small business

The Victorian Guide to Regulation provides a definitive guide to developing regulations in Victoria. In particular, it is important to examine the impact on small business, because the compliance burden of regulation often falls disproportionately on that sector of the economy.

Most of the current licenced NEPT providers are considered to be small businesses. Only three businesses are licenced to operate more than 50 vehicles.

It is expected that 7 licence holders will return their licences and seek a first aid licence as they transport none, or very few patients and will not meet the threshold for an NEPT licence in the amended Act. These companies will be the smallest companies remaining in the NEPT sector. It is noted that by transferring to a first aid licence these companies will no longer have the expense of purchasing and maintaining a NEPT vehicle

## 10.3 Assessment of impact on competition

The analysis in this RIS has concluded that, based on the information available to the department, the proposed Regulations meet the objectives better than the base case and the assessed alternative approaches.

The guiding principle in assessing competition impacts is that Regulations should not restrict competition unless it can be demonstrated that the benefits of the restriction to the community as a whole outweighs the costs, and that the objectives of the Regulations can only be achieved by restricting competition. The National Competition Policy (NCP) ‘competition test’ was used to assess the proposed Regulations against any possible restrictions on competition. The test asks the following questions relating to the proposed Regulations:

* Is the proposed measure likely to affect the market structure of the affected sector(s)?
* Will it be more difficult for new firms or individuals to enter the industry after the imposition of the proposed measure?
* Will the costs/benefits associated with the proposed measure affect some firms or individuals substantially more than others (for example, small firms, part-time participants in occupations, etc.)?
* Will the proposed measure restrict the ability of businesses to choose the price, quality, range, or location of their products?
* Will the proposed measure lead to higher ongoing costs for new entrants that existing firms do not have to meet?
* Is the ability or incentive to innovate or develop new products or services likely to be affected by the proposed measure?

Assessed against this test, the existing Regulations impose restrictions on firms entering or exiting a market by requiring specially modified vehicles to be used.

It will be more expensive to enter the industry however the cost of complying with the proposed Regulations is considered to be justified by the benefits achieved by the Regulations, and not materially greater than the costs associated with the base case.

The removal of stand-by accreditation by the changes to the Act will affect the market structure by requiring provider of stand-by services at events to obtain a First Aid licence. Consequential amendments to the NEPT regulation are therefore required to remove references to stand by services. New First aid Regulations are being developed in conjunction with the amendments to the NEPT Regulation. The changes are expected to reduce the number of NEPT licencees by 40% and result in a sector that is purely a patient transport sector. However, those businesses expected to remain in the NEPT market provide in excess of 90% of the NEPT vehicle fleet.

The proposed Regulations are likely to make it more difficult for new proprietors to enter the market, because they impose additional minimum requirements for patient and staff safety at significant cost. The new requirements mirror what is required in private contractual arrangements between AV and NEPT providers. There are a large number of vehicles not involved in the AV contracts that will incur additional costs as a result of the regulations, even where the licencee holds an AV contract. The increased costs will be largely attributable to the number of vehicles being operated by the licenced providers and therefore the proposed measures will largely affect all business equally, irrespective of whether they are large or small. As it is expected that there will still be 13 licenced NEPT businesses after the changes to the Act and Regulations are introduced, the department considers the market remains a competitive market.

Taking into account the variation in the level of acuity of patient being transported and the consequent differences in the types of vehicles and staffing required, the proposed Regulations are not considered to create a relative competitive disadvantage or advantage among existing NEPT licencees however they will increase barriers to entry to the market for new entrants, noting that existing licenced providers will also incur the increased costs..

The proposed Regulations apply equally to all businesses and consumers. Therefore, the proposed Regulations are considered to meet the NCP ‘competition test’ as set out in the Victorian Guide to Regulation.

## 10.4 Implementation and enforcement issues

The proposed Regulations are intended to commence by no later than 30 September 2021.

The current Act is being amended to make patient safety an objective, and to require patient safety and quality of service to be maintained at all times. Additional enforcement measures such as suspension of all or part of a service are being introduced into the Act.

Under the proposed Regulations, a range of new patient safety and quality of service requirements are being introduced. The department will strengthen its risk management approach to allow resources to be targeted at areas of greatest risk. It is intended that the department will gather additional information from various sources (clinical governance records, patient care records, occupational health and safety plans review of quality assurance plans and associated records, compliance history, complaints, adverse event reports, etc.) to determine the relative risks of licencees and then take steps to manage or mitigate any risks identified. In general, any measures taken to mitigate risks will be done in conjunction with the licencee to assist the licencee to improve its performance and to educate the licencee and staff as necessary. When considered necessary by the Department proportionate enforcement measures will be imposed. Court action will remain a last resort.

These measures offer a fair and proportionate range of enforcement options, which aim to educate proprietors and support them in making positive changes to their business and services offered to patients.

As the introduction of the requirement for power lift stretchers and vehicle life limits will result in significant additional costs these measures will be phased in to allow licencees to spread the costs over a number of years. There will be a three year transition period to introduce power lift stretchers, and a five year transition period to implement the 400,000km vehicle replacement requirement.

Under the current Act and Regulations senior nurse advisors of the department, as authorised officers, monitor and enforce compliance with the Act, the Regulations, and conditions of licence, by:

* inspections of establishments and the assessment of policy, procedures, and practices in clinical care, as part of the application for renewal of licence or pre-licence
* prompt and thorough complaint investigation involving site visits that may, depending on risk analysis, lead to a full site inspection
* requiring action plans from proprietors to rectify issues of noncompliance where identified and conduct follow-up inspections (these costs have not been included in the RIS as they are intermittent, depending on performance, and are generally minor in nature)

The authorised officer role has a strong educative focus and enables the meaningful exchange of information between the department and licencees. Authorised officers can assist licencees to understand and implement changes to procedures, practices, and documents to ensure compliance with the legislation. This occurs both during inspections and as part of their ongoing relationship with the sector. In addition, authorised officers provide education through specific projects to assist licencees in either complying with the legislation or developing better practices. This element of the enforcement process will remain, however the department will seek to employ paramedics in this role subject to a successful budget bid.

In all cases, the department works with proprietors to resolve any problems. Prosecution or revocation of licence are measures of last resort and have not been invoked over the life of the Act.

## 10.5 Evaluation strategy

Under the Subordinate Legislation Act 1994, statutory rules automatically expire (sunset) following 10 years of operation. This ensures that the government examines whether there is still a problem that requires government intervention, and to take account of any changes or developments since the regulation was implemented. When regulations are amended, the government assesses whether the objectives of the regulation are being met, whether practical experience suggests ways in which they can be improved, or whether a different regulatory approach is warranted. Final development of the Regulations is informed by public input through the RIS process. The current NEPT Regulations will sunset in 2026 and a RIS will be required if Regulations are remade.

This RIS covers proposed amendments to the Regulations, which are required to support amendments to the Act.

The proposed amendments will be evaluated through the RIS process in 2026. In addition, other indicators will be used to evaluate the amendments in the interim.

As noted in Section 10.4, the authorised officers will continue to visit licenced NEPT businesses using a risk management approach. These inspections provide compliance data that is used by the department as a proxy for the safety and quality performance in these facilities.

Subject to resourcing, the department intends to compare data from audits of NEPT licencees from pre and post these amending Regulations to monitor whether improved patient safety outcomes are evident. The types of matters that will be assessed are complaints (severity and number), patient care records, clinical governance committee minutes and decisions, supervised clinical practice records, maintenance of equipment and supplies, use of schedule 8 medications, implementation of power lift stretcher and lifting cushions, etc. This information will feed into the development of the 2026 Regulations when they are prepared.

The Department also intends to seek feedback three years after the introduction of the regulations from NEPT licencees on the impact of power lift stretchers, the strengthened training requirements, the impact and usefulness of the clinical governance requirements and the impact and usefulness of the OH&S plan accreditation to inform the development of the 2026 Regulations.

In relation to vehicle life limits, the safety of the service will be measured, if possible, by the number of patient injuries arising from the transport, the number of patient complaints relating to the comfort of the journey, and the number and type of WorkCover claims lodged by staff crewing vehicles.

# 11 Stakeholder consultation

From March to June 2019 the department undertook a number of targeted consultations by contacting key stakeholders, and held two public forums, to discuss the review of the Regulations to determine what should be included in the regulations and test stakeholder reactions to the departments proposals. Ongoing consultations with some stakeholders have continued since then.

Stakeholders consulted in the development of the draft Regulations and the RIS were:

|  |  |
| --- | --- |
| Colbrow Paramedics | IMS Services |
| Epworth HealthCare | LifeAid |
| Event Paramedics | Health Select |
| National Patient Transport | Medical Edge |
| Royal Flying Doctor Service | Paramedic Services Victoria |
| Wilson Medic One | Patient Transport Australia |
| St John Ambulance | Ambulance Victoria |
| Australian Medical Association | Municipal Association of Victoria |
| Health Purchasing Victoria | City of Melbourne |
| Shire of Baw Baw | Australian Festivals Association |
| AFL | Cycling Australia |
| Confederation of Australian Motorsports | Sports Medicine Australia |
| Tennis Victoria | Life Saving Victoria |
| Victorian Ambulance Union | United Voice |
| Event Aid | Team Medical Australia |
| RaceSafe | EMSA |
| Event Medical Team | First Intervention |

The meetings with the above stakeholders informed a discussion paper which was released by the department outlining the proposed changes to the Regulations. 37 submissions were received.

The majority of issues raised related to the proposals to:

* require the introduction if power lift stretchers and lifting cushions
* introduce vehicle life limits
* require the use of accredited occupational health and safety plans
* introducing clinical governance requirements
* strengthen the ongoing training requirements for staff
* require the review of patient case notes
* limit double loading of patients to low acuity patients

An overview of stakeholders’ views is provided below in section 11.1

## 11.1 Stakeholder Comments

The comments provided by all stakeholders from the initial consultation are summarised below.

#### Power lift stretchers and lifting cushions

The introduction of power lift stretchers and lifting cushions was an election commitment by the Government. General concern was expressed about the cost of implementing this measure as the cost is significant.

Attracting suppliers to regional and rural areas is extremely difficult. Significant cost increases will need to be passed on to hospitals and patients. If contracts with hospitals and AV do not cover the increased costs there may not be sufficient NEPT coverage of rural areas. If this occurs then the shortfall would need to be covered by AV who would have to invest more into regional and rural areas.

Power lift stretchers are considered to be more efficient and certainly a lot safer, leading to better experiences for both staff and patients.

Some providers may exit the industry thus reducing competition. The impact may be disproportionate on smaller providers.

A three year transition period would be needed to allow NEPT providers to spread the costs.

#### Vehicle life limits

It is proposed to introduce a NEPT vehicle life limit of 400,000km. Comments were generally, but not unanimously, supportive.

A 400,000km NEPT vehicle life limit is the policy of three of the larger NEPT providers. It is regarded as the typical useful life of vehicle, beyond which maintenance costs outweigh the cost of purchasing a new vehicle.

One responder noted that Mercedes Benz and other manufacturers advice these vehicles have a service life of up to 1 million km provided the vehicles are properly maintained

Entering the industry requires a large financial investment which is a significant barrier to entry for new players, reducing competition however this is a market cost, not a regulatory cost. The regulatory cost occurs only the extent that vehicles would otherwise operate beyond 400,000km.

#### Clinical Governance

It is proposed to introduce clinical governance requirements for all licensed NEPT businesses.

Most submissions indicated NEPT businesses already operated with clinical governance to some degree, and it was a cost of doing business. As a result, many indicated the cost of the proposal would be marginal to their business, however it was noted that the cost impact of introducing clinical governance will vary according to the provider and may be significant for providers who do not have current arrangements. No submitter opposed the proposal.

#### Staff training

It is proposed to require certain ongoing staff training to be delivered face to face. It is the opinion of the department that training such as CPR, airway management, etc. cannot be delivered online effectively.

There was a general consensus that clinical competency training (refresher and assessment) should only be in the classroom and face to face. One NEPT licencee reported that they often assessed using scenarios in the back of the ambulance to simulate real life examples.

It was also submitted that Universities and RTOs are authorised to train and assess via electronic and video conferencing systems and where this is beneficial it should be permitted to continue.

One submitter advocated for a combination of online and face-to-face training. Face-to-face can be costly and difficult to roster to avoid operational impact, particularly in a large but dispersed workforce.

Concerns were raised about potential additional costs with concern that this cost could be greater for non-metropolitan providers.

**Occupational Health and Safety Plans**

It is proposed that each NEPT licencee should operate to an accredited occupational health and safety plan.

There was general support for the proposal although a minority of submitters argued that the Occupational Health and Safety Act was sufficient regulation of the issue.

Some submitters suggested that Australian Standards for Health and Safety (AS 4801) and the International Standard (ISO 45001) are very comprehensive and could be mandated rather than list items the plan should include.

Concern was expressed at the potential cost of the proposal by some submitters while others noted they already had an accredited plan.

#### Patient Case Notes

It is proposed to require NEPT licencees to review 50% of patient case notes of medium and high acuity patients to drive continuous improvement in patient care and to uncover systemic problems in patient care that may otherwise escape detection.

Every submitter that commented on this question supported the proposal. It was noted that all NEPT licencees contracted to AV are already required to do this as part of their contract.

It was submitted that auditing of PCRs is an essential Quality Process that underpins quality improvements, accountability of clinical practice, accountability for drug administration, training and remedial learning opportunities and supports robust risk management processes within the business.

Another NEPT provider commented that Patient care reviews and patient experience are at the centre of our business. Every patient has a PCR and it is the only piece of paper (other than those used for accounting) generated by every business for every patient. PCRs are an inherent part of the industry and the best way to review NEPT practice

One submitter commented that for low acuity patients there is little value. For medium and high acuity patients where clinical observations are taken, yes.

#### Limit double loading to low acuity patients only

A number of submitters, including AV, did support single loading of all patients

One submitter wrote “A former employer of mine would often triple load patients with crews sitting in the front of the vehicle while two patients would be on the stretchers and one in the attending seat. Rarely is it efficient to double load patients, particularly in a metropolitan setting. My employer frequently pushes double loads for the sake of double loads, often with patients going to different locations and having to wait in the car, or worse get taken out and brought into another hospital while the first patient is offloaded.”

Other comments were:

“If a patient is requiring any form of clinical monitoring, who is meant to be watching them while the crew is occupied with the other patient?”

“Based on legal and WorkCover advice received, AV have mandated the use of single stretchers for all services/patients to be phased in over a 3 year period.”

# Appendix A: Cost assumptions and calculations

## A.1 Approach to assessing the regulatory options

In order to assess the options put forward in this RIS, an assessment is required of each option’s costs and benefits. The Victorian Guide to Regulation advises of the following principles in regard to conducting cost-benefit assessment:

* Before a particular regulatory proposal can be implemented, it needs to be demonstrated that the net benefits associated with the proposal are greater than the other approaches available to address the problem.
* Where possible, a dollar figure should be assigned to costs and benefits.
* Analysis should include an assessment of less tangible impacts (such as health and safety outcomes).
* Cost‐benefit analyses should also contain an assessment of risk to enable regulation to be in proportion to the risks involved.

The key objective in regulating non-emergency patient transport (NEPT) providers is to provide for the safety and quality of the services provided, and therefore protect the public that use them. For a range of reasons detailed in the RIS, non-emergency patient transport is a not a ‘typical market’ and therefore, government intervention in the form of regulation is warranted as outlined in the RIS.

Due to the number of variables involved in the provision of NEPT, it is challenging to quantify the costs and benefits of regulation in this area. There is no baseline data available to measure intervention against. Licencing and regulation of private NEPT operators has been in place in Victoria for 15 years. Only two other Australian jurisdictions have a dedicated regulatory framework applied to NEPT.

The less tangible, social impacts of the proposed Regulations include:

* improved quality of life associated to the extent that proposed Regulations lead to better health care
* greater transparency around safety and quality requirements
* benefits of improved occupational health and safety for staff and patients.

Non-quantifiable costs associated with the base case of the existing regulations include those associated with:

* a reduced confidence in the private system by patients
* decreased satisfaction by patients and health care professionals
* increased physical and psychological discomfort for patients
* decreased length or quality of life for patients.

Seven licenced NEPT providers are currently contracted to AV. The requirements of the AV contract exceed the requirements of the current Regulations. The proposed Regulations adopt a number of the AV contractual requirements. To the extent that the licenced NEPT providers provide contracted NEPT services to AV these requirements do not impose any additional cost and are therefore not included in the costings for this RIS..

To assist in assessing the costs and benefits of the viable regulatory options, this RIS utilises the multi-criteria analysis (MCA) assessment tool. This is the preferred assessment approach where it is not possible to quantify and assign monetary values to all impacts of an option.

MCA involves identifying assessment criteria relevant to the intervention objectives, weighting these criteria, and scoring alternative options against these criteria. An overall score is derived by multiplying the score assigned to each measure by its weighting and calculating the total. This provides a qualitative score for each option, and the option with the highest score represents the preferred approach.

The criteria weightings consider the relative importance each criterion in achieving the Regulations’ objectives. These values are necessarily subjective and informed by consultation with stakeholders and government policy.

The proposed Regulations and identified alternative approaches are scored relative to the base case. A scale of plus 10 (+10) to minus 10 (-10) was used, where 1 indicates a minimal positive impact and 10 indicates a high and material impact. This approach allows elements of the regulatory options to be differentiated in assessment. For example, if one option incurred costs of $2 million per year, and another option $4 million, then the former option might receive a rating of -5, while the latter would score -10.

Note: In this RIS, because the scale of costs associated with chapter 4 are far larger than for the remainder of the chapters, points have been allocated as follows:

Chapter 4 - $4 million = 1 point

All other Chapters - $1 million = 1 point

#### General assumptions

Costs associated with complying with the Regulations will vary depending on the specific circumstances of each NEPT business.

The Regulations are not the only legislative framework or set of standards that require actions relating to patient safety and health care quality. As a result, a proportion of NEPT providers are already in compliance with the Regulations in part or in full; therefore, there will be lower costs attributed to them.

Factors that may determine the extent of costs of compliance include: the resources of the business, the sophistication of the quality systems and level of staffing and management support around this.

Compliance costs for each category were estimated by:

* identifying additional (incremental) compliance tasks from the base case (the existing Regulations),
* identifying key activities required to complete compliance tasks; and
* valuing those activities based on staff time and/or cost of inputs.

The number of licenced NEPT providers has been increasing at an annual rate of 8.1% per annum since the Act and Regulations were first introduced. However, as the forthcoming amendments to the Act are likely to result in a number of smaller NEPT businesses exiting the market and transitioning to a licenced First Aid the historical business rate is not applicable in future. Further the Regulations will increase barriers to entry to the market (increased costs) so it is less likely small businesses will enter the market in future. The department anticipates the number of NEPT licencees will remain stable over the life of these Regulations.

#### Discount rate

In order to consider the cost of the Regulations over their potential life (6 years), the future costs are assessed using a ‘discount rate’. Applying a discount rate to future impacts allows them to be valued in today’s dollars (which, in turn, can be used to compare the costs and benefits of different options on a consistent basis). These amounts are known as the present values of future streams of benefits and costs.

The present value calculation is: PV = Σ Bt/(1+r)t where:

Bt is the benefit (or cost) at time period t

r is the discount rate

t refers to the year in which the benefit/cost impact occurs.

The department’s calculations:

* used a discount rate of 4.0 per cent as recommended by the Victorian Guide to Regulation (noting inflation is running at less than 2%.)
* assumed the number of private NEPT providers in Victoria fall by 40% in year one and then remain stable for the following 5 years. NB: this is not the same as the change or growth in fleet sizes operated by licencees.

## A.2 Use of power lift stretchers and lifting cushions

### Base case - the current Regulations

The current Regulations do not require the use of power lift stretchers or lifting cushions. AV advise that 72 vehicles in total are contracted to AV from licenced NEPT providers and that under the AV contract from 1 July 2019 (phased in over the following three years) these vehicles must use power lift stretchers and lifting cushions.

The costs of continuing to use manual stretchers as measured by preventable injuries to staff is up to $3million per annum as explained in Chapter 4.

### Option A the proposed Regulations

As stated previously the introduction of power lift stretchers and lifting cushions was an election commitment by the Government. The new requirement is expected to have a number of impacts:

* The cost of providing the NEPT service will increase.
* The increased costs are expected to be passed on to hospitals and non-concessional patients.
* One licenced NEPT provider has advised they will exit the industry in Victoria due to the cost of the requirement
* Occupational Health and Safety outcomes are expected to improve

#### Power Lift Stretchers

Currently licenced NEPT operators have 428 vehicles in operation. Of these 289 vehicles are expected to be affected by the proposal.

Total number of NEPT stretcher vehicles operated by licencees – **428**

Total number of stretcher NEPT vehicles contracted to AV – **72 (**contractual requirement by AV to fit vehicles with power lift stretchers)

No. of vehicles to exit the market = **44** (exiting the NEPT market voluntarily or moving to a first aid licence).

Maximum number of non AV contracted stretcher vehicles affected by the proposal is 428 – 72 – 44 = **312.**

Minimum number of non AV contracted stretcher vehicles affected by the proposal is 428 – 356 – 44 = **28**

The number of actual vehicles to be affected by the requirement is between 28 and 312. We have taken the midpoint of **170 vehicles** for the costing calculations.

Cost per power lift stretcher is $40,000 and each stretcher has a 7 year life under normal operating conditions.

If we assume 70% of the vehicles are double stretcher vehicles then the total number of stretchers required is 170 + 119 = 289.

289 x $40,000 = **$11,560,000**

It is proposed to allow a three year transition time for fleets to convert their stretchers to the required ones.

With a 3 year transition period and then replacement in years 8-10 the cost profile (assuming a linear transition) is:

Year 1 (2021) = **$3,853,000**

Year 2 (2022) = **$3,853,000**

Year 3 (2023) = **$3,853,000**

Year 4 (2024) = **0**

Year 5 (2025) = **0**

While the Regulations will not specify that only single stretcher vehicles must be used it is anticipated that 30% of dual stretcher vehicles will be moved to a single stretcher over time. In order to maintain capacity in the sector this will require approximately **50 additional vehicles** at an estimated cost of $130,000. In addition, there are fit out costs of another $30,000 per vehicle.

The cost of additional vehicles is 160,000 x 50 = $8,000,000. Companies would be expected to spread the cost over the life of the vehicle. It is estimated this is a 6 year period so the cost per annum is **$1,333,000**

50 additional crews will also be required to operate the vehicles. The cost of the extra crews is 50 x 2 x $60,000 = **$6,000,000 p.a. ongoing**. It should be noted that 85% of NEPT staff are casual. The salary for the staff includes on costs and assumes a staff member works 25 hours per week.

The total cost therefore is:

Year 1: **$11,186,000,**

Year 2: **$11.186,000,**

Year 3: **$11,186,000,**

Year 4: **$ 7,333,000**

Year 5: **$ 7,333,000**

**Total $48,224,000**

#### Lifting Cushions

Vehicles contracted to AV are already required to carry lifting cushions. ,In addition vehicles expected to exit the market are excluded. 7 Epworth Healthcare vehicles are also excluded as they do not pick up patients from their homes.

This requirement will only apply to those vehicles that collect patients from their homes. A maximum of 305 vehicles will be affected by this requirement. (428 – 72 – 44 – 7 = 305) The actual figure will probably be less.

The Mangar Elk Lifting Cushion costs $3,495.

305 x $3,495 = $1,065,975. The cushions are to be introduced in the first 12 months so the total cost is absorbed in Year 1.

**The total cost is: $11,186,000 + $1,065,975 = $12,251,975 in year 1.**

**$11,186,000 in years 2 and 3**

**$7,333,000 in years 4 and 5**

**Total Discounted Cost Calculations for Powerlift Stretchers and Lifting Cushions**

|  |  |  |
| --- | --- | --- |
| **Year** | **Real Cost** | **Discounted**  **Cost** |
| 1 | 12,251,975 | 12,251,975 |
| 2 | 11,186,000 | 10,775,769 |
| 3 | 11,186,000 | 9,944,313 |
| 4 | 7,333,000 | 6,519,010 |
| 5 | 7,333,000 | 5,572,477 |
|  |  |  |
| **Total** | **$49,289,975** | **$45,063,544** |

## A.3 Limiting NEPT vehicle life

### Base case - the current Regulations

The current Regulations do not mandate vehicle life limits. Therefore, the cost of the existing Regulations is zero.

### Option A the proposed Regulations

There are currently 428 vehicles in the NEPT fleet. Advice provide by licencees indicates that 349 vehicles are already subject to replacement at 400,00km due to company policies. A further 44 vehicles are expected to exit the market.

428 – 349 – 44 = **35** vehicles will be affected by the requirement.

The basic cost of replacing a vehicle including conversion and excluding equipment is $130,000 per vehicle. NB: this does not include the cost of stretchers as these are costed **under section A.2**.

For the purposes of the RIS we have assumed that vehicles would otherwise be operated to 600,000km before replacement. If this is so, the new requirement would increase the vehicle replacement cost by 50% for those affected NEPT businesses.

We have also assumed an even annual replacement program, noting that in reality replacement may be uneven across the years.

Vehicle replacement costs are 35 x $130,000 = **$4,550,000** spread over an assumed 6 year life instead of up to 9 years. Therefore the costs attributable to this new regulation are only those costs associated with changing the vehicles earlier than would otherwise be the case. One third of the replacement cost has been attributed to the bring forward component created by the new regulation on the assumption that the average changeover period for these vehicles otherwise would be 9 years (vehicle life is being reduced by one-third).

So, 33% is attributable to the new Regulation. So, 33% x $4,550,000 / 6 = **$250,250 per annum.**

In addition, there is a $30,000 to fit out each new vehicle so the same formula applies. 35 x $30,000 = $1,050,000 spread over 6 years. Attributing 33% of the cost over the six years is 33% x $1,050,000 / 6 = **$57,750 per annum**

**Total cost is $250,250 + $57,750 = $308,000 per annum or $1,540,000** over the life of the Regulations

The discounted cost calculations are below:

|  |  |  |
| --- | --- | --- |
| **Year** | **Real Cost** | **Discounted**  **Cost** |
| 1 | 308,000 | 308,000 |
| 2 | 308,000 | 296,154 |
| 3 | 308,000 | 273,811 |
| 4 | 308,000 | 243,417 |
| 5 | 308,000 | 208,074 |
|  |  |  |
| **Total** | **$1,540,000** | **$1,329,456** |

### Option B – Limit vehicle life to 7 years

For the purposes of this RIS it is assumed that all of the vehicles currently changed over at 400,000km are changed at an age of less than 7 years. One NEPT provider advised that metropolitan vehicles average 66,000km per year which would mean that at 7 years they have been driven 462,000km. Rural vehicles would be expected to do more kilometres than metropolitan vehicles over a given timeframe.

Therefore, the number of vehicles is the same as Option A which is 35 vehicles. Option B requires the vehicles be changed over one year later than would otherwise occur using the 6 year average life assumed in Option A

Using the assumption above the replacement cost would be spread over one additional year. So the cost attributable to the new regulations is two thirds of Option A.

22% of the cost is attributable to the new Regulation as there is an extra year to spread the cost which is an average of 22% x $4,550,000 / 7 = **$143,000 per annum.**

In addition, there is a $30,000 to fit out each new vehicle so the same formula applies. 35 x $30,000 = $1,050,000 spread over 7 years. So, 22% x $1,050,000 / 7 = **$33,000 per annum**

**Total cost is $143,000 + $33,000 = $176,000 per annum**

**This equals $880,000 over the 5 year life of the Regulations.**

## A.4 Clinical Governance

Almost all NEPT licencees have a degree of clinical governance although the sophistication varies according to the business. To the degree there is clinical governance already in place it is considered a cost of doing business.

### Base case - the current Regulations

The current Regulations do not specify clinical governance requirements. Therefore, the cost of the base case is zero.

### Option A the proposed Regulations

The costing of the proposed Regulations is based on the assumption that there will be 13 remaining providers of NEPT services after the changes to the Act are implemented.

As set out in Chapter 6 the cost of **option A is $602,007 per annum or $3,010,035** over the 5 year life of the Regulations.

**The discounted cost is $2,364,561** over the life of the Regulations

|  |  |  |
| --- | --- | --- |
| **Year** | **Real Cost** | **Discounted Cost** |
| 1 | 602,007 | 547,807 |
| 2 | 602,007 | 578,852 |
| 3 | 602,007 | 535,182 |
| 4 | 602,007 | 475,775 |
| 5 | 602,007 | 406,694 |
|  |  |  |
| **Total** | **$3,010,035** | **$2,584,310** |

### Option B a voluntary Code of Practice

Option B costs would be the same as Option A assuming the Code covers the same matters and the Code is adopted by all NEPT providers. Whether a matter is written into a voluntary code or regulations does not change the cost of implementation to the sector. Option B does reduce the cost to the department as the department would not have any oversight responsibilities.

It is likely that up to 5 providers would not adopt the Code and therefore the cost to the sector would be less than Option A.

## A.5 Staff Training

### Base Case - the current Regulations (the base case)

The base case of the current Regulations does not impose any additional costs.

There is no data on where inadequate staff training has led to poorer patient outcomes and therefore it cannot be quantified or costed.

The cost of the base case is zero.

### Option A - the proposed Regulations

##### 100 hours of clinical supervision for Patient Transport Officers (PTO)

The department has been advised that it costs $8000 - $10,000 to meet 100 hours clinical training requirement for each new PTO.

It is estimated that 155 new PTOs will require clinical supervision annually. We have used the upper estimate of $10,000 to estimate costs.

Therefore, the estimated cost is $10000 x 155 PTOs = **$1,550,000** annually

##### Face to Face training

A range of clinical training will be required to be carried out face to face and assessed for competency achievement. These are:

* Advanced life support,
* Basic life support
* Use of bag valve mask,
* Airway management
* Defibrillation
* Manual handling, and
* Stretcher handling

While this regulation is being proposed to address current gaps, these are matters that should already be trained face to face as standard industry practice. Advice from the sector is that requiring this training to be face to face would incur costs of up to $2,000 per staff member for those organisations not already providing the training face to face. It is not known how many licence holders and staff would be affected so we have estimated one third of licence holders and staff (which is about 600 staff) and so the cost is **$1,200,000 per annum**.

As set out in Chapter 7 the cost of **option A is $14,405,350** over the life of the Regulations.

The discounted cost is **$12,490,624** over the remaining life of the Regulations

|  |  |  |
| --- | --- | --- |
| **Year** | **Real Cost** | **Discounted**  **Cost** |
| 1 | 3,201,350 | 3,201,350 |
| 2 | 2,801,000 | 2,693,269 |
| 3 | 2,801,000 | 2,490,079 |
| 4 | 2,801,000 | 2,213,671 |
| 5 | 2,801,000 | 1,892,255 |
|  |  |  |
| **Total** | **$14,405,350** | **$12,490,624** |

Option B costs are:

Face to Face training $960,000 p.a. or $4,800,000 total

Mental Health training $361,080 in year 1 and $40,800 in years 2-5 giving a total of $524,280

PTO clinical supervision of $1,300,000p.a. or $ 6,500,000.

|  |  |  |
| --- | --- | --- |
| **Year** | **Real Cost** | **Discounted**  **Cost** |

1 2,621,080 2,951,300

2 2,300,800 2,212,308

3 2,300,800 2,045,403

4 2,300,800 1,818,356

5 2,300,800 1,554,338

**Total $11,824,280 $ 10,581,705**

## A.6 Occupational Health and Safety

### Base Case - the current Regulations (the base case)

The current Regulations do not specify any occupational health and safety requirements. All occupational health and safety requirements currently in place exist because of the *Occupational Health and Safety Act 2004* and existing enterprise bargaining agreements.

Therefore, the cost attributable to the Regulations in the base case is zero.

### Option A - the proposed Regulations

The proposed Regulations require the NEPT licencees to have an accredited occupational health and safety plan in operation for the business.

The cost of option A is $258,000 in year one reducing to $138,000 in the following years giving a total cost of $810,000.

The discounted cost is $715,664.

|  |  |  |
| --- | --- | --- |
| **Year** | **Real Cost** | **Discounted Cost** |
| 1 | 258,000 | 258,000 |
| 2 | 138,000 | 132,692 |
| 3 | 138,000 | 122,681 |
| 4 | 138,000 | 109,063 |
| 5 | 138,000 | 93,228 |
|  |  |  |
| **Total** | **810,000** | **715,664** |

1. WHO, Quality of Care, A process for making Strategic Choices in Health Systems, 2006. [↑](#footnote-ref-2)
2. Ambulance Victoria Health and Safety Strategy, 2016-2019. P.10, Figure 2: Claims profile 2013-2015. [↑](#footnote-ref-3)
3. Ambulance Victoria Health and Safety Strategy 2016–2019 [↑](#footnote-ref-4)
4. # Understanding corporate governance of healthcare quality: a comparative case study of eight Australian public hospitals

   [↑](#footnote-ref-5)
5. Royal Australasian College of Surgeons Research & Evaluation, incorporating ASERNIP-S Clinical Governance Frameworks – Report, 2017. [↑](#footnote-ref-6)
6. ‘The Review of Hospital Safety and Quality Assurance in Victoria’ (Department of Health & Human Services, 2016) [↑](#footnote-ref-7)
7. <https://research.aimultiple.com/process-improvement-case-studies/> [↑](#footnote-ref-8)
8. Non-Emergency Patient Transport Regulations 2005 Regulatory Impact Statement, page 1 [↑](#footnote-ref-9)
9. The criteria which must be considered by the Secretary are set out fully in Section 15 of the NEPT Act 2003. [↑](#footnote-ref-10)
10. ACIL Allen Consulting, The Non-emergency patient review final report, 2013 [↑](#footnote-ref-11)
11. , 14 *New Powered Stretchers Lower Paramedic Injuries,* Minister for Ambulance Services, 17 August 2017 [↑](#footnote-ref-12)
12. . [↑](#footnote-ref-13)
13. [↑](#footnote-ref-14)
14. Victorian Health Building Authority website 17 November 2017. [↑](#footnote-ref-15)
15. Data is from the Department survey as reported by respondents. [↑](#footnote-ref-16)
16. 2019 annual reporting data [↑](#footnote-ref-17)
17. Ambulance Victoria Health and Safety Strategy 2016–2019 [↑](#footnote-ref-18)
18. Ambulance Victoria 2017-18 annual report [↑](#footnote-ref-19)
19. In 2019 there were 1770 clinical staff working in the private NEPT sector and 4,400 clinical staff working for AV. [↑](#footnote-ref-20)
20. # Understanding corporate governance of healthcare quality: a comparative case study of eight Australian public hospitals

    [↑](#footnote-ref-21)
21. Royal Australasian College of Surgeons Research & Evaluation, incorporating ASERNIP-S Clinical Governance Frameworks – Report, 2017. [↑](#footnote-ref-22)
22. ‘The Review of Hospital Safety and Quality Assurance in Victoria’ (Department of Health & Human Services, 2016) [↑](#footnote-ref-23)
23. # Understanding corporate governance of healthcare quality: a comparative case study of eight Australian public hospitals

    [↑](#footnote-ref-24)
24. A registered Health Practitioner is a Health Practitioner registered by the Australian Health Practitioner Regulation Agency. Typically in the NEPT setting this will be a Doctor, Division 1 Registered Nurse, or a Paramedic. [↑](#footnote-ref-25)
25. *Evidence scan: Quality improvement training for healthcare professionals*, The Health Foundation, Inspiring Improvement – August 2012, The Health Foundation, London. [↑](#footnote-ref-26)
26. *The superguide: A supervision continuum for nurses and midwives* (Health Education and Training Institute 2013a). Sydney: HETI. [↑](#footnote-ref-27)
27. Ibid [↑](#footnote-ref-28)
28. Driscoll, John. *Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals*, Elsevier Health Sciences, 2006. [↑](#footnote-ref-29)
29. Snowden, et al. *Does clinical supervision of healthcare professionals improve of effectiveness of care and patient experience? A systemic review,* BMC Health Services Research (2017) 17:786 [↑](#footnote-ref-30)
30. *Using clinical supervision to improve the quality and safety of patient care: a response to Berwick and Francis*, Jonathan Tomlinson, BMC Medical Education, 2015 15:103. [↑](#footnote-ref-31)
31. 2018/19 NEPT annual reports [↑](#footnote-ref-32)
32. Journal of Safety Research, Effect of a Nurse Back Injury Prevention Intervention on the Rate of Injury Compensation Claims, Peter J. Martin, Jack T. Harvey, John F. Culvenor, Warren R. Payne [↑](#footnote-ref-33)
33. <https://www.worksafe.vic.gov.au/resources/claims-statistical-report-calendar-year> [↑](#footnote-ref-34)