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| Non-Emergency Patient Transport Review |
| Final report |
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Contents

[Transmittal letter 5](#_Toc167806785)

[Summary 8](#_Toc167806786)

[1. Introduction 15](#_Toc167806787)

[1.1. Background to the review 15](#_Toc167806788)

[1.2. Terminology and scope 17](#_Toc167806789)

[1.3. The role of NEPT 19](#_Toc167806790)

[1.4. The structure of this report 22](#_Toc167806791)

[2. Objectives for Victoria’s NEPT system 25](#_Toc167806792)

[2.1. Patients need accessible, appropriate and timely NEPT services 25](#_Toc167806793)

[2.2. The health system relies on NEPT services to support patient flow 26](#_Toc167806794)

[2.3. Workforces need safe, secure jobs that make appropriate use of their skills 28](#_Toc167806795)

[2.4. Guiding principles for reform of Victoria’s NEPT system 30](#_Toc167806796)

[3. How are NEPT services performing? 31](#_Toc167806797)

[3.1. Quality and safety are improving through regulatory reform 31](#_Toc167806798)

[3.2. Timeliness varies, with unplanned NEPT responses delaying planned services 39](#_Toc167806799)

[3.3. Disparities in costs are primarily due to poorer workforce conditions 44](#_Toc167806800)

[3.4. There are disparities between private and public workforce conditions and limited workforce planning 56](#_Toc167806801)

[3.5. Substantial environmental impacts are not being addressed as a sector 62](#_Toc167806802)

[3.6. NEPT services would benefit from better governance 62](#_Toc167806803)

[4. System design 65](#_Toc167806804)

[4.1. Separation of emergency and non-emergency transports 65](#_Toc167806805)

[4.2. Centralising booking and dispatch 81](#_Toc167806806)

[5. Improved outsourcing 98](#_Toc167806807)

[5.1. The current outsourcing model is poorly designed and not working for stakeholders 99](#_Toc167806808)

[5.2. Simplifying purchasing arrangements by separating planned and unplanned NEPT 101](#_Toc167806809)

[5.3. Regionalised coordination of services to improve scale and fix thin market risks 110](#_Toc167806810)

[5.4. Central intervention to maintain and improve market contestability 115](#_Toc167806811)

[5.5. Social procurement to improve workforce conditions and environmental sustainability 119](#_Toc167806812)

[5.6. Environment and sustainability impacts 124](#_Toc167806813)

[6. Insourcing reform options 127](#_Toc167806814)

[6.1. Insourcing can mitigate some inherent weaknesses of the current NEPT system 128](#_Toc167806815)

[6.2. An insourced model should involve separating planned and unplanned NEPT 133](#_Toc167806816)

[6.3. Insourcing will have significant impacts and would need to be carefully planned 142](#_Toc167806817)

[6.4. Insourcing and outsourcing have some common risks and benefits, and some distinctions 148](#_Toc167806818)

[7. Governance 152](#_Toc167806819)

[7.1. Improving governance 152](#_Toc167806820)

[7.2. Centralised workforce planning 155](#_Toc167806821)

[7.3. Continuous improvement of clinical quality and safety 156](#_Toc167806822)

[8. Bibliography and appendix 160](#_Toc167806827)

[8.1. List of submissions to the review 165](#_Toc167806828)

[8.2. Appendix: Comparison of wages and penalties across providers 167](#_Toc167806829)

# Transmittal letter

The Hon Mary-Anne Thomas

Minister for Health

Minister for Health Infrastructure

Minister for Ambulance Services

22 December 2023

Dear Minister,

I am grateful to have the opportunity to lead the Review of Non-Emergency Patient Transport (NEPT) in Victoria, and I am pleased to submit my final report for your consideration.

The wide-ranging terms of reference of this review have enabled a comprehensive look at NEPT services to assess if they meet the needs of the Victorian community both now and into the future. Informed by contributions from a wide range of stakeholders, the report includes the results of the review, examining procurement arrangements, timeliness of services, workforce, market fragmentation, financial sustainability and connecting Victorians to the right transport.

This review is timely, coming some 30 years after NEPT services were separated from Victoria’s ambulance services and privatised. While these private services have undergone regulatory reform in recent years, this is the first time in the sector’s history that a holistic review has been undertaken to see how well NEPT services are working, and how they can be strengthened.

This review comprises 2 parts. First, it sets out key objectives for Victoria’s NEPT system and evaluates how the system currently performs against them, identifying key priorities for improvement. Second, it describes and evaluates reform options to achieve that improvement.

Throughout the review, I have found Victoria’s NEPT system to have many strengths. Services are delivered by a skilled and dedicated workforce that is performing a pivotal role in ensuring community access to medical care, supporting patient flow across the system and freeing up Ambulance Victoria’s emergency crews to respond to the most time-critical patients. In addition, quality and safety appears to be strengthening since regulatory reforms were enacted in 2021. Patient satisfaction appears to be generally high, and adverse patient safety incidents rare.

Notwithstanding these strengths, throughout the review I have also heard a consistent expectation that the system can and should do better. Patients expect more accessible, appropriate and timely NEPT services, with an experience that is safe, comfortable and caring. Ambulance Victoria is seeking to embed and strengthen the role of NEPT in connecting triple zero (000) callers to appropriate care to improve the availability of emergency ambulances. Hospitals are looking for a streamlined system that is more responsive to their needs and that provides equitable access in rural areas. And NEPT staff consistently expressed a desire to work more strictly within their scope of practice, to have their skills fully used and focused on those who genuinely need NEPT services, and to feel a sense of value from the system that is reflected in fair employment conditions and opportunities for more training and support.

Current commissioning arrangements are a major obstacle to achieving these objectives. The overlapping responsibility of Ambulance Victoria and health services for NEPT purchasing and contract management has led to a model that is fragmented, structurally inefficient and limited in its ability to deliver benefits across the health system. This has resulted in duplicated operational overheads and increased administrative costs. It has increased diseconomies of scale in rural markets, leading to thin supply and contestability risks as evidenced through the high rate of spills of NEPT jobs to emergency ambulance crews in rural areas. This is in part due to poor market design that makes it harder to manage fluctuating demand and reliably fill rosters. Major strategic challenges – such as the industry’s transition to electric vehicles as part of the Victorian Government’s commitment to achieve net-zero emissions – are not being effectively planned for. And the short-term contracts offered to providers by Ambulance Victoria and health services are fuelling workforce insecurity, with approximately 60% of private NEPT staff on casual contracts.

Timeliness of NEPT services has proved to be variable across the sector due to the fragmentation described above. The lack of central coordination of requests and resources has limited Victoria’s ability to maximise the efficiency and productivity of NEPT resources, resulting in inefficient route scheduling and gaps in supply. And while NEPT services perform a critical role in supporting non-urgent triple zero (000) callers, protecting finite emergency capacity, this has been achieved with trade-offs. Of note, unplanned NEPT responses are disrupting and undermining the timeliness of planned NEPT services. This causes delays to patient discharges, appointments and interhospital transfers, contributing to inpatient bed block and ambulance ramping.

Despite the critical role of NEPT workers, there is limited industry-wide planning to support attraction, retention and ongoing development of a skilled and supported workforce, and there are significant disparities between private and public employment conditions. Private workers deliver the bulk of NEPT services but receive lower pay and poorer conditions than their counterparts working for Ambulance Victoria. As noted above, they are also highly casualised, with little security or portability of entitlements when sector contracts change.

In considering NEPT models in other jurisdictions, I have found that the problems seen in Victoria are not inevitable when services are outsourced. Experience elsewhere shows that both outsourcing and insourcing models can work well – or work poorly – depending on how they are set up. As such, I have not made a preferred recommendation about whether insourcing or outsourcing should be pursued. Instead, I have put forward key principles for system design and recommended approaches for both insourcing and outsourcing, depending on which of these options the government prefers.

The 2 principles I have proposed for system design are agnostic of whether services are delivered by public or private entities. First, planned NEPT services should be delinked from emergency ambulance responses, with separate entities responsible for commissioning or delivering the services. This will enable improved focus and specialisation and prevent planned transports from being deprioritised or disrupted by emergency responses, as this undermines their timeliness and efficiency. Experience in other jurisdictions also shows reduced spills to emergency services when emergency and planned responses are separated.

Second, booking and dispatch of planned NEPT resources should be centralised and managed from a whole-of-system view to ensure patients are connected with transport options that are appropriate for their needs, and to tackle inefficient route scheduling, empty return trips and inequitable gaps in supply.

As previously mentioned, and in line with the review’s terms of reference, I have also developed options for improving outsourcing and for partially or fully insourcing services.

Improved outsourcing would involve 4 key changes. First, commissioning of planned and unplanned NEPT would be separated. Second, contracts would be consolidated within areas to improve economies of scale. Third, contestability risks would be offset through government intervention in markets to reduce barriers to entry for new competitors, with specific interventions subject to feasibility. Fourth, social procurement clauses would be strengthened in contracts to improve environmental sustainability and workforce conditions. The latter would be progressed through standardisation of employee pay and conditions for contracted providers, portability of entitlements and requirements for reduced casualisation alongside surety of service volumes to support a more permanent workforce profile. These outsourcing reforms could be pursued in isolation or in conjunction with a partial insourcing approach.

Partial insourcing could see unplanned NEPT services integrated into Ambulance Victoria as part of its broader health emergency response operations. Full insourcing would combine this option with delivering planned NEPT services by the new Victorian Digital Health Command Centre, as part of its broader responsibilities for improving system flow through timely access to health services.

Whether the government decides to pursue insourcing or outsourcing, the system needs stronger stewardship. The NEPT sector needs to be managed as part of the broader health system, with effective measurement and accountability, continuous improvement of clinical quality and safety, and centralised workforce planning.

The above findings, options and recommendations have been guided by engagement with the sector and those who interact with it. I wish to thank patients and carers, NEPT staff and providers, HealthShare Victoria, health services, Ambulance Victoria, Triple Zero Victoria, industrial partners, peak bodies and all other Victorians who have made public submissions, participated in roundtables and otherwise contributed to this review. I would also like to acknowledge the expert support and professionalism of the Department of Health secretariat, and to thank representatives of other jurisdictions who generously shared local expertise and experience to inform the review.

These contributions are integral to assessing how NEPT services work in Victoria. They have helped shape the recommendations and options I present here, which I believe will provide a strong foundation for planning and delivering NEPT services into the future.

Yours sincerely,



**Steve McGhie MP**NEPT Review Lead

Summary

1. Non-emergency patient transport (NEPT) services play a crucial role in Victoria’s healthcare system, ensuring all patients can receive the medical care they need. In 2022 alone, Ambulance Victoria crews and private providers completed more than 407,000 transports.[[1]](#footnote-2) These transports were for patients who were in a stable condition but who needed clinical monitoring and support to attend medical appointments, to be discharged from or transferred between hospitals, or to attend an emergency department for care.
2. These services make a big difference in the lives of Victorians. For example, they allow frail people to see specialists when they might otherwise not be able to travel. They also help to free up hospital beds by transporting stable patients home or to a lower acuity facility – meaning sick people waiting in an emergency department can be admitted to wards sooner. And NEPT services can ensure emergency ambulances are free to reach people with time-critical health needs (such as cardiac arrests) quickly, rather than being tied up with less-urgent cases.
3. In 2022 the Victorian Government made an election commitment to undertake a review of NEPT services, to look at how well NEPT services are working and how they can be strengthened.[[2]](#footnote-3) The review comes some 30 years after NEPT services were split from Victoria’s ambulance services and privatised. It is the first time in the sector’s history that a holistic review has been undertaken to see how well NEPT services are working, and how they can be strengthened.
4. The review found the sector has many strengths. NEPT services are delivered by dedicated people who are passionate about serving patients. The sector is delivering high volumes of transports across the system. It rose to the challenge of the COVID-19 pandemic, providing critical surge support including more than 22,000 transports for COVID-positive patients who needed hospital care.[[3]](#footnote-4)
5. Victoria’s NEPT sector is unique in Australia and possibly the world: it is far from the only example in which planned transports to and from hospitals are delivered privately, but it is one of the only examples where private NEPT operators are contracted to respond to non-urgent triple zero (000) calls.[[4]](#footnote-5)
6. NEPT services perform a vital role in protecting emergency capacity, delivering more than 50,000 triple zero (000) responses a year. These responses are for patients who need clinical monitoring during their transfer to an emergency department but whose conditions are stable and do not require the skills of a paramedic crew or the urgency of an ambulance response. Evidence shows this NEPT service plays a vital role in freeing up Ambulance Victoria’s emergency crews to respond to the most time-critical patients.[[5]](#footnote-6)
7. Only a minority of NEPT services are for triple zero (000) responses, but this work tends to take priority over planned NEPT services for health services. As a result, patient discharges, appointments and interhospital transfers can be deprioritised and delayed. This ultimately has a negative impact for ambulances. Discharge delays create ‘bed block’ within hospitals, leading to ambulances spending longer ramped outside hospitals waiting to off-load patients and reducing their availability for more urgent jobs in the community.
8. While timeliness is a critical issue, across the NEPT sector, safety and quality appear to be strengthening. Adverse patient safety incidents appear rare, in line with the low-acuity nature of these services. And quality and safety have improved considerably since the regulatory reforms enacted in 2021, which made licence holding conditional on meeting clinical and occupational safety standards. This was a crucial step in the sector’s development, which for years after privatisation was regulated under the *Transport Act 1983* and licensed by the Taxi Directorate, despite the clinical nature of the services.
9. The review heard that privatisation in 1993 was explicitly aimed at achieving cost savings and efficiencies by introducing competition to the sector and weakening union control. In this regard, it has only partially succeeded. Costs are lower as intended, largely due to lower pay and conditions for the private NEPT workforce. Today, approximately 60% of the workforce is on casual contracts.[[6]](#footnote-7) But the system is structurally inefficient, with unnecessarily complex purchasing arrangements, fragmented delivery approaches, underutilisation of modern technology and limited reform to drive efficiency.
10. The review heard a consistent expectation that the system can and should do better. Patients expect accessible, appropriate and timely services to access the care they need, with an experience that is safe, comfortable and caring. Ambulance Victoria wants to maintain and strengthen the critical role of NEPT in preserving emergency resources. Health services want improved timeliness of services from a system that is genuinely responsive to their needs, and which provides equitable and affordable access in rural areas. NEPT private providers want sustainable contracting arrangements. And the workforce wants to use their skills, work within their scope of practice and to feel a sense of value from the system that is reflected in fair working conditions.
11. In exploring potential reform options, the review found that the problems seen in Victoria are not inevitable under an outsourcing model. The experience of other jurisdictions shows that both outsourcing and insourcing can work well – or work poorly – depending on how they are set up. As such, the review proposes key principles for system design that apply regardless of whether services are delivered by public and private entities, along with recommended approaches to insourcing and outsourcing, depending on which reform direction the government decides to pursue.
12. First among the recommended system design principles is structural separation of emergency and non-emergency transports. Evidence shows clearly that both NEPT and ambulance services perform better when planned transports for health services and emergency responses for ambulance services are structurally delinked, with separate entities responsible for commissioning or delivering them.[[7]](#footnote-8) This separation enables improved focus and specialisation for both entities and prevents emergency responses from disrupting planned transports and thus undermining timeliness and efficiency.
13. Applied locally, this principle means that Ambulance Victoria should remain responsible for NEPT services that respond to triple zero (000) demand, in line with its core organisational focus on responding to people with time-critical medical emergencies. It should not be involved in procuring or delivering planned NEPT transports for health services.

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| **Recommendation 1**: Planned and unplanned NEPT services should be separated, with Ambulance Victoria retaining responsibility for unplanned NEPT in line with its core organisational focus on serving people with time-critical emergencies. Planned NEPT should be managed separately to prevent its disruption by unplanned NEPT and to ensure timely patient flow into and out of healthcare facilities. |

1. Without central coordination of requests and resources, Victoria’s NEPT system does not leverage opportunities to ensure appropriate use of NEPT services across the health system and tackle inefficient route scheduling, empty return trips and gaps in supply. In contrast, all jurisdictions the review considered either had in place or were actively implementing centralised booking and dispatch systems. These systems streamline the booking process and allow for automatic central review of requests. This ensures patient eligibility and matches them with the most suitable transport option for their specific needs. Additionally, the dispatch systems use a comprehensive view of all bookings and resources to schedule pick-ups and coordinate routes. This minimises travel time and maximises the efficiency and productivity of NEPT resources.
2. Centralised booking and dispatch in Victoria would resolve much of the current fragmentation and inefficiency. The review recommends implementing this, regardless of whether insourcing or outsourcing is pursued. In designing this function, separation between planned and unplanned NEPT resources must be maintained (per Recommendation 1), with no ongoing spill over between the two. There should also be no conflict of interest between those responsible for booking and dispatch and those responsible for delivering NEPT services.
3. In line with these principles, Triple Zero Victoria[[8]](#footnote-9) should remain responsible for booking and dispatch of unplanned NEPT, in line with its role in triple zero (000) responses. A separate public entity should be responsible for booking and dispatch of planned NEPT services. The nature of the preferred entity will depend on whether outsourcing or insourcing is pursued.

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| **Recommendation 2**: Centralised booking and dispatch of NEPT resources should be introduced. This should be delivered by a public entity that does not have a conflict of interest between dispatching and delivery decisions. The entity should be accountable to both the Department of Health and health services for timely delivery of planned NEPT services.  Key minimum functions of centralised booking and dispatch should include:  a whole-of-system view and management approach to NEPT resources, enabling a more efficient approach to scheduling routes  algorithmic coordination of planned NEPT routes, with certainty of collection times provided to optimise flow, timeliness and efficiency  upgraded technology to track vehicles and communicate arrival times to patients and health services  web-based booking forms that securely integrate with health service patient information systems for efficiency  eligibility screening embedded in web bookings, with ineligible requests redirected to appropriate transport options. |

1. In considering alternative outsourcing models, the review found there is significant scope to improve existing procurement arrangements. Under the current model, there is overlapping responsibility for procurement of planned NEPT services between health services (supported by HealthShare Victoria) and Ambulance Victoria, with responsibility depending on the patient and direction of their transport. This creates significant duplication of procurement and contract management processes, which increases booking complexity and administrative costs, and can lead to poor contracting outcomes. Fragmented contracts create diseconomies of scale for rural areas in particular, leading to thin supply and contestability risks. High ease of provider contract termination makes it easier for health services to switch providers but entrenches NEPT workforce casualisation. The purchasing power of government is not used to address these issues by contractually stipulating better workforce conditions and progressing broader goals such as environmental sustainability.
2. To address these issues, if outsourcing reform is pursued, it should involve 4 key strategies. First, purchasing arrangements should be simplified by separating commissioning of planned and unplanned NEPT services. Second, there should be centralised strategic commissioning of services to consolidate contracts within areas, reducing diseconomies of scale and thin market risks. Third, there needs to be government intervention in the market to improve contestability and mitigate risks from contract consolidation, with specific interventions subject to feasibility. And fourth, contracting should involve social procurement clauses to improve workforce conditions and environmental sustainability.
3. These outsourcing reform options will go a long way towards improving outcomes from performance through greater efficiency, contestability and equity of access. They will also create a mechanism for pursuing broader social goals through procurement, ensuring a fairer deal for the workforce delivering NEPT services. Importantly, they can be achieved with relatively limited sector disruption, modest short-term investment and the potential for longer term savings.

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| **Option 1**: If NEPT services remain outsourced, the existing model can be improved by:  separating commissioning of planned and unplanned NEPT services, in line with Recommendation 1  centralised strategic commissioning of services to consolidate contracts within areas, improving economies of scale and addressing thin market risks  central intervention to maintain and improve market contestability and mitigate risks from contract consolidation, with specific interventions guided by feasibility assessment  social procurement to improve environmental sustainability and workforce conditions, with the latter progressed through standardisation of employee pay and conditions for contracted providers, portability of entitlements and requirements for reduced casualisation alongside surety of service volumes to support a more permanent workforce profile. |

1. However, outsourcing may not provide a complete solution to all issues raised during the review. Outsourcing will involve ongoing coordination costs including regulation, oversight, procurement and contract management. Consolidating contracts within areas will improve economies of scale, but this will create contestability risks that will require careful management and potential investment to offset. Centralised strategic commissioning will require capability in the responsible entity that current commissioners of NEPT may not have or not actively use. It will also require detailed design of governance and accountabilities in consultation with health services. Disparities in workforce pay and conditions will persist, albeit to a smaller extent than currently. And Victoria will need a new model for delivering unplanned NEPT, one that would not disrupt planned NEPT services for hospitals as well as making the best use of workforce skills within their scope of practice.
2. Insourcing reform provides another way to address some of these problems. Consolidating services and delivery through a public entity would resolve fragmentation and thin market risks, improving service efficiency and performance. Delivering services through a public entity would also resolve workforce casualisation and improve pay and conditions while facilitating coordinated investment and transition planning across unplanned and planned NEPT services to improve environmental sustainability.
3. As noted above, insourced NEPT delivery can work well or poorly, depending on system design. To maximise the benefits and mitigate the risks of insourcing, planned services and emergency responses must be structurally separated in line with their distinct functions, per Recommendation 1 above.
   1. NEPT responses to non-urgent triple zero (000) calls would be best delivered by Ambulance Victoria, with booking and dispatch provided by Triple Zero Victoria in line with its responsibility for delivering emergency responses.
   2. Booking, dispatch and delivery of planned NEPT services for hospitals would be best provided by the new Victorian Digital Health Command Centre (VDHCC), as part of its broader responsibilities for optimising patient flow across the health system. Under an existing government commitment, the VDHCC will be designated as the central point of authority for streamlining patient flow across the Victorian health system, with a mandate to work with health services to improve flow and enable better health service delivery.
4. A partial insourcing approach could be pursued. This would focus on insourcing of unplanned NEPT responses to Ambulance Victoria, with planned NEPT services for hospitals continuing to be delivered by private licensed NEPT providers, albeit under the reformed outsourcing model described above.

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| **Option 2a**: If NEPT services are insourced, the preferred arrangement for unplanned NEPT is booking and dispatch of unplanned non-emergency patient transports continue to be provided by Triple Zero Victoria and service delivery to be provided in-house by Ambulance Victoria, enabling full integration of unplanned non-emergency patient transports into broader statewide health emergency response operations.  **Option 2b**: If NEPT services are insourced, the preferred option is for the Victorian Digital Health Command Centre to be responsible for the following functions, as part of its broader responsibilities for improving health system flow through timely access to health services:  booking, dispatch and in-house delivery of all planned road NEPT services  centralised commissioning and booking of all non-medical transport services.  Booking of planned Air NEPT services should be informed by a feasibility study undertaken to identify how responsibilities for commissioning and delivering Air NEPT services should best be structured across the system, if insourcing of planned services occurs. |

1. Insourcing has some strategic advantages relative to outsourcing. For example, it will maximise economies of scale for planned NEPT services and it will strengthen clinical governance for unplanned NEPT responses through closer integration with Ambulance Victoria’s broader emergency response operations. But insourcing also has distinct risks including immense implementation complexity and service disruption risks during the transition, as well as higher implementation and operating costs. These relative benefits and risks need to be weighed carefully and considered in the context of broader health system priorities.
2. As such, the review does not provide a direct recommendation to pursue either insourcing or outsourcing reform options, given the weight of evidence and stakeholder input suggests that both options can work well. The review instead offers recommended models for insourcing and outsourcing, with their relative costs, benefits, opportunities and trade-offs to inform the Victorian Government’s decision.
3. Whether the government pursues insourcing or outsourcing, the system will require stronger governance and coordination.
4. Objectives for NEPT need to be clarified, and the system needs to be integrated into existing health system strategies. This should include performance and accountability frameworks that appropriately reflect roles, responsibilities and objectives for each party involved. It should also include improved collection and use of data to measure system-wide performance, and a fit-for-purpose funding model that achieves better value from funding.
5. Improved system stewardship should also include continuous improvement of clinical quality and safety across the sector. There is a need to affirm and provide confidence to stakeholders that NEPT responses, including those to triple zero (000) callers, are safe, and that regulatory reforms are delivering on objectives, and whether adjustments to regulations and/or policy are warranted.
6. Centralised workforce planning within the NEPT sector and across the broader patient transport industry must also play a role in future system stewardship. This is currently limited, resulting in service gaps and missed opportunities to better leverage the skills of workers transitioning into and out of emergency work.

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| **Recommendation 3:**  Whether NEPT services are insourced or outsourced, expectations, roles and responsibilities for NEPT services need to be clearly articulated. This requires:  greater integration of the NEPT sector into broader health system frameworks and governance  monitoring of NEPT system performance and patient experience of services to inform performance accountability and continuous system improvement  the NEPT workforce to be reflected in system workforce strategies, with a dedicated NEPT workforce plan that identifies current workforce needs and develops patient transport workforce strategies that meet future health system needs  embedded continuous improvement of quality and safety, with monitoring of patient experience and expert clinical input. |

1. As this summary shows, the NEPT system could be much better positioned to meet the needs of the Victorian community now, and into the future. Achieving this will require significant reform, investment and a staged implementation process spanning multiple years, as experience in other jurisdictions has shown.[[9]](#footnote-10)
2. This will enable NEPT services to better meet the needs of all stakeholders, delivering a better experience for patients; providing a more timely and reliable service for health services as well as Ambulance Victoria; and compensating staff with fairer conditions and secure employment.

# Introduction

## Background to the review

### Election commitment

1. It is vital for Victorians to have ready access to health care. This can only occur if there are safe, effective and appropriate transport options available for patients who need them.
2. Non-emergency patient transport (NEPT) services play a crucial role in supporting patients to access care, and they need to operate as effectively as possible. On 18 November 2022 the Victorian Government made an election commitment to review the existing procurement arrangements for NEPT services to explore what has been working and what could be done better.
3. The review was to be led by Member for Melton Steve McGhie, with a final report to be presented to the Victorian Government for consideration by the end of 2023.
4. The review aimed to assess whether outsourcing is the most effective model for NEPT services. It also sought to identify opportunities to get more value out of the system and improve experiences for patients and staff.

### Terms of reference

1. The terms of reference outline the review’s scope. The scope of the review was widened beyond the election commitment’s initial focus on procurement arrangements to allow for a more comprehensive look at what is needed to ensure NEPT services meet community needs now and into the future. This included reviewing procurement arrangements, the timeliness of services, workforce skills, fragmentation, financial sustainability and ways to better connect Victorians to the right transport.[[10]](#footnote-11)
2. These wide-ranging terms of reference allowed the review to take a comprehensive look at NEPT services to ensure they meet the current and future needs of the Victorian community.
3. The terms of reference are to:
   1. review the performance of NEPT in Victoria, defined as the timeliness, efficiency, safety and quality of public and private NEPT delivered for public health services, public hospitals and Ambulance Victoria (AV)
   2. commission and oversee independent expert contractors to analyse and compare the total costs, benefits, feasibility, financial sustainability and broader workforce and community impacts of potential alternative procurement strategies including (but not limited to):
      1. revising current procurement arrangements to reduce fragmentation, increase operational flexibility and improve workforce pay and conditions
      2. replacing current procurement arrangements with an insourced delivery model, such as bringing NEPT services within AV, or within an alternative or new public provider
   3. identify more strategies beyond procurement to improve sector performance including by improving route efficiency and resource allocation, reviewing clinical practice protocols, supporting appropriate service use, more fully leveraging workforce skills and better aligning supply with demand
   4. consider how the Department of Health can best use its governance, planning, regulatory and commissioning levers to optimise the performance of the NEPT sector
   5. develop recommendations on how to optimise performance by the NEPT sector in the short term and to position it to better meet the needs of the Victorian community in the future
   6. release an early discussion paper and call for public submissions from stakeholders responding to these issues
   7. provide regular progress updates and a final report by the end of December 2023 to the Minister for Ambulance Services.
4. The terms of reference further directed the review to:
   1. provide recommendations that endeavour to achieve practical, prioritised, efficient and sustainable outcomes that enhance the lives of people who currently (or in future will) use Victoria’s public health system
   2. consult with a range of stakeholders including patients, carers, community representatives and workforce representatives (including relevant unions, staff of public health services and public hospitals, and AV and NEPT providers).

### Consultation

1. In line with the terms of reference, the review completed extensive stakeholder consultation that included more than 12 roundtables and 33 public submissions. This included engaging with:
   1. representatives of public entities involved in the commissioning, procurement, delivery and coordination of NEPT services (including AV, HealthShare Victoria [HSV], Triple Zero Victoria [TZV] and metropolitan, regional and rural public health services)
   2. private NEPT providers (including those contracted to deliver public NEPT services and those otherwise interested in the review)
   3. Victoria’s peak health consumer agency, the former Health Issues Centre, which was commissioned to develop an independent submission on behalf of patients, carers and community representatives to the review. This was informed by conversations with 22 consumers representing a wide range of ages, lived and living experiences of ill health, harm and recovery and of demographics and use of NEPT services
   4. the NEPT workforce and their representatives, with in-camera roundtables held with staff delivering NEPT services for private providers and AV, and meetings with the Victorian Ambulance Union and Ambulance Employees Australia – Victoria.
2. In addition, the review released a discussion paper on 31 May 2023, with the aim of collecting suggestions from a range of stakeholders on practical solutions for improving NEPT services. The discussion paper outlined existing arrangements, system performance, key challenges and options for sector reform. It invited public submissions responding to the paper and the 28 questions it posed to guide contributions.
3. These submissions responding to the discussion paper, along with wider consultation and commissioned technical expertise, informed the final review report and recommendations. They are cited throughout.

### Independent expert modelling advice

1. In line with the terms of reference, independent expert contractors were commissioned to analyse and compare the total costs, benefits, feasibility, financial sustainability and broader workforce and community impacts of potential alternative procurement strategies including:
   1. revising current procurement arrangements to reduce fragmentation, increase operational flexibility and improve workforce pay and conditions
   2. replacing current procurement arrangements with an insourced delivery model, such as bringing NEPT services within AV, or within an alternative or new public provider.
2. Deloitte Australia completed this work, leveraging subject matter expertise in health system strategy, procurement and financial modelling, and NEPT reform in other jurisdictions.
3. The key output of this work was financial modelling to show the relative potential costs of a spectrum of service reform options including full outsourcing of NEPT booking, dispatch and delivery; hybrid models involving a combination of insourced booking and dispatch and outsourced delivery; and options involving full insourcing of these functions.

## Terminology and scope

### NEPT services

1. NEPT services are for patients who require transport (either via road or air) to, from and between health services.[[11]](#footnote-12) An authorised health professional[[12]](#footnote-13) has assessed these patients before their transport as meeting key eligibility criteria.
   1. These include needing clinical monitoring during transport (and/or having reduced mobility, which requires stretcher transport) but not needing a time-critical ambulance response or being in a condition that is not likely to deteriorate or become time-critical during transport.[[13]](#footnote-14)
   2. Box 1 sets out examples of NEPT-eligible patients.

Box 1: Who uses NEPT services?

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| --- |
| People from all over Victoria rely on safe, timely and affordable NEPT to access public health services. Common user examples include:  a frail patient from rural Victoria who needs to travel to a specialist hospital in Melbourne but cannot make the long journey by road and must be transported and cared for by Air NEPT  a patient who has recently suffered a heart attack, is now stable, and is being transferred from their local treating hospital to another hospital for specialist care  an aged care facility resident who needs to attend a specialist appointment at their local hospital but can only be transported lying down and so cannot safely travel seated in a taxi or facility van  a patient who has had a severe infection and needs to be expertly managed with complex infusions while travelling from a regional hospital to a specialist hospital in Melbourne. |

### Planned and unplanned NEPT

1. This report uses the terms ‘planned’ and ‘unplanned’ to distinguish between 2 kinds of NEPT transfers.
2. ‘Unplanned NEPT’ refers to services that typically originate from triple zero (000) calls from the community that are identified as lower acuity and less urgent and directed to a NEPT response.[[14]](#footnote-15)
3. ‘Planned NEPT’ refers to transfers typically booked by health services to transfer people between hospitals, from hospitals back to the community or from the community to specialist appointments.[[15]](#footnote-16)
4. These transports may be booked on the day of transport or in advance. They are for patients who an authorised health professional[[16]](#footnote-17) has assessed in-person as appropriate for NEPT.

## The role of NEPT

1. NEPT is a significant industry in Victoria. Every year, health services and AV spend about $173 million on NEPT services. This funds more than 407,000 transports a year, 91.4% of which are delivered by the private sector, which employs just under 1,700 frontline workers.[[17]](#footnote-18)
2. NEPT plays a vital role in getting Victorians to public health services[[18]](#footnote-19) and in supporting health system capacity more broadly.[[19]](#footnote-20)

### Workforce

1. Victoria’s NEPT workforce plays an essential role in the patient journey by supporting patients to move safely and comfortably between health services and the community.
   1. The size of the frontline workforce is significant, with around 1,342 fulltime-equivalent (FTE) positions from 1,767 staff.[[20]](#footnote-21)
   2. This includes around 1,183 patient transport officers, 488 ambulance attendants, 58 enrolled and registered nurses and 38 critical care nurses (Table 1).[[21]](#footnote-22)
2. This is a significant workforce. By way of comparison, AV currently employs around 5,005 on-road clinical staff.[[22]](#footnote-23)
3. The workforce is mostly employed by private providers, who deliver the bulk of NEPT services in Victoria.[[23]](#footnote-24) AV directly employs just under 4% of NEPT workers (around 69) across NEPT and clinic transport services.[[24]](#footnote-25)
4. There is no standardised enterprise agreement for the private NEPT workforce. Most workers are employed on casual contracts, with varying pay and conditions.

### Regulations

1. The Department of Health is the steward of Victoria’s health system and has a range of levers at its disposal to manage and shape the system.
2. The department’s regulatory powers are based on three instruments: the Non-Emergency Patient Transport and First Aid Services Act 2003 (the Act), the Non-Emergency Patient Transport Regulations 2016 (the Regulations) and the *Non-Emergency Patient Transport Clinical Practice Protocols* 2023 edition.
3. With these powers, the department determines who can provide NEPT services by granting NEPT licences,[[25]](#footnote-26) and the regulatory framework prescribes standards for NEPT services. This includes the minimum and maximum patient acuity that can be serviced with NEPT, how patients are transported and vehicles staffed, accreditation and quality assurance, vehicles and equipment, and infection control.
4. To ensure the safety of both the NEPT workforce and patients using NEPT services, regulations require the workforce to have appropriate skills, competencies and knowledge, including ongoing training and professional development. This includes a core set of capabilities such as patient assessment and the principles of trauma care, as well as safely administering certain controlled medicines.[[26]](#footnote-27)
5. Beyond these core capabilities, the level of qualifications and required skill set for NEPT workers varies depending on the classification of the role outlined in Victoria’s *NEPT clinical practice protocols* (Table 1). The minimum staffing requirements for NEPT differ by patient acuity and transport platform and are determined by the Regulations and *Clinical practice protocols*(Table 2).

Table 1: NEPT workforce minimum qualifications[[27]](#footnote-28)

| Classification | Minimum professional qualification |
| --- | --- |
| Patient transport officer (PTO) | Certificate III in Non-Emergency Patient Transport |
| (Endorsed) enrolled nurse division 2 (EN/EEN) | Diploma of Nursing (or equivalent) |
| Ambulance transport attendant (ATA) | Diploma of Emergency Health Care (or equivalent) |
| Registered nurse division 1 (RN1) | Bachelor of Nursing (or equivalent) |
| Critical care registered nurse | Bachelor of Nursing and postgraduate certificate and experience in a critical care area |

Note: The minimum professional qualifications may have equivalents.

Table 2: NEPT crew-mix requirements[[28]](#footnote-29)

| Acuity | Minimum crew member required to travel in patient compartment |
| --- | --- |
| Low | PTO |
| Medium | ATA (unplanned ambulance or interfacility transport)  EN/EEN (interfacility transport or, if trained and endorsed, unplanned ambulance)  RN1 (interfacility transport or, if trained and endorsed, unplanned ambulance) |
| High | CCRN |

### Multiple purchasing arrangements and multiple providers

1. The department does not directly purchase NEPT services. Instead, it funds AV and public health services, who may then use the funding to contract NEPT services.
   1. AV receives funding from the Department of Health for both emergency (ambulance and air ambulance) and non-emergency (NEPT and other) services.
   2. Health services receive activity-based funding from the department to cover all the costs associated with patient care including transport.
2. HSV is responsible for procurement and contracting negotiations on behalf of all health services. This maximises their collective purchasing power and achieves greater value in purchasing a range of goods, services and equipment that health services need, including NEPT.
   1. HSV has established a statewide contract with a panel of 8 NEPT providers.
3. In total, 10 private providers are licensed to deliver NEPT services in Victoria, with a fleet of approximately 432 stretcher vehicles.[[29]](#footnote-30) 
   1. Of the 10 private providers, AV contracts 6, while public health services (under the HSV panel arrangements) contract 8 providers.[[30]](#footnote-31)
4. AV delivers some NEPT services in-house (approximately 8.6% of the total volume they are responsible for), as do some health services.[[31]](#footnote-32) AV has a default role as the provider of last resort in the absence of the private market.[[32]](#footnote-33)
5. This means that most health services must book transfers for patients through 2 different mechanisms, depending on who is purchasing the transfer.
   1. For transfers purchased by health services, they are booked directly with private providers, which have their own call-taking and dispatching arrangements.
   2. When AV is responsible for triaging NEPT, health services book the transfer through TZV[[33]](#footnote-34) using either an online booking form[[34]](#footnote-35) or a ‘1300’ number for same-day bookings and patients with mental health needs.

### Scope of this review

1. The primary focus of this review is road-based NEPT services because these make up around 99% of all NEPT transports. However, the review also considers the intersections between road and air-based services and the implications of key reform options for the latter.
2. While non-medical transport options such as taxi services and volunteer-based community transport services are not the primary focus of this review, the report considers the intersections between these services and NEPT. It also considers options to make better use of taxi services for patients who need support to access health care but do not need a NEPT response.

## The structure of this report

1. This report has 2 parts:
   1. Chapters 2 and 3 set out key objectives for Victoria’s NEPT system, evaluate how the system currently performs against them and identify key priorities for improvement.
   2. Chapters 4, 5, 6 and 7 describe and evaluate reforms to achieve that improvement.
2. In developing these reforms, the review explored options and weighted their relative evidence and feasibility. Where there was robust evidence that a reform would improve the status quo to a greater extent than alternative options might, and with a level of investment and/or legislation change that was likely to be considered feasible, the reform was put forward as a recommendation.
3. Where there was clear evidence that a reform would improve the status quo, but not necessarily more or less than alternative reforms could, and where the level of investment and/or legislation change was also likely to require challenging trade-offs and prioritisation, the reform was put forward as one of several options for government to consider.
4. Table 3 summarises the report’s recommendations and options.

Table 3: Summary of recommendations and options

| Rec # | Recommendation or option | Chapter |
| --- | --- | --- |
| **R1** | Planned and unplanned NEPT services should be separated, with Ambulance Victoria retaining responsibility for unplanned NEPT in line with its core organisational focus on serving people with time-critical emergencies. Planned NEPT should be separately managed to prevent disruption by unplanned NEPT and to ensure timely patient flow into and out of healthcare facilities. | 4 |
| **R2** | Centralised booking and dispatch of planned NEPT resources should be introduced. This should be delivered by a public entity that does not have a conflict of interest between dispatching and delivery decisions. The entity should be accountable to both the Department of Health and health services for timely delivery of planned NEPT services.  Key minimum functions of centralised booking and dispatch should include:   1. a whole-of-system view and management approach to NEPT resources, enabling a more efficient approach to scheduling routes 2. algorithmic coordination of planned NEPT routes, with certainty of collection times provided to optimise flow, timeliness and efficiency 3. upgraded technology to track vehicles and communicate arrival times to patients and health services 4. web-based booking forms that are securely integrated with health service patient information systems for efficiency 5. eligibility screening embedded in web bookings, with ineligible requests redirected to appropriate transport options. | 4 |
| **O1** | If NEPT services remain outsourced, the existing model can be improved by:   1. separating commissioning of planned and unplanned NEPT services, in line with Recommendation 1 2. centralised strategic commissioning of services to consolidate contracts within areas, improving economies of scale and addressing thin market risks 3. central intervention to maintain and improve market contestability and mitigate risks from contract consolidation, with specific interventions guided by feasibility assessment 4. social procurement to improve environmental sustainability and workforce conditions, with the latter progressed through standardisation of employee pay and conditions for contracted providers, portability of entitlements and requirements for reduced casualisation alongside surety of service volumes to support a more permanent workforce profile. | 5 |
| **O2a** | If NEPT services are insourced, the preferred arrangement for unplanned NEPT is for booking and dispatch of unplanned NEPT to continue to be provided by Triple Zero Victoria and service delivery to be provided in-house by Ambulance Victoria. This would enable full integration of unplanned non-emergency patient transports into broader statewide health emergency response operations. | 6 |
| **O2b** | If NEPT services are insourced, the Victorian Digital Health Command Centre should be responsible for the following functions, as part of its broader responsibilities for improving health system flow:   * booking, dispatch and in-house delivery of all planned road NEPT services * centralised commissioning and booking of all non-medical transport services.   Centralised booking of planned Air NEPT services should be informed by a feasibility study undertaken to identify how responsibilities for commissioning and delivering Air NEPT services should best be structured across the system, should insourcing of planned services occur. | 6 |
| **R3** | Whether NEPT services are insourced or outsourced, expectations, roles and responsibilities for NEPT services need to be clearly outlined. This requires:   * greater integration of the NEPT sector into broader health system frameworks and governance * monitoring of NEPT system performance and patient experience of services to inform performance accountability and continuous system improvement * the NEPT workforce to be reflected in system workforce strategies, with a dedicated NEPT workforce plan that identifies current workforce needs and develops patient transport workforce strategies that meet future health system needs * embedded continuous improvement of quality and safety, with monitoring of patient experience and expert clinical input. | 7 |

# Objectives for Victoria’s NEPT system

1. This chapter provides an overview of the core objectives of NEPT services for patients, the workforce and the public health system more broadly. Subsequent chapters assess how the system is performing against these objectives and identify key priorities for improvement (chapter 3). They also describe and evaluate reforms to achieve that improvement (chapters 4, 5, 6 and 7).

## Patients need accessible, appropriate and timely NEPT services

1. NEPT services play a vital role in supporting Victorians to access health services. Without them:
   1. Patients who need help with transport to access health care, but not a lights-and-sirens ambulance response, could face long waits.
   2. Patients who need non-urgent clinical assistance during travel would have to be transported either by ambulance (at a higher cost) or a non-clinical transport service (which does not provide the required level of care).[[35]](#footnote-36)
   3. Patients would have to make their own arrangements, with the potential for some to miss out on care due to prohibitive costs or gaps in service availability, particularly for patients living in rural Victoria or requiring regular transports to care.
2. NEPT services are about more than getting patients from A to B. The experience of services matters too (refer to Box 2). Consumer views canvassed by the review highlighted the importance of the following:
   1. Physical and psychological safety – being supported to move from and into your home when needed, feeling physically secure during the transport, and having confusion and anxiety responded to through communication from a skilled workforce.
   2. Clinical care – receiving skilled and competent care that addresses your needs during transport, with rapid escalation to appropriate backup support if your condition deteriorates.
   3. Communication – receiving information in a way that accommodates needs (for example, considering vision and hearing impairments, language, literacy and technology access), that advises of arrival times (both upfront and when they change), that helps you prepare for your transport before it arrives, and that involves active seeking of consent and collaboration throughout the process.
   4. Timeliness – minimising wait times and multiloading on vehicles, when these lead to you missing appointments, experiencing prolonged and untreated pain and discomfort, or being without food or water for several hours.
   5. Accessibility – with services available when they are needed, affordable for service users, and appropriately designed for patients with mobility issues.
   6. Respect – feeling seen, heard and respected by staff who adopt a warm, empowering and affirming approach to delivering the service; and ensuring the service is respected by patients without clinical monitoring or mobility needs so it is available for those who have genuine need.[[36]](#footnote-37)

Box 2: Patient and carer objectives for NEPT services are about more than just access

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| ‘[NEPT is] a vital service that is not a taxi.’  ‘When they tune in to what you need, ask you about your needs and capabilities, listen to what you’re saying – it reduces the degree of panic you might be having. [It’s about] paying attention and modifying behaviour around what you have said.’  ‘[We need] more loving services.’  ‘A friend’s condition meant she had issues with incontinence. If she had an accident before the NEPT came, they would change their route and pick her up later to give her a chance to change – that was so important for her dignity. [Hospital] arranged this and gave a really good handover to NEPT.’  ‘Before you take over, please ask me.’  – Consumer views collected through the former Health Issues Centre community conversations |

## The health system relies on NEPT services to support patient flow

1. NEPT plays an important role in supporting the health system. It enables all patients – not just NEPT users – to access care faster. This occurs in 2 important but distinct ways:
2. Unplanned NEPT protects ambulance capacity by absorbing some triple zero (000) requests where safe and appropriate, which enables AV’s paramedic crews to focus on emergency cases that require time-critical medical attention.[[37]](#footnote-38)
3. As Box 3 shows, emergency service stakeholders see this function as crucial and one that needs to be upheld and strengthened by the review. As AV’s submission indicates, it also sees signficant potential to further grow the role of unplanned NEPT to respond to increasing emergency demand, including as a result of reforms arising from the Royal Commission into Victoria’s Mental Health System.

Box 3: NEPT services play a vital role in the emergency response system

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| ‘NEPT services are an essential component of healthcare delivery, facilitating the movement of patients between health services, hospital emergency departments, specialist facilities, community services, and their residential location. NEPT is also increasingly vital to the provision of effective emergency response … for lower-acuity patients presenting via Triple Zero and as a supplement to emergency ambulance response during major incidents ...’  – Ambulance Victoria  ‘The ever-increasing demand for services is a challenge for health services, as is the ability to resource the necessary supply of staff to meet this demand. As such, AV hopes that recommendations on a future procurement model for NEPT allows for the retention of flexibility in the deployment of NEPT resources to support emergency ambulance operations.  AV is taking on a significant workload associated with the delivery of a health-led response to mental health crises …. This is an area that AV has significantly increased responsibility and this will require an uplift in workforce planning and paramedic skill sets, even if activity is unlikely to require a traditional lights-and-sirens response. Flexibility in the use of NEPT resources provides the opportunity to manage part of that additional demand without having to use emergency ambulance resources.’  – Ambulance Victoria  ‘[NEPT] provides clinical transport for patients too infirm or ill to be safely transported using general transport. It is a frontline pre-hospital health service supporting emergency ambulance hospitals, and aged care.’  – Victorian Ambulance Union |

1. Planned NEPT protects hospital capacity. In particular, NEPT-facilitated patient transfers and discharges play a vital role in freeing up beds. This improves system-wide efficiency and increases the operational capacity and timeliness of health services.
2. As Box 4 shows, health service stakeholders see this function as essential to their own performance. They also said it needs significant strengthening – particularly for rural health services, which report challenges in securing reliable and affordable services.[[38]](#footnote-39)

Box 4: Health services see planned NEPT as critical to their own performance

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| ‘NEPT can significantly impact service flow.’  – Victorian Healthcare Association  ‘NEPT is a critical service for patient experience and care, and the operational management of access and flow.’  – Western Health  ‘… NEPT transfers from hospitals play a vital role by freeing up beds and reducing discharge delays … if a transfer is delayed … [t]his delays the process of turning the patient’s bed over … As a result, the hospital experiences a series of cascading delays in reallocating the bed – and patients end up waiting on trolleys in corridors, receiving care in a suboptimal environment.’  – Alfred Health  ‘[NEPT is] a very important part of our health system that does greatly affect our rural setting.’  – Central Highlands Rural Health  ‘[Rural health services] don't have a lot of NEPT requests but when we need them, we really need them.’   * + Rural Health Service |

1. As the rest of the report shows, the distinct service needs of the ambulance and hospital systems can be in conflict under current operating arrangements, and they require distinct service approaches.

## Workforces need safe, secure jobs that make appropriate use of their skills

1. The NEPT industry employs more than 1,760 people trained in patient transport and clinical monitoring.[[39]](#footnote-40) In addition, many degree-qualified paramedics deliver NEPT transports, as discussed in chapter 3.
2. The review’s engagement with workforces and industrial representatives found that people are dedicated to their work and are seeking to feel valued (Box 5). This can be achieved by the system:
   1. recognising the important role NEPT services play in supporting a health system under strain from the COVID-19 pandemic
   2. offering job security, supporting wellbeing, resilience and career planning, and providing a supportive environment to raise potential issues of safety or quality of care without risk to their employment
   3. providing fair wages and conditions, with entitlements accrued and retained in line with their service to the industry
   4. using their skills appropriately so they are not deployed to jobs that could be delivered by taxis and other non-medical transport services but are also not asked to do work that exceeds their safe clinical scope of practice
   5. providing a safe workplace, where vehicles and equipment are kept to occupational health and safety standards, protection from occupational violence is in place, appropriate rest and break facilities are available, and mental health and wellbeing supports are provided.

Box 5: NEPT workforce priorities provided through review consultation

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| ‘Workforce certainty, fairness and wellbeing should be a feature of the desired state, as opposed to having most staff employed as casuals with risky job security. If NEPT staff have no job security, recruitment and retention is compromised.’  – Victorian Ambulance Union  ‘[Questions of] insourcing vs outsourcing are much further down the track. We need to bank problems first and understand their causes.’  – NEPT workforce  ‘Our job has changed dramatically … We now attend more and more triple zero emergency jobs while still conducting patient transfers … we have had our safety placed at risk, as well as that of our patients, particularly when we are sent to care for patients that are clearly too ill for us to be able to provide adequate care for.’  ‘… we have had pay not just stagnate, but actually go backwards in some cases.’  – NEPT workforce  ‘There are a lot of very skilled NEPT staff in our mix [who go] unrecognised due to the fact we are not Paramedics; this is a big down fall on the system.’  – NEPT workforce  ‘[Equipment is] consistently malfunctioning and/or falling apart, not serviced, or serviced properly, and staff are ignored when safety issues are reported to management.’  ‘No other training is provided. This prohibits staff from becoming better in their role and having a better understanding of patient care and management.’  ‘The facilities [break and rest rooms] provided by the company are in an extremely poor condition, with bathrooms, kitchen and small break room only being cleaned if staff manage to have standby at branch between working all day.’  – NEPT workforce |

## Guiding principles for reform of Victoria’s NEPT system

1. These objectives have informed 4 overarching principles to guide reform of Victoria’s NEPT system, as set out in Table 4.

Table 4: Guiding principles for reform of Victoria’s NEPT system

|  |  |
| --- | --- |
| No. | Principle |
| **1** | **Patient-centred services**: NEPT services are accessible to all who need them, with transports that are timely and appropriate to need, and a patient experience that is safe, comfortable and caring. |
| **2** | **Safe emergency responses**: NEPT protects ambulance capacity by managing some triple zero (000) requests where it is safe and appropriate to do so, enabling paramedic crews to focus on emergency cases that require time-critical medical attention. |
| **3** | **Efficient hospital flow**: Protected and efficiently managed planned NEPT services support timely patient access to hospital care across the system, freeing up beds, increasing health services’ operational capacity and improving system-wide efficiency. |
| **4** | **A valued workforce**: NEPT workers make full use of their skills within their scope of practice and feel a sense of value from the system that is reflected in safe, secure and fair employment conditions. |

# How are NEPT services performing?

1. This chapter assesses how the NEPT system is performing against the objectives set out in chapter 2. It shows the sector has many strengths. It is staffed by a skilled and dedicated workforce whose work supports community access to hospital services, maintaining patient flow across the system and freeing up AV’s emergency crews to respond to the most time-critical patients. Quality and safety are improving, and adverse patient safety incidents appear rare, in line with the low-acuity nature of these services.
2. This chapter also shows the NEPT system has significant room for improvement. Planned NEPT services make up most transports, but they can be deprioritised and disrupted by unplanned work, which affects timeliness and efficiency. Commissioning arrangements are overly complicated and lead to fragmented services, duplicated operational overheads and increased administrative costs. Rural markets have high diseconomies of scale, leading to thin supply and contestability risks. Easily exited contracts enable health services to quickly switch providers when needed but entrench NEPT workforce casualisation. Also, there are opportunities to improve performance management, workforce planning and continuous improvement of quality and safety.

## Quality and safety are improving through regulatory reform

1. Quality and safety standards ensure Victoria’s health system can deliver safe and highly effective services for patients, families and carers.[[40]](#footnote-41) This requires monitoring and reporting of systemic risks to the quality and safety of services. These risks can then be mitigated by clinical governance, accreditation, standard setting and consumer partnerships.[[41]](#footnote-42)
2. As this section shows, quality and safety standards for NEPT services were negatively affected by privatisation in the early 1990s, but they have been strengthened significantly in recent years through regulatory reform. Currently, adverse safety incidents for NEPT services are rare, in line with the low-risk nature of this service. Nonetheless, there are opportunities for strengthened continuous improvement of quality and safety across the sector, including for unplanned NEPT.

### Regulation is the primary lever for driving quality and safety of NEPT

1. Before privatisation, public ambulance services delivered NEPT. This meant its quality and safety were managed under the clinical governance of the ambulance services and regulated under the *Ambulance Services Act 1986*.
2. When public NEPT services were privatised in 1993,[[42]](#footnote-43) providers were regulated under the *Transport Act 1983* and licensed by the Taxi Directorate, despite the clinical nature of the services provided. Clinical governance arrangements were determined by individual providers.
3. Over time, much stronger regulation and clinical governance of the sector has been developed to better reflect and manage the risks involved in patient transport services.
   1. In 2003 theNon-Emergency Patient Transport Actintroduced a compulsory licence scheme for all NEPT providers to operate in Victoria.
   2. In 2021 amendments to the Regulations strengthened the requirements for the safety and quality of care that providers had to meet to hold a licence (Box 6). The Regulations set minimum standards for NEPT to minimise risks to patients.[[43]](#footnote-44)
4. Since amendments to the Regulations in November 2021, oversight of sector compliance with quality and safety standards contained in the Regulations has been managed by a dedicated unit within the department (the regulator).
   1. The regulator’s functions[[44]](#footnote-45) involve licensing, enforcing workforce credentialling and staff safety including manual-handling requirements, ensuring quality assurance such as accreditation with national standards by external accreditors, and enforcing requirements for vehicles and equipment, patient eligibility compliance with *NEPT clinical practice protocols* and infection control.
   2. The regulator ensures compliance with the Regulations through education, monitoring (snap inspections, assessments) and administrative actions (statutory enforcement powers). Administrative action is the main way to enforce compliance.[[45]](#footnote-46)
5. In recent years Safer Care Victoria[[46]](#footnote-47) has extended its health system clinical oversight activities to the NEPT sector, albeit in a limited form compared with public health services. This has complemented the regulator’s work.
   1. Safer Care Victoria requires providers to report the most serious adverse patient safety outcomes (‘sentinel events’), which are subject to detailed review and follow-up.[[47]](#footnote-48)
   2. It also provides policy and accompanying guidelines to providers that set out their responsibilities when responding to other adverse patient safety events.

Box 6: The sector has generally welcomed strengthening quality and safety standards

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| ‘With relation to the current quality and safety standards for those services in Victoria, it by far exceeds the minimum requirements that are implemented across other states, and compliance far surpasses the standards.’  – Medical Edge  ‘We are not an emergency service but carry equipment and drugs for the treatment of emergency patients. Most of which is expensive has never been used and will never be used and is simply discarded once out of date … Double loading of low acuity patients has throughout the industry’s history been an efficient means of clearing hospital beds and freeing up NEPT resources. The regulator has almost prevented multi loading of patients … This restriction places a huge burden on the ability to quickly transport patients out of Health services.’  – Paramedic Services Victoria  ‘Whilst there are clear Clinical Practice Protocols that the sector adheres to, from AV’s perspective there are several constraints (for example: different interpretations of these standards between licence holders) that impact the full oversight of NEPT clinical service delivery, and that are known and could be addressed in the future. This would require a review of current roles, capacities and capabilities within organisations and across the sector.’  – Ambulance Victoria |

### Regulatory compliance is high and adverse events appear rare

1. In 2022–23 the regulator conducted 61 no-notice inspections of NEPT vehicles and equipment across Victoria. These identified overall high rates of regulatory compliance and encouraging trends of sector-wide improvement.
   1. The regulator found that NEPT providers generally provide equipment and vehicles suitable for NEPT service delivery. Vehicles are reducing in mileage and age. They are on track to meet future safety standards including powered stretchers and minimum separation requirements.
   2. Inspections of back-of-house processes also identified generally high levels of overall compliance across the sector.[[48]](#footnote-49) The regulator reports that quality assurance plans provided by NEPT services are accredited to national standards and are generally implemented effectively across organisations.
   3. Where noncompliance is identified, the regulator reports that NEPT providers are generally responsive to directions it has provided.[[49]](#footnote-50)
2. Reported[[50]](#footnote-51) adverse events in NEPT services are infrequent, in line with the comparatively low acuity of these services. In 2022–23 no sentinel events resulting in the death of a patient were reported, and minimal adverse patient safety events were reported. Adverse events are incidents that result in the harm or injury to a patient. These are distinct from sentinel events, which are the most serious incidents resulting in preventable death or serious injury.[[51]](#footnote-52)
3. Cases requiring clinical escalation were more frequent. Clinical escalation occurs for a range of reasons including when a patient’s clinical condition deteriorates. In 2022–23 less than 1% of NEPT cases were deemed not suitable for NEPT on arrival of the NEPT crew.[[52]](#footnote-53) Management of these cases included rebooking at an upgraded acuity or transporting the patient after more consultation with an on-staff or AV clinician.[[53]](#footnote-54) In total, 994 events were referred to emergency ambulances, with the NEPT crew remaining with the patient and providing clinical care[[54]](#footnote-55) until on-scene handover to an AV crew was complete.
4. To address these issues, the recently published 2023 edition of the *NEPT* *clinical practice protocols* provides for increased capability for NEPT services to provide better care and escalate where appropriate. This includes a defined escalation protocol (including referral phone numbers), additional protocols to assist NEPT crews to respond to patient deterioration, and an explicit ‘checklist’ approach to patient deterioration.

### The benefits of recent amendments to the Regulations are still to be fully realised

1. The 2021 amendments to the Regulations involved a phased approach to implementing new quality and safety standards. Key changes already in effect include the following:
   1. For vehicles, key changes include annual roadworthy checks when each vehicle has travelled 200,000 km or is 3 years of age; recurring checks of all vehicle fixtures and fittings to ensure there is no damage and there are no loose parts;[[55]](#footnote-56) and requirements to have a powered lifting cushion in all vehicles fitted with a stretcher.[[56]](#footnote-57) This helps NEPT staff when manually handling patients and improves patient comfort and safety on entry and exit from vehicles.
   2. For the workforce, staff receive annual skills maintenance training in key areas including care for mental health patients, minimum supervision requirements for PTOs (who make up most of the workforce)[[57]](#footnote-58) and explicitly defined clinical practice experience requirements.
   3. For providers, annual transport volumes must be reported to inform licensing decisions. In addition, uplifted clinical governance requirements include forming a clinical oversight committee to oversee the general clinical governance of the organisation and reporting and record keeping, running staff surveys on patient and staff safety issues, and increased clinical auditing and patient review responsibilities.[[58]](#footnote-59)
2. When the transition periods in the Regulations expire, significantly more uplift of quality and safety is expected. This includes the following requirements for vehicles:
   1. For the first time, vehicles will be subject to life limits (of 400,000 km). This requirement will be in effect from the end of 2026. It is intended to reduce the risk of breakdowns or malfunctions that could delay or disrupt medical care, or create a hazard to staff or patient safety.
   2. For the first time, all vehicles will be fitted with power lift stretchers.[[59]](#footnote-60) This requirement will be in place from the end of 2024 and will ensure staff are not avoidably exposed to workplace injuries from manually lifting patients on stretchers.
   3. Introducing separation requirements between stretchers, requiring a minimum distance between them of 350 millimetres from the end of 2026[[60]](#footnote-61) will ensure NEPT staff can safely move between and provide care to both patients within the vehicle.
   4. The regular has advised that all NEPT providers have taken steps to ensure the transition periods will be met.

### Stakeholders raised concerns about the appropriateness of some unplanned NEPT work

1. While unplanned NEPT services should be non-time critical, by definition, and for clinically stable and therefore low-risk patients, there is scope for additional risks to quality and safety to arise.
2. The review heard that additional risks are introduced partly because unplanned NEPT transports are authorised over the phone by AV secondary triage clinicians, rather than following an in-person assessment.[[61]](#footnote-62) This can increase clinical risk, with NEPT crews typically the first health professionals to assess a patient in person.
3. Workforce consultation during the review highlighted significant concerns about staff being asked to complete transports that are beyond their clinical scope of practice (Box 7).

Box 7: Stakeholders raised concerns about the safety of some unplanned NEPT jobs

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| ‘Working beyond our scope of practice … Given increasing levels of acuity, increasing training is needed.’  ‘We have our clinical protocols that we’re supposed to work within. They are getting overruled daily by clinicians for best patient outcomes.’  ‘I’m an ATA [Ambulance Transport Attendant] and a lot of my jobs don’t feel supported by my diploma (they are in excess of skill set). Clinicians don’t sufficiently understand ATA scope of practice and skillset.’   * + NEPT workforce   ‘In recent years, much of the AV workload including higher acuity cases above and beyond NEPT scope of practice and training has been offloaded onto NEPT employees with no, or bare minimum training …’   * + NEPT workforce   ‘NEPT should only be PATIENT TRANSPORT, as it was originally conceived. If you wish to respond to triple zero calls, then utilise a mixture of emergency crews from Low to Medium and High acuity. Any vehicle treating patients and taking them to hospital is an AMBULANCE.’   * + NEPT workforce   ‘We have had our safety placed at risk, as well as that of our patients, particularly when we are sent to care for patients that are clearly too ill for us to be able to provide adequate care for.’  – NEPT workforce |

### Patient experience is not consistently monitored or managed

Service responsiveness to patient experience is a key benchmark of an effective health system. This is reflected in national standards,[[62]](#footnote-63) Victorian legislation,[[63]](#footnote-64) key reviews of quality and safety[[64]](#footnote-65) and Safer Care Victoria policy.[[65]](#footnote-66)

* 1. In Victoria, health services[[66]](#footnote-67) and AV[[67]](#footnote-68) systematically capture patient experience as part of their ongoing monitoring of performance, and to inform continuous improvement.

1. Limited capture of NEPT patient experience is likely to be a common issue across jurisdictions that rely on a standardised ambulance survey that excludes NEPT.[[68]](#footnote-69) Nonetheless, bespoke surveying approaches are possible, and New South Wales has recently introduced one (refer to chapter 4).
   1. However, there is limited standardised monitoring of NEPT patient and consumer experiences in Victoria, nor standardised inclusion of these within procurement and contract management processes. The exception is AV, which monitors experiences of planned NEPT through the Victorian Healthcare Experience Survey. According to these metrics, between January and March 2022 and the same quarter in 2023, overall patient experience improved from 95.6 to 98.5%, while perceptions of waiting times improved from 78.1 to 83.7%.[[69]](#footnote-70) Throughout this period, most complaints were related to poor response times (70% of complaints).
2. Patient and carer perspectives sought as part of the review showed variable experiences of NEPT services (Box 8), with clear areas of strength and many opportunities for improvement. Issues include the following:
   1. Service quality – there can be limited scope of services relative to need (for example, no lifting equipment available or appropriate pain medications) and experiences of discomfort due to vehicle noise and vibrations.
   2. Access – significant time can be required to organise services, particularly when booking in rural areas, with pressure to take taxis and self-transport options as an alternative.
   3. Convenience – there can be significant waiting times, with multiloading potentially requiring detours and delays for the second patient, and waits for patients receiving unplanned services when these are not able to arrive quickly and can be ramped on arrival at hospital. Limits on passengers can also require alternative arrangements for carers and family.

Box 8: Patients and carer perspectives highlight variable experiences of NEPT services

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| ‘… I use them regularly to attend appointments in Melbourne for dermatologist, rheumatologist, cardiologist. I’d be lost without them as I can’t access public transport.’  ‘We encountered issues with accessibility to and from premises sometimes, which is an issue for someone with mobility issues. I believe there are areas this transport service can be improved to be inclusive of all who currently or may need to use in the future.’  ‘As a disabled person, I was constantly asked to do things I can’t do. Sometimes patients aren’t imbeciles and do know a lot about their own health.’  – Consumer views collected through the former Health Issues Centre community conversations |

1. Emergency department data also suggests access and convenience issues are worse for patients arriving by NEPT vehicles compared with ambulances. As shown in Figure 1, patient handover time[[70]](#footnote-71) performance is inferior for NEPT patients, with only 54% completed within 40 minutes compared with 61% for ambulance patients, with a median time of 37 minutes compared with 31 minutes respectively.[[71]](#footnote-72)

Figure 1: NEPT and AV handover performance

Figure showing handover performance times, as described in the text.

## Timeliness varies, with unplanned NEPT responses delaying planned services

1. This section describes issues surrounding the timeliness of NEPT services. First, it outlines the critical role that timely unplanned NEPT services perform in delivering non-urgent triple zero (000) responses, freeing up AV’s emergency crews to respond to the most time-critical patients, faster.[[72]](#footnote-73) It then shows how unplanned NEPT services can affect planned NEPT work,[[73]](#footnote-74) delaying patient discharges, appointments and interhospital transfers, and contributing to inpatient bed block and ambulance ramping.

### Victoria’s model for unplanned NEPT is unique and delivers significant benefits for AV

1. Victoria’s NEPT sector is unique in Australia and much of the world. While it is far from the only system in which planned transports to and from hospitals are delivered privately, Victoria’s system is one of only a few where private NEPT operators respond to non-urgent triple zero (000) calls.[[74]](#footnote-75)
2. This approach has evolved since 2015 when AV reviewed its clinical response model to strengthen secondary triage diversion of cases not requiring an ambulance response to alternative services, including private NEPT resources where safe and appropriate.
3. As Box 9 shows, this approach is unique in Australia. Other jurisdictions have secondary triage services (although none as longstanding as Victoria’s), but these only channel triple zero (000) cases to their state ambulance services (which contain NEPT divisions) or to community health supports. None leverage an external NEPT capability.

Box 9: No other Australian jurisdiction uses private NEPT to respond to triple zero (000) cases

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| **New South Wales** has structurally delinked its planned NEPT and emergency responses, as described in detail in chapter 4. There is a clear separation of scope between the 2 services so all emergency work is handled by the state ambulance service (which contains in-house paramedic and NEPT divisions). Planned NEPT services cannot be used to respond to true emergency cases, and any referrals from the ambulance service to planned NEPT are low in volume and manually completed.[[75]](#footnote-76)  **Western Australia** has a mixed model, with planned NEPT delivered by subcontracted providers in metropolitan areas and by the state ambulance provider (St John Ambulance) in rural areas. There is no formal connection between triple zero (000) services and NEPT. St John Ambulance is responsible for intake of both triple zero (000) calls and NEPT bookings,[[76]](#footnote-77) and its secondary triage service can divert patients when appropriate to alternative care pathways (for example, telehealth or GPs) but not to planned NEPT resources.[[77]](#footnote-78)  **Queensland** has an integrated model, with all NEPT services delivered by its state ambulance service. It rarely uses NEPT for triple zero (000) calls. Following secondary triage, a NEPT service may be dispatched to patients not requiring an emergency response, but this does not occur regularly. Queensland conducts a lower rate of NEPT than Victoria (54.3 transports rate per 1,000 compared with 67.5 in Victoria), with emergency use far greater (173.7 per 1,000 population compared with 89.7 in Victoria).[[78]](#footnote-79)  **Tasmania** has a separated model, with planned NEPT services subcontracted. In 2017 a review recommended that Ambulance Tasmania establish a secondary triage with a protocol for referring patients to NEPT services like Victoria’s.[[79]](#footnote-80) It noted paramedics report they are often dispatched to patients, only to report that the task is more suited to a NEPT response[[80]](#footnote-81) and that non-acute patients can wait for many hours to be transported by a paramedic crew who is constantly being diverted to patients with more urgent needs, resulting in a poor experience for non-acute patients.[[81]](#footnote-82) Tasmania’s NEPT regulations were revised in 2019,[[82]](#footnote-83) and a secondary triage service was launched in 2021.[[83]](#footnote-84) |

1. This model has largely proven safe, albeit with some reported concerns raised by the NEPT workforce about events in which they may be dispatched to emergency responses outside their scope of practice, as discussed in section 3.1.2.
2. The model has delivered significant benefits to the community by improving the timeliness and efficiency of emergency responses delivered by ambulances. AV’s internal evaluation[[84]](#footnote-85) of the 2015 amendments to the clinical response model[[85]](#footnote-86) found it significantly reduced the proportion of triple zero (000) calls receiving an emergency ambulance dispatch,[[86]](#footnote-87) increasing the availability of specialist care services[[87]](#footnote-88) and improving response times for the most urgent events.[[88]](#footnote-89) This is supported by interjurisdictional data that shows a significant improvement in ambulance response times in Victoria after 2015 compared with other states and jurisdictions (Figure 2).

Figure 2: The 2015 review led to large improvements in Victoria’s ambulance performance,[[89]](#footnote-90) with median ambulance response times shortening

Figure showing that, since the 2015 review, median times have increased in South Australia, Queensland, New South Wales and Western Australia, but not Victoria, where times have decreased.

### Unplanned NEPT takes precedence over planned NEPT, which can affect performance

1. While unplanned NEPT plays a critical role as outlined above, it can disrupt and undermine the timeliness of planned NEPT services. This is evident in the differences in performance for planned NEPT services commissioned by AV and those commissioned by health services. The latter are reportedly much timelier, as discussed in chapter 4.
2. AV’s planned NEPT services (the majority of planned NEPT services) are less timely because it commissions these and unplanned NEPT services jointly, paying providers for full shifts in which their crews are available to deliver both planned and unplanned transports as directed by TZV.
3. Unplanned events affect planning, scheduling and route optimisation for planned NEPT, especially when unplanned work is prioritised over planned work (Box 10).

Box 10: Unplanned NEPT events are prioritised over planned NEPT work, causing delays

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| AV contracts NEPT providers to deliver most planned NEPT, along with all unplanned NEPT. Its secondary triage service authorises diversions to unplanned NEPT and assigns timeframes (ranging from 90 minutes to 4 hours) [[90]](#footnote-91) to TZV, which it must factor in when managing dispatch.  When timeframes are exceeded, the requests default to AV for an ambulance response. However, any such response is rarely immediate because the low-acuity nature of the unplanned NEPT work means that these requests will typically go to the back of the queue for ambulance responses.  When dispatching crews to NEPT work, TZV crews typically prioritise unplanned over planned NEPT, with crews directed to attend these events first, postponing planned transports if necessary.[[91]](#footnote-92) |

1. When pre-booked NEPT is disrupted by unplanned events, it affects planned services, delaying interhospital transfers, clinic appointments and hospital discharges contingent on timely NEPT transport. This has flow-on effects that can create risks to patients.
   1. Delays to planned NEPT services contribute to ‘access block’.[[92]](#footnote-93) This is where a lack of available inpatient beds in hospitals has a cascading effect. It prevents patients in emergency departments from moving onto wards, patients in ambulances from being unloaded into emergency departments, and patients in the community from being attended to by ambulances that are waiting on ramps outside emergency departments (Box 11).
   2. This in turn redistributes risk upwards across the system. An unplanned NEPT patient should be, by definition, non–time critical. This is not the case for some patients waiting in emergency departments nor those in the community waiting for ambulance responses.
2. In ideal circumstances, booking and dispatch of NEPT services considers these broader pressures across the health system and balances them accordingly. But TZV lacks this system-wide visibility because it can only see ambulance demand and resources. In any case, TZV is directed by AV and lacks formal relationships with or accountability to health services.

Box 11: What happens when planned NEPT services are delayed?

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| ‘It may also be useful to explain what happens if a transfer is delayed. Where a patient can safely be transferred to the discharge zone or transit lounge, the patient will stay in the care of staff there. These zones free up beds but only exist because of challenges with timeliness, and cost our health service $1.5 million – $2 million per year to run.  Where a patient cannot safely be transferred to the discharge zone / transit lounge, the care team will continue to care for the patient at the bedside. This delays the process of turning the patient’s bed over. Staff necessary for that process also have to be booked, and will often be working elsewhere if the transfer is late.  As a result, the hospital experiences a series of cascading delays in reallocating the bed – and patients end up waiting on trolleys in corridors, receiving care in a suboptimal environment.’   * + Alfred Health |

## Disparities in costs are primarily due to poorer workforce conditions

1. As section 3.1 notes, Victoria’s NEPT services were previously delivered by public ambulance services but privatised in 1993.[[93]](#footnote-94) This was intended to provide several benefits including increased efficiency and cost savings due to competition, and improved service quality by creating a dedicated focus on NEPT service delivery and enabling provider choice.
2. As discussed in section 3.2, a major driver of the difference in private and public costs is the large differences in wages and conditions between private and AV employees. This includes differences in base pay along with larger variances in other conditions and allowances such as a higher superannuation rate for AV employees (14.5% for AV compared with 11% for private employees), a greater number of employee allowance entitlements and significantly larger operational shift penalties expressed through the ‘rolled-in’ rate.[[94]](#footnote-95)
3. While workforce costs are lower, the system is structurally inefficient, with unnecessarily convoluted purchasing arrangements increasing complexity and cost, fragmented delivery approaches creating diseconomies of scale and market failure, under-utilisation of modern technology, and limited reform to manage demand and improve system efficiency more broadly. These issues are discussed in turn below.

### Overlapping commissioning responsibilities increase costs and complexity

1. The Department of Health does not directly purchase NEPT services. It decentralises responsibility for purchasing and performance management of contracted NEPT services to health services and AV, with most NEPT funding sitting with AV.[[95]](#footnote-96)
   1. Eight private providers deliver for public health services through HSV panel arrangements. HSV is responsible for procurement and contracting negotiations on behalf of all health services. Health services are then free to choose which provider(s) on the panel they wish to work with. They must engage a provider using the HSV contract and may also develop a local service agreement with the provider that builds on the statewide contract and adds, for example, extra local key performance indicators and/or local volume-based discounts.
   2. AV does not have to use the statewide panel. It has opted to manage its own procurement and contracting of both planned and unplanned NEPT services, rather than working with HSV. Six private providers are contracted to provide NEPT services for AV.[[96]](#footnote-97)
2. Fragmented responsibilities for purchasing planned NEPT creates administrative complexity and duplication at multiple levels.
   1. Health services generally need to book planned NEPT services through 2 different platforms, depending on whether funding responsibility for the patient sits with AV or the health service.[[97]](#footnote-98) This further duplicates costs, with the need for extra booking systems and training of staff to use them.
   2. The complexity of funding arrangements leads to frequent billing disputes between health services and AV, which each must allocate scarce resources to resolve.
   3. AV and HSV run separate procurement and contract management functions, with duplication of function and personnel.[[98]](#footnote-99)

### Uncoordinated procurement creates geographical fragmentation

1. Rural and regional health services have aligned their choice of provider within geographical regions,[[99]](#footnote-100) despite facing no formal requirement to do so. For example, all health services in the Gippsland and Barwon South-West region are covered by a single provider, as are health services in the Hume, Grampians and Loddon Mallee regions, with a few exceptions.
2. However, AV does not typically award large regional corridors to providers.[[100]](#footnote-101) For example, in Loddon Mallee it has awarded the contract for Swan Hill and Mildura to one provider and the rest of the region to another provider. This means there are often multiple AV contractors in each geographical corridor, preventing providers from spreading high volumes in metropolitan and regional centres to supplement lower distribution rates across rural Victoria. This creates diseconomies of scale while also mitigating the risk of market failure.
3. Despite some geographical coordination within each contracting scheme (AV and HSV), geographical alignment between schemes is limited. This has resulted in a situation where there are multiple providers in almost every region of Victoria.[[101]](#footnote-102) Even when all health services in one region use the same provider to deliver their planned NEPT, AV usually contracts a different provider to deliver its unplanned NEPT in this region.[[102]](#footnote-103) It also has its own in-house NEPT divisions, with Clinic Transport Services (CTS) catering for metropolitan walker and walker-assist patients and NEPT stretcher resources for rural Victoria.
4. When there is an overlap between the AV and HSV contracts, that provider can generate economies of scale. This increases efficiency, better ensures supply and lowers costs to government. When there is no geographical alignment of providers, multiple providers must operate in each area, which:
   1. increases the volume of vacant return trips and poor vehicle and crew use (Figure 3); this inefficiency is greatest in rural areas where one-way trips can average 3 hours[[103]](#footnote-104)
   2. drives diseconomies of scale where the service volume available to each provider is diluted, making services less efficient and therefore more expensive to deliver and less reliable (discussed in section 3.3.3).[[104]](#footnote-105)

Figure 3: When transfers are not coordinated, services are less efficient

This figure shows an illustrated NEPT vehicle from a provider arriving at a hospital empty to pick up a patient. 
The figure also shows an illustrated NEPT vehicle from a different provider arriving with a patient but leaving empty. 

### Poor market design is creating coverage gaps and spills in rural Victoria

1. Metropolitan and rural health services’ satisfaction with NEPT services differs greatly, as Box 12 shows. In Victoria, health services appear well served by several suppliers competing on price and meeting available demand.[[105]](#footnote-106) They are generally reporting satisfaction with the services they directly commission while identifying extensive opportunities for improvement in those commissioned by AV.[[106]](#footnote-107) In rural Victoria, health services’ satisfaction with NEPT is much lower due to thin markets. This arises in areas with low levels of demand, where few suppliers compete to provide services, which results in higher pricing and gaps in servicing.[[107]](#footnote-108)

Box 12: Rural and metropolitan health services’ satisfaction with NEPT services differs greatly

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| ‘[The NEPT] market is already competitive and performing well … Agency managed NEPT [through an intermediary like AV or TZV] adds no value to health services delivering patient and operational outcomes.’  – Western Health  ‘We only had one private provider tender for our contract, and are very worried about them withdrawing from the local market … We recently had a 40% price increase with no ability to negotiate due to lack of alternative providers, and our unmet demand is spilling to AV which is more expensive … AV has a different provider in the region, but hasn’t engaged with attempts to coordinate contracts for coverage … competition was meant to deliver benefits for the system but is resulting in market failure for rural areas. This needs to be more actively managed, so that it is not permissible for providers to only tender for metro contracts and leave rural health services with a single provider and at risk of no coverage.’  – Regional health service  ‘[Our local provider’s] model was unviable – very expensive – and then they dropped out.’  – Rural health service |

1. The market fragmentation described in section 3.3.3 exacerbates inherent diseconomies of scale in rural areas. This in turn means:
   1. NEPT operations are less efficient and therefore more expensive for operators to run because high fixed operating costs are spread over a smaller volume of services.
   2. Public contracts are less attractive and therefore less competitively priced, as providers are less likely to offer discounts, given they assume smaller margins and have fewer competitors.
   3. Service volumes are smaller and more variable, making it more challenging to recruit permanent staff or access enough casual staff at short notice, which in turn makes workforce rosters more challenging to fill and leads to increased spill rates.[[108]](#footnote-109)
2. When areas cannot generate enough market contestation (that is, they are only serviced by a single NEPT provider and/or there are barriers to new providers coming in), there are significant risks of coverage gaps if providers withdraw. In parts of Victoria, health services have no choice of NEPT provider. For example, one rural health service reported facing a 40% price increase from their NEPT provider in 2023, with no alternative providers to shift to.[[109]](#footnote-110)
3. Fragmentation and thin markets can cause spills of NEPT jobs to emergency services. Filling rosters is inherently more challenging in smaller rural areas, where lower service volumes and smaller local populations reduce the scope to build a significant and stable workforce pool.[[110]](#footnote-111) When rosters cannot be filled, or contracted providers are unavailable or unable to deliver services for other reasons, service provision typically defaults to AV as the provider of last resort.
4. In 2022 there were 16,864 transports that were eligible to be delivered by NEPT providers but spilled to AV, with 65% of these occurring in rural areas (Table 5). These events occur when patients are still eligible for NEPT, not when the patient’s condition deteriorates and clinical escalation is required.

Table 5: Spills from NEPT to ambulance as a percentage of AV NEPT, 2022[[111]](#footnote-112)

| Type | Spills | Transports per category (AV only) | Spills rate per 1,000[[112]](#footnote-113) | As % of total spills |
| --- | --- | --- | --- | --- |
| **Metro – planned** | 1,550 | 135,296 | 11.46 | 9% |
| **Metro – unplanned** | 4,379 | 45,879 | 95.45 | 26% |
| **Metro – total** | 5,929 | 181,175 | 32.73 | 35% |
| **Rural – planned** | 4,947 | 46,546 | 106.28 | 29% |
| **Rural – unplanned** | 5,988 | 14,538 | 411.89 | 36% |
| **Rural – total** | 10,935 | 61,084 | 179.02 | 65% |
| **Grand total** | 16,864 | 242,259 | 69.61 | 100% |

### Contestability in the Victorian market may be reducing, which has significant trade-offs

1. There are multiple barriers to entering Victoria’s NEPT market. This includes start-up costs associated with building bespoke technology (for example, establishing booking and dispatch systems) and acquiring equipment and vehicles;[[113]](#footnote-114) shorter initial contract lengths;[[114]](#footnote-115) tighter profit margins due to global and local cost pressures; and hesitancy by health services to switch providers due to change management costs associated with implementing a new booking system.
2. The Victorian NEPT market has undergone significant consolidation in recent years. In 2012 there were 14 licensed providers, and between 2012 and 2021 the number of licensed providers grew to 20, before a period of consolidation. In the past 2 or so years, the number of providers has reduced from 20 to 10, with 5 licences cancelled or suspended due to non-operation or minimal operation.[[115]](#footnote-116)
3. At present, almost all NEPT services are delivered by 6 of the 10 registered providers (those contracted by AV and health services).[[116]](#footnote-117) There has only been one new entrant into the NEPT market in the past 5 years. This entrant has not yet claimed a significant share of the market and relies on broader economies of scale from its operations in other Australian states.[[117]](#footnote-118)
4. As Box 13 shows, contestability in Victoria’s NEPT market creates winners and losers. In general, it benefits metropolitan health services, which can choose between many providers based on price and performance. Rural health services have poorer choice (as discussed in section 3.3.3) and can bear the consequences of broader market disruption. So too does the private NEPT workforce, with staff losing accrued entitlements (such as sick leave and long service leave) or losing their employment altogether when their employer’s local contracts are ended or downsized.[[118]](#footnote-119)

Box 13: Stakeholders have very different experiences of market contestability

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| In 2023 a tertiary metropolitan health service, the Royal Melbourne Hospital, chose to switch its providers..  However, the Review was informed that the change had significant flow-on effects. It reportedly led to RFDS rapidly withdrawing from its supply arrangements across Hume, which, at the initiative of health services, had been coordinated into a single regional approach.[[119]](#footnote-120) RFDS stated these arrangements would be unsustainable without it also supplying services to the Royal Melbourne because this enabled scale and route efficiency across the Hume–metro geographical corridor.  National Patient Transport (NPT) has advised that delayed transition may have been a significant risk had it not already been active in the same region under an AV contract and able to leverage this existing capability and scale. However, its resources for AV were already at capacity. New arrangements had to facilitate transition-in, separate to the resources and infrastructure in place for AV.  Ultimately, the workforce bore the brunt of the changes. Local RFDS employees were offered roles with NPT but lost their accrued sick leave and long service leave entitlements in the transition. |

### There is no centralised coordination of resources to maximise route efficiencies

1. High and reliable patient volumes are critical for the efficiency of patient transport services. They enable overheads to be spread across a larger revenue base (lowering the cost per trip) and reduce the time that transport vehicles are empty or only half-full (incurring fuel and workforce costs while earning no or limited revenue) when they travel between collection and drop-off points.
2. One way to maximise route efficiencies is through consolidating service volumes, as described in section 38.b. Another is to coordinate providers within a regional area through centralised booking and dispatch (discussed in chapter 4).
3. Victoria uses neither of these approaches. Instead, booking and dispatch for AV is centrally run by TZV, and booking and dispatch for health services is decentralised to private providers, which each must operate their own call-taking and dispatching arrangements. These functions are duplicative and limit scope to invest in more technologically sophisticated approaches.
   1. Every booking and dispatch centre in Victoria (including TZV) relies on booking[[120]](#footnote-121) and dispatch[[121]](#footnote-122) processes that are highly manual with limited technological investment. As discussed in chapter 4, these approaches are inherently less efficient than algorithm-based approaches prevalent in most other logistics industries, which use computers to assess far more potential scheduling scenarios to find the most efficient option.
   2. There is also significant underinvestment in communications technology by many private operators. Health services and patients generally do not receive live updates on estimated arrival times from NEPT crews, despite this being commonplace in many other logistics industries[[122]](#footnote-123) and a standard consumer expectation now in Australia. And private providers do not have access to government radio networks, which requires TZV to phone cases through to crews, adding inefficiencies.

### AV’s in-house NEPT services are subscale

1. As described above, AV has primary purchasing responsibility for NEPT services in Victoria. However, it does not exercise its strategic commissioning powers in ways that deliver best outcomes for the whole health system. Likewise, AV’s internal NEPT delivery arm is subscale within an already fragmented sector.
2. There is no clear role delineation between AV’s in-house stretcher NEPT capability and the private market. What’s more, there is little clarity about what work it is intended to deliver compared with private contractors. Operating across 10 regional areas in rural Victoria only, the scale of AV’s internal NEPT capacity (at around 47.73 FTE and 27 vehicles, delivering 17,940 transports in 2022) is limited (Table 6). And while these internal resources might be used when spills occur in regional areas (instead of flowing to an emergency ambulance), they can also exacerbate fragmentation.

Table 6: AV’s in-house NEPT service volume – rural, 2021 to 2022[[123]](#footnote-124)

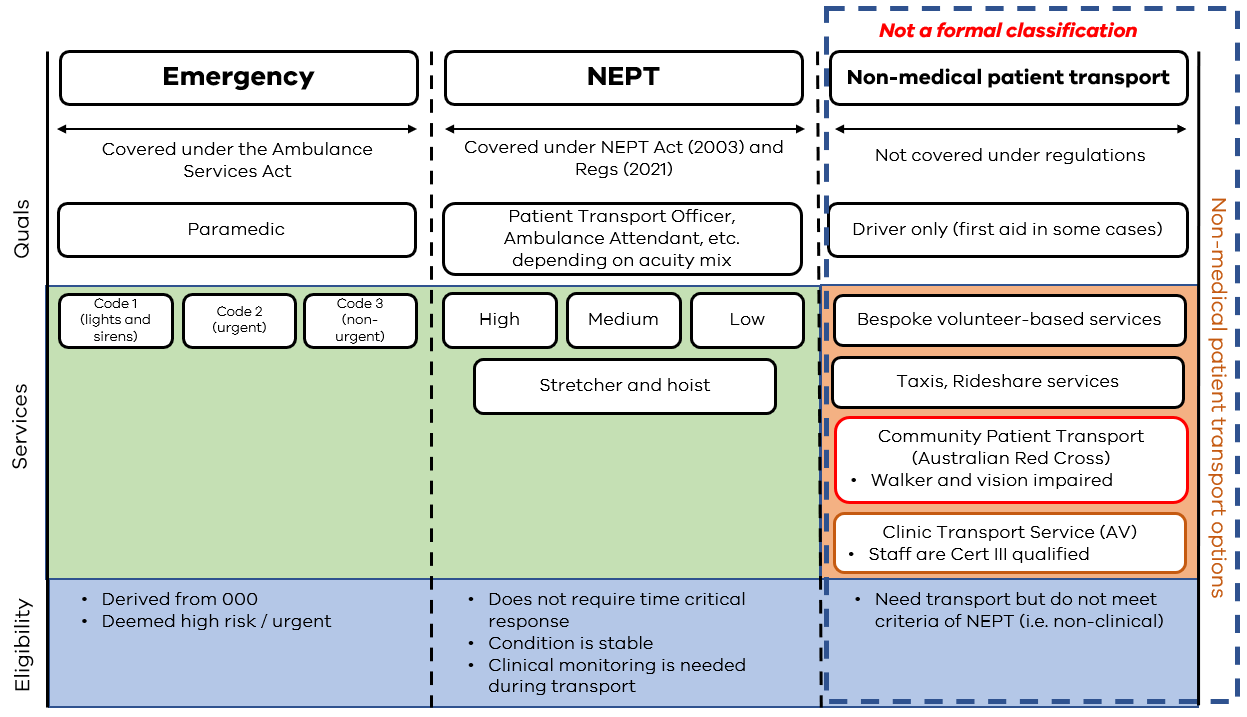
|  |  |  |
| --- | --- | --- |
| Service type | 2021 | 2022 |
| **Planned** | 14,889 | 15,030 |
| **Unplanned** | 4,270 | 2,910 |
| **Total** | **19,159** | **17,940** |

1. Stakeholders have raised the concern that AV’s NEPT is the ‘poor cousin’ of its emergency services. The organisation’s NEPT services do not receive the strategic focus or resourcing to enable a high-functioning, integrated and sustainable service.[[124]](#footnote-125)
   1. Very high rates of overtime for AV NEPT staff are incurred (21.2% compared with 17% for emergency services), mostly to cover entire shifts (as opposed to extensions of shifts). This suggests that AV has not established a NEPT workforce that can deliver the required service volume.
   2. AV’s in-house NEPT is a distinct business unit that operates in parallel to emergency and other services. While this has the advantage of protecting non-emergency resources, the internal separation means NEPT cannot leverage common resources within AV, generate economies of scale or integrate with potentially similar services.
   3. Furthermore, key improvement initiatives have not been readily integrated into AV’s business as usual. This includes addressing ineligible transports (see Section 3.3.7 below), and permitting internal and subcontracted NEPT workforces to use the Victorian Virtual Emergency Department[[125]](#footnote-126) to confirm whether a NEPT transport to hospital is appropriate when a crew suspects the patient may be suitable for an alternative pathway.[[126]](#footnote-127)

### Ineligible use is common, and alternative transport services are underused

1. Low-acuity patients make up most NEPT services, and AV advised that a significant proportion of these patients may be ineligible for NEPT. It is likely that ineligible transports are inflating NEPT demand and affecting service availability, hospital flow, patient experience and system costs.[[127]](#footnote-128)
   1. According to AV, approximately 20.9% of low-acuity patients do not meet the acuity criteria for NEPT and should be considered an ineligible transport.[[128]](#footnote-129) This occurs when patients are stable and mobile, do not need clinical monitoring and do not have impaired cognitive function.
2. Inappropriate demand for NEPT services occurs when patients are incorrectly assigned to NEPT, despite not meeting the criteria and thresholds for it. The clinical thresholds between low, medium and high acuity (as described in the Regulations) are not consistently applied.[[129]](#footnote-130) There are reports of mixed interpretations across the sector, particularly for low-acuity patients. Inappropriate demand increases pressure on the system, meaning more patients who appropriately require NEPT services wait longer or miss out.[[130]](#footnote-131)
3. The review has also heard concerns around potentially ineligible use of NEPT for patients from residential aged care facilities. For transports to emergency departments, which are usually unplanned events,[[131]](#footnote-132) 19% of emergency department arrivals via NEPT services are patients from residential aged care facilities compared with 5% of patients arriving by ambulance and 0.2% of patients arriving by other means.[[132]](#footnote-133)
4. AV has robust processes for managing eligibility for unplanned NEPT and redirecting ineligible patients. Low-acuity patients who call triple zero (000) are redirected through AV secondary triage services, where their clinical condition and eligibility for NEPT is confirmed by a paramedic. Those ineligible for NEPT are typically redirected to alternative transport options such as taxis, local general practices or the Victorian Virtual Emergency Department (VVED). Nonetheless, there are opportunities to expand the use of virtual care (Box 14).
5. However, these mechanisms do not exist for planned NEPT, which makes up the bulk of NEPT services, and for which AV and health services share contracting responsibility.
   1. Under the Regulations, NEPT events must be authorised by a health professional after an in-person assessment. However, this process is decentralised to individual services, and there is no validation or cross-checking at other points in the system. Booking requests by individual staff may result in ineligible use if clinical thresholds that are not universally understood or if awareness of alternative transport options is low.
   2. Moreover, TZV manages planned NEPT bookings on AV’s behalf and reports that it does not reject ineligible requests.[[133]](#footnote-134)
6. For patients who cannot arrange their own transport to and from health services, and need support to get there, multiple alternative transport options are funded (Figure 4).
7. These include Community Patient Transport services, other volunteer-based community transport services, taxis and rideshare services, and AV’s CTS for walker, walker-assist and hoist patients.
8. Some of these services are underused, especially compared with other jurisdictions. For example, the Department of Health contracts the Australian Red Cross to deliver the Community Patient Transport program. However, activity is no at expected levels..[[134]](#footnote-135) The department is currently evaluating the reasons for this.[[135]](#footnote-136)
9. As chapter 4 shows, other jursidictions systematically leverage alternative service platforms such as taxi, rideshare and community transport to minimise ineligible use of NEPT.

Figure 4: Patient transport classification[[136]](#footnote-137)



1. Transporting ineligible patients by NEPT increases system costs. NEPT incurs higher workforce, vehicle maintenance and fuel costs compared with taxi services. On average, the cost of a single privately provided NEPT transport is $248 to $326[[137]](#footnote-138) compared with $172.30[[138]](#footnote-139) for each taxi trip.

Box 14: Virtual review can reduce unnecessary transfers and improve patient experience

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| As section 3.1.5 notes, some NEPT transports to emergency departments are for patients who wait long periods to be seen. Patients may then need to return home following assessment, without requiring medical care or admission.[[139]](#footnote-140)  While many of these transports would have been appropriate, it is expected that some could also have been avoided had the patient had access to virtual review by an emergency department clinician before being transported. This involves a video call to the VVED, which is available 24 hours a day, 7 days a week and guarantees rapid access to AV.  The VVED is staffed by emergency doctors and specialist nurse practitioners who conduct clinical assessments and provide medical advice virtually. Where required, they will provide early treatment and referral to specialist services, GPs and other services for ongoing management. If the VVED determines that a person’s care needs are best managed face to face in hospital, then ambulance transport will be organised if the patient is too unwell to travel in a private car.  In roundtables with AV staff conducted by the review, one of the most frequently raised issues was lack of access to the VVED. Paramedics working within AV already have access to the VVED, and in 2023 they could avoid transportation to hospitals in 77% of consults.[[140]](#footnote-141) The rate would likely be higher for NEPT given the lower acuity nature of patients they serve.  VVED access makes a significant difference for patients and clinicians. It means that instead of spending time travelling to an emergency department and waiting to offload (‘ramping’) patients who do not need emergency care, paramedics are supporting these patients to access appropriate care and then moving on to other urgent callouts in the community. It is also delivering an improved experience of care for low-acuity patients who would have otherwise spent many hours waiting to be offloaded and then seen. |

## There are disparities between private and public workforce conditions and limited workforce planning

1. As noted above, the private NEPT workforce delivers the bulk of NEPT services and plays a critical role in the system. This included during the COVID-19 pandemic, where workforces provided tens of thousands of transports for COVID-positive patients needing hospital care.[[141]](#footnote-142)
2. Despite the valuable role it plays, the private workforce receives lower pay and poorer conditions than their counterparts working for AV. The private workforce is highly casualised, with no security of employment or portability of entitlements when employers’ contracts change. In addition, there is limited industry-wide planning to support the attraction, retention and ongoing development of a skilled and supported NEPT workforce, or to support the movement of patient transport workers moving between NEPT and emergency ambulance work.

### The NEPT workforce is highly casualised

1. As noted above, most of the NEPT workforce (around 60%) are employed on casual contracts.[[142]](#footnote-143) Casual contracts limit the workforce’s ability to access paid leave, paid sick leave and guaranteed hours of work, or to access notice of termination or redundancy pay, even if they work regularly for a long time.[[143]](#footnote-144)
2. While casual workers receive additional loadings to compensate for the lack of these entitlements, the instability generated by casual contracts has seen calls for NEPT providers to decrease the proportion of their workforce employed under casual arrangements. Under National Employment Standards, employers are already obligated to offer casual workers the opportunity to convert to part-time or full-time work, once they meet certain conditions.[[144]](#footnote-145)
3. It is unclear why high rates of casualisation persist despite this national requirement.
   1. For providers, casual staff allow flexibility to meet fluctuating demand because there are no guaranteed volumes from health service and AV contracts and short notice periods for termination available to the contracting party.[[145]](#footnote-146)
   2. Some private providers also claim that their workforce prefers the flexibility that casual employment offers. While this may be questionable, casualisation was not definitively raised as a priority issue for the workforce during the review’s in-camera roundtables.[[146]](#footnote-147)
4. High rates of casualisation are not apparent in NEPT services in other jurisdictions. Almost all staff of New South Wales’[[147]](#footnote-148) and Queensland’s[[148]](#footnote-149) public NEPT services are permanent, albeit with more casual staff in private surge capacity providers in New South Wales.[[149]](#footnote-150)
5. Workforce casualisation is inherent in the private contracting of surge capacity because it allows providers to scale up service provision as needed. This is more cost-effective for AV and health services, and by extension the government, than keeping latent capacity on stand-by to respond to demand surges.
6. NEPT workers can also move between employers frequently, but there is no standardised enterprise agreement (refer to section 3.4.2) and limited portability of entitlements such as sick and long service leave.[[150]](#footnote-151) As such, when contracting arrangements in an area change and AV and/or the health service switch providers and the incumbent provider exits the local market, the local workforce will lose their entitlements, which have often been accrued over long periods of employment.

### NEPT workforce pay and entitlements are structured differently across the sector

1. Currently, there is no standardised enterprise agreement for the private NEPT workforce. Several private providers have negotiated enterprise agreements.[[151]](#footnote-152) Others operate under the Ambulance and Patient Transport Industry Award, and AV’s NEPT workforce is covered by the AV Enterprise Agreement.
2. Consequently, there is variability in pay and conditions across the sector. As shown in Figure 5, there are not significant differences in the base hourly pay rates across PTOs and ATAs across private providers, which range from $28.50 to $29.09 (for PTOs) and $30.41 to $32.69 (for ATAs) an hour. For PTOs, AV does have a noticeably higher base rate, ranging from 3.9 to 6% higher than other providers, while for ATAs these base rates show little variation across providers and AV.[[152]](#footnote-153)

Figure 5: Hourly rates vary across the industry

Hourly pay rates across Enterprise Agreements as described in paragraph 69. 

1. While base wages are not significantly higher for AV NEPT employees, total weekly pay rates are much higher due to the organisation-wide rolled-in rate, where shift penalties based on rosters across the organisation are expressed as a monetary value and an average payment is made to each eligible employee.[[153]](#footnote-154) Employees of private providers do receive penalties, which are then applied to base rates, but these are only incurred for relevant shifts on an individual basis, and at a lower overall cost compared with rolled-in rate wages. The **appendix** provides a summary comparison of enterprise agreements.
2. Leave entitlements and casual rate loadings are similar across all major award structures, but AV employees receive a higher superannuation rate[[154]](#footnote-155) and a greater number of employee allowance entitlements compared with private providers. While overtime rates are similar in percentage terms, AV employees receive greater overtime amounts in general,[[155]](#footnote-156) which appears to be driven by the inefficiency of AV’s rural NEPT services.

### Workforce safety may be poorer for privately employed NEPT workers

1. The NEPT workforce faces particular safety risks due to the nature of the work such as lifting and manoeuvring patients, transporting patients who are experiencing mental ill-health, large amounts of travel by road and attending patients while vehicles are in transit.[[156]](#footnote-157)
2. Industrial representatives highlighted that broader working conditions are often poorer for the privately employed workforce compared with the public sector.[[157]](#footnote-158) For example, while both AV and TZV have comprehensive mental health support programs for their employees, similar programs for NEPT workers in private providers are limited. This is despite exposure to the same risks as public sector emergency workers for staff contracted to do both planned and unplanned NEPT work.[[158]](#footnote-159)
3. As section 3.1 notes, amendments to the Regulations have been introduced to improve NEPT workforce safety.
4. In particular, the Regulations specify that every NEPT licence holder must develop, maintain and comply with an occupational health and safety plan, accredited by an external accreditation agency for certification.
5. A factor behind introducing these amendments was an inconsistent approach to occupational health and safety that meant staff have differing levels of workplace safety depending on their employer. The ammendments aim to reduce manual-handling injuries and other injury and infection risks to staff and patients, with a secondary objective to reduce costs for the sector over time by reducing workplace injuries and thus reducing WorkCover premiums.[[159]](#footnote-160)
6. The regulator states that occupational health and safety plans provided by NEPT services are accredited to national standards and are implemented across organisations.
7. As section 3.1 details, there are other relevant amendments to the Regulations to further improve workforce safety.[[160]](#footnote-161) Many of these amendments are currently under a transitional period and will gradually come into effect over coming years.

### There is limited industry-wide workforce planning

1. While the department is responsible for implementing the Act and the Regulations, it does not play a substantive role in supporting the attraction, development or retention of the NEPT workforce. This is the responsibility of providers.[[161]](#footnote-162)
2. This is despite the significant impact of workforce casualisation and non-portable entitlements on the workforce’s economic security and wellbeing, and the impact of the Regulations on workforce demand, through specifying scope of practice and qualifications for NEPT crew members,[[162]](#footnote-163) training requirements and workforce composition for different transports.[[163]](#footnote-164)
3. Movement between the NEPT and emergency sectors is not uncommon, and NEPT staff often move to AV after earning a paramedicine degree. However, there is no formal pathway to support this transition to benefit both the employee and the respective ambulance and patient transport sectors, despite high demand for this from the sector and workforce (Box 15). At the same time, developing a workforce that is specifically interested in NEPT, rather than ambulance services, is also important for the long-term sustainability of the sector.

Box 15: Private provider support for workforce planning and pathways

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| ‘There needs to be an embracing of, and acceptance of, movement between AV and NEPT workers …. [There should be] clear indications of ways to progress, options for training, extending existing knowledge base. This could include recognition of NEPT people as being on par or equivalent to certain levels acknowledged by AV, for example, and having mirroring if not the same career progression opportunities outside and within AV.’  – LifeAid  ‘Foster closer workforce planning arrangements with key stakeholders – including AV, the [Victorian Ambulance Union] and tertiary institutions – to better understand future recruitment requirements, delivering a more stable and sustainable industry sector.’  – National Patient Transport  ‘Formalise the NEPT to paramedic training pathway. Make relevant TAFE courses free for the next decade to support a steady stream of workforce for the broader ambulance sector ... We also recommend a focus on delivering these TAFE courses in regional and rural TAFE or educational institution.’  – Royal Flying Doctor Service |

1. Limited statewide workforce planning within the NEPT sector and across the broader patient transport industry creates 2 key issues:
   1. There are limited formal pathways for paramedics transitioning out of emergency work to redeploy to non-emergency work with appropriate skill recognition[[164]](#footnote-165) and portability of entitlements. This leads to inefficient redeployment of these staff within AV to work that does not fully leverage their skills.[[165]](#footnote-166)
   2. There is an over-reliance on volunteer-based non-medical patient transport services, despite the declining community supply of volunteers.[[166]](#footnote-167) Without adequate resources to support these services, trained NEPT staff are often used to provide non-medical patient transports, which is not an effective use of their skills, nor is it cost-efficient (refer to section 3.3.7).

## Substantial environmental impacts are not being addressed as a sector

1. Like many other parts of the health system, NEPT services contribute to Victoria’s climate emissions. There are more than 450 vehicles across private providers, each with an average distance travelled of 272,000 km. Total annual emissions for the sector equate to approximately 4,500 tonnes CO2-e,[[167]](#footnote-168) about 20% of total patient transport emissions across NEPT and AV.[[168]](#footnote-169)
2. As part of the Victorian Government's broader commitments, AV has committed to achieving net-zero carbon emissions by 2045. All AV sites have been powered by renewable energy since 2022, with a transition to hybrid and electric vehicles in progress.[[169]](#footnote-170)
3. While some private providers have pledged to reach net-zero emissions,[[170]](#footnote-171) targets and timelines across the sector are mixed. Some providers have no publicly committed emissions targets. Neither AV nor private NEPT services have published transition strategies.
4. Under the current contracting arrangements through the HSV panel, there are limited evaluation and performance criteria for social procurement objectives. The NEPT panel contracts were originally established in 2015 through Health Purchasing Victoria. Subsequent extensions of this contract have meant the contracted NEPT providers have not had an environmentally sustainable business practices evaluation scorecard completed, a current requirement for all HSV tenders, because this scorecard only applies at tender.

## NEPT services would benefit from better governance

1. As the steward of Victoria’s public health system, the department is responsible for the overarching governance of NEPT services. This means ensuring NEPT ‘fulfils its overall purpose, achieves its intended outcomes for citizens or service users, and operates in an effective, efficient and ethical manner’.[[171]](#footnote-172)
2. The objectives for the NEPT sector and the role it should play in supporting the health system more broadly need to be clearly defined and integrated with health system policies and frameworks. As previously described, the department has also fully devolved its role in procurement and commissioning of NEPT services, and its primary role for NEPT services relates to regulatory and clinical oversight.[[172]](#footnote-173)
3. The funding model has resulted in system fragmentation, with each procurer, AV and health services working to their individual interests rather than balancing the priorities of the system.

### There are opportunities to coordinate parties involved in the NEPT system

1. These parties include health services, AV, separate areas within the department (including the regulator), Safer Care Victoria, HSV, the NEPT workforce and 9 private providers.[[173]](#footnote-174)
2. The department has many strategies for the health system, but these rarely, if ever, mention NEPT services or spell out the department’s expectations of NEPT services and the role these should play in the health system more broadly. For example:
   1. The department’s objectives for NEPT funding do not form part of the performance monitoring framework and its broad domains relating to high-quality and safe care, governance, financial management and timely access to care.
3. This exacerbates what can at times be a perceived lack of recognition of the important role NEPT services play in the system, which affects workforce engagement.[[174]](#footnote-175)

### Funding approaches do not balance priorities from a whole-of-system perspective

1. The funding approach does not optimise whole-of-health-system performance, with each funder, whether AV or health services, working to their individual interests.
2. This can result in conflicting demands made on private provider capacity – for example, with AV (via TZV) directing providers to prioritise unplanned NEPT over planned NEPT, and health services making competing requests for their bookings to be prioritised, usually to the advantage of larger health services over those with smaller contracts.[[175]](#footnote-176)
3. Also, multiple booking and dispatch arrangements cause fragmentation across the system and create inefficiencies in scheduling and route planning because NEPT services are not managed as a collective resource (refer to section 3.3).
4. Furthermore, funding arrangements create a moral hazard issue and do not discourage ineligible NEPT use, as discussed in section 3.3.7.[[176]](#footnote-177)
   1. Most planned NEPT services are requested by health services but paid for by AV,[[177]](#footnote-178) limiting the incentive for health services to reduce ineligible transports in these cases and limiting their ability to use more efficient or effective transport options.

### There is limited system-wide planning, performance oversight and accountability

1. As previously mentioned, the department has fully devolved its role in relation to procurement and commissioning of NEPT services to HSV, AV and public health services*.*
2. Despite having contractual responsibility for most planned NEPT on behalf of the system, AV has not fulfilled its role in a way that supports and balances whole-of-system needs. For example:
   1. AV has no engagement or accountability to health services for commissioning NEPT services, and health services have limited influence over how AV procures services.
   2. All practical decisions about dispatching NEPT rest with TZV, which often redirects planned resources for hospitals to unplanned work for AV, affecting health services’ patient flow.
3. The department[[178]](#footnote-179) and AV have set ambitious climate change targets as part of Victoria’s Net Zero 2050 targets, as described in section 3.5. However, they have not actively considered how the NEPT sector contributes to these emissions, nor embedded strategies to reduce them – for example, through procurement policy or potential infrastructure investment.[[179]](#footnote-180)
4. The sector collects significant amounts of data, but this is fragmented and there is only limited analysis to understand impact on patients and the system. Data is often self-reported and inconsistent, making it challenging to quantify capacity and demand, measure system efficiency and identify opportunities for improvement at the system level.[[180]](#footnote-181)
5. As discussed in section 3.4.4, there is limited statewide workforce planning in the NEPT sector. This creates a poorly coordinated approach to understanding workforce needs and implementing strategies that help support delivery across the sector to ensure the future needs of patients, services and the system are anticipated, understood and planned for.

# System design

1. This chapter outlines reforms to improve the design of Victoria’s NEPT system. It focuses on 2 key design elements: structural separation of emergency and non-emergency transports, and centralised coordination of services through a single intake point for bookings and coordinated dispatch of crews.
2. As this chapter shows, both NEPT and ambulance services perform better when planned transports for health services and emergency responses for ambulance services are structurally delinked, with separate entities responsible for commissioning or delivering them. This separation enables better focus and specialisation for both entities, reduces routine disruptions of planned transports by emergency responses and minimises spills of planned work to emergency ambulance crews. This improves the timeliness and efficiency of both NEPT and ambulance services.
3. Efficient NEPT services also require centralised coordination of resources. All jurisdictions the review surveyed either have in place or are actively implementing centralised booking and dispatch systems. These screen requests for eligibility, match patients to the most suitable transport option for their specific needs and use a comprehensive system-wide view of all bookings and resources to coordinate routes for efficiency. As such, these systems can help resolve much of the current fragmentation and inefficiency.
4. These design elements are beneficial regardless of whether services are delivered by public or private entities. Subsequent chapters show how these principles can be applied in an improved outsourcing model (chapter 5) or an insourcing model (chapter 6).

## Separation of emergency and non-emergency transports

1. This section shows there are significant challenges with AV’s current management of NEPT resources, which is consistent with broader evidence and interjurisdictional experience that shows health system performance tends to be poorer when planned NEPT and emergency responses are delivered by the same resource pool or commissioned by the same organisation. This section explores options for resolving these issues and recommends delinking planned NEPT and emergency responses to enable performance benefits to both the delivery of planned NEPT and emergency responses.

### There are significant challenges with AV’s management of NEPT resources

1. As described in chapter 3, AV controls most statewide NEPT (60.8% of total NEPT) through a combination of in-house delivery[[181]](#footnote-182) and service procurement,[[182]](#footnote-183) and by influencing booking and dispatch (which TZV delivers for AV).[[183]](#footnote-184)
2. The overlapping health service and AV responsibilities for planned NEPT services create significant added system complexity as outlined in chapter 3. This increases administrative costs, fragments the market, duplicates procurement functions and creates other overheads.
3. The review also heard that AV’s planned NEPT services that are externally commissioned do not perform as well as those that health services commission directly.
4. This may be in part due to their deprioritisation and disruption by unplanned NEPT events, as described in chapter 3. When dispatching NEPT resources on AV’s behalf,[[184]](#footnote-185) TZV prioritises emergency responses above health service needs[[185]](#footnote-186) and redirects NEPT crews from planned to unplanned pick-ups when necessary. This has significant flow-on consequences, with each delayed discharge disrupting 5 patients’ access to care.[[186]](#footnote-187)
5. Health services also report frustration that the planned NEPT services commissioned by AV cannot be easily directed to address their priority access and flow pressures (Box 16), which TZV has limited visibility of.[[187]](#footnote-188)

Box 16: Health services find performance is poorer for the planned NEPT services AV procures

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| ‘Five years ago, Western Health in conjunction with the Department of Health participated in a trial during which WH were provided the responsibility, accountability and funding for managing all their NEPT services directly with their contracted service provider. During this trial period WH experienced significant improvement in NEPT service responsiveness and alignment with internal access and flow priorities.’  – Western Health  ‘There is clear value for Alfred Health in being able to decide exactly which transfers to prioritise. As the review notes, NEPT transfers from hospitals play a vital role by freeing up beds and reducing discharge delays ... Alfred Health has the power to prioritise these transfers through the two NPT vehicles that it has booked. However, Alfred Health has much less capacity to prioritise patient discharges home [which are managed by AV], and is therefore left without a potential tool to manage patient flow through (and out of) the hospital.’  – Alfred Health |

1. TZV, AV and health services do not appear to routinely collaborate to understand health service needs and construct formal or informal service agreements for delivering planned NEPT.[[188]](#footnote-189) AV also does not appear to actively use its significant strategic commissioning powers to improve efficiency and performance in the NEPT sector.[[189]](#footnote-190)
2. AV’s funding for NEPT services makes up just 8% of its organisational budget and competes with core organisational priorities.[[190]](#footnote-191)
3. It has proved challenging for AV to make operational improvements to NEPT, such as tackling transports for ineligible patients and market failure issues in rural Victoria, while it faces more urgent imperatives including delivering emergency ambulance responses.
4. In submissions to the review, there was consensus across all stakeholders, including AV, that direct delivery of NEPT services should not be a core organisational priority for AV and that it is not well positioned to deliver these services on a larger scale (Box 17).

Box 17: Stakeholders see NEPT as a lower priority for AV

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| ‘While our core service is to provide emergency medical response, we also provide a number of other services, including NEPT … AV’s current preference is to insource NEPT to an entity other than AV …. Allowing AV to focus on its core business of emergency response, in line with the new AV Strategic Plan and the Ambulance Services Act [… and] maintain our focus on providing the highest quality care to the sickest patients in our community.’  – Ambulance Victoria  ‘The lack of clear delineation between emergency ambulance services and NEPT creates industrial tension between different elements of the NEPT sector. Further, AV delineation would allow AV to focus on its primary role of providing emergency ambulance services and remove much of the fragmentation and inefficiencies in the system.’  – State Medical Assistance  ‘There should be a distinction between NEPT and Emergency operational sectors. This would drive efficiency in operations, cost appropriate services and avoid dilution of scheduling priorities.’  …  ‘Separation of Emergency and NEPT avoids complexity in scheduling. This is easiest done by keeping AV and [TZV] on Emergency tasks, while NEPT is managed locally by health services.’  – Western Health |

### These challenges are best resolved through ceasing AV’s role in planned NEPT services

1. Given high stakeholder consensus about these current challenges, the review has considered various options to reshape AV’s role in future delivery of NEPT services.
2. The rest of this section sets out the review’s recommended approach of structural separation of planned and unplanned NEPT.
   1. This would see AV remain responsible for unplanned NEPT in line with its core organisational focus on serving people with time-critical emergencies.
   2. AV’s role in planned NEPT would cease. These services (the majority of NEPT) would be commissioned and delivered separately to prevent their deprioritisation and disruption by responses to unplanned events and ensure they focus on their core role of enabling timely patient access to health services.
3. An alternative option the review explored, but does not recommend, was to maintain AV’s existing commissioning responsibilities but structurally delineate booking, dispatch and delivery of planned and unplanned NEPT services so crews cannot be redirected from planned to unplanned work.
   1. This was not recommended because it may not improve the timeliness of planned services (Box 18), and it would not resolve the broader system complexity arising from overlapping procurement responsibilities.
   2. It would also not resolve the problem of poor alignment between planned NEPT and AV’s core organisational focus, which creates the risk AV would deprioritise planned NEPT.
   3. Finally, it would also not reduce risk of NEPT work spilling to ambulance resources, which the review found may occur more frequently if AV is responsible for NEPT, as discussed in section 4.1.2.1.
4. AV also provided another option in its submission to the review, which the review explored but does not recommend. This option involves centralising all NEPT services (both planned and unplanned NEPT) within an independent government body external to AV.
   1. This option would create an entity with a dedicated focus and specialisation on NEPT and reduce scope for NEPT work to spill to emergency ambulances.
   2. However, the review decided not to recommend this option because it would keep planned and unplanned NEPT together. This model maintains the risk of perpetuating deprioritisation of planned transports and the risk they will be disrupted by unplanned emergency responses.

Box 18: Separating planned and emergency responses within an entity may be insufficient

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| The experience of New Brunswick (a province in Canada) suggests that creating a distinct unit for NEPT within an ambulance service does not achieve the full impact on performance that full structural separation would provide, as seen in examples like New South Wales.  In March 2019 Ambulance New Brunswick established a dedicated patient transfer service as part of its role as the single provider of emergency and NEPT services in the province. Prior to that, when an ambulance undertook a patient transfer it was not available for emergency services.[[191]](#footnote-192) The 2019 reforms aimed to strengthen the entire service for both emergency and non-emergency clients.  Figure 6 shows there was a drop in planned NEPT performance over the quarter when the reforms occurred, but timeliness quickly recovered over the next 12 months or so. However, while both unplanned NEPT and ambulance performance was maintained despite rising demand for emergency ambulance services, performance of planned NEPT has deteriorated. This indicates that internal separation might not be enough to protect planned NEPT transfers from emergency demand and ensure these patients receive timely access to health care.  Figure 6: Timeliness of emergency and non-emergency services in New Brunswick[[192]](#footnote-193)  Figure detailing the results from New Brunswick, as described in the text. |

#### Evidence shows benefits from delinking planned NEPT and emergency responses

1. As this section shows, there are significant performance benefits to both delivering planned NEPT and emergency responses when the 2 services are delinked.
2. The main reason for this is because emergency responses and planned NEPT are fundamentally different. The services are delivered for 2 different customers – hospitals and ambulance services – and they have distinct service needs.
3. As discussed in chapter 2, the main role of ambulance services is to respond to people with time-critical emergencies. Unplanned NEPT services can play a critical role in supporting these efforts. Whenever a triple zero (000) call can be appropriately redirected to a NEPT service, an ambulance is freed up to attend to the people in greatest need. This requires access to a flexible pool of NEPT resources that can be redirected to callouts where safe and appropriate, following assessment by paramedics and nurses within AV’s secondary triage service.[[193]](#footnote-194)
4. On the other hand, health services seek to support timely access to health care for their patients. For care to be timely, health services must manage their inpatient beds efficiently, with timely patient discharges to prevent ‘bed block’. This occurs when an insufficient supply of beds leads to patients being backed up in emergency departments and on ambulance ramps. While timely discharge is influenced by many factors, timely and reliable planned NEPT services play an important role.[[194]](#footnote-195)
5. When ambulance services run, directly deliver or commission planned NEPT services, their needs can predominate over those of health services.[[195]](#footnote-196) These issues may be mitigated through governance that creates clear accountability for performance of both emergency responses and planned non-emergency transports, but this does not solve the problem of competing priorities. A wide range of priorities can be explicitly measured and monitored, but they cannot all be met by one organisation – not everything can be a priority.
6. Consistent with this, high spill rates are seen in jurisdictions where a single entity is responsible for both ambulance responses and NEPT.[[196]](#footnote-197) Of course, it is difficult to draw firm conclusions from models in other jurisdictions because there are other factors beyond system design that influence outcomes. However, New South Wales provides a relatively clear example, having experimented with both integration and separation of planned NEPT and emergency ambulance services, with a stark difference in performance between these 2 models.
7. As Box 19 shows, New South Wales’ planned NEPT performed poorly when it was delivered by its ambulance service. As a result, multiple recommendations over many years were made through external reviews to separate the two. This was ultimately achieved in 2014.
8. New South Wales Ambulance’s (NSWA) NEPT division, Patient Transport Services, was moved to a separate public entity, HealthShare NSW, with progressive onboarding of hospital-based NEPT services afterwards. A range of improvements were implemented, including centralised booking and dispatch as discussed in section 4.2.
9. Significant performance benefits rapidly followed separation of NEPT and ambulance in New South Wales, discussed in greater detail in Box 19 below. These include:
   * 1. very large declines in spills of NEPT work to emergency vehicles (from 15.7% in June 2014 to less than 1% in 2023)
     2. much improved NEPT timeliness (with the proportion of declines doubling from 32% before the separation to 65% in 2023)
     3. slightly improved ambulance performance, with faster responses to the most urgent incidents within 3 to 12 months after separation
     4. broader improvements in employee safety, customer satisfaction and financial efficiency.

Box 19: Separation of planned NEPT and emergency responses improved performance in New South Wales

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| **Why were ambulance and NEPT services separated?**  NSWA was previously responsible for delivering NEPT services. A 2008 inquiry[[197]](#footnote-198)found this was not working well, with approximately half of NSWA NEPT transports undertaken by emergency ambulances.[[198]](#footnote-199) Diverting emergency ambulances to NEPT jobs was increasing response times for emergency cases, putting patients at risk.[[199]](#footnote-200)  It was recommended that patient transport work be separated into 2 operational streams: emergency and non-emergency.[[200]](#footnote-201) Modelling showed this would reduce or eliminate the amount of time ambulances were unavailable to respond to emergency cases due to NEPT commitments and, in Sydney, reduce or eliminate occasions where booked patients were kept waiting for NEPT transport because of an influx of emergency calls.[[201]](#footnote-202)  This finding was echoed by other reports[[202]](#footnote-203) but not implemented. This led to hospital groups (local health districts, or LHDs) developing their own NEPT services in addition to those under NSWA.[[203]](#footnote-204) Each of these LHD-run services had different procedures, practices and reporting requirements, and there was a lack of coordination across LHD boundaries, resulting in inequality of access, patients having to wait too long for drop-off or pick-up from appointments, and inefficient use of resources.[[204]](#footnote-205) Transport NSW was also operating a community transport service for disadvantaged groups in the community to access health care.[[205]](#footnote-206)  The outcome of the delayed separation was ongoing poor performance for NSWA[[206]](#footnote-207) and fragmentation and duplication across the system.[[207]](#footnote-208)  **What did separation involve?**  In 2012 the New South Wales Government committed to separating NEPT and ambulance services by moving NEPT from ambulance into a dedicated Patient Transport Service run by a separate public entity, HealthShare NSW.[[208]](#footnote-209) NEPT fleets from NSWA, all metropolitan LHDs and 2 of the rural and regional LHDs were integrated into a common NEPT service. The rollout of the new system was staggered from 2014.[[209]](#footnote-210)  A number of key improvements were implemented following the separation. These included:  centralised booking and dispatch (Box 23 in section 4.2.3) – this included a single webform for booking with embedded patient screening and redirection to alternative platforms, and centralised visibility of all NEPT resources, an algorithm to support route scheduling and dispatching, as well as real-time analytics enabling rapid identification and resolution of issues affecting system flow  investments in improving patient experience, including an ‘Uber’-style tracking application allowing patients to track their pick up and arrival times, and patient feedback forms to identify and address concerns and inform future service improvements[[210]](#footnote-211)  a simulation model for NEPT capacity to enable service improvements to be prospectively modelled, tested and shared with stakeholders, before they were piloted[[211]](#footnote-212)  a reservations model that locks in bookings with a guarantee they will not be reprioritised, giving greater certainty regarding transport times for patients and health services. This enables improved discharge planning and readiness among health services and more efficient scheduling of planned NEPT collections to improve patient, staff and clinician experience, reduce wait times and increase system efficiency (Box 23 in section 4.2.3).  Today, NSWA and HealthShare NSW’s NEPT service have full separation of scope. NEPT is structurally delinked from NSWA: it does not respond to any triple zero (000) demand, and it can only be booked by hospitals and clinicians. NSWA manually refers only 3 to 5 transports a day (increasing to 5 to 10 during surges) to NEPT[[212]](#footnote-213) – these patients have been triaged as not meeting the acuity threshold for an ambulance but require non–time critical transport and clinical monitoring to access care.  **What were the outcomes of separation?**  The timeliness of NEPT services improved rapidly and significantly following separation, with 48% of NEPT services arriving on time by February 2015, compared with only 32% before the separation in 2013 (). By 2023, timeliness had risen to 65%.[[213]](#footnote-214) To increase it further, a ‘reservation model’ (Box 23 in section 4.2.3) was piloted in late 2023. This model, which relies on full separation of planned NEPT from emergency responses, further improved timeliness by 25% and vehicle productivity by 14%[[214]](#footnote-215) during the pilot alone.  The proportion of NEPT work done by NSWA declined quickly and significantly after separation, from 15.7% in June 2014 to 6.4% less than 12 months later, in February 2015 (Figure 7). A year later it had fallen to 3.2% in April 2016. At this point, most of the remaining work done by ambulances was outside NEPT operating hours.[[215]](#footnote-216) By 2023, less than 1% of NEPT work under HealthShare NSW’s responsibility was delivered by emergency ambulances, compared with 8 to 12% in LHDs outside HealthShare NSW’s NEPT coverage.[[216]](#footnote-217)  A 2023 partner experience survey showed overall satisfaction was at 7.3/10, one of the highest of all business lines across HealthShare NSW. This is a steady increase from the first partner experience survey in 2019, which scored 6.3/10. HealthShare NSW advises that satisfaction metrics since the service transitioned from NSWA have significantly changed but have progressively improved.  Figure 7a: Improved system performance in NSW, following separation of NEPT and NSWA  Refer to Boxes 19 and 23 for the information contained in this bar chart.  Figure 7b: Improved system performance in NSW, following separation of NEPT and NSWA  Refer to Boxes 19 and 23 for the information contained in this line graph.  NSWA’s performance appears to have been temporarily disrupted during the transition,[[217]](#footnote-218) but then it improved. Figure 8 shows a slight decrease in the percentage of Priority 1A events responded to within 10 minutes, but this returned to normal within 12 months and rose above historical performance thereafter. Otherwise, available performance data remained constant throughout the transition. Moreover, consistent performance during growth in total ambulance service demand can indicate an improvement in actual performance.[[218]](#footnote-219)  Figure 8: Performance of NSW Ambulance before and after separating NEPT[[219]](#footnote-220)  Refer to Boxes 19 and 23 for the information contained in this line graph. |

1. Clear role delineation and clarity of focus has enabled New South Wales’s NEPT service to address issues that remain chronic problems in Victoria as discussed in chapter 3. These problems include ineligible bookings and poor timeliness for planned NEPT collections (Box 23 in section 4.2.3).
2. Other jurisdictions examined during the review also demonstrate challenges in delivering NEPT services from the same resource pool. For example:
   1. In Western Australia, metropolitan NEPT was separated from ambulance services after publishing the 2009 Joyce Report, which found that interhospital transfers were having a negative impact on the availability of emergency resources.[[220]](#footnote-221) In regional areas however, there is still a single provider (St John Ambulance) for planned NEPT and emergency responses.[[221]](#footnote-222) During periods of low demand or for after-hours transfers, all available ambulance resources can be used to perform planned NEPT. This has created significant risks to meeting emergency demand in rural areas.[[222]](#footnote-223)
   2. Across Queensland there is also a single provider for planned NEPT and emergency responses (Queensland Ambulance Service). There is a high rate of spills of planned NEPT transports to emergency services (approximately 20%).[[223]](#footnote-224) Queensland has a lower overall rate of NEPT use (54.3 responses per 1,000 population in Queensland compared with 67.5 in Victoria) and a higher rate of emergency use (173.7 responses per 1,000 population in Queensland compared with 89.7 in Victoria).[[224]](#footnote-225)
3. These examples, along with the challenges associated with AV’s current responsibility for NEPT services and the clear evidence of improvement from separating planned NEPT and ambulance services in New South Wales, suggest there would be significant benefit in structurally separating these services in Victoria.

### The review recommends structural separation of planned and unplanned NEPT services

1. It is recommended that Victoria’s planned NEPT services be separated from unplanned NEPT, with the latter remaining under AV control, as set out in Recommendation 1.
2. Rather than a single entity delivering or procuring both forms of NEPT, responsibility for these would be split as follows:
   1. AV would remain responsible for unplanned NEPT, in line with its core organisational focus on serving people with time-critical emergencies.
   2. Planned NEPT, the majority of NEPT services, would be split from unplanned NEPT and AV. This will prevent its disruption by responses to unplanned events and ensure it focuses on its core role of enabling timely patient access to health services.
3. This recommendation applies regardless of whether NEPT services are insourced or outsourced, noting options to pursue both outcomes are provided in chapters 5 and 6:
   1. If NEPT is insourced, AV would be responsible for delivering unplanned NEPT in-house, while a separate public entity would be responsible for delivering planned NEPT in-house (refer to chapter 6).
   2. If NEPT remains outsourced, AV would be funded for all unplanned NEPT, while planned NEPT would be procured separately (chapter 5).
4. This separation can be achieved without risk of unplanned services (which make up 15.0% of total NEPT transports) becoming subscale.[[225]](#footnote-226)
   1. In an insourcing scenario, unplanned NEPT services would be integrated into AV’s broader emergency response operations (chapter 6).
   2. In an outsourcing scenario, AV will commission unplanned NEPT services through HSV, coordinating with planned NEPT contracts to ensure sufficient scale that balances both the need of AV and health services (chapter 5).[[226]](#footnote-227)

Recommendation 1: Structural separation of planned and unplanned NEPT services

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| Planned and unplanned NEPT services should be separated, with Ambulance Victoria retaining responsibility for unplanned NEPT in line with its core organisational focus on serving people with time-critical emergencies. Planned NEPT should be managed separately to prevent its disruption by unplanned NEPT and to ensure timely patient flow into and out of healthcare facilities. |

1. Separation of planned and unplanned NEPT would deliver significant benefits for the health system, as described above and in greater detail in chapters 5 and 6. In brief, it would:
   1. enable funding arrangements to be simplified with a single point of commissioning for planned NEPT, improving ease of booking and reducing administrative costs and duplication
   2. minimise routine deprioritisation and disruption of planned NEPT by unplanned NEPT to support emergency responses – this would enable these services to become more reliable, timely and efficient, delivering a better user experience for patients, a more effective flow management resource to health services and lower service costs to the system
   3. maintain appropriate alignment of unplanned NEPT with the emergency response system, with ongoing integration into triple zero (000) call-taking and dispatching and opportunity for closer alignment with AV emergency responses and clinical governance through service model innovation
   4. create dedicated focus for both NEPT and emergency responses, streamlining operations and fostering specialisation, expertise and innovation within each service. This would enable both services to focus on tackling core challenges, including addressing growing emergency demand, and reducing spills and lifting timeliness for planned NEPT.

### The impacts of separation for AV will need to be carefully managed

1. As noted above, separating planned and unplanned NEPT services is recommended regardless of whether these services are delivered by public or private entities. Subsequent chapters provide options for implementing this separation through an improved outsourcing model (chapter 5), or a full or partial insourcing model (chapter 6).
2. Regardless of whether full, partial or no insourcing occurs, separating planned and unplanned NEPT means that AV will no longer be responsible for planned NEPT services. This has significant implications that will need to be planned for and managed through the transition.
3. First, separation will have financial implications for AV because its funding for planned NEPT would be reassigned to the separate entities procuring (chapter 5) or delivering (chapter 6) these services.
   1. While planned NEPT funding is a minor component of AV’s balance sheet, its removal will need to be done in a way that minimises impacts on other parts of its operations.
   2. As such, implementing this recommendation may offer a timely opportunity for a broader reconsideration of AV’s funding model to ensure greater transparency and clarity between revenue and services.
   3. Because AV jointly commissions planned and unplanned NEPT services, disentangling these funds will require a detailed costing study to understand the appropriate funding required to deliver timely unplanned NEPT services and efficient planned NEPT services.
4. Separation will also have performance implications for AV, which will need to prepare for the logistical implications of no longer being able to redirect planned NEPT capacity as needed and develop new strategies for leveraging its resources to maintain and improve emergency response performance.
   1. As chapter 3 notes, planned NEPT supports AV’s emergency response performance because TZV prioritises hospital work below emergency work when assigning NEPT resources to jobs and redirects NEPT crews from planned to unplanned pick-ups as needed.[[227]](#footnote-228) This negatively affects planned NEPT and health system flow but has an interim benefit for AV’s emergency responses.
   2. Separating planned and unplanned NEPT will mean that TZV and AV will no longer be able to do this. They will also have access to fewer crews across the state (affecting travel times from the nearest available vehicle to an incident). Also, while AV will retain access to planned NEPT resources under the *Statewide health emergency plan*, it will not be able to draw on these resources when it is under routine or short-term capacity constraints (for example, due to workforce shortages or demand surges).
   3. These factors mean that AV will need to holistically consider how it will maintain and improve emergency performance without access to planned NEPT resources, including through appropriate funding of unplanned NEPT (as discussed above), redeployment of the existing workforce to emergency work (refer below) and broader innovation in its emergency response model.
5. Separation may also have operational implications for AV’s CTS division (Box 20). If AV is no longer responsible for planned NEPT stretcher services in line with the recommendation to separate planned and unplanned NEPT, it would be logical for it to no longer be responsible for the planned NEPT walker services delivered by CTS, with this function to be separated along with NEPT stretcher services.

Box 20: There is an opportunity to make better use of AV’s Clinic Transport Services workforce

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| The primary focus of this review has been NEPT stretcher services. Walker, walker-assist and hoist transports are also delivered through a range of workforce and contracting models, including AV’s in-house CTS in metropolitan areas, with some private subcontracting and taxis in rural areas.  Walker transports tend to be for low-acuity and low-risk patients who typically do not meet requirements for NEPT but need transportation. Most patients are receiving dialysis; some are for oncology, radiation therapy or hyperbaric therapy. To be eligible for these services, patients must be able to walk unassisted, climb 2 steps into a minibus, enter and exit a station wagon comfortably with minimal assistance and travel comfortably in a seated position. Increased clinical risk factors make a patient automatically ineligible.[[228]](#footnote-229)  Every year, around 112,000 transports are delivered for walker, walker-assist and hoist patients.[[229]](#footnote-230) Funding sits with AV,[[230]](#footnote-231) which provides centralised booking and dispatch in-house[[231]](#footnote-232) and provides transports primarily through in-house delivery, with some outsourcing.  There is significant reform opportunity to better leverage the skills of the CTS workforce, which encompasses some 62.8 FTE of PTOs, ATAs and paramedics. AV advises that a significant proportion of CTS services may be for patients who need support to access health care but not clinical monitoring during transport. These patients could be redirected where appropriate to non-medical transport services, freeing up CTS staff to support emergency and urgent responses within AV, with appropriate upskilling and training where required.  As part of this reform work there may also be an opportunity to explore best possible uses for ambulance community officers in AV.[[232]](#footnote-233) |

1. This creates opportunities for the PTOs, ATAs and paramedics currently employed in CTS to support emergency and urgent responses within AV, with appropriate upskilling and training where needed. This would have several benefits:
   1. It would improve organisational performance for AV, which already needs to expand its recruitment of paramedics and PTOs to respond to increasing demand (as described in chapter 3). It will improve overall rostering practices, reducing overtime and improving access to leave and workforce flexibility. It could potentially include an expanded in-house unplanned NEPT service.[[233]](#footnote-234)
   2. It would improve workforce satisfaction by delivering services that better use their skills and competencies with no loss of employment or entitlements. This may also improve financial sustainability, noting that the costs of delivering CTS are currently not covered by the revenue it generates.
   3. It would expand internal pathways for AV staff to engage in emergency work during different career stages, including pathways to retirement or return to work and safe duties.

## Centralisation of booking and dispatch

1. As chapter 3 outlines, there are challenges with cost duplication, service fragmentation, inefficiency and delays for NEPT services in Victoria. These issues are in part due to limited coordination and inefficient booking and scheduling of NEPT services. This prevents services from being limited to eligible patients and routes from being scheduled to minimise travel time and maximise timeliness and productivity of NEPT resources.[[234]](#footnote-235)
2. Around Australia and in other jurisdictions, health systems are addressing these issues through centralising booking and dispatch systems for their NEPT services.[[235]](#footnote-236) This involves making a single entity responsible for centralised intake of NEPT requests from health services and coordinating their NEPT resources to meet demand. There is clear evidence these systems improve NEPT performance and can address high levels of inefficiency in both the booking and dispatch of planned NEPT services in Victoria.

### Fragmented booking and dispatch creates inefficiency in Victoria’s NEPT system

#### Booking processes are much less efficient for planned than unplanned NEPT

1. While planned NEPT services have a complex but largely decentralised booking model, all bookings for unplanned NEPT are managed by TZV and involve a single intake process with embedded patient eligibility screening.
   1. Unplanned NEPT transports typically originate via triple zero (000) calls. TZV call-takers follow a structured script to identify callers who can be referred to AV’s secondary triage for further assessment to understand their suitability for an alternative service, including an unplanned NEPT response.[[236]](#footnote-237) Secondary triage clinicians authorise NEPT response where suitable[[237]](#footnote-238) and redirect patients who are not eligible to taxis and other transport options.
2. In contrast, planned NEPT bookings are highly fragmented and involve no centralised eligibility screening because these bookings are authorised by a health professional after an in-person assessment.
3. As described in chapter 3, health services typically need to book planned stretcher NEPT transfers through at least 2 different pathways, depending on the patient, with multiple additional pathways for walker and walker-assist patients.[[238]](#footnote-239)
4. Unlike the process for unplanned NEPT, there is no central triaging of planned NEPT requests to ensure patient eligiblility. A signficiant proportion of the planned stretcher and walker or walker-assist NEPT transports AV funds may be for ineligible patients.
5. Booking processes for planned NEPT tend to rely on manual approaches that are inherently slower, prone to human error and involve duplication in development costs where investments in improvements are made. For example:
   1. AV’s CTS service only accepts fax bookings, despite a relatively large-scale service (around 250 bookings per day).[[239]](#footnote-240)
   2. Taxis can be booked via AV’s secondary triage service, AV’s CTS service or directly by health services.[[240]](#footnote-241)
   3. AV’s stretcher NEPT services can be booked via phone or a webform, which generates a PDF that TZV call-takers manually copy into its computer-aided dispatch system (for an average 700 bookings per day).[[241]](#footnote-242) This neutralises any time savings, while human error further extends handling time.[[242]](#footnote-243)
   4. Some private providers have developed tailored webforms that reduce booking complexity for health services and enable limited autofilling of patient information.[[243]](#footnote-244) Others use more manual approaches.
6. The wide range of booking mechanisms increases costs and reduce market competition.
   1. They directly add cost through the time lost to training many health service staff to use them, and they indirectly add cost through reduced competition.
   2. Across the system, very few health services engage more than one NEPT provider,[[244]](#footnote-245) while most contract with a single provider. HSV has advised that many health services avoid switching providers, even in the face of significant fee increases, to avoid the significant change-management costs involved.

#### Dispatching processes are also highly inefficient for planned NEPT

1. Dispatch arrangements for planned NEPT transports are likewise decentralised and, again, vary by patient depending on the NEPT funding source.
   1. For NEPT patients funded by AV, dispatch of both AV and private provider crews is managed by TZV,[[245]](#footnote-246) while dispatch of CTS resources is run entirely by AV.[[246]](#footnote-247)
   2. For NEPT patients funded by health services, dispatch is decentralised to the same private providers, who have dedicated internal teams to deliver this function.
2. This fragmentation of contracting[[247]](#footnote-248) prevents NEPT services from being managed as a collective resource. This creates inefficiencies in scheduling and route planning, with no ability to plan patient collections or redirect or swap NEPT resources to avoid the following issues:
   1. empty return trips (for example, where an AV-contracted crew transports a patient from a metropolitan to a regional hospital, and a health service-contracted crew transports another patient from the same regional back to metro, with both crews at risk of returning empty)
   2. overtime (for example, when a crew is at the end of its shift but has not completed a patient transport and cannot hand over the patient to a nearby crew with capacity if they are from different companies, or the same company but contracted by separate parties)
3. Collectively, these issues lead to chronic frustrations and delays in the sector, as Box 21 shows.

Box 21: A lack of central NEPT resource coordination creates frustration and delays

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| ‘As if to illustrate the absurdities in this system, yesterday evening we were sent to a local hospital to relieve a crew from our company who were doing an AV-contracted shift, as were we. It was around 1730 and we were a 1930 finish. The other crew was either on overtime or due to knock off.  When we got to the ED we could not find them. After talking to the clerk and triage nurse they said, “They are down the back”. Actually they weren’t. They had got a bed and cleared before we got there but we didn’t know that.  An AV paramedic crew were ramped and due to knock off. We offered to mind their patient (who was low acuity and within our scope) so they could clear. Between the AV crew, the hospital, us, [TZV] and the AV duty manager we tried but it all got too hard. Contractual obligations. Different companies etc. While trying to sort it, the AV crew eventually got a bed.  There was a NEPT crew from another company there as well who were also ramped and wanting to knock off, but of course we were unable to help them either.  The ED had a patient who was waiting to be transferred to a ward at another hospital. The triage nurse asked if we could take that one and free up a bed. We could have easily done that one and got back to base on time. But we couldn’t. Because that patient was booked as a private transfer under the hospital’s contract with our company, and we were doing an AV-contracted shift. I had to explain the whole thing about us being the same company, yes, but an AV car, and yes, we were probably going back empty but sorry can’t help.  Eventually, we were sent back to our Branch having achieved exactly nothing. A complete waste of the last 2–3 hours of our shift where we could have helped out one or even two crews to clear, go home or go back on the road.’  – NEPT workforce[[248]](#footnote-249) |

1. A lack of modern technology and analytics further undermines dispatch efficiency for planned NEPT.
   1. TZV is the largest provider of dispatch in the system, and a specialised provider of these services in its own right.[[249]](#footnote-250) However, there is significant opportunity to improve on the current approaches:
      1. TZV allocates NEPT jobs to private providers contracted by AV without much visibility of the provider’s existing bookings. This limits its ability to allocate jobs across crews based on their existing booked trips, thus avoiding the need for return trips with vacant vehicles.
      2. TZV’s dispatching approaches are manual, with decisions based on individual call-takers’ geographical knowledge and judgement about the relative priority of different patients, rather than algorithms shown to outperform human judgement.
      3. These algorithms enable huge numbers of possible route combinations to be tested in order to find those with the shortest travel times, reducing patient wait times and improving resource productivity. They are fundamental to performance in other logistics industries and have been shown to outperform human judgement in real scenarios (Box 22).
      4. For example, a published NEPT-specific experiment based on a real scenario provided by an ambulance service found algorithmic scheduling reduced patient waiting time during transport by up to 13.33% and increased NEPT vehicle use by up to 29.35%.[[250]](#footnote-251)
   2. Health services and patients generally do not receive live updates on estimated arrival times from TZV or directly contracted NEPT providers, despite this being commonplace in many other logistics industries[[251]](#footnote-252) and a standard consumer expectation now in Australia. This contributes to poor user experience for health service staff and patients, and it can cause delays if patients are not ready to depart when NEPT crews arrive.

Box 22: Calculating optimal routes for NEPT vehicles cannot be done by human expertise alone

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| ‘Computing optimal routes for ambulances is a non-trivial problem that depends on the number and characteristics of the available ambulances, as well as their location. Several incompatibilities may arise due to the limited number of positions available in each ambulance, the equipment included, or depending on the legislation related to patient transport and minimum service conditions in each country.  The Non-emergency Patient Transport Services Route Planning problem could be defined as the determination of the daily schedule for each available ambulance indicating the stops to be performed during the day, including the estimated time for the ambulance to arrive to each point of the route, and the patients that should be get on or off the ambulance at the stop.  Most companies perform the service assignment by means of experts that are aware of the limitations of the system and the constraints that should be addressed in order to have a feasible solution, which is often a suboptimal one since human experts are not able to test enough combinations in an adequate time.’  – Fogue M, et al. (2016) Non-emergency patient transport services planning through genetic algorithms, *Expert Systems with Applications*, vol. 61, pp. 262–271. |

#### Planned NEPT resources are uncoupled from management of health system flow

1. NEPT plays an essential role in health system flow,[[252]](#footnote-253) affecting patient discharges, interhospital transfers, ambulance ramping and load balancing, as well as broader emergency department, intensive care unit and inpatient capacity management, and specialist clinics.
2. However, most NEPT services are dispatched by TZV, which lacks formal links with the hospital system and prioritises NEPT resources in line with AV’s needs rather than those of health services. TZV has minimal visibility of health service resources and inpatient capacity, beyond ambulance ramping, which is a lagging indicator that only alerts TZV to bed block after it arises.[[253]](#footnote-254)
3. TZV is also accountable for its performance to AV, not health services, and so is incentivised to use NEPT to optimise ambulance services ahead of broader health system flow. As such, its internal prioritisation guidance directs call-takers to generally prioritise unplanned above planned NEPT.[[254]](#footnote-255)
   1. TZV’s specific ranking of priorities places home-to-hospital transfers first (often unplanned NEPT), followed by planned NEPT for hospital appointments, followed lastly by planned NEPT for hospital discharges.
   2. TZV uses the planned NEPT capacity funded by AV as effective surge capacity for unplanned NEPT, leading to redirecting planned NEPT transports to unplanned events, with flow-on impacts for health service performance.
4. Health services can direct their providers on prioritisation of different patient transports. Depending on purchasing arrangements,[[255]](#footnote-256) this can lead to competing requests between health services to the same provider, with the operator prioritising resources in the way that best enables them to optimise performance against their contracts with each health service. Smaller health services may be poorly served by this approach, where larger health services with greater purchasing power may be more influential in resource allocation decisions.
5. Transport requests are continuously reprioritised after booking by both TZV and health services, making it impossible to optimise scheduling and directing of resources across the state. Stability of bookings would enable the NEPT sector to increase productivity by planning routes in the way that maximises the number of transports each crew can do in a day, improving timeliness of services across the board. As Box 23 shows, this has led to significant improvements in system performance in New South Wales.

### Options to improve booking and dispatch

1. The review considered several options to strengthen booking and dispatch approaches in Victoria’s NEPT system. The recommended approach is to preserve TZV’s current centralised booking and dispatch role for unplanned NEPT, and to create a bespoke centralised booking and dispatch function for planned NEPT that is delivered by a separate public entity. This would uphold the structural separation between these functions in line with Recommendation 1.
2. Centralising booking and dispatch for planned NEPT services would deliver significant benefits. It would create efficent scale to invest in a system that streamlines the current booking process and allows for automatic central review of requests, assessing patient eligibility and matching them with the most suitable transport option for their specific needs. It would also create efficient scale to invest in a contemporary algorithm-based dispatch system that uses a comprehensive view of all bookings and resources to coordinate routes, minimising travel time and maximising the efficiency and productivity of NEPT resources.
3. These benefits are strongly evident in New South Wales (Box 23), where an advanced booking and dispatch capability has delivered measurable improvements in system performance.

Box 23: Centralised booking and dispatch plays a central role in New South Wales’ NEPT system

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| As part of consolidating NEPT services, New South Wales introduced a single centralised booking and dispatch system (Box 19 in section 4.1.2.1).[[256]](#footnote-257) The main aim of this was to improve efficiency by managing all transport requests and NEPT resources centrally so routes could be planned to minimise empty return trips and increase multiloading when patients were on common routes.  **New South Wales’ booking system connects patients with the right transport for them**  The online booking system has 2 key functions: to check patients’ eligibility and to connect them with appropriate transport based on this. When transport requests are made for ineligible patients, this system automatically books a taxi for them.[[257]](#footnote-258) In 2022–23 approximately 53,000 taxis were leveraged for dialysis patients alone, saving $21.3 million.[[258]](#footnote-259) This function will be expanded further in future.[[259]](#footnote-260)  The booking system also enables patients and health services to check the status of requests and view estimated arrival times in real time, ensuring patients are ready to go when the NEPT crew arrives and reducing the number of follow-up phone calls and miscommunications that can occur.  **New South Wales’ dispatching process is designed to maximise system efficiency**  New South Wales uses a mathematical algorithm to allocate resources rather than manual decision making.[[260]](#footnote-261) The technology handles routine scheduling and dispatching by reviewing the capabilities, availability and location of patient transport vehicles, and scheduling the optimal combination of transport. This autoscheduling is based on rules defined by the Patient Transport Service. This frees up the booking hub team to focus on any transports that fall outside the ‘norm’ and communicating with health services to facilitate requests. Work is underway to regionalise this model, with ongoing central coordination of routes using the algorithm and regional staff to liaise with local health services and crews. This model has shown promising productivity benefits to date.[[261]](#footnote-262)  **Central booking and dispatch generate data to underpin broader system management**  Central tracking of resources through the booking and dispatch system creates detailed performance data on patient experience,[[262]](#footnote-263) transport timeliness and resource productivity. HealthShare NSW is accountable to health services for performance as measured using these data,[[263]](#footnote-264) and the data are also used to deliver broader system management functions by HealthShare NSW.  This includes continuous internal monitoring of timeliness and productivity, with real-time analytics to support system planning and rapid decision making such as proactive escalations to approve overtime or to bring on extra crews in targeted areas to prevent delays. Data are also used to identify where system improvements are needed, to prospectively model their impact and to monitor their results, as shown below.  HealthShare NSW works with local LHDs to manage NEPT demand. Each local hub has a daily way of working, including meeting with the relevant LHD to discuss demand and planning for the day. Established escalation pathways exist if there are unexpected increases in demand or the need to replan and reprioritise, escalating to the Ministry of Health if there are competing priorities between LHDs. This ensures overall system outcomes are maintained.  **Improving timeliness and productivity through a ‘reservations’ pilot**  While significant improvements in performance have been achieved, New South Wales considers that there is more room for improvement. Previously health services have had limited certainty of vehicle arrival times because these frequently change in response to reprioritisation of requests by health services. This leads to escalations and manual interventions in the algorithm by HealthShare staff. In the face of uncertainty about collection time, health service staff tend to book their patients for the next-available collection time regardless of whether they are ready for discharge, leading to 22,000 on-the-spot cancellations a year.  To address this, in late 2023 New South Wales piloted a ‘reservations’ approach to allocating trips (Figure 9). This locks in bookings with a guarantee they will not be reprioritised, giving greater certainty about transport times for patients and health services to improve flow and timely access to care. In the first week of the pilot alone, there were significant improvements, with 81% of trips on time, only 1% of jobs delayed by more than an hour and productivity increasing by 14%.[[264]](#footnote-265)  Figure 9: New South Wales ‘reservation’ model is improving timeliness and efficiency  [To be provided]  **Maintaining capability for rapid escalation and resolution of flow issues using ‘fly cars’**  Alongside the reservation model, New South Wales will also introduce ‘fly cars’. These are unbooked vehicles kept available during every shift. This enables rapid response to urgent escalations without disrupting the broader planned NEPT system, which relies on the stability of scheduling and arrival times. This model will progress the closer integration of health service flow management and NEPT that emerged during the COVID-19 pandemic, where there were daily discussions between New South Wales’ health service, ambulance and NEPT managers about load balancing across the system to manage surging demand and hospital capacity constraints. |

1. There are high levels of consensus among stakeholders about support for centralised booking and dispatch, as shown in Box 24.
   1. It is acknowledged that some private providers have recommended that this function be provided by a single private entity. This is not supported given the risk of conflict of interest between booking and dispatch functions delivered on behalf of the system, and the private provider’s incentive to bolster its own internal NEPT service delivery operations.

Box 24: Stakeholders generally support centralisation of booking and dispatch

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| ‘Consider a single point of booking to ensure consistency in authorisation, adherence to the Regulations, and oversight of operations.’  – Ambulance Victoria  ‘The Victorian NEPT process needs a system hub to coordinate all of the NEPT providers to improve timely transfers and improve efficiency.’  – Central Highlands Rural Health  ‘This submission supports any reform model discussion and analysis that prioritises a centralised coordination function to cover all non-emergency patient transport call-taking and dispatch across the State.  …  ‘... any reform model that includes a centralised booking and dispatch system, would contribute more positively to patient care, efficiencies in service delivery and would prioritise health of Victorians.’  – Triple Zero Victoria  ‘Implement centralised booking systems or platforms that streamline the NEPT booking process, such as a universal dispatching system.’  – Medical Edge  ‘Addressing fragmentation through centralised and coordinated booking and dispatch services to benefit the entire sector to improve patient flow and timeliness by maximising all resources available in the NEPT system.’  – Royal Flying Doctor Service  ‘Consolidate all NEPT bookings into one management team, such as the ESTA facility.’  – LifeAid‘  Local management of NEPT is vital for effective bed flow management within healthcare services.’  – Victorian Healthcare Association  ‘…standardisation will deliver the benefits of centralization without the potential disruption to the industry.’  – National Patient Transport |

1. Around the world, several health systems are planning, or have successfully implemented, integrated planned NEPT booking and dispatch into statewide capacity command centres. This includes Western Australia, South Australia and Queensland (as detailed in Box 25), as well as in overseas jurisdictions such as the United States.[[265]](#footnote-266)

Box 25: Several jurisdictions are bringing NEPT and all-flow management together

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| In Western Australia, NEPT services are currently managed through a decentralised model via direct hospital requests to a panel of private contractors. A recent parliamentary review[[266]](#footnote-267) identified the need for central coordination of all NEPT services. Western Australia’s regional health service provider has piloted a centralised booking and dispatch system to oversee patient transport to and from regional and metropolitan hospitals. Metropolitan Western Australia is now implementing a statewide centralised booking and dispatch service.  This centralised booking and dispatch service will be delivered through the stand up of a State Health Operations Centre that has visibility of patient flow across the system and responsibility for coordinating it. The operations centre will centrally operate key coordination functions such as NEPT booking and dispatch (which is currently decentralised to multiple NEPT service providers) and ambulance secondary triage. The operations centre will also co-locate other key functions such as triple zero (000) call-taking and dispatch, and the Acute Patient Transfer Coordination service operated by the WA Country Health Service. The co-location of these functions will allow for joint management of patient flow within the system,[[267]](#footnote-268) enabling resource allocation and proactive management of patient transport services to respond to demand pressures as efficiently as possible to support the system’s performance.  In 2023 South Australia launched a State Health Control Centre as part of its 2023 winter demand strategy.[[268]](#footnote-269) With plans to scale over the next 12 months, this control centre will give 24/7 oversight of the entire health system, allowing for better coordination to respond to blockages and ensure resources are directed where they are needed. The control centre will be linked with SA Ambulance Services, which is also responsible for coordinating NEPT. Initially based in a separate location, the control centre will move into the new ambulance service headquarters when it opens in 2025.  In Queensland, the Queensland Ambulance Service (QAS) operates a centralised booking and dispatch model with visibility of all NEPT resources across the system. It also has QAS officers co-located in regional health service network Patient Access and Coordination Hubs across the state. These hubs act as effective command centres for optimising health service patient flow, load balancing ambulance arrivals and coordinating patient transfers for the region in consultation with QAS, with real-time data to understand demand and manage the end-to-end patient journey. |

1. The Victorian Government has committed to establishing a Victorian Digital Health Command Centre (VDHCC) as the central point of authority for streamlining patient flow across the health system.
   1. The government made a commitment to establish the VDHCC in 2022 as part of the broader Parkville Precinct redevelopment. While the precinct redevelopment is not expected to be complete before 2032, health system engagement has progressed during 2022 to inform design of the functions, governance and operating model of the VDHCC, including exploring interim arrangements as the broader Parkville redevelopment progresses.
   2. As described in Box 26, the VDHCC will be a neutral entity directly accountable to the department for improving health system flow. It will have a clear mandate and responsibility to work with health services to improve the timeliness of patient access and enable better health service delivery. Neutrality will benefit the system by ensuring NEPT resources are allocated according to system priorities, rather than the competing interests of individual stakeholders.
   3. The VDHCC will also deliver important system coordination and logistical functions, with real-time visibility of activity across the full system.

Box 26: The VDHCC will be responsible for driving timely patient access to health services

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| The Victorian Government has committed to establishing the statewide VDHCC.[[269]](#footnote-270) As per the government’s commitment, the VDHCC will streamline system-wide flow, support access to care via virtual specialist support to clinicians in rural hospitals, and contribute to medical research, improving patient outcomes.  The VDHCC follows the setting up of capacity command centres around the world and in Australia[[270]](#footnote-271) to improve health system access, flow and outcomes. These command centres are used to maximise health system capacity. They act like air traffic controllers: directing patient flows to where capacity is available, load balancing across the system, and identifying and troubleshooting access bottlenecks *before* they result in delays.  This increases bed use (from 84 to 94%, in a leading command centre),[[271]](#footnote-272) enabling more patients to be treated within existing hospital capacity. This reduces costs and improves access to care for patients across the health system. Less time is spent waiting for inpatient beds to become available, reducing obstacles to offloading ambulances, admitting patients from the emergency department, and moving patients off surgical waiting lists and through theatres onto wards.  Command centres achieve these improvements by transforming capacity management from a fragmented, manual and retrospective exercise to a system-wide, digitised and proactive one. They:  co-locate staff responsible for managing patient flow across the system so they can make decisions rapidly and collaboratively, rather than in a disjointed way  digitise their workflows and use predictive analytics and artificial intelligence to forecast patient volumes and bottlenecks before they emerge, for proactive resolution.  A key task of command centres is patient transfers and retrieval, in which NEPT plays a critical role. The VDHCC’s load-levelling responsibilities will also see it using NEPT as a lever to address excess demand and bed block in at-risk health services through transfers and prioritising discharges. |

1. The review explored an alternative option to create a single point of centralised booking and dispatch for both planned and unplanned NEPT, as recommended by TZV (Box 27).
2. This is not recommended in this review because there are limited apparent benefits for planned NEPT in the approach. Planned NEPT does not benefit from integration in emergency response services (per Recommendation 1), where it is unlikely to be a priority. TZV is also unlikely to benefit from delivering planned NEPT, which risks diluting its focus on an already broad span of responsibilities for emergency events, as noted by AV (Box 27).

Box 27: TZV and AV have contrasting views on whether TZV should play a role in planned NEPT

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| ‘During submissions to the [TZV] Capability and Service Review (the Ashton Review), AV advocated for the separation of [TZV’s] public safety (Police and Fire) call-taking and dispatch responsibilities from Health, but this was not supported. Additionally, transferring responsibility for NEPT CD from [TZV] to AV was highlighted as an opportunity to streamline [TZV’s] operations and embed an organisational focus on emergency events. AV notes that [TZV] currently provides limited non-emergency call-taking and dispatch functions to other emergency services, and … there is an opportunity to ensure [TZV] can better meet their emergency key performance indicators.’  – Ambulance Victoria  ‘This submission supports any reform model discussion and analysis that priorities a centralised coordination function to cover all non-emergency patient transport call taking and dispatch across the State… [TZV] is prepared to work with any or entity to support this.’  – Triple Zero Victoria |

1. While TZV has organisational experience in booking and dispatch, as noted above, its current approaches would have to be replaced by investment in contemporary booking and dispatch systems.[[272]](#footnote-273) As such, it has little advantage over other organisations to deliver this function.
2. The review explored but does not recommend a similar option to locate centralised booking and dispatch of planned NEPT services within AV’s CTS division.
   1. As per the TZV model, this option would enable booking and dispatch to be built into an existing aligned resource, albeit one that would require similar levels of new investment to establish given existing CTS processes are manual (for example, bookings are received via fax).
   2. This option has advantages over the TZV model in that there is separation between planned and unplanned NEPT booking and dispatch (CTS is not involved in emergency responses). However, a weakness is that it still involves delivery by an emergency response entity that lacks organisational focus on planned NEPT or accountability to health services for its effective delivery.
3. A final option the review explored and does not recommend involved standardising, rather than centralising, booking and dispatch (Box 24).
   1. This option has some benefits including addressing issues with current booking processes and involving reduced change management costs.
   2. However, it also has significant limitations, which include duplicating costs in requiring all providers to individually implement the same new system specifications and functions (for example, assessment of patient eligibility and automated connections to appropriate services aligned with patient need). Most significantly, it would involve continuing to decentralise dispatch, missing the opportunities to resolve system fragmentation and improve efficiency.

### The review recommends centralised booking and dispatch

1. Based on the above evidence, the review recommends that booking and dispatch of Victoria’s NEPT services should be centralised, as set out in Recommendation 2.
2. Two key principles apply in considering which entity is best placed to deliver this function:
   1. There should be no conflict of interest between those responsible for booking and dispatch and those responsible for delivering NEPT services.
   2. Booking and dispatch must uphold the separation of planned and unplanned NEPT resources (per Recommendation 1), with no ongoing spill over between the two.
3. On this basis, booking and dispatch should be structured as follows:
   1. TZV should remain responsible for booking and dispatch of unplanned NEPT, in line with its role in triple zero (000) responses.[[273]](#footnote-274)
   2. If planned NEPT remains outsourced, albeit under improved arrangements (chapter 5), the VDHCC should be responsible for its booking and dispatch.
   3. If planned NEPT is insourced, the public entity responsible for delivering planned NEPT in-house would also be responsible for its booking and dispatch on behalf of health services.[[274]](#footnote-275)
4. For planned NEPT services, centralisation of booking and dispatch should deliver the following functions at a minimum:
   1. It should have a whole-of-system view of NEPT resources, enabling centralised coordination of them to improve route efficiency.
   2. Coordination of planned NEPT routes should be algorithm-based rather than manual, in line with contemporary best practice across patient transport and other logistics industries.
   3. Certainty of collection times should be provided to health services to ensure they can appropriately manage patient flow, improving access, timeliness and efficiency.
   4. Modern tracking technology should be used to monitor vehicle progress and communicate up-to-date arrival times to patients and health services.
   5. The booking system should be web-based and sufficiently integrated with health services’ patient administration systems and electronic medical records to enable autopopulation of forms with demographic and diagnostic information.
   6. The booking system should contain embedded eligibility screening and redirect ineligible transport requests to appropriate alternative transport options.
5. Centralised booking and dispatch will require upfront investment and change management, as discussed in the next section. However, it is expected it will improve performance and reduce system costs over time by eliminating duplication of existing processes and enabling broader efficiencies for both NEPT services and health services through improved service timeliness and route efficiency.

Recommendation 2: Centralised booking and dispatch

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| Centralised booking and dispatch of NEPT resources should be introduced. This should be delivered by a public entity that does not have a conflict of interest between dispatching and delivery decisions. The entity should be accountable to both the Department of Health and health services for timely delivery of planned NEPT services.  Key minimum functions of centralised booking and dispatch should include:  a whole-of-system view and management approach to NEPT resources, enabling a more efficient approach to scheduling routes  algorithmic coordination of planned NEPT routes, with certainty of collection times provided to optimise flow, timeliness and efficiency  upgraded technology to track vehicles and communicate arrival times to patients and health services  web-based booking forms that are securely integrated with health service patient information systems for efficiency  eligibility screening embedded in web bookings, with ineligible requests redirected to appropriate transport options. |

### Implementing centralised booking and dispatch

1. In all reform scenarios, TZV will remain responsible for booking and dispatch of unplanned NEPT, but it will cease its role in planned NEPT. The department will need to engage with other parties to manage the impacts given the transition of ESTA to TZV.[[275]](#footnote-276) Key impacts include:
   1. flow-on funding impacts
   2. workforce impacts, with TZV staff ceasing roles on planned NEPT. However, there may be opportunities to redeploy members of the workforce within the organisation or to the VDHCC (or another entity, subject to review direction).
2. The VDHCC will need to be established as an entity, including industrial engagement, workforce recruitment and training, development of an appropriate funding model and procurement of IT and capital infrastructure.
   1. Funding considerations will need to include initial establishment of the VDHCC’s centralised booking and dispatch capability, offset over time (in an outsourcing scenario) by reduced prices for NEPT services. Centralising this function will reduce costs for providers.
3. Planning will need to support the transition of staff currently delivering booking and dispatch functions in private providers and (subject to broader decisions)managing CTS services in AV.
   1. Depending on the VDHCC’s staffing requirements, strategies may include, for example, supported transition to the VDHCC, or to other roles in TZV.
4. Implementing a centralised booking and dispatch model will require stakeholders to accept reduced local control in the interests of improved system-wide performance.
   1. This risk is considered manageable, as local control is already relatively limited under the existing model, where AV (through TZV) controls booking and dispatch of a large portion (45.0%) of planned NEPT.
   2. In addition, rural and regional health services are already voluntarily trading off a degree of local control in exchange for improved servicing through regional coordination of contracts.
   3. Metropolitan health services are not doing this, but the largest users of NEPT services could preserve significant local control through maintaining hospital-based vehicles for their exclusive use, as they do currently,[[276]](#footnote-277) and receiving supplementary transports through the centralised model. Over time, if the VDHCC can demonstrate equivalent timeliness and reduced costs through centralised dispatching, these health services may voluntarily reduce the use of hospital-based vehicles.
   4. Private operators (in an outsourcing scenario) will need to be confident of the efficacy and impartiality of the booking and dispatch model, particularly in the transition process.
5. Change management and consultation will be required to design and establish the operating model and establish service-level agreements with private providers (in an outsourcing scenario), health services and overarching accountabilities to the department.
6. Over time, the VDHCC will be able to innovate and evolve the model, as has occurred in New South Wales, demonstrating shared benefits and building confidence among system stakeholders along the way.

# Improved outsourcing

1. This chapter explores opportunities to deliver improved value for the health system from an improved outsourcing model, in line with the review’s terms of reference.[[277]](#footnote-278)
2. It shows there is a significant opportunity to improve value from current outsourcing arrangements. These are poorly designed and not working for many stakeholders – neither the patients who use NEPT services, AV or health services purchasing them, nor the workforce and private companies delivering them.
3. If the government decides to pursue improved outsourcing, it can achieve best value through 4 key initiatives:
   1. separating commissioning of planned and unplanned NEPT services, in line with Recommendation 1[[278]](#footnote-279)
   2. centralised strategic commissioning of services to consolidate contracts within areas, improving economies of scale and addressing thin market risks
   3. central intervention to maintain and improve market contestability, and mitigate risks from contract consolidation, with specific interventions subject to feasibility
   4. social procurement to improve workforce conditions and environmental sustainability.
4. As discussed in chapter 3, most NEPT funding is currently directed to AV to provide free NEPT services for concession patients, with a minority to health services. AV undertakes its NEPT procurement independently of HSV and, as such, the purchasing power of HSV on behalf of health services is limited.[[279]](#footnote-280)
5. The above reform options will shift this, significantly increasing the purchasing power of HSV and health services to improve outcomes from procuring planned NEPT services. This will maintain the benefits of outsourced NEPT delivery while supporting more efficient and effective market coverage, improving patient experience and system flow, and enabling the sector to deliver on social objectives.
6. The detail of these reforms and relevant implementation considerations are described in turn below. They are proposed to be implemented in tandem with broader recommended improvements to system governance as discussed in chapter 7, involving performance measurement and accountability, workforce planning and regulation for patients and occupational health and safety.

## The current outsourcing model is poorly designed and not working for stakeholders

1. As described in chapter 3, the commissioning model for NEPT services is inherently inefficient. The key drivers of these issues are summarised below.
2. Most NEPT services are currently outsourced to private providers, with commissioning of services decentralised by department to individual health services (with procurement services provided by HSV)[[280]](#footnote-281) and AV.[[281]](#footnote-282) There is significant duplication of procurement and contract management processes, with health services and AV each separately contracting private providers to deliver planned NEPT, driven in part by their overlapping purchasing responsibilities for these NEPT services.
3. These overlapping purchasing responsibilities increase complexity in the booking process and add administrative costs in billing and staff training.[[282]](#footnote-283) They also lead to poor contracting outcomes. Health services are the primary users of the NEPT services contracted by AV, but they have no visibility of contracts nor any influence on provider performance. They also order but do not pay for planned NEPT services, blunting incentives to ensure appropriate use of these services.
4. Fragmented commissioning approaches also affect procurement outcomes, particularly in rural areas with low levels of demand that create diseconomies of scale. This makes NEPT operations less efficient and public contracts less attractive as well as less competitively priced. Small and variable service volumes also lead to NEPT staffing challenges and contribute to high rates of casualisation in the sector.
   1. AV and HSV currently play a limited role in addressing these issues. Although there is coordinated provider selection between health services within regions under the HSV panel, most NEPT services fall under AV’s responsibility, and it does not coordinate provider selection with health services.
5. Rural areas are also particularly vulnerable to contestability risks. When areas are only serviced by a single NEPT provider, and there are barriers to (or limited incentives for) new providers coming in, there are significant risks of coverage gaps if the provider withdraws.
6. HSV and AV take steps to preserve contestability. For example, both work with multiple providers (rather than contracting with a smaller number of providers based on best price).
   1. In 2023 HSV also ran supplementary sourcing processes to broaden the panel when market composition changed, which sought to improve coverage in at-risk regions.[[283]](#footnote-284) It also supports health services and providers through contract transitions.
7. However, there are opportunities improve contestability by making it easier for new competitors to enter the market. For example, HSV has economies of scale in procurement, using its purchasing power on behalf of the health system to help secure common items (for example, personal protective equipment, linen and waste disposal). This ensures all organisations can access bulk purchasing discounts regardless of their size. But HSV’s services are not currently available to private providers. Private providers miss out on cost-saving opportunities, with higher costs translating to higher pricing of public contracts.
8. HSV and AV’s respective contracting approaches[[284]](#footnote-285) both contribute to workforce casualisation. Both contracting arrangements are fixed-term in nature,[[285]](#footnote-286) do not provide guaranteed service volumes, and can be terminated with limited notice. The review heard these conditions help fuel the need for providers to maintain a casual workforce profile due to uncertain work volumes.[[286]](#footnote-287)
   1. The purchasing power of government is not used to address these issues by contractually stipulating better workforce conditions, nor to progress broader social goals such as environmental sustainability.
9. The remaining sections of this chapter show how government can improve outcomes from outsourcing through a new commissioning model that addresses the above issues by:
   1. simplifying purchasing arrangements through separating commissioning of planned and unplanned NEPT services (section 5.2), in line with Recommendation 1[[287]](#footnote-288)
   2. strategic commissioning of services to address diseconomies of scale and thin market risks (section 5.3)
   3. government intervention to improve contestability, mitigating risks from market consolidation (section 5.4)
   4. embedding social procurement conditions in contracts to improve workforce conditions and environmental sustainability (section 5.5).

## Simplifying purchasing arrangements by separating planned and unplanned NEPT

1. As chapter 4 shows, system performance can suffer when planned NEPT and emergency responses are delivered by the same resource pool or commissioned by the same organisation, while performance benefits can be realised when the services are delinked.
2. In line with this finding, the review recommends separating planned and unplanned NEPT. In the context of outsourcing reform (the focus of this chapter), this would entail changing purchasing arrangements so that:
   1. purchasing responsibility for all planned transports becomes the responsibility of health services – this would prevent deprioritisation and disruption of planned transports and ensure they focus on their core role of enabling timely patient access to health services
   2. AV would remain responsible for commissioning unplanned NEPT services, in line with its core organisational focus on serving people with time-critical emergencies.
3. As Table 7 shows, this change alone would drastically reduce the complexity of purchasing responsibilities, which would reduce administrative and billing costs and improve service booking across the system.

Table 7a: Purchasing responsibility: Unplanned (triple zero (000) derived)

| Patient type | Current responsibility: AV | Current responsibility: Health services | Proposed responsibility: AV | Proposed responsibility: Health services |
| --- | --- | --- | --- | --- |
| All | Yes | No | Yes | No |

Table 7b: Purchasing responsibility: Planned – to/from community

| Patient type | Current responsibility: AV | Current responsibility: Health services | Proposed responsibility: AV | Proposed responsibility: Health services |
| --- | --- | --- | --- | --- |
| General patient | No | Yes | No | Yes |
| Concession patient[[288]](#footnote-289) attending a public admitted facility or emergency department | Yes | No | No | Yes |
| Concession patient attending HIP/specialist clinic | No | Yes | No | Yes |
| TAC, DVA or VWA[[289]](#footnote-290) | Yes | No | No | Yes |

Table 7c: Purchasing responsibility: Planned – interhospital transfer

| Patient type | Current responsibility: AV | Current responsibility: Health services | Proposed responsibility: AV | Proposed responsibility: Health services |
| --- | --- | --- | --- | --- |
| General, Concession or DVA patient attending a public admitted facility or emergency department | No | Yes | No | Yes |
| Concession patient attending a non-admitted facility | Yes | No | No | Yes |
| TAC or VWA | Yes | No | No | Yes |

Note: These tables exclude private health services. Under the current arrangements, health services are responsible for booking all planned NEPT cases. Depending on the circumstances listed above, health services will either purchase NEPT services directly from the private market or request services through the TZV booking system where AV is the purchaser. Further detail on payment responsibilities can be found on the [Department of Health website](https://www.health.vic.gov.au/patient-care/ambulance-services-payment-guidelines) <https://www.health.vic.gov.au/patient-care/ambulance-services-payment-guidelines>.

As the VDHCC is proposed to coordinate booking and dispatch of NEPT, centralised purchasing of services by it rather than health services would be necessary to enable this. Potential models for operationalising this are discussed in Box 30.

DVA = Department of Veterans' Affairs; TAC = Transport Accident Commission; VWA = Victorian WorkCover Authority

1. As Box 28 shows, most stakeholders, including health services and private providers, strongly support this option.

Box 28: Stakeholders strongly support consolidating funding for planned NEPT services

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| ‘Revert NEPT framework to traditional outsourcing model, where HSV source contracts, and health services manage those contracts directly. Health services then retain control and accountability for the risks of NEPT outcomes for patient and access & flow management. Funding in this scenario for all NEPT services will be allocated to Health Services with an increase in [National Weighted Activity Unit funding] or a specified grant.’  – Western Health  ‘The administrative burden of health services to review the invoicing from multiple payers is problematic and would be better resolved through funding directly to health services rather than different financial models depending on service agreement.’  – Austin Health  ‘Adopting a strategic approach to tackling fragmentation, including moving [community service obligation] funding model from AV to public health services to better control patient flow.’  – National Patient Transport  ‘[There is a] significant proportion of the market being managed by an ambulance service, resulting in funding competition between emergency and non-emergency service delivery.  …  ‘The allocation of funding via the Ambulance Payment Guidelines and the operational reality of the application of the model is pivotal to the systemic issues within the sector. It would be of great benefit for this to form part of the scope of this review, and/or be a formal recommendation stemming from the review.’  – Ambulance Victoria |

1. As chapter 4 notes, this shift in purchasing responsibility would require reassigning most of AV’s NEPT funding because most service volumes it is currently funded for are planned NEPT. Being responsible for unplanned only would see a reduction in transports commissioned by AV from its current 60.8% of all transports down to 15.0%.
2. Careful consideration will need to be given to the payment arrangements, in particular non-concessional patients. This includes patients who are covered by the AV Membership Subscription Scheme.
   1. Currently, if subscription scheme patients receive planned NEPT transport delivered through AV, the fees are covered by their membership. Under a model where a third party coordinates a private provider for an equivalent service, a payment mechanism to recognise the patient’s membership status would need to be established.
3. Consideration will also need to be given to where funding for NEPT services should sit. For example, it could be redirected to health services, or centralised in the entity responsible for booking and dispatch of NEPT on behalf of health services. These issues are discussed below.

### The review recommends centralised commissioning of planned NEPT by the VDHCC

1. Once funding for planned NEPT is consolidated and redirected to health services, there are several different options for commissioning the services themselves:
   1. devolved commissioning, where health services individually select their preferred NEPT provider(s) from the HSV NEPT panel, agree to additional local performance accountabilities through service-level agreements with providers as desired, and manage provider performance directly (status quo model)
   2. regionalised commissioning, where groups of health services jointly select and contract manage NEPT providers – for example, using regional joint venture agreements between health services[[290]](#footnote-291)
   3. centralised commissioning, where provider selection and contract management is delivered by one entity being either HSV or the VDHCC. This would be accompanied by clear accountabilities between this entity and health services. This entity would either hold planned NEPT funding centrally and provide health services with NEPT, or funding could sit with health services, who would pay the central entity for the cost of NEPT services they use (Box 30).
2. The review heard from some providers that a more centralised commissioning approach would be beneficial (Box 29). It would require a single purchasing agent that has visibility of all service needs and supply, to reduce fragmentation. While rural health services generally prefer regionalised over devolved commissioning,[[291]](#footnote-292) the review also heard from metropolitan health services that they value local control (Box 29).
3. The commissioning model ultimately needs to be compatible with centralised booking and dispatch (refer to Recommendation 2 in chapter 4). The entity delivering this function needs the right levers in place to coordinate NEPT resources in a way that maximises efficiency for the system, with necessary controls over these resources. However, as chapter 4 notes, it may be possible to strike a balanced approach by continuing to provide health services with the option to have hospital-based vehicles in addition to centrally coordinated ad hoc transports, depending on what is most cost-effective for them.[[292]](#footnote-293) Also, as discussed below, the VDHCC will have visibility of health service access pressures as part of its core accountabilities for improving system flow. It will use this visibility to dispatch NEPT resources strategically.[[293]](#footnote-294)
4. The entity managing the contract needs to have full visibility of provider performance, and its incentives need to align with the overarching objectives of the funding. Current contracting approaches, whereby planned transports to and from health services and the community can be managed under separate HSV and AV contracts, show how multiple commissioning approaches can lead to inefficient coordination of services, impeding patient flow. Also, further devolution of commissioning through health service agreements across a range of providers will affect the ability to achieve system-level objectives.

Box 29: Stakeholder views on coordinating commissioning and local control

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| ‘Hospitals in regional areas selecting their own provider has the potential to fragment the market. [Fragmentation] can be minimised by the use of a single purchasing agent, who has visibility of all purchasing of service needs and all service provider locations, especially in regional areas.’  – Health Select Services  ‘[Develop] a more centralised contract management and operations system. This would be more efficient and ensure greater transparency of work offered between NEPT crews and their jobs (planned and unplanned), so that there can be better concentration of resources, connection between providers and the systems they operate within.’  – LifeAid  ‘Under the current system, not all health networks have an HBV [hospital-based vehicle] service provider under their AV contract … Eastern Health is one such example, with no HBV provider. NPT currently has [a service agreement via HSV] with Eastern Health, and we often hear reports of delays with their discharge bookings. In comparison, we have [service agreements] with Monash Health AND hold the HBV service provider relationship under the AV contract, which means we can work directly with Monash Health to move their patients, assisting them to meet their ED targets and ambulance transfer times.’  – National Patient Transport  ‘Alfred Health has the power to prioritise [patient discharges] through the two NPT vehicles that it has booked. However, Alfred Health has much less capacity to prioritise patient discharges home [managed through the AV contract], and is therefore left without a potential tool to manage patient flow through (and out of) the hospital.’  – Alfred Health  ‘Eastern Health … [does] not have a[n AV] Hospital Based Vehicle provider like almost all other Metropolitan Health Services. It is unclear why this has been the case when it equates to approx. 1000 cases per month ... The delays experienced may relate to the lack of [AV] Hospital Based Vehicles.’  – Eastern Health |

1. On this basis, the review does not recommend devolved and regionalised commissioning because the purpose of planned NEPT funding will be to optimise patient flow across the health system, and individual and regional groups of health services would only be able to see and focus on their own services. This can lead to outcomes that are helpful to people or groups but harmful to the collective, for example:
   1. providers prioritising performance for larger health services over smaller ones, based on their purchasing power
   2. health services switching contractors to reduce their costs in ways that jeopardise provider sustainability and market contestability in other regions.
2. A centralised commissioning model avoids these risks, and it is best delivered by the VDHCC alongside its broader NEPT booking and dispatch functions as proposed in chapter 4. The VDHCC will have – to a much greater degree than the department or HSV – total visibility of statewide patient flow, and a singular focus on optimising it for the system.
3. Under this model, HSV would continue its role to facilitate procurement and contracting negotiations, but it would do so on behalf of the VDHCC.[[294]](#footnote-295)
4. As part of its responsibilities for centralised booking and dispatch, the VDHCC would also engage HSV to procure non-clinical transports at scale.[[295]](#footnote-296)
5. As per the New South Wales model, the VDHCC would need to develop clear service-level agreements, governance and accountabilities with health services, in particular for timeliness of services and responsiveness towards local flow pressures.[[296]](#footnote-297)

Box 30: Funding and payment options under a centralised commissioning model

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| There are several ways to structure the funding and payment arrangements to support this model that can mitigate the risk of inappropriate use of NEPT, promote efficient use of services and deliver a financially responsible and sustainable model. These options are set out in Table 8 to illustrate how the model could work but would need to be worked through with health services and HSV in the implementation planning stage.  Option 1 involves central commissioning of NEPT services by VDHCC, with usage fees paid by health services. Health services would be funded for all transports (inclusive of the community service obligation patients AV is currently funded for). This option would ensure health services retain a financial incentive to minimise inappropriate booking of NEPT services for ineligible patients, resolving the principal–agent issues inherent in the current model.[[297]](#footnote-298) However, it involves administrative complexity and means health services would bear the costs of VDHCC commissioning decisions.  Alternatively, option 2 would see community service obligation patient funding provided directly to the VDHCC to purchase NEPT services, with no billing of health services for the NEPT services they book. While this reduces administrative burden, it means the VDHCC would carry the financial risk of ineligible bookings made by health services. However, it would also mean the VDHCC has ‘skin in the game’ to ensure efficient and effective commissioning outcomes are achieved through competitive tendering, and to coordinate resources effectively to ensure cost per use for NEPT is driven down across the sector.  Under a third option, the VDHCC would have no role in funding and payment. Where community service obligation patient funding is provided directly to health services, NEPT services are booked with private providers through the VDHCC, and private providers bill health services directly. This option is likely to create a new principal–agent issue where there is mismatch between performance and financial accountability. That is, the VDHCC will purchase services and have corresponding contract management responsibilities, but health services would be responsible for payment.  Under all the above options, in delivering centralised booking and dispatch the VDHCC would have primary responsibility for driving effective performance of providers. However, implementation planning should explore the scope to retain some level of performance monitoring that links health services with NEPT providers to support timely service provision and local resolution of any issues that could arise.  As previously flagged, further analysis on the most efficient arrangement for non-concessional patients, including those with AV subscription scheme coverage, is required as part of implementation planning. As part of its governance role, the department would maintain oversight to ensure billing for health services involves cost recovery alone, with no margin to support other VDHCC activities. |

Table 8: Potential commissioning approaches to be explored in implementation planning

| Option | Commissioning | Payment | Procurement |
| --- | --- | --- | --- |
| 1. VDHCC commissions, and bills health services for use | VDHCC | Health services | HSV |
| 2. VDHCC commissions, with no billing to health services for use | VDHCC | VDHCC | HSV |
| 3. VDHCC books and dispatches only | Health services | Health services | HSV |

### HSV would coordinate procurement of planned and unplanned NEPT services

1. Under the current model, AV directly procures NEPT services, rather than working through HSV.[[298]](#footnote-299) This has led to missed opportunities to coordinate purchasing within regional areas to improve scale and efficiencies.
2. These issues are likely to be exacerbated if AV continues to procure its NEPT services directly under a future model, noting this will involve AV only holding funding for unplanned NEPT services, which make up a much smaller proportion of the market (as previously noted, 15.0%, in contrast to the 60.8% of total NEPT services AV currently procures).
3. To avoid this, AV will need to engage HSV to procure its unplanned NEPT services (including surge resources), in coordination with the VDHCC’s planned NEPT services.[[299]](#footnote-300)
4. This would enable HSV to align planned and unplanned contracts in a way that ensures sufficient scale across geographical areas. This will allow the public health system’s full purchasing power to be leveraged in procuring these services, harnessing a core function of HSV. As noted, HSV’s current role in NEPT is limited, so HSV would have to develop capability and have dedicated capacity to support this approach.
5. While contracts would be coordinated, planned and unplanned NEPT services would still be separately commissioned to ensure private contractors remain accountable for meeting the needs of both AV and health services (via the VDHCC). This contrasts with the status quo, where private contractors of AV are accountable to AV alone.

## Regionalised coordination of services to improve scale and fix thin market risks

1. As section 5.1 summarises, rural Victoria is poorly served by current outsourcing arrangements, with thin markets arising where areas have limited demand and few suppliers competing to provide services, leading to diseconomies of scale.
2. This is exacerbated by market fragmentation. As noted, HSV does play a role in coordinating health services’ private provider selection within regions, but AV holds the majority of NEPT funding and does not participate in this.
3. This coordination of providers is driven by health services, which have individual choice of panel providers but have chosen to align their contracts,[[300]](#footnote-301) demonstrating the value health services have placed on geographical coordination of providers.
4. HSV considers that providers are not willing to maintain fleet, depots and personnel in areas without enough volume to justify the investment. By contrast, delivering large and geographically consolidated volumes of NEPT services means individual NEPT providers can capture economies of scale to ensure efficient pricing and consistent service coverage across thin rural markets.
5. The rest of this section shows how awarding contracts to ensure geographical coverage could improve equity of access to NEPT services for all patients, regardless of their location in Victoria, and allow for service design that optimises system-wide flow, enabling timely patient access to care.
6. Strategies to mitigate the contestability risks of this approach are outlined in section 5.4.

Figure 10: Distribution of private provider contracts across the state (the commercially sensitive information has been redacted)

Figure 11: Distribution of private provider contracts across metropolitan Melbourne (the commercially sensitive information has been redacted)

### Achieving viable scale through geographical coordination of NEPT contracts

1. Published evidence from relevant industries[[301]](#footnote-302) shows that large operators with more investment capacity tend to be more technically efficient than small operators[[302]](#footnote-303) because they can leverage economies of scale in their operations.
2. Accordingly, to improve economies of scale and address supply gaps in rural areas, this section outlines a recommendation to consolidate contracts on a geographical basis.
   1. This section assumes consolidation of funding for planned NEPT services in health services as recommended in section 5.2, point 20. This assumption relies on aligning procurement approaches between HSV and AV to enable selection of the same provider(s) within a given area and maximise economies of scale, as discussed in section 5.2.2.
3. Geographically coordinated contracts can be designed in at least 3 different ways, each with varying trade-offs between scale and contestability.[[303]](#footnote-304) For example:
   1. A single-provider statewide monopoly could be established through a franchise arrangement, such as the Yarra Trams model,[[304]](#footnote-305) or through a Public Private Partnership model (Box 31).
   2. Approximately 3 metro-regional corridors[[305]](#footnote-306) could be created. These would enable providers to access high-volume and higher-margin metropolitan areas to cross-subsidise servicing of low-volume rural areas.[[306]](#footnote-307)
   3. Five rural-only regional contracts could be created, with decentralised purchasing of NEPT services by health services within metropolitan Melbourne, where the market can sustain multiple providers.

Box 31: A private provider proposal for a Public Private Partnership (the commercially sensitive information has been redacted)

1. These options are described for illustrative purposes only, with no preferred approach recommended. Ultimately, HSV would need to undertake detailed expert market analysis and a feasibility assessment before choosing a specific model.
2. Most, if not all, of the above options would involve significant structural reform, requiring careful planning of patterns of NEPT trips to ensure geographical zones match patient needs. If corridors or zones are not aligned with existing patterns of behaviour, this risks creating inefficiencies downstream.
3. Subject to the model chosen, the transition process for private providers may require significant investment, particularly around ensuring regional depots are developed to manage flow within rural areas and between the metropolitan area. Any recommissioning by geography would also have workforce impacts that would need to be managed in implementation (section 5.5).

Box 32: South Australia has consolidated all its outsourced NEPT contracts

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| In South Australia, all outsourced NEPT has been consolidated under a single provider, St John Ambulance. Under this model, separation between planned NEPT work and emergency response is maintained, with the latter delivered by SA Ambulance Services.  While there are benefits from market consolidation, including improved economies of scale in thin markets, lower costs and improved performance, this can also lead to surety risk, and relying on a single provider can result in significant disruption to the sector with no fallback providers available.  In Western Australia, a 2022 Standing Committee into Western Australia’s ambulance services[[307]](#footnote-308) heard that as the sole provider of emergency ambulance services, St John Ambulance has an unfair competitive advantage over the panel arrangements across the state but particularly in rural areas where they have the right of first refusal. It was recommended that the Department of Health removes St John Ambulance’s right of first refusal for rural interhospital transfers.  Single-provider models do also appear able to work well. In New Brunswick, Canada, emergency and non-emergency operations are outsourced to a single publicly run provider, Ambulance New Brunswick. While Ambulance New Brunswick is directly accountable to the Minister for Health, all operations and service delivery is undertaken through a contract with Medavie Health Services, the private sector company charged with managing the delivery of the provincial ambulance service on behalf of the Government of New Brunswick.[[308]](#footnote-309) Despite using a single-provider model, Ambulance New Brunswick has been successful in maintaining strong NEPT performance, including for both planned and unplanned transfers, as is shown in Figure 6 (chapter 4). Ambulance New Brunswick manages a centralised booking and dispatch system that coordinates both emergency and non-emergency resources, which uses technology for triaging and automatic vehicle routing. |

## Central intervention to maintain and improve market contestability

1. Coordinating contracts around a single provider in a region is critical to resolving the poor servicing that rural areas receive under the current outsourcing model. It can create benefits but also risks:[[309]](#footnote-310)
   1. In some cases, market consolidation can lead to lower prices, as operators gain scale efficiencies and can compete more aggressively on price[[310]](#footnote-311) and operational performance.[[311]](#footnote-312)
   2. In other cases, consolidation leads to higher prices (as opposed to scale economies being shared with consumers), particularly when organisations merge but do not integrate operations, leading to increased market power but limited internal efficiencies.[[312]](#footnote-313)
   3. Even when market consolidation leads to positive outcomes such as lower prices and improved performance, it can still create surety risks, where a single point of failure can result in substantial disruption across the sector with no fallback providers available.[[313]](#footnote-314)
2. To maximise these benefits and mitigate risks, a range of strategies can be considered. These include:
   1. centralised commissioning to ensure multiple providers are engaged in contracts, maintaining market depth (section 5.4.1)
   2. giving private providers access to HSV’s bulk procurement arrangements for NEPT equipment and consumables, expanding scale economies to new market entrants (section 5.4.2)
   3. subject to feasibility, the state providing depots (with potential for bundled maintenance services) to lower barriers to entry for new providers and reduce switching costs and lead times (section 5.4.3).
3. Strategies discussed elsewhere in this report would also support contestability by enabling new market entrants to operate efficiently from the outset, even without significant market share. These include:
   1. centralised booking and dispatch as recommended in section 4.2.3 (Recommendation 2), which will remove a start-up cost for new providers,[[314]](#footnote-315) remove a major barrier to switching providers for many health services[[315]](#footnote-316) and optimise all planned NEPT routes for efficiency regardless of provider scale
   2. portability of workforce pay and conditions as discussed in section 5.5.1, which will make it much easier (and less harmful) for workers to move between employers when contracts change, reducing another barrier to contestability.
4. While some of these strategies will require government investment, this is expected to lower prices through improved technical efficiency as well as contestability. This is consistent with transport industry analysis that suggests government investment (that is, new technologies and materials) in private providers is a significant determinant of operator efficiency because it improves quality, reliability and security.[[316]](#footnote-317)

### Centralised commissioning of services to maintain market depth

1. When commissioning is decentralised, there is limited scope to coordinate purchasing to ensure a minimum number of providers remain active in the market.
   1. Under the current outsourcing model, health services must engage providers from HSV’s statewide panel but have free choice of which provider they wish to contract.
   2. As a result, voluntary coordination of contracting by health services acting within regional blocks has seen 52 of 58 health services engage only 2 of the 8 providers on the HSV panel. This risks creating a duopoly market when most NEPT funding shifts to health services.
2. To avoid these issues being perpetuated at a larger scale, it will be critical that provider selection is centralised rather than decentralised, as described in section 5.2, point 20.
3. Under a centralised commissioning model, HSV would work on behalf of the VDHCC and AV to preserve market depth. For example, this could occur through:
   1. continuing AV supplementary contracts for unplanned work[[317]](#footnote-318) and coordinated VDHCC and AV contracts for surge capacity[[318]](#footnote-319)
   2. approved subcontracting arrangements, enabling smaller providers to deliver work on behalf of the primary contract holders.[[319]](#footnote-320)

### Giving private providers access to HSV’s bulk procurement arrangements

1. There are opportunities to improve economies of scale and interoperability of services across the sector through bulk procurement of consumables, equipment and key services. This could include, for example, consumables, uniforms, vehicles, medical equipment and electronic stretchers, and services such as laundry and waste disposal.[[320]](#footnote-321)
2. This would bring Victoria closer to HealthShare NSW’s supply chain approach for NEPT. There, all NEPT crews (public and private) working for HealthShare have access to the same public linen, laundry, medical consumables and equipment, and medical waste services.
   1. This enables crews to deposit used linen for laundering and waste for disposal at health services as needed when they are collecting patients, rather than delaying collection by returning to depots to deposit it, which occurs in Victoria.
   2. Providers can take patients with their current linen and equipment, rather than requiring the provider to switch it for their own, which further reduces departure delays, again in contrast to Victoria.
3. Currently HSV’s role is to be an independent public sector provider of supply chain, procurement and corporate services for Victoria’s public health services.[[321]](#footnote-322) Extending these bulk-purchasing arrangements to private NEPT providers would give new market entrants immediate access to scale economies in their supply chain without having to first achieve scale in operations. HSV would need to ensure savings that arise from bulk procurement translates to lower fees charged by providers, leading to the dual benefit of lowering prices for health services and AV.

### State provision of depots, with potential for bundled maintenance services

1. Further improvements to contestability could be achieved through HSV reducing capital investment requirements by centralising common-use assets – in particular, depots. Under this scenario:
   1. HSV purchases and leases depots, or takes out leases and sublets them, to private providers.
   2. This would centralise regional resources, removing some of the service provider barriers to entry, and facilitate easier changeover of service providers if required, reducing risks to contestability and service continuity.
   3. HSV considers that, based on its low cost of capital, this could deliver value for money. It could also encourage delivery of purpose-built facilities (for example, those built to support electric vehicles) that have a payback period exceeding the current typical NEPT contract term.[[322]](#footnote-323)
   4. There may be scope to achieve operational and cost savings through co-locating with these depots with AV (with some coordination or co-design) and potentially bundling maintenance contracts.
2. This is an option that would need more exploration. HSV would need to:
   1. conduct a thorough assessment to confirm the materiality of impact
   2. explore whether and how the use of the centrally procured aspects would be mandated
   3. engage with providers to confirm the suitability of procured products
   4. negotiate pass-through of the savings to public contracts.
3. Also, NEPT providers have existing depots in place, so their suitability would need to be assessed and purchased if deemed suitable, otherwise providers would have discretion to maintain or sell these assets. Consideration of ongoing asset management would also be required, whether through HSV as the asset owner or the occupier as a condition of leasing/subletting.

## Social procurement to improve workforce conditions and environmental sustainability

1. As chapter 3 shows, there are significant concerns with the social aspects of the NEPT sectors under current arrangements. In particular:
   1. employment conditions can be poor, with heavy casualisation of the workforce, which can adversely affect wellbeing and create indirect risks to clinical and occupation safety
   2. patient transport has a significant environmental impact, with no cohesive sector plans to decarbonise the industry as part of Victoria’s broader commitments to achieve net-zero emissions by 2045.
2. The below sections outline how social procurement levers can be used to address these issues.

### Tackling workforce casualisation

1. As discussed in chapter 3, high rates of casualisation in the private NEPT workforce limit people’s ability to access entitlements under enterprise agreements.
2. While casual workers receive rate loadings to compensate, by their nature casual contracts do not offer secure access to work, nor entitlements enjoyed by permanent staff including various types of leave (paid personal, carer, compassionate, parental [except for an eligible casual], annual), public holidays, notice of termination or redundancy pay.
3. The Victorian Ambulance Union has reported the insecurity associated with casual work also affects employees’ willingness to report issues due to concerns over potential loss of shifts and income.[[323]](#footnote-324)
4. As previously noted, uncertain service volumes may be inherent in Victoria’s current outsourcing model, which makes provisions for health services and AV to change contract volumes or switch providers with 30 to 60 business days’ notice. This may contribute to a higher reliance on the casual workforce to meet fluctuating demands.
5. The outsourcing reforms described earlier in this chapter – in particular, increased surety of service volumes managed through the HSV panel and geographical coordination of contracts (section 5.3) – will allow private providers to shift to a more secure and permanent workforce profile.
6. Providers will need to be accountable for sharing the benefits of greater surety of work with their workforces. Mechanisms for achieving this are discussed in section 5.5.2.
7. It is important to note that shifting from a heavily casualised workforce profile to a more permanent one is likely to increase costs while delivering broader benefits.
   1. Casual staffing arrangements involve lower on-costs and enable hours to fluctuate in line with demand. By contrast, permanent staff are entitled to guaranteed hours irrespective of demand, which can mean that some capacity is paid for but not used.
   2. At the same time, there can also be efficiencies from permanent employment arrangements. These may include lower recruitment, training, rostering and absenteeism costs due to a more stable workforce, with potential for higher productivity and skill development over time, improved quality and consistency of work, higher employee morale and engagement (refer also to Box 33).

Box 33: Workforce perspectives on casualisation

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| ‘… rostering for full-timers is not great, so a lot of people want to be casual so they can pick their days.’   * + NEPT workforce   ‘If rostering was better casuals would prefer to be permanent.’   * + NEPT workforce   ‘Workforce certainty, fairness and wellbeing should be a feature of the desired state, as opposed to having most staff employed as casuals with risky job security. If NEPT staff have no job security, recruitment and retention is compromised.’  – Victorian Ambulance Union  ‘Rostering punishments are also used against staff who have upset management in some way, whether directly or indirectly … Due to the company strategically placing management in charge of running WHS [work health and safety] committee meetings, it is extremely difficult to bring up, and pass a lot of major concerns or issues, as these concerns are immediately shutdown, and sometimes not even recorded by management. HSR [health and safety representative] staff have been ambushed by CEO and management in attempts to scare people into submission ... causing staff to either quit the committee or temporarily step away and stay silent for a period of time, and also take needed mental health days, due to being terrified that they are going to lose their job for doing the right thing by employees and attempting to make the workplace a safe and healthy environment.’   * + NEPT workforce |

### Standardising employment conditions

1. As discussed in chapter 3, there is no standardised enterprise agreement for the private NEPT workforce, with rates determined by provider enterprise agreements, the Ambulance and Patient Transport Industry Award or the AV enterprise agreement.
2. The multiple and varied enterprise agreements across the sector do not allow for portability of entitlements – in particular, long service leave – regardless of employment type. As Box 34 shows, this can lead to a significant loss in entitlements for even long-serving members of the workforce when health services and AV change contracting approaches within an area, or when a provider scales down operations or exits the market.

Box 34: Lack of portability of long service leave entitlements has a significant impact on staff

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| ‘I started in the [NEPT] industry 1997. In those 18 years I have worked for four different companies ... The first two companies I worked for actually lost their contracts and had to shut down. The third company I worked for lost contracts and reduced the size of its workforce.  It was never my choice to change employer, I had to leave. Each time I went to a new company, I had to start from square one regarding my accumulation of long service leave. My first 6 years in the industry I didn’t gain long service credits at all because I kept on losing them as I changed employer. I was unable to carry over accrued entitlements.  In addition, the first two companies I worked for engaged me on a casual basis so there was also no redundancy pay.  I wasn’t leaving my employer for a promotion, I had to go where the work was. I have a family that I need to support. I don’t think it’s fair that I didn’t have any opportunity to collect long service …  I am now eligible for long service leave. However, if our company had lost their contract at the start of this year, I would have had to start all over again.’  Source: Ambulance Employees Australia Victoria, Submission 20 to the Inquiry into portability of long service leave entitlements, 2016. |

1. Several private providers[[324]](#footnote-325) have suggested that standardising NEPT workers’ pay and conditions would provide greater clarity and security for workers, reduce the complexity associated with multiple enterprise agreements and awards and provide a level playing field for providers.
2. The review supports this recommendation and proposes that HSV contracts require contracted private providers to guarantee standardised workforce conditions to their NEPT workforce above the award.[[325]](#footnote-326) This option leverages HSV’s purchasing power to uplift and standardise pay, introduce long service leave portability and address rates of casualisation.
3. This can be achieved this through 2 mechanisms: introducing a sector-wide enterprise agreement, or stipulating pay and condition requirements in private providers contracted under the HSV panel.
   1. Under a sector-wide enterprise agreement, all providers would be legally bound to pay the NEPT workforce consistent pay rates. This would also be an opportunity to introduce leave portability across providers operating under the agreement and to introduce targets for casualisation rates (which has occurred under previous private provider enterprise agreements),[[326]](#footnote-327) enabled by the surety of service volumes discussed above. This approach would require union involvement, where relevant unions would act as bargaining representatives.[[327]](#footnote-328)
   2. Using the mechanism of HSV contracting requirements would ensure consistency of wages across the sector by stipulating NEPT employee pay rates under the contracting arrangements, as has occurred in other sectors (Box 35). This option could also contractually require providers to participate in Victoria’s Portable Long Service Benefits Scheme, subject to feasibility (Box 36). This approach would need union consultation before pay rates are stipulated.
4. Regardless of the mechanism, increased wage conditions would result in an increase in provider costs and would ultimately be met by government through higher fees.
   1. For example, a wage uplift to close the disparity between private and AV NEPT workforce base wages would cost upwards of $3.4 million annually,[[328]](#footnote-329) with significantly higher costs if the much larger differential in entitlements (including all operational and shift penalties and allowances) was closed.
   2. The costs may be partly offset by efficiencies achieved through the broader reforms proposed in this review, noting these will also require investment to realise.
5. It is acknowledged that private providers also provide services to private health services, and an increase in wage conditions would also flow on to these services. However, this is a small percentage (15.1%)[[329]](#footnote-330) of private providers’ work and could be passed on or absorbed.
6. It should also be noted that such contractual changes would be best addressed through open market tender because they may represent a significant deviation from the existing scope and affect supplier competitiveness.[[330]](#footnote-331)

Box 35: Increasing pay and conditions under the Security Services State Purchase Contract

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| The Victorian Government has used its purchasing power to increase pay for comparatively low-paid and insecure workers.  From 1 February 2023 security companies engaged under the State Purchase Contract must pay security workers 6% above the Security Services Industry Award 2020,[[331]](#footnote-332) equating to a $58 to $63 increase in weekly wages.[[332]](#footnote-333)  This also includes controls on subcontracting arrangements,[[333]](#footnote-334) comprehensive training, employment security and job rotation, with a range of governance mechanisms in place to ensure compliance.  This has required modest government investment to ensure compliance, including contract administration, reporting and auditing activities.[[334]](#footnote-335) |

Box 36: Victoria’s Portable Long Service Benefits Scheme

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| One potential mechanism for providing the NEPT workforce with long service leave portability is through Victoria’s Portable Long Service Authority, which is responsible for administering Victoria’s Portable Long Service Benefits Scheme.[[335]](#footnote-336)  This scheme was introduced in 2019 to ensure eligible workers in the community services, contract cleaning and security industries could accrue long service benefits based on service to an industry, rather than years with a single employer. Currently, the NEPT workforce is not eligible for the scheme.[[336]](#footnote-337)  Introducing long service leave portability may lead to modest increases in costs to government because the scheme requires providers pay a levy, which is likely to be passed on through higher fees.  As with the Sick Pay Guarantee option (Box 37), noting the current exclusion criteria relates broadly to health or related services, it may be difficult to implement access to the scheme specifically to the NEPT workforce, and/or lead to advocacy from other industries to expand access. However, it may be feasible for NEPT providers with public contracts to effectively participate by providing long service benefits to the Portable Long Service Authority, based on a requirement provided through HSV contracts. |

1. The review also considered, but did not recommend, expanding the Victorian Government’s Sick Pay Guarantee to include NEPT workers. This scheme provides Victorian casual and contract workers in certain jobs up to 38 hours a year of sick and carer’s pay (Box 37). However, this would only be beneficial if other reform recommendations designed to reduce casualisation are not implemented. The review considers that the mechanisms described above would better and more directly address issues around sick leave entitlements.

Box 37: Victorian Government’s Sick Pay Guarantee does not cover NEPT workers

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| The NEPT workforce is currently not eligible for the Victorian Government’s Sick Pay Guarantee (SPG) scheme, which is restricted to people working in the most insecure jobs. However, as a highly casualised workforce providing care to vulnerable patients, incentivising the NEPT workforce to take sick leave when appropriate would align with the SPG scheme’s aim to reduce workplace illnesses and keep businesses safer, and help limit the spread of infectious diseases.[[337]](#footnote-338) In the absence of sick pay entitlements for casual workers, access to the SPG pilot would also help grant the majority of the NEPT workforce additional wage security.  However, other considerations make the SPG challenging to expand to NEPT workers. It will remain in a pilot phase until 2025, so continuation is not guaranteed and will be a future decision for the Victorian Government.[[338]](#footnote-339) Including NEPT workers in the SPG pilot would require more government investment, estimated to be in the vicinity of $650,000 a year.[[339]](#footnote-340) Since the NEPT workforce sits outside eligible ANZSCO work groups, it may be more difficult to implement an expansion of the SPG specifically to the NEPT workforce, and/or will lead to advocacy from other industries to further expand SPG eligibility. |

## Environment and sustainability impacts

1. As set out in chapter 3, the NEPT sector has significant environmental impacts, but it lacks a coordinated sector approach to address these as part of the Victorian Government’s commitment to achieving net-zero emissions by 2045.[[340]](#footnote-341) As such, achieving a sector-wide reduction in environmental impacts will require a significant change.
2. There are broader challenges to achieving net-zero emissions, which include a combination of supply and access to new low- and zero-emission vehicles, and charging infrastructure both in depots and around the state.
3. These issues are not confined to the patient transport industry, and the Victorian Government has set ambitious targets for other transport industries. For example, the government has set targets to drive change in the transport sector, including all new public transport bus purchases to be zero-emission vehicles from 2025, and that zero-emission vehicles will make up 50% of all new light vehicle sales by 2030.[[341]](#footnote-342)
4. These challenges are also being actively confronted by ambulance and NEPT sectors in other jurisdictions (Box 38).

Box 38: Other systems are making faster progress towards more ambitious net-zero targets

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| **NHS England** has committed to all NEPT being undertaken in zero-emission vehicles by 2035.[[342]](#footnote-343) This will be driven by procurement practices (NHS England outsources planned NEPT). Targets will be applied to the overall contract or lead provider, with an aggregate proportion of all vehicles to be used as part of the service to meet the targets.[[343]](#footnote-344) Other actions such as data collection, core standards, contract length and collaboration across geographical areas will be key enablers for achieving this ambition.  NHS England has already introduced the world’s first zero-emission ambulance in the West Midlands and has 7 ambulance trusts currently trialling zero-emission emergency vehicles, with more expansion planned.[[344]](#footnote-345)  In **Ontario, Canada**, hybrid ambulance fleets have been trialled with the aim of reducing greenhouse gas emissions and promoting low-carbon transportation. A study of their environmental and financial viability found it possible to achieve a full return on investment of hybrid systems.[[345]](#footnote-346)  In **New South Wales, St Vincent’s Hospital Sydney** recently became the first hospital in Australia to include an electric ambulance in its fleet, which is used for non-emergency patient transport including local discharge and interhospital transfers.[[346]](#footnote-347) It expects savings in fuel costs of up to 70%, as well as maintenance savings of around 40%, with the vehicle fast charging and able to travel distances of up to 280 km when fully charged, with a quieter, smoother experience for patients. |

1. In either an insourcing or outsourcing scenario, decarbonisation would be most efficiently pursued through a transition strategy that covers both emergency transports and NEPT, given the ambitious targets, research and economies of scale in investment, and government incentives and support that will be required (for example, electrified depots and charging facilities at health service ambulance ramps and car parks).
2. Through outsourcing, HSV can use its purchasing power to address inconsistencies in provider commitments to reducing environmental impacts by including environmental sustainability targets in contracts, such as fleet emissions targets. This option would be applicable under procurement options where HSV manages the tendering and contracting process.

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| **Option 1**: If NEPT services remain outsourced, the existing model can be improved by:   1. separating commissioning of planned and unplanned NEPT services, in line with Recommendation 1 2. centralised strategic commissioning of services to consolidate contracts within areas, improving economies of scale and addressing thin market risks 3. central intervention to maintain and improve market contestability and mitigate risks from contract consolidation, with specific interventions guided by feasibility assessment 4. social procurement to improve environmental sustainability and workforce conditions, with the latter progressed through standardisation of employee pay and conditions for contracted providers, portability of entitlements and requirements for reduced casualisation alongside surety of service volumes to support a more permanent workforce profile. |

# Insourcing reform options

1. As chapter 5 shows, there is a significant opportunity to improve current outsourcing arrangements for patients, staff and the operation of the health system.
2. Where the previous chapter explored how current system performance issues might be responded to through improved outsourcing arrangements, this chapter considers how they could be improved through insourcing some or all NEPT services, in line with the review’s terms of reference.[[347]](#footnote-348)
3. Insourcing involves undertaking NEPT functions within the public sector, as opposed to by contracted organisations within the private sector. This chapter focuses on the insourcing of NEPT delivery, rather than booking and dispatch of NEPT services (addressed in chapter 4).
4. This chapter shows that insourcing (like outsourcing reform) can improve performance of the NEPT system. Consolidating services offers the opportunity to resolve fragmentation and thin market risks, improving service efficiency and performance. And delivering services through a public entity offers a means of addressing workforce casualisation and pursuing comprehensive environmental sustainability objectives with coordinated action and investment, where needed, across the NEPT and emergency transport sectors.
5. Insourcing has some strategic advantages relative to outsourcing, including by maximising economies of scale for planned NEPT services and more closely integrating unplanned NEPT with AV’s broader emergency response operations. But insourcing also has distinct risks, including immense implementation complexity and service disruption risks during the transition, as well as higher implementation and operating costs. These relative benefits and risks need to be weighed carefully and considered in the context of broader health system priorities.
6. As the interjurisdictional examples canvassed in this chapter show, there are different ways to design an insourced model. These design choices influence whether an insourced model is effective or ineffective. The review considers that for insourcing to be effective, the critical enablers include:
   1. separating emergency and non-emergency responses, as discussed in chapter 4 (Recommendation 1). If NEPT services are insourced, the review recommends that AV remains responsible for unplanned NEPT (in line with its core organisational focus on responding to people with time-critical medical emergencies), while planned NEPT should be delivered by a separate public entity
   2. centralising booking and dispatch, also discussed in chapter 4 (Recommendation 2). The review recommends that the VDHCC delivers this function because it best aligns with its role of coordinating patient flow, where other public entities would be less appropriate.
7. This chapter concludes by providing an overview of expected implementation impacts, key considerations for other parts of the health system, and roles and responsibilities in implementation.

## Insourcing can mitigate some inherent weaknesses of the current NEPT system

1. As chapter 3 shows, there is a significant opportunity to improve the design of NEPT services.
   1. The efficiency of services is negatively affected by complex commissioning arrangements that create fragmentation of services, duplication of operational overheads and administrative costs, as well as underinvestment in technology by both private providers and public entities (section 3.3.1).
   2. Rural areas are poorly served, with gaps in supply, limited competition and high rates of spills of NEPT services from private contractors to AV’s emergency crews (section 3.3.3).
   3. The workforce is heavily casualised, with no portability of entitlements across employers, resulting in a loss of benefits to staff when changing contracts. The review heard there is a risk to security of employment when potential concerns about patient safety and workforce are raised (section 3.4).
   4. While reported adverse patient safety events are rare, given the low acuity of NEPT patients, there is inherent risk of these occurring during unplanned NEPT services and concerns about the frequency of crews being dispatched to events outside their professional scope of practice (section 3.1).
   5. The review heard the system is poorly coordinated, with AV (the entity funded for most NEPT services) accountabilities no longer fit for purpose, limited effective monitoring of system performance, a lack of workforce planning for the sector and room to strengthen continuous improvement of quality and safety.
2. Insourcing NEPT services would help to address these challenges, as set out below.

### Consolidating purchasing and delivery arrangements would improve efficiency

1. As previously shown, funding and purchasing arrangements for NEPT services are overly complicated, which increases administrative costs for both purchasers and providers (refer to section 3.3.1). If service delivery was insourced,[[348]](#footnote-349) the complexity of current outsourcing arrangements would reduce. This would standardise staff recruitment, rostering and training, and depot management. It would enable a single and consistent approach to purchasing and payment, and it would also simplify related administrative arrangements (for example, streamlined funding and billing).
2. Like the outsourcing reforms discussed in chapter 5, insourcing also provides a way to increase economies of scale in NEPT service delivery by consolidating fragmented operations within a public entity to generate efficiencies and surety of supply through increased scale. This would deliver a range of efficiencies, including by:
   1. sharing a single workforce across all service delivery, enabling better matching of staff skills to work requirements, reducing overtime and unfilled shifts that can result in contract penalties
   2. increasing route efficiency, which would enable optimal deployment of NEPT vehicles according to geographical location, pick-up/drop-off times, patient acuity and resource availability (including vehicle capacity and crew scope of practice).
3. This can be enabled through the following improvements, noting these outcomes can also be supported through centralised booking and dispatch of transports (whether insourced or outsourced), as already recommended in chapter 4 (Recommendation 2):
   1. greater market density, improving the ability to match crews to more proximate transport requests and vector routes to minimise empty-vehicle trips
   2. greater data-driven insights created through whole-of-system visibility of demand and service operations, which facilitates analysis of performance, identification and prospective modelling of potential service innovations, evaluation and continuous improvement
   3. the ability to spread fixed technological investment costs that support improved operating efficiency (for example, proprietary route optimisation dispatch algorithms) across a much larger revenue base
   4. long-term reduction (following a short-term increase, during the transition) in organisational overheads (such as human resources, payroll, executive management structures, procurement and maintenance) that are currently duplicated across private providers, noting that most in Victoria can already leverage scale in these operations through national and international parent companies
   5. increased purchasing power, enabling providers to negotiate better prices for equipment, consumables and infrastructure,[[349]](#footnote-350) noting that these can also be progressed through parent companies or through HSV as discussed in chapter 5.
4. This can also deliver benefits for patients. Consolidating multiple providers into a public sector entity has the potential to improve patient experiences through improved consistency of a single service and reliability of access through guaranteed service delivery across Victoria.

### Consolidating services would address market failure, improving rural services

1. As section 3.3.3 describes, whereas metropolitan and regional centres have the depth to generate healthy market competition, rural areas generally do not have enough patients requiring NEPT transport for optimal contestation between private providers. This is causing gaps in supply, higher prices and increased spills of jobs to AV’s emergency crews.
2. Insourcing would effectively resolve these issues, partly because servicing would no longer rely on financial incentives (a public provider would be required to supply services needed) and partly because rural volumes would be consolidated to improve economies of scale as described above.
3. Of course, as section 6.1.2 shows, it is also possible to use regional contracts to deliver economies of scale. While contracting a single provider in a region would involve contestability risks, they can be mitigated through government intervention (for example, potentially, state ownership or head leases of depots) that ensures it is easy to switch providers within a region if price rises are excessive or performance suffers.
4. On the other hand, a sole public supplier’s pricing and performance would not depend on market competition. This is a benefit for rural areas but also a risk for the market overall: a sole public provider would not face the same market competition and incentive that private providers do to be the supplier (or employer) of choice. A sole public provider would have limited incentives to reduce prices, improve efficiency or focus on continuous improvement, as well as initiatives to attract, support and retain the workforce. As Box 39 shows, single-provider public models can work well or poorly.

Box 39: Single-provider public models can work well and less effectively

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| As the sole public NEPT provider, QAS does not face market pressures to increase efficiencies (for example, automating route planning and dispatch, rather than using manual approaches, or maximising use of NEPT crews to respond to low-acuity triple zero (000) demand) or bolster coverage (for example, by reducing spills, with emergency ambulances delivering around 20% of NEPT services). However, it does participate in improvement initiatives driven by the broader health system, including regional and statewide patient access and coordination hubs.  In contrast, HealthShare NSW’s consolidation of public NEPT services appears to be highly effective, as discussed in chapter 4, showing that sole public-provider models can work both well and less effectively, depending on broader factors including separation from emergency transports (per Recommendation 1). |

### Insourcing offers a mechanism to improve workforce terms and conditions

1. As highlighted in section 3.4, the employment conditions of Victorian NEPT workers differ significantly depending on whether they work for a public or private employer.[[350]](#footnote-351) In effect, many of the benefits of outsourcing that benefit public purchasers of NEPT services – including the much lower costs of contracts and the ability to switch providers or change orders with limited notice – are made possible by lower wages and insecure work for private sector staff.
2. Chapter 5 describes how the government can respond to these issues with an improved outsourcing model that includes social procurement conditions requiring greater employment security for workforce (enabled by improved contractual certainty for providers) and improved pay and conditions.
3. Insourcing offers a more comprehensive opportunity to address these issues by employing staff under public enterprise agreements.[[351]](#footnote-352) It would involve direct negotiations between the workforce and government, rather than with private providers. And with fewer entities involved, there may be increased bargaining power for employees in the negotiations.
4. Since there would no longer be uncertain service demand and funding affecting employment arrangements under an insourcing model, the levels of staff employed permanently would be expected to reflect more closely those seen in New South Wales, where most employees of HealthShare NSW’s Patient Transport Service are on permanent employment arrangements.
5. Access to paid leave, sick leave, guaranteed hours of work and portability of entitlements would improve as a direct result, alongside staff feeling able to raise concerns without risk to their employment.
6. Depending on the form they take, the enterprise agreements would likely also improve workforce pay and conditions – for example, with the potential to bring base pay in line with that for existing public sector NEPT staff and to better compensate staff for working unsociable hours.
7. In contrast to outsourcing reform, insourcing offers the opportunity to achieve these benefits for the workforce without the associated compliance activities and costs (which have been required in other social procurement exercises – see, for example, Box 35 in section 5.6). It is also likely that insourcing represents a more complete solution than the approach offered under outsourcing, as discussed above.
8. While reduced casualisation should be achievable without significant cost, improved base pay and entitlements would come at a significant taxpayer cost. This would need to be balanced with the benefits to the workforce, NEPT service delivery and the broader health system if insourcing options are pursued.
9. Likewise, insourcing would improve collective bargaining power, making it easier for the workforce to organise and coordinate advocacy efforts to improve pay and conditions. This is a benefit to the workforce and a potential risk to costs and is more specific to insourcing.

### Insourcing offers a mechanism to further environmental goals

1. Insourcing of NEPT services also offers an opportunity to pursue broader social goals. For example, as chapter 3 notes, the NEPT sector has a very significant environmental impact, producing more than 4,500 tonnes in carbon emissions per year and without a sector-wide strategy to address this.
2. While social procurement conditions provide an opportunity to address this within the context of improved outsourcing arrangements, insourcing is also a viable way of doing this.
3. In either scenario, decarbonisation would be most efficiently pursued through a cohesive industry transition strategy that covers both emergency and non-emergency patient transport services, given the ambitious targets, research and development and economies of scale in investment, and the government incentives and support that will be required to transition the vehicle fleet and build the necessary enabling infrastructure (for example, electrified depots and charging facilities at health service ambulance ramps and car parks).

### Insourcing would strengthen clinical governance for unplanned NEPT in particular

1. As section 3.1 describes, significant effort is involved in supporting and ensuring private NEPT industry compliance with the Regulations. This includes effort within private NEPT operators that have internal clinical governance resources and processes, and by a small regulatory unit within the Department of Health. Oversight of public NEPT services delivered by AV and health services are managed under their existing broader clinical governance arrangements.
2. In an insourcing scenario, existing clinical governance arrangements across private providers would be consolidated within a public entity. The existing regulatory framework will likely also need to change, given current legislative requirements for NEPT are specific to services provided in exchange for money while other public entities such as health services and AV are regulated under distinct legislative instruments that are not specific to NEPT.
3. Continuing regulation and oversight of the private NEPT sector would need to remain in effect, given that NEPT services would continue to be required by private hospitals and other public clients such as the Coroners Court of Victoria.
4. Insourcing of unplanned NEPT services to AV (section 6.2.1) would enable this work to be integrated into broader emergency response operations. This would bring Victoria’s model in line with other jurisdictions (Box 40).
5. The clinical governance of unplanned NEPT would benefit from being part of AV’s operational structure. In particular, crews undertaking unplanned NEPT would be integrated with AV’s broader operating standards and have rapid access to an escalation pathway in circumstances where a patient deteriorates.
6. The timeliness of planned NEPT services would also improve, with existing disruption of these services by unplanned NEPT responses minimised. This would improve patient access to acute, subacute and specialist health care, with broader potential benefits for patient safety, experience and clinical outcomes.

Box 40: Victoria is unique in having private providers deliver triple zero (000) responses

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| Research conducted during the review found that the delivery of unplanned NEPT either outside of ambulance or the public sector occurs rarely, if at all, in other jurisdictions:  In **New South Wales**, the public planned NEPT service (HealthShare NSW Patient Transport Service) does not respond to any triple zero (000) demand, with a clear separation of scope from NSWA and no functional overlap and operational integration between the 2 services. All cases within an emergency scope are completed by NSWA, and there is limited manual dispatching of non-emergency cases (only 3 to 5 per day, compared with an average of 200 per day in Victoria) from NSWA to the Patient Transport Service.  In **Western Australia**, St John Ambulance is the state provider of emergency ambulance services. There is no formal channel for diverting low-acuity ambulance cases to planned NEPT resources, for which there are separate call-taking channels (triple zero (000) patients can be assigned as Priority 1, 2 or 3, whereas planned NEPT are assigned as Priority 4 using a separate pathway, with no connection between 1–3 and 4).[[352]](#footnote-353) In this way, unplanned NEPT is delivered as part of ambulance services, with full separation from planned NEPT.  In **Queensland**, the public ambulance service delivers all NEPT services, seldom using NEPT to deliver emergency responses in any event. |

### Consolidating services would simplify overarching management

1. Consolidating services through insourcing would facilitate more holistic management of resources across the state. This would maximise opportunities for planning to optimise service delivery and improve patient experiences (for example, including the efficiency of vehicle and staff allocations) and enable the development of coordinated workforce development and growth across the NEPT sector.
2. Reform of outsourcing could also facilitate improved management and governance as discussed in chapter 5, but insourcing may be a more complete solution. For example, there would be fewer entities delivering NEPT services (2, as recommended in section 6.2) and the Regulator would no longer need to play a significant role in the system.

## An insourced model should involve separating planned and unplanned NEPT

1. Around Australia and overseas, different insourcing models operate with varying degrees of effectiveness (refer to Box 41 for examples). Insourcing can work well, and it can also work poorly. The effectiveness of the model depends on its underlying design principles (discussed in chapter 4) to enable efficient management of resources and effective separation between planned and unplanned or emergency work.
2. The following sections consider how these principles apply to an insourcing model in Victoria and which public entities would be best placed to lead the delivery of planned and unplanned NEPT services.
3. The purpose of insourcing would be to improve the coordination, coverage and consistency of services delivered across Victoria. Insourcing would ensure:
   1. workers are employed under the same pay and conditions across the sector and that they receive consistent training and development that builds skills in response to system need
   2. the delivery of services would fall under the clinical governance of a public entity, which would be more able to directly improve or adjust quality and safety.
4. Insourcing may also enable improved health system management, where NEPT demand across the sector can be understood and planned for. It may also be able to address the issue of thin markets in rural areas (where AV is already required to intervene as the provider of last resort) and support whole-of-system prioritisation by balancing both clinical need and patient flow from a single framework.
5. In line with Recommendation 1, planned and unplanned NEPT services are proposed to be delivered by separate entities.
6. No proposal has been made to separate metropolitan and regional services within these models (for example, with insourcing of regional services alone to resolve thin market risks).
   1. This is because transport volumes would be too small and diseconomies of scale too great under such a model. This risks potentially decreasing reliability in rural areas for patients and health services and increasing costs to government. In addition, the efficiencies to be gained from centralised booking and dispatch would be potentially limited since many transports happen between metropolitan and rural areas (rather than within the regions alone), leading to empty return trips across these routes.
7. Instead of structurally delineating rural NEPT services, the public entities delivering planned and unplanned NEPT services will need to develop strategies that tailor their service delivery models to the needs of rural health services and patients.

Box 41: Other jurisdictions show that insourcing can work well or poorly, depending on design

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| **New South Wales has experimented with both effective and ineffective insourcing models**  As discussed in detail in chapter 4, New South Wales has experimented with 2 kinds of insourcing models: a prior, unsuccessful model in which most planned NEPT services were fully integrated with ambulance services, with others fragmented across the system with no overarching coordination, and the current, highly successful model where there is full separation between planned and emergency responses, and centralised coordination of the former. This shows how insourcing arrangements can have both negative and positive impacts, depending on their design.  While most of New South Wales’ services are delivered by a public entity, HealthShare NSW[[353]](#footnote-354) also outsources approximately 20% of services to a panel of private providers to maintain sustainable access to surge capacity. This is discussed below.  **Queensland’s fully insourced model is undermined by significant spills to emergency crews**  QAS delivers both emergency ambulance and NEPT services, with centralised booking and dispatch of both. This model has benefits, as NEPT is separated operationally but leverages ambulance depots, facilitates handover of low-acuity patients from triple zero (000) calls, and supports collaboration during mass casualty events. QAS offers are also integrated into health service Patient Access Coordination Hubs, with real-time data sharing and collaboration to support efficient patient flow coordination across the system.  These design features have benefits but are undermined by high spill rates, with approximately 20% of QAS NEPT transports delivered by emergency crews. This is much higher than the total NEPT spill rate of 3.5% in 2022 that AV experiences and the 0.86% seen in New South Wales since separating services. This may be due to QAS’ underinvestment in NEPT (as previously occurred in NSWA), with limited NEPT service hours and capacity. |

### As an emergency response, unplanned NEPT could be delivered by AV

1. As described in chapter 3, the role of unplanned NEPT is to improve outcomes for people with urgent care needs. Whenever a triple zero (000) call can be appropriately redirected to a NEPT service, an ambulance is freed up to attend to people in the community experiencing the most time-critical medical emergencies. Evaluations show this diversion is critical to protect ambulance response times and improving patient outcomes.[[354]](#footnote-355)
2. Given this function, unplanned NEPT cannot be operationally separated from TZV, which is the initial intake point for unplanned NEPT demand due to its role in call-taking and dispatch of triple zero (000) calls.[[355]](#footnote-356) TZV will need to remain responsible for dispatch of unplanned NEPT responses, since these are time-critical and need to be redirected to emergency ambulances if a NEPT resource is unavailable (rather than simply waiting until one is, as can occur for planned NEPT). These also need to be rapidly escalated to emergency resources if a patient deteriorates or their needs prove higher in the field than initially assessed by AV secondary triage.
3. While unplanned NEPT could continue to be dispatched by TZV and delivered by a public entity other than AV, this creates risks and inefficiencies when transferring cases between NEPT and emergency crews due to spills and clinical escalations. There are no stakeholder proposals for such a model and no known precedents for it. As Box 40 notes, delivering unplanned NEPT either outside of the ambulance or the public sector occurs rarely, if at all, in other jurisdictions.
4. On the other hand, insourced delivery of unplanned NEPT to AV may be able to deliver significant benefits, both relative to service provision by a different public entity and compared with outsourcing, even under improved procurement arrangements. For example:
   1. Placing unplanned NEPT under AV’s broader emergency service clinical governance would enable stronger management of the intrinsic clinic risk of emergency responses, as discussed in section 6.1.
   2. Integrating unplanned NEPT services with AV’s broader emergency response operations would improve economies of scale for unplanned NEPT services, which will be a risk in relation to maintaining their separation from planned NEPT services (whether via insourcing or outsourcing), as recommended in chapter 4.
   3. Unplanned NEPT accounts for the largest portion of spills to emergency services (61.5% of total spills). As such, AV delivering unplanned NEPT would keep the cycle of diversion from emergency and escalation to emergency within AV (depending on demand and other external factors), rather than diverting to a separate agency and then escalating back again, which would be challenging from a coordination perspective.
   4. Unplanned NEPT could provide an internal workforce pathway through which AV paramedics could transition, redeploying to less urgent and lower acuity cases for experience and skills maintenance at points in their career (for example, during periods on WorkCover or in early stages of their career), as will be discussed in chapter 7.
   5. Finally, unplanned NEPT would enable AV to develop or expand innovative workforce models that pair staff with differing levels of skills and experience to respond to lower acuity cases. This would free up dual-paramedic ambulance crews to focus on the most urgent callouts, improving response times for the patients who need care fastest.
      1. One example of innovative workforce models is AV’s Medium Acuity Transport Service, which pairs experienced paramedics with graduate paramedics. The model is successful, and there could be scope to develop another lower acuity service leveraging NEPT workforces with appropriate supervision (Box 42).

Box 42: AV’s Medium Acuity Transport Service shows the potential of innovative workforce models

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| AV has introduced a Medium Acuity Transport Service to support demand management of low- to medium-acuity cases on standard emergency operational resources. This has created a new workforce pathway, with crews staffed by a Graduate Bridging Paramedic and an Advanced Life Support paramedic.  An evaluation of the program found that Graduate Bridging Paramedics felt confident and well-prepared to transition into the graduate program,[[356]](#footnote-357) while also finding the proportion of less-urgent code 2 and code 3 cases attended by an Advanced Life Support resource was significantly lower by the end of the service’s trial.  The service currently consists of 22 crews, operating from 8 am to 11 pm. This model could be expanded to other staff, including the NEPT workforce, with support and appropriate supervision.[[357]](#footnote-358) |

1. On this basis, if NEPT services are insourced, unplanned work should continue to be booked and dispatched by TZV and delivered by AV (Option 2a). This option could be pursued as a standalone insourcing solution (in conjunction with outsourcing reforms, as set out in chapter 5), or in combination with insourcing of planned NEPT services to a separate public entity, as detailed later in this chapter.

Option 2a: Insourcing of unplanned NEPT to AV and TZV is preferred

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| If NEPT services are insourced, the preferred arrangement for unplanned NEPT is booking and dispatch of unplanned NEPT to continue to be provided by Triple Zero Victoria and service delivery to be provided in-house by Ambulance Victoria. This would enable full integration of unplanned non-emergency patient transports into broader statewide health emergency response operations. |

1. Insourcing would see AV deliver unplanned NEPT responses, requiring significant adjustment of its current operations.
2. At present, AV outsources 47,140 unplanned NEPT responses a year while delivering 17,940 in-house across planned and unplanned.
3. Should insourcing proceed, the intent is that routine outsourcing of unplanned NEPT services would cease, unless required due to state emergency management arrangements, or to ensure sustainability of surge capacity arrangements (as discussed in section 6.3.2).
4. It is anticipated that at least some unplanned work could be delivered by the existing workforce (of which approximately 17,940 transports are delivered in-house) and potentially also CTS responses, with appropriate upskilling[[358]](#footnote-359) and potentially establishing a new workforce classification where required.
5. Insourcing unplanned work to AV would also have a significant impact on the broader NEPT system, removing 12.8% of private providers’ current work.[[359]](#footnote-360) These impacts are discussed in section 6.3.2.

### If insourcing is pursued, planned NEPT should be delivered by the VDHCC

1. As described in chapter 1, the role of planned NEPT is to facilitate timely access to health services. When planned NEPT services run efficiently, patients can get the care they need and go home as soon as they are ready. Specialist outpatient clinics can run to schedule and patients can be discharged on time. This helps prevent ‘bed block’, where an insufficient supply of beds leads to patients being backed up in emergency departments and on ambulance ramps.
2. Planned NEPT services have very little to do with ambulance services or triple zero (000) call-taking but are connected with a health service’s progression of patient care. As such, it is unclear what benefit a planned NEPT service can derive from integration within an ambulance service. Also, having ambulance services deliver planned NEPT appears to be associated with poorer performance for both planned NEPT and emergency ambulance services, as discussed in chapter 4. Notably, there have been very high levels of consensus among stakeholders, including AV, in opposing insourcing to AV.[[360]](#footnote-361)
   1. As Box 43 shows, AV considers that it has significant existing and competing priorities and prefers insourcing into a separate public entity on the grounds of managing costs to government, enhancing sector governance, embedding standardised processes and enabling AV to maintain a clear focus on delivering emergency and time-critical care to the sickest patients.

Box 43: AV prefers insourcing into a separate public entity

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| ‘AV’s new Strategic Plan 2023–2028 identifies and responds to several challenges, including but not limited to… record low Code 1 operational response performance … Cultural reform – following review by the Victorian Equal Opportunity and Human Rights Commissioner … numerous multi-year projects and programs which will limit its ability to take on additional transformational activities ... constrained financial environment requiring AV to explore efficiencies … Revising operating models – with current systems and processes not meeting current requirements … [and] negotiations on the AV Enterprise Agreement 2024 … Any changes to the procurement model and ways of working for AV that arise from the NEPT review recommendations will need to be managed in line with the above competing priorities. AV will advocate for any recommendations made to be in alignment with its strategy and the objectives of ambulance services outlined in the *Ambulance Services Act 1986*.’   * + Ambulance Victoria |

1. Should insourcing progress, responsibility for delivering planned NEPT best rests with a public sector organisation that can provide dedicated strategic focus, resourcing and planning. This organisation would have access to other levers for improving patient flow across the health system,[[361]](#footnote-362) without the interference of unplanned NEPT, which serves a different function in the system. On this basis, insourcing of planned NEPT services into AV is not recommended, at least initially.[[362]](#footnote-363) Instead, if insourcing is desired, a separate public entity would need to deliver planned NEPT services. Three public entities were explored for this purpose:
   1. the VDHCC
   2. HSV
   3. a public health service.
2. The preferred option, the VDHCC, has advantages over other options in that it will be a neutral entity designated as the central point of authority for streamlining patient flow across the health system.[[363]](#footnote-364)
   1. Neutrality will benefit both AV and health services by ensuring NEPT resources are allocated according to system priorities, rather than the interests of individual stakeholders. The VDHCC will protect planned NEPT delivery from interfering factors that would affect other potential locations: AV would prioritise unplanned NEPT at the expense of planned services, and a public health service would have a conflict of interest between the NEPT sector and the needs of its staff and patients. HSV would be neutral, but it is not deemed a suitable alternative (discussed below).
   2. The VDHCC will have significant in-house clinical expertise, drawing on the specialist clinical resources of the health services in Parkville.[[364]](#footnote-365) It will have a range of in-house operational and health system management functions, including delivering adult and paediatric retrieval services, which sometimes draw on planned NEPT services.[[365]](#footnote-366)
   3. The VDHCC will also deliver important system coordination and logistical functions, with real-time visibility of activity across the full system and responsibility for coordinating responses during emergencies and periods of surge, and providing routine overarching governance and a central point of escalation for interhospital transfers. Planned NEPT resources are vital to both surge responses and efficient transfer and broader flow management.
3. Under this option, VDHCC would be the public entity delivering the centralised booking and dispatch of planned NEPT resources as recommended in chapter 4. Per this recommendation, this function would include embedded eligibility screening and redirecting ineligible requests to appropriate transport options. This would allow the VDHCC to also directly manage non-medical community transport services, which support broader patient flow objectives.
4. HSV is considered a poor candidate for delivering NEPT services, given limited alignment between its current capabilities and strategic priorities and what would be required to deliver planned NEPT services at scale.
   1. While its counterpart HealthShare NSW is responsible for in-house delivery and commissioning of NEPT services and appears to deliver this function effectively (refer to chapter 4), HealthShare NSW has organisational experience in in-house delivery of large-scale shared services for the hospital system (including food, linen and cleaning services), in addition to procurement services on behalf of health services. In contrast, HSV’s role and capabilities are currently confined to the latter.
   2. Consistently, HSV’s own submissions to the review highlighted a lack of alignment between its existing capabilities and funding and what would be required to operate NEPT services, along with competing strategic priorities.[[366]](#footnote-367)
5. A public health service was also considered a potential option for delivering planned NEPT services. It is not without precedent for individual health services in Victoria to deliver functions on behalf of the broader system.[[367]](#footnote-368)
   1. At present health services are, like AV, focused on improving performance following the profound impacts of the COVID-19 pandemic, which delivered shocks in patient demand, workforce supply and system costs.
   2. More broadly, experience shows there can be increased risk in housing system functions in individual health services. This can lead to a perception among health services and other stakeholders that the responsible health service has a conflict between its local interests and broader system needs.
6. Based on the above considerations, the VDHCC is considered the public entity best placed to deliver planned NEPT services should these be insourced.[[368]](#footnote-369) The transition will require the department to play an active role in stewarding the sector through implementation and ensuring service continuity, with no gaps in NEPT services.
7. Implementation of insourcing would require the department to expedite its setting up of the VDHCC as a new public entity, completing development of core organisational architecture (for example, its operating model, governance, funding, performance monitoring and accountabilities and enterprise agreement) ahead of functions specific to planned NEPT (for example, building a centralised booking and dispatch function, establishing depots and procuring vehicle fleet, IT systems and other equipment and consumables).
8. Noting the significant lead time to establish the VDHCC and the complex transition process involved, interim arrangements are crucial to mitigate service continuity risks. An interim service plan could include stop-gap payments to incentivise service delivery until the transition is complete. Like the situation in New South Wales, an incremental transition approach would likely be practicable. This would involve the work of one provider being transferred from AV and the VDHCC at a time, which would lengthen the transition process but may mitigate change risks.
9. The department will also need to actively manage risks to health services and AV performance, given that disruptions to NEPT can rapidly flow through to broader disruptions to patient flow. This may require commissioning extra capacity from private providers through the transition to offset disruptions.
10. All private sector staff currently delivering NEPT services for public health services would transition from their current employers to VDHCC if they wished. They would be employed under terms and conditions set out in a new enterprise agreement, receiving standardised wages and conditions.
11. AV would cease its role in planned NEPT services, as discussed in chapter 4. AV staff currently delivering planned NEPT services would maintain existing terms and conditions. AV staff would be provided options to work in the VDHCC or in other parts of AV’s operations.
12. A feasibility study should be conducted to determine the best commissioning approach for Air NEPT services, once the government decides on the overarching reform approach. This study should generate advice on how Air NEPT services can best be commissioned to reduce unnecessary Air NEPT (while ensuring that patients are still provided with appropriate transport options, enabling them to access healthcare services in a timely way) and maintain timeliness of emergency air transports.
13. Responsibility for commissioning of all non-medical community transport services (including taxis, rideshare services and community transport services) would transfer to the VDHCC.
    1. This would reduce duplication of contract administration and increase economies of scale through a single point of procurement for these services,[[369]](#footnote-370) which are currently purchased in a decentralised way across the system.
    2. It would also enable bookings of them to be integrated into the centralised NEPT booking and dispatch system, improving ease of booking for health service staff and ensuring requests are appropriately triaged, with service responses aligned with patient need.

Option 2b: Insourcing of planned NEPT to the Victorian Digital Health Command Centre is preferred

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| If NEPT services are insourced, the preferred option is for the Victorian Digital Health Command Centre to be responsible for the following functions, as part of its broader responsibilities for improving health system flow through timely access to health services:  booking, dispatch and in-house delivery of all planned road NEPT services  centralised commissioning and booking of all non-medical transport services.  Booking of planned Air NEPT services should be informed by a feasibility study undertaken to identify how responsibilities for commissioning and delivery of Air NEPT services should best be structured across the system, should insourcing of planned services occur. |

1. Once planned NEPT functions are successfully transitioned to the VDHCC and have matured, the government may wish to consider whether the services should be transitioned into AV, as some stakeholders have suggested.[[370]](#footnote-371) For this to occur, several conditions should first be met:
   1. Insourced delivery of planned NEPT services by the VDHCC will need to have fully matured, with effective workforce and operating models in place, including centralised booking and dispatch. Performance metrics should demonstrate satisfactory timeliness, productivity, cost efficiency, quality, safety and patient experience.
   2. AV will need to demonstrate its capacity and capability to take on an enlarged scope of work, with its own performance metrics showing satisfactory emergency response performance, appropriate management of demand, and financial sustainability with the capability to support a bigger workforce.
   3. A compelling strategy should show, to the satisfaction of all key stakeholders, that transition can achieve more improvements in the performance of planned NEPT services, without detrimental impacts on other parts of ambulance and health system performance. This would also involve a clear plan to maintain operational separation between planned and unplanned NEPT after integrating the former into AV, and to ensure NEPT services are responsive to health services’ needs and priorities.

## Insourcing will have significant impacts and would need to be carefully planned

1. Insourcing would have profound impacts on the NEPT system, as this section shows. Chief among these are the financial impacts for government and the likelihood of a large-scale market exit among private NEPT providers. This will have flow-on effects for other public and private purchasers of their services, as well as significant health system disruption from long-term structural reform.

### The upfront and ongoing costs of insourcing are expected to be significant

1. As section 3.3 shows, current outsourcing arrangements are significantly cheaper than insourcing, with most of the cost differential relating back to disparities in workforce wages and conditions between NEPT staff employed by AV and those working for licensed private NEPT providers.
2. Transferring the private workforce to public contracts is expected to involve significant cost. Workforce costs account for the majority of NEPT service delivery costs. Modelling completed by Deloitte Australia for this review indicates that on-costs for NEPT staff employed by AV could be expected to sit at around 2.6 times[[371]](#footnote-372) private sector on-costs, based on current enterprise agreement provisions.[[372]](#footnote-373) While a tailored enterprise agreement would be developed for the VDHCC, balancing workforce needs with operational considerations, this would still be expected to offer more generous pay and conditions to workforce, modelled by Deloitte at around 1.4 times[[373]](#footnote-374) the private sector on-costs.
3. As chapter 5 notes, it is also important to acknowledge that shifting from a heavily casualised workforce profile to a more permanent one is also likely to increase costs (for example, from the requirement to provide permanent staff with permanent hours irrespective of demand, which can fluctuate) while delivering broader benefits (such as the potential to reduce administrative costs and increase productivity with a more stable workforce).

### Market exit for private NEPT providers is likely, with flow-on impacts for the system

1. This section focuses on the impacts of insourcing reforms when fully implemented. Transition risks and requirements are explored in section 6.4.
2. Full insourcing of both planned and unplanned NEPT services will have profound impacts on the private NEPT industry.
3. The NEPT industry currently relies heavily on public NEPT contracts. The NEPT services subcontracted by AV and public health services make up 84.8% of all transports in Victoria.[[374]](#footnote-375) Ceasing these public contracts may lead to market exit by many of the 10 licensed and actively operating NEPT providers in Victoria.[[375]](#footnote-376)
4. For 5 publicly contracted companies, AV and health service contracts make up more than 99% of their NEPT volumes. They are unlikely to be sustainable without this work.
5. The other publicly contracted company, St John Ambulance, delivers 77% of its NEPT transports for AV and health services, with the rest expected to be a combination of deceased persons’ transports for the Coroners Court and work for private clients including private hospitals.
6. The remaining 3 NEPT operators do not rely on public contracts, but they are very small scale, with each delivering just 200 to 4,000 transports a year (all for private clients).
7. The flow-on effects of some or all these companies exiting the Victorian market may be limited for private hospital purchasers of NEPT services. NEPT transport volumes for purchasers other than health services and AV are relatively limited, at under 25,000 per year.[[376]](#footnote-377) Two of the 9 providers of these transports do not currently hold public contracts subject to insourcing, but the loss of density in the market may affect competition and pricing.
8. Flow-on effects for first aid services, which some NEPT providers also deliver, are also expected to be comparatively limited. This is because while 3 of the publicly contracted NEPT providers also deliver first aid services, they only make up a small part of the first aid services market, accounting for 3 of the 35 licensed first aid service providers,[[377]](#footnote-378) and servicing just 1 in 5 first aid services–supplied events.[[378]](#footnote-379) These providers may also choose to remain in the market without NEPT contracts (in other states, some of these providers deliver first aid services without local NEPT business),[[379]](#footnote-380) although potentially at a higher price if their NEPT services cross-subsidise other low-cost or free service offerings.
9. Implementation planning must consider the impacts of changes to the NEPT market on ‘stand-by services’. AV receives requests to provide stand-by services at public events (such as music festivals) for participants who experience unanticipated illness or injury. At times, AV has had arrangements to subcontract some of these requests to the private NEPT market.[[380]](#footnote-381) Disruptions to the private market through insourcing may limit AV’s ability to outsource these services.
10. Full insourcing is not expected to significantly affect Air NEPT services, which are primarily delivered through an insourced model at present.
11. The main consequence of private NEPT operators exiting the market is likely to be reduced access to surge capacity for AV. During periods of surge in the past, AV has needed to commission an extra 30 shifts per day (or approximately 3% of workload), which could be expected to deliver around 120 extra daily transports.
12. These volumes may be beyond the capacity of the private NEPT sector to provide if current publicly contracted providers exit,[[381]](#footnote-382) noting that the sector could not consistently fill all these shifts under current conditions.
13. Experience elsewhere shows that private NEPT providers struggle to provide public surge capacity on demand without a baseline of ongoing public contract volumes to sustain them, given the very small scale of private NEPT work. For example, HealthShare NSW has had to engage a panel of 8 private providers for ongoing delivery of 20–25% of its NEPT services after ad hoc surge capacity contracts to support in-house (public) NEPT services proved unsustainable.[[382]](#footnote-383)
14. The above-described impacts are likely to be attenuated in a partial insourcing scenario, where only unplanned NEPT services (12.8% of privately delivered work) are brought in-house.
15. In a full insourcing scenario, implementation planning will need to consider what services currently provided by the private market need to continue but are at risk and test the feasibility of different options for sustaining those services. For example, this could occur through either:
    1. insourcing these services at an additional cost (for example, having the VDHCC and AV maintain latent in-house surge capacity)
    2. authorising public providers to meet private demand for a fee (for example, requiring the VDHCC to provide planned NEPT services to private hospitals on a cost-recovery basis, noting this would create significant regulatory complexity)[[383]](#footnote-384)
    3. strategically commissioning some private capacity, potentially through a bundling approach (for example, bringing together the Coroners Court contract with an NEPT surge capacity contract) that guarantees sufficient minimum volumes to several private providers to remain sustainable.

### Structural reform will involve a long-term transition process

1. The process of transitioning existing and fragmented NEPT services to public hands is a complex one that will take years to plan for and execute, with significant service continuity risk in the interim.
   1. New South Wales’ experience of bringing multiple NEPT services under one roof took several years (Box 44), including at least 2 years to move from government announcement to implementation and another 3 years to achieve full separation of workforce and assets (for the initial wave of consolidation, noting that many regional LHDs have still not been brought into the consolidated model).
   2. Victoria’s experience in a full insourcing scenario would be more complex because the transition would be from private to public hands, rather than public to public, with a much weaker obligation on private providers to maintain service continuity in the event that insourcing was announced.

Box 44: Transition process for establishing HealthShare NSW’s Patient Transport Service

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| The New South Wales Government committed in 2012 to reforming NEPT services. This was to involve formally separating NEPT and ambulance services, transferring NEPT from ambulance into a separate entity, HealthShare NSW,[[384]](#footnote-385) and implementing a centralised booking system to manage all NEPT requests.[[385]](#footnote-386)  This was a multiyear process. The initial transition began 2 years after the government announced the reforms. It took another 3 years to achieve full separation of people and assets,[[386]](#footnote-387) with NEPT fleets from NSWA, all metropolitan LHDs and 2 of the rural and regional LHDs integrated into HealthShare NSW through a staggered rollout[[387]](#footnote-388) from 2014 to 2016.[[388]](#footnote-389)  Change management was a critical part of the separation. Staff coming from NSWA and LHDs were under different awards, had different cultures, systems, processes, management and ways of working. All these differences were challenging to manage during the transition and took time to optimise.  There was a need to overcome a historical expectation that NEPT work could be transferred across to ambulances once NEPT capacity was reached,[[389]](#footnote-390) and to make it clear to all that NSWA had very limited opportunity to assist with NEPT activity to ensure they had capacity to respond to triple zero (000) requests.  Between finalising the transition in 2016 and 2020, the consolidated team started coming together and significant improvements were achieved, including a 13% reduction in lost time injury frequency rate, a 50% increase in customer satisfaction, a cost reduction of around $6.5 million,[[390]](#footnote-391) an 84% reduction in on-scene cancellations and 25% reduction in patient waiting times.[[391]](#footnote-392) The COVID-19 pandemic subsequently created significant opportunities for increased integration of the NEPT service into system flow management, but it also slowed progress on strategic goals. Momentum is now starting to build again, with a raft of service improvements introduced in 2023.  Today, HealthShare NSW delivers 220,000 transports a year across 7 major hubs and several satellites, operating 18 hours a day, 7days a week. Remaining LHDs deliver approximately 50,000 transports a year and will be integrated into the HealthShare NSW service over 2024 and 2025.[[392]](#footnote-393) |

1. Preparing for insourcing will be a complex process, requiring extensive due diligence, planning and stakeholder engagement.
   1. Legislative changes may be required to specify the new functions for the VDHCC as a newly established public entity, and existing legislation that applies to the NEPT sector would also need to be amended.
   2. Clinical escalation processes would need to be established to enable the escalation of patients from the VDHCC to AV (or potentially to internal retrieval services, which the VDHCC will also house as part of its broader system flow management functions) if there is clinical deterioration. Processes would also need to put measures in place for surges in demand and to manage responses to major emergencies.
   3. There would be a multiyear lag for transferring the workforce, procuring vehicles and establishing depots under an insourced model. This would pose a risk of interim NEPT supply and performance, with implications for patient flow across the system, and a risk of spills to emergency services.
   4. As discussed in chapter 4, significant complexity would also be involved in the operational and financial separation of planned from unplanned NEPT within AV. This also creates risks to the stability of AV’s performance, with potential to affect emergency responses if not well managed.
2. Private providers have warned that a transition to insourcing is likely to involve significant risks. These include interrupting current investment in new regulations and quality standards (for example, fleet renewal to meet the new vehicle standards described in section 3.1.3), the potential for providers to abandon existing contracts or not renew AV contracts (which expire in June 2024) and activate termination clauses within current HSV contracts. It may also disincentivise retention of staff.
3. To manage transition risks, an interim service continuity plan would be needed with stop-gap measures and extraordinary payments to incentivise providers to maintain service delivery until the transition is complete.
   1. Like New South Wales, the Victorian Government could pursue a graduated transition to an insourcing model (for example, transitioning work from one private provider to VDHCC and AV at a time), which would lengthen the transition but potentially mitigate change risks.
   2. The department will need to actively manage risks to health services and AV capacity, since disruptions to NEPT can rapidly flow through to broader disruptions to patient flow. This may require commissioning extra capacity from private providers during the transition to offset disruptions.

## Insourcing and outsourcing have some common risks and benefits, and some distinctions

1. The implementation costs and risks discussed above are significant and need to be weighed against the many potential benefits of insourcing outlined in section 6.1. This includes the potential of insourcing unplanned NEPT to strengthen clinical risk management and introduce innovative new emergency response models and workforce pathways.
2. While some of the reform benefits outlined can only be achieved through insourcing, some can also be achieved to a similar or equivalent extent through outsourcing, as described in chapter 5 and summarised in Table 9. Both insourcing and outsourcing reform options offer a way to consolidate purchasing and delivery arrangements to reduce administrative complexity, improve system efficiency and address market failure, and to further social goals including improved workforce benefits and environmental sustainability.

Table 9: Key potential benefits and risks of insourcing options compared with outsourcing reform

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| --- | --- |
| Strengths and opportunities | Weaknesses and threats |

| Distinct to insourcing | Common across both insourcing and outsourcing reform options | Distinct to insourcing |
| --- | --- | --- |
| * For unplanned NEPT, stronger clinical governance and opportunities for AV to develop innovative new emergency response models and workforce pathways * Improved rostering efficiencies and minimised duplication of overheads through consolidation into fewer entities * Simplified system management, including reduced procurement and regulatory oversight requirements * Scale, government investment and accountability to innovate and improve performance and cost | * Simplification of purchasing arrangements, reducing complexity and cost * Consolidation within areas to improve efficiencies and fix supply gaps * Centralised booking and dispatch to improve route efficiency, with whole-of-system data to underpin real-time flow escalations and continuous improvement * Access to HSV’s purchasing power to reduce input costs in procuring equipment and consumables * Ability to further social goals, including workforce benefits and environmental sustainability * Implementation complexity, including change management and investment | * High transition costs and increased long-term operating costs * High disruption to industry, with flow-on impacts for other public and private customers of NEPT providers * Long transition time, with interim service continuity risks * No market competition influencing performance and cost |

1. Stakeholder views in terms of whether to insource or outsource services are split (Box 45). For example, private providers are strongly opposed to insourcing, while the Victorian Ambulance Union is supportive. AV prefers insourcing, but to a separate public entity. Health services did not directly comment on whether they prefer insourcing or outsourcing but are seeking to achieve greater influence over planned NEPT services than in the current state. The workforce raised diverse views on insourcing: while some support insourcing to AV, others expressed concern over AV’s commitment to delivering NEPT services.

Box 45: Stakeholder perspectives on insourcing are mixed

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| **AV supports insourcing to a separate entity, and TZV supports insourcing of booking and dispatch**  ‘AV’s current preference is to insource to an entity other than AV. The key drivers behind this preference are the expected lower cost to AV and the health system, and the opportunity to allow AV to focus on its core business of emergency response, in line with the new AV Strategic Plan and the Ambulance Services Act.’  – Ambulance Victoria  **Private providers are opposed to insourcing**  ‘Evidence indicates that insourcing encounters substantial financial limitations, while privatised models are considerably more cost-effective.’  – Medical Edge  ‘The insourcing model is inherently flawed. The insourcing model will not deliver the required outcomes, and represents a risk to the state by the inherent features of a monopoly model.’  – Health Select Services  ‘If the government excludes secondary providers and not-for-profits from providing NEPT services, they will potentially face hurdles including … potential reduction in innovation and loss of agility … lack of choice for hospitals and health care providers … community perception that change represents a loss of services, particularly in rural and remote communities.’  – Royal Flying Doctor Service  ‘SMA is strongly opposed to the insourcing option.’  – State Medical Assistance  **Metropolitan health services seek local control, while rural health services see benefits in consolidation**  ‘Local management is vital for effective bed flow management.’   * + Victorian Healthcare Association   ‘It is WH’s experience that using an intermediary such as AV and [TZV], adds complexity, risk and costs … Agency managed NEPT adds no value to health services delivering patient and operational outcomes.’  – Western Health  ‘Having a single provider – AV or perhaps another statutory provider – and they all come under that one banner, therefore they’re all linked and can be reformed.’  – Central Highlands Rural Health  **The workforce raised diverse views on insourcing**  ‘… the NEPT system should, over time, be consolidated into a single, public sector agency expert in the planning, coordination, and provision of patient transport: as a business unit of Ambulance Victoria … When NEPT is fully insourced, operating systems are mature and an operating rhythm is established, NEPT can be handed back to Ambulance Victoria as a complete package.’  – Victoria Ambulance Union  **Individuals’ submissions supported insourcing**  ‘Bring them back into public hands.’   * + NEPT workforce   ‘I believe this should all come back under one individual entity … and remove the private companies.’  – NEPT workforce  ‘I would wish that this review into NEPT would see us to be brought back under Ambulance Victoria.’  – NEPT workforce  **Workforce contributions through roundtables were more mixed**  ‘If we’re to keep it insourced we need to improve management. There’s been reform failure –not through lack of trying from [the AV NEPT management staff].’  – NEPT workforce  ‘AV’s NEPT resources do a great job in freeing up emergency capacity, but there’s a lack of clarity on the level of commitment of AV to its own NEPT resources – does it want to retain them or divest?’  – NEPT workforce  ‘Having worked across both sectors, there are significant differences between the standards of private providers and AV. I feel a lot safer working for AV. It takes significant time to have issues / maintenance jobs addressed in private, a lot of the equipment is outdated, and there’s pressure to keep vehicles on the road even where safety may be compromised.’  – NEPT workforce  ‘The grass is not greener on the AV side. Our training is not sufficient. Training two and a half years behind in some cases. Lack of visibility of NEPT in the organisation – management doesn’t know it exists.’  – NEPT workforce  ‘AV has no management structure for non-emerg. Thought private providers were bad until I came to AV. There are perks in terms of quality of vehicles and equipment. There’s a lack of oversight in AV – in [my prior private employer] every case was audited. In AV, we’re lucky if two cases get audited a month. We have one person looking after training but they also look after first responders. Haven’t done a training package since I started which was a single day. For rostering – paramedics returning to work are put on ATA shifts and AV ATAs are having to fight for shifts. I don’t think AV is the right place for NEPT. It should be public but separate.’  – NEPT workforce |

1. The review does not provide a direct recommendation to insource or not, given the weight of evidence and stakeholder input suggests that both insourcing and outsourcing reform options can work well. Ultimately, the Victorian Government will need to weigh their relative costs, benefits, strengths and opportunities.
2. However, if insourcing is a preferred course of action, the review has provided a preferred model for achieving this. This involves delineating planned and unplanned NEPT services, in line with their distinct functions, which are best delivered separately per Recommendation 1. Planned NEPT services would be best delivered by the VDHCC as part of its broader responsibilities for optimising patient flow across the health system, and unplanned NEPT services are best delivered by AV, in line with its responsibility for delivering emergency responses.

# Governance

1. The previous chapters set out key objectives for Victorian NEPT services, how they currently perform against those objectives and ways to improve performance through reforms to service design and delivery.
2. This chapter examines overarching stewardship of NEPT services. It shows how NEPT services can be better coordinated, managed and supported through improved governance, better workforce planning and a focus on the continuous improvement of quality and safety.
3. As this chapter shows, whether insourcing or outsourcing is pursued, the system will require governance and coordination. As part of reform implementation, it will be important to clearly outline the objectives for NEPT and the roles and responsibilities of key stakeholders. It will also be important to integrate NEPT services into existing health system strategies, including performance and accountability frameworks. This should be supported by improved collection and use of data to measure the impact and a fit-for-purpose funding model.
4. Centralised workforce planning within the NEPT sector and with related industries, such as ambulance services, must be pursued. At present, this is limited, which results in missed opportunities to attract, support and retain staff working in the NEPT sector. This includes leveraging the skills of staff who may be transitioning into and out of AV.
5. Finally, improved stewardship should also include continuous improvement of quality and safety across the sector, guided by the *NSQHS standards guide for ambulance health services*.[[393]](#footnote-394) There is a need to affirm and provide confidence to stakeholders that NEPT services, including unplanned NEPT responses, are safe, whether regulatory reforms are delivering on objectives, and whether adjustments to regulations and/or policy are warranted.

## Improving governance

1. System governance involves ensuring that a system ‘fulfils its overall purpose, achieves its intended outcomes for citizens or service users, and operates in an effective, efficient and ethical manner’.[[394]](#footnote-395)
2. Governance can involve bringing together a range of system levers to achieve this. These include: setting overarching strategy and delineating roles and responsibilities; setting funding models and incentives; measuring performance and holding parties to account; planning services and infrastructure; regulation, oversight and continuous quality improvement; and workforce planning and engagement.
3. The department’s main role in relation to NEPT services is a regulatory one.[[395]](#footnote-396) The department determines who can provide NEPT services by granting licences, and it is responsible for holding providers to account for complying with regulations. The department has fully devolved its role in procuring and commissioning of NEPT services to AV and public health services. Funding arrangements have led to system fragmentation, with AV and health services working to their individual interests rather than balancing the priorities of the whole health system.

### Outlining objectives and coordinating efforts towards common goals

1. The department has several strategy and policy documents that govern the delivery of services within the health system. These include policy and funding guidelines and the department’s performance monitoring framework. However, these strategies rarely mention NEPT services or set out the department’s expectations of NEPT services and the role these should play in the health system more broadly.
2. The department needs to set clear objectives for NEPT services and ensure these objectives are reflected in existing health system strategies. Defining these objectives ensures that all stakeholders involved in the commissioning, delivery and regulation of NEPT have a shared understanding of the desired outcomes for NEPT services. It will also support stakeholders to work in a coordinated way and towards common goals. These objectives should guide decisions, including resource allocation and performance measurement.
3. These objectives should encompass direct outcomes to be delivered for different stakeholders such as improving system-wide patient flow through timely and efficiently prioritised NEPT services and an improved experience of services for patients. Objectives should also specify a broader vision, such as fostering more sustainable and equitable NEPT services.
4. In setting these objectives, it will be important to consider alignment with the Act, the Regulations, clinical practice protocols, ambulance service payment guidelines and ambulance fee structure.

### Performance measurement, oversight and accountability

1. An accompanying measurement strategy will be needed to translate these objectives into accurate and accessible data to help the government understand the impact of NEPT services and support continuous improvement and accountability.
2. As chapter 3 notes, the NEPT sector generates significant data, but collections are fragmented. There is a reliance on self-reported data and limited central access to and collation of disparate data collections. This makes it difficult to quantify capacity and demand, measure system efficiency and identify opportunities for improvement at the system level.[[396]](#footnote-397)
3. In 2023 the Victorian Government’s Public Accounts and Estimates Committee recommended that, following this review, the department should develop new performance measures for NEPT, including performance information relating but not limited to timeliness, quality, regulatory compliance, access and supply.[[397]](#footnote-398) This will require improved definition, capture and collation of performance data.
4. Measurement will underpin strengthened accountability in the NEPT system at multiple levels. Measures will be designed to support the key principles established in chapter 2, which include patient-centred services, safe emergency responses, efficient hospital flow and a valued workforce.
5. Measurement will also support continuous innovation and improvement. By establishing clear metrics and regularly reviewing data across the system, it will be feasible to benchmark performance of NEPT services over time and identify areas where services are excelling and areas that need more attention. In turn, service innovations can be developed, with their impacts prospectively modelled and outcomes evaluated through centrally collated data.

### Redesigning funding

1. As chapter 3 shows, Victoria’s current approach of funding both health services and AV for NEPT services has generated significant system fragmentation, which adds complexity, duplication and cost. It also does not optimise whole-of-health system performance, with each funder making conflicting demands on private provider capacity.[[398]](#footnote-399)
2. Fragmented funding arrangements can result in overusing services and unnecessary transports, where there are limited incentives for major actors to generate efficiencies and reform their operations in ways that benefit the overall sector. For example:
   1. AV’s funding model is based on service delivery (number of transports), with no clear incentive to reduce ineligible transports.
   2. Most planned NEPT services are booked by health services but paid for by AV,[[399]](#footnote-400) limiting the incentive for health services to reduce ineligible transports in these cases and use more efficient or effective transport options.
   3. Providers are not funded for cases that involve appropriate assessment and care but not transportation of a patient, as discussed below.
3. In future, new funding approaches will need to be developed that addresses these issues. As AV’s submission to the review notes, ‘The allocation of funding via … guidelines, and the operational reality of the application of the model, is pivotal to the systemic issues within the sector’.[[400]](#footnote-401)
4. Chapters 4, 5 and 6 identify recommendations and options that will improve these issues, including through:
   1. separating funding for planned and unplanned NEPT (as recommended in chapter 4) and consolidating funding for planned NEPT through either outsourcing reform (chapter 5) or through shifting to an insourced model (chapter 6)
   2. implementing a centralised booking and dispatch function (chapter 4) that effectively enforces payment guidelines at the point of booking by screening patients for eligibility and directing them to services (with NEPT or community transport options where available, for ineligible patients) that align with their needs.
5. While these steps will help to address issues for planned NEPT, broader issues with AV’s funding model may remain. This is because AV has several other services (such as secondary triage, which plays a key role in NEPT as discussed in chapter 3) that do not directly generate government revenue and rely on government funding from other services, including planned NEPT, which AV will no longer manage.
6. As such, NEPT review implementation will necessitate a potentially timely reconsideration of AV’s broader funding model to ensure greater transparency and clarity between revenue and services.

## Centralised workforce planning

1. As discussed in chapter 3, despite the issues relating to the NEPT workforce’s economic security and wellbeing, and the impact of the Regulations on workforce requirements and demand, there is no effective coordination across the sector in the attraction, development or retention of the NEPT workforce. Equally, there is no statewide planning that considers how this workforce can strategically support emergency services and the patient transport sector more broadly.
2. While government is supporting a pipeline of NEPT workforce by providing free TAFE for the Diploma of Emergency Health Care (the minimum qualification required to work as an ATA, who represent 28% of the NEPT workforce),[[401]](#footnote-402) an absence of workforce planning makes it difficult to determine whether this investment is delivering the most efficient skill mix for the sector.[[402]](#footnote-403)
3. Stronger workforce coordination presents an opportunity to link the NEPT workforce with emergency and other patient transport pathways (refer to Figure 5 in section 3.3.7) for staff interested in stepping up or down in scope of practice over their career.
4. As such, the review recommends that the department delivers a sector workforce strategy to provide a centralised, coordinated approach to understanding workforce needs across the patient transport sector and how these can be met. This will ensure the future needs of patients, services and the system are anticipated, understood and planned for.[[403]](#footnote-404)
5. The method of delivering a workforce strategy may take different forms, depending on broader government decisions about delivering NEPT services through an insourcing or outsourcing model. For example, the strategy could be delivered by the department or by a new entity (as part of a broader insourcing model design), or commissioned through an external organisation such as a tertiary education provider.
6. A workforce strategy would recognise the role of NEPT in supporting whole-of-health-system objectives, how NEPT services are provided to best achieve this, and what skills are needed to deliver these services, including step-up and step-down career pathways.
7. In particular, the workforce strategy would consider:
   1. strengthening training and development approaches – for example, through opportunities presented by Victoria University Centre for Paramedicine, promotion and/or access to free training in rural areas where there may be workforce supply gaps or reducing duplication of training effort across providers
   2. formalising pathways from NEPT to paramedicine and vice versa – for example, by allowing for coordination and considered planning of NEPT and AV workforces, allowing individual providers to build in planned pathways for their workforce, or enhancing opportunities for paramedical workforce to transition to the NEPT sector[[404]](#footnote-405)
   3. implementing other options to support NEPT workforce – for example, through approaches to support staff movement between providers (such as when contracts change), recognition of prior service or ensuring the workforce is performing at the top of scope, including recognition of previous training where appropriate.

## Continuous improvement of clinical quality and safety

1. Chapter 3 describes how quality and safety standards across the NEPT sector are generally improving, with high levels of compliance with the Regulations, low rates of adverse events and regulatory changes that will continue to enhance quality and safety as they are phased in. Chapter 3 also identifies concerns raised by stakeholders, including reported issues with the safety and quality of some unplanned NEPT responses and a variable system focus on patient experience.
2. As part of strengthened system governance and stewardship, there are opportunities to address these issues by uplifting and embedding the continuous improvement of clinical quality and safety across the sector. This section shows how.

### Continuous improvement of quality and safety is a core governance function

1. Continuous improvement is the systematic, ongoing effort to sustainably improve care and services for patients who interact with Victoria’s health system. The Institute for Healthcare Improvement’s Model for Improvement is a commonly used framework for continuous improvement that focuses on asking critical questions, setting objectives and building diverse teams to achieve change.[[405]](#footnote-406)
   1. This applies the plan-do-study-act cycle to gain insights and test potential changes in real-world settings so changes can be rapidly implemented. This involves identifying goals and developing a plan, implementing it, monitoring improvement outcomes and adjusting goals and methods iteratively.
   2. This process aims to achieve incremental and sustainable improvement changes by constantly exploring new avenues for uplift. This is distinct from regulatory compliance, which ensures quality and safety is consistent with accepted standards across the system.
2. Fragmentation that persists across the NEPT sector limits the ability to undertake continuous safety in a cohesive way, including addressing system-level drivers that undermine quality and safety. Instead, continuous improvements can only occur at the local level, and providers often lack incentives to pursue improvement strategies. Strengthened continuous quality improvement for the NEPT sector will be necessary whether outsourcing continues as the dominant delivery model, or whether services are partially or fully insourced.[[406]](#footnote-407)
   1. In an outsourcing scenario,[[407]](#footnote-408) coordinated continuous improvement would require the department (including the regulator) to work with AV and private providers to commission or undertake a sector-wide review. This would include identifying reforms to be consistently implemented across AV and private providers, with enabling policy changes enacted by the department or service improvements enacted by health services.
   2. In an insourcing scenario, continuous improvement and review would occur within the broader clinical governance processes of AV and the VDHCC. For example:
      1. The VDHCC would work with health services to design, pilot, evaluate and scale operational improvements for planned NEPT, as HealthShare NSW has done (refer to chapter 4).
      2. AV would similarly develop and implement service innovations for unplanned NEPT, potentially alongside broader innovation and expansion of low-acuity emergency response models and workforce roles, as discussed in chapter 6.

### Assessing the safety and quality of unplanned NEPT services

1. The initial focus of continuous quality and safety improvement work may need to be on unplanned NEPT. The review heard consistent workforce concerns from both AV and private sector staff that NEPT crews may be assigned to unplanned cases that exceed their scope of clinical practice.[[408]](#footnote-409)
   1. As discussed in chapter 3, concerns were heard that the lack of prior in-person assessment can increase clinical risk, particularly in an environment where a wide variety of presentations are potentially being diverted from emergency responses.
2. This suggests a need to confirm that the emergency incidents being assigned to NEPT crews following triple zero (000) calls and assessment by AV’s secondary triage service are ones that crews are suitably skilled, equipped and supported to manage. Assessment is needed to confirm these cases fit within workforce scopes of practice, and to confirm that sufficient emergency resources exist to meet demand without routine allocation of higher acuity emergency responses to NEPT.
3. The review recommends that expert clinical input be sought to examine these issues and provide findings on the safety of unplanned NEPT services. This process should also identify whether adjustments to current policy and regulations are warranted. Granular advice should be sought regarding how and where quality and safety issues may be occurring and to directly inform targeted responses, including appropriate adjustments to service delivery and regulations if necessary.

### A strengthened focus on patient experience

1. As chapter 3 identifies, patient experiences of NEPT services are not monitored in a standardised or systematic way. The exception to this is AV’s monitoring of planned NEPT experiences through the Victorian Healthcare Experience Survey, which identifies poor NEPT timeliness as the major source of dissatisfaction. However, the survey only includes planned NEPT (in-house and contracted by AV) and CTS, not unplanned NEPT or planned NEPT delivered under HSV contract.
2. Sector-wide, as part of a strengthened role in governance and stewardship, there are important opportunities to uplift and embed continuous improvement of clinical quality and safety.
3. Monitoring of patient experience is crucial for tracking the impact of service delivery across the sector, identifying and evaluating changes to improve NEPT performance, and achieving accountability for funding, as discussed in section 7.1.2.
4. There are multiple ways to engage patient groups within continuous health service improvement, including one-off events or feedback through social media, through to ongoing participation on boards and committees.[[409]](#footnote-410) There is limited evidence supporting the benefits and sustainability of a mechanism for consumer engagement, although the literature supports the use of mixed methods to capture the diversity of patients.[[410]](#footnote-411) As such, the review recommends that patient experience is monitored through multiple avenues that might include:
   1. expanding existing patient experience surveys currently used by AV, noting the significant expected costs associated with development and operations
   2. using innovative methods of directly surveying patients – this would draw on the learnings from jurisdictions, such as New South Wales, where QR codes and paper forms at the point of service enable direct feedback on NEPT services, which is then fed into service improvements and planning
   3. monitoring social media platforms for mentions and feedback related to NEPT services.
5. Once data sources are established, these can be tracked over time and trends established.
6. While evidence on the optimal approach is limited,[[411]](#footnote-412) these approaches would be considered by commissioning entities and providers in both insourcing and outsourcing scenarios.

|  |
| --- |
| **Recommendation 3:** Whether NEPT services are insourced or outsourced, expectations, roles and responsibilities for NEPT services need to be clearly outlined. This requires:  greater integration of the NEPT sector into broader health system frameworks and governance  monitoring of NEPT system performance and patient experience of services to inform performance accountability and continuous system improvement  the NEPT workforce to be reflected in system workforce strategies, with a dedicated NEPT workforce plan that identifies current workforce needs and develops patient transport workforce strategies that meet future health system needs  embedded continuous improvement of quality and safety, with monitoring of patient experience and expert clinical input. |

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## List of submissions to the review

1. Alfred Health
2. Ambulance Victoria
3. Austin Health
4. Central Highlands Rural Health
5. Individual – Private Workforce
6. Eastern Health
7. Triple Zero Victoria (TZV)
8. Health Select Services
9. Health Issues Centre (ceased operations in March 2024)
10. HealthShare Victoria
11. Individual – AV Workforce
12. Individual – AV Workforce
13. Individual
14. LifeAid Emergency Care
15. LINK Community & Transport
16. Individual – AV Workforce
17. Medical Edge Australia
18. Individual – Private Workforce
19. Individual – Private Workforce
20. Individual – Private Workforce
21. Individual – Private Workforce
22. Northern Health
23. National Patient Transport
24. Paramedic Services Victoria
25. Royal Flying Doctor Service Victoria
26. State Medical Assistance
27. St John Ambulance Victoria
28. Victorian Ambulance Union
29. Victorian Healthcare Association
30. Western Health

## Appendix: Comparison of wages and penalties across providers

| Type | Ambulance Victoria | National Patient Transport | Royal Flying Doctor Service | Health Select | Ambulance and Patient Transport Award |
| --- | --- | --- | --- | --- | --- |
| Agreement | Ambulance Victoria Enterprise Agreement 2020  Applies to Ambulance Victoria | National Patient Transport Pty Ltd Victorian Employees Enterprise Agreement 2023  Applies to NPT | Royal Flying Doctor Service Victoria Patient Transport Employees Enterprise Agreement 2021  Applies to RFDS | Health Select and Employees Enterprise Agreement 2021  Applies to Health Select | Industry Award 2020  Applies to other providers |
| Pay-base rate range 2023 | * PTO: $30.22 – $32.44 * ATA: $32.20 – $34.99 * Clinic transport officer: $28.05 – $29.17   Note these are base rates before the ‘rolled-in’ rate is applied for eligible employees | * PTO: $28.67 – $29.27 * ATA: $32.67 –$35.00 * Client service officer: $28.67 –$29.27 | * PTO: $29.09 –$29.51 * ATA: $32.64 –$37.65 * Admin: $27.02 –$35.85 | * PTO: $28.51 * ATA: $32.19 –$40.12 * Communications call-taker: $28.51 | * PTO: $28.50 –$28.89 * ATA: $30.41 –$30.82 * Communications call-taker: $28.50 –$28.89 |
| Casual employment | Ordinary time rate of pay per hour, plus: (a) 25% for all work on weekdays (b) 75% for all work on weekends (c) 100% for all work on public holidays | Ordinary time rate of pay per hour, plus: (a) 25% for all work on weekdays (b) 75% for all work on weekends (c) 100% for all work on public holidays | Ordinary time rate of pay per hour, plus: (a) 25% for all work on weekdays (b) 75% for all work on weekends (c) 100% for all work on public holidays | Ordinary time rate of pay per hour, plus: (a) 25% for all work on weekdays (b) 75% for all work on weekends (c) 100% for all work on public holidays | Ordinary time rate of pay per hour, plus: (a) 25% for all work on weekdays (b) 75% for all work on weekends (c) 100% for all work on public holidays |
| Shift penalties | * For rostered hours starting between 6 am and 6.30 am or finishing between 6 pm and 8 am – paid 4.5% of the Ambulance Paramedic Year 3 aggregated based rate for each rostered period of duty. In addition, any finish between 12 am and 8 am – paid 0.5% of this base rate * Weekend: rate of time and one half * Unsociable shift incentive: $162 per shift on Friday, Saturday or Sunday and finishes between 1 am and 8 am   *Points 1 and 2 form part of the rolled-in rate for eligible employees* | * Hours between 6 pm and 10 pm will be paid an extra $7.35 per hour * Hours between 10 pm and 7 am will be paid an extra $9.92 per hour * Weekend: 50% loading on pay rate for FT and PT * Public holidays: 150% loading on pay rate for FT and PT   *The employer will complete a regular reconciliation to ensure employees are better off overall in relation to the award* | * Hours between 6 pm and 10 pm– extra $5.00 per hour * Hours between 10 pm and 6:30 am – extra $7.00 per hour * Ordinary hours worked on Saturday and Sunday is 150% of hourly rate for FT and PT * Public holidays: 250% of hourly rate for FT and PT   *The employer will complete a regular reconciliation to ensure employees are better off overall in relation to the award* | * Hours between 6 pm and 10 pm will be paid an extra $7.50 per hour * Hours between 10 pm and 7 am will be paid an extra $10.00 per hour * Ordinary hours worked on Saturday and Sunday is 150% of hourly rate for FT and PT * Public holidays: 250% of hourly rate for FT and PT   *The employer will complete a regular reconciliation to ensure employees are better off overall in relation to the award* | * A shift allowance of $53.09 is payable to employees whose rostered hours of ordinary duty finish between 6 pm and 8 am or start between 6 pm and 6 am * Ordinary hours worked on Saturday and Sunday is 150% of hourly rate for FT and PT * Public holidays are 250% of hourly rate for FT and PT, and 200% for casuals |
| Overtime | Mon–Fri: Time and a half for the first 2 hours and double time thereafter – applies to rolled-in rate  Weekend: double time – does not apply to employees on the rolled-in rate (weekday rate applies) | Mon–Fri: Time and a half for the first 2 hours and double time thereafter  Weekend: double time | Mon–Fri: Time and a half for the first 2 hours and double time thereafter  Weekend: double time | Mon–Fri: Time and a half for the first 2 hours and double time thereafter  Weekend: double time | Mon–Fri: Time and a half for the first 2 hours and double time thereafter  Weekend: double time |

1. This figure covers both road and air transports across public and private contracts statewide, including spills to emergency that should have been undertaken by NEPT resources. [↑](#footnote-ref-2)
2. Government of Victoria (2023, December 14) ‘Massive boost to the next generation of paramedics’, Dan Andrews MP. [↑](#footnote-ref-3)
3. This equates to 22,320 patients in 2021–22. [↑](#footnote-ref-4)
4. Many examples have been found where planned NEPT services such as interhospital transfers are delivered privately, but delivery of triple zero (000) responses by private NEPT operators is rare. Where this occurs, it is usually a private ambulance service delivering both NEPT services and emergency ambulance responses. For example, this occurs in New Brunswick (a province in Canada) where both NEPT and ambulance services are delivered by a single private entity, Ambulance New Brunswick. This is distinct from Victoria’s model, where triple zero (000) NEPT responses are (mostly) not delivered by emergency ambulance services. [↑](#footnote-ref-5)
5. As discussed in: Ambulance Victoria (2017) *Delivering our patients the right care, at the right time, at the right place: revised Clinical Response Model evaluation report*. Doncaster: Ambulance Victoria Department of Research and Evaluation. [↑](#footnote-ref-6)
6. This has been revised down from the 85% figure (Source: Department of Health (2021) *Non-Emergency Patient Transport Amendment Regulations 2021: regulatory impact statemen*t, p. 78) used in the May 2023 NEPT Review discussion paper following consultations with private providers. [↑](#footnote-ref-7)
7. These findings are discussed in chapter 4, which compares system performance in jurisdictions with and without structural separation of planned NEPT services and emergency responses. [↑](#footnote-ref-8)
8. These functions were previously the responsibility of the the Emergency Services Telecommunication Authority, and from 15 December 2023 were conferred to Triple Zero Victoria. [↑](#footnote-ref-9)
9. Refer to chapter 4 for a discussion of the multi-year reform implementation journey in New South Wales. [↑](#footnote-ref-10)
10. On 14 April 2023 the Victorian Government released the terms of reference for a review of NEPT services in Victoria. Source: **Department of Health (2023) *Non-emergency patient transport review – terms of reference*.** [↑](#footnote-ref-11)
11. NEPT transfers occur either between hospitals, or between hospitals and the community. [↑](#footnote-ref-12)
12. This means a registered medical practitioner, a registered nurse or a registered paramedic. [↑](#footnote-ref-13)
13. Source: **Department of Health (2021) *Non Emergency Patient Transport Regulations 2016* (incorporating 2021 amendments).** [↑](#footnote-ref-14)
14. Triple zero (000) calls are received received by TZV, where TZV staff follow an script to allocate a case type to each call. Those identified as lower acuity and less urgent are directed to AV’s secondary triage service. AV nurses and paramedics working in secondary triage provide further assessment of the patient over the phone. These staff have the skills and can use the systems and suports to diagnose the needs of low-acuity patients over the phone and divert them to NEPT or other alternatives as required. This process determines whther an ambulance, NEPT response or another alternative is the most appropriate for the patient. Secondary triage is also equipped to provide self-help advice for callers seeking reassurance. If NEPT is deemed appropriate, AV authorises the use of NEPT and directs the patient’s call to ESTA who can dispatch a NEPT crew. [↑](#footnote-ref-15)
15. Such as outpatients, radiological, cancer treatment and other specialist appointments. [↑](#footnote-ref-16)
16. In contrast to unplanned NEPT, where assessment provided by AV secondary triage occurs over the phone. [↑](#footnote-ref-17)
17. AV employed another 69 frontline workers, noting paramedics also play a role in delivering NEPT services at AV. [↑](#footnote-ref-18)
18. Without NEPT services, patients who need help with transport to access health care, but not a lights-and-sirens response, could face long waits. Patients who need non-urgent clinical assistance during travel would have to be transported either by ambulance (at a higher cost) or a non-clinical transport service (which does not provide the required level of care). And some patients may have to make their own arrangements, with the potential for prohibitive costs for patients living in rural Victoria or requiring regular transports. [↑](#footnote-ref-19)
19. The diversion of non-time-critical triple zero (000) requests to NEPT supports AV to focus on emergency cases that require time critical medical attention. In public emergencies, NEPT services can also take on the lowest acuity ambulance callouts in situations where demand exceeds ambulance capacity, such as during the 21 November 2016 thunderstorm asthma event when triple zero (000) calls suddenly increased by 73% Source: Emergency Management Victoria (2017) *Emergency Management Victoria Operational Review 2016–17.* NEPT transfers from hospitals also play a vital role by freeing up beds and reducing discharge delays, improving system-wide efficiency, and increasing the operational capacity and timeliness of health services. [↑](#footnote-ref-20)
20. This includes both public and private staff. [↑](#footnote-ref-21)
21. Source: NEPT provider annual reporting 2022–23 collected by the Department of Health. [↑](#footnote-ref-22)
22. Source: **Ambulance Victoria (2023) *Ambulance Victoria annual report 2022–23*.** [↑](#footnote-ref-23)
23. Source: NEPT provider annual reporting 2022–23 and AV reported figure. [↑](#footnote-ref-24)
24. Source: Data provided by Ambulance Victoria. [↑](#footnote-ref-25)
25. It is an offence for a person or a body corporate to operate a NEPT service unless they hold a licence and s 13 provides the Secretary of the department the authority to grant a NEPT licence. Source: Parliament of Victoria (2003) *Non-Emergency Patient Transport and First Aid Services Act 2003*, s 5. [Victorian legislation]. The Act also provides inspection and enforcement powers to authorised officers to require providers of NEPT services to produce vehicles and documents for inspection, for the purpose of monitoring compliance with the NEPT Act and Regulations. [↑](#footnote-ref-26)
26. NEPT practitioners can administer 5 Schedule 4 medicines (amiodarone, ipratropium, methoxyflurane, ondansetron, salbutamol). Administration of Schedule 8 medications is not currently a clinical option for NEPT staff under the clinical scope of practice. [↑](#footnote-ref-27)
27. Source: Department of Health (2023) *Non-emergency patient transport clinical practice protocols*, 2023 edition. [↑](#footnote-ref-28)
28. Ibid. [↑](#footnote-ref-29)
29. Source: NEPT provider annual reporting 2022–23. [↑](#footnote-ref-30)
30. In addition, some private hospitals (such as Epworth Healthcare – one of the 10 licensed providers in Victoria) run in-house fleets. [↑](#footnote-ref-31)
31. For example, hospitals may maintain their own small fleet to manage transfers between their own campuses. [↑](#footnote-ref-32)
32. Source: **Department of Health (2021) *Non-Emergency Patient Transport Amendment Regulations 2021: regulatory impact statement*, p. 22.**  [↑](#footnote-ref-33)
33. TZV transitioned from ESTA in December 2023. The TZV process is underpinned by the *Transport framework*, which is a set of workflows used during the booking process to confirm the clinical state of the patient and identify the most appropriate transportation platform. [↑](#footnote-ref-34)
34. This automatically generates an assessment of patient acuity. [↑](#footnote-ref-35)
35. For example, community transport servicing low-acuity/non-clinical, non-urgent cases. Also, the department has a contract with Red Cross to provide medically necessary transports for vulnerable cohorts that do not qualify for NEPT but have no other transport options. [↑](#footnote-ref-36)
36. Source: Health Issues Centre (2023) *NEPT Review discussion paper submission*. [↑](#footnote-ref-37)
37. In public emergencies, NEPT services can also take on the lowest acuity ambulance callouts, if demand exceeds ambulance capacity to the point where it will be impossible for a paramedic crew to reach those cases in time. An example of this is the 21 November 2016 thunderstorm asthma event, when triple zero (000) calls suddenly increased by 73%. Source: Emergency Management Victoria (2017) *Emergency Management Victoria Operational Review 2016–17*. [↑](#footnote-ref-38)
38. As discussed in chapter 3. [↑](#footnote-ref-39)
39. In 2022–23, there were 1,698 staff across the private providers and 69 staff in AV’s in-house NEPT division. [↑](#footnote-ref-40)
40. 38 The Australian Commission on Safety and Quality in Health Care defines patient safety as prevention of error and adverse effects associated with health care; and quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Source: Australian Commission on Safety and Quality in Health Care (2019) *The state of patient safety and quality in Australian hospitals 2019*. Part 5A of the *Health Services Act 1988* also includes NEPT in relation to quality and safety. [↑](#footnote-ref-41)
41. 39 This combination is considered best practice in Australia. Source: **Australian Commission on Safety and Quality in Health Care (2019) *The state of patient safety and quality in Australian hospitals 2019*.** [↑](#footnote-ref-42)
42. NEPT services provided by the Metropolitan Ambulance Service were directly privatised. NEPT services provided by regional ambulance services were not (because they were primarily staffed by volunteers) but were displaced over time by private NEPT providers. [↑](#footnote-ref-43)
43. Specific changes in 2021 included: all medium- and high-acuity patient transports must be single loaded, all stretcher vehicles must be fitted with power lift stretchers only, life limits on NEPT vehicles cannot exceed 400,000 km and increased requirements for workforce skills maintenance. Source: **Department of Health (2021) *Non-Emergency Patient Transport Regulations 2016* (incorporating 2021 amendments).**  [↑](#footnote-ref-44)
44. The department’s regulatory powers are based on 3 instruments: the *Non-Emergency Patient Transport and First Aid Services Act 2003*; the *Non-Emergency Patient Transport Regulations 2016*; the *Non-emergency patient transport clinical practice protocols*, 2023 edition. [↑](#footnote-ref-45)
45. There is no provision for issuing infringements within the Act or the Regulations. [↑](#footnote-ref-46)
46. Safer Care Victoria is an administrative office of the Department of Health under s. 11 of the *Public Administration Act 2004*, responsible for helping health services to prevent and learn from patient harm, identify and deliver service improvements, and engage with consumers. NEPT is now included in the legislative reform agenda for the *Health Legislation Amendment (Quality and Safety) Act 2022* for statutory duty of candour responsibilities. Because NEPT is a private sector enterprise, other quality and safety guidelines that are mandated for public facilities are optional for NEPT. [↑](#footnote-ref-47)
47. Sentinel events are managed in line with Safer Care Victoria’s sentinel events process for the wider health system. This requires providers to report the event within 24 hours and conduct a detailed root cause analysis, open disclosure to patients and families, and review of internal policies and processes to learn from such incidents and further improve safety. Adverse events are assigned an incident severity rating (ISR) on a scale of 1 to 4 that guides the level of investigation required. Sentinel events (often referred to as ‘never events’) are ISR level 1 incidents that result in the death of, or serious physical or psychological injury to, a patient. [↑](#footnote-ref-48)
48. Additional inspections carried out as part of the licence renewal process include an assessment of back-of-house processes. For example, clinical governance arrangements have been found suitable, with formalised clinical oversight committees providing expert clinical advice and improvement processes. [↑](#footnote-ref-49)
49. Most regulatory action consists of education to support NEPT services in achieving compliance. The regulator observes there are high levels of responsive compliance across the sector. [↑](#footnote-ref-50)
50. NEPT providers are not required by the Regulations to report all adverse patient safety outcomes, only sentinel events. [↑](#footnote-ref-51)
51. Source:Safer Care Victoria (2023) *What are adverse and sentinel events?* [↑](#footnote-ref-52)
52. There is no definitive data, but these events can be caused by external factors, hospital bookings, AV coding, etc. Either way, this is considered by the Regulator to show that NEPT providers have escalation processes and actively use these as required: 2,486 events on average over 2021–22 and 2022–23, divided by average transports completed by the private market. Source: NEPT provider annual reporting 2021–22 and 2022–23. [↑](#footnote-ref-53)
53. While the outcomes of these events are not captured in standard reporting, the Regulator advises that there are likely to be 4 possible scenarios arising from them: (1) the patient may not have been transported at all and remained at the facility while an alternative approach for them was developed; (2) the booking would have been cancelled and the transport either rebooked to a different level of NEPT acuity; or (3) referred to AV or Adult Retrieval Victoria; and (4) the patient may have still been treated by a NEPT crew, after consultation with an on-staff or AV clinician. [↑](#footnote-ref-54)
54. In line with their scope of practice. [↑](#footnote-ref-55)
55. These checks must occur at 200,000 km, 400,000 km and, if an exemption for continued use has been granted, annually until 600,000 km is reached. [↑](#footnote-ref-56)
56. A lifting cushion is a device attached to the seat that safely lifts patients with frailty or mobility issues (such as elderly people) when the air pressure pump is activated. This is expected to help NEPT staff when manual handling patients and improve patient experience by improving comfort and reducing safety issues on entry and exit. [↑](#footnote-ref-57)
57. There are 1,183 PTO staff among a total of 1,767 NEPT workers. [↑](#footnote-ref-58)
58. For example, 50% of medium- or high-acuity cases must be reviewed. Source: **Department of Health (2021) *Non-Emergency Patient Transport Regulations 2016* (incorporating 2021 amendments), s 38 (5).**  [↑](#footnote-ref-59)
59. Currently there are no lifting equipment requirements. [↑](#footnote-ref-60)
60. Changed from the less prescriptive ‘sufficient room’ requirement. [↑](#footnote-ref-61)
61. Under the Regulations, a patient’s clinical condition should be observed and recorded before transporting them. [↑](#footnote-ref-62)
62. The National Safety and Quality Service Standards (2021) sets national standards on what consumers can expect from the health system, which health services are obliged to meet. This includes partnering with consumers such as through enabling consumer participation in system design and governance, and shared decision making and effective communication in the delivery of care. Source: **Australian Commission on Safety and Quality in Health Care (2021).** *National Safety and Quality Health Service Standards* (2nd ed.). [↑](#footnote-ref-63)
63. The *Victorian Health Services Act 1988* has provisions for capturing the patient experience. Each health service board must include at least one director who is ‘able to reflect the perspectives of users of health services’. [↑](#footnote-ref-64)
64. The *Targeting Zero* (2016) review of hospital safety and quality assurance in Victoria found that Victoria should adopt a stronger focus on improving patients’ experience of care. Refer to the [*Targeting Zero* review report](https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria) <https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria>. [↑](#footnote-ref-65)
65. The [*Partnering in healthcare framework*](https://www.safercare.vic.gov.au/publications/partnering-in-healthcare) <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare> outlines the department’s approach to partnership and consumer participation that aims to bring consistency across Victoria, involve consumers in care and describe consumer priorities. [↑](#footnote-ref-66)
66. Patient experience is surveyed across the Victorian health services sector using the Victorian Healthcare Experience Survey. [↑](#footnote-ref-67)
67. AV participates in the [Victorian Healthcare Experience Survey](https://vahi.vic.gov.au/news/vhes-program-grows-new-and-improved-mental-health-and-ambulance-surveys) <https://vahi.vic.gov.au/news/vhes-program-grows-new-and-improved-mental-health-and-ambulance-surveys> and also uses the cross-jurisdictional [Council of Ambulance Authorities survey](https://www.caa.net.au/patient-experience-survey) <https://www.caa.net.au/patient-experience-survey>. Survey respondents include patients transported by ambulance services for emergency and urgent categories. The patients, or their carers, are asked to rank their satisfaction with ambulance services and treatment, including overall satisfaction, call answering time and paramedic treatment. [↑](#footnote-ref-68)
68. Most Australian jurisdictions use the Council of Ambulance Authorities survey, which is limited to emergency and urgent categories, and so does not capture non-emergency transports. Data collection on patient experience does occur for ambulance services through the *Report on Government Services*; however, NEPT is not specified in chapter 11. [↑](#footnote-ref-69)
69. Source: Victorian Government Department of Health (2023) Victorian Healthcare Experience Survey. The ‘planned ambulance’ component of the VHES has a low response rate of 14% or a sample of 824 patients over 12 months. While these are weighted to account for the general patient population (and so are demographically representative), they are unlikely to be representative of all patient views given the low overall response rate. The VHES also does not cover all NEPT services, only planned NEPT that is delivered in house or subcontracted by AV and CTS. It does not include unplanned NEPT or planned NEPT under HSV contract. [↑](#footnote-ref-70)
70. The time from arrival at an emergency department to the time the patient is transferred to the hospital and handover is complete. [↑](#footnote-ref-71)
71. The department’s analysis of the 2022–23 Victorian Emergency Minimum Dataset. [↑](#footnote-ref-72)
72. As described in chapter 1, AV uses unplanned NEPT to protect its emergency resources. The diversion of non–time critical triple zero (000) requests to NEPT allows AV to focus on emergency cases that require time-critical medical attention. [↑](#footnote-ref-73)
73. As described in chapter 1, health services use planned NEPT to enable patient flow across the health system. NEPT ensures patients can arrive to medical appointments and other care in a timely and resource-efficient way. Importantly, NEPT plays a critical role by freeing up hospital beds and reducing discharge delays, improving system-wide efficiency, and increasing the operational capacity and timeliness of health services. [↑](#footnote-ref-74)
74. While other jurisdictions in Australia outsource planned NEPT services, none outsource unplanned NEPT services. Low-acuity triple zero (000) responses are delivered by public ambulance services and by their paramedics (and internal NEPT crews in cases). Likewise, while planned NEPT services were often outsourced in other jurisdictions, outsourcing of unplanned NEPT tended to occur as part of full outsourcing of emergency responses (that is, where a single private entity delivered both ambulance and unplanned NEPT services). [↑](#footnote-ref-75)
75. While the separate planned NEPT service can pick up ambulance work that fits within a NEPT scope, volumes are very low (3 to 5 cases per day) and any referrals that do occur are relatively manual, further deterring the diversion of ambulance cases to NEPT. Triple zero (000) calls are triaged by New South Wales Ambulance (NSWA). If NSWA determines a patient does not meet clinical thresholds for an emergency resource but still requires transport and monitoring/supervision, NSWA will redirect the call to the Virtual Clinical Care Centre for secondary triage by a registered paramedic or nurse. NSWA must communicate with HealthShare NSW (which runs planned NEPT services) via telephone, and the booking is manually entered into the planned NEPT computer-aided dispatch system. All calls received from NSWA are clinically assessed by a NEPT clinician to ensure the scope and capacity is available. [↑](#footnote-ref-76)
76. Planned interhospital transfers are labelled priority 4 in the system and booked through a dedicated phone line run by St John Ambulance. [↑](#footnote-ref-77)
77. This is the case even for triple zero (000) calls where there is no threat to life. These are classified as non-urgent (priority 3), are reviewed by a doctor and paramedic before dispatch when capacity permits and must be attended within 60 minutes. These calls may require a high level of care, but there is no threat to life and therefore lower urgency. As such, priority 3 might include cases that would be unplanned NEPT in Victoria. Source: Standing Committee on Public Administration (2022) *Delivery of ambulance services in Western Australia: critical condition*, report 37. [↑](#footnote-ref-78)
78. Source: Productivity Commission (2023) Ambulance services. In: *Report on Government Services 2023* (Part E). [↑](#footnote-ref-79)
79. Department of Health (2017) *Review of Ambulance Tasmania Clinical and Operational Service: final report*, Tasmanian Government. [↑](#footnote-ref-80)
80. The review states: ‘For example, a clinically stable elderly patient may simply need transport to hospital or an alternative medical facility for a test to rule out the possibility of a serious condition. In this example, the patient is stable and the need for support is real but not urgent. In these circumstances, paramedics suggested that they should have the ability to transfer the transport task to a non-emergency patient transport service (either public or private) allowing the paramedic to be available for a more urgent case’, pp. 32–33. [↑](#footnote-ref-81)
81. These patients will most likely also have a long wait in the emergency department. Refer to the quote in the previous footnote. [↑](#footnote-ref-82)
82. *Ambulance Service (Non-emergency Patient Transport) Regulations 2019* (Tas). [↑](#footnote-ref-83)
83. Rockliff J (2022) ‘New emergency telehealth provider to support Ambulance Tasmania’. [↑](#footnote-ref-84)
84. Note that it is not possible to differentiate the specific impact of increased diversion to private NEPT resources from other diversion strategies implemented through the CRM review, which reduced pressure on hospital emergency departments by lowering attendances by an estimated 11,600 people per annum. [↑](#footnote-ref-85)
85. Data analysis compared the first 3 months of the fully implemented CRM (October 2016 to January 2017) with the same period in the previous year. Source: Ambulance Victoria (2017) *Delivering our patients the right care, at the right time, at the right place: revised Clinical Response Model evaluation report*. [↑](#footnote-ref-86)
86. The volume avoiding an ambulance dispatch increased from 9.6% historically to 16.5% after implementation. [↑](#footnote-ref-87)
87. For example, 92.1% of patients in cardiac arrest were attended by MICAs post-implementation, compared with 87.7% historically. [↑](#footnote-ref-88)
88. Defined as code 1, code 2 and code 3 events. Annually, almost 7,000 extra code 1 cases will now receive a response within 15 minutes compared with before the changes to the Clinical Response Model. [↑](#footnote-ref-89)
89. Source: Productivity Commission (2023) Ambulance services. In: *Report on Government Services 2023* (Part E). [↑](#footnote-ref-90)
90. For example, 18.9% of unplanned events are assigned a 60-minute response time requirement, compared with 0.08% for planned events. Source: Data provided by TZV. [↑](#footnote-ref-91)
91. Appointments are also prioritised over hospital discharges. Source: Advice received from Ambulance Victoria. For NEPT flowing through TZV, priority is assessed in 2 separate places: AV secondary triage (unplanned) and TZV call-takers (planned). TZV have separate dispatchers for planned and unplanned NEPT with dedicated resources, but unplanned work is still prioritised and dispatchers can allocate between channels. [↑](#footnote-ref-92)
92. Source: Australian College of Paramedicine (2022) *Inquiry into impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales. Submission No. 28.* [↑](#footnote-ref-93)
93. This model was delivered by the former Metropolitan Ambulance Services, which provided both emergency and non-emergency patient transport. [↑](#footnote-ref-94)
94. Where shift penalties based on rosters are expressed as a monetary value and an average payment is made to each eligible employee. [↑](#footnote-ref-95)
95. AV receives a block grant for unplanned NEPT, as well as the bulk of funding for planned NEPT (69.9% of total public NEPT services), while health services receive funding for a subset of planned NEPT services (30.1% of total public NEPT services), via activity-based funding arrangements. Source: NEPT provider annual reporting 2022–23. AV delivered and contracted transports/total NEPT public transports = 242,259 of a total 351,884. [↑](#footnote-ref-96)
96. AV procures NEPT services through a tender approach. Private providers nominate regions they are willing to supply and specify the price they would require to do so. From these bids, AV allocates regions to providers. [↑](#footnote-ref-97)
97. Refer to section 1.3.3: Multiple purchasing arrangements and multiple providers [↑](#footnote-ref-98)
98. AV is not required to use the HSV NEPT panel as public health services are. [↑](#footnote-ref-99)
99. In metropolitan Melbourne there is no coordination of providers but little imperative (or incentive – as private providers have reportedly told health services they would not offer volume discounts for coordination of contracts among neighbouring services) to coordinate providers given the greater service volume in those areas. [↑](#footnote-ref-100)
100. Providers have the right to be the preferred (but not exclusive) operator for unplanned NEPT in each of the 17 zones, but with limited coordination of neighbouring zones. [↑](#footnote-ref-101)
101. Data sourced from HSV NEPT service providers list, November 2023. [↑](#footnote-ref-102)
102. On a technical level, AV and HSV define regions differently, which further limits coordination. AV uses the Health Service Partnerships definition and HSV uses the Department of Families, Fairness and Housing divisions. [↑](#footnote-ref-103)
103. Source: AV internal analysis. [↑](#footnote-ref-104)
104. It should be noted that Health Select’s coverage under the HSV arrangements would support efficiencies for providing surge capacity under the AV contract. [↑](#footnote-ref-105)
105. As discussed below, this is based on low spill rates of 1.4% for planned NEPT, noting some level of spills will be inevitable due to unexpected but appropriate clinical escalation. [↑](#footnote-ref-106)
106. Multiple health services have raised a preference for services commissioned directly under the HSV contract, enabling a more responsive and accountable service, as opposed to NEPT booked by AV, which engenders a disconnect between health services and NEPT. [↑](#footnote-ref-107)
107. Thin markets are characterised by low levels of demand and/or supply and occur when there too few providers and/or too few buyers within a public or private market for it to function efficiently. Thin markets increase the risk of price volatility and/or local monopolies and can create inefficiencies or market failure (that is, complete market collapse where no providers remain or there are significant gaps in coverage). Refer to Girth AM, Hefetz A, Johnson JM and Warner ME (2012) ‘Outsourcing public service, delivery: management responses in noncompetitive markets, *Public Administration Review*, vol. 72, no. 6, pp. 887–900. Thin markets and market failures are also more likely to occur in rural areas or when catering for people with highly specialised needs (that is, low demand). Refer to: Carey G, Malbon E, Reeders D, Kavanagh A and Llewellyn G 2017, ‘Redressing or entrenching social and health inequities through policy implementation? Examining personalised budgets through the Australian National Disability Insurance Scheme’, *International Journal for Equity in Health*, vol. 16, no. 192. [↑](#footnote-ref-108)
108. Of the total NEPT services (planned and unplanned) that spilled to emergency crews in 2022, 65% occurred in rural areas. Of these rural spills, 54% were unplanned transports and were directed to NEPT following triage but then redirected to emergency crews when no NEPT options were available. [↑](#footnote-ref-109)
109. Advice from Mildura Base Public Hospital to the NEPT Review. [↑](#footnote-ref-110)
110. This situation is compounded by the fragmented approach to contracting in rural areas, where AV and health services do not typically coordinate procurement to ensure a single NEPT supplier operating in each town (Figure 2). For example, in Mildura in 2023, there were effectively 3 different NEPT workforce rosters: AV’s own NEPT staff, RFDS (contracted to the hospital) and NPT (contracted by AV to service Mildura and Swan Hill, but not the broader geographical corridor). [↑](#footnote-ref-111)
111. Excludes CTS volumes. Of the 16,864 spills, 4,025 were of an ‘unclassified’ type. These unclassified transports have been allocated to planned or unplanned on a pro rata basis. [↑](#footnote-ref-112)
112. Denominator is based on NEPT volume (planned and unplanned) delivered or procured by AV only (that is, HSV services are excluded). This acts to increase the reported rate of spills in the table. [↑](#footnote-ref-113)
113. Global supply chain shortages have created extended waits for new NEPT vehicles, with AV also facing significant waits and generally ahead of private providers in the queue for these. [↑](#footnote-ref-114)
114. The HSV contract had an initial term of 3 years, followed by a series of extensions, the most recent being for 5 years. The AV contracts had an initial term of 3 years with the option for 2 12-month extensions. This compares to contract lengths of 4 years with a procurement process undertaken at the end of each period in New South Wales, and 5 years with potential extensions up to 10 years in Western Australia. [↑](#footnote-ref-115)
115. This non-operation arose from the abolishment of accreditation for ‘stand-by’ services for NEPT through the 2021 reforms. [↑](#footnote-ref-116)
116. Source: NEPT provider annual reporting 2021–22. [↑](#footnote-ref-117)
117. State Medical Assistance – which was added to the HSV panel in 2023 and only serviced private hospitals prior. [↑](#footnote-ref-118)
118. These issues are discussed in section 3.4. [↑](#footnote-ref-119)
119. Twenty-eight days’ notice were provided. [↑](#footnote-ref-120)
120. TZV’s booking process is largely manual, The online booking portal ‘Webform’ is not integrated with TZV’s computer-aided dispatch system, so data must be manually transposed, leading to inconsistencies in information handling and human error. The online portal is also reported to be subject to frequent service disruptions, and booking form requests can be left in the cloud, remaining unactioned for extended periods. [↑](#footnote-ref-121)
121. Dispatching approaches are also largely manual, with decisions based on individual call-takers’ geographical knowledge and judgement about the relative priority of different calls. By contrast, some jurisdictions have introduced mathematical algorithms to optimise route planning. These algorithms are fundamental to performance in other logistics industries and outperform human judgement. For example, a published NEPT-specific experiment based on a real scenario provided by an ambulance service found algorithmic scheduling reduced patient waiting time during transport by up to 13.33% and increased NEPT vehicle utilisation by up to 29.35%. Refer to: Fogue M, et al. (2016) Non-emergency patient transport services planning through genetic algorithms, *Expert Systems with Applications*, vol. 61, pp. 262–271. [↑](#footnote-ref-122)
122. For example, Australia Post and other delivery services, and most taxi and rideshare services. [↑](#footnote-ref-123)
123. This number excludes spills to emergency services in order to capture existing operational capacity for AV’s in-house NEPT service. [↑](#footnote-ref-124)
124. Participants at the AV NEPT workforce roundtable noted a lack of clarity in the level of commitment of AV to its own NEPT resources, even though AV’s NEPT resources play an important role in freeing up emergency capacity. [↑](#footnote-ref-125)
125. Participants at the AV NEPT workforce roundtable noted that it would be helpful if non-emergency crews had access to the Victorian Virtual Emergency Department. [↑](#footnote-ref-126)
126. For example, a taxi to an emergency department or priority primary care centre. [↑](#footnote-ref-127)
127. There are patients who do not qualify for NEPT but who need a stretcher to access care and lack viable alternative transport options for this. This is distinct from people who neither qualify for NEPT nor need a stretcher. There are also patients who do not qualify for NEPT and who do not need a stretcher but who need assistance to move from their home into a vehicle and from the vehicle into the hospital. This review explored the range of alternative services that may better support these patients. [↑](#footnote-ref-128)
128. Source: Advice from AV (from online booking system). Note: AV does not have visibility over all services (approximately 73% only). [↑](#footnote-ref-129)
129. For planned NEPT, acuity is determined by the clinician requesting the NEPT service for their patient. For unplanned NEPT, acuity is determined by the AV secondary triage clinician. [↑](#footnote-ref-130)
130. Discussion at the AV NEPT workforce roundtable noted: ‘Many instances where stretcher vehicles are being tied up when a stretcher is not required. Clinic transport / sedan vehicles have a role to play here. The impact is particularly challenging in rural where a stretcher vehicle could be taken offline for a number of hours.’ [↑](#footnote-ref-131)
131. [↑](#footnote-ref-132)
132. The department’s analysis of the 2022–23 Victorian Emergency Minimum Dataset. [↑](#footnote-ref-133)
133. TZV submission, p. 6. TZV advises that AV’s *Transport framework* has been amended to further validate acuity, aligning to the Regulations and enabling TZV to refuse bookings if criteria are not met. However, TZV advises that its capability to do this is yet to be realised. [↑](#footnote-ref-134)
134. The number of total trips delivered for 2022–23 was 7,092. [↑](#footnote-ref-135)
135. Factors preventing uptake could include low demand, low awareness of the service, lack of an accessible booking platform, lack of resource/workforce supply to meet demand (with declining volunteerism partly due to the COVID-19 pandemic) or providing a service that is not targeted for the patient group. [↑](#footnote-ref-136)
136. While CTS staff are qualified to same level as NEPT low-acuity crews, CTS does not involve clinical monitoring and all patients must be ambulant. [↑](#footnote-ref-137)
137. Source: HSV NEPT fee schedule effective 1 May 2023. These prices are an average of transport prices where the distance is less than 50 km. Further fees apply for distances greater than 50 km, and additional loadings apply for bariatric and complex patients and for after-hours and weekend transports. The ranges represent costs for low- and medium-acuity transports. [↑](#footnote-ref-138)
138. Based on 18,998 trips costing a total $3,272,865. [↑](#footnote-ref-139)
139. Of those patients arriving at emergency departments by NEPT, 22% return home without being admitted. Source: 2022–23 Victorian Emergency Minimum Dataset. [↑](#footnote-ref-140)
140. AV analysis in the Virtual Emergency Department (VED Operational Report November 2023. Data from December 2022 to November 2023. [↑](#footnote-ref-141)
141. For example, there were 22,320 NEPT transports of COVID-positive patients in 2021–22. [↑](#footnote-ref-142)
142. As previously noted, this has been revised down from the 85% figure used in the review’s May 2023 discussion paper following consultations with private providers. [↑](#footnote-ref-143)
143. Source: Fair Work Ombudsman (2023) ‘Casual employees’. [↑](#footnote-ref-144)
144. They must be employed by the employer for a period of 12 months and have a regular pattern of hours on an ongoing basis for greater than 6 months. Source: *Fair Work Act 2009*, s 66B. [↑](#footnote-ref-145)
145. Under the HSV contract service-level agreements, a health service may terminate with 30 days written notice. For AV contracts, AV may terminate with 60 business days’ notice. [↑](#footnote-ref-146)
146. A participant at the NEPT workforce roundtable noted that ‘rostering for fulltimers is not great so a lot of people want to be casual so they can pick their days. If rostering was better, casuals would prefer to be permanent’. [↑](#footnote-ref-147)
147. New South Wales Patient Transport Service delivers approximately 80% of road services in the metropolitan region. Ninety per cent of the state-based workforce are full-time, with casual staff maintained by public providers to support flexibility. Source: HealthShare NSW stakeholder interview. [↑](#footnote-ref-148)
148. In Queensland, which operates a primarily insourced NEPT model, the workforce is mostly permanent, with extra casual staff employed to support the sector. Source: Queensland Ambulance Service Assistant Commissioner stakeholder interview. [↑](#footnote-ref-149)
149. The majority of the external provider workforce are casual employees delivering the remaining services, including surge requirements. Source: HealthShare NSW stakeholder interview. [↑](#footnote-ref-150)
150. Casual employees are, however, entitled to long service leave under the *Long Service Leave Act 2018*. Refer to the [Victorian Government website](https://www.vic.gov.au/long-service-leave) <https://www.vic.gov.au/long-service-leave>. [↑](#footnote-ref-151)
151. Health Select, RFDS, NPT and St John Ambulance. [↑](#footnote-ref-152)
152. There are also discrepancies in the number of pay levels across agreements, leading to a disparity in maximum rates, particularly for ATAs. [↑](#footnote-ref-153)
153. As such, individual shift penalties and weekend rates are not paid to AV operational employees, rather they receive the standard rolled-in rate of pay regardless of when their roster. [↑](#footnote-ref-154)
154. This is 14.5% compared with, for example, 11% for the private provider NPT. [↑](#footnote-ref-155)
155. These apply to the higher rolled-in rate. However, AV employees on the rolled-in rate receive standard overtime rates on weekends, compared with double time in other enterprise agreements. [↑](#footnote-ref-156)
156. These risks are not unique to the patient transport and ambulance services sector (for example, paramedics face similar conditions) but between the NEPT sector and other fields where manual labour and patient care are not primary considerations. [↑](#footnote-ref-157)
157. Participants at the private provider NEPT workforce roundtable noted working condition and safety issues such as instances of being sent to COVID jobs while pregnant, delays in getting equipment repaired, resourcing issues leading to a lack of sufficient meal breaks and fatigue management and insufficient training over many years. However, other participants who have worked across private and AV NEPT noted that, ‘The grass is not greener on the AV side’, as training is also not sufficient. [↑](#footnote-ref-158)
158. This variation in pay and conditions was illustrated in Victorian Ambulance Union’s response to The Royal Commission into Victoria’s Mental Health System. Source: Victorian Ambulance Union (2019) *Preliminary submission to the Royal Commission into Victoria’s Mental Health System*. [↑](#footnote-ref-159)
159. Source: Department of Health (2021) *Non-Emergency Patient Transport Amendment Regulations 2021: regulatory impact statemen*t, p. 78. [↑](#footnote-ref-160)
160. These include lifting requirements and separation between stretchers, while changes to vehicle maintenance and life limits will 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. [↑](#footnote-ref-161)
161. It should be noted the Victorian Government has recently made the Diploma of Emergency Health Care free of charge. Refer to: Victorian Government (2023) ‘Free TAFE for more Victorians’. The department also runs a biannual engagement forum and is developing its 10-year workforce strategy. [↑](#footnote-ref-162)
162. Non-emergency patient transport clinical practice protocols. [↑](#footnote-ref-163)
163. The Regulations require NEPT providers to ensure that whenever a low-, medium- or high-acuity patient is transported, there are 2 crew members crewing the vehicle and that a suitably qualified and competent crew member travels in the patient compartment. Regardless of acuity, the minimum requirement to be a crew member operating a NEPT vehicle is a PTO. Refer to section 1.3.2, Table 1. [↑](#footnote-ref-164)
164. This is partly due to the Medicines and Poisons Regulation 2021 restricting the use of paramedics outside of AV. [↑](#footnote-ref-165)
165. For example, paramedics transitioning to retirement may work for CTS within AV, despite the limited use of their skills in this role, rather than for the NEPT sector where their skills can be more fully used. The lack of defined NEPT career structure is further limited by the differential in entitlements between AV and other providers, leading to inefficient redeployment of staff within AV. [↑](#footnote-ref-166)
166. A decline in volunteers, from about 1 in 3 Australians in 2010 to just over 1 in 4 in 2022,is likely to have limited the alternative transport options delivered by other organisations. Although this has been affected by the COVID-19 pandemic, predictions suggest volunteering is unlikely to return to pre-COVID levels. Source: Volunteering Australia (2023) *National* s*trategy for* v*olunteering 2023*–*2033.*  [↑](#footnote-ref-167)
167. Calculated from estimated kilometres travelled per year using annual NEPT fleet data submitted to the department’s Regulation, Risk, Integrity and Legal Division. [↑](#footnote-ref-168)
168. The AV vehicle fleet emitted about 13,540 tonnes of CO2-e in 2022–23. Source: Victorian Health Building Authority [↑](#footnote-ref-169)
169. Refer to the [Ambulance Vicroria website](https://www.ambulance.vic.gov.au/about-us/sustainability/environment/%3e.) <https://www.ambulance.vic.gov.au/about-us/sustainability/environment/>. [↑](#footnote-ref-170)
170. NPT has stated an aim to reach [zero emissions by 2050](https://www.nptgroup.com.au/our-purpose/sustainability/#:~:text=NPT%20will%20be%20continually%20working,for%20zero%20emissions%20by%202050) <https://www.nptgroup.com.au/our-purpose/sustainability/#:~:text=NPT%20will%20be%20continually%20working,for%20zero%20emissions%20by%202050>. The Royal Flying Doctor Service aims to reach [zero emissions by 2040](https://www.flyingdoctor.org.au/vic/about/environmental-sustainability/) <https://www.flyingdoctor.org.au/vic/about/environmental-sustainability/>. [↑](#footnote-ref-171)
171. Source: Office of Public Management and Chartered Institute of Public Finance and Accountancy (2004) *The good governance standard for public service*s. [↑](#footnote-ref-172)
172. As delivered by the Regulation, Risk, Integrity and Legal Division, and Safer Care Victoria. [↑](#footnote-ref-173)
173. Some of these have public contracts, with others delivering private work that is publicly regulated. [↑](#footnote-ref-174)
174. For example, private NEPT workers were not included in pandemic retention and winter surge payment schemes, despite taking on a significantly increased workload through the pandemic and provided a large proportion of COVID-positive patient transports. Source: AEAV (2021) ‘No surge payment for NEPT’. [↑](#footnote-ref-175)
175. These issues would be resolved through other proposed reforms, with separation of planned and unplanned NEPT, and centralised booking and dispatch of planned NEPT. [↑](#footnote-ref-176)
176. [↑](#footnote-ref-177)
177. They are primarily for concession patients. [↑](#footnote-ref-178)
178. Department of Health targets include seeing passenger fleet vehicle emissions reduce year on year until they are fully electrified in 2032. [↑](#footnote-ref-179)
179. Fleet electrification will require investment in enabling infrastructure such as charging facilities at health services. [↑](#footnote-ref-180)
180. For example, AV’s data is limited to NEPT it is funded for, while the department collects high-level self-reported data for all privately provided services that excludes AV in-house work and has high levels of inconsistency in provider interpretation of fields (this data is sufficient for regulatory oversight but does not support a broader understanding of the system for performance oversight purposes). Providers generate large volumes of data for health services and HSV, but there is no central visibility or use of this. [↑](#footnote-ref-181)
181. AV delivers 37,925 transports a year using in-house NEPT resources and, by exception, ambulance crews. These comprise 24,610 planned and 13,315 unplanned transports. [↑](#footnote-ref-182)
182. AV purchases NEPT capacity from private providers to deliver both planned and unplanned services (77.3% and 22.7% respectively of AV-purchased services). [↑](#footnote-ref-183)
183. AV also directly provides screening of unplanned NEPT services (performed by AV secondary triage). [↑](#footnote-ref-184)
184. AV is responsible for commissioning planned NEPT services for concession patients. [↑](#footnote-ref-185)
185. Each event is reviewed and assessed by TZV to determine which should be prioritised. While there are not strict policies around prioritisation, generally speaking the event ordering is as follows: (1) unplanned transports; (2) planned transports to health services (for appointments); and (3) planned transports from health services (discharges). TZV does not collect precise data on the frequency of disruptions of planned by unplanned NEPT. [↑](#footnote-ref-186)
186. Namely, the discharge (or interhospital transfer) of the patient awaiting NEPT; the patient moving from an assessment unit to the discharged patient’s bed; the patient moving from the emergency department to the assessment unit; the person moving from a ramped ambulance to an assessment unit; and the person waiting for an ambulance in the community. [↑](#footnote-ref-187)
187. TZV can track ambulance ramping across health services, but it does not have visibility of internal pressures or specific discharges that need to be prioritised. [↑](#footnote-ref-188)
188. Advice from TZV. [↑](#footnote-ref-189)
189. For example, AV is the entity with the single largest pool of NEPT funding in the health system, but it does not work with health services and HSV to coordinate procurement of NEPT services to manage thin market risks in regional areas (refer to chapter 5). This is despite these issues being a key driver of spills of NEPT work to emergency resources (chapter 3). AV is aware of the opportunities to improve efficiency and performance in the NEPT sector through a commissioning approach that will form part of AV’s procurement and contracting uplift (noting that commissioning has never been a feature of AV’s business practices prior to the appointment of a new procurement manager in 2023). [↑](#footnote-ref-190)
190. NEPT expenditure was $97.6 million in 2021–22 of a total $1.3 billion. [↑](#footnote-ref-191)
191. Source: EM/ANB (2019) *EM/AMB strategic plan 2019–2022: transforming the community together*. [↑](#footnote-ref-192)
192. Source: Medavie Health Services (2023) ‘Statistics’. For clarity, data on scheduled and unscheduled transfers have been combined into ‘planned NEPT’. Performance standards in New Brunswick depend on the service type and range for urban and rural areas: the emergency response standard is under 9 minutes (urban) and 22 minutes (rural) 90% of the time; the unplanned transfer response standard is under 15 minutes (urban) and 20 minutes (rural) 90% of the time; and the planned transfer response standards is either under 60 minutes (for pre-booked events, urban and rural) or under 120 minutes (for unscheduled events, urban and rural) 90% of the time. [↑](#footnote-ref-193)
193. Unplanned cases are expected to be assigned a medium-acuity NEPT resource to manage potential risks given these patients have not been assessed in person. Medium-acuity enables a flexible response depending on the situation on the ground, where ATAs can respond to a wider range of event types. [↑](#footnote-ref-194)
194. These mostly need to be low-acuity resources, with most work done during the day, in contrast to unplanned NEPT which is an all-hours service. [↑](#footnote-ref-195)
195. Even though most NEPT services are delivered *for* health services. [↑](#footnote-ref-196)
196. For example, QAS is responsible for both NEPT and ambulance services, and approximately 20% of its NEPT transports are delivered by emergency crews. Similarly in regional Western Australia, St John Ambulance is responsible for both NEPT and ambulance services and reportedly also sees high rates of spills. [Source: Jurisdictional consultations as part of Deloitte Australia’s modelling analysis.] NEPT delivery by ambulances is a high-cost model that can affect timeliness of responses for patients needing urgent care. [↑](#footnote-ref-197)
197. Source: Parliament of New South Wales (2009) *The management and operations of the NSW ambulance service*. [↑](#footnote-ref-198)
198. Despite increases in NEPT resource base (p. 9). This includes 100% of rural NEPT services delivered by ambulances (p. 1). Source: NSW Department of Health (2008) Submission to the Legislative Council, General Purpose Standing Committee No.2 The Management and Operations of the Ambulance Service of NSW, p. 1. [↑](#footnote-ref-199)
199. Source: [Report 27 – October 2008, p. 130](https://www.parliament.nsw.gov.au/committees/Pages/inquiryprofile/the-management-and-operations-of-the-nsw-ambulance-service.aspx#tab-reportsandgovernmentresponses) <https://www.parliament.nsw.gov.au/committees/Pages/inquiryprofile/the-management-and-operations-of-the-nsw-ambulance-service.aspx#tab-reportsandgovernmentresponses>. Reportedly a key source of frustration to the paramedic workforce. [↑](#footnote-ref-200)
200. With different resources, ambulance fit outs and staff capabilities for each operational stream, refer to Head Review. [↑](#footnote-ref-201)
201. Source: **New South Wales. Legislative Council. General Purpose Standing Committee No. 2 (2008) *The Management and Operations of the Ambulance Service of NSW*, p. 40.**  [↑](#footnote-ref-202)
202. The *Garling Report on Acute Care Services in NSW Public Hospitals* (which found that NEPT compromised the delivery of emergency services and recommended the development of a separate NEPT strategy); EY, which in 2008–09 recommended establishing a small number of booking hubs to coordinate a number of providers, and the O’Reilly Review of Ambulance Services, which recommended a single dedicated service to manage NEPT, p. 3. [↑](#footnote-ref-203)
203. **NSW Government, Health (2012) *Reform plan for NSW Ambulance*, p. 14.** [↑](#footnote-ref-204)
204. **Ibid.** [↑](#footnote-ref-205)
205. Alongside social services and other activities. Source: **NSW Government, Health (2012) *Reform plan for NSW Ambulance*, p. 14.** [↑](#footnote-ref-206)
206. In 2011–12, there were approximately 420,000 NEPTs undertaken by Local Health District Health Transport Units and NSW Ambulance, with approximately 104,000 of these conducted using emergency ambulances. 2012 NSW ambulance reform plan. Source: **NSW Government, Health (2012) *Reform plan for NSW Ambulance*,** p. 15. [↑](#footnote-ref-207)
207. Particularly without the benefit of a coordinated statewide approach to booking and dispatch (refer to section 4.2). **Source: NSW Government, Health (2012) *Reform plan for NSW Ambulance*, p. 14.**  [↑](#footnote-ref-208)
208. HealthShare NSW is a statewide governmet organisation that provides shared services to support the delivery of patient care within the NSW health system. In additon to patient transport services, HealthShare NSW delivers statewide services in the following areas: human resource services, financial services, food and patient support services, linen services, procurement services, a service for cleaning and restocking ambulances and a service known as EnableNSW, which assists people with a disability to live and participate in the community. Refer to the [HealthShare NSW website](https://www.healthshare.nsw.gov.au/about) <https://www.healthshare.nsw.gov.au/about>. [↑](#footnote-ref-209)
209. Refer to [Non-Emergency Patient Transport Combined DO / GM Meeting](https://www.health.nsw.gov.au/Performance/Pages/do-gm-march-2015.aspx) <https://www.health.nsw.gov.au/Performance/Pages/do-gm-march-2015.aspx>. [↑](#footnote-ref-210)
210. Forms are QR code or paper form. [↑](#footnote-ref-211)
211. Refer to [Non-Emergency Patient Transport Combined DO / GM Meeting](https://www.health.nsw.gov.au/Performance/Pages/do-gm-march-2015.aspx) <https://www.health.nsw.gov.au/Performance/Pages/do-gm-march-2015.aspx> and to Boness T and Mayes H (2018) Improving patient transport in New South Wales, *Impact*, 2018:1, 42–45. [↑](#footnote-ref-212)
212. Advice received from HealthShare NSW. This compares to an average of 200 ambulance referrals to NEPT services per day in Victoria. [↑](#footnote-ref-213)
213. Advice received from HealthShare NSW. [↑](#footnote-ref-214)
214. Ibid. [↑](#footnote-ref-215)
215. Fifty-six per cent of NEPT work delivered by ambulances was outside NEPT operating hours (between midnight and 6 am), compared with only 30% in June 2014 before the separation. Refer to HealthShare’s [June 2016 NEPT update](https://www.health.nsw.gov.au/wohp/Documents/ahnm-frost-nept.pdf) <https://www.health.nsw.gov.au/wohp/Documents/ahnm-frost-nept.pdf>, p. 4. [↑](#footnote-ref-216)
216. Advice received from HealthShare NSW. It should be noted that these spill rates are for greater metropolitan Sydney, for which HealthShare NSW is responsible. The districts in which higher spill rates are predominantly rural, where other factors such as thin markets increase the risk of spills. [↑](#footnote-ref-217)
217. Note that this may have been due to other factors. [↑](#footnote-ref-218)
218. Source: Data extracted from *Report on Government Services*. In 2011–12, the rate of incidents per 1,000 population was 95.3, increasing to 110.8 in 2019–20. [↑](#footnote-ref-219)
219. Source: Data extracted from NSWA publicly available data. [↑](#footnote-ref-220)
220. Source: **Western Australia (2023) *Special Inquiry into Emergency Ambulance Service Performance and Response Times: final report*.**  [↑](#footnote-ref-221)
221. In metropolitan areas of Western Australia, St John Ambulance provides ambulance services, and health services subcontract NEPT services to a panel of private providers. [↑](#footnote-ref-222)
222. The WA Country Health Service oversees road and air NEPT and must contract St John Ambulance for delivery in the first instance. This arrangement was established in 2009 to supplement limited emergency resources. Source: **Parliament of Western Australia. Legislative Council Standing Committee on Public Administration (2022) *A new century for ambulance services: Response to the Legislative Council Standing Committee on Public Administration ‘Critical Condition: Inquiry into the Delivery of Ambulance Services in WA’*. [Report No. 37].** [↑](#footnote-ref-223)
223. Advice from the QAS. [↑](#footnote-ref-224)
224. Source: **Productivity Commission (2023) Ambulance services. In: *Report on Government Services 2023* (Part E).**  [↑](#footnote-ref-225)
225. In 2022 unplanned NEPT was 57,190 events of a total 416,914 sector-wide (which includes work for private customers of NEPT). [↑](#footnote-ref-226)
226. As discussed in chapter 5, this would enable AV and HSV to align contracts in a way that ensures sufficient scale across geographical areas. Separate contracting approaches would ensure private contractors remain accountable for meeting the needs of both AV and health services, in contrast to the status quo where private contractors of AV are accountable to AV alone. [↑](#footnote-ref-227)
227. While AV is responsible for commissioning planned NEPT services for concession patients on behalf of health services, emergency responses are prioritised above health service needs, leading to redirection of NEPT crews from planned to unplanned pick-ups. [↑](#footnote-ref-228)
228. These include patients who: require intervening treatment, monitoring, IV therapy, oxygen or clinical observations while in transit; require transport for mental health conditions; are unable to travel with other patients for infection control or other reasons; need to be transported directly to an emergency department; have weight, girth or clinical requirements that mean an alternative resource (for example, CPAV) is warranted in the circumstances. [↑](#footnote-ref-229)
229. Includes 65,776 delivered by AV CTS and 27,162 by private contractors. There are also 18,998 transports delivered by taxis directed by AV (111,936 in total). [↑](#footnote-ref-230)
230. AV has a responsibility to transport community service obligation patients under the *Ambulance payment guidelines*. About 80% of patients transported by CTS are pensioner or concession patients. AV has advised that the function of CTS ensure AV meets its responsibilities under the *Ambulance payment guidelines*. Source: AV advice to the review. [↑](#footnote-ref-231)
231. This is fully separated from TZV and delivered by an in-house capability. [↑](#footnote-ref-232)
232. Ambulance community officers are first responders, who are employed on a casual basis to work ‘on call’ at either a community or a paramedic branch. They are trained to provide advanced first aid in rural and remote communities where the ambulance caseload is low, the ambulance branch is not staffed on a full-time basis or where the paramedic is not generally rostered to work with a second paramedic. These officers are trained to provide a support service to qualified paramedics; they provide early interventions and can transport patients to hospital. Refer to the [AV website](https://www.ambulance.vic.gov.au/careers/become-a-first-responder/) <https://www.ambulance.vic.gov.au/careers/become-a-first-responder/>. [↑](#footnote-ref-233)
233. For example, to alleviate potential concerns with clinical governance (as described in chapter 3) and to meet all market demand in an insourcing scenario (chapter 6). [↑](#footnote-ref-234)
234. This is known across industries as a ‘vehicle routing problem’, solvable through applying data and algorithms to central booking and dispatch decisions, as discussed later in this report. Refer to: Mehmood R, Rashid R and Graham G (2015) ‘Big data logistics: a health-care transport capacity sharing model’, *Procedia Computer Science*, vol. 64, pp. 1107–1114; Oliveira JA, et al. (2015) ‘Non-emergency patients transport-a mixed integer linear programming’, *International Conference on Operations Research and Enterprise Systems*, vol. 2, SCITEPRESS. [↑](#footnote-ref-235)
235. This includes Queensland, New South Wales and Western Australia. [↑](#footnote-ref-236)
236. This initial triage by TZV follows an approach defined by AV. [↑](#footnote-ref-237)
237. The secondary triage clinicians also assign response time requirements to each case, depending on patient risk and acuity. If a private resource is not dispatched in time to meet these requirements, the cases default back to an emergency ambulance and are generally placed at the back of the queue due to their low acuity. [↑](#footnote-ref-238)
238. This includes AV’s CTS division, taxis, rideshare providers and community transport operators (section 3). [↑](#footnote-ref-239)
239. A total of 92,938 services across 2022. Source: Data provided by AV. [↑](#footnote-ref-240)
240. As well as via AV’s secondary triage services for unplanned NEPT. [↑](#footnote-ref-241)
241. A total of 252,982 services managed by TZV in 2022–23. Source: Data provided by TZV. [↑](#footnote-ref-242)
242. The information in the booking form differs to the fields in the computer-aided dispatch system, leading to inconsistencies in information handling and increasing the inherent risk of human error (such as incorrect phone numbers, location fields or omission of patient information), which increases average handling time. The online portal is also reported to be subject to frequent service disruptions, leading to cybersecurity risks and booking form requests left in the cloud, unactioned for several hours. TZV submission, pp. 4–5. [↑](#footnote-ref-243)
243. For example, National Patient Transport offers health services a single booking form giving visibility of all its bookings in one place, regardless of the funding sources. It automatically redirects AV-funded patients’ bookings to TZV for prioritisation and dispatch. The webform also autofills basic demographic information about the patient through integration with health service patient administration systems. [↑](#footnote-ref-244)
244. This may also be partly due to the opportunity to achieve volume-based discounts through contracting all of their internally funded NEPT from a single provider. [↑](#footnote-ref-245)
245. Namely, all unplanned and most planned NEPT. When these services are subcontracted to private providers, AV purchases shifts (not individual transports). During these shifts the private NEPT vehicle is entirely at TZV’s disposal and can be dispatched by TZV across both planned and unplanned work as required, with unplanned generally the overriding priority. [↑](#footnote-ref-246)
246. This service is for low-acuity, more mobile patients. CTS services are largely delivered in-house by AV staff, but some CTS capacity is also purchased from private operators in regional areas. [↑](#footnote-ref-247)
247. As discussed in chapter 3, while health services have coordinated planned NEPT purchasing around a single provider in each region or subregion, AV procures its planned NEPT services separately. [↑](#footnote-ref-248)
248. Note: Submission lightly edited for length and to remove any identifying information. [↑](#footnote-ref-249)
249. As TZV provides dispatching for emergency patient transport, along with fire and police. [↑](#footnote-ref-250)
250. Fogue M, et al. (2016) Non-emergency patient transport services planning through genetic algorithms, *Expert Systems with Applications* vol. 61, pp. 262–271. [↑](#footnote-ref-251)
251. For example, Australia Post and other delivery services, and most taxi and rideshare services. [↑](#footnote-ref-252)
252. This is discussed in the jurisdictional scan below. [↑](#footnote-ref-253)
253. That is, coming too late to enable proactive flow management to occur. [↑](#footnote-ref-254)
254. TZV has advised this is not a hard-and-fast rule. For example, if the dispatcher sees there is significant ramping at one particular hospital, then they may do the discharges first to free up some beds before bringing in the hospital to the emergency department patient. [↑](#footnote-ref-255)
255. Some health services purchase NEPT capacity on a per-shift basis (enabling them to secure these vehicles for their exclusive use, and direct them based on their own priorities) and may also purchase additional capacity as needed on a per-transport basis. [↑](#footnote-ref-256)
256. This booking and dispatch system provides holistic oversight and management of all insourced (~80%) and outsourced (~20%) service delivery across greater metropolitan Sydney, Illawarra Shoalhaven, Central Coast and Hunter New England. Planning is underway to extend this booking and dispatch function to all regional areas to achieve statewide coverage. Source: New South Wales Government (2012) *Reform plan for NSW Ambulance*. [↑](#footnote-ref-257)
257. While health services can book taxis independently, it was found that staff within health services may not always have ready access to cab charges, and so were using NEPT as a more straightforward alternative in the interests of facilitating timely patient discharges. [↑](#footnote-ref-258)
258. Advice from HealthShare NSW. [↑](#footnote-ref-259)
259. As from HealthShare NSW. As Ambulance Victoria’s submission to the review notes, ‘NSW has introduced taxis as a service provider for low acuity transports – a provider that is more accessible, responsive, and significantly cheaper than an ambulance service. Given the growth in demand for low acuity transport across Victoria, this may be a more sustainable approach for this type of patient transport, although raises the question of when the transport of patients should be left to alternative non-clinical services’, p. 10. [↑](#footnote-ref-260)
260. They use Logis Solutions Computer Aided Dispatch. [↑](#footnote-ref-261)
261. Defined as trips per hour. Advice from HealthShare NSW. [↑](#footnote-ref-262)
262. Patient feedback data are also collected (using QR codes and paper forms) on a range of metrics to inform future service improvements and ensure any concerns are addressed more efficiently. [↑](#footnote-ref-263)
263. With service level agreements on resource timeliness, and health service experience tracked. [↑](#footnote-ref-264)
264. Advice from HealthShare NSW. [↑](#footnote-ref-265)
265. For example, Judy Rietz Capacity Command Centre (Maryland) provides centralised operational support across multiple sites to streamline patient flow. This includes coordinating booking/dispatch of interhospital transfers. [↑](#footnote-ref-266)
266. Into the delivery of ambulance services, including NEPT. Source: **Parliament of Western Australia. Legislative Council Standing Committee on Public Administration (2022) *A new century for ambulance services: Response to the Legislative Council Standing Committee on Public Administration ‘Critical Condition: Inquiry into the Delivery of Ambulance Services in WA’*. [Report No. 37].**  [↑](#footnote-ref-267)
267. At this stage, these functions will remain with their current operators; however, further integration may be explored in the future in partnership with operators. [↑](#footnote-ref-268)
268. Source: Government of South Australia (2023) ‘Winter demand strategy released as new health control centre launched’. [↑](#footnote-ref-269)
269. Source: Premier of Victoria (2022) ‘Australia’s biggest hospital project to boost research’. [↑](#footnote-ref-270)
270. Including Queensland, Western Australia and South Australia. [↑](#footnote-ref-271)
271. Johns Hopkins hospital network, an early adopter of capacity command centres. [↑](#footnote-ref-272)
272. TZV’s own submission to the review noted it would require significant investment: ‘ESTA acknowledges the discussion papers reference to reform opportunity that insourcing may provide (via AV or another public entity). The funding, resourcing and health capability requirements that accompany such and arrangement is extensive … Any transition toward partial or full insourcing would require transformational reforms and a whole of sector uplift.’ With respect to booking and dispatch, TZV has advised its current approaches for NEPT are largely manual and that investment would be required to uplift these to the degree required to deliver a modern NEPT scheduling service statewide. [↑](#footnote-ref-273)
273. This should be the case regardless of whether unplanned NEPT is insourced or outsourced. [↑](#footnote-ref-274)
274. There would be no conflict of interest in this circumstance, given it would be the sole provider of planned NEPT services. [↑](#footnote-ref-275)
275. From 2024–25, funding for TZV will no longer flow through the Department of Health but will be provided by the Department of Justice and Community Safety. The Department of Treasury and Finance, Department of Community Justice and Safety, TZV and AV will need to be engaged regarding this funding impact. [↑](#footnote-ref-276)
276. The Hospital Based Vehicle program collects and transports patients as and when required by a health service and their associated campuses. AV established hospital-based vehicles to assist in managing demand from major metropolitan health services (9 in total currently) and providing them with a localised service to move patients as required. This service is also contracted to the private market via AV’s service agreements. [↑](#footnote-ref-277)
277. These direct the review to consider how current procurement arrangements may be revised to reduce fragmentation, increase operational flexibility and improve workforce pay and conditions [↑](#footnote-ref-278)
278. Refer to section 4.1.3. [↑](#footnote-ref-279)
279. AV awards contracts based on a competitive tendering process in line with Victorian Government purchasing guidelines. [↑](#footnote-ref-280)
280. Eight private providers are on the HSV panel for public health service use (noting only 3 were actively contracted by health services at the time of writing); 6 of these providers are also contracted by AV. [↑](#footnote-ref-281)
281. Six private providers are contracted through AV; 4 provide services by geographical area, and the other 2 provide surge capacity. [↑](#footnote-ref-282)
282. Where the purchaser of planned NEPT services can be AV or health services, depending on the type of patient and direction of travel. This means that staff will often have to book through a different channel (via AV or directly with their provider) depending on these factors, except where the provider offers a booking system that resolves this issue. It also fragments NEPT service delivery when a health service’s contracted NEPT provider is not the same as AV’s for their region. [↑](#footnote-ref-283)
283. Source: HSV NEPT Review discussion paper supplementary submission. [↑](#footnote-ref-284)
284. As noted in section 3.3.3, AV and HSV independently contract private providers using different approaches. AV funds providers on a per-shift basis; HSV contracts enable health services to choose whether to fund providers on either a per-transport basis or a dedicated hospital vehicle rate. [↑](#footnote-ref-285)
285. Initial NEPT contracts for health services tendered through Health Purchasing Victoria began in 2015, with an expiry date in 2018. Contracts have subsequently been extended, with the most recent extension in 2023. AV contracts expire on 30 June 2024. AV has sought to extend contracts for another 15 months to 30 September 2025, with an option for a further extension at the discretion of AV. [↑](#footnote-ref-286)
286. As one provider stated during a roundtable: ‘We can’t offer our staff certainty until we have it ourselves’. However, it is acknowledged that casual rates do vary considerably across employers and some have previously taken steps to reduce casualisation. National Patient Transport committed in its 2019 enterprise agreement to increase the proportion of permanent employees by a minimum of 30%. Source: National Patient Transport (2019) *National Patient Transport Ptd Ltd Victorian Employees Enterprise Agreement 2019*, p. 10. [↑](#footnote-ref-287)
287. Refer to section 4.1.3. [↑](#footnote-ref-288)
288. Concession classification includes Pensioner, Health Care Card holders and compulsory mental health patients. [↑](#footnote-ref-289)
289. For patients covered by the TAC, DVA and WVA, reimbursement would be sought through these schemes, as is currently the case. [↑](#footnote-ref-290)
290. This already occurs for some procurement and shared back-of-house services. [↑](#footnote-ref-291)
291. This is evident in rural health services’ current practice of coordinating contracts, as discussed in section 5.4.1. [↑](#footnote-ref-292)
292. As chapter 4 notes, the largest users of NEPT services could preserve significant local control by maintaining hospital-based vehicles for their exclusive use, as they have currently, and receiving supplementary transports through the centralised model. Over time, where the VDHCC can demonstrate equivalent timeliness and reduced costs through centralised dispatching, these health services may voluntarily reduce use of hospital-based vehicles. [↑](#footnote-ref-293)
293. Visibility of rural urgent care centres is also needed. [↑](#footnote-ref-294)
294. HSV managing the procurement of NEPT services for a single contract manager, the VDHCC, also allows for a greater standardisation performance and quality requirements. [↑](#footnote-ref-295)
295. As discussed in chapter 4, a centralised booking system would contain embedded eligibility screening and direct all planned transport requests to appropriate transport options. For transports not eligible for NEPT, this outsourcing option would also allow taxi and/or rideshare to be procured at scale by HSV, and enable transfer of community transport commissioning from the Department of Health to the VDHCC. [↑](#footnote-ref-296)
296. As discussed in chapter 4, HealthShare NSW has worked with local health districts to design, pilot and scale innovations to improve both timeliness (the reservations model) and responsiveness to local pressures (‘fly cars’). [↑](#footnote-ref-297)
297. The principal–agent problem refers to the potential conflict in interests that arise when one entity takes actions on behalf of another entity. In the current state, this appears where AV are responsible for purchasing transports for concessional patients to and from health services. [↑](#footnote-ref-298)
298. All health services are required to use HSV’s procurement services, but AV is allowed to use HSV’s services selectively with HSV’s approval [↑](#footnote-ref-299)
299. The commissioning framework will need to spell out the roles and responsibilities for AV and HSV including when to engage for contract renewal, noting air NEPT needs sign-off by Department of Treasury and Finance. [↑](#footnote-ref-300)
300. Source: HSV NEPT Review discussion paper supplementary submission. [↑](#footnote-ref-301)
301. Transport, logistics and large-scale procurement industries. [↑](#footnote-ref-302)
302. Source: Jarboui SAMI, Forget P and Boujelbene Y (2013) ‘Public road transport efficiency: a stochastic frontier analysis’, *Journal of Transportation Systems Engineering and Information Technology*, vol. 13, no. 5, pp. 64–71. [↑](#footnote-ref-303)
303. Rural areas remain the area of uncertainty for AV where a lack provider certainty NEPT patients emerge as triple zero (000) callers. [↑](#footnote-ref-304)
304. The state owns the network assets, which are leased to the franchisee for the contract term. [↑](#footnote-ref-305)
305. For example, South East, North East and North West, aligning with the existing division of metropolitan Melbourne into 3 regions. The number and boundaries of corridors would, however, ultimately be determined through market analysis. [↑](#footnote-ref-306)
306. Some health services in metropolitan areas provide statewide services and so would be transferring patients outside their corridor; however, this should not be an impediment to a corridor-based model where centralised booking and dispatch is in place to coordinate these out-of-corridor transports and this issue can be managed through contract arrangements. Further, this is a feature of the existing model where health services generally deal with one contractor, who won’t necessarily have contracts in all of the regions a health service is transferring its patients to. [↑](#footnote-ref-307)
307. Source: Western Australia Government (2022) *Delivery of ambulance services in Western Australia: critical condition*, report 37. [↑](#footnote-ref-308)
308. Source: EM/ANB (2022) *EM/ANB annual report 2021–22.* [↑](#footnote-ref-309)
309. Source: HSV NEPT Review discussion paper supplementary submission. [↑](#footnote-ref-310)
310. For example, the American railroad industry experienced significant horizontal integration via mergers between 1983 and 2003, dropping from 39 to 7 operators, with the top 4 market share growing from 66% to 94%. This resulted in an 11.4% reduction in industry costs, following an increase in volumes and route efficiency, leading to decreases in average unit prices. Source: Bitzan JD and Wilson WW (2007) ‘Costs and consolidation: efficiency gains and mergers in the US railroad industry’, *Review of Industrial Organization*, vol. 30, pp. 81–105. [↑](#footnote-ref-311)
311. A study of vertical integration in the American airline industry (where larger airlines merge with smaller regional players, rather than subcontracting them, to operate a subset of their routes) led to better operational performances (for example, fewer delays/cancellations) compared with those relying on independents. This was attributed to better goal alignment in integrated airlines. For example, when adverse weather conditions affected flight scheduling, independent regionals had no incentive to prioritise their partner major’s flights over other airlines. In both cases of integration, consolidation gave providers more autonomy in optimising their transport networks. Source: Forbes SF and Lederman M (2010) ‘Does vertical integration affect firm performance? Evidence from the airline industry’, *The RAND Journal of Economics,* vol. 41, no. 4, pp. 765–790. [↑](#footnote-ref-312)
312. Refer to, for example, Gaynor M 2016, ‘New health care symposium: consolidation and competition in US health care’, *Health Affairs Forefront*, http://healthaffairs.org/blog/2016/03/01/new-health-care-symposium-consolidation-and-competition-in-us-health-care/. Many of the mergers discussed are hospital mergers involving combination rather than integration of facilities. [↑](#footnote-ref-313)
313. For example, medical waste disposal in regional Victoria was processed by a single provider, which experienced the failure of critical infrastructure, resulting in large amounts exported interstate and significant disruptions to health services. However, the waste provider had a statewide monopoly (following market consolidation). This option involves creation of multiple regional monopolies, along with contestability reforms to make it easier to transition in new providers in the event of provider exit. [↑](#footnote-ref-314)
314. Providers typically need to invest significant resources in individually developing bespoke booking systems that can integrate into health service patient administration systems and AV’s webform but would no longer need this upfront investment if booking and dispatch were provided centrally. [↑](#footnote-ref-315)
315. While some health services have local system interfaces that overcome this issue, in general health services have to train staff to use new booking systems when they switch providers. This is reportedly a major barrier to switching due to the time cost involved, and it is neutralised when a single booking system is provided centrally. [↑](#footnote-ref-316)
316. Source: Jarboui SAMI, Forget P and Boujelbene Y 2013, ‘Public road transport efficiency: a stochastic frontier analysis’, *Journal of Transportation Systems Engineering and Information Technology*, vol. 13, no. 5, pp. 64–71. [↑](#footnote-ref-317)
317. This is expected to be sustainable, given that AV already currently contracts 2 providers who have no planned NEPT contracts to deliver relatively small volumes of unplanned work. (The providers are Medical Edge and Paramedic Services Victoria, which each deliver about 16,000 patient transports a year. Total unplanned volumes are 60,455 per year.) [↑](#footnote-ref-318)
318. Noting, per HealthShare NSW’s experience, providers would need additional work alongside surge capacity to be sustainable. [↑](#footnote-ref-319)
319. Source: HSV NEPT Review discussion paper supplementary submission. [↑](#footnote-ref-320)
320. These are provided as illustrative examples only, noting that HSV would need to do a detailed opportunity analysis to confirm specific areas of focus. [Other inquiries](https://committees.parliament.uk/work/4834/competition-in-the-local-bus-market/publications/) < https://committees.parliament.uk/work/4834/competition-in-the-local-bus-market/publications/ > have found that when the life span of fleet is short and the scale of fleet procurement is large, central ownership and leasing by private providers is not an effective model. [↑](#footnote-ref-321)
321. And AV, which – in contrast to health services – retains flexibility to opt in and out of HSV services.  [↑](#footnote-ref-322)
322. HSV advice to the Department of Health. [↑](#footnote-ref-323)
323. Source: Department of Health (2021) *Non-Emergency Patient Transport Amendment Regulations 2021 regulatory: impact statement*, p. 8. [↑](#footnote-ref-324)
324. Source: NPT, RFDS and St John Ambulance NEPT Review discussion paper submissions. [↑](#footnote-ref-325)
325. This would likely require the department to negotiate the conditions with employers, with HSV reflecting the agreed conditions in contracts. [↑](#footnote-ref-326)
326. NPT committed in its 2019 enterprise agreement to increase the proportion of permanent employees by a minimum of 30%. Source: National Patient Transport (2019) *National Patient Transport Ptd Ltd Victorian Employees Enterprise Agreement 2019*, p. 10. [↑](#footnote-ref-327)
327. All employers would need to agree to enter into a new enterprise agreement, otherwise the bargaining representative can apply for a determination by the Fair Work Commission to compel them. [↑](#footnote-ref-328)
328. Calculated by AV. PTO and ATA rate midpoints multiplied by total NEPT PTO and ATA FTE, minus the sum of private provider PTO and ATA FTE rate midpoints multiplied by their PTO and ATA FTE. [↑](#footnote-ref-329)
329. Source: NEPT provider annual reporting: total private transports/total private provider transports = 55,835 of 369,290 transports. [↑](#footnote-ref-330)
330. Source: HSV NEPT Review discussion paper supplementary submission. [↑](#footnote-ref-331)
331. This has been limited to the labour component of contracts (65–85% of the total). The Department of Government Services will audit providers to ensure pass-through to workforce pay, noting extra resources are required to administer this initiative (~3 FTE for 150 entities). [↑](#footnote-ref-332)
332. Six per cent of the security officer level 1 and level 5 minimum weekly rates of $960.20 and $1054.10 respectively. Source: *Security Services Industry Award 2020*. [↑](#footnote-ref-333)
333. The workforce employed by subcontractors must have the same employment conditions as those the head contractor had committed to, and any subcontracting must be approved by the head agency (Department of Government Services) and the contracting agency. [↑](#footnote-ref-334)
334. This includes ensuring the supplier is providing appropriate information to their workers about their rights, establishment of an inspectorate, a survey of workers to see how they are being treated, an audit to ensure suppliers make the relevant payments, and greater reporting and oversight including more direct meetings with suppliers. Costs are equivalent to approximately 3 Victorian public service FTE for onboarding of new entities (of which there are 150) and ongoing oversight, along with about $150,000 to run payroll audits. [↑](#footnote-ref-335)
335. Subsequent to the Parliament of Victoria’s *Inquiry into portability of long service leave entitlements* in 2016, a Portable Long Service Benefits Scheme was implemented in July 2019. [↑](#footnote-ref-336)
336. Health or related services (as defined in s. 3(1) of the *Health Services Act 1988*) are not classified as community services work for the scheme. [↑](#footnote-ref-337)
337. WorkSafe Victoria notes that employees in the healthcare and social assistance industries, including patient transport, have a higher risk of being exposed to COVID-19, for example, and recommend workplaces implement policies and information to support employees to stay away from the workplace when unwell. Refer to the [WorkSafe Victoria website](https://www.worksafe.vic.gov.au/controlling-covid-19-risks-healthcare-and-social-assistance) <https://www.worksafe.vic.gov.au/controlling-covid-19-risks-healthcare-and-social-assistance>. [↑](#footnote-ref-338)
338. However, including NEPT workers may set a precedent for any future casual work sick pay arrangements. [↑](#footnote-ref-339)
339. Assumes 60% casual staff of the total 1,767 total workforce by headcount are eligible, and 70% eligible staff take the full 38 hours under the scheme at minimum wage (0.7 × (0.60 × 1,715) × 38 × $23.33). [↑](#footnote-ref-340)
340. Source: Department of Energy, Environment and Climate Change (2023) ‘Climate action targets’. [↑](#footnote-ref-341)
341. Source: *Victoria’s climate change strategy*: Transport sector emissions reduction pledge. [↑](#footnote-ref-342)
342. Source: NHS *Net zero travel and transport strategy*. [↑](#footnote-ref-343)
343. Source: NHS: *Report of the non-emergency patient transport review 2021*. [↑](#footnote-ref-344)
344. Source: NHS *Net zero travel and transport strategy*. [↑](#footnote-ref-345)
345. Provided the price of fuel remains high and the cost of repairs and maintenance for the vehicles does not increase substantially as the units approach the end of a 6-year operational service life. Source: Edwards S (2021) ‘The financial and environmental viability of municipally operated hybrid ambulance fleets in Ontario: calculating the return-on-investment of hybrid ambulance assets in Oxford County from 2017–2021’, *MPA Major Research Papers*, p. 203. [↑](#footnote-ref-346)
346. Refer to the [St Vincent’s website](https://www.svhs.org.au/media/news/st-vincents-first-electric-ambulance) <https://www.svhs.org.au/media/news/st-vincents-first-electric-ambulance>. [↑](#footnote-ref-347)
347. These direct the review to consider replacing current procurement arrangements with an insourced delivery model, such as bringing NEPT services within AV, or within an alternative or new public provider. [↑](#footnote-ref-348)
348. The review recommends insourcing into 2 entities, with one responsible for planned NEPT services and another responsible for unplanned NEPT services. [↑](#footnote-ref-349)
349. For example, vehicles, consumable products such as bed linen and clinical equipment, services such as cleaning, laundry and vehicle maintenance, and purchases or leases of depots, branches and corporate headquarters. [↑](#footnote-ref-350)
350. This includes significant disparities in total pay and benefits and high levels of casualisation for the private workforce, which limits access to paid leave, sick leave and guaranteed hours of work. It also creates a perceived risk to staff’s security of employment when they raise potential concerns about patient safety and workforce. There is also no portability of entitlements across employers, resulting in a loss of benefits to staff when contracting approaches change. [↑](#footnote-ref-351)
351. As discussed in section 6.2.2, this could be either under AV’s existing enterprise agreement or a newly negotiated enterprise agreement specific to NEPT services under a separate public agency. [↑](#footnote-ref-352)
352. Source: Western Australia Legislative Council (2022) *Inquiry into the* *Delivery of ambulance services in Western Australia: critical condition* (Report 37). [↑](#footnote-ref-353)
353. Some regional local health districts also deliver NEPT services on a transitional basis. [↑](#footnote-ref-354)
354. Source: Ambulance Victoria (2017) *Delivering our patients the right care, at the right time, at the right place: revised clinical response model evaluation report*. [↑](#footnote-ref-355)
355. This assessment process involves TZV staff following an algorithm that allocates a case type to each call, with AV’s dispatch grid identifying the type of response to each case type. Patients identified as lower acuity and less urgent are directed to AV’s secondary triage service for further assessment to confirm appropriateness for an unplanned NEPT response, or diversion to another service. [↑](#footnote-ref-356)
356. Source: Ambulance Victoria (2022) *Medium Acuity Transport Service evaluation report*. [↑](#footnote-ref-357)
357. That is, a qualified paramedic supervising an ATA. [↑](#footnote-ref-358)
358. For example, supporting a number of Certificate III-qualified PTOs and CTOs to train as diploma-qualified ATAs to resource the medium-acuity profile of unplanned shifts. [↑](#footnote-ref-359)
359. Of the 369,290 unplanned transports, 47,140 are fulfilled by the private market. [↑](#footnote-ref-360)
360. No stakeholders – including AV – proposed that planned NEPT be delivered by AV, with the exception of the Victorian Ambulance Union, which proposes that NEPT first be delivered by a separate public authority before eventually transitioning into AV. [↑](#footnote-ref-361)
361. In particular, a singular focus on planned NEPT would allow specification of workforce, infrastructure and other assets, and sector relationships. [↑](#footnote-ref-362)
362. It may still be possible to insource services to AV in future, as recommended by the Victorian Ambulance Union. This has not been recommended at this stage, given it is inconsistent with the recommendation to pursue structural separation of planned NEPT from emergency responses (Recommendation 1). However, a theoretical approach may involve a transitional approach wherein planned NEPT services are insourced into the VDHCC in the first instance. Then, once public delivery of planned NEPT services is stable and running effectively, and ambulance services are also running efficiently and meeting their performance expextations, planned NEPT could be transitoned from the VDHCC into AV. [↑](#footnote-ref-363)
363. As mentioned earlier in this report, the VDHCC will be a neutral entity directly accountable to the Department of Health for improving health system flow. It will have no conflict of interest between its system-wide NEPT role and local objectives (for example, as a health service delivering planned NEPT services on behalf of the health system might be perceived to have). And it will have a clear mandate and responsibility to work with health services to improve the timeliness of patient access and enable better health system delivery. [↑](#footnote-ref-364)
364. This includes the statewide services for emergency care and major trauma (The Royal Melbourne Hospital), midwifery and obstetrics (The Royal Women’s Hospital), paediatrics (The Royal Children’s Hospital) and oncology (Peter MacCullam Cancer Centre). [↑](#footnote-ref-365)
365. Refer to the clinical practice protocols. [↑](#footnote-ref-366)
366. For example, capability relating to booking and dispatch operation, service delivery and state ownership of assets. Source: HSV NEPT Review discussion paper supplementary submission. [↑](#footnote-ref-367)
367. For example, Northern Health currently delivers the Victorian Virtual Emergency Department service on behalf of the system. [↑](#footnote-ref-368)
368. Note that it would still be able to deliver centralised booking and dispatch of services if these were to remain outsourced. [↑](#footnote-ref-369)
369. Via HSV. [↑](#footnote-ref-370)
370. The Victorian Ambulance Union’s recommendation is that a new statutory authority (Victorian Patient Transport Authority) is established to oversee insourcing, as well as lead broader reform actions, including establishing stronger governance mechanisms. The Victorian Ambulance Union proposes that NEPT services – once in a more mature state – could then be transitioned into AV. [↑](#footnote-ref-371)
371. This is 104.6%, which factors in AV’s rolled-in rate compared with 40.8%. [↑](#footnote-ref-372)
372. Note that current enterprise bargaining may result in additional future costs that have not been captured as part of the review. [↑](#footnote-ref-373)
373. This is 56.4% compared with 40.8%. [↑](#footnote-ref-374)
374. This figure excludes NEPT services delivered by AV. The 6 publicly contracted providers delivered 313,455 NEPT transports in 2022–23, of a total 369,290 delivered privately. [↑](#footnote-ref-375)
375. Six companies are contracted by AV; 8 are contracted by HSV. [↑](#footnote-ref-376)
376. This is 24,030 in total, most of which are delivered by St John Ambulance (14,426 more transports). [↑](#footnote-ref-377)
377. These providers are the Royal Flying Doctor Service, Medical Edge Australia and St John Ambulance. [↑](#footnote-ref-378)
378. In 2022–23, these providers accounted for 21.5% of the events attended by first aid providers. Source: NEPT provider annual reporting data for First Aid Services, 3,943 first aid services events. [↑](#footnote-ref-379)
379. For example, St John Ambulance delivers first aid services in Queensland and New South Wales where it does not have NEPT contracts. [↑](#footnote-ref-380)
380. It should be noted that since the 2021 amendment to the NEPT Act and Regulations, the accreditation scheme for stand-by services has been repealed and replaced by licensing for the first aid services sector. First aid providers must attain a separate licence to provide ‘stand-by services’. [↑](#footnote-ref-381)
381. The 3 other NEPT operators in Victoria are very small scale, with each delivering just 200 to 4,000 transports a year (all for private clients). [↑](#footnote-ref-382)
382. Distribution of service volume is based on performance, availability and cost. While external providers are not guaranteed minimum volumes, the ability to provide surge capacity for HealthShare NSW seems dependent on NEPT workload during business as usual. [↑](#footnote-ref-383)
383. Current regulations only apply to services that are delivered for fees. If the VDHCC were to take up this role, it would become subject to the Regulations, rather than operating under its own clinical governance. [↑](#footnote-ref-384)
384. HealthShare NSW is a public entity separate from NSWA, which manages patient transport services among a range of other health system procurement and supply chain functions including human resource services, financial services, food and patient support services, linen services, procurement services, a service for cleaning and restocking ambulances and a service known as EnableNSW, which assists people with a disability to live and participate in the community. Refer to the [HealthShare NSW website](https://www.healthshare.nsw.gov.au/about) <https://www.healthshare.nsw.gov.au/about>. [↑](#footnote-ref-385)
385. The purpose of this was to ‘overcome the current situation where vehicles can be dispatched with single passengers when others are waiting for transportation to the same destination and other occasions where vehicles return empty when there are people waiting by’. Source: **NSW Government, Health (2012) *Reform plan for NSW Ambulance***, p. 15. [↑](#footnote-ref-386)
386. Advice received from HealthShare NSW. [↑](#footnote-ref-387)
387. Refer to [Non-Emergency Patient Transport Combined DO / GM Meeting](https://www.health.nsw.gov.au/Performance/Pages/do-gm-march-2015.aspx) <https://www.health.nsw.gov.au/Performance/Pages/do-gm-march-2015.aspx>. [↑](#footnote-ref-388)
388. Advice received from HealthShare NSW. [↑](#footnote-ref-389)
389. Source: NSW Health (2015) Non-Emergency Patient Transport Combined DO / GM Meeting. [↑](#footnote-ref-390)
390. Refer to the [HealthShare NSW website](https://www.healthshare.nsw.gov.au/about/news/pts) <https://www.healthshare.nsw.gov.au/about/news/pts>. [↑](#footnote-ref-391)
391. Refer to the [HealthShare NSW website](https://www.healthshare.nsw.gov.au/about/strategic-plan#:~:text=What%20was%20achieved%20under%20the,Lost%20Time%20Injury%20Frequency%20Rate) <https://www.healthshare.nsw.gov.au/about/strategic-plan#:~:text=What%20was%20achieved%20under%20the,Lost%20Time%20Injury%20Frequency%20Rate>. [↑](#footnote-ref-392)
392. Advice received from HealthShare NSW. [↑](#footnote-ref-393)
393. Currently in draft form. Consultation on the draft NSQHS Standards Guide for Ambulance Health Services (2023). [↑](#footnote-ref-394)
394. Source: Office of Public Management and Chartered Institute of Public Finance & Accountancy (2004) *The good governance standard for public services*. [↑](#footnote-ref-395)
395. As Central Highlands Rural Health noted in its submission, ‘The department has a very much hands off approach, focusing on regulation but not directly engaging NEPT services’. [↑](#footnote-ref-396)
396. For example, AV’s data is limited to NEPT it is funded for, while the department collects high level self-reported data for all privately provided services that excludes AV in-house work and has high levels of inconsistency in provider interpretation of fields (this data is sufficient for regulatory oversight but does not support a broader understanding of the system for performance oversight purposes). Providers generate large volumes of data for health services and HSV, but there is no central visibility or use of this. [↑](#footnote-ref-397)
397. Specifically for the ambulance non‑emergency services output for inclusion in the 2024–25 Budget. [PAEC 2023–24 Budget Estimates Report](https://www.parliament.vic.gov.au/get-involved/inquiries/BE2023-24/reports) <https://www.parliament.vic.gov.au/get-involved/inquiries/BE2023-24/reports>. Report tabled 3 October 2023. [↑](#footnote-ref-398)
398. For example, with AV (via TZV) directing providers to prioritise unplanned NEPT over planned NEPT, and health services making competing requests for their bookings to be prioritised, usually to the advantage of larger health services over those with smaller contracts. These issues would be resolved through other proposed reforms, with separation of planned and unplanned NEPT, and centralised booking and dispatch of planned NEPT. [↑](#footnote-ref-399)
399. This is because they are primarily for concession patients. [↑](#footnote-ref-400)
400. Source: AV NEPT Review discussion paper submission. [↑](#footnote-ref-401)
401. The Victorian Government also supports a pipeline of nurses, who make up 5% of the NEPT workforce, by providing scholarships to new domestic students enrolling in a professional-entry nursing course in 2023 and 2024. [↑](#footnote-ref-402)
402. The Diploma of Emergency Health Care is the base qualification for an ATA, which is the minimum crew member required to travel in a patient compartment for medium-acuity transports. For low-acuity transports, which makes up 76% of contracted NEPT activity, PTOs need a base qualification of a Certificate III Non-Emergency Patient Transport. Workforce planning could align with broader professional career frameworks. Source: Australisian College of Paramedicine. Consultation paper on paramedicine: [*Draft clinical practice framework for Australasia*](https://paramedics.org/news/your-say-clinical-practice-framework) <https://paramedics.org/news/your-say-clinical-practice-framework>. [↑](#footnote-ref-403)
403. There is an opportunity for this to align with the department’s forthcoming 10-year workforce strategy. [↑](#footnote-ref-404)
404. Noting this may be limited by differences in conditions across AV and the private sector. Pathways between NEPT and paramedicine is a key discussion item at the Biannual Engagmenet Forum, including recognition of prior learning, university assessment processes and engagement with professional bodies. [↑](#footnote-ref-405)
405. Sources: Institute for Healthcare Improvement (2023) *How to improve: model for improvement*; Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP (2009) [*The improvement guide: a practical approach to enhancing organizational performance*](https://www.ihi.org/resources/publications/improvement-guide-practical-approach-enhancing-organizational-performance) (2nd edition). [↑](#footnote-ref-406)
406. Continuous improvement could align with the Safer Care Victoria’s [*Partnering consumer framework*](https://www.safercare.vic.gov.au/publications/partnering-in-healthcare) <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare> and the Australian Commission on Safety and Quality in Health Care’s [*Partnering with consumers standard*](https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard) <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard>. [↑](#footnote-ref-407)
407. Where the existing regulatory framework would still apply to unplanned NEPT services delivered by private providers, as noted in chapter 5. [↑](#footnote-ref-408)
408. The workforce (including staff of both AV and private providers) raised this issue on multiple occasions during the consultation period. [↑](#footnote-ref-409)
409. Refer to the the [Australian Commission on Safety and Quality in Health Care website](https://www.safetyandquality.gov.au/faqs-about-partnering-consumers-nsqhs-standards-second-edition) <https://www.safetyandquality.gov.au/faqs-about-partnering-consumers-nsqhs-standards-second-edition>. [↑](#footnote-ref-410)
410. Ibid. [↑](#footnote-ref-411)
411. There is limited evidence supporting the benefits and sustainability of a mechanism for consumer engagement, although the literature supports the use of mixed methods to capture the diversity of patients. Source: Dalton J, Chambers D and Eastwood A (2015) Service user engagement in health service reconfigurations: a rapid evidence synthesis. *Journal of Health Services Research & Policy*. [↑](#footnote-ref-412)