T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Ambulance Victoria

Melbourne – Friday 20 June 2025

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WITNESSES

Anthony Carlyon, Executive Director, Specialist Operations and Coordination, and

Dr Tegwyn McManamny, Executive Director, Quality and Clinical Innovation, Ambulance Victoria.

The CHAIR: Welcome back to session 2 of the Legal and Social Issues Committee Inquiry into Ambulance Victoria. I am Joe McCracken. I am the Chair of this inquiry. We will go around and introduce our committee.

Michael GALEA: Good morning. Michael Galea, Member for South-Eastern Metropolitan Region.

Ryan BATCHELOR: Ryan Batchelor, Member for the Southern Metropolitan Region.

Tom McINTOSH: Tom McIntosh, Member for Eastern Victoria Region.

Anasina GRAY-BARBERIO: Good morning. Anasina Gray-Barberio, Northern Metro.

Georgie CROZIER: Good morning. Georgie Crozier, Member for Southern Metropolitan Region and Shadow Minister for Health.

Renee HEATH: Renee Heath, Eastern Victoria Region.

Rachel PAYNE: Good morning. I am Rachel Payne from the South-Eastern Metropolitan Region.

The CHAIR: Perfect. Thanks. I will just read this out and then we will get into your opening statements and questions.

All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information that you provide during the hearing is protected by law. You are protected against any action for what you say during this hearing, but if you go elsewhere and repeat the same things those comments may not be protected by this privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is recorded and you will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and put on the committee's website. For Hansard, could you please just state your full name and the organisation you are appearing on behalf of.

Anthony CARLYON: Anthony Carlyon, Ambulance Victoria.

Tegwyn McMANAMNY: Tegwyn McManamny, Ambulance Victoria.

The CHAIR: Thanks very much. I will give you 5 minutes if you want to make an opening statement, and then we will go to questions from there.

Anthony CARLYON: Thank you, Chair. I would like to acknowledge we are on Wurundjeri land today, part of the Kulin nation, and pay my respects to First Nations people right across the lands on which Ambulance Victoria provides its care, also acknowledging any Aboriginal or Torres Strait Islander people listening to us today or here in person. I would also like to acknowledge the members of the Legal and Social Issues Committee. I thank you for the opportunity to speak today. I also recognise that this inquiry has heard from many members of the community and our stakeholders. It has also heard from members previously and today working with Ambulance Victoria, and we thank them for their contributions. We do look forward to the committee's recommendations and contributing to your findings.

As I said, my name is Anthony Carlyon. I am a registered paramedic and I am the Executive Director of Specialist Operations and Coordination at Ambulance Victoria. I have held a number of frontline, regional and executive leadership positions in Ambulance Victoria since first starting on-road in the western suburbs 20 years ago. Previous to that I worked in an ambulance service in New South Wales. Specialist Operations and Coordination provides direct specialist care as well as clinical advice to health services, responding paramedics and the Victorian community through our communication centre staff, our secondary triage team, our adult

retrieval unit, air ambulance and stroke specialist services. We also provide emergency management functions and coordination of major events affecting the Victorian community through our emergency management unit.

Calls for an ambulance in Victoria set a record in 2023–24, with May recording the highest ever monthly demand with 92,246 calls. It is now routine for 90,000 calls to be received per month, and average calls are approximately 50 per cent above those that we saw in 2019–20. The increase in demand for emergency health care is primarily driven by population growth and an ageing population, as well as an increase in patients presenting with more complex medical needs. Those that present to us today have multiple clinical problems, and in particular cardiac and respiratory issues, mental health issues, alcohol and other drug concerns and issues in relation to accessing timely care and affordable out-of-hospital care. Due to delayed care in the community and other drivers these presentations often require multiple levels of care, both prehospital and in emergency departments and other health services.

Our secondary triage team receive approximately 40 per cent of all 000 calls today where they look to provide an alternative to emergency ambulance dispatch, with approximately 20 per cent of all cases today referred to an alternative service provider. In addition they provide welfare support to patients who are often waiting for an ambulance in the community.

These outcomes lead all other jurisdictions and are a key enabler in preserving ambulances for the services that they are needed most. Today we are trialling innovation in many areas. Video-assisted triage is not occurring anywhere else in this country, and we do that routinely in our secondary triage service today as well as referring patients to the Victorian virtual emergency department, whether that be for a paramedic attending on scene or within the community itself.

We are also very engaged in the delivery of paramedic practitioner roles, which we hope will serve communities and help people stay well in communities in the future rather than requiring an ambulance response. To reduce delays, address demand and keep emergency ambulances for those who need them most, we continue to work with our health service partners on improving timely access to care through initiatives such as the timely emergency care collaboration and implementation of the timely transfer standards. We are engaging with partners in health services, government agencies and other emergency services to ensure that our shared critical systems are optimised to support AV responders, effectively connect patients and ensure health emergencies are managed at scale across the state of Victoria. We want to provide the right care at the right place for all our community.

Call-taking dispatch by its nature operates in an environment of inherent risk, and we work closely with Triple Zero Victoria, TZV, to continuously improve call taking dispatch, manage workload and meet community expectations. The work is extensive, balancing both short-term and long-term goals, and we remain open to further changes to the model in the future in collaboration with our workforce, unions and TZV. Our communication centre staff are exceptional, often operating in demanding circumstances, balancing industrial requirements, ensuring staff wellbeing and prioritising resourcing with patient safety always front of mind. The spirits and workload of our paramedics and those who support them is paramount. We have a solid foundation to begin with. But we widely acknowledge the changing demographics and needs of our workforce, and we have much work to do. Joining me today is Tegwyn McManamny, and I will let her introduce herself and her role in Ambulance Victoria.

Tegwyn McMANAMNY: Thanks, Anthony. Good morning. My name is Tegwyn McManamny. I am the Executive Director of Quality and Clinical Innovation. I am responsible for the quality and clinical innovation division, which oversees AV's clinical governance, patient safety and patient experience, research, evaluation, operational capability and training, quality assurance and clinical risk systems, as well as continuous innovation and improvement. I am an experienced intensive care paramedic. I have worked at Ambulance Victoria since 2010 across both rural and metropolitan Victoria, and I was appointed to this role as Executive Director in February 2025. I am responsible for Ambulance Victoria's clinical governance framework, which ensures we have a foundation for robust clinical governance systems to deliver the best care to the Victorian community. It ensures that our people understand and are supported to perform their roles and responsibilities in providing safe and high-quality care. I am the responsible executive for the delivery of high-quality training programs across Ambulance Victoria, from our graduate ambulance paramedics through to our intensive care and paramedics and first responders across the state. We all play a key role in ensuring that best care is provided to

the Victorian community, and we are so proud of the service that they provide. Thank you for your time. Anthony and I look forward to answering any questions.

The CHAIR: Thank you very much. I will hand over to Mr Galea first.

Michael GALEA: Thank you, Chair. Thank you both for joining us this morning. Just at the outset, and I have got some information from your submission here as well, I am just wondering if you could run through the technical process for how dispatch works. At what points, for example, are calls marked off to secondary triage or to urgent dispatch, and what sort of paramedic oversight do you have over that process to guide what is hopefully the best outcome? And then, if there is time, I would also like to ask you about the video-assisted triage, but I might just get you to go through the mechanics of the process first.

Anthony CARLYON: I am happy to do so. All callers in Australia, regardless of jurisdiction, when they call 000 are answered in the first place by Telstra. Telstra will ask any caller where they are calling from and what service they require – in the case of Victoria, 'I'm in Victoria, and I require an ambulance.' Those calls are then transferred to TZV, Triple Zero Victoria, who are the statutory authority responsible for call-taking dispatch in Victoria. They will then be processed, depending on the type of call, by a TZV call taker, who will then work through a series of questions in order to determine, first and foremost, whether there is a direct life threat. The first thing we want to understand is if somebody is in imminent peril, so they will work through that. They will also work very hard to establish and affirm the location of any case, because it is mission-critical that we understand where our patients are.

Going through that process, they will answer a series of questions. There will be 33 protocols that patient can be allocated to, but there are thousands of determinants in relation to those protocols – for example, there numerous types of chest pain: chest pain with shortness of breath, chest pain, with pain et cetera. They will then be allocated a priority zero, a code 1, a code 2 or a code 3. There are lesser codes related to non-emergency, but they are the priority ambulance calls.

If they are priority zero, an immediate dispatch will obviously occur, and most often that will have multiple resources. It might be an intensive care unit with an advanced life support unit, it may be those alongside fire service et cetera, depending on the nature of the case. Obviously the code 1 responses are largely treated the same as priority zero cases, notwithstanding the response that that case may have may alter; it may not get two responses, it may get a single response. And then we have code 2. Now, code 2 cases remain as emergency ambulance cases, but not with an immediate lights-and-sirens requirement. Code 3 cases almost exclusively go through to our triage services for a further assessment, and that is where they get a clinical assessment by triage practitioner, either a nurse or paramedic in our triage services area. It is important that, right through that process, the coding can change. So a case can start out as a code 1 and then be reduced. Equally, it can be upgraded depending on the information that is provided.

In relation to the call communication centres themselves, call takers do have the ability to refer a particular case to a clinician in our environment in order to assess whether there are some clinical requirements to be further discussed. They can, for example, video conference call in with a patient and the call taker in order for a clinician to intervene. Clinicians equally monitor all cases, as do our communications support paramedics and our duty managers, who are more about resourcing. But they are monitoring cases all the time and they do have the ability to upgrade or downgrade, notwithstanding the propensity is more often to upgrade than downgrade. But they have options to do both in that system.

Through our triage services, they obviously have the opportunity to provide a range of outcomes for a patient. As I said in my opening today, more than 40 per cent of patients are being seen today or receiving a further triage by secondary triage practitioners, with more than 20 per cent of cases today not resulting in an emergency ambulance dispatch.

Michael GALEA: Thank you. I did want to ask more but I am out of time, so thank you very much.

The CHAIR: That was excellent, Mr Galea. Thank you. We will go to me now. Call-out times and the KPIs around those are sitting around 65 per cent at the moment, when the target is 85, 90 per cent. Why are they not being met?

Anthony CARLYON: There is a lot of complexity in community health today. What I would say is the three most significant cases that we receive today are mental health. Mental health cases are now the highest proportion of any cases that we receive. Eleven per cent of cases across the community are related to mental health in the community today. The two second-most frequent cases that we go to are cardiac and shortness of breath cases. These cases traditionally are more complex and difficult to manage, diagnose and access via other mechanisms other than a paramedic responding to them. People in the community are now presenting with multiple comorbidities, so they will not just have one thing wrong with them, they will have multiple issues and complexities. They are often living in communities longer and are elderly and isolated.

What we also find today, specific to type, is it takes far longer for us to manage cases today than it did historically. Some of that is to do with the progression of profession as an organisation in relation to professional standards around how we assess patients. We are travelling further than we ever have before. Just on the basis of community, these are on the peripheries of the city, for example, today. We have longer travel times to hospital because of traffic congestion. We assess patients in far more robust ways than we did five, six, seven or eight years ago. So the pragmatic reality is the case load is significantly increasing. But what I would say in relation to demand is that over the last two years we have reduced significantly, proportionally, the amount of people we are taking to hospital. We have really held response time in the sense that paramedics are referring far more people off to alternatives to emergency transport today.

The CHAIR: Have you had a chance to look through the submissions that are publicly available on the website?

Anthony CARLYON: I have. Hopefully I am not going to be asked to recall every one of them, but yes.

The CHAIR: No, no. I am not asking you that. I am going to quote from a submission here – submission 25 – that cites a 5-hour wait for a patient in a critical condition. Is that acceptable?

Anthony CARLYON: No, it is not. I cannot recall the submission itself. What we would say is we take these examples of any sorts of patient harm not only seriously but we feel true emotion when we are not serving the Victorian community as we need to today. We do have to have a system that prioritises the sickest patients. In general terms, we think we get that right. But the pragmatic reality is there are cases in the community today where, for a range of reasons, we do not get the response that we would like to provide.

The CHAIR: The most recent example that we have seen in the media is about the bloke in Blackburn who did not get to hospital and bled out and died. That is a pretty traumatic experience that anyone involved would obviously feel great sympathy for. That is a pretty damning situation, isn't it?

Anthony CARLYON: It is tragic for that family, it is tragic for that gentleman and it is tragic for our responders who would have gone to that case. It is tragic for everybody involved. We are at a position right today that we cannot speak to the detail of exactly what happened because that obviously will be subject to coronials and will be subject to full reviews that we will do ourselves. But based on the circumstances that we have been presented with and we are aware of, it is a tragic circumstance, and we should have done, and ideally we would do, better in these circumstances.

The CHAIR: What support do you provide for the first responders around that situation? Obviously they are traumatised because they could not get there; it is an awful situation. What supports are provided to them?

Anthony CARLYON: We have a very robust counselling service at Ambulance Victoria. We have not only peer support – so those paramedics absolutely would have received a call from a peer support officer, so that is a paramedic or somebody that is also a responder and understands how we deliver our services. In addition to that we have our in-field team managers and senior managers that would respond and go and see those people and make sure they are okay, follow-ups the next day et cetera, offerings of psychological support and counselling through our psychological services. I think our Victorian Ambulance Clinician's unit is recognised as one of the best going around, and we would have given them every support, notwithstanding these things do hit people hard; they do hit people hard.

The CHAIR: Sorry, my time has gone up too by the way – apologies. I will hand over to Ms Payne now. Are you ready to go?

Rachel PAYNE: Thank you, Chair. Thank you both for presenting before us today. I just want to go back to what Mr Galea was talking around dispatch, and what we are hearing from some of the workforce is that there is not really that capacity to be able to override – that if something is classified as a certain higher-end code, it may actually be something that could be overridden at lower level. But in your presentation you mentioned that there is that capacity to elevate or to also downgrade if need be. Can you please just talk us through some of those instances where the system is fit for purpose? You sort of mentioned working with the workforce on improvements: what are you hearing from your team?

Anthony CARLYON: I think we would be completely open that there is a level of frustration from our paramedic responders in the community. We acknowledge their experience, and we all have reference points ourselves in relation to responding to cases that did not turn out to be what we thought they would be. I spoke about the inherent risk and the types of cases that we are seeing today; they are quite often very hard to distinguish between how sick a patient is at a point in time. We do err on the side of caution. The call-taking and dispatch system today has strengths and weaknesses; I think we accept that from the system, and we are committed to work through those. There are obviously the very extreme cases that appear in the media. They happen from time to time, and I get why people focus on those, and equally there are many cases that, when we arrive, are of less acuity than others may be, but I think we have to be fair in relation to the actual data. That caseload is in the vicinity of 90,000 cases per month, so overwhelmingly people do need ambulances today; despite that fact, there is a difference between compliance in a call-taking sense, for example, versus comparing that to what happens when you arrive. TZV's call-takes today are about 98 per cent compliant relative to that system.

I would also highlight our transport rates today by code: 74 per cent of code 1 patients are transported to hospital, 71 per cent of code 2s are transported to hospital, and 64 per cent of code 3s are transported to hospital; 66 per cent of those patients are either admitted or receive care and treatment in a short-stay unit. So, in short, they are categorised as category 2 or category 3 in the hospital system – in short, they are very sick. Now, the question comes: if you receive treatment and you are well in the community and it does not get to that point, could you be treated in a different way et cetera? I think they are a reasonable questions and questions for us to have, but I also say that what we what we are doing very strongly today is we accept we have more code 1s than we would like, but we equally remove far more lower acuity cases from dispatch and manage them in our triage service than any other jurisdiction anywhere. We have a range of other demand management strategies. Are we where we need to be in relation to code 1 response time today? No, we are not; we accept that. They are the targets we have, and we work to them. I would also say they are not the only measure of an efficient and effective ambulance service, but we fully accept they are our targets, and we fully accept the community does accept that they are our targets.

Rachel PAYNE: The way that we do dispatch in Victoria – is it the same across other states or is there disparity between each of the states?

Anthony CARLYON: The main difference is TZV, who were created just over 12 months ago or 18 months ago as the statutory authority for call-taking and dispatch for all emergency services. Other jurisdictions do have the call-taking and dispatch that sit within their services themselves, and they are connected in a different way, but call-takers – dispatchers – undertake the exact same training in New South Wales, Queensland and other jurisdictions. The only exception in Australia is Canberra. All services in Australia essentially use the same system, and they use that ProQA system today. There is no difference with that. If you look at the results, for want of a better term, the larger jurisdictions have higher volumes of code 1 over the last few years than we have had, notwithstanding we had a very large peak coming out of the COVID period of time. That has stabilised but has remained very high.

Rachel PAYNE: Thank you – and thank you for all the work that you do.

Anthony CARLYON: Thank you.

The CHAIR: Thank you. I will now hand it over to Mr McIntosh.

Tom McINTOSH: Thanks for being here. Ms McManamny, I am going to come to you because I notice there is a lot in here about culture in the work you do, and section 5 of the terms of reference talks about culture. I want to flip it on its head a bit, because I had a personal experience where I had to call a paramedic for

a family member about 18 months ago, and I was blown away by the kindness and the care of the paramedics. My uncle two weeks ago had a really serious stroke. I spoke to him days afterwards, and he is fine, but he can remember the paramedics' names, and he spoke about them like family instantly and just talked about the care.

You will not remember all the regions we are in, but I am Eastern Victoria, and I have been fortunate to open a number of ambulance stations in the last couple of years and have met the auxiliary teams who have set up these branches from within the communities, who fundraised, built the original branches and now are getting more professionalised, more fit-for-purpose branches which the state is funding. It just strikes me how it has grown out of community in our regional and rural areas, and to me I think that is a real acknowledgement of what the community experience when they are supported by paramedics, because otherwise community would not open up and support that. I just wonder if you can talk a bit about the culture. It is an incredibly important but obviously a stressful job, but what the community experience and how that culture has been built and maintained – you just hear so often the experience of Victorians is incredible when dealing with paramedics and other staff, and of course the fact that we have got ambulance community officers volunteering to come in and be in those roles speaks to the culture there that people want to be a part of.

Tegwyn McMANAMNY: Thank you for your question. It is a great question, and I love your observations. We are so proud of the work that we do, and I am so proud of the work that I do as a paramedic as well. I still undertake operational on-road shifts, and I am so grateful for the work that we are able to do. I think that it is great to hear about your wonderful experiences, and I think one of the things that really brings this home to me is that 97.4 per cent of Victorians rate our care as being exceptional and having really positive experiences, so I am really buoyed by that. In rural and regional areas our auxiliaries are the linchpin of a lot of our ambulance branches, and I think there are some fantastic examples – we have recently had the Yarrawonga ambulance auxiliary pitch in to buy some really critical training equipment that is quite specialised for staff: paediatric mannequins and a birthing mannequin.

Tom McINTOSH: Same in Yarram too. I have been there.

Tegwyn McMANAMNY: It is amazing. Some specialised IV arms – they really provide this additional support, listening to our paramedics and what their additional needs are, which is absolutely fantastic. Certainly you spoke to our ambulance community officers, and we also have community emergency response teams in some areas of Victoria as well who are community members themselves, and they will often have a day job and then also work providing care in their local communities, and we really rely on the fantastic care and support that our ambulance community officers and our CERT teams provide. It is absolutely critical. Does that answer your question adequately? Would you like a little bit more clarification on that?

Tom McINTOSH: Could you just go into that stat, the 97 per cent satisfaction? It does not surprise me, but I think that is incredible. It speaks well, so if you want to expand on that, please feel free.

Tegwyn McMANAMNY: We undertake the Victorian health experience survey every year, as every other health service in Victoria does, and we have the Council of Ambulance Authorities survey that we do every year as well. We can compare ourselves to our health service partners, but it is probably best to compare ourselves to our other ambulance partners within Australia, New Zealand and Papua New Guinea. The CAA one, I will have to take on notice, but it is very similar numbers. Our communities have really, really high, fabulous experiences with our paramedics, and I think it is because –

The CHAIR: Sorry. Sadly, that is time up, I am afraid.

Tegwyn McMANAMNY: Thank you, Joe.

The CHAIR: I will pass on now to Dr Heath.

Renee HEATH: Thank you very much for coming in. I take on board what you said, Anthony, about how some specific cases get in the media and there is a bit of a flurry around that, so I am going to specifically talk about three that I know of that have not been in the media. One is submission 149. It notes that a MICA paramedic had been dispatched for a severe eye injury when it ended up being somebody with mascara in their eye. And now we will talk about two in my region: one, two weekends ago, where an 18-year-old was severely bashed, unconscious, with a broken eye socket – some pretty serious things happening. He waited 2 hours for an ambulance. His mum and dad then had to come and find where he was and take him to the hospital. One

more example that I will bring up is of a young girl in Sale who called up an ambulance and was told that she had period pain and to take Panadol and maybe Panadol and Nurofen. Her husband got more and more anxious about it, called the ambulance again – same advice. He called again two days later and a non-emergency ambulance was sent from Morwell. Once they got there, they straightaway sent a MICA paramedic because this girl was about to die of a severe infection. Now, I bring those up because they are not widely spoken about, but it raises a serious question that the coding and triage system is obviously failing in some senses. Who is responsible for that and what is being done about it?

Anthony CARLYON: I will start. They are obviously terrible stories, Dr Heath.

Renee HEATH: That is all right. We can move past that because it is not about individuals, it is about a system here.

Anthony CARLYON: Well, from a system perspective, TZV have been established in law to undertake call-taking and dispatch on behalf of all of the emergency services, and that includes Ambulance Victoria. We obviously overlay a dispatch grid or clinical response model over the top of that, and the system is generally significantly risk averse. Those examples are clearly cases where we would undertake a Full root cause analysis, provided we have the detail around those cases. And what we do is we meet every single morning to review the work and the cases that we have seen or have come across in previous days. Tegwyn's team engage with TZV every single month in relation to undertaking quality audits – so both quality and quantitative orders in relation to performance. Wherever we find anything systemic or any particular case that we have not done properly – if we had information on those cases, we would have made contact with those patients and callers immediately because they would concern us immensely. We would look to engage with TZV in relation to 'Have they missed something? Has it been coded incorrectly?' et cetera and look to improve that as a process.

I can only go to the point that today this particular process is in place in 4000 communication centres around the world. If we thought there was a very obvious alternative that was evidence based and safe that we could implement, we would advocate for moves to those processes; we do not believe they exist today. So we can only say it does not always get it right – and those stories obviously impact us considerably – but we will look to continuously improve the system because we want our paramedics to go to the cases they need to go to best.

Renee HEATH: Yes. Thank you. We have heard a lot of evidence that – and I take on board that people are very thankful, including myself – the culture is not perfect. In fact we have heard some pretty terrible, terrible evidence. I want to know in terms of triage – and we want to support people to get a diagnosis right. Eighty per cent of a diagnosis is from a history. Is the problem that they are not trained? Is the problem a poor work culture? Or is it that they are understaffed and do not have the time to do their job efficiently?

The CHAIR: Your time is up, Dr Heath. But I will give you 20 seconds if you want to respond.

Anthony CARLYON: Are you talking about the call takers?

Renee HEATH: Yes.

Anthony CARLYON: Dr Heath, the issue you have is that everything is about supply and demand in the end, and it is about having your demand ready to meet your supply at any point in time. If you, for example, had clinical people triaging out the front of the case, what would happen in fact is you would have large bottlenecks of people in the community waiting. And if you look at a call today, a call from a call taker in TZV – 3½ minutes that takes – a clinical triage takes a minimum of 15 minutes. So if you just extrapolate the 90,000 cases that are coming in per month –

Renee HEATH: So understaffing.

Anthony CARLYON: the pragmatic reality is what would result as a consequence of that is large proportions of people waiting in the community. And one of our real clear focuses is, we know if you just move cases around and say, 'You can be a code 2 versus a code 1,' they still end up in the ambulance ecosystem and require an ambulance response. Whereas if we take those cases at the end of the case, we are actually able to remove them in entirety. I get your point in relation to there being strengths and weaknesses in relation to the process. We believe the way we are doing it today is the safest, most effective way to do it, but we are really open to greater and further engagement in that call-taking process in the future.

Renee HEATH: I appreciate it. Thank you.

The CHAIR: Thank you. We are going to have to move on. Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thank you, Chair. Thank you both for your presentation this morning. I want to ask – you have already spoken about the increase in demand for your services. During the time of peak demand if someone is calling an ambulance because they have got a serious condition – for example, our son had an anaphylaxis episode, and we called the ambulance. We were told, 'We can't definitively tell you how long it will take.' We administered EpiPen. I asked for advice: should we just get in the car? Obviously you are in a very panicked and anxious state. I was told, 'We cannot advise you whether you just do that or you wait for the ambulance.' Now, if the caller or the dispatcher knows that the ambulance is going to be more than an hour, what current measures are there to ensure that dispatchers can advise community members to make that decision? I know you mentioned that you are being risk-averse, but the balance of that I imagine would be quite difficult to make. But that also saves community members from waiting for an hour for an ambulance that may or may not come or be delayed.

Anthony CARLYON: Thanks for your question. I do appreciate one of the most anxious periods that you can have is after you have called 000, and that period in between an ambulance arriving is very difficult for members of the community. What I would say is lower acuity cases today, those that are not priority 0 or 1, are given a timeframe. And this timeframe could be 30 to 60 minutes. So we do give timeframes as part of that process for cases that are not immediate emergency lights and sirens. We do not give timeframes for emergency lights and sirens, and I know that might seem counterintuitive, because whatever is the closest ambulance at that point in time will be redispatched to move to those cases.

I do really appreciate the challenge that comes with the community in relation to the 'Should I stay or should I go' process. For us some of the complexity, if you just think about this clinically – if someone is having chest pains, standing up to walk out to a vehicle is going to potentially result in a cardiac arrest. So we do need to look at those circumstances based on what we are presented with at the time, but we do appreciate the conundrum that callers to 000 do face at that point in time.

Interestingly, one of the pieces of work that does sit in our SOP moving forward that we have promoted and we think is a very good thing is we are going to publish our wait times in the future. We are advancing to publish our wait times in the future, because we think that may, as a parent, allow you very early in the piece to make some decisions around that. We are very keen to get far more transparency and information to consumers and callers and patients so that they can make some of these decisions, as well as manage demand in a way that removes as many cases as possible from a dispatch so that you are not waiting when your child has anaphylaxis.

Anasina GRAY-BARBERIO: Great. Thank you. You said in your presentation that one of the highest reasons people are calling is because they are facing mental health challenges. What kind of extra training for paramedics is offered for professional development to deal with these usually complex cases as well? We heard from the police last hearing that mental health call-outs should not be dealt with from a police perspective – it should be a health response. What do you say to that?

Tegwyn McMANAMNY: Do you mind if I start with that?

Anthony CARLYON: Yes, you start.

The CHAIR: I will just say quickly your time is up, but I am happy for you to go to the question for 30 seconds or whatever you can provide.

Anasina GRAY-BARBERIO: Thank you.

Tegwyn McMANAMNY: Sure. You are spot on: 11 per cent of our overall call-outs now are to patients experiencing ill mental health in the community. We have been working really hard following the mental health royal commission with some of the work related to mental health reform. All paramedics have got fantastic training in mental health and how to look after and care for mental health patients in the community, including through de-escalation if there are troubles. I think we need to be very, very careful in making sure that we do not always link mental health with a police response; it must be a health-led response. I think it actually can be

very damaging for patients with ill mental health to always be linked to requiring police. It should not be like that. We work closely with police when required, but generally we require their support for patients who are experiencing either a very severe mental health crisis, right at the tip, or more commonly, severe drug and alcohol intoxication. That is where our problems really lie. There is more to do. We absolutely have to do more. We are working on this. It is a really significant issue for Victoria and for Australia in general.

Anasina GRAY-BARBERIO: Thank you.

The CHAIR: Thanks very much. I will hand over now to Ms Crozier.

Georgie CROZIER: Thank you very much for appearing before the committee and for your evidence. Mr Carlyon, you spoke about the right care at the right place, and today there is obviously a very concerning story around the bungle between AV and police and the communications on that. It is another tragedy that has occurred, and we keep seeing these tragedies occurring week after week. There is something going wrong. There are systemic issues. You talked about the triage and the clinical oversight. Are there gaps in the system, especially in regional Victoria, around that clinical oversight?

Anthony CARLYON: I think we have challenges in relation to the tyranny of distance and geography in rural Victoria. The reality of the situation is that our ability to get resources to somebody in rural Victoria is often and sometimes more complex than it is in more urbanised environments. One of the strengths, I think, that we are looking at today is that 7 per cent of all 000 callers today will get a welfare check from our triage service paramedics. That is not happening in any jurisdiction. So if people are delayed in the community –

Georgie CROZIER: Where are the gaps, I am asking. Where are those specific gaps? Do we need some form of digitalised communication system that has not been rolled out in AV yet?

Anthony CARLYON: It is a really good point. The emergency management operational communications program, which is aiming to provide digitalisation across our rural workforce, is the first piece before we provide mobile data to our rural paramedics in Victoria. Digital radio is now in place in Barwon South West and is rolling out across the Grampians region at the moment. The technology takes time because it is following the building of towers as they go across the state, so it will roll out around the state –

Georgie CROZIER: Are other emergency services using that digitalised communication?

Anthony CARLYON: Some services already have digitalisation. We are not ready –

Georgie CROZIER: That is right. Other services have, but AV has not. That is a real problem.

Anthony CARLYON: Technology and digitalisation of health care is absolutely where all parties involved in health need to focus in the future. Thankfully, what I would advise the committee is that we are now very close to progressing with mobile data for rural Victoria. It will be an absolute game changer for people in rural Victoria.

Georgie CROZIER: But it should have been there by now, shouldn't it, really?

Anthony CARLYON: In an ideal world we would have the same platform in rural Victoria that we have –

Georgie CROZIER: Have the police and fire services got it?

Anthony CARLYON: Ideally, we would have it across the state –

Georgie CROZIER: Have the police and fire services got it?

Anthony CARLYON: The police have it. I am not 100 per cent sure about fire. I would have to take that one on notice.

Georgie CROZIER: Okay. On another matter, when were you first made aware of the funeral that occurred with the breaches through COVID – that paramedic funeral?

Anthony CARLYON: I had no awareness at the time at all. I had no awareness of the investigation. My clear awareness of that actually happened when it hit the paper. I knew that there was an investigation –

Georgie CROZIER: What, just recently?

Anthony CARLYON: Recently. At the time, I had some awareness that there was an investigation in relation to COVID, but I did not have any detail about that. The guard of honour issue – yes, I only became aware at that point of time. My only part in that process today is as the acting CEO. A couple of months ago, when it was very prominent in the media, I spoke to our workforce at length.

Georgie CROZIER: So you have seen the report?

Anthony CARLYON: No, I have not seen the report.

Georgie CROZIER: Who has got the report?

Anthony CARLYON: It is not sitting with me. That is probably a question best asked of our professional standards team. I have not seen the report, no.

Georgie CROZIER: The CEO would have it, though, surely.

Anthony CARLYON: I cannot confirm who does not have it today, but obviously others that present today will have the opportunity to answer that question.

Georgie CROZIER: Okay. Thank you. I want to just go back to the point around non-emergency patient transport and the support that they provide in regional areas. Can you just –

The CHAIR: Your time is up, but I will give him 30 seconds to respond.

Georgie CROZIER: Can you just quickly respond to the value of that service to support AV?

Anthony CARLYON: They are mission-critical.

Georgie CROZIER: Thank you.

Anthony CARLYON: Mission-critical, non-emergency. Delivering care to the Victorian community takes Every one across the whole system, and non-emergency are a very important part of that.

Georgie CROZIER: Thank you.

The CHAIR: Mr Batchelor.

Ryan BATCHELOR: Thanks, Chair. I just want to clarify: on the demand question, you said that now you are receiving 90,000 calls per month. Is that right?

Anthony CARLYON: Correct.

Ryan BATCHELOR: And you said 50 per cent higher than some?

Anthony CARLYON: Than 2018–19.

Ryan BATCHELOR: So at the moment we are on a monthly basis 50 per cent higher than we were five years ago.

Anthony CARLYON: That is correct.

Ryan BATCHELOR: Right. That is a lot. To unpack a little bit more about the highest categories of case presentations, I suppose, or cases you are dealing with, mental health was the highest, but also there are intoxication issues. Can you just unpack that a little bit more for me?

Anthony CARLYON: The three largest case loads – today it is now mental health. Eleven per cent of all ambulance demand is mental health today, so it is a substantial number. If you do the math, every 8 seconds we are responding to somebody in the community suffering from a mental health condition. The next two categories are respiratory cases and cardiac cases, and they obviously then align with a whole range of comorbidities and ageing in the community. So they are the three main ones. There is then more of a distinction

in relation to other case loads generally classified as 'illness' or 'sick person', and we manage the vast majority of those in a different setting.

Ryan BATCHELOR: Given the mental health cases are now the highest, at 11 per cent, do you know how long it takes to respond to each of those cases on average compared to a respiratory or a cardiac case? I am trying to understand whether not only the type of condition you are responding to has changed, but has that change then changed the amount of time that it takes to respond to each call?

Anthony CARLYON: We do 90,000 mental health cases per annum. Seventy-five per cent of them we do in isolation, just Ambulance Victoria. So they are health-led responses that paramedics respond to. Fifteen thousand cases are often dual-responded with Victoria Police, and those cases can take longer depending on the circumstances of who arrives first to those cases. I cannot tell you whether those cases take longer, but they can do. We also, for example, have TelePROMPT within our triage services, so we do look to see whether we can manage those mental health conditions via our telephone triage rather than taking these people off to hospital. They can take longer in general terms, those three case types we are talking about. They do take longer to assess and make decisions around care, but we would have to do the data.

Ryan BATCHELOR: Sure. The other thing I just wanted to go to is this technology question – you sort of touched on it a little bit with Ms Crozier. Technology is changing the way that the ambulance system works. What have been the biggest changes in the last few years in terms of technological adaptation in the service?

Anthony CARLYON: I think that number one – and I hope our paramedics would say the same – is the advent of now having personal issue iPads. Our hardware, for want of a better term, was ageing. The fact that our paramedics now have a personal issue iPad in their hand.

Ryan BATCHELOR: And what has that allowed them to do today they could not do before?

Anthony CARLYON: It is substantial. Not only is it quicker – it allows us to ingest the data quicker – but we had a fantastic story out of Mansfield recently where one of our paramedics went and provided an education. They actually brought up a patient suffering from croupe and allowed the patient or their family to listen to croupe, as an example. So there is an ability to provide some education through that technology. It is just a far better process today. The next one, no doubt, is the rollout of digital radio into rural Victoria, and as I said, the most significant improvement that we will get in the future is mobile data network access to our paramedics in rural Victoria. They will be able to see all the same scene safety and information. They will be able to download information, so they will reduce radio traffic, which I think is a very important factor in how we deliver a service.

Ryan BATCHELOR: Why?

Anthony CARLYON: Well, radio traffic is time-consuming, and that distracts you from being able to do other things. If you look at the growth – and we plan to bring about another 55 staff into our communication centres between Duty Managers, Communications Support, Paramedics and Clinicians over the course of the next two years – that just frees them up to be able to assess and do things in a different way than they do today. So it will improve paramedic safety in rural Victoria once we get that in place, and it will make their ability to communicate far easier.

Ryan BATCHELOR: Thanks, Chair.

The CHAIR: Thank you. We have still got 10 minutes more of questions or thereabouts, so we are just going to go back and forth. If anyone wants to jump in with a question, just let me know and we will go from there.

I want to talk about submission 74. This comes from a paramedic. They say:

> As a paramedic working for AV for over 10 years, I do not feel safe, supported or valued by management or the organisation. Once logged on at work, we simply become a number and must follow orders. If we question an order or voice a concern (normally regarding safety, fatigue, meals) we are, in no polite manner, told to just do it and stop complaining.

That is pretty bad.

Anthony CARLYON: That is not a reflection that sits comfortably with me at all, Chair, and I reflect on that with sadness. That is not the environment that we want to have at Ambulance Victoria, and it is certainly not the way we aim to carry ourselves as an organisation. We have done considerable work practically in relation to how we support our paramedics in the field. In particular recruitment is a large factor. We had significant gaps in relation to people being appointed into management positions, particularly frontline managers. We have essentially addressed that now, and the vast majority of positions in Ambulance Victoria are filled. We have also delivered upstander training and leadership development training for the vast majority of managers in our organisation. It is really about leadership, it is not about KPIs. This is not about anything other than really supporting our people to do the best job that they possibly can. We have also recently just delivered and got approval from our board for a people plan. We want to practically improve the experience of our workforce. Our people plan picks up the four main components of health, safety and welfare risks that we have in Ambulance Victoria. They are fatigue; psychosocial support, which I think goes to your question there around if somebody does not feel supported to do their work in the workplace – they cannot bring their best to work; manual handling; and occupational violence, which is the fourth part of it. We are also strengthening through both the enterprise agreement and our 'work first' policy procedures the ability for our people to get their meal breaks and –

The CHAIR: I do understand that. When you look at this inquiry, we have had a number of submissions that are either 'name withheld' or 'confidential' – there is a reason for that. People are feeling unsafe to come forward. That is clearly a reflection on the culture at AV. Surely you have got to say there are some improvements to be made.

Anthony CARLYON: Agree.

Tegwyn McMANAMNY: Hundred per cent.

Anthony CARLYON: Yes, we agree. The way we often say it is: the way in which we deliver clinical services in this state is something we should and all Victorians should be very proud of. We would like to replicate that level of expertise and outcome to leadership to our organisation and supporting our people.

The CHAIR: I will hand over to Mr Galea.

Michael GALEA: Thank you, Chair. Thank you again, both. Earlier we were discussing the technicalities of the dispatch process. You touched on, obviously, one of the most important things, finding out where people are. Obviously, some people are going to have an easier time of communicating that than others based on circumstance, language barrier, whatever else might be going on at the time. If there is an issue with identifying from what the person is telling you, do the systems that you have – probably more TZV have – in place allow for any geotracking of mobile phone locations? Are there any other supports you can use to determine location beyond what the person on the phone is able to tell you?

Anthony CARLYON: Yes. There are two parts to accessibility. Obviously some of them communicate with TZV via a phone or text services, so there is the ability with people that have communications issues, for example, who use text. There is also a framework called what3words, which basically allows a geospatial reference in relation to longitude and latitude to pinpoint exactly where we are communicating to. There are also for our responders things like location management systems for ambulances themselves. It is not a perfect science, but generally we can pinpoint a reasonable proximity to where a patient is. There are challenges. There can be challenges in rural Victoria in relation to properties with 3000 and 4000 numbers. But generally there is an ability with geospatial longitude and latitude to find a patient.

Michael GALEA: Excellent. That is good, and it is also interesting that What3words can be used as well. So if someone says What3words words to you, they can then –

Anthony CARLYON: Correct.

Michael GALEA: That is very good to know. In terms of the video-assisted triage, I understand that that is an emerging technology that you are using. At what point in the process would you be applying that? What sort of circumstances is it beneficial or not beneficial to be used in, and where you do use it what sorts of different outcomes are you seeing?

Anthony CARLYON: There are certain cases in which we would not use it. Exclusion criteria, off the top of my head: unreliable patients – there are certainly certain mental health conditions. I guess I would start at the start. First is that we have to get agreement from a caller in relation to accessing the video triage, for a range of privacy reasons and things, and some of our paramedics may not 100 per cent be comfortable using that technology. We are up at around 20 per cent I think usage at the moment; between 16 and 20 per cent of cases can access video-assisted triage. And we are finding diversion rates are greater via those cohorts than other mechanisms. And the real example is: we all know when you cut yourself it sometimes can feel far worse than it actually is. The ability of our triage practitioners to actually see a laceration, for example, today is really a game changer in relation to not only providing advice around 'Lift your arm up' and bandaging et cetera but giving people assurance that they are injured but it is not as difficult to treat as it may be.

Michael GALEA: Thank you.

The CHAIR: I will hand over to Ms Crozier.

Georgie CROZIER: Thank you, Chair. Thank you again. During your evidence you spoke about data and the critical element that provides in being able to respond appropriately. And we have heard reports again from the Northern Hospital about the manipulation of data being undertaken in that emergency department from the offloading of patients from trolleys into the emergency department. We know that the ramping of ambulances is rife right across the state, right across the system, so that data is compromised when it is being manipulated. What is your view around the veracity of the data and the auditing process?

Anthony CARLYON: Thank you for the question. Data is critical, obviously. Having reliable, effective data allows us to assess both the care and how long it takes us to do things –

Georgie CROZIER: And resourcing.

Anthony CARLYON: and resourcing, and to make decisions around our resourcing. Our paramedics obviously correct and input data themselves. Our expectations are set very, very clearly with our workforce in relation to the importance of data. They are people of science, so they do see data as important. We trust our paramedics to input data when it should be inputted. At the moment there are two data sources across the state.

Georgie CROZIER: So that is a problem, isn't it?

Anthony CARLYON: I think ideally bringing those data sources together in the future so that we have one point or source of truth will be the position that we need to get to.

Georgie CROZIER: Can you just provide the committee a little bit more explanation around those two data sources?

Anthony CARLYON: Well, there is the Victorian emergency management dataset, which is essentially data that is captured within the hospital environment. We do have access to some of it via different means, generally retrospectively as part of audit et cetera. But we also have our own data, which is largely driven either out of the computer-aided dispatch system that sits within TZV – data gets ingested and extracted from there – but also our tablets that we spoke about before, the VACIS system, and that is where our paramedics actually input data into the system itself. Now, obviously there is then a process that looks to reconcile those two data points to get to the point where the correct point of truth is today.

Georgie CROZIER: Are you worried about that –

The CHAIR: Sorry; I know Ms Gray-Barberio has got one last question before we finish.

Anasina GRAY-BARBERIO: Thank you, Chair. I just want to ask you – I did not get a chance to ask before: when will you be actually publishing that waitlist data that you answered about to my question before?

Anthony CARLYON: We are about to have our technical people come in. I might leave it for them to answer. We are well advanced in relation to the preparation, but our digital people will come in – our executive director of business technology and programs, who is also our CIO – and probably be able to provide you a better answer than I can give you today.

Anasina GRAY-BARBERIO: Okay, great. Thanks.

The CHAIR: That brings a close to this session. Once again, thanks very much for coming in and giving evidence. We appreciate it. You will get the transcript at the end to have a look through and proof if you need to.

Witnesses withdrew.

WITNESSES

Gavin Gusling, Chief Information Officer, Business Technology and Programs,

Shannon Elston, Director, Data and Solutions, and

Daniel Howarth, Director, ICT Technical Services and Cybersecurity, Ambulance Victoria.

The CHAIR: Welcome back for the next session of the Legal and Social Issues Committee's Inquiry into Ambulance Victoria. I am Joe McCracken. I am the Chair of the inquiry. We will go around and introduce the rest of our committee members.

Michael GALEA: Good morning. Michael Galea, Member for South-Eastern Metropolitan Region.

Ryan BATCHELOR: Ryan Batchelor, Member for the Southern Metropolitan Region.

Tom McINTOSH: Tom McIntosh, Eastern Victoria Region.

Anasina GRAY-BARBERIO: Anasina Gray-Barberio, Northern Metropolitan.

Georgie CROZIER: Georgie Crozier, Southern Metropolitan Region and Shadow Minister for Health and ambulance services.

Renee HEATH: Renee Heath, Eastern Victoria Region.

Rachel PAYNE: And I am Rachel Payne from the South-Eastern Metropolitan Region.

The CHAIR: Perfect. Thanks so much. I am just going to read this out so you know your rights in this inquiry.

All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information that you provide during the hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go elsewhere and repeat the same things those comments may not be protected by the same privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded and you will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and put on the committee's website. For Hansard, can you just please state your full name and the organisation you are appearing on behalf of.

Daniel HOWARTH: Daniel Howarth, Ambulance Victoria.

Shannon ELSTON: Shannon Elston, Ambulance Victoria.

Gavin GUSLING: Gavin Gusling, Ambulance Victoria.

The CHAIR: Perfect. Thanks very much. I will give you guys 5 minutes to make an opening, and then we will go to questions, okay? Perfect.

Gavin GUSLING: Thank you, Chair. I would like to acknowledge all those that have come before us to make Australia what it is today – from all races, creeds, countries, religions, mobs and any other association that they may have. I would also like to acknowledge the members of the Legal and Social Issues Committee. Thank you for the opportunity to speak here today. I also recognise that the inquiry provides an opportunity for the community and members of AV, past and present, to discuss their experiences and what they believe to be opportunities and challenges for AV.

I am Gavin Gusling, the Chief Information Officer at Ambulance Victoria. Joining me here today is Shannon Elston, Director of Data and Solutions, and Daniel Howarth, Director of Technical Services and Cybersecurity. We are directors within the business technology and programs division at Ambulance Victoria.

As the executive responsible for technology and programs I am responsible for ICT strategy, digital technology, innovation, security and policy setting. My division develops systems architecture, major system changes as well as the introduction and integration of new systems, master data management and data governance. We are also responsible for data-sharing agreements and ongoing maintenance of applications in infrastructure and hardware, including real-time support for IT end users.

Shannon Elston is the director responsible for data and solutions within Ambulance Victoria. Shannon's team provides intelligent decision support to help improve Ambulance Victoria's operational and corporate services. Ultimately that provides better patient outcomes as well as managing and supporting our application landscape.

Daniel Howarth is the director responsible for technology services and cybersecurity. He ensures reliable connectivity and robust technology and enables the AV workforce to deliver best care whilst keeping our information protected from cyber incidents. Daniel's team of technical experts are focused on keeping our systems, networks and telecommunications secure and accessible and available anywhere.

Again, thank you for the time to meet today. We are now happy to take any questions relating to Ambulance Victoria's technology and programs.

The CHAIR: Thank you very much. You have beaten the clock, so well done. I will start off with questions, and then we will just go back and forth from there. Let me just get myself organised. The elephant in the room is the data breach in March this year. What happened?

Gavin GUSLING: We had a situation where an individual made some poor choices. We are on a continuing path to improve our cybersecurity stance as we constantly improve to defend against those who would do malicious damage both within the organisation and outside the organisation. What that means is that an individual made some poor choices as they were leaving the organisation.

The CHAIR: Who is ultimately responsible for protecting against data breaches at AV? Is it you or is it –

Gavin GUSLING: Ultimately it is me. But I want to be clear here: the particular individual had access to the information as part of their role in the organisation. I used the term earlier: they made some poor choices, because they gathered that information and then emailed it to themselves prior to then leaving the organisation. We detected that as part of a solution called data loss protection, or DLP. At the time we had only just implemented it. It was still at pilot stage. We detected that particular information leaving the organisation, and then there were a number of events that happened that raised it as a flag. The time the email was sent, the fact that they had resigned from the organisation and the size and volume of the information all raised a flag, which our cybersecurity response team then responded to.

The CHAIR: Sure. Okay. I appreciate that. Mr Howarth, I have got a question for you. Cost reductions in the organisation – have you been offered any incentives to reduce costs, such as with the Microsoft licensing that happened recently?

Daniel HOWARTH: Sorry, any –

The CHAIR: Incentives, you know –

Daniel HOWARTH: Personally?

The CHAIR: As part of your work.

Daniel HOWARTH: I have received no personal incentives.

The CHAIR: Like KPIs as part of your performance.

Daniel HOWARTH: No, I do not believe so. We have I think had great success as part of the negotiations around Microsoft licensing agreements just recently. On 1 June we signed a new three-year renewal for the Microsoft agreement with the health sector. We have had some really good support from HealthShare Victoria and the Department of Health. It is a whole-of-health agreement, and AV actively participates in that agreement.

The CHAIR: How much was saved?

Daniel HOWARTH: We got a number of discounts and licensing exemptions from Microsoft that supported us to be able to uplift our licensing and improve our security posture, ultimately.

The CHAIR: Have you been able to identify any other inefficiencies or cost savings in your particular area that might be of benefit?

Daniel HOWARTH: We are constantly looking to make sure we are getting value for money out of our spend and out of our budgets. There are always opportunities to improve what we do, and I think this Microsoft one is just one of many examples.

The CHAIR: Okay.

Daniel HOWARTH: Maybe another important example – so it was not us negotiating this directly – is not too long ago the whole-of-government VTS contract for telecommunications was implemented. This gave us further cost savings that we were able to reinvest and improve our services.

The CHAIR: We have had a lot of submissions that say that resources are not properly allocated in AV. Would that be an opinion that you would support or not?

Daniel HOWARTH: I do not know if it is my place to give opinions on these things, but –

The CHAIR: In your particular role, though, in a technical sort of environment, obviously, given that there has been such a big data breach, do you think more resources should have been put towards that or not?

Daniel HOWARTH: I would like to say I think we get incredible support from our executive and our board around cybersecurity. AV has been implementing a cybersecurity program now for a number of years that has had funding to support that. As a result of that funding and those uplifts, I think we have got a number of metrics and recognitions from various parties, including VMIA and vendors like Microsoft, and we are somewhat at the forefront in cybersecurity.

The CHAIR: My time is up, sorry. I will hand over to Mr Galea.

Michael GALEA: Good morning. Thank you for joining us. Mr Gusling, you mentioned that your systems flagged the data breach quite quickly, so would it be fair to say that the resources that you have did capture that pretty much immediately?

Gavin GUSLING: Because of the nature of the way that the data-loss protection system works, there are a number of events that have to occur before it flags as suspicious. As I did mention earlier, the system at the time was in pilot implementation, so we had only really just switched it on. It did take us seven days before we stood up what we call the cyber breach process. Because of the combination of those events that had to take place, as well as the fact this was the very first time that we had ever actually exercised it, whilst we had a draft process in place, we had not even exercised that particular process. So this was a real, live example of something that happened, and we responded accordingly.

Michael GALEA: So that was not a pilot process. Is it still in pilot, or is it now fully operational?

Gavin GUSLING: It is fully operational now.

Michael GALEA: Great. You never want to have the experience, but that experience obviously informs your capacity and ability to respond.

Gavin GUSLING: Absolutely. And I believe that should an event occur again, we would respond quicker based on the fact that we have got a path that we can now walk well on.

Michael GALEA: We have spoken – this might be for you, Mr Howarth, as well – about technology and the systems. You mentioned the Microsoft arrangement as well. In the previous session we were speaking about iPads being rolled out to paramedics infield to support them in their work. What sorts of technologies are

you focusing on, whether they are physical or software-based technologies, to make the work of paramedics easier and, most importantly, more effective?

Gavin GUSLING: I think that the iPad is a very good example of a tool that we put in place that is designed to be able to not only make their life easier but make information accessible to the entire workforce. It allows us to connect the workforce back into the corporate organisation better, and as you heard earlier today, it allows the workforce to connect patients to the right care at the right time. That includes things like VVED and even as far as providing infield support for, as you heard my associate Anthony mention this morning, the family that listened to the croup video. Those are the things that we can now provide. That project is now finished and rolled out to all of our operational staff. We are doing the next phase, which will introduce the iPads to our volunteer workforce, the ambulance community officers and the community emergency response teams. At the same time, in parallel, we are now looking at how we can leverage that technology and get things like infield clinical support available. Today, if a clinician is infield, they would use a regular telephone and call back to one of the centre offices and receive clinical support if they felt they needed it infield. We are looking at how we can do that using video capability on the device and extend those supports. It is about how we not only enable best practice for the paramedics infield but how we support them to continue to deliver their work as clinicians.

Michael GALEA: As well as the VVED, it could be that what you are talking about is in a sense a clinical version of that between paramedic and an AV clinician.

Gavin GUSLING: That is exactly what it is.

Michael GALEA: So they have got the know-how, and they have got that backup, virtually –

Gavin GUSLING: Even beyond just going straight to another paramedic, for our stroke and telemedicine team it is the ability to connect directly back to a specialist who can then provide infield direction around the best outcomes for that patient.

Michael GALEA: You said that you are in the process or are about to roll this out to ACOs as well.

Gavin GUSLING: Yes.

Michael GALEA: Does that mean that every paramedic currently has –

Gavin GUSLING: Every rostered paramedic that does more than 25 shifts a month has a device issued to them. For our casual staff, again if they do more than 25 shifts per year, they will have a device issued. If they do less, it is part of our shared pool. It is the same for our volunteer workforce. For the ACOs and CERTs, there is a shared pool for each of the respective teams.

Michael GALEA: I realise you are not the operational side, but is there any feedback you have had about the difference that this technology has made in how paramedics can do their work?

Gavin GUSLING: Yes, I am not a clinician, but equally I spend a fair bit of time out on the road in branches and in emergency departments, and the feedback has been extremely positive. It is much quicker to be able to complete their tasks, much easier to input information and much quicker to get them back out on the road.

Michael GALEA: Thank you. Thank you, Joe.

The CHAIR: I will hand over to Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thank you, Chair. Thank you all for coming this morning. I have some questions. With the cyber infrastructure that you currently have, and possibly what you are looking ahead to in terms of innovation, how is that going to protect patient health records to ensure that there are not any further occurrences of breaches?

Gavin GUSLING: I will ask Mr Howarth to respond in detail, but what I would say is that there are two parts to this. Just for the record, we will not talk about the detailed configuration, because that would be inappropriate and would effectively give a threat agent the ability to be able to access the information more

easily, but I am very happy to talk about the broader construct and what we do to ensure that patient data is safe. We have a number of checks and balances that we run across the organisation, and as I say, we continue to improve our cybersecurity stance. That is then offset and balanced by our internal audit partners that then check our homework so we are not checking our own homework in that space. We also run a very rigorous cybersecurity program to do things like penetration testing and testing of our own systems and solutions to ensure that they are of the highest calibre, but I will just pass over to Dan for that.

Daniel HOWARTH: Thanks, Gavin. I think I can talk to a number of points here. Firstly, collectively across the health sector there is a broad cybersecurity program, and there is the set of controls that we all adhere to and report our performance and evidence up to that we are adhering to a selection of controls that are aimed at preventing, detecting and recovering from cyber incidents. In addition to this, we actively engage third parties to review our homework, if you like, to do things like penetration testing and to do security assessments against our configurations to make sure that we are adhering to best practice and we can gather up recommendations for improvements, and we actively go on that. There is a particular score with the Microsoft set. We are pretty proud of the fact that we are about 70 per cent higher than organisations about a similar size.

Anasina GRAY-BARBERIO: Great.

Daniel HOWARTH: So we are actively focused on that. We have got an incredible team. Our cybersecurity team is divided into three sections. We have a team that is actively looking for threats and detecting threats, and we have tools in place that help us monitor right across all our environments against all the different types of threats that exist – so not just the data loss prevention one from internal staff. Then we have a governance, risk and compliance team that does a whole range of work around everything from e-discovery to looking to the environment to support our privacy teams, our professional standards teams, and also then looking at all our policies, procedures and compliance scorecard-based type reporting.

Anasina GRAY-BARBERIO: Great. Just in the interests of time, we had your colleague Anthony in here just before you, and I asked him about wait times for calling an ambulance. He said that waitlist data will be published but that I was better to direct this question to you. When will that data be made available publicly?

Gavin GUSLING: I am happy to answer that one. Thank you. We have really just kicked off the project to envisage what that might look like, and the endgame for us is something similar to that which you would see in an ED in a major hospital, where they publish the wait-room times, like for Northern or Monash and those sorts of things you might see today. I would be hopeful that we could get it in by the end of the year, but there is still a little way to go to ensure that we have the right cyber controls in place and that we are not publishing information that would not be beneficial to the public. So there is a little way, but our target –

Anasina GRAY-BARBERIO: So you are hoping for the end of the year?

Gavin GUSLING: I am hopeful to have it done by the end of the year.

Anasina GRAY-BARBERIO: Great. Okay. Thanks very much.

The CHAIR: Your timing was perfect. Thanks very much. I will now hand it over to Dr Heath.

Renee HEATH: Thank you. Thank you for coming in today. I am just going to follow on from Mr McCracken's line of questioning. Now, Scott Crawford, who I am sure you know of, of the Ambulance Managers & Professionals Association described the incident – and I will quote him – as 'another dumpster fire at Ambulance Victoria', saying members are exasperated. How was this situation left to go on for so long?

Gavin GUSLING: Perhaps I could start there. I think it is a fairly emotive way to describe it. We are obviously remorseful about the fact that the incident happened, and we responded as quickly as we could –

Renee HEATH: Three days is a long time in terms of cybersecurity.

Gavin GUSLING: It is. However, we have a number of checks and balances that we have to go through before we act on an incident, because part of our obligation is to not create more harm – so to not actually tell people about the number of false positives that we receive across the organisation – so we have a number of things we have to do before we actually start the process. I would suggest that the ongoing improvements across the organisation – the prime example there is that particular incident we detected internally. We notified

the staff and we acted accordingly. The two or three major incidents before that were not detected inside the organisation. And we have put further controls in place that would now detect those sorts of things, including things like we constantly monitor our entire landscape for personal and private information or health information which is held in insecure locations. We do that today regularly, and we have millions of files that we check in real time to ensure that that information is not exposed outside those –

Renee HEATH: Just picking up on your comment, 'we notified the staff', that you said just then, how were the 3000 AV workers who have been impacted notified?

Gavin GUSLING: We went through our standard notification process, so for those that we could contact directly, we did. We went as far as contacting –

Renee HEATH: Phone call, email?

Gavin GUSLING: They were emailed, and we did live internal town hall type meetings. Also, for those staff that were not with the organisation anymore but their information was captured, we called them. I personally contacted the union to seek contact details. We ended up with six people that we could not contact in the end that we actually sent registered letters to, and all of those letters were delivered. So I am very comfortable that everybody was contacted in that space.

Renee HEATH: Thank you. Do you concede that there is a problem with payroll at Ambulance Victoria?

Gavin GUSLING: I would ask you to define the question a little better, please.

Renee HEATH: One submission, submission 163, noted that pay slips are 'hard to decipher and do not contain adequate information'. Do you agree with that?

Gavin GUSLING: Absolutely. We have heard that message from our staff and we have a board-approved project, which will kick off in July, called project synergy. That particular project will replace our payroll system and our HR system with the intent to provide clear –

Renee HEATH: Why is that taking so long?

Gavin GUSLING: For a couple of reasons. One is we had to go through a discovery process in the first place, and I know that one of the other submissions talks about rostering and roster flexibility.

Renee HEATH: It does. I was going to ask about that. They do not line up. The rosters do not line up with the pay slips.

Gavin GUSLING: Absolutely. We had to do the system that was at the most risk for the organisation, and that was our rostering system. So we have replaced the rostering system; it went live for all the prime rostered staff late last year, and we are in the middle of doing our volunteer workforce now. That will complete in August. We will then kick off the HRIS project, which will replace both our core HR systems, and that includes our payroll system.

Renee HEATH: Thank you. I will just comment that this issue has gone on for years and years. I will just leave it at that, because I have run out of time anyway.

The CHAIR: Thanks, Dr Heath. I will hand over to Mr Batchelor.

Ryan BATCHELOR: Thanks, Chair. Gentlemen, thanks so much for coming in today. I might just go to one of the things that we heard earlier, the changing nature of the calls, the cases, the caseload that Ambulance Victoria and the paramedics on the front line are receiving and the way that is both increasing substantially in terms of volume but also the nature of those changes. I am just interested from a business intelligence point of view: in what ways does this part of the organisation provide information on what is changing in the nature of the incoming to inform practice improvement?

Gavin GUSLING: Perhaps I will start and then let Shannon talk to the detail. We have quite an extensive information landscape, most recently with what we call our focus reports, which cover everything from clinical and patient support all the way through to our standard operational reports. That is part of the ongoing uplift

that we have in our data warehouse and in our information management provided by our insights team, which are an award-winning team in this space in providing these sorts of supports and reports. But I will hand over to Shannon to talk to the detail in that space.

Shannon ELSTON: Last year we won the CAA award for excellence in terms of those focused dashboards – so allowing data to be transparent and drillable by the organisation to provide real-time and accurate insights into all aspects. We continue to build that out and evolve that as we build out a data-rich environment to inform the business.

Ryan BATCHELOR: What is that showing? So you have got a dashboard. What is it showing?

Shannon ELSTON: It is layers of dashboards, not just one simple dashboard, specific to hierarchy within the business in terms of what the business needs and the business expectations. We work closely in terms of developing those products with our business partners to ensure that we can provide them the best value and views of information that inform their operational decisions, understanding the inherent value of their work. I have got a talented team of data scientists, of data analysts, of forecasters and of technical staff that not only build algorithms and machine learning to gather complex data fields to provide real-time, accurate and understandable insights for the business to make informed decisions, but we also work more broadly within the health sector, trying to enrich both our partners and our datasets so that we have got an end-to-end view of the ecosystem. That work continues. I think it is certainly a piece of work that will well outlive our tenancy in this function. But the aspiration is, if we can make transparent information to everybody within the decision points –

Ryan BATCHELOR: So who would get that?

Shannon ELSTON: including the patient, who is our key customer. Inherently, everything must go back to the patient, who is the core person here. To make the informed decisions, to get them the timely care and give them the best care at the time of the situation is what we aim for.

Ryan BATCHELOR: So there is significant investment going in behind the scenes to draw out the necessary insights from the data that is available to do service improvement, and that is going all the way from management down to patient.

Shannon ELSTON: Correct. I mean, technology is ever evolving, right? The landscape we find ourselves in is historically siloed, so there are complexities around getting different software to talk to each other. So it is breaking down those walls and finding new ways or innovative ways to use modern technology and modern tools to enable us to break down those barriers and share that information.

Ryan BATCHELOR: How is that being received by the organisation?

Shannon ELSTON: Very well. I think it is well accepted. It is a step change, and like with all step changes, there are challenges. Acceptance of people – it is a natural thing to be challenged by change. It is about taking people on that journey and walking them through that experience to show them what we are now capable of technology-wise, but also to be conscious of and give them a better business outcome. At the end of the day we are here to service and support our frontline paramedics, who are doing such a fine job on the road, and that is at the core of our BTP teams. Key at heart to the efforts and lengths that my staff continually commit and overcommit their energies to is that we are not only servicing the paramedics who are doing such a frontline job but our family, our friends, our community of Victoria, to ensure that they get the best possible service that they can from Ambulance Victoria.

Ryan BATCHELOR: Thanks very much. Thanks, Chair.

The CHAIR: Thanks. I will move on to Ms Payne.

Rachel PAYNE: Thank you, Chair. Thank you all for presenting before us today. I just want to go back to the conversation around systems, because we have had some witnesses who have presented to us throughout this inquiry talking about their experiences being a regional representative or a regional paramedic compared to those in the metro areas. I am generally talking about the dispatch and the information that is provided upon dispatch. You mentioned iPads earlier and information being accessible. What we have heard from some of

those witnesses was that they were put into situations that were quite risky because the information they received was only via a call, rather than information that was actually on a dispatch monitor. Can you talk us through that and why there is this disparity between those that are working in the regions compared to those working in the metro areas?

Gavin GUSLING: Yes, I am happy to, thank you. Thank you for the question. The reality is it is a leftover from the merger of Rural Ambulance Victoria and the Metropolitan Ambulance Service. At the time, there were two very different modes of dispatch, and to be quite honest, we are only just catching up now. So right now we have digital radios that we are rolling out across the rural regions today. We are about halfway through that project. That will provide equivalent digital radio communications for all of our rural staff. Next year we are rolling out, in conjunction with Emergency Management Victoria, our mobile data network to the rural fleet, which will replace the current paging network for dispatch. So in metropolitan Melbourne they have what is called an MDT, a mobile data terminal, which if you have looked in the front of an ambulance or a police car, you would see something very similar. It is a screen with all the data on it. The intent, working with our partners in EMV under the state contract, is to provide an app called PSCore, which is an app version of MDT on a device. We will start that rollout in the middle of next year, and that probably will not take the same amount of time for the rural radios because we do not have to pull vehicles off road to do that work. Please do not hold me to the dates because the program has not been built yet, but I would suggest in somewhere between six and 12 months we would have that rolled out across all of regional Victoria. Then by that time the actual contract for the MDTs will have run out in metro, and we will run the same solution into metropolitan Melbourne. So there will be one dispatch solution across the entire state, one radio network across the entire state, which will then help with things like fleet availability, rostering – all of those sorts of things. We will not have this invisible boundary that circulates metro Melbourne, and it will give us far more flexibility in that space as well as, most importantly, provide all the information to the first responders, whether they be volunteer responders or uniformed paramedics, to ensure their safety, as well as to ensure the right patient outcomes.

Rachel PAYNE: That is really helpful. Thank you for providing the timeline to the best of your effect as well – much appreciated.

The CHAIR: You have still got about a minute to go if you have got more questions.

Rachel PAYNE: No, that was exactly what I wanted to ask. Thank you.

The CHAIR: Okay. Thank you. I will now hand over to Ms Crozier.

Georgie CROZIER: Thank you, Chair. Thank you for all being before us. Mr Gusling, can I just confirm from Dr Heath's questioning around the payroll issues – I have had a number of paramedics that have contacted me over the years to say that they get paid incorrectly. They do not get paid overtime, and they are often single women that rely on being paid accurately. I think you said that the system was being fixed and rolled out. Did you provide a timeframe?

Gavin GUSLING: The rostering system has been rolled out. The new HR and payroll system will start in July.

Georgie CROZIER: How long will that take to implement?

Gavin GUSLING: I would suggest – and we have not got the detailed planning yet – in the first quarter of next year we would do the payroll piece.

Georgie CROZIER: So are there still problems with those pay slips from paramedics getting not paid properly?

Gavin GUSLING: I cannot talk to the detail of –

Georgie CROZIER: Just yes or no.

Gavin GUSLING: I believe, as there are in any organisation, errors in payroll.

Georgie CROZIER: That is fine. Thank you. Mr Howarth, can I just go to you now: are you aware of any incidents regarding procurement misconduct within your department?

Daniel HOWARTH: No.

Georgie CROZIER: And have any issues been raised with you about problems with invoicing at all over the last few years?

Daniel HOWARTH: I do not believe so – invoices specifically. I mean, there are always operational activities that go on with invoicing, but I would say across IT, working with procurement and legal departments, we have a very rigorous procurement practice. I am happy to go into some details of how that works, if you would like.

Georgie CROZIER: So you would have regular auditing undertaken through that process?

Daniel HOWARTH: Yes. It is part of the enterprise's overall auditing program – procurement is audited.

Georgie CROZIER: And with that procurement process with vendors, invoices are paid on time and are paid in total? They are not split and some other form of payment is provided to those various vendors?

Daniel HOWARTH: Nothing that I am aware of. If I can maybe just share with you very quickly, just to give you some confidence, we run a weekly process with our procurement and legal team where IT meets with procurement and legal. All of our procurement activities are listed and discussed, and actions are taken against each of them.

Georgie CROZIER: Has that been an ongoing process?

Daniel HOWARTH: This has been an ongoing process for over two years now, and there were other processes in place before that. There are contract recommendation approvals that are undertaken for all the orders. I would say high 90 per cents of our audits are done under government contracts, so we are leveraging existing government terms and conditions under e-services or other older Victorian government contracts.

Georgie CROZIER: And are all invoices paid on time to the various vendors? Is AV able to do that on a timely basis?

Daniel HOWARTH: I am not aware of any incidents where we have had complaints about timely payment.

Gavin GUSLING: I have had no vendors escalate to me that they have not been paid on time, so I expect that they are being paid within the agreed timeframe.

Georgie CROZIER: There have been a number of issues raised over the past few years around allegations of fraud and looking at what is happening within AV, and I think you explained at the outset around one person and their misconduct. They were emailing out, and you uncovered all of that. I think you said that individual used poor choices or something through their –

Gavin GUSLING: They made a poor choice, yes.

Georgie CROZIER: So you are absolutely assured now that those sorts of breaches cannot occur again?

Gavin GUSLING: I cannot sit here – no technology professional could sit in any room – and give you a 100 per cent guarantee that is not going to happen. What I can do is tell you that we have very significant processes and procedures in place supported by systems and real-time monitoring.

Georgie CROZIER: We have heard a lot about the culture of AV. VEOHRC have done their report – it is toxic; it has got problems. So why was this person so malicious?

Gavin GUSLING: I am not sure that they were malicious. I think they were opportunistic.

Georgie CROZIER: In terms of taking that data?

Daniel HOWARTH: Can I provide an update, Gavin?

Gavin GUSLING: Sure.

Daniel HOWARTH: The individual's reasons for taking the data – they were not just taking data, they were taking some policies and procedures. They were going to a new role, and they thought what they were taking would help them in their new role. So that was their explanation of the situation. We just heard from Victoria Police yesterday in terms of them wrapping up, and we have got a meeting with them next week to finalise this. But they have no reason to think there was anything criminal involved here, and they are as confident as they can be also, having done forensic evidence across the user's devices, that all the containment measures that we took as part of our discovery have cleaned up the data that they took, and there was no evidence of that data being captured, stored anywhere else or further forwarded on. I think as part of any mature cybersecurity practice and globally recognised methodologies, part of our job as cybersecurity professionals is to assume breach. This is very fortunate. This was a person who had authorised access in the role, and she had access to this data, but fortunately we have not had a breach from an external party-type scenario from the controls we have put in place. But this was an example along those lines, I guess, and we have contained that.

Shannon ELSTON: It presents us an opportunity now too in terms of enabling compliance and literacy, if we are able to work with individuals that take these sorts of actions – perhaps the gaps there – and we have got governance in place and an ethics framework and a data governance framework where we are lifting the knowledge of the organisation and the employees so that they know taking such actions is not endorsed and not appropriate in those circumstances.

The CHAIR: Thank you. Sorry, we have got to move on. I am sorry, but we can come back to it.

Tom McINTOSH: Thank you, Chair. Thanks for being here. Listening to Ms Payne's question around the digital radio rollout to rural Victoria, I just want to ask: are there any other technologies that perhaps are being used in metro that are not being used in regional or rural areas? Are there any divides on the tech used, or perhaps does technology get used in one place more than others simply due to geography and population?

Gavin GUSLING: Apart from my comment earlier around the existing differences between the two, metro and rural, we are actually pushing technology fairly hard into the rural space. As part of that mobile data network that I was talking about, we are actually rolling out satellite connections to 100 vehicles. Those vehicles that work in the remotest parts of the state will have direct connections to ensure that they have access to all that same information regardless of where they are in the state. Also, for our rural staff, for the iPads that we talked about, we provide two SIMs in those devices. They get both an Optus SIM and a Telstra SIM, so they have the best possible chance of coverage no matter where they are in the state. What we also are doing for our rural ambulances – today we have what is called an MG90, a wireless hotspot in the back of the ambulance in metro. They are actually being transferred out of metro and put into rural because in metro it does not really make much difference to the mobile phone coverage. So we are taking those devices and moving them into the rural fleet to ensure that they have the best possible connection possibilities. Ultimately, we are dependent on the carriers, and the public safety mobile broadband that is a few years away – federally funded – will help. But I think we are continuing to drive those sorts of opportunities into rural Victoria.

Tom McINTOSH: In the previous session we touched on various equipment that regional and rural branches have – that they get and they use and train on and whatnot. So as far as training goes in your space, is that done centrally or at branches? How do you work that?

Gavin GUSLING: Physical face-to-face training is done centrally, but equally we have videoconferencing capabilities. We also have a virtual paramedic augmented reality simulation that is used across the state. So there are a number of ways. But face to face is generally done centrally out of our Sunshine training facility.

Tom McINTOSH: Yes. And, sorry, the augmented reality –

Gavin GUSLING: Yes. Effectively it is built from a federally funded investment. We leveraged some game developers to create virtual simulations that allow a paramedic, no matter where they are in the state, to be able to use – predominantly on a PC, but they could if they had the capability, and we do not supply them – augmented reality glasses to be in situations and train in simulations.

Tom McINTOSH: I have been up at Goongerah, which is not you, but our remote bush nurses at Goongerah and right up around Orbost have telelenses where they are able to come in to specialists with snake bites and various other things, and the other specialists see exactly what they are seeing and are able to draw onto the screen. It is quite incredible.

Gavin GUSLING: You heard me earlier before talking about the iPad and the ability to do exactly that on the iPad, and that is our next step once we have got that in and solid.

Tom McINTOSH: Yes. Sensational. Chair, how am I going? The other question I would just ask, I suppose, is on AV being at the forefront of technology. I presume that is a position that you pride yourself on. It sounds like the technology rollouts are occurring and you are always looking to stay at the front end of what is coming, what is emerging, given how quickly everything does emerge now.

Gavin GUSLING: I think that the real opportunity for the organisation is in technology and innovation. I have only been with the organisation for four years, and I have driven some significant improvements and requested and received some significant investments to continue to drive that going forward.

Tom McINTOSH: Yes, you have got those investments backing up that available technology change.

Gavin GUSLING: Where we need to, yes.

Tom McINTOSH: Yes. Fantastic. Thank you.

The CHAIR: That is time, Mr McIntosh, but luckily we have still got 15 minutes spare, which means we can open it up to all questions now. I am going to roll off again, and then we will go back and forth between different members. If you have got questions and I do not see you, just give me a nudge or throw something at me, okay?

You guys obviously are at the forefront of the implementation of the technology. I want to understand the rollout and particularly how you are going to manage it so that current staff undertaking their roles are not under pressure while you are introducing all the changes, such as the iPads, the HR processes and the different systems like that. How is that going to be rolled out?

Daniel HOWARTH: As part of these projects we usually have a change manager that works with the technology teams and with the operational teams to support the paramedics in terms of the change in adoption. It is possibly something you know more about than me, Gavin.

Gavin GUSLING: Perhaps I could add that, along with a change manager, we have a structured change management approach. We also leverage what we call light duties paramedics – those paramedics that for whatever reason cannot be on the road. We include those uniform members as part of the project delivery team. The reality is that change can be difficult for people, and we support them through the process. We have obviously our wellbeing group that continue to support as well. There is some pressure around change and innovation and introducing new systems. We have to continue to communicate and facilitate that change as best we can.

The CHAIR: I meant particularly in terms of staff capacity there. You have got staff already doing a job and you are transitioning them to another way of doing their job or to different tools to use in their job. How are you going to go about doing that in a workforce which is already under significant pressure?

Gavin GUSLING: I would have to say that pretty much every new piece of technology that we have introduced has been welcomed by the entire workforce. If I use the biggest change that we have made, the iPads, that was welcomed with open arms. The way that we introduced that was that we used the inbuilt leadership structure, the team managers and senior team managers, as part of their standard briefing process and introduced the new technology. We did a number of roadshows across a number of branches, spoke on multiple occasions online and did all those sorts of things to continue to land the message. It is important, through our operational workforce, to give them some space and ensure that they do have some opportunity to play with the device and to get to use it. One of the reasons we went down the path of an iPad was that it was the one that was most requested by the staff.

The CHAIR: We have had so many submissions saying that the rostering structure – the 10/14 – basically means paramedics are on the go constantly when they clock on. Is there an allowance for getting used to the technology?

Gavin GUSLING: There is not a rostered allowance, but there is time that is allowed for administrative tasks as part of their normal rostering process.

The CHAIR: So that is where that is going to go, then?

Gavin GUSLING: It would pick up into that.

The CHAIR: How much is that?

Gavin GUSLING: I would have to take that question on notice.

The CHAIR: Okay. Thank you. Do you guys want a question?

Michael GALEA: Thank you. Yes. I might pick up on the same thing. With the rollout of these new technologies, obviously an important part is not just the rollout of the physical infrastructure but supporting the team to be able to use it to their best ability so that they can get the most value out of it. What sort of training is done? We can use the iPads as an example, but in broader terms as well, what sort of training is typically done? Is that done through your teams or through the operations side?

Gavin GUSLING: It would depend on the technology that was being deployed. But if we use the iPad as an example, my team as part of the project built a number of short video vignettes around particular functions. There was a 2-minute video that said 'This is how you put in your clearing time' or 'This is how you make changes to the patient care record.' They were published on our intranet, and we also did a lot of face-to-face time with staff. I have operational staff and paramedic staff that are part of my team with operational experience, and they go out in the field. To be honest, you get far better acceptance with a uniform member talking to another uniform member, and they spend time on the ground in the branches talking to the staff and physically showing them the devices and how it might work. We also were very conscious of, as you mentioned before, Chair, the time available and so we made the process as similar to what they already have from a workflow perspective, but we cleaned up and improved the interface so that it was actually easier to use. A good example of that is we actually showed the device to a New South Wales paramedic – they also use the same system that we use, a system called VACIS – and he picked up the device and used it with no training at all and was quite supportive of the fact that it was very intuitive and very easy to use.

Michael GALEA: And integrated. Are there specialist apps on the devices, or are they the same apps that people like us might use but they are just being used for the very impressive things that paramedics do?

Gavin GUSLING: There are some specialist apps that are specific to the operation, and they relate to various clinical functional for use. But equally it is an individual issue device, and we trust our paramedics to do the right thing, so they can load whatever apps they like on it.

Michael GALEA: Yes, sure. You mentioned the New South Wales comparison there. Do other state ambulance services have similar programs?

Gavin GUSLING: The system that we run in the back end, VACIS, the Victorian ambulance clinical information system, is actually provided to New South Wales –

Michael GALEA: Do they piggyback off the Victorian system?

Gavin GUSLING: We have a cohort that actually builds that application and supports it for all the states, so Tasmania, ACT, Victoria and New South Wales all use the same system. Queensland use a much older version of the system, and they also have iPads in front. All the other states have Windows devices.

Michael GALEA: So Victoria and Queensland are the only states with iPads?

Gavin GUSLING: Yes.

The CHAIR: Thanks. Ms Crozier.

Georgie CROZIER: Thank you, Chair. Can I just go back to Mr Howarth in relation to the comments he made around the weekly meetings you have with the legal department around those procurement processes, the contracts, the invoicing – that has been happening for how long?

Daniel HOWARTH: At least two years.

Georgie CROZIER: At least two years. What happened before then?

Daniel HOWARTH: Before then it was just less formal, I guess, in that sense, but we had –

Georgie CROZIER: So there was no sort of legal oversight of that procurement?

Daniel HOWARTH: No. Legal reviews all the contracts. I suppose this process that we have put in place over the last couple of years is –

Georgie CROZIER: Why did you put it in place? Was there an internal investigation from AV to look at your department around these –

Daniel HOWARTH: No, it was really about us being all able to stay in sync with the volumes of transactions that we were doing, the detail of the process that is currently in place. It is quite involved. Having come out of commercial organisations, it is quite a rigorous and well-governed process. It is really a case of just making sure that we are staying on top of all of the processes and all the activities that go into a procurement.

Georgie CROZIER: For that period of time that you have been with the organisation – I do not know how long you have been there for. How long have you been there for?

Daniel HOWARTH: About seven years.

Georgie CROZIER: Seven years. You say that that robust process has been in place to ensure –

Daniel HOWARTH: I can talk from an IT perspective, obviously.

Georgie CROZIER: the governance of these procurement processes, the contracts that you have put in place for these very large vendors and companies which taxpayers are paying a lot of money for, and we need to ensure that they are robust and being overseen properly. I am just interested in the last two years, why that formality has been put in place with the legal department.

Gavin GUSLING: Perhaps I can help.

Georgie CROZIER: Well, I am asking Mr Howarth because he was commenting on it.

Gavin GUSLING: It went in place at my request because –

Georgie CROZIER: Why did you request it?

Gavin GUSLING: I was looking to create better efficiency across the organisation. We were being held up in the process. Because of that complex process, we were finding ourselves at a point where contracts were not being renewed by their expiry dates –

Georgie CROZIER: Was there a problem with those expiry dates and renewal and paying for those contracts?

Gavin GUSLING: No issue with paying. What we have is global vendors that only produce invoices four weeks out. The process was so complex as such that we could not get through it in four weeks – through our legal team, through our procurement team and ultimately to our finance team. Depending on the value of the contract, it may have even had to go to the board. We could not get through that process in time, so I asked for a more formal process to be put in place that allows us to move through that process quicker.

Georgie CROZIER: But it was just off the back of that large volume that you got in the last couple of years.

Gavin GUSLING: Correct.

Georgie CROZIER: Right.

Gavin GUSLING: I can only talk for the time that I have been with the organisation, and it was an opportunity that I saw for improvement.

The CHAIR: Okay.

Georgie CROZIER: I know that Dr Heath has got one.

Renee HEATH: I just have a clarifying question about – oh, sorry, is it my call, Chair?

Georgie CROZIER: I was just talking about –

Ryan BATCHELOR: No, I was just saying it sounds like a good improvement that they have made in the business processes.

Georgie CROZIER: Well, I think there were problems identified. That is why I was asking.

The CHAIR: Hold on, let us just let the witness respond, please. Dr Heath.

Gavin GUSLING: Just before you end, I would just like to say that I did not see any problems or any issues with the procurement process.

Georgie CROZIER: None at all?

Gavin GUSLING: I did not. What I saw was an opportunity to improve, and we took that opportunity.

Georgie CROZIER: Thank you.

The CHAIR: Dr Heath.

Renee HEATH: Mine was just a clarifying question following on from Mr Galea, where we were talking about devices, and you said, 'We trust our paramedics. They can load whatever apps they like on them.' What do you mean, 'whatever apps'? There is no prescription of what apps are being used or streamlined processes?

Gavin GUSLING: We push a number of apps. We have the equivalent of an app store inside the organisation where we can push specific applications out to all the devices, but equally we allow the individuals to be able to load any app that they choose to beyond that. So we prescribe the ones that they need to do their job, but equally, because this is their own device, they can use their own iTunes account and load whatever apps they like.

The CHAIR: Even TikTok, by the sounds.

Renee HEATH: Yes, that is right – snake, bubble.

The CHAIR: Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thank you, Chair. My question is to Mr Elston. You spoke earlier about the team that you oversee, a team of data engineers, data scientists, who are in charge of algorithms. Now, we heard from the Victorian Ambulance Union last week, and one of the problems or challenges that they identified was around dispatch coding and how algorithms were misaligned with patient acuity. How often is your department speaking with this department to ensure that these bottlenecks are able to be ironed out? Do you have regular meetings where you, I guess, talk about what the challenges are and how your team can ensure that the algorithms are doing the jobs that they are supposed to do? Another thing they also highlighted was how difficult it was to override algorithms. Sorry, there are a couple of questions there. So I will leave it to you to answer. Thank you.

Shannon ELSTON: Quite a few questions. There are proprietary products that we obviously use, which I think probably in previous sessions my predecessors would have identified, in terms of ProQA software there now, which are rigorously clinically assessed and reviewed on a regular basis by those divisions. It is probably more relevant for those teams to comment on those. However, what I would say from a data landscape perspective is that we work very collaboratively with our operational partners in looking for every opportunity that we can to explore data that we have and take opportunities that we can to improve the customer experience. Algorithms and machine learning and, dare I say it, AI, as it is tabled and continues to develop within IT, continue to evolve.

AV, currently in our environment, are looking to build the foundations to enable us to make a step change in utilising the future of that technology. But to do that, first we need to overcome those silos that I talked about earlier and ensure that the data can be accessed in a timely manner and that it is accurate to be able to inform those decisions. Data quality really underpins our ability to make informed decisions and ensure that we are getting the absolute right outcome for our patients. That underpins where we need to continue to invest in our maturity in our data landscape to enable that, so that we can build the tools that will actually be able to then assist our paramedics in making informed decisions.

The CHAIR: All right. Thank you very much. That is perfect timing. Gentlemen, thanks very much for your time today and your evidence. We appreciate it. You will get a copy of the transcript to look through, and if there are any typos or any small things, you will get a chance to have a review of it anyway.

Thanks very much. That brings this session to a close.

Witnesses withdrew.

WITNESSES

Jesse Maddison, Executive Director, People and Culture, and

Fleur Behrens, Director, Professional Standards and Behaviours, Ambulance Victoria.

The CHAIR: Welcome to the next session of the Legal and Social Issues Committee Inquiry into Ambulance Victoria. I am Joe McCracken. I am the Chair of the inquiry, and we will go through and introduce our committee members as well.

Michael GALEA: Good morning. Michael Galea, Member for South-Eastern Metropolitan.

Ryan BATCHELOR: Ryan Batchelor, Member for the Southern Metropolitan Region.

Tom McINTOSH: Tom McIntosh, Member for Eastern Victoria Region.

Anasina GRAY-BARBERIO: Good morning. Anasina Gray-Barberio, Northern Metro.

Georgie CROZIER: Good morning. Georgie Crozier, Member for Southern Metropolitan Region and also the Shadow Minister for Health and ambulance services.

Renee HEATH: Renee Heath, Eastern Victoria Region.

Rachel PAYNE: Good morning. I am Rachel Payne from the South-Eastern Metropolitan Region.

The CHAIR: Thank you. I will just read this out so you know where we are at. All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore, the information that you provide during the hearing is protected by law. You are protected against any action for what you say during this hearing, but if you go elsewhere and repeat the same things, those comments may not necessarily be protected by that same privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded, and you will be provided with a proof version of the transcript at the end, so if you want to go through and correct any small errors, that is fine.

Just for the Hansard record, can you please just say your name into the microphone and then the organisation that you are appearing on behalf of, please.

Fleur BEHRENS: Fleur Behrens, Ambulance Victoria.

Jesse MADDISON: Jesse Maddison, also from Ambulance Victoria.

The CHAIR: Thanks very much and welcome to today. I am going to put 5 minutes on the clock for you guys to give an opening, and then we will go to questions from there. Thank you and welcome.

Jesse MADDISON: Thank you very much, Chair. Thank you for the opportunity to appear today. Firstly, I too would like to acknowledge the traditional owners of the lands upon which we are meeting today and pay my respects to elders past and present and any Aboriginal and Torres Strait Islander people with us today or listening in to today's hearing. I would like to also acknowledge the members of the Legal and Social Issues Committee. I thank you for the opportunity to speak to you today. I also recognise that this inquiry provides an opportunity for the community and members of AV past and present to discuss their experience and what they believe to be the opportunities and challenges for Ambulance Victoria.

I am Jesse Maddison, Executive Director of People and Culture at AV, and with me today is Fleur Behrens, the Director of the Professional Standards and Behaviours Department. I am the executive, and I am responsible for providing leadership and direction for the organisation's workforce strategy, organisational development and cultural program. This includes diversity, inclusion and expertise in support in the areas of health and safety, wellbeing and support services, human resources, employer relations and also payroll services, which I note there has been some discussion on already today. Fleur is responsible for the Professional Standards and

Behaviours Department, or PSBD. The PSBD commenced on or around 5 June 2023 and operates to AV's report and complaints system for unlawful and harmful workplace conduct, including investigation of misconduct. They promote a culture of safety, integrity and respect at AV.

We acknowledge that there have been a number of public submissions relating to cultural issues, alleged misconduct, bullying and harassment, and there is obviously work to do in that space. The safety and wellbeing of our people remains our number one priority, and we want to build a fair culture of respect, care and integrity where people feel safe and supported so our frontline paramedics can do the work that is absolutely important for the community. While AV has implemented a number of strategies to improve the culture, we realise that sustained change requires ongoing commitment and effort, and we are committed to creating a positive and respectful workplace where everyone thrives. Thank you very much for the time and welcoming us here today, and obviously we are here and happy to take questions from the committee.

The CHAIR: Thank you very much. I will now hand it over to Mr Galea.

Michael GALEA: Thank you, Chair. Thank you both for joining us. I would like to start with culture, the issues that you have identified as well in your opening remarks. We did have VEOHRC appear before our committee last week, as I am sure you would have seen. Not to try and paraphrase them too much, but the broad indication from them was that a lot of work has been done in changing and fixing processes in some of the more critical end of things – and this is probably more your area Ms Behrens – but there is still a lot of work to do in terms of the day-to-day stuff, the day-to-day cultural issues that the majority of the workforce are dealing with on a day-to-day basis, which is possibly why with the attitudes we have not seen them change as much as might have been hoped. Can you talk to me about the work that has been done in this space particularly? What work has been done to address these concerns, and when do you expect to see those workplace attitudes change as a result?

Jesse MADDISON: Thank you, Deputy Chair. It is obviously a very good and pertinent question, and I think it is a good summation that you have provided of the work that VEOHRC have done and where they have assessed the organisation is up to. I suppose I would start with cultural change. It is not something that is an overnight process. It does require sustained effort over a long period of time. Any organisation's culture is obviously as a result of the history that has gone before, and to change attitudes that have been built in to ways of conducting yourself does take a lot of effort. I think, as you have indicated, VEOHRC, in their report card, if you like, say we have done pretty well in some things, and to the other end of the spectrum we have still got a bit of a way to go in a range of other areas.

I think one of the criticisms also from VEOHRC, which I think is a reasonable one, is that they have indicated that we have taken a bit of a compliance approach to their recommendations. One of the things we have done in response to that, given the VEOHRC work for the organisation has come to an end, is we have made really a kind of subtle but I think quite an important change, if you like, of moving away from a direct response to VEOHRC's recommendation to building them in. I think Mr Carlyon mentioned earlier today the first Ambulance Victoria people plan, which does pick up a raft of those recommendations and built them in to our people plan, where we are really saying, 'We are not doing this because somebody else has said this is a good thing; we are doing this now because we want to own it.' We say, Ambulance Victoria say, that this is a piece of work that needs to be sustained and needs to be ongoing over a period of time.

Obviously the work we are doing is not just for our frontline paramedics, but they are the majority of the workforce. What we have heard is that they do not feel that there has been this change or the change is significant enough for them to feel it at the front line. So one of the other parts we have done – I think a real part of the people plan – is two-way communication. We do have new employee engagement forums which allow that two-way dialogue to, firstly, I suppose, be clear around the things that we are doing that we hope will change that experience. Then we are able to hear back genuinely from the frontline paramedics: do they feel the change? Have we got the priorities right? What things more do we need to do? I think that other part of the criticism we have really heard is around our paramedics do not feel that we are listening to what they want and what they need to change that experience, which ultimately, beyond creating a better workplace for them, I think does improve – a happy workforce does improve outcomes for the community, which is the reason that we are all here and for the work that we are doing.

Michael GALEA: Absolutely. The two-way dialogue is very important. In terms of the organisation's relationship with the union, what steps in particular are you taking, if anything, to improve that dialogue and to ensure that concerns – whether it is direct from employees through internal channels or whether it is through delegates and HSRs or other ways through the union – are being attended to and as quickly as possible being resolved?

Jesse MADDISON: Obviously the unions are a critical stakeholder. Being parties to industrial instruments means that they have a number of levers that they can pull, and also in our environment the density of membership is great, so they are a really important stakeholder. In relation to our paramedic workforce I think it is fair to say we have been through a quite bruising industrial campaign, which does happen. We have got constraints from our side. The union is obviously seeking a range of improvements through these processes. We obviously respect the right of unions and their members to engage in protected industrial action, which occurred. We have now landed that agreement, and we are now in the stage of implementing it. I think from the time that I have been there – we have got three key unions; I think the relationships are good in terms of being able to work through complex issues, which every workplace has, and particularly in one like ours that has a very complex service delivery model. Any rostered workforce has a range of complexities beyond a 9-to-5 office kind of environment. But I do think, post that industrial campaign, the relationships with the unions is good – which does not mean that there is unanimous agreement on all issues; it just means that where we do have differences of opinion, the relationship is mature enough to work through those issues. Ultimately the goal always is trying to arrive at a mutually beneficial kind of outcome, and I think there is always compromise on both sides, because I think at the end of the day both Ambulance Victoria and the unions have their members, our employees, at the centre of what they want to do in terms of making it a good workplace.

Michael GALEA: Thank you.

The CHAIR: Thank you very much. I have got a few questions to get to, so I am going to fire through them fairly quickly. You sort of touched on it before in your opening: does AV have a culture problem?

Jesse MADDISON: Clearly the report from VEOHRC indicates that there is, and I would say from my short time that there is clearly a range of areas that need improvement.

The CHAIR: We have got submissions from employees. As you probably have seen on the website, there are a significant number of submissions that are 'name withheld' or 'confidential'. The reason why they are like that is because they are afraid of reprimand, repercussions and those sorts of things. That really speaks to a really poor culture, wouldn't you agree?

Jesse MADDISON: That can clearly be one interpretation that is open on the evidence, and I am not going to dispute that. I suppose what I would say perhaps goes against that somewhat in terms of the amount – which has its downsides as well, and I will touch on that – of formal complaints that come into Fleur's area around alleged misconduct. There are a number – a number that is higher than what we would like, because I think it does point to other cultural issues. But in terms of the point you make, Chair, around people being concerned about retribution, I think there is also evidence to suggest that people are comfortable in coming forward and making complaints.

The CHAIR: Well, we have got more evidence that suggests that people cite intimidation, bullying and gaslighting.

Jesse MADDISON: And I think that is –

The CHAIR: They do exist?

Jesse MADDISON: Clearly they do, and that is why we are on the cultural journey that I spoke about in terms of the people plan, so we are not shying away from that, Chair. I suppose I was just trying to also say that there is other evidence to suggest that a range of people that may not have in the past had that confidence to come forward and make complaints are now doing so. I suppose I said earlier that cultural change is a thing that takes time – and perhaps we are seeing some of it – but we have got a way to go. And I am not suggesting we are at the end point yet at all, Chair.

The CHAIR: I can understand some people might feel comfortable coming forward, but we have got submissions that say that HR processes are rarely consistent, with some submissions saying they are used to settle scores.

Jesse MADDISON: I do not want to go into individual matters, but I would say this: we do have a very robust process in relation to misconduct matters. They are both covered under industrial instruments. It does require proper investigation. People get formal allegations; they get an opportunity to respond. They are obviously entitled to have representation, whether that is a union or somebody else. We put a proposed outcome; they are able to respond to that before we make final decisions. I would say that there are proper processes in place. That is not to say that people who are subject to them go, 'That was a fantastic experience I had,' because nobody ever likes being subject to those kinds of processes. But I would say that there are very clear processes that do provide for procedural fairness.

The CHAIR: One of the submissions, 154, stated that they were an AV employee. They were diagnosed with cancer. They requested alternative duties. They were:

> … informed by the regional director that alternative duties could not be offered because the cancer diagnosis was not caused …

by AV. Why is there this seeming inability for AV to be able to work with its staff in a constructive way?

Jesse MADDISON: I do not obviously know the background of that particular case, but if that is the circumstances, obviously that is not what we would like to see and that is not an appropriate response to that kind of condition. Obviously that experience that employee has had is really something that we want to change, because that is not appropriate.

The CHAIR: Of course. One of the other submissions, submission 7 – they are a health and safety representative. They said they:

> … face the same issues where whenever they raise an issue they get dismissed and gaslit into believing there is no problem and that they are the problem.

Why is that continually evidence that we hear?

Jesse MADDISON: Again, I do not know the particular background of that, and I am not here to dispute that because that is an individual's experience.

The CHAIR: So you do admit that that is a problem?

Jesse MADDISON: Were that occurring, that would be a problem. I would say also, though, Chair, that we do work very closely with our health and safety representatives. There are a range of forums where I think you will find evidence as well to the contrary where we do work very closely and collaboratively resolving issues. But those examples that you have provided, Chair, are not what we want to see and not the –

The CHAIR: Submission 12 to this inquiry cites a:

> … lack or inconsistent application of process, nepotism, widespread bullying and exclusion endemic to Ambulance Victoria (AV). These behaviours are entrenched and to a substantial degree tolerated (or frequently perpetrated) by senior managers.

Are senior managers part of the problem?

Jesse MADDISON: I would say in any organisation, and AV would be no different, that there will be pockets where senior management need to be sort of upskilled around dealing with matters. It is certainly one of the key planks of the people plan that we mentioned earlier around leadership and management capability, not just in the frontline paramedic area but also across the corporate areas.

The CHAIR: We are talking bullying, nepotism, abuse. I mean, this is not low-level stuff, and this is more than just training. This is serious.

Jesse MADDISON: It is hard obviously, Chair, to respond to specific cases without the detail, and I am not here to argue about people's experience, because it is clearly not appropriate where that is occurring. What we are on, as I indicated earlier, is a journey, and I think we have come some of the way. Are we at the destination yet? Clearly not. We have got a long way to go yet, and we have recognised that there is a lot of effort going into that ongoing journey of cultural reform.

The CHAIR: Thanks. My time is up. I will go to Ms Payne.

Rachel PAYNE: Thank you, Chair, and thank you to you both for presenting before us today. Just based on your submission and some of the witnesses that presented before us, I have been looking at accessibility of flexible working arrangements, which was something that was key for a lot of the paramedics that we spoke to. What was relayed to us was that there is a real disconnect there between what is available to a paramedic through flexible working arrangements and actually getting those arrangements in place with their management team. It was reported to us that a lot of the paramedics had to do their own due diligence and create a flexible working arrangement to present to their management. Often that would be discounted or knocked back, and it would be a process of months of negotiation to get to that point. Can you just talk us through flexible working arrangements? What are you hearing from your people, what are you hearing from the employees and what sort of data are you collecting to see the uptake of that and if the program is successful?

Jesse MADDISON: Yes, thank you. It is a very good question, and it is one on front of mind of a lot of people across the organisation. I suppose the first thing I would say is that – because we do have a lot of people on flexible work arrangements, and I am not suggesting it is a bad thing, but before I get to there – one of the things it would seem to point to is, and some of this has come up in conversation earlier today around rostering and the rosters not being, you know, is the right word perhaps contemporary or up to date. I think you have, like you said, heard some evidence around that. I mean, one thing is the fact that we do have around a quarter of our paramedic workforce on flexible work arrangements –

Rachel PAYNE: About a quarter – wow.

Jesse MADDISON: would seem to mean that there is an issue with the rostering that so many people need to go through that formal process to have arrangements that meet other elements of their life – children et cetera. I think you have heard evidence earlier today and you might hear more later this afternoon around some of that sort of roster reform work that we are doing, trying to take out those double 14-hour night shifts, which clearly are not user-friendly for a large number of people, and looking at people-based rostering. That work is still ongoing. Any members of the committee who have worked in a rostered environment, people set their lives – even if they do not necessarily love their roster, they obviously set their lives up, so when you change it, it means they have got to make other arrangements as well. Again, it is not something you can do quickly, and there is always a lot of competing interests around how what might work for me does not work for Fleur. So changing rosters is a complicated business, but it is one that we are progressively working through. I think that is the first point, because having a quarter of a workforce on FWAs points to an issue beyond that.

The process itself for FWAs, I think, is a frustration for everyone – for managers and for the individuals – where you are caught up in these kinds of negotiations. Obviously, one of the things that are looked at is operational requirements. People put their hand up to work in what is clearly a 24/7, 365-day organisation, and they have other competing priorities as well. Marrying those two things up is obviously complicated in terms of a manager who is trying to support an individual but also has the community and the business to consider. Those negotiations unfortunately do lead to some friction in the workplace because people have got competing interests even if ultimately the end point is a common denominator – that is, servicing the community. So yes, I agree it is a complex thing. When you have got such a large volume of our workforce on that, it is a whole industry that has to sit around that kind of process and the negotiation and final outcomes. The flexible work arrangements are of limited duration, so it means that even if you get one for six months or 12 months, time unfortunately goes quicker than you would like in all aspects of life, and then you are up to renegotiating it again. So yes, it is an issue. But I think the first thing that we are looking at is the rostering. Hopefully that will provide a bit of relief. One of the things that we are doing is the shorter 8-hour night shifts, which might be more manageable for people's lives.

Rachel PAYNE: Some of the complaints that we have received from paramedics who have a flexible work arrangement currently in place were that their situations do not change, whether it be that they are parents or that they are caring for someone else – elderly parents and things like that. So that renegotiation of those flexible working relationships puts a lot of strain on their relationship with their superiors as well.

Jesse MADDISON: I agree, and I think that is something that we clearly need to have a look at. There is not a one size fits all with these. A flexible work arrangement is designed to have a look at individual circumstances, so I think, yes, duration is certainly a very good point. Where it is clear that people's

circumstances are not going to change for one year, two years or three years, why would you do a six-month or a 12-month? So I think that is certainly one of the things that is currently being looked at.

The CHAIR: Time is up now, I am afraid.

Rachel PAYNE: Thank you.

The CHAIR: I will hand over to Mr Batchelor.

Ryan BATCHELOR: Thanks very much, Chair. Thank you for coming in today and joining our in-depth discussion with senior representatives of Ambulance Victoria. I think it has been a really great day, traversing a range of areas at the organisation, because it is obviously a big organisation, it is a complex organisation and there are a lot of things that have been going on particularly to try and do that organisational change and improvement.

One of the things that the committee has received a lot of, both through submissions that have been name withheld and through some evidence that we have taken in closed session, is that there are a number of complaints that have been made about the complaints handling procedures that people have experienced at Ambulance Victoria. Obviously, when there is a disagreement in the workplace, it is never easy, particularly when allegations have been made and need to be investigated. I am just interested in whether and how Ambulance Victoria has reviewed, changed or improved its complaints handling processes and procedures in recent years. If you could take us a bit through that, that might lead to some further questions.

Jesse MADDISON: I might start, and perhaps Fleur might be able to supplement. The short answer is yes, there are a number of pathways for people to be able to formally raise complaints, including the 'speak up' system, which means that people can – picking up some of the earlier questions – where they do not feel comfortable, raise a complaint anonymously, which is not the situation in all workplaces. That does provide for where people do not feel comfortable. Obviously, that can lead to issues about what we can do with it sometimes.

Ryan BATCHELOR: We face similar issues.

Jesse MADDISON: Yes. It does provide an avenue. Then there is also where people are very comfortable putting their name forward and then that does get assessed. Fleur can go into more detail around the really robust processes they have got in her department. There are a range of mechanisms that have been updated and reviewed over the last few years. These are always very hard. Interpersonal conflict in the workplace I think is one of the most challenging things to deal with, where people hold, very reasonably, their own beliefs about what has happened and what needs to be fixed. Some of it does come back to that sort of management uplift around getting in early where they see it, because every workplace will have it.

The other bit that I think is important and where we need to do better – I have only been with the organisation a short period of time, and I am not using that to avoid the question. I have had a number of people who have wanted to come and speak to me confidentially about the experience they have had, and that has been a very useful opportunity for me, really, to hear firsthand from people who have not had a good experience in the workplace, whether it is through some of these mechanisms or generally, and have not felt they can come forward. One of the things that I have really taken away from that process is that people a lot of the time just want to feel heard, that their issue is serious and is being taken seriously. I think that is one of the things for me. You cannot necessarily resolve everybody's problem, but the first thing is being able to hear and get what people have got to say and what their experience is and take it, not always at face value necessarily, but hear what they have got to say. But then there are formal mechanisms for a range of different matters, and like I said, perhaps Fleur can give a bit more detail in relation to those kinds of enhancements.

Ryan BATCHELOR: That would be great. We have got about a minute left, if you could.

Fleur BEHRENS: Sure. I am happy to take you through those. And thank you for the question. Arising from the VEOHRC report there were six design principles that were part of the recommendations, and we really took those and brought those to life. That is around being person centred; accessible; flexible; timely; fair and impartial; and transparent and accountable. We built those into the structure of our department in terms of there are three different teams in my department that report to me. I have a case management triage team, an

investigations team and a policy and research team. And that really supports our function in terms of we have embedded the person-centred approach. When someone makes a complaint to us, they are allocated to a case manager. That case manager responds to them 95 per cent of the time – at the moment, based on our current data – within two business days, and that person follows their matter from end to end. We are not always necessarily, I suppose, getting people the outcome they want, but we do have someone, a contact person, that supports them and guides them through the process. We have really built that in. We have a continuous improvement approach. We have what I think is quite a unique thing that we do in this space –

The CHAIR: Sorry to interrupt. Time has run out, but I will give you some time – 30 seconds – to conclude your response.

Fleur BEHRENS: Sure. We have a participant experience survey. At the end of our process we actually ask the participants in it what their experience has been – did they feel respected, did they feel heard, did they feel that the process was fair, was it concluded in a timely way, all things considered. We actually ask for that feedback from our participants in a process, and then we have a monthly continuous improvement process that we go through to build that in and to get that feedback and try and incorporate that.

The CHAIR: Thanks very much. Dr Heath.

Renee HEATH: Thank you. Thanks so much for coming in and being here with us today. Something that has concerned me since the start of this inquiry is the amount of withheld names, for the reasons that Mr McCracken and others have gone over, but also, when we had those closed sessions, how staggeringly similar the evidence was from so many people that had never spoken to each other and did not know each other. I guess my question is to you, Fleur, as the head of professional standards and behaviours. Submission 39 cites an example of bullying in the workplace and an escalation process that went nowhere, then senior exec have not investigated or mediated the issue but swept it under the carpet. How often does this happen?

Fleur BEHRENS: Thank you so much for the question. I cannot speak to that particular matter; I do not know the details of it. What I can talk to you about, though, is how it works when something comes to us. One of our design principles is about accessibility, so we launched our anonymous SpeakUp pathway so we can receive anonymous complaints. At the moment, in the last quarter, the utilisation of that has grown a little bit over time; it is now sitting at 20 per cent. So 20 per cent of the complaints that we are receiving at the moment are coming in through that anonymous SpeakUp pathway, and that is really important because those are otherwise complaints that I presume we may not have received.

Renee HEATH: What sorts of things are coming through that?

Fleur BEHRENS: It is quite varied in terms of the categories. We have done a concerted piece of work around sexual harassment in the organisation, so we have launched a new policy, the first standalone sexual harassment policy for AV; we launched that with the sex discrimination commissioner. We have done masterclasses around that, and what we saw is an increase both in complaints of sexual harassment after that work but also greater utilisation of sexual harassment complaints coming in through that SpeakUp pathway as opposed to our other pathways, which are email, online forms, those types of things. It is not all sexual harassment that comes through SpeakUp; it is fairly broad in terms of the different categories, but it has been utilised more, more recently, for those types of complaints. Once we receive a complaint, we have someone who works in triage who assesses that in terms of seriousness and need for immediate make-safe type actions. It is then allocated to a case manager and goes to our multidisciplinary assessment committee that is made up of different representatives from the different teams in the department, and we then consider: what is the most appropriate pathway for it to go down? So it is appropriate for the matter to be addressed locally by local management if it is a lower-level type matter; we see the most common type of thing reported to us is incivility and bullying and harassment-type behaviours – predominantly incivility is the most common behaviour – then we will refer it back locally and support local managers to manage that. If it is bullying and harassment, sexual harassment or other types of more serious matters then it will be referred through the investigation pathway, and the investigation team takes that. I am really confident –

Renee HEATH: How many cases are open?

Fleur BEHRENS: 199 as at the end of March.

Renee HEATH: 199, wow. How many of those are anonymous?

Fleur BEHRENS: I do not have that in front of me. I am happy to take that question on notice.

Renee HEATH: Yes, please. Does the fact that you are receiving so many of these anonymous complaints point to a culture of fear, in your opinion?

Fleur BEHRENS: What the data is telling us is that we receive a lot of incivility-related matters and matters that could I think be dealt with earlier and not necessarily need come to us. Where I would like to see us get to is that we build the confidence and capability of our leaders to address those issues as they arise, setting the standard so that those things do not escalate to a complaint to my department. I think there is a journey that we are on about building confidence in the organisation, both in terms of that if you make a complaint the complaint will be dealt with –

Renee HEATH: Something will happen.

Fleur BEHRENS: Yes, something will happen, but also where I want to get that to and I think the whole organisation wants to get that to is that actually I can make that complaint to my manager and if they have got the scope and the confidence and the capability then they will deal with it locally. It might be very serious and still need to come to us, but if it is a lower level matter then we build that confidence. I think there is a journey of uplift.

Renee HEATH: Are you aware that apparently with a whole lot of AV staff there is a running joke that if you want six months off, paid leave, you get done for misconduct? That is something we have heard over and over again in the closed settings.

Jesse MADDISON: I think it is a hard way to get time off.

Renee HEATH: But are you aware that that is a –

Jesse MADDISON: I actually have not heard that, but I would have thought it is quite a hard way and a probably dangerous way, because it might mean that you are ultimately no longer working for Ambulance Victoria.

The CHAIR: Time has expired on that question, I am sorry. I am going to hand over to Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thanks very much, Chair, and thank you both for being here. The workforce composition: women make up 54 per cent of AV. Would that be an accurate approximation?

Jesse MADDISON: The frontline paramedics.

Anasina GRAY-BARBERIO: You just mentioned, Fleur, the patterns or the themes of complaints that are coming through around sexual harassment. I just want to bring you back to the VEOHRC phase 1findings, where statistics show that 52.4 per cent of survey participants experienced bullying but only 17.4 per cent experienced sexual harassment. Has that gone up? Have those sorts of figures increased from what you are seeing coming through the complaints? And you mentioned before that people need to feel confident to submit these complaints through the system, but how about trust? Where does that sit? Do employees in AV trust the system, so that if they are going to make a complaint they are actually going to see action – you spoke about this, Jesse – where they feel heard and it is substantive?

Fleur BEHRENS: Thank you for your question. I think trust is building. It is an area that I would say the organisation, coming out of and taking on board and committing to implementing the VEOHRC reforms – VEOHRC clearly spelled out that there was a significant issue. It is an area of work that has been really important for our department in terms of making sure that we promote and make people aware of the pathways, that they can come to us, that they can come to us anonymously, because there are issues that people have cited – people have spoken to me about their fears about coming forward – so we are trying to really actively address that. I just do not have, unfortunately, the data in front of me, but there is evidence of under-reporting. We know from our People Matter survey that there was an indication that the last one was about 17 per cent – it might not have been 18, as you have said – had experienced sexual harassment type behaviour in the past 12 months.

Anasina GRAY-BARBERIO: Is that disproportionately affecting women?

Fleur BEHRENS: I would say that, based on the data of what we have received, we have a higher number of complainants that are female. In terms of the People Matter data, I do not have that in front of me, but I am happy to take that question on notice in terms of the impact of that. Certainly what is reported to us is a lot lower, so we know that there is under-reporting occurring in the organisation and are trying to really actively tackle that with some of the initiatives that we have got. We have created posters with QR codes that we have asked our branch managers to put on the back of all the toilet doors that inform people what sexual harassment looks like and how to make a complaint, and we try and make that as easy as possible. We are trying to give our leaders in the organisation the language so they can talk to their teams really actively about these types of issues. We produce quarterly reports for our workforce about what data we are seeing in terms of types of behaviours. We have a prevention-focused plan. For the past six months we have focused on sexual harassment as the main one, and we are going to circle back to incivility in the next six months. But we are doing a learning module for sexual harassment. We have done the masterclass, those types of things, really trying to promote those issues so that we give people the language and the confidence to come forward. But I think in reality for us we know it is an ongoing journey. I would hope – it sounds bad – if the numbers go up, that to me at the moment would be a good thing if the number of reports coming to us went up. I think that would be positive because it would demonstrate that people are trusting the system more.

Anasina GRAY-BARBERIO: Thank you. In volume 2 of the VEOHRC report some of the issues that they identified – this is related to women – were progression for women and diverse backgrounds. Some of the challenges that they raised were the lack of flexibility for women and women with disabilities. How are you addressing this to ensure equality is upheld in your culture and your systems?

Jesse MADDISON: Thank you. It is a good question. Perhaps I might be better placed than Fleur, because it probably sits under the broader remit of people and culture, and part of it I think comes back to the sort of flexible work arrangement question and the rostering. I think those are a couple of elements of it that need to improve: the rostering – how we manage those sorts of flexible work arrangements; and also our reasonable adjustments policy, which is one of the key policy planks that is in development at the moment, because there are more women paramedics than men. I might be showing my age a little bit now, but not that long ago – 1987 – there were no female paramedics. So again, historically we are – using this word – on a journey, but there is clearly more to be done there to support a more diverse workforce than what we have traditionally had, and being able to support –

Anasina GRAY-BARBERIO: And how long do you reckon you will be using –

The CHAIR: Sorry. Time is up, I am afraid, but I will give you a couple of seconds to respond quietly, if you have got any further comments to make – or not.

Jesse MADDISON: I do not know. Was there a last bit of question?

Anasina GRAY-BARBERIO: No, please finish your –

Jesse MADDISON: It is another one with more work to be done, clearly, to support the flexible arrangements rostering that is more fit for purpose given a diverse workforce, and to support, specifically to your question, females as well in the workforce.

Anasina GRAY-BARBERIO: Thank you.

The CHAIR: I will hand over to Mr McIntosh.

Tom McINTOSH: Thank you, Chair. Thank you both for being here, and thanks for taking so much time to go through the issues of culture and the work that you are doing. Obviously with the staff and the volunteers within the organisation that the community values so much, putting that work in is incredibly important. I do not think it matters whether it is a bank, a sports club, a political organisation; when you have got people, they can clash and we can have friction and we can see that play out in a variety of ways. But I think that trust-building you spoke to and honouring, particularly, this workforce that we value so much as a community with a fair and just culture is really important.

Jesse, you made the point that the endpoint is servicing the community and I think that is a really interesting point. Ms Heath in an earlier session talked about how it is about the system, not the individual, which I think you were just sort of – but I would say it is actually about the individual and we build the system to service the individual experience. I raised my personal experience with Dr McManamny before, but also what I hear back from community about valuing ambulance, ACOs, all the stuff, so much – then there was that 97 per cent satisfactory feedback of Victorian consumers' experience of AV. Can you just talk to me about that 97 per cent? I think it comes back to the word you said before about servicing, that commitment to servicing the community that is obviously experienced by the community.

Jesse MADDISON: Yes, and thank you for the question. It is a very good one, and I think it does raise perhaps contradictions between what the community is overwhelmingly experiencing from our paramedics but then what our paramedics are telling us as an employer – it is a different experience than what the community is experiencing. I think that is the challenge for AV, about how we get the experience that the community is receiving overwhelmingly from the paramedics, that that is the experience our people are feeling as employees at the organisation. Because it is quite an interesting kind of dynamic, if you like, that it seems kind of out of whack. It shows a couple of things: I suppose for me it is the professionalism of our paramedics, the great work they do and how committed they are to the actual work that they are employed to do, and I think even some of VEOHRC's information and from our People Matter surveys around that, as an enabler, how do you harness that kind of professional attitude to bring it in-house about this being how we want to treat each other and how managers should be modelling those behaviours that are felt and seen by the community?

I think that is really the challenge for AV. People know what it is, the good stuff. But how do we flow it through more generally, noting, like you have picked up, where there are people in a workplace doing stressful work, there will always be some interpersonal issues. But again, how do you get to those early and have managers who have the confidence to be able to have those difficult conversations – and they are called difficult conversations because they are. But I think they are the bits that are really key to changing the experience for our people. Then you have those processes in place that deal with misconduct, and again there will always be instances of that. But at the moment there is too much of that and not enough of the good stuff. I think that is, again going back to the work, the kind of journey that we are on.

Tom McINTOSH: I think where it almost borders on a vocation, where the community benefit is so large or so vital, that there are a number of professions where you have to watch that line, I suppose, between the work or the volunteer force and just what is given.

Jesse MADDISON: Yes, it is obviously a very stressful job. What are the outlets for people to deal with the stress of the work without passing it on to their colleagues? Again, Mr Carlyon earlier today talked about some of those wellbeing supports. I think that has really changed over time from people just used to not talking about the stress of the work and just bottling it up, which was the traditional way of dealing with work stress, to having the range of wellbeing services that we have got in place now and people being a lot more open to reaching out and using them. The stigma is not as it used to be, but there is still stigma if I say that I am not really coping. What are people going to think of me? That is other work that I think has changed a lot over time, but there is still further work to go. But, as Mr Carlyon said, we have probably got some of the best internal supports for our paramedics than any of the emergency services organisations.

Tom McINTOSH: Yes. Right across society we have got to get to that position, where we are not yet.

The CHAIR: Time is up, sadly.

Tom McINTOSH: Thank you, Chair. I appreciate your time.

The CHAIR: Thank you. Ms Crozier.

Georgie CROZIER: Thank you, Chair. Thank you both for being before us this morning. Ms Behrens, you said words to this effect: incivility matters do not necessarily need to come to your department. I do not want to trivialise the issue, but do you think harassment and bullying are being weaponised with staff against managers and managers against staff?

Fleur BEHRENS: Thank you for the question. Certainly it is one of the issues that managers have talked to our department about, and just very recently the data has started to come out telling us where the differential is

in terms of who is the complainant and who is the respondent. Then we have done a little bit of a deep dive more recently just to contextualise that. When we launched the department, we built a case management system from the ground up. We have done various sprints with the assistance of our BTP area to build the capability of our case management system so we can now see more and more trends as time goes on. What we are seeing is that our management levels are overrepresented as respondents in complaints as compared to the proportion of the workforce that they make up. But when we have looked at the ones on file at the pathway that we have determined in terms of what is the appropriate way for this to be managed – is it something that we think is lower level and can be managed at a local area, or is it something that requires an investigation in our department – it is overwhelmingly matters that we refer back for local resolution, or there is no further action taken.

Georgie CROZIER: Thank you. Is it correct that a number of senior managers have been stood down, in one case for two years, as a result of vexatious allegations?

Fleur BEHRENS: I am not sure I can answer that without the specific detail of the matter.

Georgie CROZIER: Well, have senior managers had vexatious allegations made against them and therefore they have been stood down, in one case for up to two years? An investigation would have been undertaken into that, and if it was, what was the outcome of that investigation?

Fleur BEHRENS: Without knowing the specific individuals you are talking about, it is very difficult for me to answer the question. There are a number of matters that I have seen in terms of 'name withheld' submissions that, from what I can ascertain, are matters that were commenced under the previous system, and we may have had some involvement in terms of closing those. We have not had any matters where we have had findings in relation to vexatious complaints.

Georgie CROZIER: No matters relating to vexatious allegations?

Fleur BEHRENS: No.

Georgie CROZIER: So you have had senior managers that have been stood down for a number of years though, haven't you?

Fleur BEHRENS: I am aware of one case where there was a senior manager that was –

Georgie CROZIER: Was that investigated by your department?

Fleur BEHRENS: It was investigated by an external client.

Georgie CROZIER: And what was the outcome?

Fleur BEHRENS: That is subject to legal professional privilege. I am not able to –

Georgie CROZIER: This is a parliamentary inquiry so we have privilege –

Michael GALEA: There are legal proceedings underway. She is entitled to answer as she sees fit.

Georgie CROZIER: Excuse me. Is that being pursued in a legal matter at the moment?

Fleur BEHRENS: No. The matter is finalised, but the report and the substance of that report is privileged.

Georgie CROZIER: So how many people have been stood down? How many deeds of release have been undertaken in the last 10 years? How many employees at AV have been stood down – in this case for two years – based on a vexatious allegation. You are saying you cannot give us any information, but there are a number of others that we know have been stood down over the years. What has the cost been to the taxpayer while these people have been stood down and those deeds of release have been provided?

Fleur BEHRENS: As I mentioned earlier, since our department opened in June 2023, we have not had any matters where there have been findings of –

Georgie CROZIER: I am not talking about 2023. I am talking in the last 10 years, because this issue has been going on for years.

Michael GALEA: You are asking a department that has been open for two years.

The CHAIR: Just let the witness respond.

Georgie CROZIER: I am concerned, Mr Galea and other members, that there is a problem within AV and the issues are still ongoing even though the department has been set up. There are many issues, and I would like to know how many deeds of release have been provided over the last 10 years. You might not have that. Obviously you will not have that information on hand, but there have been significant numbers of people that have been stood down with deeds of release. And what has the cost to the taxpayer been?

The CHAIR: Time is up, but you have 30 seconds to respond.

A member interjected.

Georgie CROZIER: It is an important issue.

The CHAIR: Time is up, and you have got 30 seconds to respond.

Georgie CROZIER: You can take it on notice.

Fleur BEHRENS: I am happy to take that on notice.

Georgie CROZIER: Thank you very much indeed.

The CHAIR: That ends the number of the questions that we have got here in a timed sense, but we are going to go back and forth. We have got a few minutes left. Mr Galea, you have got a couple of minutes if you would like.

Michael GALEA: Thank you. Just in terms of the support provided to all staff but particularly frontline paramedics, they obviously work very long hours in often trying and different situations. In terms of the work that is done to keep them safe, both obviously from difficult situations but also from issues such as overtiredness and other things like that, what sort of work are either of you – I am assuming this is more for you, Mr Maddison. What is your department doing to support that, and are there any changes that you are making?

Jesse MADDISON: Yes. That is a very good question. Fatigue obviously is a big issue. Overtime can come in a few different forms. It can be kind of incidental. Obviously, you know, if you get a case towards the end of your shift, depending upon the nature of it, you cannot just kind of go home. Then there is also full shift overtime with unplanned absences and needing to fill gaps in the roster. It is quite a significant issue, given the stressful work they do and some of the shift lengths are quite long. In the most recent bargaining round, end of shift was certainly one of the key matters.

Michael GALEA: Something I heard a lot about as well.

Jesse MADDISON: I think we were able to arrive at a solution that is two-phased. The second phase will kick in sort of November this year. Again, there is obviously quite a bit of work to ensure that we are balancing up those competing interests of people being able to finish their shift and go home at the appointed time versus servicing the community and not leaving people who have serious health issues that need to be emergency treated left without a paramedic. So there is some work being done to ensure that there is a system in time. The union were very clear in those negotiations. I think there have been some of those conversations –

The CHAIR: Time is up on that question, I am afraid.

Jesse MADDISON: Sorry.

The CHAIR: But if you want to conclude within the next 10 seconds, you are welcome to.

Jesse MADDISON: It is a bit hard. We are getting there. It is an issue, and we are certainly working on it. It is something that needs to be resolved in a better way than currently.

The CHAIR: Thanks. One very last question from me, and it is to Ms Behrens here. I was looking at submission 54 to the inquiry, and I want to read it out to you because it is about the professional standards and behaviour division. It states, and this is from the individual writing it:

> I don't think much has changed in the way they handle serious allegations. After being physically, emotionally and sexually harassed by a fellow paramedic requiring an intervention order to be put in place by Victoria Police due to concerns regarding my safety, my perpetrator was allowed back in the workforce after 5 out of 8 allegations were substantiated. This person was stood down for 12 months with full pay. Shortly returning to the workforce, and less than 6 months after returning the are alleged to have committed a similar offence …

That has been a case while the unit has obviously been operating. They are saying that they do not think the process has really changed at all. You guys are saying that it has changed substantially. Who is responsible for investigating something of this nature, and why aren't things seemingly changing?

Fleur BEHRENS: Thank you for the question. It is a name-withheld submission, as I understand it, so I am not able to speak to the particulars of any given case, but we have a very robust system in place in terms of sexual harassment, and in our sexual harassment policy we have been very clear that we have a zero-tolerance approach to that and that substantiated findings will be treated as serious misconduct. Of the 35 sexual harassment matters of complaints that we have received since the department opened, we have terminated the employment of 19 per cent of those matters. We make available reports to our workforce that we are trying to build confidence around transparency. So, de-identified, we publish quarterly what the outcomes of our process have been. I cannot speak to the specifics of that particular matter. Not all complaints of any particular type of conduct are substantiated, and so the outcome depends on what is substantiated, and that process is fair and robust.

The CHAIR: 508, according to this one.

Fleur BEHRENS: But I do not know of what specifics were substantiated and what were not, so I cannot really speak to the outcome.

The CHAIR: It just seems to be that even though this unit has been put in place, it does not seem there is any substantial change, and that is what this submitter says.

I am out of time, unfortunately, and so are we for this session. Thanks very much for your time today and your evidence. We will close this session.

Witnesses withdrew.

WITNESSES

Andrew Crisp, Interim Chief Executive Officer,

Shelly Park, Board Chair, and

Danielle North, Executive Director, Regional Operations, Ambulance Victoria.

The CHAIR: Welcome back, to session 5 of the Legal and Social Issues Committee's Inquiry into Ambulance Victoria. I am Joe McCracken, the Chair, and we are going to go around and introduce the committee members as well.

Michael GALEA: G'day. Michael Galea, Member for South-Eastern Metropolitan.

Ryan BATCHELOR: Ryan Batchelor, Member for the Southern Metropolitan Region.

Anasina GRAY-BARBERIO: Good afternoon. Anasina Gray-Barberio, Member for Northern Metro.

Georgie CROZIER: Good afternoon, everyone. Georgie Crozier, Member for Southern Metropolitan Region and Shadow Minister for Health and ambulance services.

Renee HEATH: Renee Heath, Member for Eastern Victoria Region.

Rachel PAYNE: Good afternoon. I am Rachel Payne, and I am a Member for the South-Eastern Metropolitan Region.

The CHAIR: We will also be joined, I am assured, momentarily by Mr McIntosh, who has just gone out to get some fresh air. He will not be too far away.

All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information that you provide to this hearing is protected by law. You are protected against any action for what you say during the hearing, but if you go elsewhere and repeat the same things those comments may not be protected by that same privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing. Transcripts will ultimately be made public and put on the website. For the Hansard record, are you each able to say your name, your title and the organisation that you are appearing on behalf of. Thank you.

Danielle NORTH: Danielle North. I am the Executive Director of Regional Operations at Ambulance Victoria.

Andrew CRISP: Andrew Crisp, Interim CEO, Ambulance Victoria.

Shelly PARK: Shelly Park, Chair, Ambulance Victoria.

The CHAIR: Thanks very much. I understand that you guys have got 8 minutes to go for a start, if that is all right. Patrick just told us before that you wanted 8 minutes. Have you got slides as well that you want to look at?

Andrew CRISP: No.

The CHAIR: All right. I will start the clock now, and we will go over to you guys.

Shelly PARK: Thank you, Chair. I would like to start by acknowledging the traditional owners of the land on which we are meeting today, the Wurundjeri people. I would also like to pay my respects to elders past and present, and Aboriginal elders of the communities who may be with us at today's hearing or listening online. I would also like to acknowledge the members of the Legal and Social Issues Committee. I thank you for the opportunity for us to speak with you today. I also recognise that this inquiry provides an opportunity for the

community and the members of AV, past and present, to discuss their experiences and what they believe to be opportunities and challenges for Ambulance Victoria.

Joining me here today is Andrew Crisp, Interim Chief Executive Officer, Ambulance Victoria, an experienced leader with over 45 years experience in policing and emergency management, and Danielle North, the Executive Director of Regional Operations, who has dedicated 24 years to AV, starting her time as a paramedic before taking on roles such as clinical instructor, team leader and area manager with the metropolitan area. Danielle joined the executive team in May 2024 and, along with Anthony and Tegwyn, who you met this morning, and David Anderson, our medical director, provides our executive team with strong clinical insight, advice, guidance and observations about the role that our frontline people play.

I have been the Board Chair since August 2022 and have led our board of independent non-executive directors overseeing our responsibility, as outlined in the ambulance Act. AV is an independent statutory authority and in my role as Chair I work with the Department of Health and the minister to ensure that the board has the required skills, competency and diversity to provide strong, insightful stewardship of the organisation. The board of Ambulance Victoria possesses diverse and extensive qualifications and expertise in governance, clinical governance, government, technology, health leadership, finance law and community engagement. As a relatively new board, with members predominantly joining between 2022 and 2024, it is dedicated to reforming and governing a significant transformation program to meet its objectives of providing high-quality ambulance services to all Victorians. The board prioritises stewardship, clinical governance and risk management. It has an established robust committee structure, including the quality and safety committee, which ensures that services align with clinical standards, and the finance committee, which focuses on financial sustainability – guided by our statement of priorities and our *Strategic Plan 2023–2028*.

Whilst the board do not engage in day-to-day operations, we provide strategic oversight and receive regular reports on operational performance. We acknowledge the well-documented challenges facing the organisation. These are not short-term issues, are not quick turnarounds, and we are actively addressing them with a long-term view. Our board discussions consistently prioritise the wellbeing of our people, their safety and the communities that we serve. Clinical outcomes remain strong, and we are proud of the performance against the statement of priorities clinical indicators, which reflect our adherence to high standards of patient safety, clinical effectiveness and patient-centred care. I could not sit here without acknowledging that we are all deeply impacted when things go wrong.

Before I hand over to Andrew, who will share some words with you also today, we are committed to learning from this inquiry. We have heard a range of experiences from our staff, and we have approached these with fairness, due diligence and a focus on equity. The board remains steadfast in its responsibilities and is determined to govern with integrity, transparency and a deep commitment to the people of Victoria. Thank you. Andrew.

Andrew CRISP: Thanks, Shelly, and thank you, Chair and committee. I would also like to acknowledge the traditional custodians of lands on which we are meeting today, the Wurundjeri people, and pay my respects to elders past and present and to any First Nations people with us here in the room or joining us online. I would also like to acknowledge you as the committee and thank you for the opportunity to appear here today.

I am sitting here as the interim CEO of AV, a role I did not think I would ever hold. My background, however, has been in working in uniform with our emergency services as a police officer for 40 years and as Victoria's emergency management commissioner for five years. I provide that background, as it is important in terms of my time with AV and the opportunity to work with people in an organisation where there is a common purpose, and that is to keep Victorians safe. I have done ride-along shifts with MICA and ALS paramedics, visiting many branches and work locations across the state. Importantly, I have also had the opportunity to attend a number of the regional staff service awards. All those interactions have reinforced for me this focus on a common purpose and everyone wanting AV to be the best it can to support our community. While this is a strong message from people working across AV, I have also heard it from family members that attended those service awards, who were so proud of their family member and also felt part of the broader AV family.

I want to take this opportunity to thank all our hardworking professional paramedics, doctors, nurses, first responders, corporate people, support people, everyone that is so focused on delivering an excellent service for this particular state. I also want to thank the families and friends of all our staff, who provide them with such

amazing support. We know at times shiftwork does get in the way of family events and celebrations, and I acknowledge that. Quite rightly, many positive stories are told about our paramedics, first responders and world-leading researchers. However, just briefly, in terms of the corporate and the support areas, I visited the fleet workshop in one of our regional centres and spoke to a few mechanics, and I was blown away. I knew that they obviously maintained our vehicles, but I did not realise all the work they actually do to maintain our stretchers. They have actually come up with quite a number of innovative ways that the manufacturer had not even identified. They knew their role as part of a big team, and I saw the pride they had in Ambulance Victoria.

With that common purpose, pride and passion for what you do, there will be times when you become frustrated when you cannot do the best that you want to do. I heard that on my visits to branches and work locations, where I always asked our people to tell me what was on their minds, or I would ask what the one or two things are that you want me to bring up with the new CEO. There were definitely some key themes resulting from those discussions that are consistent with matters raised in submissions to you and matters explored by you that I heard last Friday and earlier today. Those themes include rostering flexibility, leadership stability, uniform representation at the executive level, call taking and dispatch, corporate support, pay slips, culture and behaviour. In those discussions there was acknowledgement that there have been some positive developments, and the introduction of iPads and digital radio for regional Victoria have been very well received. The themes and areas for improvement are all things our executive is actually well and truly focused on, as is the board. You have already heard from some of my colleagues today, and no doubt there will be matters that you wish to explore with us this afternoon.

I have every confidence in our AV executive leadership team and our new CEO Jordan Emery. I also have confidence in the broader leadership group at Ambulance Victoria, who are passionate about serving our community and working together with our health service partners to provide the best care to all Victorians. As I transition to the role of chair of the AV board, I am thankful for my experience as the interim CEO. I am deeply invested in the future success of Ambulance Victoria and ensuring we deliver the best emergency health outcomes that are possible for our community. Thank you for your time, and I am happy to take your questions.

The CHAIR: Thanks very much. You timed that beautifully with about 8 seconds to go, so well done. I will hand it over to Ms Crozier.

Georgie CROZIER: Thank you very much. Thank you all for being before the committee this afternoon. Mr Crisp, you just said there is room for improvement and it is a focus of the board, so I am asking you and Ms Park. There is not a paramedic or anyone with pre-hospital experience on the board. Is that an oversight and gap that you think would benefit the organisation, if somebody with that experience was on the board?

Andrew CRISP: I will let Shelly as the current Chair speak to that, but I will admit that, front of mind, I have been thinking of that as I come into the chair's role. As Shelly quite rightly pointed out, it is a very diverse group of people on the board, and whilst some might not have been paramedics, there is strong nursing background and medical background across –

Georgie CROZIER: I am not discounting any of those. It is that pre-hospital and paramedic experience.

Andrew CRISP: Exactly. It definitely should be a consideration.

Georgie CROZIER: Thank you. Can I just go back to Public Accounts and Estimates hearing last Tuesday 10 June, when you told that committee that you were surprised when you came to Ambulance Victoria to find:

> that there was not the digital coverage for Ambulance Victoria. I am used to coming from a policing background and emergency services where those types of communications need to be kept basically secret …

So encrypted radio messaging in other words.

Andrew CRISP: That is right.

Georgie CROZIER: You have previously held the role of commissioner of Emergency Management Victoria. Surely you would have known that AV did not have that capacity, considering you came from that role.

Andrew CRISP: I did know. I remember when the budget bid went in, but I was not sure as to where AV was in terms of introducing or implementing digital radios.

Georgie CROZIER: Okay, so just on that, you were aware of the budget bids and you were responsible for allocating that funding when you were EMV commissioner?

Andrew CRISP: No, no.

Georgie CROZIER: Well, you had an oversight. Any distribution of that funding?

Andrew CRISP: No, not at all.

Georgie CROZIER: That came from the government.

Andrew CRISP: That is right. That is exactly right.

Georgie CROZIER: In that role – obviously police and fire services have got this service and AV do not – what was your recommendation to government?

Andrew CRISP: The budget bid was prepared before my time in that role.

Georgie CROZIER: Before you were EMV commissioner?

Andrew CRISP: That is right.

Georgie CROZIER: Okay. All right. Have you got any insight as to why AV has missed out on this funding, given it is so critical to emergency services management?

Andrew CRISP: Look, I will have to be honest, I do not know. I would imagine budget bids had been put up previously and for whatever reason were not accepted, but I do not know specifically why.

Georgie CROZIER: We have seen today's story where there has just been a shocking mix-up with information getting out and the issue around police and Ambulance Victoria not communicating. Should it be ramped up to be an absolute priority for the system?

Andrew CRISP: The rollout of digital radio across regional Victoria is a priority, and it will be completed by the middle of 2026.

Georgie CROZIER: So you can guarantee it will be complete by the middle of 2026?

Andrew CRISP: That is right, yes.

Georgie CROZIER: Okay, guaranteed. If I can just go to another question around the paramedic funeral that occurred during COVID. You obviously were not in Ambulance Victoria. Ms North, I think you were there. Could the committee have a copy of the report, please?

Andrew CRISP: If I could, I will come to that. Again, I do not want to split hairs around this, but it was not a funeral. There were private funerals that were actually held –

Georgie CROZIER: Just the report that was undertaken in relation to those events.

Andrew CRISP: Yes. I will have to take that on notice.

Georgie CROZIER: I am not expecting to have it now, but I think the committee would like to have a copy of that report. Thank you.

Andrew CRISP: If I am able to provide a copy –

Georgie CROZIER: This is parliamentary privilege, Mr Crisp. The organisation has that report, and I am asking on behalf of the committee for it to be provided.

Andrew CRISP: I will take that on notice. If I am able to provide the report, I will provide the report.

Georgie CROZIER: Why can't you?

Ryan BATCHELOR: He will take it on notice.

Georgie CROZIER: Ms North, what did you know about that event?

Danielle NORTH: I did not know anything about that event until it became public this year in the media reporting in April.

Georgie CROZIER: Ms Park?

Shelly PARK: I came into Ambulance Victoria in August 2022. When I came in, after two weeks, I think it was, in early October, I got approached by IBAC and asked to meet with IBAC. What I learned then was that there was a report that had been referred to IBAC. The previous chair had taken the principal officer role and reported that to IBAC. I was not aware of that as I came into the organisation. I met with IBAC and then spoke with the board about the findings that IBAC referred back to us. I cannot speak about the details of the IBAC report. You will be –

Georgie CROZIER: There was not an IBAC report. The report came back. AV did the report, and you have the report. The committee would like it.

The CHAIR: Time is up, I am afraid. If you want to respond within the next 30 seconds, you are welcome to. Otherwise I will pass it on.

Shelly PARK: I will wait. I am sure it will come again.

Georgie CROZIER: It was not an IBAC report.

The CHAIR: Thank you. Mr Galea.

Michael GALEA: Thank you, Chair. Thank you all for joining us. As has been acknowledged in the opening remarks, there have been some well-known and well-led issues with Ambulance Victoria, especially its executive team, over past years. What specific changes have been put in place in terms of the executive team? It is probably an appropriate time to ask you, Mr Crisp, but happy for you to answer as well, Ms Park, as you come out of your role. What changes have you been able to undertake and what do you still expect to be taken under the new team?

Andrew CRISP: Thank you very much for the question, Mr Galea. I will be up-front: there has been significant change at the executive level over the last 12 months or so. As you heard from Mr Maddison, he has not long been in the organisation, so he is relatively new as the Executive Director of People and Culture. Tegwyn McManamny, the Executive Director, has taken over the quality role, so new positions. Again, the appointment of Tegwyn is the first time that we have had a paramedic in that particular role. As Shelly mentioned before, when you look at the executive team now, including Anthony Carlyon, Danielle and David Anderson, our medical director, you have actually got four uniforms around the table. This was an issue that was raised with me previously by paramedics, but now they are actually seeing four uniforms around the table.

We are at the moment looking at recruiting the executive director for enterprise services, so our business corporate finance areas. Again, there have been internal announcements, but I am not sure whether the committee is aware, but Mr Carlyon is moving to a more senior role at RFDS. I am not sure if it is appropriate for me or not, but he has been around for 20 years and has served this organisation and this community very well, so I would just like to acknowledge his incredible effort to AV and the community.

Michael GALEA: We will acknowledge that service then too. It is good to hear indeed, because that is the concern that I have heard from frontline members as well, being in my electorate or beyond – the concern about the lack of uniforms in the higher levels and then the disconnect between decisions made and the practicalities on the ground. Have you had any feedback yet, based on those roles you have just mentioned, as to that culture changing?

Andrew CRISP: Yes. I will let Danielle speak to this as well, but when we have been out visiting branches I have heard a lot of positive feedback, particularly in relation to the recent appointment of Tegwyn, because not

only does it bring another uniform, another woman into our senior executive team, but she is also based in regional Victoria. It is an opportunity for people in regional Victoria to identify with someone that is now on our executive. Danielle, do you want to –

Danielle NORTH: Yes, thank you, Mr Crisp. I think not only is it about the appointment and the representation in senior leadership teams, it is about the ability that we have to continue to go out and work with our workforce to understand the issues that they face, to be connected to the challenges that they face, to spend time in the emergency departments, to spend time at branches, to spend time on road in operational capacity – to ensure that we are contemporary with the information that we have and that we understand the issues as they evolve across our organisation. I think there is a component about representation, but there is a component about a contemporary approach to the way that we represent and work with our staff to be sure we understand the issues right across the system, to better represent the work that we need to do to lead forward.

Michael GALEA: Thank you.

Andrew CRISP: And if I could – sorry, I did forget someone. Our new CEO obviously has a very strong paramedic background, so I think that shifts the focus. I think it is five–four now on the executive team in terms of uniforms.

Michael GALEA: If I can just ask, on the point – it is really great obviously seeing executives going in and seeing things as they happen. From my prior experience in the industrial relations sector – different industry altogether – it was very common for when an executive was coming in, everything would be fixed up, everything would be made pretty and perfect, and staff would be over-rostered, so everything is looking great. Is there propensity for that to happen with AV on executive visits? Or do you do random visits, drop-ins, things like that, so that you are seeing a bit more of an accurate picture?

Danielle NORTH: I certainly do not see that. I get a very real response from our workforce. My visits, when I drop in, are very unannounced and unplanned, and I will just drop by a branch and say hello or drop into an emergency department and see what is happening and have a chat to people about their experiences and the delays and whatever might be pertinent for them. Certainly they are not structured. I do not think a structured visit is helpful. I think the intent is to actually be present with the people and hear and see what is occurring. I think if were to structure those, it would be a tremendous missed opportunity about really understanding where we need to put our focus.

Michael GALEA: I would agree.

Shelly PARK: Can I build on that further: the board also does visits. For example, when I have gone out with David Anderson, our chief medical officer, we do not tell people where we are going; we turn up, both at hospitals and at branches, and the engagement and the opportunity of staff speaking with us is full, frank and not predetermined. I am just giving you the assurance of that – that it happens at every level.

The CHAIR: We might have to move on now. Ms Gray-Barberio, it is over to you.

Anasina GRAY-BARBERIO: Thank you very much. Thank you all for being here. In your opening remarks, Ms Park, you spoke about a focus on patients, outcomes and equity, but in the VEOHRC findings, one of the ongoing barriers that they pointed out was a focus on compliance over intent in change management. Now, prior to your arrival we had your director for people and culture, and this question was also put to him. Is there still a mindset of compliance over intent to change?

Shelly PARK: I believe there is not a mindset now of compliance over intent to change. I think the change that we have had at the executive level is leading that, along with the focus of the board. We are very focused on the change, and you would have heard that a lot of the priority recommendations have either been enacted, or are on the way – there were two that were remaining outstanding, and they are both now in our new people plan. What VEOHRC talked about was we had missed some of the intent. That has been heard. Ro Allen and her team had met with the board and the executive and have unpacked that, so we have the full understanding of what they have heard, and then the people plan – and how we have rolled that out throughout the organisation as to accountabilities for delivery – is looking to deliver on that intent. This is a long-term process of reform.

Anasina GRAY-BARBERIO: The Victorian Ambulance Union said that with regard to people and culture there is high burnout, high stress, big workloads, heavy workloads for paramedics. How are these reforms capturing these challenges that your workforce are bringing to you – not just the change in leadership, but how is it changing structurally and what kind of intersectional lens are you also applying to this?

Shelly PARK: The change in structure – and I will get Mr Crisp to talk more about that – is happening at every level. Transformational change cannot happen by only a board or an executive, and one of the things that we have heard very much is it needs to be end to end. So there are processes in place, and I will let Andrew talk to some of the detail.

Andrew CRISP: This is a multifaceted issue in terms of looking after our people and building morale. It is not just the one thing. Again, we are taking more of an outcomes focus when it comes to recommendations, whether it is the People Matters survey or the VEOHRC report or a psychosocial survey that we actually do. Again, what our organisation – I sort of touched on it in my opening – is doing is about leadership stability, and that makes such a difference. I know that Jesse was talking about uplifting the ability of our leaders. Again, on visits when I have gone out I have been told team manager positions have been vacant for three years or maybe even longer, but just recently we filled 72 or 74 team manager positions; I think it is half-a-dozen area manager positions. That is such an important component, because people know who their leaders are and leaders can actually take an interest in their people. I am not suggesting that those that act in the role do not do that, but leadership stability is critical.

Danielle NORTH: Yes, I can certainly support that. One of the key areas of focus in the operational leadership over the last 12 months since I have commenced in this role is about the appointment of as many senior leadership positions as we possibly can, notwithstanding that we will always have acting arrangements given the leave provisions that we have in our organisation. In the time since I have commenced we have appointed a regional director that was a vacant position; as Mr Crisp has said, six area manager positions have been appointed; and I think it was 76 team manager positions recently announced in the last couple of weeks. Some of those are lateral transfer positions for leaders moving across the state and some of those are appointments through career advancement. I think that is particularly important, because we cannot lead the cultural change in isolation; this is something that we have to do as a team. I heard a little bit of conversation this morning in relation to trust, and actually having leaders that are in place that build relationships with their teams, that understand the needs of our workforce – and it is a very unique environment to work in Ambulance Victoria, and it is a very unique environment in the operational space – to have that leadership present, to have a strong understanding and relationship and mutual respect between our leaders and our workforce enables people to actually deliver better outcomes and to be better supported in their workplace, so I think that is a really positive step forward.

Anasina GRAY-BARBERIO: Thank you. Just on what you just spoke about – mutual respect, reciprocity – how are you sharing power with the paramedics?

Danielle NORTH: There are a couple of things that we are doing in support. There is the more formal approach that we have with regard to training and uplift. We are supporting our leaders with the Leading Together program of work that is being rolled out across the operational leadership. We are also supporting our 475 operational managers who have undertaken the upstander program. That is an embedded end recommendation through the VEOHRC findings where we actually support our leaders to uplift and be able to respond to matters of concern that are raised by our workforce. We are also making sure we open and understand the needs of our people through hearing from our people directly. The employee engagement forums have been established, and we had our first series of those, where every branch in March held –

Anasina GRAY-BARBERIO: Yes, I think the people and culture director spoke to that.

Danielle NORTH: Correct, yes.

Anasina GRAY-BARBERIO: I will just finish up my line of inquiry, because I am sure I am coming to the close.

The CHAIR: It is over, yes.

Anasina GRAY-BARBERIO: Can I just ask one quick question?

The CHAIR: Tiny.

Anasina GRAY-BARBERIO: Does the executive leadership team have a community advisory committee that advises them on, obviously, the cross-culture of paramedics, of lived experience? Do you have that?

Andrew CRISP: We do.

Danielle NORTH: The board does.

Andrew CRISP: Yes, the board does.

Anasina GRAY-BARBERIO: The board does. Okay, great. Thank you.

The CHAIR: Okay. I will go Dr Heath.

Renee HEATH: Thank you very much. Thanks so much for coming in and being here today. Mr Crisp, you were at PAEC last week, and you were asked a question about what percentage of MICA paramedics are currently on WorkCover or on long service leave. I knew you were taking that question on notice, so I just was hoping we could get those answers today.

Andrew CRISP: Yes.

Danielle NORTH: I can give you that information now.

Renee HEATH: Thank you.

Danielle NORTH: I can confirm the current MICA workforce is 586. At the moment, in May of 2025, we have 26 MICA paramedics that have a period of leave in relation to WorkCover and 11 in relation to long service leave.

Renee HEATH: Okay. Thank you. Long-term sick leave, as in greater than one month – how many?

Danielle NORTH: I would have to take that question on notice.

Renee HEATH: Thank you. Yes, all right. And how many of these staff have a written return-to-work plan that is being managed by AV?

Danielle NORTH: I would have to take that specific detail on notice.

Renee HEATH: Thank you. I would appreciate that.

Danielle NORTH: But certainly for anybody that has been away from the workplace for a period of time, whether that be on personal leave, whether that be on WorkCover for whatever reason, how we support our people returning to the workplace is incredibly important, and we have got some processes and systems around that. But certainly the number that have plans in place, I would have to take that on notice.

Renee HEATH: Thanks so much. Was there anything else you wanted to add on those things?

Andrew CRISP: No, no – other than I would be very surprised if there were too many that did not have a plan in place.

Danielle NORTH: Correct.

Andrew CRISP: Because the expectation would be that there is a plan.

Renee HEATH: To get them back into work.

Andrew CRISP: Yes.

Renee HEATH: The committee has heard from the VEOHRC report, and a number of issues were raised around inclusion and diversity. I know that AV has created a number of roles to address that. I understand there are the senior lead, diversity and inclusion – there is a role there – gender equality program lead, cultural and

racial marginalised program lead, Aboriginal and Torres Strait Islander program lead and disability inclusion program lead. What cost is that to the taxpayer? What sort of remuneration are these roles receiving?

Andrew CRISP: Again, in terms of specific dollars, I would have to take that on notice. However, what I would say is there are benefits associated with actually having those roles in the organisation. We need to work with and we want more of our paramedics reflecting the broader community that we actually serve. So again, to bring people into the organisation that can inform our thinking, our policy, our operational practice, our clinical practice is critical to us as an organisation.

Renee HEATH: I completely agree with that. What we did hear, particularly in the closed sessions, is that there is a bit of a concern around the lack of clinical experience or the lack of on-the-ground experience, and quite a number of witnesses felt that representation, in a sense, became more important than the actual operational aspect of it and that potentially AV is prioritising diversity above clinical experience. Would you say that there is any truth in that?

Andrew CRISP: Look, you know, in the seven or eight months I have been in the role I do not know how many times I have heard patient first, patient centred. That is definitely the focus of this organisation.

Renee HEATH: I know they are really good mottos, but the outcomes – there are a lot of KPIs that we are failing in. We have heard about ambulances not turning up – you know, that people have waited hours. We have seen in the media somebody bled out and died in Box Hill – we all know about that – while ambulances were ramped one suburb over. We are not asking about what the motto is – we completely agree with that – but what about the outcomes and the actual experience and the clinical experience? What is informing that?

Danielle NORTH: I think there are a couple of things there. Paramedicine is a degree-based career, and so there is a comprehensive recruitment process that is undertaken to look at people's individual experiences. They undertake processes around interviews, psychometric testing, medical and physical assessments, drug and alcohol testing, reference checks and the like, with a view to identifying the best graduate paramedics coming into our organisation to deliver the very best care for the Victorian community. In response to your concerns around the timely delay, there are a couple of components there. You heard from my colleague Tegwyn McManamny this morning, whose area is responsible for clinical education and provides really robust clinical education and ongoing clinical education for our operational workforce. That is part of the development of paramedics ongoing. We provide 20 hours of continuing education every year. With regard to system delays, where we see that, that is incredibly distressing; nobody wants to see that type of delay. Certainly for our people that respond and for the patient and their family it is incredibly distressing. That is an issue around volume, demand and pressures in the broader health system as opposed to clinical qualification and skill.

Renee HEATH: So underfunding, not enough staff.

The CHAIR: Time is up there, I am afraid. Do you want to respond quickly to that? I will go to Mr Batchelor afterwards.

Danielle NORTH: Sorry, could you clarify the question?

Renee HEATH: You said it is about the demand –

Danielle NORTH: About the system under pressure.

Renee HEATH: Then we could take an educated guess that there is underfunding and not enough staff.

Danielle NORTH: I think it is about the system of care that we provide. You have heard, I think, some data this morning that talked to the 31 per cent increase in code 1 volume that we have seen since the beginning of COVID and a health system that is under significant pressure as a result and the increasing complexity of the patient presentations that we are seeing. We are seeing increasing patients with mental health concerns, respiratory, cardiac concerns. We are not isolated in Victoria in seeing those changes and increased demands. That is a nationwide and in fact international challenge that we all experience working in health.

The CHAIR: Thanks. I am going to pass over to Mr Batchelor now.

Ryan BATCHELOR: Thanks, Chair. Thank you all for coming in. Mr Crisp, it is a big organisational change piece that you are really seeking to undertake collectively. I was going to ask how that is being received by the workforce. I feel it has been answered a little bit about that, but in particular, how has the journey that you need to go on been received by the people you have to work with to achieve it?

Andrew CRISP: Again, both Danielle and Shelly can contribute to this really, really important point. I know it sounds clichéd, but it is all about our people. We are nothing without our people, no matter what their role is in the organisation. For me, it has always been about looking, listening and learning, getting out and about, being open and transparent and being prepared to hear the tough comments – the criticism. We do not learn unless we actually, to start with, build a culture where people are prepared to say what they think and what they feel. My position has always been that I do not care whether you wear a uniform or you do not wear a uniform, you are the most senior person in the organisation or the most junior; you will no doubt have an idea, a thought, and then it is about what opportunities, system structures and processes you put in place to ensure that those really good ideas get to the people that can actually make the decisions.

I will say in terms of Ambulance Victoria that there is a lot of decision-making that gets pushed up to a level that I do not think is appropriate at times, and that is another piece, because if we want to empower our leaders then there is nothing worse than, 'You can't make that decision. We've got to actually push it up.' There is a lot more that we want to do and need to do around devolved leadership. I was somewhat interested when I came into the organisation to see that we have incredible leaders across the organisation at all levels, but I do not think we are doing everything we can to support them. There is no mandatory leadership training for people to work their way from TM to STM to area manager. They learn from the good people and the examples of those that they do not want to follow. But this is all part of the change piece, so it is the people, it is the culture and it is about having a culture where people feel comfortable and confident to speak up. Danielle touched on the program that we have got running around that.

Shelly PARK: Talking about SpeakUp, people are becoming a lot more comfortable in speaking up. As we go around the organisation, at every board meeting we start off with a patient story, so we invite the voice of patients as well as the voice of our people. There is doubt that as I have spoken with so many people in my time at Ambulance Victoria they have not all experienced the issues that we are hearing at hand, so there is difference across the organisation, and I am convinced that every person wants to be incredibly proud of what they do, and they are all bought into and are very open with giving ideas of what we can do to be different.

Ryan BATCHELOR: Just going from that to sort of looking to the future – Shelly, as the current Board Chair, and Andrew, coming into the role – how is the board going to know that it is working? From a governance point of view, what are the things that you are looking for to know that the change journey that the organisation is on is being successful?

Shelly PARK: We have got a whole range of indicators that we hear at both board and at subcommittee, and I will hand over to Andrew in a moment about going forward. We get quarterly reporting on a large number of things. What we look at are patient complaints, staff complaints, RCAs; the quality subcommittee has got a whole process of what they look at. We get the data along with the balance of conversation, so I have an expectation that every board member goes out – they go out with the paramedics, they are out, they are out with the communities, both regional and metro –

Ryan BATCHELOR: So the board is in touch with the organisation and the community.

Shelly PARK: to hear the stories. I spend time, for example, with Danielle, with others, so we need to hear it at every level.

Ryan BATCHELOR: Yes.

Shelly PARK: So that is the start of hearing it, and I can tell you the stories I hear today are very different to the stories I heard three years ago.

Andrew CRISP: Just to add to that, and I will give Danielle the opportunity, we know across the public service the People Matter survey is conducted, and it is certainly of value; however, I think there is an opportunity in terms of actually reinforcing what we think we are hearing from our people to conduct more

shorter, sharper pulse surveys throughout a year just to just to check on where we do believe that we should have areas of focus. I think that is another accountability mechanism that would be really important.

The CHAIR: Sorry, I just am aware that time is up. Do you want to have 10 seconds to respond or say something?

Danielle NORTH: No, I think I am comfortable with that.

Ryan BATCHELOR: Thanks very much.

The CHAIR: That is fine. Thank you. Ms Payne, over to you.

Rachel PAYNE: Thank you, Chair. Thank you all for presenting before us today. Many of the questions I had have already been asked, but I would like to continue the conversation around building a sustainable workforce and particularly taking into consideration that resilience has to be a big part of your job. I just wanted to understand a little bit more of your experiences of going and speaking with your colleagues on the ground and building that capacity around resilience and sustainable workforce.

Danielle NORTH: Yes, it is an incredibly important question, and it is really important – the role of a paramedic or first responder is quite difficult at times, there is no question, and you are impacted by shiftwork, you are impacted by some of the type of case exposures that you see, and you are impacted by the pressures in the health system and the workload demands, and we certainly hear from our workforce pretty consistently about the challenges that they face. We have a very well established wellbeing and support services department at Ambulance Victoria, and I know my colleague Anthony Carlyon spoke to it briefly this morning. We have peer support available to our workforce. We have a peer support dog program, we have a chaplaincy program, we have internal psychologists who provide outstanding care to our people, and we have a network of clinicians across the state of Victoria providing care to our workforce and their immediate families to support them with some of the challenges that they may experience by the nature of the work that they do. We also have a 24-hour counselling line that is available 24/7 for any staff member that might need support at any given time, given the 24-hour nature of the business that we do. So I think supporting and educating our graduates as they come into the organisation around the type of work that they do – providing education and support around things like sleep, sleep patterns, fatigue, the expectations that we have in the organisation, how they can access support, how they can set themselves up to be successful in the future, so really thinking about their own mental health and wellbeing when they are well, coming into the organisation, and how they can maintain that ongoing and the importance of that. I think that is incredibly important because – and I can certainly speak about, after more than 20 years in ambulance, some of the work that you are exposed to being really difficult and some of the workload pressures that we see. Sometimes it is not the workload exposure but the workload demands that can have impact for our people as well, so the priority that we have around mental health and wellbeing is absolutely significant. I think it is leading the way nationally in relation to the support that we provide our people, and I think it is something that we need to hold very dear, and I think it is something that we have seen a real cultural shift in in the time that I have been in the organisation. Certainly when I commenced it was really quite frowned upon to talk about your wellbeing and to talk about some of the pressures that you were experiencing, and certainly – and in line with community expectation, I think – we have seen a really significant shift over recent years about people willing to seek support, care for their mental health and talk about their experiences to ensure that they are well and have really healthy long careers with us.

Rachel PAYNE: Thank you.

Andrew CRISP: Can I just add, if that is okay, to that. I want to go back to that point. We have got 262, 263, 264 branches across the state, and before we talked about 76 team managers being appointed. So it just goes to show –

Rachel PAYNE: It is significant.

Andrew CRISP: And I think part of this is actually, if you are a team manager, you know, it is your family. You get to know your people, they get to know you, and again that goes such a long way to building that resilience and supporting our people.

Rachel PAYNE: Most certainly. Just on a practical level, we have heard from quite a few witnesses before us around the lack of accessibility to FWAs and the fact that some of those agreements can take months to establish, and then once they are actually established they are then reviewed quite consistently over a period of time, whether that be every six months or every 12 months. Some of these practicalities just seem like a bit of common sense, really. Please forgive that as a committee we are trying to make recommendations going forward.

Andrew CRISP: I am happy to start, and I know Danielle is very much across this. But I did hear some of what Jesse Maddison was saying to the group. Again, it is roughly 22 per cent of our paramedic workforce that is on an FWA at the moment.

Rachel PAYNE: Yes, about a quarter. It is a significant proportion of the workforce.

Andrew CRISP: And I concur with what he is saying. An FWA – do not get me wrong – is a very useful tool, but it has taken the place, to a large extent, of good rostering. Again, there are opportunities, and you have heard about where we want to go with rostering. Again, I have heard when I have gone out to branches – and I have no doubt Danielle has – that at times people feel that the only way that they can achieve that sort of balance in their life is to go through the FWA process. What I also did identify when I came into the role – again, this is not a criticism of the way things have happened and the way things are structured; however, I was somewhat surprised that the centralised rostering that sits within AV actually sits in enterprise services over in the corporate area. It actually does not sit in one of our operational portfolios.

What we are doing is actually moving our rostering, our whole division in relation to that, across to Anthony Carlyon's area. Again, from discussion out in branches – I am a fairly simply person – what I say when I go out and I speak to the paramedics is, 'You know how many trucks you need to put on the road and what shifts. You should be able to sort of work it out yourself.' What we want to see with moving rosters across is actually more of a hub-and-spoke model, where you have got people in the centre that are working very, very closely with each of the regions and giving them more autonomy in relation to how they can deliver rostering. But I know this is an area Danielle is a lot more across than I am.

Danielle NORTH: Thanks. I think –

The CHAIR: Sorry, I just note that we are out of time. But I am happy if you want to respond in the last 20 or 30 seconds or something like that.

Rachel PAYNE: Thank you, Chair.

The CHAIR: That is all right.

Rachel PAYNE: That would be great.

Danielle NORTH: Okay. Thank you. So there are a couple of components to your question. I think roster reform is quite complex, and I am happy to provide further detail around that. With regard to FWA, I certainly concur. I think there is a tremendous opportunity that we are working on at the moment. Staff that have FWAs, we know often their circumstances do not change in six or 12 months, whether that be family circumstances or whatever their needs may be. To have people go through a process is not an efficient way, and it is not a great experience for our workforce. We have heard that very clearly. One of the pieces of work that we are leading at the moment is around strengthening our part-time provisions, so that for those that are anticipating or seeking a longer term flexible arrangement, that it is not a temporary contractual arrangement, that we actually build pathways through part-time employment and then create avenues for people to return in the future should they choose to. That work is being scoped out at the moment, it is underway, and I think it is one of the mechanisms that we have in place to address some of the flexible challenges that we have had historically with our rosters as part of the roster reform work.

Rachel PAYNE: Fantastic. And obviously in turn building a sustainable workforce.

The CHAIR: Thank you, Ms Payne.

Danielle NORTH: Correct. And a better experience for our workforce, that if somebody does choose to –

The CHAIR: Thank you very much. We will move on.

Rachel PAYNE: We are getting wound up.

The CHAIR: Sorry. I have to, because I am the next one. Now, Mr Crisp, we have had six CEOs in the last five years. You talked about trust in leaders. How can staff have trust in leaders when they keep changing?

Andrew CRISP: It is a fair question. I recall a conversation I had when I went out to visit a branch, and I was talking to some paramedics. They were quite young, but everyone looks young to me. This paramedic, you know, I was talking about what I wanted to do in the role, and she said, 'Well, how much time should I really invest in you?' And it was a fair comment, because she knew that I was interim. I had made it quite clear. Shelly can speak to the recruitment of the new CEO, but I am sure that we have selected the right person, who is here for the long haul around this to really drive the change that is required.

The CHAIR: But I mean, you would have to concede that over the last five years there has been a terrible amount of change in senior leadership.

Shelly PARK: Oh, there absolutely has.

The CHAIR: And that has had an impact on the organisation that probably would not be positive.

Shelly PARK: I need to take that, as Chair. When I came into the organisation there had been an interim, because Tony Walker – and it is on public record – had been very unwell. There was a period of time where there were acting chief executives because he was unwell, so I think there are some contexts that sit behind. Then we went to market; when Tony resigned, we then needed an interim. We had borrowed really strong leadership from health, however, that was not sustainable long term; we needed to go to market. We then employed Jane Miller; it is on record as to when Jane resigned. The board made a decision that we needed some more stability before we actually went to market to ensure we got the right calibre and experience of person to lead the organisation forward for a considerable period of time. Andrew was the deputy, and the board asked Andrew to step into that role to gain stability. I had conversations with the union around the need for that, and we both agreed that that was needed before we brought new leadership in.

The CHAIR: That is fair enough. One of the common themes that we have seen throughout different submissions is the fact that there seems to be a disconnect between senior management and frontline staff, or even, dare I say it, lower-level managers. One of the submissions – it is submission 109 – says that:

> Ambulance Victoria are not being a fair and representative employer … Management is disconnected from the frontline staff serving and protecting the community. We've post faith in our management and demand change.

The change that you have outlined does not sound like it is really hitting the ground.

Andrew CRISP: I think I do recall reading that, but I am not sure when it was written and the context around that. But I can only speak from the experience when I do go out and visit, and again, Danielle can speak to that. We are getting a lot of feedback about how much more visible the executive is now. Danielle?

Danielle NORTH: Thank you, Mr Crisp. I think the other thing I would add to that is it is about representation, and as we spoke about earlier it is about being present and actually being out with our workforce and hearing the experience that they have. The other thing I would add is that we have recently introduced the daily operating system, which we call DOS in Ambulance Victoria, that brings our leaders together in three tiers every day. Every morning every region holds a DOS with all of the team managers that are on shift – all of the senior team managers and area managers – to understand the issues that have arisen overnight and that are forecast to be challenged over the course of the day, whether that be any particular local health service, whether that be a safety matter for a patient or for a crew, whatever that might be. Those matters are then escalated through a tiered process, through tier two and then tier three at the executive level every day, to ensure that we have got the best connection with our leadership. One of the things that struck me when I have been out and about is not only what team managers have fed back to me, that they actually have felt more connected to their colleagues in a way that is very different than what they have in the past, so it is a step forward –

The CHAIR: I have only got limited time left, so I am going to ask one quick one. One of the other submissions has said that:

> Money continues to be wasted and poorly spent with executives profiting while the public struggle.

This is submission 55.

> Hundreds of young paramedics are waiting for jobs, yet AV refuse to hire them and improve resourcing. Management fails to support its operational staff, leaving AV personnel tired, exhausted, and the public disadvantaged.

That is not one that is uncommon. That theme continues to come through regularly in a lot of submissions. Are these people all wrong – because by the sounds of what I have heard today, some of the comments I have heard are saying that is not really what you guys are hearing.

Andrew CRISP: I am hearing about change. I am hearing –

The CHAIR: But what you are talking about is much about the future, but we are talking about right now. Do you concede that that is the situation that the organisation is in right now, with comments like that?

Andrew CRISP: Sorry, what is your actual question?

The CHAIR: I just read out the quote there from submission 55. It talked about AV personnel tired, exhausted; the public disadvantaged; and AV refusing to hire young paramedics. Is that the situation that the organisation is in now?

Andrew CRISP: If that is that person's personal experience about feeling tired and overworked, that is not good, and we need to continue to do more work around that. In terms of employing paramedics we are about to start recruitment for a number of paramedics. I think they start next Monday.

Danielle NORTH: Yes, there are some starting on Monday. I can talk to the recruitment numbers if that is helpful.

The CHAIR: Just quickly – I am out of time – you have got 20 seconds.

Danielle NORTH: So for 2024–25 we recruited 229 new graduate paramedics, following 258 that were recruited in 2023–24, and going back to 2022–23 we recruited 358 paramedics.

The CHAIR: Thanks. I am going to pass to Mr McIntosh now.

Tom McINTOSH: Thank you. Thanks, Chair, for sharing your thoughts on the importance of the stability of leadership. Mr Batchelor raised indicators for success. I think you talked about perhaps some data metrics that may be able to identify that. Mr Crisp, you talked about ideas coming up and being captured. I suppose my question to you is to go back a step to get to that success and ideas being captured. What are the visions for you? What are the themes, the priorities that you see going forward over the next six, 12 months? What are the practical things or more broad-based themes that you will see maybe get to that success?

Andrew CRISP: Again, there are the three key themes. It will be around people, performance and financial sustainability. I think there is an opportunity to build accountability and at the same time share learnings across the organisation. I have floated an idea I have seen work in another organisation I have been involved with – again, I will say it was Victoria Police – known as the compstat process, where twice a year I guess Danielle's role would go out to a region and would sit down with that regional leadership team, go through a number of indicators that that the board have set for the CEO and the CEO has then transferred onto the executive team and then sit down and go through that data, holding that team to account but not in an adversarial way. Of course whenever you are being questioned around your data, then you need to be on your game and you need to be able to explain why. But it is also a way, if you were to do that across the state, you would pick up learnings and themes across the state, and you could feed that back into the centre and make sure there was a focus on those particular issues. The new CEO for Ambulance Victoria has not started as yet, but I have got a long list of things – not just things that paramedics and other people have told me – that I actually want to pick up with him. I know Danielle does that to a certain extent, but I think there is an opportunity to do it statewide and coordinate it and feed things back into the centre.

Danielle NORTH: There are a couple of components to that. I spend a lot of time with the regional management teams and really talking about the issues that they are experiencing and our divisional priorities and where we need to focus with regard to the performance standards and the like. The other thing that we have

done and are continuing to do is bring together our area managers who are senior operational leaders across the state in person and online throughout different points of the year to really work through our divisional priorities, to set our standards and to hear from them about their experiences and what they see in delivering care in their respective teams across the state. So our area managers are responsible for ambulance service areas. They are quite large geographical areas right across the state. There are approximately 40 or so area managers, and they are critical frontline leaders, senior leaders in the operational space. Bringing them together to share ideas, share understanding, develop our divisional priorities and set our standards is a really important step forward that we have embedded I think in the last 12 months.

Shelly PARK: The last thing I would add, with a new chief executive coming in, is the trust and engagement of the workforce front line, right through executive and the connectedness of that, because that is what we need for a really high-performing organisation. We know there is much research out there that when you have that, you will actually have people who are performing at their best and it will also actually help impact on fatigue.

Andrew CRISP: Can I also just add – and sorry to go back to what I was talking about before in relation to governance and accountability – it certainly should not just be the first line, the front line that is held accountable. Again, the way I have seen this done previously is actually in corporate areas, and given some of the discussions that you have had as a committee about holding some of the corporate support areas to account as well, it does work both ways.

Shelly PARK: And timeliness.

Andrew CRISP: Yes.

Tom McINTOSH: Have I got time for one more?

The CHAIR: You have got 30 seconds.

Tom McINTOSH: Great. Just as far as the organisation that is representing your workforce – working for them, leveraging up, understanding the experience and expertise and themes you are hearing, from a high level of the organisation – how would you see working on that front and adopting and absorbing good ideas coming through?

Andrew CRISP: Did we ever touch on the Gippsland community?

The CHAIR: You probably have only got about 30 seconds to answer this. Sorry, just time is running out.

Andrew CRISP: Thank you for the question. We do have a community advisory committee that is a subcommittee of the board, which does an incredible job. We ran a community forum down in Gippsland, and again, this was an opportunity to listen to the voices not just of our paramedics and our people who are working there but community leaders and anyone from the community. It is an opportunity to listen to others and to then feed that into a regional plan. There were themes we were hearing from that particular session, and about 86 people attended. We are going to look at doing that across the state – so, listen, listen, listen.

Shelly PARK: Can I just say one thing. Our CACs are also voices and hearing for us. They feed back to us what they hear in the community and what they hear from our paramedics. Again, what they are saying to us is they are hearing the dialogue shift – a really important point.

Tom McINTOSH: Great. Thank you all very much.

The CHAIR: That brings an end to the formal part of the questions, but we have still got about 4 or 5 minutes left, so I am going to go to Ms Crozier and then one of you guys as well. Okay. Ms Crozier.

Georgie CROZIER: Thank you, Chair. Can I just ask, Ms North: you talked about your recruitment numbers quickly, but how many have left the organisation? Because the union have said, 'We don't need any more paramedics.' So are these positions just filling the attrition?

Andrew CRISP: Yes. I will let Danielle look at the numbers.

Georgie CROZIER: And then I have got another question for you.

Andrew CRISP: Yes, sure. Our attrition rate at the moment is 5.2 per cent, so in effect we are recruiting to attrition and a number in terms of people that might be on WorkCover or long-term leave.

Georgie Crozier: Yes. Those WorkCover figures are very important; that is why the committee needs those. Thank you very much.

Andrew CRISP: Yes.

Georgie CROZIER: Could I go to another question very quickly – the Ballarat communication centre. We know the response time in regional Victoria is pretty woeful. There are lots of instances where we get reports of some very bad outcomes. The duty managers positions are left unfilled. Why are they, and why are they being moved into Melbourne and not having that regional oversight? What is the reason for that?

Danielle NORTH: My understanding is that they are not being moved into Melbourne, so they remain in the BALSECC call centre.

Georgie CROZIER: But on occasions they come to Melbourne, don't they?

Danielle NORTH: On occasion.

Georgie CROZIER: But how often?

Danielle NORTH: Our technology services enable us to provide support across the state, both from the metropolitan location and from the regional location. I think it is important to make sure that we have the right skill set at all times to provide support to the regional communities, and those roles are ongoing. They are available in the BALSECC call-taking centre and are filled by qualified staff, both from metropolitan Melbourne and regional Victoria.

Georgie CROZIER: Mr Crisp.

Andrew CRISP: I will just add to that: our focus is on retaining those positions at BALSECC. We keep doing work in terms of a roster that works for everyone and recruiting accordingly. That is our focus.

Georgie CROZIER: It is important to have that regional oversight.

Danielle NORTH: Absolutely.

Andrew CRISP: Yes, definitely.

Georgie CROZIER: Thank you.

The CHAIR: You had 10 seconds to spare.

Georgie CROZIER: I can keep going.

The CHAIR: No, no, that is all right. Mr Galea.

Michael GALEA: Thank you, Chair. I will put this to you this time, Mr Crisp, but please, as you see fit. I would like to pick up on what you were discussing with Ms Payne about flexible work arrangements. I was quite interested in your remark that previously the rostering function was under corporate services. I am wondering if that sort of explains – not having that operational or P and C lens on it – why there is such a high degree of FWAs if those sort of in-built flexibilities are not being accommodated. With this transition into the operational site, which sounds to me like a good idea, do you expect to see a reduced need for FWAs as a formal process if those commonsense flexibilities can be built into rosters without them?

Andrew CRISP: Again, Danielle can add to my comments, but I would expect to see that, because if people are not getting the roster they want, then for a lot the only avenue is to go through an FWA. So if we can develop this sort of hub-and-spoke model and give our regions some further accountability and responsibility to

develop more local-based rosters, I would like to think that – the savings then have to be quantified – in terms of the number of hours spent on the process of FWAs, there would be savings all round.

Michael GALEA: Which would be extensive.

Andrew CRISP: And again, a happier workforce.

Michael GALEA: Indeed, which is an even better outcome.

Andrew CRISP: Exactly what we want.

Michael GALEA: But you are also right – much less resources, because negotiating anything like an FWA would be very time-intensive.

Andrew CRISP: Exactly, yes.

Danielle NORTH: If I may add to that, I think it is not only about the alignment of the rostering from a corporate structure perspective; I think it is about the roster design. Historically in Ambulance Victoria we have had what is called a 10/14 roster, which is the two 10-hour days and two 14-hour nights, and that was introduced decades ago in a very different environment than what our workforce experience now. The workload volume was significantly less, the demographic of our workforce was very different than what we have in our organisation currently, and it has not evolved to what our contemporary needs are.

Georgie CROZIER: And you are looking at that design?

Danielle NORTH: Correct. The roster reform work picks up around flexibility, it picks up around fatigue and it picks up around workforce satisfaction, and we are doing some work now to prioritise the removal of the double night shift. It is no longer fit for purpose, and we are doing that work currently, and we will do that across metropolitan and regional areas and we are also having a look at our on-call rosters to ensure that our people are supported. There is a structural element around where the rostering function sits. There is a rostering design component, and part of the roster reform is stepping away from the double night shift in what was a very archaic system structure that was established many decades ago and is not reflective of our current workforce demands or our workforce expectations. It does not meet our people's needs, and so we really need to evolve our roster design work, and that is part of the roster reform program that we will be delivering as part of the people plan.

Shelly PARK: And can I just add on that, we also have to take our people with us, because we have still got some people that really like the 14-hour night shifts, but that is not meeting the needs for every person across Ambulance Victoria. So it is very challenging, and we have to take our workforce with us.

The CHAIR: Time is up, unfortunately. I thank everyone for appearing today. I appreciate your time and your evidence that you have given. We will call that an end to this session. Once again, thank you very much for your time.

Committee adjourned.