T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Ambulance Victoria

Melbourne – Friday 13 June 2025

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WITNESS *(via videoconference)*

Darren Midgley, Alliance of Rural and Regional Community Health.

The CHAIR: Welcome back to the second session of the Legal and Social Issues Committee Inquiry into Ambulance Victoria. I welcome witnesses here today. Darren, welcome to you. Can you just state your name and the organisation you are appearing on behalf of, please.

Darren MIDGLEY: My name is Darren Midgley. I am the Chief Executive Officer of Sunraysia Community Health Services representing ARCH, which is the Alliance of Rural and Regional Community Health.

The CHAIR: Thanks very much. We are just going to go around and introduce the committee as well. I am Joe McCracken. I am Chair.

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

Ryan BATCHELOR: Ryan Batchelor, Southern Metropolitan Region.

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

Anasina GRAY-BARBERIO: Morning, Darren. Anasina Gray-Barberio, Northern Metro.

The CHAIR: And we have got some online as well, I think.

Rachel PAYNE: Hi, Darren. I am Rachel Payne. I am from South-Eastern Metropolitan Region.

The CHAIR: Beautiful. Thank you very much for that. Darren, I will just read this out as well. 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 being recorded, and you will be provided with a proof version of the transcript following the hearings. Transcripts will ultimately be made public and posted on the committee's website.

We have got your submission, which we have gone through. Would you like to make any opening comments before we go to questions, Darren?

Darren MIDGLEY: Yes, sure. Firstly, thank you for the opportunity to speak today. As I said, I represent the Alliance of Rural and Regional Community Health, ARCH, which is a network of 11 independent community health services reaching 87 per cent of rural and regional Victoria. Our footprint gives us a deep insight into the unique health challenges our communities face, including chronic illness, geographic isolation and extremely limited access to general practitioners, specialists and allied health professionals. In this context paramedics often become the first and only point of healthcare contact. Ambulances are called for non-urgent issues because no other options exist. As a result, our already stretched ambulance services are being used to fill a gap left by a fragmented and under-resourced primary care system.

But while this demand grows, we are watching our paramedic workforce burn out. The 2023–24 national workforce survey of clinical paramedics paints a sobering picture: 22 per cent intend to leave the profession within four years and another 40 per cent within the next five to 10 years. This is not just a retention issue; this is a workforce sustainability crisis. At the heart of this crisis is one fixable factor: the lack of access to meaningful, secure and flexible work arrangements. Paramedics, like other health professionals, need career pathways that allow them to adapt and to take time away from high-stress frontline roles without leaving the profession entirely. Many are carers, parents or individuals simply needing a reprieve from traumatic work, but the current system does not support them. Under the existing model paramedics seeking alternate or part-time roles, such as in community health settings like the CP@clinic, must navigate an opaque and inconsistent

secondary employment process. Flexible work arrangements are approved in short blocks. Applications are administratively burdensome, and in many cases paramedics report being discouraged or even penalised for seeking them. Some have been told to go casual, giving up their job security, leave entitlements and professional stability. This is out of step with what is considered routine in other health disciplines. Nurses, for example, frequently move between clinical and non-clinical roles with the ability to return. They can access part-time work without risking their long-term career. Paramedics deserve the same.

At ARCH we are pioneering a solution: the CP@clinic program, a community paramedic model that has demonstrated proven outcomes overseas and is already showing success in Victoria. In addition to reducing ambulance call-outs and emergency department visits by up to 25 per cent, CP@clinic also provides paramedics with a much-needed pathway to continue serving while stepping away from emergency response work. These roles offer stable hours, lower exposure to trauma and the opportunity to apply clinical skills in a preventative, empowering setting. But we are struggling to scale the program, not because of lack of interest from paramedics but because of inflexible employment policies that make it risky or impossible for paramedics to participate. We urge this inquiry to prioritise reform in the following areas.

Firstly, to establish robust, streamlined and predictable flexible work arrangements for paramedics and to treat them as a right, not a favour; to remove disincentives for seeking part-time or community-based roles, such as the pressure to go casual; to create clear, supported return-to-scope pathways so paramedics can step into community roles without fear of losing their professional status; and finally, to fund and expand proven models, like CP@clinic, which provide both a workforce-retention mechanism and a direct solution to rural health inequities. These changes are not just in the interests of paramedics, they are in the interests of Ambulance Victoria, the broader health system and the rural and regional communities we serve. Let us ensure the flexibility is not the exception but the standard, so that our paramedics can continue to serve safely and sustainably.

The CHAIR: Thanks very much. We will move to questions now, Darren, and I will go first. You mentioned in your submission the challenges in retaining the paramedic workforce, and you particularly touched on things like stress and burnout. Can you just expand on that and why that is such a huge issue?

Darren MIDGLEY: Yes. I think, from conversations I have had with the paramedics that we employ and have employed, stress and burnout are significant issues with the constant pressures they face with exposure to quite traumatic scenes as they respond to the emergency needs of people in road trauma and other traumas. Their work arrangements are very demanding and very inflexible, so they do not have opportunity to recover or to, I guess, deal with some of the traumas that they experience, and they feel very unsupported by the current model so many are leaving the industry.

The CHAIR: Can I just ask you there: why do they feel unsupported by the current model?

Darren MIDGLEY: What I hear when I speak to the paramedics in our employ is that they feel unsupported. They feel that there is a significant rigidity and a lack of flexibility, so it is very difficult for them to move in and out of Ambulance Victoria because the system, as they explain it to me, does not allow them the flexibility to come and go. They risk losing their benefits, whether that be long service leave or their contracted benefits that they have within the service. Ambulance Victoria, as I understand it, makes it very difficult for them to move into other, non-serving roles within Ambulance Vic and then to come back into Ambulance Vic later.

The CHAIR: Okay. Thanks very much. Just before my time runs out – I have only got a minute left – also in your submission you noted that particularly in regional Victoria it is very difficult. Can you just talk about that as well? I am a regional MP; I am interested to hear what is so challenging.

Darren MIDGLEY: I think, again from speaking to the paramedics that I interact with, there is a shortage of resources in regional areas. That might mean that they are working very long shifts or lots of overtime or they are caught up ramped up at hospitals and stuck with patients – it is a compromise when the system has some deficits and some challenges – they have to stay with their patient until they can safely hand them over in an emergency setting and before they can get out on the road to the next one. But also there is a requirement to do some time in the regional areas, and they find that is a bit restrictive for them as well.

The CHAIR: No worries. Thanks very much. I will now hand it over to Mr Galea.

Michael GALEA: Thank you, Chair. Thank you for joining us this morning, Mr Midgley. It has been very interesting to read your submission. I do actually want to come to the CP@clinic, but just before I do, you mentioned at the outset your concerns with a lot of this being necessitated by issues in primary care. Of course that is probably a bit beyond the scope of our inquiry, but in terms of programs such as the Victorian virtual ED system and in terms of things like the community pharmacy program, which is rolling out more simple scripts, how important do you think programs like those are to alleviating that pressure on primary care and therefore alleviating the pressure that you are seeing?

Darren MIDGLEY: I think every strategy is helpful, and those are certainly some very helpful strategies. In my experience as a community health CEO, a lot of people do not understand how to access the VVED and so they often require some support to navigate that. I guess that is also where our CP@clinic model can be really helpful, because our paramedics are out there in the community dealing with those complex chronic issues, and they are helping those people with very poor or very low health literacy navigate a very complex health system. That might be that they connect them up with VVED or it might be that they connect them up with nurse practitioners or other specialists who can assist them with their needs. There has been some really great evidence around the hospital avoidance benefits of the CP@clinic, simply by helping people navigate the complex health system that we all work within.

Michael GALEA: Indeed, because it is probably far too easy for it to become siloed, so your service really helps to break that down. And it is good to know that it is not just about what is in your service, it is about what is then being connected to – for example, connecting them to a community pharmacist or the VVED, for example.

Darren MIDGLEY: Absolutely.

Michael GALEA: The statistic you have got about 19 to 25 per cent reduction in ED presentations: it is very, very impressive. Is it mostly through those sorts of early interventions that that is being achieved?

Darren MIDGLEY: Yes, it is. Those figures come from McMaster University and where this model has been piloted and trialled and has been running for a long time in Canada. We are taking this Canadian model and we are rolling this out in regional Victoria and evaluating the model.

Michael GALEA: I am very sorry to cut you off, because I have only got a few seconds left. Latrobe is working with you, I see. Will they be releasing some data on the effectiveness of your program at some point?

Darren MIDGLEY: Yes. There will be data that will come out as part of an IMOC grant to evaluate this program. There is data starting to come out now, but it will be formally released later in the year, yes.

Michael GALEA: I very much look forward to seeing that. Thank you very much.

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

Georgie CROZIER: Thank you very much, Chair. And thank you, Mr Midgley, for presenting to the committee and for your submission. I am, I think you are aware, very familiar with the CP@clinic program that is run for the Sunraysia district and the work that you are doing, especially with those communities that are sometimes vulnerable and a little bit disconnected, so that they feel that support. Can I go to your point, though, around paramedics. I think you said one of the reforms that is required is to remove the disincentives. Could you just explain to the committee a little bit more what you mean by that?

Darren MIDGLEY: I think one of the difficulties that paramedics face is the difficulty in moving in and out of Ambulance Vic. The disincentive – as far as the ambulance paramedics talk to me about it – is they have a lot of pressure that if they want to leave Ambulance Vic and come back they should go casual. Whereas a nurse can go in and out of clinical roles and into other roles and then come back into acute roles or community roles, that is not so easy for a paramedic, who faces a lot of pressure to either resign or to go casual, and then they lose the opportunity to maybe work part-time across both sectors. So I think there needs to be some exploration of how paramedics might be able to work part time without losing substantial benefits or deskilling, because they are forced to either abandon working with Ambulance Vic or go casual and might face the opportunity of very limited shifts at that point.

Georgie CROZIER: I just want to expand on that. What is your understanding that Ambulance Vic require that there is not that flexibility? And my second part to that question is: is that impacting women more than others, or is it just to, you know, try and have that flexibility and they want to go out for family reasons? Is that contributing to some dissatisfaction and shortages and pressures in the system as well?

Darren MIDGLEY: That is a good question, Georgie. My understanding is probably a little limited. My understanding is that there are some good provisions for supporting women around flexibility. My understanding from speaking to paramedics is that it is not so much that, it is when somebody wants to leave Ambulance Vic or reduce the amount of time they spend in Ambulance Vic it is a lot more difficult to reduce their contracted hours and then work part-time.

Georgie CROZIER: And that is a requirement of Ambulance Vic to have that rigidity in relation to their work hours and contracts, is it?

Darren MIDGLEY: My understanding is that that is the paramedics' experience. I am not sure whether that is a requirement of Ambulance Vic, but that is the experience of paramedics.

Georgie CROZIER: Thank you very much.

The CHAIR: Thank you. We will now go to Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thank you, Chair, and thank you, Mr Midgley, for joining us this morning. According to the paramedics that you have spoken to, there is a lack of flexible, meaningful and secure work, Then also in your submission you mentioned that the CP@clinic program offers an alternative career pathway for paramedics. Given the huge footprint that the alliance covers regionally, what benefit is there for paramedics to take up working at the CP@clinic model that you have available, the program that you have trialled here in Victoria, and how does this reduce health inequities regionally for communities out there?

Darren MIDGLEY: What a great question. I think the benefits to the paramedics are that they understand chronic disease. Paramedics are well positioned to assist people with poor health literacy navigate complex chronic disease and to access other services to support them. The benefit also is that with paramedics with such great skills and robust skills, we can utilise those skills in a community primary care environment, where they are not exposed to the trauma of roadside accidents or other traumas that they might experience in their work.

We can utilise their skills to assist people to navigate the complexities of the health system – of finding other resources to support them, to engage them. Sometimes this is about social engagement and reducing loneliness and addressing a lot of the mental health issues that people have, but also little things that we do not have the time in busy EDs to explore. One example I would give is of a client that our community paramedics saw, who was a frequent flyer in emergency departments – he would keep bouncing in with uncontrolled seizures. The reality was that this person was living in a very disadvantaged situation and actually could not afford the medications, so he was reducing the dosage of medications to make them last longer, which meant that his medications for his epilepsy were at a subtherapeutic level, and of course the consequence was he kept having seizures and bouncing into ED. Our paramedic was able to identify this and assist this client to find some alternate ways of –

Anasina GRAY-BARBERIO: Sorry to cut you off, Mr Midgley. I have just got one quick question to ask you: what is the early feedback you are getting in a Victorian context regarding the Canadian CP@clinic from the community?

Darren MIDGLEY: It is very well received by the community, and we are seeing significant engagement. We are particularly targeting areas where there is significant disadvantage, so we are going into community accommodation and supported accommodation for people who are quite disadvantaged. The benefit is great, and when we align that community paramedic with other services, such as exercise programs, the benefit is magnified, because we get some movement and we get some further social engagement – a breakdown in loneliness. We find that the community members start to support themselves as well and each other.

Anasina GRAY-BARBERIO: Thank you.

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

Ryan BATCHELOR: Thanks very much, Chair. Thanks, Darren, for coming along. Obviously there has been a lot of focus in both your submission and in the questions today about the CP@clinic model. Beyond that, I am just interested in any reflections you have got about the importance of broader strengthening of primary care in regional areas to support both health care but also ambulance and paramedic response. It strikes me that obviously the needs of service delivery in rural and regional areas often require a different service response mix than we would have in metropolitan areas. I am just wondering if you have got any broader reflections about the way that the primary health system interacts with the paramedic response and what other areas you think might be able to be improved to support that.

Darren MIDGLEY: It is a critical issue. Rural and regional areas do face significant health disadvantage. The evidence shows us that people's health outcomes are poorer the further they live from metropolitan areas. So, again, paramedics are a great resource, they are very skilled people, they understand the health system and they are well positioned to interact with other services to support people and achieve better health outcomes. We find the prevalence and the expansion of urgent care centres is fabulous, and often we are finding locally in Mildura, where I work, that the paramedics, when they go to a call-out and it is not an urgent call-out that needs to go to ED, do refer people to the urgent care centre, and that is a very helpful resource as well.

Ryan BATCHELOR: Right. You think that there is an emerging productive relationship between the ambulance services and these urgent care clinics that are providing an alternative presentation point to emergency departments?

Darren MIDGLEY: I absolutely think so. I think one of the opportunities is that we spend a lot of money investing in the acute sector, but we are missing the opportunity to make that upstream investment and prevent people from presenting. It is much cheaper, much more economical and health outcomes are better if we can address the issues before people need to access and utilise hospital services. So I would call for a greater investment in primary health care and in community health and make that upstream investment so that we do not have people presenting later in crisis to emergency departments and drawing upon the resources of Ambulance Victoria.

Ryan BATCHELOR: That is an excellent way to finish my block of questions. Thanks very much.

The CHAIR: Thank you, Mr Batchelor. Ms Payne, it is over to you.

Rachel PAYNE: Thank you, Chair. Darren, thank you for your submission today. I just wanted to pivot off your comments around inflexible employment and robust, streamlined and flexible working arrangements. Ms Crozier brought up the issue around if this is impacting women predominantly in the workforce, and what we are hearing, from what we have heard from those that work in the profession, is that it is actually causing them to second-guess if they do want to continue in the profession. I just wanted to hear anecdotally what stories you are hearing as well.

Darren MIDGLEY: Thank you. I have not heard a whole lot around issues for women in Ambulance Vic, and we employ both men and women through the CP@clinic programs across rural and regional Vic. The issue has been not so much gender based, it has been around the inflexibility of Ambulance Vic in allowing those employees to move in and out of the service. We are seeing this emergence of community paramedic roles, and CP@clinic is one of a number of different community paramedic roles that are emerging now, and I think the opportunity has to be provided for some flexibility for people to move in and out of those community roles, sometimes for a break from the acute, from Ambulance Vic and from the trauma that they might experience but also in terms of pathways to retirement and slowing down a little and changing tack.

I am a nurse, and as a nurse I can work in thousands of different areas of nursing, go in and out and in and out and in and out, and if I get a bit bored with one area, I can just pivot and work in another. That is not so easy for a paramedic. Paramedics have significant skills and those skills are transferable, and I think it is time for an evolution of paramedic skill and paramedics as a profession. I think we need paramedics who can work at top of scope, we need some paramedics that can step back from time to time and have a break from that top of scope practice or to do some more diverse work. We have such chronic issues, and our health system is really struggling, particularly in Victoria. Here is a really available workforce that can contribute to making a difference, particularly in rural and regional Victoria, where we really struggle to attract and to retain a skilled

workforce – doctors, nurses, physios. We can utilise the paramedic workforce to support health improvements in regional Victoria if we are clever about it.

Rachel PAYNE: Thank you so much.

The CHAIR: Ms Payne, do you have any more questions at all?

Rachel PAYNE: No, Chair. All of my questions have been answered. That was just one on the fly. Thank you.

The CHAIR: No worries. Thanks very much. We have gone through all the questions here in the room too, so we are finishing a little bit early here actually. Darren, I just want to thank you for your time today, and I really do appreciate your attendance here. I know the committee really appreciate that as well. We are going to close off this session today. Thank you very much again. I wish you all the best.

Darren MIDGLEY: Thank you so much for having me.

Witness withdrew.