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

Danny Hill, Secretary, Victorian Ambulance Union.

The CHAIR: Welcome to this session for the Legal and Social Issues Committee Inquiry into Ambulance Victoria. Our witness for today is Mr Danny Hill from the Victorian Ambulance Union. Danny, just for the record, would you mind stating your full name and the organisation you will be appearing on behalf of?

Danny HILL: Danny Hill. I am a former advanced life support paramedic from Werribee and the current elected secretary of the Victorian Ambulance Union.

The CHAIR: Thank you very much. We will go through the committee and introduce ourselves. I am Joe McCracken, I am the Chair.

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

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

Georgie CROZIER: Georgie Crozier, Southern Metro, Shadow Minister for Health and ambulance services. Morning.

Anasina GRAY-BARBERIO: Anasina Gray-Barberio, Northern Metro Region.

The CHAIR: And we have got a member online as well.

Rachel PAYNE: Hi, Danny. Rachel Payne from the South-Eastern Metropolitan Region.

The CHAIR: Thank you very much. I will just quickly read this out and then we will get to openings. 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 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 hearing. Transcripts will ultimately be made available and posted on the committee's website.

I will give you, Mr Hill, an opportunity to make an opening, and we will go through some questions and if we have time at the end, we might be able to fire off some extra ones. I will hand over to you first to make your opening. Welcome and thank you.

Danny HILL: Thank you. I do have a short statement I would like to read. I am going to start by saying this: in Victoria today we have enough paramedics to handle the emergency workload. Now, it might seem strange to hear the union secretary say that, but it is true. We have enough paramedics to handle the emergency workload, but we do not have enough paramedics to handle both the emergency workload and all of the additional non-emergency work our members are asked to deal with every single day.

We have some of the best paramedics anywhere in the world right here in Victoria, and when they can get to you in the required timeframe your chances of survival are as good here as anywhere else in the world. But right now one in three emergency patients do not get an ambulance in time. The key reason is that every day on every shift our paramedics are effectively logged off from responding to emergencies and are instead deployed to other non-urgent duties. They are organising GP appointments, they are performing social work or organising services for aged care and mental health patients, they are taking patients home from hospital and they spend hours caring for patients in hospital corridors. To be clear, this is all important work performed by other hardworking healthcare workers and patients do need these services, but it does not require an emergency ambulance and it certainly does not justify blocking paramedics from responding to real emergencies in the community.

You do not have to listen to the union on this. In 2015 the Victorian government formed the ambulance performance policy consultative committee, the APPCC, bringing together paramedics, AV, government, Department of Health, health experts and the union to improve ambulance performance. A key recommendation in the final report was to reaffirm AV as an emergency service. Now, while that committee did deliver improvements in many areas, it is our view that the work to reaffirm AV as an emergency service has failed dismally, and paramedics spend less time than ever responding to actual emergencies and more time than ever plugging gaps in other parts of the health system. But it is important to know how close we came to getting it right. By late 2018 AV response times improved. Almost 90 per cent of code 1 lights-and-sirens cases got an ambulance in 15 minutes – fastest response times in Australia. This coincided with our members reporting a more manageable workload and, generally speaking, a more positive workplace culture. This was largely achieved by making improvements to the call-taking and dispatch process. While a lot of focus is on ambulance ramping, in our view the biggest problem and the real opportunity for solutions sits in reforming our call-taking and dispatch process, which uses computer software that inappropriately sends our paramedics to non-urgent cases under lights and sirens.

This, more than anything, is where we need your help. I have no doubt that in this inquiry you will be told that there is work underway to improve call taking and dispatch, but it is important to understand what work is and is not underway. There is work to educate the public on when to call an ambulance and when to look for alternative options. This is excellent work, and it should continue. AV has a world-leading secondary triage service, and where a person calls – for example, with abdominal pain – they speak to an experienced paramedic or nurse who can further assess the patient and find a more appropriate pathway than an emergency department. This is excellent work, and it should continue.

Dispatch grid reform – this is where it becomes complex. There is work to improve what is called the dispatch grid, which determines that a chest pain requires a code 1 lights-and-sirens response and an abdominal pain, for example, requires a code 2 non-lights-and-sirens response. There is regular review of the dispatch grid, and where medical evidence shows that a particular case type can be safely downgraded to a code 2, that happens. This work contributed to a reduction in code 1 lights-and-sirens cases from over 85,000 cases per quarter in 2015 to less than 60,000 cases per quarter in 2017 and to a massive improvement in code 1 response times. This is excellent work, and it should continue.

However, it is our view that there is limited further improvement that can be achieved without the final body of work – call-taking reform. This is the missing piece – accurately categorising a patient's main presenting problem before the computer software categorises the case as a lights-and-sirens emergency. A genuine example: just the other night, not far from here, a patient called 000 for an ingrown hair on their chest. It was sore but clearly not an emergency. The call taker followed the algorithm: 'Do you have pain?' 'Yes.' 'Where is the pain?' 'My chest.' On that basis alone, the software dispatches that case as a potential heart attack requiring a lights-and-sirens response from the nearest crew. The system searches for the worst-case scenario, not the most likely scenario.

While there is ongoing work to improve dispatch, secondary triage and public education, there is nothing happening that we can see to improve the accuracy of call taking. AV will tell you that the call-taking software used in Victoria is used by 2000 ambulance services around the world. This is correct, but only in Victoria is the ambulance call taking not performed by the ambulance service but by another organisation who do not employ clinicians. In every other jurisdiction the ambulance service has responsibility for call taking and, if needed, paramedics can listen in on the call. The patient with an ingrown hair, for example, can be assessed further and, if appropriate, paramedics can override the algorithm and find a more appropriate pathway for the patient. This does not happen here.

Again, you do not have to listen to the union on this. In 2017 AV designed a solution called revised ambulance dispatch to put paramedics into the call-taking process. It is a teams-based model involving TZV call takers and AV paramedics working together to improve the accuracy of call taking. This was good work – designed by AV alongside TZV, approved by government and supported by the union – but it failed because the two organisations could not reach agreement on who would take responsibility when the algorithm is overridden. The VAU has been advocating for that work to restart, but it is very difficult to find anyone in senior levels of AV or the government who is interested in completing this work. In our view, this one problem and the failure to address the inaccuracy in the call-taking system have led to a crushing, overwhelming, unsustainable workload comprising mainly unnecessary non-emergency work. The flow-on effects are felt right across the

ambulance workforce, the workplace culture, the relationship with management and the safety of our members. It also affects the community because their emergency ambulance service is effectively being sent in the opposite direction to the actual emergencies. There are now over 100,000 code 1 cases per quarter and only 65 per cent of patients get an ambulance on time, and it will probably get worse.

It is our view that AV must return to its core role of being an emergency service. If we do that, as I said at the beginning, we probably actually have the right amount of paramedics to handle the genuine emergencies. If we do not do that and if we keep spreading our members' work across the entire health system – non-urgent duties – it is not hundreds of new paramedics that we will need to recruit each year, it is going to be thousands. I am happy to take any of your questions. Thanks.

The CHAIR: Thanks very much, Mr Hill. I will go first, and then we will go through the rest of the committee. You said in your submission that it is the union's view that the government must immediately intervene to return AV to its core service and its core role of being an emergency service. It is not at the moment?

Danny HILL: No. I do not believe that is their priority. And I think that the example you gave before, Ms Crozier, about crews being ramped at hospital – they are working, they are performing duties, they are performing work, in the hospital. They are performing work out there in the community, organising GP appointments – the administrative task of organising GP appointments. It is actually an offence to obstruct an emergency service from performing emergency work, and we see that happen every single day. They are being obstructed. They are pleading, 'Please, let us go.' We had a case in Maroondah, I believe it was about last year sometime, where the crews were pleading to be able to respond – a MICA crew – and get out and help a case, and it ended up in an argument with the hospital, who, you know, were doing their best.

But we are not seeing Ambulance Victoria I think respected to a degree and an understanding that their work is – the taxpayers pay for the ambulance service to respond to them in the time of emergency. From that point of view they have quite a limited role; we are seeing them spread across so much work. When you talk to our members – and I am sure you have heard this in your discussions with our members – it is their biggest frustration. They do not want emergencies to happen, they want to be there when they happen – and they cannot be there when they happen. And when we look at the case that is in the media today, that is just devastating for our members. They know they could get there and intervene and maybe get a good outcome, but they cannot get there. It just feels like the criteria to reserve AV for its emergency work is coming second to plugging other gaps in the system.

The CHAIR: I was going to say: in your submission too you put some case studies about ramping – I think they are case studies 3 and 4 from my notes here – where you actually talked about one of the incidents where someone passed away due to ramping. I mean, surely that cannot be allowed to continue?

Danny HILL: No, it should not be allowed to continue at all. And you know no-one is saying that these patients do not need care in the hospital corridor, but they do not need an ambulance crew with them in the hospital corridor. You know, employ the right – we support advocacy for more staff in the hospitals to do that work, but it is not the role of paramedics to be working in hospitals. The paramedic skill set is delivering the pre-hospital care before they get to the hospital and outside of the hospital, and they are unable to do that because the hospital is saying, 'No, you're working here now.' Just the other night we had crews ramped for 7 to 8 hours at Bendigo Hospital, and we are aware of an elderly patient who fell on the floor and waited 9 hours to get an ambulance. They are working – they are an employee of the hospital, effectively logging off their emergency service role to work in the hospital. And that is where we need government assistance to bring it back to, 'You're an emergency service. You're there to do the emergency work. You don't work at the hospital.' That is just what we do not see under attention, and we ought to.

The CHAIR: I am imagining a lot of your members are – correct me if I am wrong – incredibly frustrated that that is the case at the moment, that they have to endure that, for what, 6, 8, 10 hours?

Danny HILL: Yes, and ready to quit as a result. I mean, they train hard. They have done a degree. Some of them have gone on to do further postgraduate study in intensive care. We have got the best paramedics anywhere in the world right here. They can hear on the radio that there are cases out there in the community that they can get to and they can make a big difference, and they are not able to get to them.

I noticed, in one of the other presentations earlier, talk about paramedics working in community care. That is going to be a real risk for us – that people will say, 'Well, I can actually practise my skills in the primary care area.' I think that is going to be a real risk for us if we do not return. The members want to be busy. They do not want to sit around. They want to be busy doing the work they signed up to do.

The CHAIR: How many? Anecdotally you said that some are ready to quit. Is that actually a real possibility?

Danny HILL: We conduct research with Swinburne and RMIT University, and that is in our submission. The number of paramedics thinking about leaving the profession has risen from 39 per cent in 2020 to 45 per cent in 2022 and now 57 per cent in 2024. The job is just not what it used to be, and as a result the people who suffer the most are the patients.

The CHAIR: My time has expired, but I am going to pass over to Mr Galea.

Michael GALEA: Thank you, Chair. Mr Hill, thank you very much for the work that you do and of course the work that your members do. There is so much that I want to jump into. RAD, stage 3 – if I can just clarify, currently are you saying that there is no ability at all for practitioners to override the algorithm? For example, in the case you gave about the chest hair, that cannot be overridden and it has to be treated as a code 1, lights and sirens, even though you know that it is not?

Danny HILL: Yes. It is important to be clear: TZV are doing absolutely nothing wrong. They are doing what their statutory obligations are, which are to identify using the software, a system called ProQA by a company in America called AMPDS, which searches for the worst-case scenario. They identify the case type based on an algorithm of questions that they follow. Another example, and I am not saying this to be funny: a person who put their jacket on and could not get out of their jacket, so could not move their arms – an ambulance was called for them because their arms could not move – was categorised as a stroke. Now, in other jurisdictions paramedics can lean in on that call before that becomes a stroke. We cannot do that here. TZV create it as a stroke, dispatch it to AV as a code 1 stroke and then AV have some ability to look at the case in relation to how it is dispatched.

We always went to sudden-onset abdominal pain as a code 1, because of a fear of it being an abdominal aortic aneurism. Evidence showed that was rarely the case, so those cases were all downgraded to code 2s – and safely. That is the sort of intervention AV can do. But as far as the questioning component – we represent the call takers as well; they say, 'We know there's nothing wrong with this person' – they have got an algorithm to follow. RAD was about having for every four call takers one paramedic listening in on those calls, providing some nuance, some clinical oversight. It was a good idea. But no, to this date there is no ability at that part of it for clinicians to intervene and I guess refine the questioning, put more nuanced questions to the patient.

Michael GALEA: And that is the critical part that you are saying makes such a difference – that if that was addressed, that would solve a lot of the other issues.

Danny HILL: Yes. It is the ability to override the algorithm. Yes, you use the system, it is otherwise a good system –

Michael GALEA: You understand why it is going to go worst-case scenario of course, but you need that human intervention.

Danny HILL: Of course. Yes. That is right. There is always going to be risk aversity and overtriage built into the system; we would expect that. But it is at the point where it is creating unnecessary work. That person with their arm stuck in the jacket – the crew going to that case is a code 1. They are not able to go to the elderly patient who has fallen over and hurt her hip, who is going to be a code 2, so that patient waits 9 hours for someone who needs someone to undo a zip for them. It just does not make sense. It is just a matter of some common sense, some questioning. Again, this was AV's work, this was AV's design, and it is very, very hard to draw out of them the need for further work in that area.

Michael GALEA: Are your members seeing any increase in, to put it bluntly, the abuse of the Triple Zero system by members of the public who are calling for non-emergencies?

Danny HILL: I do not think there is an increase in – I mean, I would not characterise it as abuse. I would characterise it as a lack of understanding and at times no other options. There are big differences, for example, in rural areas. If you are getting a doctor's appointment at short notice in Cobram, it is going to be completely different to the same scenario in Essendon. You might have someone who knows no different, and they dial 000, and so they should. It is about having the ability once those calls come through – and they always will come through, because there may be a mental health component or a misunderstanding component – to channel them back through the same system that we do with secondary triage, providing some clinical insight, clinical nuance to it, and getting the patients the help they need.

For some of these patients a hospital emergency department is not the right place for them. It is not a good place for them to sit. An elderly patient that we are taking out of an aged care facility to sit in a hospital corridor for 10 hours – it is not good for them, it is not nice, and we can do better. But when they are categorised as a stroke, what choice do we have?

Michael GALEA: Exactly. So those other services that we have touched on this morning do play a role too in preventing that, you would say?

Danny HILL: Yes. That is exactly right. It should be a holistic system, but the ambulance component is limited to the emergency response.

Michael GALEA: Thank you.

The CHAIR: I am going to hand over to Ms Crozier now.

Georgie CROZIER: Thank you, Chair. Thank you very much, Mr Hill, for your submission and for the evidence you are providing to the committee this morning, which is very, very helpful, and for the work you do on behalf of those you represent, the paramedics –

Danny HILL: Thank you.

Georgie CROZIER: that do keep us safe and are trying to do the best that they can. I want to go back to your point where I think there is a degree of frustration, as you said, around the system, around AV and government not addressing this really critical issue around the dispatch grid. Why is that? What is your view about an unwillingness, if you like, of those two entities not to understand exactly what is going on, and to your point, the common sense that needs to be applied here, given the scenarios that you have provided to the committee?

Danny HILL: I do not know. I do not get it. They front PAEC. You give them a grilling at PAEC, as you should.

Georgie CROZIER: Try to.

Danny HILL: They would be completely in their rights to respond to you by saying that the system is crushing us, the system is killing us. They do communicate that hospital ramping puts them under pressure. We do not hear them advocate the same way around the effect that call taking is having on their services, and they should be. I truly do not get it. I do not know the answer. I hope it is something that we can, I would say, with some positive changes at senior levels of the organisation, that might be something that will change, but I truly do not get it. Even a cynic would look at the 100,000 cases a quarter and only hitting 65 per cent of them within the required timeframe and say, 'Well, are you judging us on the right cases?' We would back them 100 per cent if they said, 'No, you are not.' Judge us on the 80,000 or the 60,000 genuine emergencies, not just the 100,000 that have been categorised as code 1 by the computer.

Georgie CROZIER: That is a very good point. Do the criteria need to be reviewed and reassessed in relation to the work that is actually being done and how it is being reported, do you think?

Danny HILL: I think the reporting is right. I think the system is wrong in what is created as a code 1 case. Again, all these patients do need assistance. The case that is correctly identified as a code 2 goes through to secondary triage, where our members in the secondary triage service do phenomenal work in finding alternative pathways, in looking for other options, in talking to the patients and re-escalating if they need to. We do not have that ability – when the cases are code 1, it does not go through that filter, and I think that is a big part of it

that is missing. We actually see there are about half the amount of code 2s as code 1s, and for those, so many of them are sent off to other alternative pathways.

Georgie CROZIER: We have had witnesses that have spoken to us about this issue, their clinical experience of being involved in assessing cases when the public ring 000, and decisions by AV to move them from regional Victoria back into the city. They cannot actually do the work that they really need, and they feel that that is putting those communities, or those emergency services, and the ability to respond really at risk. I am just curious as to what you might say around that ability to be able to provide that emergency service and to have that oversight, to have those clinicians. How many are we talking about will be required to oversee that Triple Zero dispatch system properly, do you think?

Danny HILL: In the revised ambulance dispatch model, I believe it was only a few dozen additional staff that needed to be on the floor at any one time, but it is not just about that. That is the easy part. I think the challenge is that, as I understand it, the breakdown with RAD level 3 happened where there was a discussion about ESTA at the time, now TZV, saying, 'Well, if you're going to override the algorithm, fine, but you take responsibility for that,' which I actually think is right. That is a completely different transaction in an ambulance service that does all of those things anyway versus swapping the risk from one statutory authority to another, and I believe that is where it became challenging.

Georgie CROZIER: That is the problem?

Danny HILL: And that is where we need government lean-in to try to assist with moving it along. It cannot be that hard to solve, and it is our biggest area of finding solutions.

Georgie CROZIER: Thank you.

The CHAIR: I will now pass it over to Ms Gray-Barberio.

Anasina GRAY-BARBERIO: Thank you, Chair, and thank you, Mr Hill, for your attendance today, as well as for your submission and for representing your membership. I just want to expand further. You said in your opening statement about a missing piece that often is not given the attention that it needs is around the dispatch and reform of the call-taking system. Some of the committee members have already asked around the processes to change the overriding algorithms, but the software itself – can that not be overhauled? Would that give a more long-lasting solution to this specific area?

Danny HILL: No, and it is even worse than that. The upgrades to the software build on the risk aversion. We have actually had lines of questioning where, for example, someone has called up and said, 'I've got abdominal pain.' 'Does the pain go to your chest?' 'Yes.' A common one is jaw pain and toothaches. People call up saying, 'I've got a toothache.' The toothache becomes jaw pain, and jaw pain is a sign of a heart attack. So those are questions that are often asked. TZV call takers used to have the ability to ask further questions. 'But what you're calling for, you're saying, is the toothache?' 'Yes, that's right.' That would be categorised as a toothache. But those lines of questioning were removed, so it grabs the worst-case scenario. The design of the system is to be risk averse and to eliminate as much risk as possible.

Anasina GRAY-BARBERIO: But in the process of being risk averse, that is now creating –

Danny HILL: We say it is creating risk.

Anasina GRAY-BARBERIO: these blockages and more work, and obviously increasing the inaccuracies of the call-outs as well?

Danny HILL: Yes, absolutely. Again, we have members who work – and they do a fantastic job – in those departments taking those calls. They are saying to us, 'We can tell it's just a toothache, but you can't argue with the system.' They do not have the ability to do that. Other ambulance services do. In the UK they have moved to a different program called Pathways, which is about trying to build different levels of nuance at different categories into the system, and they can easily channel into aged care support or mental health support. We are building that to a degree here in Victoria, and secondary triage here is very good. But it does not attack the most inaccurate part of the system, which is the unnecessary code 1 cases. To me, that is just being left to drift and keep drifting, and I do not see a strong desire to turn that around.

Anasina GRAY-BARBERIO: Okay, thank you. I just want to touch on some of your other points in your submission. Obviously, your people are the most valuable asset here. In regard to the point around fraud and embezzlement, why are members constantly being left out to dry when it comes to payroll and payslips for the work that they do? Can you speak more to that to the committee around those issues? Because we have heard from other witnesses about an increase in burnout and stress and not being remunerated in a timely manner or having issues related to remuneration being dealt with in a timely manner. What are you seeing or what are you hearing from your members around this?

Danny HILL: Payroll – again, we have got fantastic people working in there; there are just not enough of them. The service has grown. The size of the operational workforce has grown enormously over the past 10 years, but we have not seen the same increase in the support services like HR, payroll, rosters, communications – all the areas that make the members do their work and function as best as they can out there on road. I cannot speak to the fraud allegations that brought this inquiry forward – we were not involved; we were not representing anyone in that space. I can say that that department has been significantly understaffed for a long, long time, and I am not surprised they were doing massive amounts of overtime. We go in there and work with them and try to help them and try to solve problems on behalf of our members, but they are working incredibly hard. I always get frustrated when we hear talk about 'back of house' services. They are frontline in supporting the paramedics. And we just do not have enough of them.

Anasina GRAY-BARBERIO: Thank you.

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

Ryan BATCHELOR: Thanks, Chair. Thanks, Mr Hill, for your evidence today and obviously the work that you and your members do every day. I want to get you to go back to some of these questions about dispatch. You talked a little bit in your answers before about the problem of, I will be polite and say, 'risk passing' between TZV and AV. I was going to ask who you think should take responsibility. I think you might have hinted at the answer.

Danny HILL: AV.

Ryan BATCHELOR: You think it should be AV?

Danny HILL: Yes. That does not mean you have to throw away the entire system that we have got. There is an argument to bring it back into AV completely, but the solution designed by AV – the union does not have enough oversight and insight to actually construct and design the solution. AV, TZV and the government, in consultation with the union, did design what we thought was a really good option. Part of what we talked about and what came out of the APPCC around improving response times was two arms to it: the dispatch grid reform, which took about 100,000 cases a year out of the code 1 system and into code 2s, and then the call-taking accuracy component. That all sort of fell apart towards the end of 2019. COVID then hit and obviously priorities were elsewhere, but we have been trying to get them to re-engage with it and say –

Ryan BATCHELOR: Get it restarted.

Danny HILL: We want to come in and help advocate for it, because we actually thought –

Ryan BATCHELOR: What do you think the barrier to the restart is? Why do you think that it has not been revisited and reinitiated?

Danny HILL: Look, I would say part of it came down to it just not being on the agenda for senior executive members and Ambulance Victoria at that time. I think a lot of the people heavily involved in design of solutions probably left the organisation over that period of time. It is really hard to get people to talk about it or talk about how maybe it is not RAD, maybe it is a different solution, but to actually talk about the problem with call taking – and we do hear them say, 'Yes, we are working on call taking; we're fixing call taking and dispatch' – you know, you are fixing dispatch, you are not fixing call taking; there is nothing happening there. As I said in my previous answer, that problem, from our point of view, is only going to get worse.

Ryan BATCHELOR: Earlier in evidence you talked about the sort of way that the algorithmic decision-making, for want of a better term, is creating risk aversion. What do you think some of the drivers of that risk

aversion are in the first place in the system more broadly? What do you think some of the pressures to category escalate are in the underlying system?

Danny HILL: I assume the design of the product is to make sure people are not under-triaged, which makes sense. You are always going to have a degree of risk aversion and over-triage built into the system; no-one argues with that. Someone who complains of chest pain when they cough will probably get an ambulance under lights and sirens, because you cannot rule out that it is not a heart attack, but for someone who has got an ingrown hair on their chest, you can with a bit of common sense. Again, when this system is being run by an ambulance service with the ability to have some degree of clinical override, the system may work well.

Ryan BATCHELOR: Do you still think, though, based on the experience with the RAD program, that you could inject that element of clinical override without necessarily unpicking the entire call and dispatch system? Do you think that it is a possibility to work within it to make the modifications that you think would improve it?

Danny HILL: When we had AV present that idea to us, yes, we said that looks like it works. We obviously talk to our union colleagues in other states – they have pressures with call taking and dispatch, but they are not dealing with some of these very bizarre and unusual ones that we seem to be getting here in Victoria.

Ryan BATCHELOR: So there is something different in that.

Georgie CROZIER: Why is that? The algorithm?

Danny HILL: Because it is an ambulance service that is able to override – they employ teams with paramedics in there so they have the ability to override it, whereas in Victoria that would be a shift of risk between two separate organisations rather than one organisation that probably accepts that risk anyway.

Ryan BATCHELOR: Thanks.

The CHAIR: Thank you. I am going to go to Ms Payne, who is online.

Rachel PAYNE: Thank you, Chair, and thank you, Danny, for your very detailed submission. You raised this in your opening remarks and in the submission as well around that period around late 2018 where AV response times were improved, probably at their best. I just wanted to work out. Is that sort of where the right strike of the balance was landed, and is it the intention to get back to that sort of outcome or is it that we need to improve from that point, obviously post pandemic?

Danny HILL: We definitely need to improve from that point, but I think, from the workforce, they could actually see that positive work was happening in that space. When this does not work well it flows on to every part of working life for our members. AV on paper look great. They have got all the policies, all the procedures – HR, peer support, counselling – all those things on paper, but it is underwritten subject to operational demand. Operational demand wins over the priorities of the workforce every single time. When you have got a system that is crushed by its workload our members do not get the support that they need. It is harder for them to negotiate flexible work arrangements. It is harder for them to get off shift on time, get their meal breaks on time. I think going back to where we were in, you know, 2017, 2018, we probably saw a bit more positivity, because you could see that the work was moving and things were happening.

Rachel PAYNE: And that is coming out of that APPCC development and that collaboration between the workforce and AV?

Danny HILL: Absolutely. A lot of good work came out of that, and I will not write it off. We did have a lot of improvement. We introduced power-lift stretchers, which reduced manual handling injury. We introduced improved supports in relation to mental health. But you know, the mental health impacts of the current system are incredibly serious at the moment. When I was on road, and this was 12 years ago now, you would go to some of the worst cases, but you got back to your branch and you got some downtime where you could de-stress, defuse, have a discussion about the cases you had just been to. Crews do not get that now. There is an awful case that is on the front page of the paper today. The crews need the ability to defuse with their colleagues before they take those things home to their family, and when they cannot do that they really carry it quite hard. The downtime that they used to get, which protected people from some of the trauma that they see, their relationships, the conversations with their colleagues during that small amount of downtime, helped them

to survive the trauma and the traumatic cases that they see. That is really wearing. It is a very damaging experience to go to these cases and not get the ability to have a bit of downtime and de-stress and vent to your colleagues, and bang, you are off to another one, which is probably why we are seeing the lifespan of paramedics is really shortened now.

Rachel PAYNE: Thank you. You did just raise flexible working arrangements, which is something that has come up from quite a few witnesses, and the lack of I guess accommodation of flexible working relationships. Did you want to expand on that a little bit more from your members' experience?

Danny HILL: I can, and I can give you an example from a member I spoke to just last night who is a single mum in a small country town with four children. I will de-identify the location, but let us say Cobram, for example. Every year she has to renegotiate her flexible work arrangement, and AV try to get this person to take on more night shifts, more weekends, and she says, 'What do you think has changed in relation to child care in Cobram in the past year that suddenly I can take on nights and weekends?' They have got to go through this battle with their employer, often to hit an arbitrary target of how many night shifts, and we are just going to lose those people. It is up to AV to decide: do you want to keep the diverse workforce of working parents – women are certainly over-represented in that sort of battle – or do you not? Because at the moment they are driving people like that out of the job.

Rachel PAYNE: Thank you.

The CHAIR: Thanks. I will now go to Ms Hermans, who is also online.

Ann-Marie HERMANS: Thank you, Mr Hill. I really appreciate your submission, and thank you so much for coming in and advocating on behalf of so many ambulance workers. There are a number of things that I wanted to pick up on, and you were just touching on them in terms of – there are a few different ones – senior management and the disconnect that there is there. What would be a suggestion that perhaps has come from the union in terms of how this disconnect could actually be rectified? We have only got a few minutes and I have got quite a few questions, so if we can just keep it succinct, I would appreciate it, thank you.

Danny HILL: Of course. Look, I would say we have seen a settling of the senior ranks in Ambulance Victoria just in the past six months, so I have a degree of optimism that we have probably got some newer people that we can work with. We have probably lost some of the, you know, people that we have had over the past couple of years where we have struggled to engage.

So I have got some optimism. Again, I come back to this one problem that really affects every part of AV's operation and the relationship with management – the workload, and it is the workload created by the current call-taking system, which we really need our political leaders' help with. Once we start working on that, we can fix anything. If we do not fix that, I do not think we can fix anything.

Ann-Marie HERMANS: I appreciate that you have mentioned dispatch crews and miscoding, wrong coding, unnecessary code 1 cases and so forth, but I would like to get to ambulance ramping. Obviously a lot of your workers are stuck in that ramping situation because there is nowhere for them to go. They feel a sense of obligation to stay with the patient. The hospital has not really taken them on. This breakdown and this disconnect between the hospital actually taking on the responsibility for the patient and Ambulance Victoria being able to hand over the patient seems to be where the ambulance ramping is taking place and where the breakdown is. Could you please talk a little bit further on that and perhaps some solutions that might resolve this, where Ambulance Victoria could have their ambos actually get out, back on the field, and be able to walk away knowing that the patient is getting the care that they need?

Danny HILL: You are spot on. But I do not think it is from a sense of obligation that the paramedics feel that they need to stay with the patients – they have to do it. They cannot just leave the patient and walk away. They would be probably in breach of some of their professional obligations, not to mention face some disciplinary action, potentially. As far as solutions go – and I will say that hospitals are under strain, and members have started to report some improvement since the new standards have come into effect. It is mixed and there is clearly a lot to iron out with it, but there is some small improvement.

In our submission we put forward what is called the Leeds model, which was that during the COVID wave in the UK where every health service had a massive blowout in their ambulance offload times, the Leeds hospitals

did not. They adopted zero tolerance to ambulance ramping. They had an ambulance team with a senior doctor the moment that the paramedics arrived, started the work, got them offloaded as quickly as they possibly could and got them out there offroad. They were the only hospital system that did not see an increase. They maintained what they currently had.

We have been advocating for some of those ideas. There were some funded in early 2022, but I think part of the problem is that the hospitals take the funding for that and just roll it into their, you know, 'We'll stick you up on that ward or we'll stick you somewhere else', not dedicating it to ambulance offload. I think part of what I hope comes out – and it remains to be seen whether it will work with the new standards – is that there is some degree of enforcement, of having the right people at the offload ramp as soon as the paramedics come in, so that they can get the intervention from the hospital that they need early and they can get back out there on the road.

Ann-Marie HERMANS: Thank you for that. In terms of our committee – there is the time – is there anything else that you wanted to add on the complex toxic workplace culture and the processes?

The CHAIR: Sorry, Ms Hermans, your time has run out. I am very sorry. Because it is a tight schedule here, I have got to be fair on that one.

Ann-Marie HERMANS: I understand.

The CHAIR: We have only got a couple of minutes left, and I know there are a couple of questions that need to be asked. I have put the timer down to a bit less so that we can get through those. Ms Crozier and then Mr Galea.

Georgie CROZIER: Very quickly. Thank you, Mr Hill. You said mental health impacts of the current system are incredibly serious. I am just wondering, in terms of the MICA staff, who are under huge pressure, have you got an update on the number of MICA staff that are currently on leave or WorkCover or just out of the system because of those stresses that you spoke of?

Danny HILL: I do not have the figures. Ambulance Victoria obviously have a lot of staff off. Their lost time injury frequency rate I believe is about 11.2, which would make it several hundred.

Georgie CROZIER: Is that higher than normal?

Danny HILL: Yes, it is very, very high, but we do not have a breakdown of ALS versus MICA. In areas like Geelong, metro west, Ballarat and Bendigo you do see a reduction in MICA services, and we hear crews calling for MICA backup, which they do not do lightly. They know that MICA are there because of what they provide. MICA paramedics can place someone into an induced coma on the side of the road. They can do a surgical insertion of an airway into a patient's throat. They are at an elite level, and they should be reserved for the most time-critical work.

Again, they as a specialist resource are also being tied up on non-essential work and are therefore not able to get to the patients that desperately need their care. That is a big frustration for them. And when we do see dropped shifts across the MICA workforce, we see entire regions not having any MICA capability, so those patients in those areas do not get intensive care capability.

Georgie CROZIER: They are at huge risk. Thank you very much.

The CHAIR: Mr Galea.

Michael GALEA: Thank you. Just on your remarks and submission on governance, and to Ms Payne's point as well, you said that there are issues of communication between, for example, operational and HR support. You have also said that there has been improvement when it comes to the establishment of the professional standards and behaviours department. Have you seen improvements in the communication – as a former union official, I have dealt with many of these exact issues in a different setting – in terms of getting that HR support, for example, and other communication between AV departments. Has there been any progress?

Danny HILL: Well, as a union official, you would know that 90 per cent of our work is often making one part of an organisation talk to another part. They could probably get rid of us pretty quickly if they did that. But no, it is really difficult. AV works in silos and it can be very hard. Often what we are saying to operational

management is, 'Have you got advice from the workplace relations department?' It is very, very challenging. We have members who do incredible work in their areas. A good example would be our rosters department, who allocate the staff to their locations across the state but they follow a set of directions given to them by the workplace relations department. The regional management teams will get stuck into the rosters department and blame the rosters department for things that have happened that the person is not happy with. Often so much of our work is unscrambling the egg and finding what the problem is. I would say at times I feel like we do a better job of that than the organisation does themselves, and it leads to enormous frustration and can lead to unnecessary infighting amongst the workforce that we could solve if they understood their own organisation a little bit better.

Michael GALEA: Thank you.

The CHAIR: Thanks very much for that. Mr Hill, thank you very much for your appearance today. We really appreciate it. We are going to end this session now. I wish you all the best. Thank you.

Danny HILL: Thanks very much.

Witness withdrew.