T R A N S C R I P T

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Budget Estimates 2018–19

Melbourne — 17 May 2018

Members

Mr Danny Pearson — Chair
Mr David Morris — Deputy Chair
Mr Steve Dimopoulos
Mr Danny O'Brien
Ms Fiona Patten
Ms Sue Pennicuik
Ms Harriet Shing
Mr Tim Smith
Ms Vicki Ward

Witnesses

Ms Jill Hennessy, Minister for Ambulance Services,

Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Mr Greg Stenton, Chief Finance Officer, Corporate Services,

Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning, Department of Health and Human Services, and

Associate Professor Tony Walker, Chief Executive Officer, Ambulance Victoria.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2018–19 budget estimates.

All mobile telephones should now be turned to silent.

I would like to welcome the Minister for Ambulance Services, the Honourable Jill Hennessy, MP; Ms Kym Peake, Secretary of the Department of Health and Human Services; Mr Terry Symonds, Deputy Secretary, Health and Wellbeing; Mr Greg Stenton, Chief Finance Officer, Corporate Services; Associate Professor Tony Walker, Chief Executive Officer, Ambulance Victoria; and in the gallery, Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning.

Any witness who is called from the gallery during this hearing must clearly state their name, position and relevant department for the record.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege.

The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as available. Verified transcripts, any PowerPoint presentations and handouts will be placed on the committee's website as soon as possible.

Witness advisers may approach the table during the hearing to provide information to the witnesses if requested, by leave of myself. However, written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

Members of the media must remain focused only on the persons speaking. Any filming and recording must cease immediately at the completion of the hearing.

I invite the witness to make a very brief opening statement of no more than 5 minutes. This will be followed by questions from the committee.

Visual presentation.

Ms HENNESSY — Thank you very much, Chair, and welcome to the new people in attendance at the committee hearing. I will go through my presentation very quickly.

This first slide sets out the investment that is being made in the 2018–19 budget and provides some historical context. Obviously this investment provides a 5.4 per cent increase on the funding that was provided for in the 2017–18 budget. That was in and of itself a 27.9 per cent increase on the previous year. In the last four years the total ambulance services budget has increased from 696.5 million in 14–15 to $1.08 billion in 2018–2019. Again just to emphasise the point, Chair: that is a 55 per cent increase in the ambulance services budget in the last four years. We also want to continue to support our ambulance services and our paramedics by providing additional funding to meet demand for a growing population and improving community access to ambulance services through additional paramedics and equipment, and this new investment in the 2018–19 budget builds on our track record in investing in ambulance services.

If I could go to the next slide, Chair, we inherited a system where ambulance response times were essentially in crisis. They were the worst in mainland Australia. As part of both our investment and our reform we have significantly improved ambulance response times. The implementation of our revised clinical model together with a $500 million investment in November 2016 has resulted in significant and increasing improvement in ambulance response performance, with quarter 3 of 2017–18 the best quarter 3 in nine years. So we are starting to see really significant pay-off from the work that is being done.

The next slide is about delivering better clinical outcomes, because it is not just about response times and getting there. We get there for a purpose — so that we can intervene in life-saving situations for people. As this

slide outlines, our record investment in ambulance services is not only improving ambulance response times but, together with reform, including our clinical response model, our ambulances are responding faster and delivering much better clinical outcomes. As the budget papers themselves have shown over recent years, the proportion of adult ventricular arrhythmias and ventricular fibrillation cardiac arrest patients with vital signs at hospital has been improving, so too is the proportion of adult patients suspected of having a stroke who were transported to a stroke unit with thrombolysis facilities within 60 minutes.

Beyond these measures recorded in the budget papers, the most recent data on the average response time for patients experiencing a cardiac arrest is now 7.7 minutes, which is the best response ever. Paramedics attended 6034 cardiac arrests in 2016–2017, which was the most ever. Survival for patients in a shockable rhythm to hospital discharge was the highest ever at 34 per cent. In 2016–17 a record 379 patients were discharged alive from hospital, which is a significant improvement. These are important outcomes, they are life-changing and life-saving outcomes. They are a testament to our ambulance service, our paramedics — and again demonstrate why investments and reform and supporting our paramedics are so critical, because they demonstrate these kinds of outcomes.

If I could go to investing in our paramedics, of course there has been much human outcry about paramedics who have been injured, and a sense of lack of accountability for those that injure our paramedics. I am pleased to advise this committee that the Attorney-General is immediately working on law reforms to address that specific issue. There are other really important reforms that we have put in place for our paramedics around training, because they are exposed to occupational violence and aggression. No training was in place in the past. Ambulance services were receiving one day a year when it came to training. We have now increased that to 5 days per year around occupational safety. We are better at using things like virtual reality to train our ambulance services as well in respect to occupational violence and aggression.

Mental health is still an area that we have made a first and foremost priority. We have made significant investments around improving mental health and wellbeing through things like peer support, but also issues such as fatigue. When you do not invest in more paramedics, fatigue is also another really significant driver of post-traumatic stress as well. We have also made significant investments in things like a big trial in the north-western part of Victoria for body-worn cameras for all of our paramedics as well. I am pleased to say that the Productivity Commission identified that our retention of paramedics, which is usually a good indicator around workplace culture, has gone from the national rate of 2.6 and we are at 1.7 now in Victoria.

Ms SHING — Over what period is that?

Ms HENNESSY — The latest official data has that over a couple of years, essentially. RoGS is a little bit behind the mark. Additionally, the People Matter Survey of Ambulance Victoria has demonstrated the highest ever employee engagement score. So, investing in our paramedics goes to their clinical training, it goes to their occupational health and safety, it goes to the equipment that they have, it goes to the culture of an organisation that makes mental health and wellbeing a mainstream issue in the same way that things like back injuries have traditionally been a mainstream issue.

Aggression and occupational violence against our paramedics remains a significant challenge, but at every level we are going to continue to invest in and support our paramedics. I think that almost takes me to time.

The CHAIR — Thank you, Minister. We will have government questions now until 12.57 p.m. and I might lead off. In your presentation you talk about the investment that has been made, and there was also a slide in there too about response times. In terms of the dispatch grid, what impact has the investment had in terms of Ambulance Victoria's dispatch grid?

Ms HENNESSY — Well, it has been essential. I mean, the reality is that under the other system people died because they did not get an ambulance, and we are trying to make sure that you match your response and the acuity of your response to the acuity of the patient. As I said, three and a half years ago we had the worst response times on the Australian mainland, and it was very clear that something needed to be done. At its worst in 12–13 just 73 per cent of code 1 cases met the 15-minute benchmark. As part of the response to that, there was reform that was pursued, initially at the behest of the Ambulance Performance and Policy Consultative Committee, which again brought together clinicians, paramedics and people who run emergency departments and determined that a review of the dispatch grid be undertaken. That review was overseen by an independent clinical panel — not decisions of politicians, decisions of clinicians.

Dr Jo Flynn, who would be known to many people as the head of the Medical Board of Australia, undertook and chaired that review, and that recommended that these changes be made in order to ensure that we could prioritise those cases that were missing out , particularly things like cardiac arrest, stroke and road trauma. It also uncovered and demonstrated and highlighted some of the extraordinary things that our paramedics were being called to, and paramedics themselves will tell you about being called to hangovers, headaches and, you know, small cuts where you do not require a lights and sirens response. That was occurring at the expense of getting to cardiac arrest, stroke and road trauma patients as well.

So that clinically revised model was introduced in 2016. The latest data has us gone from, as I said, the worst on the mainland to now 83 per cent of ambulances attending the most critical engagements within 15 minutes, with a statewide average of 11 minutes and 21 seconds. It has been absolutely critical, not just to the improvement in performance but improvement in the morale for our paramedics that used to feel so frustrated at being called out to cases that did not require a lights and sirens response.

The CHAIR — Have you got any data or evidence about the satisfaction from the paramedics as a workforce perspective?

Ms HENNESSY — Look, I would refer to the comments that I made in my presentation around what the Productivity Commission has found: 1.7 per cent in terms of attrition rate. That is a fantastic indicator and a really significant improvement. In terms of the People Matter Survey as well, that is demonstrating that our paramedics are feeling far more engaged than ever they had before, but of course I am very conscious of matters of recent times where paramedics rightfully feel very frustrated around their exposure to acts of occupational violence and aggression.

The CHAIR — Minister, I will move along now. The budget paper reference is budget paper 3, page 237, and it relates to the satisfaction rating from patients — 97.4 per cent of patients are either very satisfied or satisfied overall with the services received from paramedics. Can you advise the committee how many complaints are received by Ambulance Victoria?

Ms HENNESSY — Very little, I have got to say. I think the rate is something like three in every 10 000 calls results in a complaint to Ambulance Victoria. I would put that in stark contrast to the plaudits — certainly I know both Professor Walker in his capacity as the CEO and I, as minister — and the incredible gratitude that people feel for our paramedics and the work that they do each and every single day. We also like to celebrate our paramedics with Thank A Paramedic Day and we have got some other activities. They are important, as is doing things like paying our paramedics properly, and I know we have debated this issue many times in this committee. But just the changes from the work value case, giving our paramedics a fair pay rise and ensuring that our paramedics are valued where it counts in their pay packets again has been another really important part. Most paramedics anecdotally will also say that the culture has significantly changed, and I want to give my thanks to all of the leaders of Ambulance Victoria — to Tony and his team and of course the board, chaired under Ken Lay's fantastic leadership. But all of the leaders that exist in branches and crews across the state feel an enormous sense of pride in their work. They feel incredibly invested in the success and care for their crews as well. The data demonstrates that that has occurred — that there has been significant improvement — but as I said, there is significantly more work to be done.

The CHAIR — Again going back to budget paper 3, page 236, there is a high proportion of VF/VT cardiac patients presenting at hospital with vital signs.

Ms HENNESSY — Yes.

The CHAIR — Can you talk to the committee in a little bit more detail about that and what the data shows in terms of some of those changes and what is at the back of the changes?

Ms HENNESSY — Look, I mean it just makes sense that if you make more ambulances available and you dedicate them to responding to the most urgent cases, you will improve the cardiac survival rates. In Victoria we are among the best cardiac survival rates in the world. That is more than just a ranking. It absolutely means that people are living and perhaps living with less disability than they might have if they had survived in the past. Paramedics are now arriving at cardiac arrest faster than ever before, with a record number of patients surviving. The cardiac arrest registry of 2016–17, their annual report shows statewide ambulance response times to cardiac arrests have improved to 7.7 minutes. That is the fastest response time ever. That means that patients

were being defibrillated within 9.2 minutes, which is 1 minute faster than last year. It was 11.5 minutes in 2012–13 at the height of the ambulance crisis, so these are making incredibly significant and incredibly important differences to whether or not people live or die.

The CHAIR — I mean, I was quite surprised by the survival rate. It is actually quite low in terms of people who have had a cardiac arrest. Is it something like about 10 per cent or 20 per cent, something like that in terms of —

Ms HENNESSY — It is very low, and I might invite —

The CHAIR — I was quite surprised by that, because you hear often people say that — I suppose that is the difference between heart attacks and cardiac arrests, but Professor Walker —

Ms HENNESSY — Absolutely. I mean, the issue with a cardiac arrest is the heart is not pumping. The person is technically not alive, hence the nature of that data. It is an extraordinary thing to bring someone back from a cardiac arrest as well.

The CHAIR — Thank you, Minister. We will have opposition questions until 1.07 p.m.

Mr MORRIS — Good afternoon to those who have not been at the table before. Professor Walker, a couple of days ago of course we had the issue of the quashing of the sentence. Last night I understand — or early this morning, more accurately — there was another incident in Epping where paramedics were attacked by someone that they were trying to assist. Can you try and give the committee some indication of the impact that not only these two incidents but the ongoing pattern of violence is having on our paramedics and on our ambulance officers?

Ms HENNESSY — Is your question to me, Mr Morris?

Mr MORRIS — No, to Professor Walker.

Assoc. Prof. WALKER — Occupational violence is a significant issue for our workforce. Despite the fact that we have put in a number of changes around improved training using new, innovative techniques — better assessment of those calls at the point of call, trialling new and different issues such as body-worn cameras and a very clear policy position to our paramedics that they do not put themselves at risk and they can exit a scene if they want to — we are still seeing paramedics being exposed to occupational violence.

Today in Victoria every 50 hours a paramedic is actually either physically or verbally assaulted in the way they are reported to us. They are reporting being exposed to around 14 events a day where violence or aggression was part of a scene that they were attending. We have seen a reduction in the number of paramedics who have been injured as a result of occupational violence over the last 12 months as a result of the initiatives, but nevertheless any episode of occupational violence is one too many and it does have an impact on our workforce.

Mr MORRIS — Can I then ask you about some specifics on that? Can you indicate to me in the first three-quarters of 2017–18 how many emergency cases did paramedics attend where they were exposed to violence or exposed to aggression?

Assoc. Prof. WALKER — I can give you the 2017 figures. I could not give you across that time period but I can get that information for you. There were 147 actual assaults against paramedics in 2017 compared to 234 assaults in 2016; that is a 38 per cent reduction. I have got the hours, as I mentioned before, of the 14 episodes a day where they are reporting being exposed to, but I have not got the actual figure of that for you today.

Mr MORRIS — Would those incidents be classified as occupational violence incidents or is that more broadly?

Assoc. Prof. WALKER — They would be incidents where they have actually been exposed to a violent situation, not necessarily violence against them.

Mr MORRIS — Right, okay.

Ms HENNESSY — Observation, bystander — aggression is just another issue where, whilst there may not be a physical assault, it is still a very stressful environment for anyone, as well as paramedics, to be in.

Mr MORRIS — Can we get the occupational violence figures as well?

Assoc. Prof. WALKER — Yes, we can. I can get those for you, absolutely.

Mr MORRIS — You do not have them with you?

Assoc. Prof. WALKER — No, I do not, not today, no. Sorry.

Mr MORRIS — If we can get them, that would be helpful. Can I ask you, how many paramedics are currently injured and off work due to employment-related violence or assaults?

Assoc. Prof. WALKER — I would have to take that on notice and bring that back to you, Mr Morris.

Mr MORRIS — If you could also advise us at the same time what percentage of operational officers that figure is.

Assoc. Prof. WALKER — Yes, I can do that.

Mr MORRIS — There are, as I understand it, 500 to 600 occupational violence incidents a year, on average, where there is abuse, threatening, assault. How many of those get referred to police and how many of those that do result in an arrest and/or a conviction?

Assoc. Prof. WALKER — I would have to come back to you on that one. We encourage our workforce to report incidents, all incidents where they have been assaulted. They will not always do that, but we encourage them to do so. I would have to come back with the actual figures on that, Mr Morris.

Mr MORRIS — There are obviously some issues with the law as it stands, and the minister said earlier that she had spoken to the Attorney-General with a view to making some changes. Have you at any time raised concerns about the law with the government?

Assoc. Prof. WALKER — No, I have not, no.

Mr MORRIS — Can I then ask you a little bit about the body-worn camera trial?

Assoc. Prof. WALKER — Yes.

Mr MORRIS — The release last year said it would be rolled out from June — July and run for six months, so presumably it was going to conclude at the end of last year; is that pretty right?

Assoc. Prof. WALKER — It was going to run through for six months. We have continued it for a further period into 2018. We did not feel we had sufficient data yet to be able to make a final position on the outcomes of it, so we are extending the trial further to get more volume, sadly.

Mr MORRIS — I was going to ask you a series of questions about that. So you are still collecting the data?

Assoc. Prof. WALKER — That is correct.

Mr MORRIS — Do you have an indication of so far how many times the cameras have been activated?

Assoc. Prof. WALKER — I would have to confirm it for you. I think it is about 90 times that the cameras have actually been activated. The feedback we are getting from staff is that it is making a difference to them, but, again, we are waiting for the final report to have a proper evaluation to be able to give a defined position on that.

Mr MORRIS — And has the footage been used in any investigations or prosecutions?

Assoc. Prof. WALKER — To the best of my knowledge — actually I do not know the answer to that. I would have to confirm that for you. It has certainly been made available if required, but I am not sure if it actually has been used.

Mr MORRIS — When do you expect the trial to finish and, beyond that, when do you expect to make a decision on whether there will be a full rollout or not?

Assoc. Prof. WALKER — I would expect that the trial — again, depending on the data we can get — would be completed in the coming months. I would hope August/September should give us sufficient information or sufficient time, but it will depend, again, on whether we have got, from a proper research and evaluation point of view, sufficient data to be able to make a decision on it. One of the challenges we have is that the feedback from our staff is that it is making a difference, but it has also been implemented with a range of other strategies, such as occupational violence training and other things, so we are wanting to carefully try and identify its specific benefit other than the fact that our staff are using it and are encouraged by it.

Ms HENNESSY — So there has been a drop in the figures. The question is: what is the correlation and what is the causation around some of the other — all of the training work, all of the reform around walk away if you are not safe and the improved relationship and information exchange with police, and getting a dataset that is deep enough in order to extract those potential impacts on what the results of it might be.

Mr MORRIS — Professor Walker, when did you first ask the government to support a body-worn camera trial?

Assoc. Prof. WALKER — I think it has been in conversations for the last couple of years, Mr Morris. I could not give you the exact date. We have been talking to government about a range of initiatives. As we have looked at the issue of occupational violence, we have been looking at what innovative ways we could potentially put in place to deal with that. I think in conversations, certainly at the departmental level, we have been talking about **t**hat as one thing to consider, but I could not give you the exact date. It has certainly been within the last couple of years.

Mr MORRIS — So, Minister, presumably in response to the initial conviction in December 2016 of the two drunken women who assaulted the paramedic in Reservoir, you put out a media release a week later announcing the trial of body-worn cameras but, as we have just heard, there had been a conversation going on for some time. I think there was a report in the *Herald Sun* that suggested it was at least six months before that.

Ms HENNESSY — Mr Morris, can I assure you, if you are attempting to kind of ascribe immediate —

Mr MORRIS — I am just trying to get the time line.

Ms HENNESSY — There has been significant work been done at the department in respect of occupational violence and aggression for all of our health service workers, and paramedics are one cohort of that. From that, a hospital violence prevention fund was established, and through that work it was identified what are the priorities for investment, and the body-worn cameras for Ambulance Victoria were one of those. This is part of a broader body of work in the Department of Health and Human Services, supported by the hospital violence prevention fund and consistent with —

Mr MORRIS — What we are trying to find out is how long before it was funded, which appeared, coincidentally perhaps, to be two weeks after an awful incident.

Ms HENNESSY — Mr Morris, can I assure you there has been ongoing work, including things like investment in the training and investment in the body-worn cameras. That work has not been abstract by Ambulance Victoria. It has been part of the general hospital violence prevention fund work that has been done right across the health sector.

Ms PENNICUIK — Minister, Secretary, Professor Walker and everyone else who is here, thank you for coming. It has been very interesting to be listening to that conversation about the prevention strategies you have been employing to prevent or minimise and reduce occupational violence, which of course is not acceptable, against paramedics or anyone in the hospital system, in the school system or anywhere else in a workplace. I would like to just turn to another occupational health and safety issue which has been raised in your presentation, and that is the issue of manual handling injuries. There is funding for new equipment to prevent manual handling injuries. I wonder if you could say whether — and I do not have a lot of time with you, Minister and Professor Walker, on this — the rollout of the stretchers is complete, the new stretchers that will

prevent needing to lift people. And also: it is 60 per cent of the injuries in Ambulance Victoria; what is the other 40 per cent or thereabouts of injuries are made up of?

Ms HENNESSY — Thank you, Ms Pennicuik. I will answer the first part of your question, and I may have to either take it on notice or enlist Professor Walker's insights. Yes, the rollout of all of the Stryker stretchers in every vehicle is complete. I am looking to make sure he is not nodding nervously. Yes, it is complete. It is essential just around musculoskeletal injury. We have also invested in what we call CPAV vehicles. They would be used for larger patients who are very difficult to transfer and transport. We are also at the point where of our intake we are hitting 60 per cent rates of women. Women have only been in the ambulance services for 30 years. All sorts of assumptions around their physical capability were in place, so the Stryker stretchers are important not just in terms of getting patients into vehicles but also the transfer and transport of patients at hospitals. At every point they have been incredibly welcome. In terms of the composition of the rest of the injuries I will ask Mr Walker if he has any either anecdotal or direct knowledge, and if not, we will take that on notice.

Assoc. Prof. WALKER — Thank you, Minister. So 60 per cent is manual handling. The balance of that is made up of both mental health injury, which is a big issue, and we have been investing and working hard with our workforce in that area, and also areas such as shoulder injuries or other manual task injuries that fall into that as well. But the majority of that other 40 per cent is mental health injury.

Ms PENNICUIK — There are two questions I would like you to follow up on because time is short: whether your figures are from WorkCover or WorkSafe, whether you base it totally on that, or whether you collect your own information — for example, in the survey of ambulance officers about their happiness with the job or satisfaction with the job. Do you ask these types of questions as well? Because I know from my years working in occupational health and safety that whilst you have got WorkSafe or WorkCover statistics, they do not cover a lot of injuries, in particular manual handling injuries, and in particular mental health injuries are under-reported.

Ms HENNESSY — Yes, significantly.

Ms PENNICUIK — So whether you are just relying on that. I think that might all have to be taken on notice because I am anticipating the Chair —

The CHAIR — Unless you can answer it in 10 seconds.

Ms HENNESSY — We get the vibe of what it is that you would like us to come back to, and yes, we will absolutely do that.

Ms WARD — Minister, following on from Ms Pennicuik's questioning around support for the paramedic workforce, if I can get you to pull out budget paper 3, page 76, 'Supporting demand for ambulance services'. Could you please talk us through how paramedics are being supported?

Ms HENNESSY — I might ask Tony to talk about some of the incredible programs that are being run, because it is probably one of the things that paramedics raise with me most frequently — their appreciation around the programs that are being run. If there is any other feedback that comes back it is, 'All of the reform is fantastic, but don't overwhelm us with too much at the one time'. Both the occupational violence and aggression programs have won awards. The mental health stuff has been kind of revered and identified as first-rate by many other sectors. I might ask Tony to talk to the detail of that.

Ms WARD — Thank you.

Assoc. Prof. WALKER — Thank you. Over the last few years we have been very heavily focused on the health and wellbeing of our workforce as a priority. That is very much about that we will not accept that injury — either mental injury or physical injury — is just a natural part of the job. So there has been — as we talked before about the work in the manual handling space — the rollout of new stretchers. We are currently rolling out manual handling training that is using, again, virtual reality to develop situational awareness for our staff to significantly reduce that over this period of time.

Over the last couple of years our real focus has been on the area of mental health and wellbeing. We have partnered with Beyondblue to roll out an innovative mental health education training program to all of our staff

that is really focused on breaking down the stigma around talking about mental health and giving them the skills to be able to recognise in themselves when they are experiencing mental health issues or, importantly, in their colleagues, and at the same time to be able to refer them on to our counselling and other services, which have also increased over the last couple of years. I am pleased to say that since we have implemented the mental health and wellbeing training we have seen an 84 per cent increase in the number of paramedics who are utilising our telephone and counselling services, and we have also seen a 30 per cent increase in paramedics and volunteers who are accessing our face-to-face counselling. Stigma is breaking down in our organisation. We still have a lot more work to go, and we are also looking at, again, innovating. There was last week the introduction of a pilot for six months for a peer support dog, which is working with our peer support team —

Ms WARD — Oh, yes. Bruce.

Assoc. Prof. WALKER — Bruce, yes. He is well-known now. Again, we are constantly pushing to see what it is we can do to continue to improve the wellbeing of our staff and to address the fact that this is a difficult job they do and it can take its toll on them over time. Our data is heading in the right direction, but we cannot ever think we have got there. We have got a lot more still to do.

Ms HENNESSY — One of the things we noticed or learned when looking at the over-representation of paramedics in suicide rates — I think when we first looked at it, and Professor Walker can correct me if I am wrong, it was four times more than the average Victorian. It was higher than returned US army personnel — extraordinary. It is not just being exposed to one trauma; it is the long-term experience of being exposed to trauma. The other group that were important as part of that measurement were retired paramedics as well, so people who had done this for so many years. In places like rural and regional Victoria when you go to a car trauma it might be the son of your best friend. All of those kinds of things have an incredible impact on people.

It has gone from being a pretty male-dominated workforce to a much more diverse workforce. To get groups that traditionally may not reach out for health services or have the inclination to reflect upon the impact that work is having on them, I think is really significant. AV have also put really significant support into things like the Retired Ambulance Association, because that is just another group of people where it is an opportunity to support people that might have all sorts of impacts in their life because of trauma that has not been treated yet.

Ms WARD — It is good to see how formalised this is becoming because I know with my own local paramedics that there would be cafes that they would gather in and that is where their debriefing would be. That was where they would work with each other to try and give each other the mental health scaffolding, if you like, to support them. The fact that it is becoming much more formalised now is terrific. I am really, really glad to hear that.

Mr MORRIS — Just a quick follow-up to Professor Walker, if I may. It has been reported that the major problem in this state of violence, particularly against ambulance officers in this context, is illicit drugs. Is the problem ice?

Assoc. Prof. WALKER — Ice is an issue; however, alcohol is the biggest issue. So if we look at what is driving occupational violence it is predominantly still alcohol. Methamphetamines are an issue, there is no question, but it is predominantly alcohol.

Mr D. O'BRIEN — Secretary, just a quick one. The minister earlier referred to the report by Jo Flynn that was the subject of an FOI request. Its release has been upheld by the information commissioner, and I understand now that the 60-day period for appeal has passed. Will that report now be made available?

Ms PEAKE — I am going to have to take that on notice, Mr O'Brien, but I am happy to come back to you with a clear answer as soon as possible.

Mr D. O'BRIEN — Okay, thank you. If I could go back to Professor Walker re funding for ambulance services, page 226, budget paper 3. As you have told us previously in these hearings, a key measure of ambulance performance is the proportion of patients transferred to an ED from an ambulance within 40 minutes. The target for this performance measure is 90 per cent, and the most recent quarterly result has it at 85.1 per cent, which is actually down from 88.4 per cent in the same quarter in 2015. This measure does move around of course, but it has never been better than it was in January and March 2015. Why is this KPI not improving?

Assoc. Prof. WALKER — Well, it is an overall system KPI for the health system so I can talk to it from our perspective. Our perspective would be that it is largely due to increasing demand within services that is driving that. We have certainly got initiatives in place to work with health services to manage any delayed transfers. We obviously have a distribution system we are now accountable for in moving patients around the system. I probably could not speak to the broader health system. The secretary or others might be better to speak to that.

Mr D. O'BRIEN — What are the ramifications for the ambulance service though with ambulances having to wait longer to transfer?

Assoc. Prof. WALKER — The reality of that means that an ambulance is not available to respond to the community, which is why we focus heavily to try and work with health services to free them up as quickly as possible.

Mr D. O'BRIEN — Okay. Do you have an expectation of when you will be able to meet the target of 90 per cent again?

Ms HENNESSY — Could I just make a point, Mr O'Brien: part of that target is a health service target, as opposed to an Ambulance Victoria target, so your question might be better directed to Mr Symonds to talk about some of that work, because it is not within Ambulance Victoria's control; it is a transfer at the hospital site and a lot of the coordination that we have in EDs.

Mr SYMONDS — Thanks for the question. I would say hospitals are dealing with, firstly, a significant increase in demand that we have heard about — not just overall demand but an increase in high-acuity presentations, many of them brought by ambulance. As I talked about earlier in the previous session, their focus is on treating the most urgent patients first, and sometimes that means that even other ambulance-brought patients will wait longer so that the most urgent patients, however they arrive, are seen first.

Mr D. O'BRIEN — Thank you. Going back to Professor Walker: noting the other comments made about the broader health system, is this figure a result of the focus being put on response times and therefore the pressure building up at the other end?

Assoc. Prof. WALKER — It is a shared KPI, and as demand grows from the health system we are experiencing that in our 000 numbers of call-outs as the health services are by the number of patients that attend them.

It is a measure of, if you like, the pressure the system is under. It is an important measure for us and for the broader health system because it is part of our overall ambulance response performance. The quicker we can move any crews out of hospitals obviously the more quickly they are available.

Mr D. O'BRIEN — As you said, they are more available.

Assoc. Prof. WALKER — That is correct.

Mr D. O'BRIEN — Very quickly, if I —

Ms HENNESSY — And also the composition of the ED, what is happening at an ED at the time of arrival for people that may not have arrived in an ambulance is the other critical input into that.

Mr D. O'BRIEN — Minister, I have got 15 seconds.

Ms HENNESSY — Sorry, Mr O'Brien.

Mr D. O'BRIEN — Can I have a question on notice? You said last year that real-time monitoring of ambulances was not in place. Is that yet available now, Mr Walker?

Assoc. Prof. WALKER — So, I think —

Mr D. O'BRIEN — If I could have that on notice, if that is possible. Thank you.

Ms PATTEN — Obviously I am interested in the introduction of the supervised injecting centre in North Richmond, and one of the reasons for this is the large number of ambulance call-outs to that small region. We

know that when a similar centre was established in Sydney we saw a significant, in fact dramatic, reduction in ambulance call-outs in the proximity to that centre. So I was particularly interested in whether currently do we have a number on how many ambulance call-outs are made in the North Richmond area, and maybe even at a statewide level, for drug-related incidents?

Ms HENNESSY — I am sorry; I do not have that information available.

Ms PATTEN — I would be interested if it is available, even to get it —

Ms HENNESSY — I am not sure if Mr Walker has. I am sure there is something insightful that we would be able to provide for you.

Assoc. Prof. WALKER — I have not got the statewide figure with me. I do know that within the City of Yarra, based on Turning Point data, which is the shared data we are working on, there were 427 heroin-specific ambulance cases in 2014–15, which is the latest recorded data, and that has come up from 339 in 2012. So there have been increases.

Ms PATTEN — Yes, so it has been on the increase. I think we are all optimistic that those numbers will go down with the establishment of the centre in North Richmond. I am assuming those are significant numbers for one region — 400.

Assoc. Prof. WALKER — Well, they are. Yes, and the reality is —

Ms PATTEN — I mean, is there an average?

Assoc. Prof. WALKER — I would have to take that on notice. I have not got that information with me.

Ms PATTEN — Yes, to compare — it would be interesting to compare. Assuming going forward that we will see a significant drop in those numbers, where would those ambulances go? Where do they come from and where would they be redistributed to if there was a decline, even a sharp decline?

Assoc. Prof. WALKER — Well, in essence it reduces the case load within the City of Yarra for those particular types of cases. An ambulance fleet is mobile, moving around, but in essence by reducing the volume of case load in those areas what you end up doing is improving your ambulance response to other patients in the community, which is obviously why we were supportive of this trial.

Ms PATTEN — Yes. Thank you. I would be interested in those figures. It is probably even general curiosity, but I did note that we are getting 12 more ambulances in this budget. How much does an ambulance cost?

Ms HENNESSY — I am going to have to ask. I know they are expensive —

Ms PATTEN — I know the matchbox ones.

Ms HENNESSY — but they are not as expensive as our air ambulances.

Ms PATTEN — No.

Assoc. Prof. WALKER — I will have to confirm with you. I think it is around $200 000 fully fitted out.

Ms HENNESSY — And that is with the full fit-out in it?

Assoc. Prof. WALKER — That is correct.

Ms PATTEN — Right. So we are getting 12 new ones. How many do we have?

Assoc. Prof. WALKER — All up, the fleet is around 600 around the state.

Ms HENNESSY — But with the fleet, Ms Patten, also, for example, in the Melbourne CBD, we have paramedics on motorcycles to get through congestion in order to get to patients.

Ms PATTEN — So there are 600-plus.

Assoc. Prof. WALKER — Inclusive.

Ms HENNESSY — Inclusive. They are not all ambulances as you would think of as a van-style car.

Ms PATTEN — Yes. So with the increase of 12, that is a 2 per cent increase.

Ms HENNESSY — We made a really significant increase two budgets ago where we invested and bought more vehicles, more CPAV vehicles, which are complex patient —

The CHAIR — Order! I would like to thank the witnesses for their attendance: the Minister for Ambulance Services, the Honourable Jill Hennessy, MP —

Ms HENNESSY — What a dramatic point to end on, Chair.

The CHAIR — Ms Peake, Mr Symonds, Mr Stenton, Associate Professor Walker and Dr Grigg. The committee will follow up on any questions taken on notice in writing. Written responses should be provided within 10 business days of that request.

Witnesses withdrew.