Ambulance Victoria 2021-2022 Annual Report

715 paramedics recruited

1,042,902 ambulance responses

19.8% of Triple Zero calls given advice or alternative care

\* The data shown above is full time equivalent (FTE).

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#### Acknowledgement

We acknowledge the Traditional Owners of country throughout Australia and their continuing connection to land, sea and community. We pay respect to them and their cultures and to elders past, present and future.

#### Disclaimer

This publication may be of assistance to you but Ambulance Victoria do not guarantee that the publication is without flaw of any kind or is wholly appropriate for your particular purposes and therefore disclaims all liability for any error, loss or other con-sequence which may arise from you relying on any information in this publication.

## Ambulance Victoria

# Strategic Plan Summary

### Outcome 01 An exceptional patient experience

* Providing safe, high quality, timely and expert patient care every time.
* Helping people to make informed decisions about their emergency health care.
* Connecting people with the care they need.
* Using research and evidence to continuously learn and improve our services.

### Outcome 02 Partnerships that make a difference

* Working with communities to deliver local emergency health care solutions.
* Collaborating with our partners to improve health outcomes.
* Planning for and responding to major events and emergencies.
* Sharing knowledge, experience and data.

### Outcome 03 A great place to work and volunteer

* Keeping our people safe, and physically and psychologically well.
* Providing an inclusive and flexible workplace.
* Developing a culture of continual learning and development.
* Embedding an ethical, just and respectful culture.

### Outcome 04 A high performing organisation

* Embracing innovative ideas, systems and technology.
* Being accountable for our actions and outcomes.
* Improving our integrated service model.
* Operating in a financially and environmentally sustainable way.

## Our Values

* Being respectful
* Working together
* Openly communicating
* Being accountable
* Driving innovation

### Patient Care Commitment

We save and improve lives by providing outstanding care for our patients. Our Patient Care Commitment is our promise to every patient and sits at the heart of everything we do.

### CARING

We care about our patients as individuals and treat them with dignity. We respect their unique needs and circumstances and their right to contribute to decisions about their care wherever possible.

### SAFE

Our patients are safe in our hands and experience no harm. Our systems and practices protect our patients and our people to deliver better patient outcomes. We are committed to life-long learning, and if we see something wrong, we speak up.

### EFFECTIVE

Our patients receive great care, informed by the best available evidence and research. Our people have the expertise and support to ensure every patient receives the right care, at the right time, every time.

### CONNECTED

We are a front door to the emergency health system and connect patients to the care they need. Our patients experience coordinated transition between services, including effective and appropriate sharing of information for excellent continuity of care.

# Chair and CEO Report

##### Ken Lay AO APM ,Chair, Ambulance Victoria

##### Professor Tony Walker ASM Chief Executive Officer, Ambulance Victoria

Ambulance Victoria (AV) and its people have a long and proud history of responding to challenges and providing best care to all patients – especially in times of need.

As the lives of many Victorians started to return to normal in 2021-2022, we remained confronted by a once-in-a-lifetime health issue, COVID-19, that continued to place significant pressure on our people and our partners.

The coronavirus (COVID-19) pandemic presented many obstacles to health services across the world. The significant planning and processes we developed over many years gave us a solid platform to meet these challenges.

We created a COVID-19 Incident Management Team to enable us to manage the pandemic while allowing other parts of the business to provide our usual service to the community. Our workforce and our patients continued to be protected from COVID-19 infection through strict health and safety measures, including vaccination of all staff and the ongoing use of Personal Protective Equipment (PPE).

We undertook record recruitment, including 716 paramedics, and implemented a medium acuity transport service to help free up paramedics for the most life-threatening cases. We forged partnerships with external agencies, to create a surge workforce to support our paramedics to deliver high quality care in the face of record demand.

Our Triage Services were also bolstered by new recruits to become the largest service of its type in any ambulance service in the world. This further increased our capacity to assist Victorians, with 19.8 per cent of Triple Zero (000) callers for ambulance provided advice or safely directed to appropriate, alternative care against a target of 15 per cent.

While our work continued to be driven by the Strategic Plan 2017-2022, we also discovered new ways of working. In collaboration with Northern Health, we launched a dedicated pathway for on-road paramedics to refer patients to an in-home virtual emergency department service in October 2021. The service commenced expansion state-wide in March 2022 and named the Victorian Virtual Emergency Department (VVED). During its first nine months, paramedics referred more than 10,000 patients to this service with 75 per cent of patients recommended for alternate care pathways that better suited their needs, leading to a decrease in AV transports to hospital and improving ambulance availability.

Our TelePROMPT service, which in conjunction with Eastern Health connects people experiencing mental health emergencies with a mental health clinician through telehealth, was also integrated into our business-as-usual response.

As part of the Ambulance Improvement Plan 2022-25, AV secured $121m Victorian Government investment to enhance performance and demand management through the delivery of new on-road initiatives, including additional capacity for Secondary Triage and our regional and metropolitan communications centres.

We implemented 22 Medium Acuity Transport units for lower priority cases. This pilot program supported the development of a new graduate pathway and increased options for our qualified workforce seeking flexible working arrangements.

New 24-hour branches now operate out of Thomastown, Hoppers Crossing and Bayswater. We added peak period units in Boronia, Craigieburn, Leongatha, Mernda, Moe, Templestowe and Warragul to provide additional coverage during peak demand period and converted Cobram, Korumburra, Mansfield and Yarrawonga branches to 24-hour coverage.

While COVID-19 restrictions prevented us celebrating in person, we recognised the significant anniversaries of 50 years of Victoria’s Mobile Intensive Care Ambulance (MICA), and 60 years of Air Ambulance services. The advent of MICA brought coronary care and intensive care into the streets, homes and workplaces of Victorians who needed urgent medical help. Air ambulance services across the world have been modelled on ours.

We are incredibly proud of the work of our people during such a challenging period, and the care we have been able to provide our patients across Victoria.

In 2018-2019, before the COVID-19 pandemic started its march across the globe, AV recorded its best annual response performance of 83.9 per cent of Code 1 cases responded to within 15 minutes. But increased demand, the prevalence of COVID-19, the impact of patients delaying care, and the furloughing of paramedic and hospital staff have all since contributed to our declining response performance. The last nine months of 2021-2022 were the busiest in Ambulance Victoria’s history, with three consecutive quarters of record demand.

We responded to over one million incidents in Victoria by road, up 26,864 incidents on 2020-2021, and our Air Ambulance team responded to 7,758 incidents (51 more cases than 2020-2021). In February 2022 we announced four new Beechcraft King Air fixed-wing aircraft would take to the skies from 2024 to replace our existing aircraft.

A 16.7 per cent increase in time-critical Code 1 emergencies had an impact on our performance. We reached 67.5 per cent of Code 1 cases within 15 minutes – below the state-wide average target of 85 per cent – and our average Code 1 response time was 15 minutes and 2 seconds. For the most critically ill Victorians – our Priority 0 cases – we were on scene delivering life-saving care within or under our 13-minute target in 76.9 per cent of cases.

While we know more needs to be done to meet our targets and community expectations, it is important to recognise that response times are only one measure of a quality ambulance service. We continue to meet or exceed all our patient quality and care measures, leading to better outcomes in the survival and quality of life for heart attack, stroke and trauma patients.

We attended a record number of cardiac arrest cases, representing a 6.1 per cent increase on last year and continuing an increasing trend. The trajectory of bystander cardiopulmonary resuscitation (CPR) and survival trends are now slowly moving back to pre-COVID levels. Adult survival to hospital for patients presenting in a shockable cardiac rhythm has improved to 54.7 per cent in 2021-2022 compared with 52.5 per cent in the previous financial year.

Never has our health system experienced such a prolonged and difficult health emergency as the global COVID-19 pandemic. At the same time, our organisation was confronted as never before by an independent review commissioned by AV that found too many of our people had been harmed in a workplace lacking equality, fairness and inclusion.

The Victorian Equal Opportunity and Human Rights Commission’s (the Commission’s) Report into Workplace Equality in Ambulance Victoria was released in two volumes, in November 2021 and March 2022. We have accepted all 43 of the Commission’s recommendations and are embarking on a roadmap of reform to drive long-term cultural change.

While the Commission acknowledged long-term culture change is hard and can take some time, we share its confidence that we can achieve this transformation together.

From the release of Volume 1, we have been laying the foundations for the long-term reforms to create a safer, more equal, fair and inclusive workplace. This includes establishing a new Equality & Workplace Reform Division, improved governance arrangements with external expertise, and additional safety measures.

We have the opportunity in front of us for meaningful and generational change. Our dedication to treat patients with dignity and respect, must be matched with the everyday experiences of our people.

Our collective challenge is to create an equal workplace at Ambulance Victoria, that is safe, fair and inclusive. This means working with our people to actively transform our systems, structures and previous ways of working that were causing inequality or harm. We must keep our people safe and support them to thrive.

We all rightly deserve Ambulance Victoria to be a great place to work and volunteer, as we provide best care to our community.

Signed by Ken Lay AO APM Chair and Professor Tony Walker ASM CEO

# Declarations and Attestations

### Responsible Body Declaration

In accordance with the Financial Management Act 1994, I am pleased to present the Report of Operations for Ambulance Victoria for the year ended 30 June 2022.

Signed by Ken Lay AO APM, Chair of the Board

Melbourne, 25 August 2022

### Data Integrity Declaration

I, Tony Walker certify that Ambulance Victoria has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Ambulance Victoria has critically reviewed these controls and processes during the year.

Signed by Professor Tony Walker ASM, Chief Executive Officer

Melbourne, 25 August 2022

### Conflict of Interest Declaration

I, Tony Walker certify that Ambulance Victoria has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 Compliance reporting in health portfolio entities (Revised) and has implemented a ‘Conflict of Interest’ policy consistent with the minimum accountabilities required by the VPSC.

Declaration of private interest forms have been completed by all executive staff within Ambulance Victoria and members of the Board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documenting at each Board and Board Committees meeting.

Signed by Professor Tony Walker ASM, Chief Executive Officer

Melbourne, 7 October 2022

### Integrity, Fraud and Corruption Declaration

I, Tony Walker certify that Ambulance Victoria has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption risks have been reviewed and addressed at Ambulance Victoria during the year.

Signed by Professor Tony Walker ASM, Chief Executive Officer

Melbourne, 7 October 2022

# Report of Operations

We continued to provide Best Care to Victorians while keeping our people safe. We grew the organisation to address the complex and growing needs of the community to ensure Victorians were triaged to the right pathway of care. We provided the most appropriate clinical care to each patient, where they needed it and when they needed it.

It was a year like no other for AV.

The global COVID-19 pandemic continued to impact on the health of our community, leading to sustained record emergency demand.

We welcomed the largest annual intake of paramedics in our history and, during the height of the pandemic, partnered with other organisations to create a surge workforce to help paramedics care for our community.

And, while its content and themes were confronting, an independent review into workplace equality at AV provided us an opportunity for meaningful and long-term cultural change within our organisation.

Despite the challenges, our people continued to achieve. Whether it was on the front line in an ambulance, on the phone triaging calls, or behind the scenes managing supplies or finances, every member of our team contributed in an important way.

In 2021-2022, our work continued to be guided by our four strategic outcomes:

An exceptional patient experience

Partnerships that make a difference

A great place to work and volunteer

A high performing organisation

# An exceptional patient experience

AV's Best Care framework continued to shape our vision to provide a caring, safe and exceptional experience for all patients – from the call for help through to hospital discharge and every step in between.

In 2021-2022, our innovative technology, combined with improved resourcing, created safer, more comfortable and patient-led experiences. This included the Victorian Virtual Emergency Department, developed in partnership with Northern Health to provide patients with better care in the home and reduced transports to emergency departments, and the TelePROMPT program with Eastern Health. This program connected paramedics on-scene with patients who have mental health conditions, to mental health clinicians.

### Ambulance Victoria Best Care

AV is committed to providing a caring, safe, effective, and connected experience to every patient, every time – it is what we call Best Care.

This year, despite the continuing challenges of the pandemic, we worked together to build and embed systems, structures and processes that support and enable our people to provide an exceptional patient experience.

This section of the report provides a closer look at some of this year’s key activities that deliver against our Best Care goals.

## Our Best Care Goals

##### Caring

We are responsive to and respectful of patient needs and circumstances.

##### Safe

Our patients and staff are safe and experience no harm.

##### Effective

We provide the right care, in the right way, with the best possible outcomes.

##### Connected

We connect patients to the care they need.

### Patient Care Academy

The Patient Care Academy harnesses expertise across AV, our patients and expert partners to plan, design and improve models of patient care. We are tackling the challenges we face at AV and across the emergency health sector, using an evidence-based and human-centred approach to achieve better outcomes. This innovative work is grounded in empirical research, data and the lived experience of our people, patients and healthcare partners.

### Residential Aged Care Enhanced Response (RACER)

The Residential Aged Care Enhanced Response (RACER) pathway connects and coordinates Triple Zero (000) calls from residential aged care facilities to better meet patients’ needs and avoid unnecessary transport to emergency departments.

This alternative care pathway, developed in 2022 and scheduled for launch in 2022-2023, also helps minimise unnecessary, disruptive, and stressful transfers for patients in residential aged care facilities.

The RACER pathway has been designed to use Victoria’s Virtual Emergency Department to bring the emergency department to the patient rather than transporting them. An aged care specialist role will be introduced in Triage Services to help expand AV’s in-house expertise and support our referral service triage practitioners.

## RACER health benefits

* Improve the patient experience and outcomes for residential aged care facility residents, their families, and carers.
* Provide access to the right services for the patient’s needs within residential aged care facility services.
* Reduce the risk of delirium and healthcare acquired trauma, infections and mortality that can be a complication of hospitalisation of older people.
* Reduce non-urgent call outs and improve ambulance availability for the acutely unwell.
* More than 100 stakeholders from across the sector (including health services, aged care facilities, and consumers) were engaged to contribute to the development of this pathway.

### Palliative Care Connect

Palliative Care Connect is being developed to enhance the experience of palliative and end-of-life care patients. The academy worked with regional teams to identify evidence-based strategies that support patients and provide a clear pathway for escalation of care.

### Frequent and Complex Caller Care Connect

The academy established a new caller pathway to better recognise, support and respond to callers with complex needs. Through early identification of frequent callers, we can more readily assess complex needs and integrate services with other healthcare providers.

### Mental Health Care Connect

Following recommendations of the Royal Commission into Victoria’s Mental Health System, AV worked in partnership with Victoria Police, the Emergency Services Telecommunications Authority (ESTA) and various Victorian government departments in response to Recommendation 10 — Supporting responses from emergency services to Mental Health crises. The Mental Health Care Connect initiative, part of the Recommendation 10 implementation, will support paramedics and police to better care for people with mental health issues calling Triple Zero (000).

### TelePROMPT

TelePROMPT has improved how we help people experiencing mental health emergencies by connecting paramedics on-scene with a mental health clinician through telehealth.

The service, which commenced as a pilot, has now been integrated into our business-as-usual response, allowing us to provide better support for people experiencing mental health emergencies and reduce transports to hospital.

While 74 per cent of people receiving care from TelePROMPT came from metro Melbourne, the percentage of rural interactions rose across the course of the pilot. The median age of patients managed through TelePROMPT was 37 years of age with women most frequently using the service during the pilot phase (58.3 per cent).

AV’s TelePROMPT service won two awards this year:

* The Excellence in Patient Care Award in the Council of Ambulance Authorities Awards for Excellence.
* The Best Care Award in the AV Excellence Awards.

### Safeguarding Care

AV responds to several hundred cases of family violence and child safety every year.

Our paramedics, first responders and triage practitioners play a vital role in responding to our community at times of crisis. AV became a prescribed organisation under the Family Violence Multi Agency Risk Assessment and Management (MARAM) framework in April 2021. AV’s Safeguarding Care (SGC) team supports operational staff to connect patients at risk, or experiencing harm, to the care they need.

The team, formed in March 2021, is committed to creating and improving the systems, structures and processes that support staff in the areas of:

* Child safety and protection
* Family violence
* Information sharing with other agencies.

A new Safeguarding Care officer provides advice and support to on-road crews to make reports and referrals and liaises with Victoria Police and The Orange Door family violence services. In 2021-2022:

* 711 child safety and family violence cases were reviewed.
* 186 reports were made to child protection to keep at-risk children safe.
* 19 patients were referred to specialist family violence agencies for additional support, improving responses to patients at risk and experiencing family violence.
* Safeguarding Care facilitated 211 discussions with paramedics about providing care to patients with child safety concerns or family violence.

### Improving responses to patients at risk and experiencing family violence

As part of state-wide family violence reforms, AV strengthened its workforce capacity to identify, respond to, and prevent family violence. These Department of Health funded measures included:

* The Multi-Agency Risk Assessment and Management (MARAM) framework to identify areas for action.
* A series of webinars for first responders.
* A family violence training package co-designed with subject matter experts, Victoria Police and victims of family violence.
* Joining the Victorian Government Elder Abuse and Safeguarding Advisory Committee.

‘The role as SGC officer has been really rewarding. I am an advocate for vulnerable adults and children in our community, and I support my colleagues by following up or reporting on situations of child safety and family violence they have encountered on the road. Paramedics are very appreciative, saying things like ‘Thanks for letting me know the outcome, that has really put my mind at ease’.

Ishelle Pollard – Safeguarding Care Officer and Paramedic

## Victorian Virtual Emergency Department

Telehealth services have been at the forefront of healthcare innovation since the beginning of the COVID-19 pandemic.

The pandemic increased pressure on ambulance and hospital resources, with staff isolating due to illness or exposure. Alternative care pathways for patients, and adjustments to workplace arrangements for staff, became more important than ever.

AV collaborated with Northern Health to establish a dedicated infield ambulance referral pathway for on-road paramedics to refer patients within the hospital's catchment to the Victorian Virtual Emergency Department (VVED).

VVED provides in-home virtual clinical assessment, medical advice, treatment, and local referrals to appropriate services for patients who would normally attend an emergency department via ambulance or self-presentation. The service aims to connect patients to care pathways that best match their health needs in a timely manner. At the same time, VVED serves to decrease AV transports to hospital, improving AV resource availability in the community.

Within one week of the project launch in October 2021, the number of patients presenting with COVID-19 rapidly increased in Melbourne, highlighting the need to broaden the initial geographic boundaries beyond Northern Health’s catchment.

At the three-month mark, over 350 patients had been referred to the VVED service within the north-east metropolitan area, with 84 per cent safely referred to community-based healthcare, avoiding transport to hospital.

While still in its infancy, the ambulance referral VVED pathway demonstrated enormous benefit in bringing healthcare to the home and reducing the number of patients transported to the emergency department, especially those with COVID-19.

Following a Victorian Government commitment of funding for a state-wide VVED service, AV rapidly commenced a staged rollout to provide access for all paramedics attending patients with COVID-19 during the peak of the Omicron wave from April 2022.

The South-East Health Service Partnership – inclusive of Alfred Health, Monash Health and Peninsula Health – commenced delivery of VVED for residents in the south-east metropolitan catchment.

During the first nine months from inception, infield paramedics referred over 10,000 patients to a VVED service. Approximately 78 per cent of patients with suspected or confirmed COVID-19, and approximately 72 per cent of patients with non-COVID related injury or illness, were recommended alternate care pathways.

The VVED pathway within AV has room to grow and plans are already underway to commence expanding to other sectors of the organisation, including our Secondary Triage service and the non-emergency patient transport service.

## Patient safety and experience

The pressures in the healthcare system stemming from COVID-19 continued to challenge AV’s capacity to provide a timely response and the best possible care.

This year, we established improved monitoring of patient safety and experience to better understand the impact of response delays throughout the patient care journey, from calling Triple Zero (000) through to discharge from ambulance care.

### Patient feedback

We value the opportunity to understand our patients’ experience of care and we seek feedback in several ways, such as the Victorian Healthcare Experience Survey. This year, despite the challenges of COVID-19, 96.1 per cent of respondents rated the overall care and experience of AV’s emergency services as good or very good, which is similar to previous years.

We also gained valuable feedback through the receipt of compliments and complaints. Pleasingly, despite the pressure on our service, a great number of consumers and other healthcare partners contacted us to commend our work. Negative feedback is equally valuable, as it provides us with an opportunity to learn and improve.

Most of the complaints received identified waiting times, from call taking through to ambulance arrival, as a key issue.

The main theme of compliments was staff professionalism and clinical care, exemplified by a patient’s comments as shown above.

‘I called an ambulance for the first time in my life yesterday to my house. I can't thank the two paramedics who came enough. They were in one word SUPERB. Took 5 minutes for them to correctly diagnose my problem… They were caring, knowledgeable and patient. Just thank you so much, you're the best.’

### Promoting a positive patient safety culture through learning and improvement

AV launched a clinical discussion series for operational employees aimed at promoting open dialogue and reflective practice on pressing clinical care topics. This online, interactive forum promoted learning and systems improvement and explored clinical care and practice. The series provided opportunities for staff to share insights and receive input from clinical subject matter experts.

The reflective practice helped to establish a positive learning environment that focused on continuous improvement in the care we provide to the community.

### Accessibility Action Plan

AV’s Accessibility Action Plan 2020 – 2022 outlines how we will better meet the needs of people living with disability, including our patients, our staff and our community. As the Plan’s implementation nears completion, AV is building a communication tool that will empower people living with disability to better understand and access our services.

At the same time, we are training and equipping our paramedics with the knowledge, skills and resources to improve engagement with people with disability, their carers and support networks.

To achieve this, AV partnered with Scope Australia in 2021 to develop new training and communication resources for emergency health services workers across the patient journey. These include dialling Triple Zero (000), first response and treatment by ambulance staff, and handover to hospital emergency department staff. Gippsland and Metropolitan Melbourne were the trial sites for this work.

While the impact of COVID-19 reduced our ability to engage within our workforce, it allowed us to take a deeper dive into the co-design, development and testing of our new tool to better support patients with complex communication needs. This innovation and associated training aims to enhance communication between operational staff and our patients when implemented in 2022-2023.

### Victorian Stroke Telemedicine

The Victorian Stroke Telemedicine (VST) service helps diagnose and treat people with acute stroke. Working remotely from the patient, VST specialists help local doctors treat stroke patients locally and arrange transfers to tertiary centres for potentially life-saving surgery.

VST connects clinicians at 19 participating sites throughout Victoria and Tasmania with a network of stroke specialists and neurologists.

We believe the increase in demand for the VST service can be partly attributed to a greater awareness and acceptance of telehealth and telemedicine during the COVID-19 pandemic.

‘Telemedicine is now second nature rather than a second thought’.

Professor Chris Bladin, Director Stroke Services at Ambulance Victoria.

In 2021-2022 there were:

* 3875 consultations
* 238 cases recommended for tissue plasminogen activator (tPA)
* 207 cases recommended for endovascular clot retrieval (ECR).

VST not only helps people with acute stroke but also contributes to the upskilling of clinicians in regional health services. VST consultants play a vital role in bringing the latest in acute stroke research and treatment to our sites.

Our group of 25 specialists find working for VST extremely rewarding. Not only can they provide a diagnosis for the patient, but they can also offer remote expert support to the medical and nursing staff at VST sites.

This year, we implemented changes to our VST roster structure by reducing the length of busy overnight shifts to improve the work / life balance of our staff.

### Mobile Stroke Unit

Australia’s first Mobile Stroke Unit continued to provide cutting-edge care to patients in the community.

Patients can receive time-critical clot-dissolving treatment (thrombolysis) in as little as 15 minutes of the stroke ambulance arriving on scene.

The Mobile Stroke Unit was launched in November 2017 and data from its first year showed patients were treated with thrombolysis 42.5 minutes faster compared to all recognised acute stroke hospitals in Melbourne (median first ambulance dispatch to needle).

The most recent data (up to 2022) shows the proportion of patients that can receive thrombolysis within the first hour after symptoms – the ‘stroke golden hour’ – increased 12-fold from 1.5 per cent to 18 per cent. In addition, facilitation and triage of patients needing specialised clot retrieval thrombectomy results in this treatment occurring 51 minutes faster across Melbourne (median first ambulance dispatch to arterial puncture).

The design of the next-generation Mobile Stroke Unit has been completed and forms part of a multi-stage grant awarded to the Australian Stroke Alliance, led by the Royal Melbourne Hospital and key partners including Ambulance Victoria.

Work has also commenced to purchase and fit out a new ambulance with specialist stroke capability, following philanthropic investment and $12 million in Victorian Government funding to establish a second mobile stroke unit in Melbourne’s south-east in 2023.

##### Patient experience

One of our patients, Diana, complimented the ED, Medical and VST teams and felt she was managed ‘like the most important person in the world’.

Another patient said, ‘This stroke was nothing like my last stroke (over 10 years ago). Last time I came in and I was told we had to wait to see what life would be like. This time I was treated like a VIP. Everything was fast. I was treated with a drug and, look at me… I can’t believe I am better! My wife is going to cry when she sees how great I am.’

### Ambulance Improvement Plan

As part of the Ambulance Improvement Plan 2022-25, AV secured a $121m Victorian Government investment to enhance performance and demand management through the delivery of new on-road initiatives, including additional capacity for Secondary Triage and our regional and metropolitan communications centres.

### Improvements this year

* We implemented a fleet of Medium Acuity Transport units to help free up valuable resources to respond to the most urgent and time-critical cases. The new service of 22 vehicles and 165 dedicated staff has a focus on providing care to priority 2 and priority 3 cases. This pilot program also supported the development of a new graduate pathway and increased options for our qualified workforce seeking flexible working arrangements.
* We implemented three peak period units in Moe, Warragul and Leongatha to provide additional coverage during peak demand periods.
* Four branches were converted to 24-hour coverage at Cobram, Mansfield, Yarrawonga and Korumburra.
* Three new 24-hour branches now operate out of Thomastown, Hoppers Crossing and Bayswater.
* We implemented four new units in Mernda, Craigieburn, Boronia and Templestowe to assist with peak demand periods.
* Our communications centres expanded with 16 new clinical support paramedics in our metropolitan and rural centres, as well as planning to support new clinician roles in the latter half of 2022.

The Ambulance Improvement Plan further boosted secondary triage service capacity, following last year’s increase, with 27 new referral services triage practitioners recruited, and a further 16 planned by September 2022.

In addition to increased resourcing, funding was also provided to AV Care Connect initiatives aimed at delivering connected care using alternative service providers.

### Dual Crewing

We continued our work to convert a number of rural single officer locations to dual crewing. This initiative provided additional resourcing to Inglewood in February 2022 as well as planning for Euroa, Murchison, Yarram, Paynesville, Foster, Charlton, Beaufort and Rupanyup in the latter half of 2022.

### New aircraft on the horizon

Our fixed-wing aircraft fleet – which provides a vital link between rural communities and metropolitan health services – will soon undergo a major upgrade to become the most innovative in the country.

In February 2022, we announced we would continue our relationship with Rex (Regional Express) subsidiary Pel-Air Aviation Pty Ltd with four new Beechcraft King Air fixed wing aircraft from 2024.

The state-of-the-art aircraft will feature the latest technology and provide additional comfort, safety and care for patients and flight paramedics. The aircraft will be fitted with high-tech stretcher loading systems, which provide a faster and smoother ride for patients and less risk of injury for paramedics and flight crews.

Ambulance Victoria will also work with Pel-Air to develop an Australian-first pilot fatigue monitoring system to ensure an improved focus on safety.

### Air Ambulance 60th Anniversary

Air Ambulance celebrated 60 years of world-class pre-hospital aviation care in May 2022.

Air Ambulance was established in Victoria in 1962 with one rotary wing and one fixed wing aircraft.

Sixty years on, our fleet of four fixed-wing aircraft and five helicopters provide a vital link between rural communities and metropolitan health services.

Fixed-wing aircraft – typically staffed by Advanced Life Support (ALS) flight paramedics – and helicopters – crewed by Mobile Intensive Care Ambulance (MICA) flight paramedics – service Victoria, parts of southern New South Wales, northern Tasmania and South Australia.

The service is supported by a dedicated team of flight co-ordinators, pilots, aircrew officers, doctors, engineers, trade assistants, retrieval services and administrators.

This year, our Air Ambulances responded to 7,758 incidents, 51 more than the previous year, with our fixed-wing fleet responding to 5,282 incidents, an increase of 217 incidents.

The fixed-wing planes fly patients with acute medical conditions requiring surgery, and transfer often critically injured and ill patients from regional hospitals to specialist care. Our air fleet also transports people from remote and rural areas for treatments such as chemotherapy and radiotherapy.

‘Frequent flyer’ 71-year-old Judith Harper said without AAV she wouldn’t be here today. Judith underwent brain surgery in 2018, followed by radiotherapy.

‘I always feel so safe and well-looked after on the fixed-wing planes which fly me monthly for my chemotherapy sessions from Warrnambool to Melbourne. The paramedics are incredibly kind, and their clinical expertise doesn’t go unnoticed.’

‘While it’s difficult to confirm the number of lives saved since 1962, over the past decade, AAV has assisted more than 50,000 people throughout Victoria and our bordering communities. People all over the world use AAV as a model. That’s something to be celebrated.’

AV’s Manager of Air Operations, Anthony de Wit

### MICA 50th anniversary

AV celebrated the 50th anniversary of Mobile Intensive Care Ambulance (MICA) – a revolution that paved the way for Victoria’s world-class pre-hospital care.

Australia’s first MICA service — only the third in the world — commenced operations from a converted Dodge vehicle on 9 September 1971.

Before long, the MICA unit was responding without doctors on board and attending 250 cases each month.

Three other MICA units were soon established at Frankston Hospital, the Alfred Hospital, and the Western General Hospital. Today, there are 600 MICA paramedics in metropolitan and rural regions, providing an internationally recognised level of care.

50 years on, the MICA service continues to evolve. Women now make up 20 per cent of the MICA paramedic workforce.

### A message from Ambulance Victoria CEO, Professor Tony Walker ASM

The advent of MICA brought coronary care and intensive care into the streets, homes and workplaces of Victorians who needed urgent medical help.

Rather than rushing patients to hospital, MICA brought hospital level care to them with ambulance officers able to provide ground-breaking treatment such as defibrillation for patients in cardiac arrest.

The skills, training and clinical expertise of all Victorian paramedics, including Advanced Life Support (ALS) paramedics, had their foundations in the early days of MICA.

Today's MICA paramedics are highly trained specialist clinicians with a postgraduate qualification. They are capable of comprehensive patient assessment, the administration of a wide range of drugs and are able to perform advanced procedures to treat life threatening illnesses and injuries.

Year on year, MICA has continued to deliver quality care to the community. It has saved the lives of countless patients across the state and touched the lives of many more.

There are people alive today because our MICA paramedics did extraordinary things in extraordinary circumstances to deliver fantastic care.

As we celebrate 50 years of MICA, we thank the pioneering ambulance officers, doctors and administrators for their vision, dedication and determination.

We truly stand on the shoulders of giants.

### Membership

Operating since 1935, the AV Membership Subscription Scheme (MSS) provides Victorians with protection against the cost of using ambulance services, including emergency and clinically necessary non-emergency transports as well as providing AV with an additional direct source of revenue.

With 2.82 million members and approximately 400,000 direct interactions per year, MSS is often the first point of contact with AV for Victorians.

Our contact centre operates 60 hours per week through our service partner Startek to handle membership enquiries and payments.

Service Victoria also provides an optional channel for our members to join, renew, make a payment or update contact details.

In 2021-2022 the MSS generated more than $97 million in direct revenue and covered more than $270 million worth of transports for our members.

### Membership Subscription Scheme

In 2021-2022, the Membership Scheme attracted 89,000 new memberships resulting in a total net growth of 32,000 memberships more than the previous year.

COVID-19 presented a challenging year for the Membership Scheme in terms of ensuring required staffing levels were maintained to meet contracted service levels. Sick leave and agent attrition resulted in higher than expected wait times, averaging slightly greater than three minutes for customers.

### Snapshot

* $97 million direct revenue provided
* 1.37 million membership policies
* 2.82 million people covered
* 54% Family members
* 46% Single members

##### Usage

* Members used 17% of all Ambulance Victoria transports
* This resulted in 187,000 Ambulance transport invoices that were covered for our members

##### Customer Contact

We have a 60-seat call centre operating 60 hours per week located in Melbourne, committed to serving our members across multiple channels

* 345,000 Phone calls
* 15,000 Online chats
* 35,000 Emails and letters

##### Customer Satisfaction

We continue to adapt to the challenges presented by COVID-19, with our Contact Centre transitioning to a hybrid working-from-home model, whilst continuing to service our members and maintaining a high customer satisfaction rate.

AV continues working together with our service providers to ensure that our members continue to receive the high level of service they expect.

* 97% Satisfied

### Quality Account 2020–2021

In lieu of publishing a full Quality Account for 2020-2021, due to the ongoing focus on responding to the Victorian community during the COVID-19 pandemic, AV published key patient stories and improvement in care projects on the AV website ‘Voices from the Community’ page which can be found at [www.ambulance.vic.gov.au/community/voices-of-our-community/community-voices/.](http://www.ambulance.vic.gov.au/community/voices-of-our-community/community-voices/)

This provides an ongoing opportunity to highlight patient experiences and provide patients’ unique perspective of their care back to the community.

### COVID-19 Clinical Practice Guidelines

COVID-19 led to two years of constant change in everyday paramedic practice. We are proud to have been at the forefront of providing evidence-based care for patients with COVID-19. An important part of this process was ensuring our clinical practice guidelines and procedures were kept up to date, in line with rapidly developing research and emerging variants.

These guidelines supported the health system by establishing safe referral pathways for low-acuity patients to be cared for in the community. This allowed the hospital system to focus on caring for patients who were more severely ill from COVID-19.

As well as informing clinical practice, the models of care in our COVID-19 guidelines informed other ambulance services and broader health care system guidelines. We shared our guidelines with many Australian and New Zealand ambulance services to support development of their own models.

### Property

The Victorian Health Building Authority (VHBA) delivered new branches at Templestowe and Lilydale in May 2022.

AV delivered the new Rawson Ambulance Community Officer branch, located at a Victorian State Emergency Services site, and secured a lease for nearby paramedic accommodation. Additional paramedic accommodation locations were also delivered in Skipton, Lismore, Heywood, Warrnambool, Rupanyup and Bright. Relievers quarters were converted into rest and recline facilities to support the upgrade of Daylesford, Yarrawonga and Mansfield branches to 24-hour services.

AV also delivered minor infrastructure works to 30 locations under Ambulance Improvement Plan programs.

Temporary branch fit outs and relocations occurred at Ararat, Rochester, Oak Park, Epping and Inglewood to enable VHBA to start branch renewal works. Wedderburn branch was relocated early this year and Werribee (Bridge St) reinstated to provide increased growth and surge resources.

Our minor works program delivered 180 small to medium projects at multiple locations across the state and CCTV infrastructure was upgraded at 256 locations. Approximately 450 privacy locks were fitted to rest and recline rooms at branches across the state to improve staff personal safety.

We also undertook office accommodation works at our Burwood business centre and Doncaster headquarters.

# Partnerships that make a difference

Partnerships are at the core of AV’s mission to achieve the best health outcomes for our patients.

Throughout the year, we initiated a range of productive collaborations across various sectors, from transport to health education, to meet the needs of diverse communities across the state.

### Community and Consumer Plan

The AV Community and Consumer Engagement Plan 2020-2022 recognises that shared leadership and action by our organisation and the community is needed to deliver Best Care to our patients.

We are committed to ensuring our local level engagement is place-based and achieves local outcomes. We aim to support the community to prepare for health emergencies, including heat health, fire and floods, and ensure local community engagement reflects diverse community views.

This year, our six Operational Community Engagement Liaison Coordinators, situated in each Victorian region, developed localised engagement plans to meet and respond to local community needs, and delivered community engagement material in accessible languages and formats.

Other highlights to improve engagement include:

* A revised and relaunched Patient Charter of Rights and Responsibilities, endorsed by our Consumer Advisory Committee.
* Patient experience stories and information shared on our Voices of the Community webpage.
* Establishing a new Partnering with Consumers Committee to guide AV’s workplan and meet National Standards into the future.
* Work with lived experience consumers to help co-design new pathways for patients with mental health conditions.

### GoodSAM (Smartphone Activated Medic)

The GoodSAM smartphone app links patients in cardiac arrest with nearby community members and life-saving public defibrillators following a Triple Zero (000) call.

We know that when someone is in cardiac arrest, every minute without CPR reduces their chance of survival by up to 10 per cent. Any adult in the community who knows CPR can now sign up to GoodSAM, which connects responders to patients in those first critical minutes of cardiac arrest while paramedics are on the way.

A recruitment and awareness campaign in October 2021 saw the number of registered GoodSAM community responders ready to step in and help grow by 1,010.

The results of quick intervention by GoodSAM responders are being felt right across Victoria, helping to save more than 55 lives since the program was introduced in 2018, including Croydon North grandfather Paul Laister who survived a cardiac arrest after receiving CPR from his wife Beth and a GoodSAM Responder.

The 66-year-old collapsed in his study, with his grandson quickly phoning Triple Zero (000). Within minutes, GoodSAM Responder Chloe Wirth, an occupational therapist, arrived to help. Chloe took over CPR and continued until paramedics arrived. After spending three weeks in ICU, Paul returned home and has since made a full recovery. He and Beth reunited with Chloe in September 2021.

During the year, we continued to expand community engagement to include first aid training providers, hospitals and local community groups across Victoria.

### Heart Safe Communities

After pausing due to COVID-19 in 2020, the Heart Safe Community program recommenced in 17 locations across Victoria in 2021. The initiative aims to improve survival rates for people suffering out of hospital cardiac arrest (OHCA) by teaching community members how to perform CPR and use an automated external defibrillator (AED).

Our Call Push Shock program focuses on the willingness and capability to recognise a cardiac arrest and take action in three simple steps: Call Triple Zero (000), Push on the chest to start CPR immediately, and Shock using an AED, if available.

This year, we delivered ongoing community awareness and active engagement via 226 Call, Push, Shock sessions, reaching 16 per cent of community members across these 17 locations.

The sessions promoted 160 public access defibrillator registrations and 69 GoodSAM responder signups.

We are proud to announce these 17 locations have graduated as ‘Heart Safe’ by reaching their set targets. To celebrate the success of the program and to further expand and embed the learnings of the Heart Safe Community initiative, 12 new Heart Safe Communities are scheduled to commence around the state in July 2022.

This year, we delivered ongoing community awareness and active engagement via 226 Call, Push, Shock sessions.

##### Victoria’s Heart Safe Communities

Pilot sites:

* Tatura
* Bellarine Peninsula
* Inverloch

2022 graduate sites:

* Beechworth
* Boort
* Camperdown
* Clunes
* Donald
* Euroa
* Healesville
* Mallacoota
* Murrayville
* Murtoa
* Port Fairy
* Queenscliff
* Red Hill
* Robinvale
* Rosedale
* Smythesdale
* Terang

New sites (from mid-2022):

* Bacchus Marsh
* Chiltern
* Coleraine
* Dunolly
* Hopetoun
* Kinglake
* Lismore
* Longwarry
* Stanhope
* Trentham
* Violet Town
* Yallourn North

### TLC for Kids

It was our privilege to continue our support for TLC for Kids – a not-for-profit charity that provides memorable experiences for children with terminal illness. Paramedics voluntarily provide expert care and clinical treatment, enabling children to enjoy treasured experiences.

Despite ongoing challenges around COVID-19 restrictions, risk and workforce fatigue, we managed several trips this year, including visits to the Melbourne Aquarium and Scienceworks. These memorable trips were captured on GoPro cameras for loved ones to enjoy and remember.

While a second TLC Ambulance has been delayed due to supply chain issues, we look forward to the possibility of expanding this service to regional Victoria.

The TLC for Kids and AV partnership also featured in an episode of the Victorian-based Paramedics show.

### Shocktober

The month long Shocktober campaign adopted a digital engagement approach to highlight the importance of knowing Call Push Shock and encouraging the Victorian community to sign up to GoodSAM. Throughout the month:

* An additional 1,010 community members were added to our GoodSAM program (400 of those in the first few days of the campaign) well exceeding our target of 500.
* 134 online sessions were delivered, reaching over 6,900 Victorians.
* Shocktober social media posts reached over 510,000 people, including 3,500 Victorians who tuned into a paramedic delivering a CPR refresher on Facebook Live.

##### Results snapshot

* 12 Call Push Shock resources in additional languages
* 3,700 people reached through live CPR sign up sessions
* 279 Media mentions
* 6,900 people reached through CPR training with a paramedic
* 510,000+ Social media reach
* 3,120 people watched the AED & CPR training video
* 76 AEDs registered
* 134 Shocktober online events
* 1,010 new GoodSAM responders
* 2,400 visits to the Shocktober website

‘I feel much more comfortable now to deliver CPR and use an AED. I'm excited to sign up to GoodSAM.’

### Ambulance Victoria Chas Martin OAM Museum

Chas Martin OAM, served his community for over 60 years, providing care for his many patients before embarking on a role preserving our history at the Ambulance Historical Society Museum.

In 2005, he accepted the challenge to establish an Ambulance Museum to preserve our state’s vintage ambulances, memorabilia, and history. Chas’ name became synonymous with the Ambulance Museum, and right up until the end, he was often working several days a week to help preserve Victoria’s ambulance history.

To honour Chas’ incredible contribution, the museum was renamed the Ambulance Victoria Chas Martin O.A.M. Museum. Sadly, Chas passed away a few weeks later, aged 84.

His life was celebrated in a service at the Victoria Police Academy Chapel, before his many ambulance friends gathered in his memory at the museum that now bears his name.

### Stroke Foundation partnership

Stroke is one of Australia’s biggest killers and a leading cause of disability, but more than 80 per cent of strokes can be prevented. Receiving prompt treatment for stroke can be the difference between life, death or permanent disability.

AV partnered with the Stroke Foundation during Stroke Week in August.

Paramedics delivered the Act F.A.S.T. Save Lives presentation to 14 community groups, reaching 362 Victorians. Educating people on F.A.S.T signs of a stroke (face, arms, speech, time) and the importance of calling Triple Zero (000) will improve health outcomes for stroke victims.

# A great place to work and volunteer

Ambulance Victoria is committed to developing a culture of continual learning and development.

Ambulance Victoria is committed to creating a safe, fair and inclusive workplace. Sadly, allegations in 2020 revealed discrimination, sexual harassment and bullying, highlighting we had lost our way. It became essential to open up to an external review to provide hope and a clear way forward.

While we recognise there is much work to do, we also need to acknowledge this year’s progress.

We continued to look after our people’s mental and physical health. We engaged with our communities and we were bolstered by our incredible volunteers. We look towards the future with new recruits, new systems and new commitments that, combined, will once again make AV a great place to work and volunteer.

### Victorian Equal Opportunity and Human Rights Commission Review

In late October 2020, allegations of discrimination, sexual harassment, bullying and victimisation at Ambulance Victoria emerged publicly and privately. AV engaged the Victorian Equal Opportunity and Human Rights Commission to conduct an independent review, which was delivered in full to AV in March 2022.

The Commission’s findings were confronting. Too many of our people had been harmed and our systems had not always provided adequate support. In fact, the Commission found that often the systems themselves caused the harm and failed to provide equality, fairness and inclusion.

Following the review, the Commission’s report and its recommendations will serve as our guide to long-term reforms.

When the second and final volume of the report was released, our CEO Professor Tony Walker ASM wrote the following message to our people:

‘How we create our future workplace at Ambulance Victoria is open for all of us.

To create as individuals. To create in our teams. To create together as an organisation.

When I talk about an equal workplace at Ambulance Victoria, I imagine a workplace that is safe, fair and inclusive. A workplace where people in the same, or similar circumstances are treated equally.

When I talk about an equal workplace, I think of a workplace that actively transforms our systems, structures and previous ways of working that were causing inequality or harm.

I want everyone who works here to make choices about their personal and professional lives based on what is right for them and for their families.

I want everyone who works here to help create a workplace where everyone can thrive.

You are important to us. We will support you to thrive. We will keep you safe from harm. If you raise concerns, they will be addressed.

The vision is clear, and I’m asking you to help shape how we get there.

Thanks to everyone who came forward during the review and through the Commission’s expertise, we now have a deep understanding of what we need to do.

As the Commission acknowledges, long-term culture change is hard and can take some time. But it has confidence, and I have confidence, that we can achieve this transformation together.

In addition to our roadmap to equality and workplace reform, you will help create your AV workplace culture through how you show up every day.

As a foundation for that, we must reset our values – to guide how we want to work, treat each other and make decisions.

The values won’t be determined by me, or the Executive. You will be asked to develop our new values and I will accept what you say.

The only way we will change is through everyone understanding ‘it starts with me’ and actively choosing to define, own and live our values.

Every single day.

The structures and systems that support those values – such as rostering, flexibility, career progression and transition to retirement – will be based on what you have said is important and best practice insights into what will help change your experience for the better.

You rightly deserve Ambulance Victoria to be a great place to work and volunteer.

I believe that we can be a safe, fair and inclusive workplace and provide best care to our community.

In fact, we can’t truly have one without the other.

We must create a workplace that works for you and enables best care for our patients. You are too important not to get this right.’

Professor Tony Walker ASM, Chief Executive Officer

AV is now at the start of a significant journey of cultural and structural reform. Our work is underway, and we have established the foundations required to create an organisation that is safe, fair and inclusive. Steps taken so far include:

* Reflecting on the drivers of unlawful and harmful conduct and inequality so we can understand what happened and how to improve.
* Examining options for a restorative engagement scheme so our people can share their stories and our leaders can listen and learn.
* Installing privacy locks across our branches and starting work to audit safety in isolated work environments so our people are afforded the same level of protection against harm, regardless of where they work.
* Starting work to reintroduce Contact Officers so our people can reach out to trusted peers for advice and guidance if they have experienced or witnessed unlawful or harmful conduct.
* Starting work to reset our organisational values so the values resonate for our people, and we create clear expectations of appropriate workplace behaviour.
* Setting up the Equality and Workplace Reform Division to drive efforts to create a safe, fair and inclusive AV.
* Establishing the Ambulance Victoria Equality & Workplace Reform Steering Committee, comprised of internal and external representatives, including our people, the unions and professional associations, so there is robust governance and oversight of reforms.
* Establishing an Equality & Workplace Reform Staff Reference Group in early 2022 to represent the voice of the workforce, performing a critical role in helping to shape the way we approach the reforms to create a safe, fair and inclusive organisation.
* Taking steps to create a fair, effective and transparent report and complaint system, as well as anonymous reporting pathways, so we improve how we respond if unlawful and harmful conduct occurs.

### Equality and Workplace Reform Division

In early 2022, we set up the Equality and Workplace Reform Division, as recommended by the Victorian Equal Opportunity and Human Rights Commission. The division’s role is to lead and coordinate efforts across AV to create a safe, fair and inclusive organisation. The initial focus will be implementing recommendations arising from the Commission’s independent review, with the aim of creating a workplace that is good for our people and enables best patient care.

By May 2022, the structure of the new division was finalised and recruitment commenced. We understand that to achieve real change we need to employ people who are aligned with our vision and values. To this end, we will bring together a mix of existing, experienced staff and new employees who will bring diverse capabilities, experiences and processes.

In late March 2022, Simone Cusack joined AV as our inaugural Executive Director, Equality & Workplace Reform.

She reflected on her reasons for joining AV:

‘Through listening to the experiences and views of people who came forward during the review, you become committed to implementing the changes they have told you will help to create a safe, fair and inclusive AV, that will make a difference when they turn up to work or volunteer each day. Now is the time for action, for AV to implement the changes recommended by the Commission. And I want to follow that through and be here to support the organisation and its people.’

## Diversity and Inclusion

The Council focuses on creating awareness of key areas of diversity: gender, age, disability, sexual, and cultural and linguistic diversity as well as Aboriginal and Torres Strait Islander peoples.

### Cultural Safety – improving our engagement

AV provided seed funding for all six operational regions to improve engagement with First Nations communities. Each project aimed to improve the experience of care and the services we provide. Each region worked with local communities to create a culturally appropriate project that best represented the region.

In Barwon South West, local Aboriginal artist BJ O’Toole painted a mural of local significance in front of the regional office. The artwork represents the elements of Mother Earth, water, sun, people and animals. Bunjil the Eagle represents the creator of land and protector of all things, including people’s health.

In Hume, artwork by Aboriginal artist Tom Day was created for Shepparton branch. The artwork’s symbols represent the diversity of natural elements in the region, including water, mountains and rocks. The piece sits alongside a new indigenous garden and will be used for community activities.

Furthermore, Acknowledgment of Country plaques were placed at branch entrances in Yorta Yorta country (Echuca and Kyabram), increased cultural awareness training was undertaken in Gippsland, and posters featuring acknowledgement and Aboriginal and Torres Strait Islander symbols were developed to support community events across the metropolitan region.

### Diversity & Inclusion Council

In 2021, AV welcomed its second iteration of a Diversity & Inclusion Council, following an invitation to employees to nominate for a two-year membership.

The Council focuses on creating awareness of key areas of diversity: gender, age, disability, sexual, and cultural and linguistic diversity as well as Aboriginal and Torres Strait Islander peoples. The Council supports data collection to help understand the diversity of our workforce. This knowledge now informs AV events and our multicultural employment program.

### Reconciliation Action Plan

As part of our continued program of work towards reconciliation, AV is developing its first Reconciliation Action Plan and proudly published a Statement of Commitment to Reconciliation.

Feedback from Reconciliation Australia to AV’s first Reconciliation Action Plan draft has been incorporated into a fresh draft which has been re-submitted for a second review.

### Statement of Commitment to Reconciliation

At AV we recognise the diverse and unique heritage of Aboriginal and Torres Strait Islander peoples and value the knowledge of countless generations of custodians. Moving forward we are committed to working together to build a fair and just future.

We will come together with Aboriginal and Torres Strait Islander communities to identify, understand and develop opportunities.

To prioritise Aboriginal culture and communities, we will celebrate Aboriginal and Torres Strait Islander culture so that we can show respect and dignity to the people we live and work with.

Our goal is fair and impartial care and service of Aboriginal and Torres Strait Islander peoples. We will achieve this by acknowledging that the attitudes we hold can either positively or negatively impact health outcomes. We will work to address a positive shift in these attitudes.

We commit to collaborate with Aboriginal and Torres Strait Islander communities with the aim of creating safe and supportive environments for individuals and families which promote strength and resilience.

We are committed to working with Aboriginal and Torres Strait Islander communities to understand our shared priorities and integrate sustainable services which contribute to improving outcomes of physical, emotional and social health and wellbeing.

This is the beginning of our shared journey. We will listen and learn from each other to create a healthy and vibrant future together.

### Working Towards Gender Equality

Important steps were taken to address gender equality and meet obligations set in the Gender Equality Act 2020. The Act defines activities that government organisations can implement to promote and improve gender equality in the workplace.

A Workplace Gender Audit from July to September 2021 looked at data for a range of indicators that monitor gender equality. We shared its findings with our workforce and employee representative groups for consultation, and their input informed the creation of our first Gender Equality Action Plan.

The Gender Equality Action Plan, developed in conjunction with a cross-functional work group, was also informed by recommendations from the Independent Review into Workplace Equality undertaken by the Victorian Equal Opportunity and Human Rights Commission.

The final Gender Equality Action Plan was submitted to the Commission for Gender Equality in the Public Sector in June 2022, with implementation to occur through to 2025.

In the last three months of 2021, AV established processes to undertake gender impact assessments on any new or updated policies, programs or services with a direct and significant impact on the public. By combining reflection, analysis and external research, the gender impact assessment process enables us to improve gender equality across the organisation.

## Health and safety

### Health & Safety Action Plan

In the final year of our Health and Safety Action Plan (2019-2022), we continued to improve the cultural maturity of health and safety across the organisation.

We rolled out our service-wide manual handling program, Smart Moves, which delivers the most comprehensive and intensive skills training in manual handling to date. The success of this program led to a new AV manual handling instructional smartphone application, developed in-house by our Health & Safety team. The Smart Moves app — a natural extension to professional development training – features guidance, videos and step-by-step instructions for operational staff to keep them safe on the job.

We also implemented an interactive Power BI dashboard that provides dynamic and streamlined reporting options across multiple levels to capture data for occupational health and safety, and return-to-work performance. The new dashboard allows for more in-depth data analysis to understand themes and trends.

AV consistently rates as a scheme-leading employer in government agency and emergency services sectors for successful return-to-work performance at all measured timeline increments (weeks 13, 26 and 52 of the claims cycle). While the average cost of WorkCover standard claims rose nearly 13 per cent, this was primarily driven by the increase in total psychological claims compared to physical claims. Psychological claims tend to result in longer time lost than physical claims and be more expensive to treat.

### Fatigue management

AV’s Fatigue Management Committee, established in May 2021 to undertake detailed analysis of incidents specifically related to fatigue, continued to focus on supporting the establishment of an effective Fatigue Risk Management System.

The Committee plays an important role in staff welfare, following a risk management approach to ensure all fatigue risks are identified, understood, monitored and controlled. The Committee delivered a fatigue workplan in May 2022 and its Incident Review Working Group met for the first time in April 2022.

The Committee has started to develop new fatigue management guidelines in consultation with the workforce and unions.

### Occupational Violence

AV is committed to preventing injuries, both physical and psychological, arising from occupational violence. While the overall number of occupational violence hazards/incidents/injuries (HIIs) reported and the number of HIIs reported per 100 FTE are the lowest they have been in three years, the percentage of reports that ultimately result in injury is rising.

### Mental Health Action Plan 2019-2022

AV continues to provide support for our people and their immediate family members, with peer support, pastoral care, and counselling services available 24-hours a day. These supports are provided in person or via telehealth, which has increased access to care across the state.

AV has now delivered its three-year Mental Health Action Plan 2019-2022, which sets our road map for achieving happy and healthy people delivering great care.

Over the course of this plan, we have seen significant reform and expansion of our Wellbeing and Support Services department. We increased the availability of clinicians through a comprehensive public procurement process, expanded our Peer Support program with updated training and procedures and improved governance processes, and invested in our Pastoral Care program to provide state-wide coverage.

This year, we continued to deliver mental health education and training for staff and families. AV SMART 2.0 – an introductory psychological support service for AV employees and volunteers to manage their psychological wellbeing and build resilience – was provided to 1453 people state-wide.

We continued to implement our Skills for Life Adjustment and Resilience (SoLAR) pilot program with Phoenix Australia, undertook our third Psychosocial Survey to measure the health and wellbeing of our people, and focused on stigma reduction through the establishment of communication plans and engagement activities.

Pleasingly, over the course of the plan’s implementation, we saw an increase from 6,603 contacts in Year 1 to 10,758 in year 3, in the use of our counselling services. This reflects our focus on early intervention and the improved accessibility of care for AV staff, first responders and family members.

To build on AV’s continued commitment to the wellbeing of our people, we embarked a significant co-design and consultation process to develop the new Mental Health and Wellbeing Action Plan 2022-2025.

The new plan, to be launched in July 2022, is focused on four key pillars:

* Prevention and education
* Early intervention
* Building on our strengths
* Partnering for success

Designed to respond to the needs of our organisation in an integrated way, the plan retains the person-centred model of care that has been a key feature of our wellbeing programs and encompasses a suite of services.

1,453 staff members and their families received mental health education – AV SMART 2.0

### Respiratory Protection Program

The AV Respiratory Protection Program was formally implemented in January 2021 after an initial trial period in November 2000.

Through the program, masks are tested on each operational employee to ensure a complete seal to ensure protection against droplet and airborne pathogens.

Almost 7,000 mask fit tests have been conducted to the end of June 2022. A re-testing program has commenced for staff members who participated in the first wave of testing in 2021, with ongoing re-testing proposed every 18 months.

### COVID-19 Rapid Antigen Testing

During the peak of COVID-19 in late 2021, AV implemented and piloted a program of rapid antigen testing of our people in line with guidelines issued by the Department of Health for workers who perform duties at multiple health care settings. This program was highly successful in identifying and isolating staff who test positive at critical location sites prior to the commencement of shifts. The process was extended to a variety of internal departments at AV before it became standard operating practice.

### COVID-19 and Influenza vaccination programs

As a Victorian health service, we strive to set an example to protect each other and the community, and that’s why vaccination is so important. We know that COVID-19 vaccination helps to protect our critical health workforce, our patients, our families and loved ones, and our community.

AV supported public health orders issued in late 2021 and January 2022 mandating that specified workers – including all AV employees, volunteers and contractors – be adequately vaccinated against COVID-19. We established a team to monitor and oversee this process and confirm vaccination status via internal human resources systems.

Similarly, AV supported Department of Health Directions that mandate influenza vaccinations for healthcare staff in public and private hospitals, ambulance services and public residential aged care by 15 August each year. We are committed to a 100 per cent influenza vaccination rate, with 54.5 per cent of all of AV staff having received their influenza vaccinations by 30 June 2022.

### Extensive recruitment

As demand for our services grew, so too did our workforce. In 2021-2022, AV recruited 716 paramedics – the largest number of paramedic recruits in AV’s history.

Our new recruits comprised:

* 647 graduate paramedics (including 60 Medium Acuity Transport Service Graduate Bridging Program paramedics)
* 69 qualified paramedics

The 2022-2023 recruitment program commenced early, with 60 graduate paramedics and one qualified paramedic commencing induction on 27 June 2022.

In addition, 68 new Referral Service Triage Practitioners commenced with AV to help match Triple Zero (000) callers with care that better meets their needs than an emergency ambulance.

### Advancing Paramedic Roles Implementation Program

The Advancing Paramedic Roles Implementation Program trial commenced in March 2021 and continued throughout 2021-2022 to pilot a community paramedic model of care in collaboration with two small rural health services.

To prepare for the trial, Paramedic Community Support Coordinators (PCSCs) attended a Monash University community paramedicine course, obtaining further knowledge and a suite of new skills and abilities relevant to the primary healthcare environment.

Two PCSCs spent two days a week with local health services in Mallee Track (Ouyen) and Tallangatta, supporting staff in Urgent Care Centres, delivering education to nursing and ancillary staff and collaborating around patient care. The PCSCs also conducted community visits and followed up referrals from health service providers, AV crews and the community.

The trial was formally evaluated with the final report scheduled to be delivered in July 2022.

### Ambulance Auxiliaries

Ambulance Auxiliaries are part of our fabric, and the additional support they provide AV contributes to better patient outcomes and a healthier Victorian community. Their sense of community and passion for their local area enable them to make significant contributions over and above government grants which is truly appreciated by AV.

AV has over 350 Auxiliary volunteers – ranging from community members to Ambulance Community Officers and paramedics – who build strong relationships with local businesses and organisations, leading to significant contributions towards operational and medical equipment, branch improvements, and training and education.

Funds raised through community events such as plant sales, barbecues, cake raffles and trivia nights make a significant difference to the service that ambulance branches provide within their local communities.

This year, we witnessed exceptional contributions from our 44 Ambulance Auxiliaries, despite fewer opportunities for fundraising due to the impact of COVID-19. Across rural Victoria, Auxiliary volunteers donated their time and energy to raise money to help their local ambulance branches.

Supported by the Community Fundraising team, Ambulance Auxiliaries raised approximately $345,000 in 2021-2022.

Through the generosity of donors, branches benefit from purchases such as specialised training manikins for paramedics to practise new skills. Auxiliaries also help to improve public access to automated defibrillators across Victorian communities by moving internal AED units to external, publicly accessible cabinets.

##### Auxiliary Purchases

* 15% Branch Improvements
* 1% Vehicle Equipment
* 11% AED Gifting Program
* 58% Operational/Medical Equipment
* 15% Training and Education

Figures based on 2021-2022 data.

Utilisation of Auxiliary funds over the last financial year.

##### What our volunteers say

‘Being a member of an Ambulance Auxiliary is a dedication to a wonderful cause – the satisfaction of knowing that Heathcote and district now has two of the best equipped ambulances in the state due to the contribution of the community.’

Barbara Walker-Donnelly, Heathcote Ambulance Auxiliary, 31 years of service

‘Over 20 years ago we became aware that an ambulance service would be invaluable to the local region. We had the time and the energy and wanted to contribute to the health, safety and peace of mind of our community. We have so much fun along the way and have made many new friends. Joining Ambulance Victoria has enriched our lives. Thank you!’

Frances Schulz & Ruth Wilson, Paynesville Ambulance Auxiliary, 17 & 22 years of service

# A high performing organisation

Ambulance Victoria is committed to operating in a financially and environmentally sustainable way.

AV continued to pursue technical innovation, reimagining the work environment to meet the challenges of COVID-19. Faced with the reality of staff unavailability, we developed a surge workforce of more than 1,700 personnel drawn from a range of partner agencies and university paramedic students. We adapted and transformed as an organisation, introducing new ways to look after our people and the planet.

### Performance

The global COVID-19 pandemic continued to have an unprecedented impact on demand for emergency care. While the lives of Victorians started to return to normal following restrictions, the extraordinary strain on our paramedics, first responders and the entire health system persisted.

This led to three consecutive quarters of record demand for emergency ambulances, from October 2021 to June 2022.

In 2021-2022, we responded to 377,386 time-critical Code 1 cases – a substantial increase of 53,820 lights and sirens cases (16.6 per cent) than the same time a year earlier.

This demand had an impact on performance, with 67.5 per cent of Code 1 cases responded to within 15 minutes, below the state-wide average target of 85 per cent.

The state-wide average response time to Code 1 cases was 14 minutes and 58 seconds compared with 12 minutes and 48 seconds last year.

For the most critically ill Victorians – our Priority 0 cases – we were on scene delivering life-saving care within or under our 13-minute target in 76.9 per cent of cases.

While we strive to meet our response performance targets and community expectations, it is important to recognise that response times are only one measure of a quality ambulance service. We continue to meet or exceed all our patient quality and care measures, leading to better outcomes in the survival and quality of life for heart attack, stroke and trauma patients.

There was also a 13.9 per cent increase in cases handled by Adult Retrieval Victoria, which provides clinical coordination, retrieval and critical care services. The team handled 6,365 cases in 2021-2022 – compared with 5,587 for the previous year – and 3,096 patient movements by road and air.

### AV’s next strategic plan

AV’s Strategic Plan (2017-2022) was approved by the Minister for Ambulance Services in June 2017, focusing on outstanding emergency health care every time. We commenced development of the next strategic plan in late 2020, ahead of the scheduled commencement on 1 July 2022.

Due to the significant workload demands of COVID-19 and the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) Review, the Minister for Ambulance Services, on the recommendation of the Board and with the support of the Department of Health, endorsed an extension of the current plan for an additional year.

This pause is providing time to consider recent learnings and better understand wider community and health system needs. Development of the new Strategic Plan has recommenced and will launch on 1 July 2023.

### Cardiac Arrest

AV attended 7,360 cardiac arrests in 2021-2022 compared with 6,934 the previous reporting year, continuing a trend of cardiac arrests attended by AV steadily increasing each year.

It is well established that rapid access to defibrillation is paramount to cardiac arrest survival, with evidence showing that reducing delays to defibrillation leads to better outcomes for patients in a shockable rhythm, including improved quality of life outcomes. The Victorian Ambulance Cardiac Arrest Registry (VACAR), an AV-led registry, routinely monitors timeliness of emergency medical services’ response to cardiac arrest and whether defibrillation is provided by AV, first responders or public access defibrillators (PADs).

Data from 2021-2022 is consistent with previous years, with cardiac arrest survival to hospital observed to be higher when patients are first defibrillated by a PAD compared to when AV is first to shock (68 per cent compared with 54 per cent in 2021-2022, and 65 per cent versus 50 per cent in the previous reporting year). Similarly, the proportion of patients who survive to hospital discharge is higher when first defibrillated by a PAD compared to when AV is first to shock (48 per cent compared with 24 per cent in 2021-2022 and 50 per cent compared with 27 per cent in 2020-2021).

Out-of-hospital cardiac arrests that are witnessed by bystanders have more positive survival outcomes, particularly when cardiopulmonary resuscitation (CPR) is applied. Bystander CPR ensures that patients in cardiac arrest are over six times more likely to be in a shockable rhythm when emergency services arrive (unadjusted, 2021-2022). The importance of bystander CPR cannot be underestimated, and although trends over the past 10 years illustrate an increase of bystander CPR and PAD use, the COVID-19 pandemic has influenced the ability of bystanders to intervene.

Essential safety measures implemented across the state to reduce the spread of COVID-19, including periods of shutdown or ‘stay at home’ orders, meant that fewer cardiac arrests occurred in public places and fewer patients were treated with PADs. Furthermore, safety requirements including donning of personal protective equipment, though vital for the safety of the public and our crews, increased time to interventions for cardiac arrest patients and combined with the stay-at-home measures led to reduced survival in cardiac arrest.

The trajectory of bystander CPR and survival trends are, however, slowly moving back to pre-COVID-19 levels. Adult survival to hospital discharge for patients presenting in a shockable rhythm has improved at 54.7 per cent in 2021-2022 compared with 52.5 per cent in the previous financial year. Adult survival for patients presenting in a shockable rhythm has decreased, at 27.3 per cent in 2021-2022 compared with 30.2 per cent in the previous year, however this data should be interpreted with caution as almost seven per cent of cases in the most recent period are missing hospital follow up information.

The VACAR 2020-2021 Annual Report, containing more comprehensive data on out-of-hospital cardiac arrest survival and management, can be found on the Ambulance Victoria website.

\*Data extracted on 26/07/2022

Figures reported in previous year’s report may have changed due to factors such as constant quality control of data, changes in outcome status based on hospital data/patient follow-ups

Adult survival to hospital discharge for those presenting in a shockable rhythm: unknown survival status = 41 (6.6 per cent). This number is expected to decrease in time and reflects current delays in data transfer processes.

## COVID-19

### COVID-19 Incident Management Team

Throughout the pandemic, AV’s paramedics and first responders rose to the challenge of working in a complex and changing environment, while managing the same personal pressures that were felt across the Victorian community.

As the complexity of the pandemic increased, an AV COVID-19 Incident Management Team (IMT) was established to oversee the whole of organisation activity to prepare for and respond to an expected surge in workload and demand. Based in the Department of Health and co-located with our Emergency Management Unit, the COVID IMT focussed on all matters relating to AV’s response to COVID including safety, operations, planning, logistics, finance and administration, public and workforce communication, and intelligence.

### Surge Workforce

As part of our approach to manage extraordinary demands resulting from the COVID-19 pandemic, from September 2021 AV implemented a surge workforce with the support of partner agencies.

While qualified paramedics remained responsible for patient care, a hardworking surge workforce of 1700 people supported and worked alongside our staff at emergencies and hospitals as required.

Complex logistics lay behind identifying, recruiting, inducting and managing a diverse workforce of approximately 1,246 first responders from outside of AV. With additional support from more than 500 AV Ambulance Community Officers (ACOs) and Community Emergency Response Team volunteers (CERT members), the total surge workforce of more than 1,700 people allowed us to continue to provide Best Care to the Victorian community.

* AV’s COVID-19 Surge Workforce included:
* AV Ambulance Community Officers (ACOs)
* AV Community Emergency Response Team volunteers (CERTs)
* St John Ambulance Australia (Victoria) – first aid volunteers
* State Emergency Service (SES) volunteers
* Life Saving Victoria volunteers
* Hatzolah Melbourne CERT responders
* Australian Red Cross volunteers
* Australian Defence Force personnel
* Undergraduate paramedicine students
* Returned retired paramedics
* Contracted nurses

Successfully assimilating the surge responder group into our existing workforce, while undertaking clinical skill assessment and categorisation, also posed a significant challenge.

We worked with our partners in the education and emergency management sector to recruit and train the surge workforce. Over six months, a dedicated team of paramedic educators from our Operational Capability division provided more than 10,000 hours of training in advanced first aid, infection control, manual handling, safe driving, and mental health to prepare the surge workforce to work alongside paramedics.

The creation of an additional workforce saw surge responders fill 60 to 110 shifts a day to play a critical role in maintaining AV’s operational capacity. Up to 30 June 2022, this equated to approximately 25,043 shifts or approximately five per cent of response shifts.

The implementation of the COVID-19 surge workforce set a new standard for upscaling an ambulance workforce in a time of sustained demand.

The contribution of all our surge response partners – to AV and the Victorian community during the pandemic – cannot be underestimated. We appreciate and value all personnel who assisted our paramedics and our patients during this challenging period.

AV commenced gradually scaling back the surge workforce from April 2022.

### Paramedic Support Hubs

Following their establishment in July 2020, Paramedic Support Hubs were maintained at hospitals throughout 2021-2022.

A total of 24 paramedic support hubs were established, including 14 at metropolitan hospitals and 10 across regional Victoria.

Each hub includes bathroom and basic kitchen facilities, with a team manager stationed at each hub to provide support to hospital liaison and to AV operational staff on their arrival at hospital. The hubs also provide a safe place for operational staff to complete their patient care records.

## Demand Management Strategies

### Patient offload teams

In 2021-2022, we expanded the use of AV offload teams at emergency departments.

In an effort to allow paramedics to offload patients as quickly as possible, offload areas were created at six metropolitan and two rural health services. Staffed by a paramedic supervisor and agency nurses, these facilities allow for three patients at a time to be cared for by one healthcare professional, freeing up three ambulances to return to the community.

### Grid changes

AV’s dispatch grid is a database of more than 1000 classifications that are assigned to patients during Triple Zero (000) calls. This year saw three tranches of changes to the dispatch grid in response to COVID-19, with a total of 35 event types changed.

Safely recategorising these case types increased the number of low acuity events diverted to secondary triage for further assessment and consideration of appropriate alternate service providers, allowing the emergency fleet to be prioritised for critical, high acuity cases. The grid changes occurred following thorough assessment, including oversight from AV’s Medical Advisory Committee. Following implementation, the COVID-19 Patient Safety Monitoring Group undertook extensive patient safety monitoring.

### Secondary Triage

Our Secondary Triage team continued to expand and is now the largest service of its type within any ambulance service in the world. In 2021-2022, 19.8 per cent of Triple Zero (000) callers were safely provided advice or alternative health care rather than an emergency ambulance.

During periods of peak demand, about 45 per cent of state-wide Triple Zero (000) call volume was able to be directed to Secondary Triage.

This allowed AV to better connect 156,581 Victorians with appropriate services that not only provide the patient with Best Care but help increase ambulance availability to respond to those people who need us the most.

In response to the changing environment due to the COVID-19 pandemic, new ways of managing calls needed to be developed. A new role was created within Secondary Triage – the Practitioner Assist. Forty Practitioner Assists were recruited to work alongside our triage practitioners, to further increase our ability to provide Triple Zero (000) patients advice and support.

To add flexibility and minimise the impact of furloughing of staff we refined and expanded our working from home capability. Many of our triage practitioners continue to work from home, with access to all department systems – a first for an Australian ambulance service.

Our working-from-home model ensures we continue to provide world-leading Secondary Triage to the people of Victoria.

* 68 new triage practitioners
* 48 practitioner assists
* 21 additional workstations

## Australia Day Honours

### Ambulance Service Medal Australia Day 2022

Six AV paramedics and a CERT volunteer were recognised for their outstanding service and contributions in the 2022 Australia Day Honours List.

Josephine Brookes ASM

Ms Josephine Brookes demonstrated exceptional service, providing training and public education as the Paramedic Community Support Coordinator for AV in Mitta Mitta/Towong, North-East Victoria.

Through developing and implementing a service-focused approach to supporting rural communities, Ms Brookes has markedly improved patient outcomes. Ms Brookes has also encouraged meaningful collaboration, respect, and support for patients and health agencies in the district.

Ian Dunell ASM

Mr Ian Dunell has dedicated the past 16 years to volunteering with AV as a Community Emergency Response Team (CERT) member and has served as team leader for the past 10 years.

During this time, Mr Dunell has demonstrated passion, support and care for his team and the Kinglake community. Following the 2009 Victorian Bushfires, Mr Dunell was instrumental in rebuilding Kinglake’s CERT and establishing new protocols.

The pandemic again highlighted Mr Dunell’s strength and dedication to his volunteer role; he led the Kinglake CERT through this period while maintaining a high level of engagement and comradery.

Bernard Goss ASM

Mr Bernard Goss has been a dedicated frontline paramedic for 40 years. Following the 1998 Longford Incident, Mr Goss was instrumental in providing post-event support to paramedics who suffered post-traumatic stress, well before AV introduced any formal psychological support service into the organisation.

Mr Goss continued to demonstrate distinguished service in the provision of mental health support for current and retired paramedics, bringing the How Are You Travelling (HAYT) program to Gippsland in May 2016. HAYT provides a safe place for paramedics to discuss challenges and stressors of the job and share their mental health experiences.

Gavin Keane ASM

Mr Gavin Keane is a career paramedic with more than 47 years of service with AV. He has also volunteered with the Lang Lang Community Emergency Response Team since its inception 17 years ago.

Mr Keane has volunteered thousands of hours to train recruits and taught CPR and use of automated external defibrillators. He was instrumental in obtaining over 50 public access defibrillator sites in Lang Lang and surrounding communities.

Ziad Nehme ASM

Mr Ziad Nehme is an Advanced Life Support paramedic who has worked to improve the evidence base for paramedic care. He has made a significant contribution to pre-hospital emergency care and resuscitation research.

Mr Ziad’s research has influenced local and international resuscitation guidelines, and co-authored and managed AV’s Air Versus Oxygen In myocarDial infarction (AVOID) study.

Frances Scott ASM

Ms Frances Scott has been an integral part of the Woods Point Ambulance Community Officer team for 31 years.

As team leader, Ms Scott responds to remote jobs, treating patients before paramedic road crews arrive. She drove the conversion of an old hospital into a functioning Ambulance Community Officer station and worked tirelessly to fit out a troop carrier to access remote areas.

Glenice Winter ASM

During her 28 years of dedicated service, Ms Glenice Winter has demonstrated outstanding clinical leadership in the provision of education and mentoring of Advanced Life Support (ALS) and Mobile Intensive Care Ambulance (MICA) paramedics.

Ms Winter helped create a clinical learning culture within AV, adopting creative methods to deliver tailored clinical sessions for staff. She was one of the first female MICA paramedics at AV and is recognised as a pioneer for women in the workplace.

### Order of Australia Medal 2022

David Cottee, Vicki Cottee and Sandi Grieve, were recognised with the Medal of the Order of Australia (OAM) in this year’s Australia Day Honours List.

Mrs Vicki Cottee has contributed significantly to the Talgarno community as an Ambulance Community Officer since 2006, and by providing first aid at local events. Vicki has helped secure donations to the CERT to buy medical equipment, including six defibrillators for the area.

Mr David Cottee has contributed significantly to the Talgarno community as an Ambulance Community Officer for 16 years. David voluntarily taught taekwondo for 18 years, and is a member of various local committees.

Ms Sandi Grieve has been recognised for her service to community health including her significant contributions at the Walwa Bush Nursing Centre over 33 years, and as CEO since 2003. Sandi is among the Remote Area Nurses across Victoria who provide support as co-responder to help AV paramedics deliver best care.

## Awards

### AV Excellence Awards 2021

The AV Excellence Awards recognises the exceptional work and dedication of our employees, volunteers and auxiliary members.

These peer-nominated awards raise awareness of the people and projects that demonstrate AV’s values. Winners are:

* TelePROMPT for Best Care
* AV Healthy Signs – Auslan for Community Engagement
* Mallacoota First Responder Team and Mallacoota PCSC for First Responders and Volunteers
* Covid-19 Infection Prevention & Control Response for Health, Safety and Wellbeing
* Tiarni Allan, Senior Officer – First Responder Programs for Inclusive Culture
* Rachelle Pellow, Acting Regional Director Gippsland for Leadership
* Mental Health Destination Tool for Performance and Innovation
* Deb Riseley, Patient Review Coordinator for Performance and Innovation
* AV Uniform Recycling for Social and Environmental Responsibility

### Dr David Komesaroff Initiative Award 2021

The Dr David Komesaroff Initiative Award is awarded every three years to an AV paramedic for exceptional achievements. It encourages paramedics to be innovative and put their ideas into practice to continually improve paramedic practice in Victoria.

MICA Flight Paramedic Ben Meadley received the award in recognition of a PhD submission relating to the physical demands on paramedics working on helicopters.

### CAA Awards

The CAA Awards for Excellence recognise the hard and innovative work of member ambulance services from Australia, New Zealand and Papua New Guinea. AV won in both the patient care and leadership categories in the 2021 Awards:

* The TelePROMPT service claimed the Excellence in Patient Care award
* Social and Environmental Responsibility (Framework and Action Plan) took out the Excellence in Leadership category.

Six AV entries were confirmed as finalists in the 2022 CAA Awards.

Winners were to be announced in August 2022.

### CAA Women in ambulance awards

The CAA Awards for Excellence recognise the hard and innovative work of member ambulance services from Australia, New Zealand and Papua New Guinea. AV won in both the patient care and leadership categories in the 2021 Awards:

* Anna Devereux, Senior People Partner
* Bronwyn Lambert, Paramedic Educator
* Debbie Ray, Area Manager
* Eileen Craven, Project Manager Solution Delivery
* Lindsay Mackay, Director Triage Services

### Rod Moore Memorial Award 2022

The Rod Moore Memorial Award was established in honour of respected paramedic Rod Moore who overcame many hurdles to succeed as a paramedic before his death in 2007. The Award recognises paramedics who demonstrate exceptional drive, determination, personal development and improvement throughout their graduate phase.

This year’s recipient, Juan Audish, was commended for immense character, stamina, grace and professionalism.

# Workforce Data

This workforce information is provided in accordance with the Minister for Finance’s Reporting Direction 29: ‘Workforce data disclosures in the report of operations – public service employees.’

## Total staffing numbers

Full-Time Equivalent (FTE) Staff 2021-2022 (Size of the workforce):

| Staffing Numbers (FTE) – Annual Report Category | 2021-22 | 2020-21 |
| --- | --- | --- |
| On road Clinical Staff[[1]](#footnote-1) | 4,983.9 | 4,497.2 |
| Operation Support and Managerial Staff[[2]](#footnote-2) | 598.9 | 513.0 |
| Other Managerial, Professional and Administrative Staff[[3]](#footnote-3) | 515.1 | 503.0 |
| TOTAL | 6,097.9 | 5,513.2 |

## Mobile Intensive Care Ambulance paramedics (MICA)

This group of MICA employees forms part of AV’s Full-Time Equivalent Staff 2021-2022:

| MICA Staffing Numbers | 2021-22 | 2020-21 |
| --- | --- | --- |
| MICA Full-Time Equivalent Staff | 552.1 | 547.4 |
| MICA Full-Time Equivalent Trainees | 44.0 | 46.9 |
| TOTAL | 596.1 | 594.3 |

### 1,014 Ambulance Community Officers (ACOs)

AV employs 1,014 casual Ambulance Community Support Officers (ACOs) who also provide emergency response. These employees are represented in the above on-road clinical staff FTE numbers based on their hours worked converted to equivalent full-time positions.

### 716 Newly recruited paramedics

This included 647 graduate paramedics and 69 qualified paramedics.

The 2022-2023 recruitment program commenced early, with 60 graduate paramedics and one qualified paramedic commencing induction on 27 June 2022.

### 250 Volunteers

In addition, AV engages 250 Community Emergency Response Team volunteers (CERTs) who provide emergency response in 2021-2022.

#### Notes

The three staff categories are as follows:

* On-road clinical staff – include paramedics, team managers, patient transport officers, retrieval registrars, clinic transport officers and clinical instructors, etc.
* Operation support and managerial staff – include senior team managers, area managers, regional directors, rosters staff, communications staff, rehabilitation advisors, occupational health and safety advisors, logistics staff, fleet staff, duty team managers, telecommunication staff and clinical practice staff, etc.
* Other managerial, professional and administrative staff – include all other staff who do not fall into the above two categories.

# Health, Safety and Wellbeing

### Statistics

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2021-22 | 2020-21 | 2019-20 |
| Number of workplace fatalities | 0 | 0 | 0 |
| Lost Time Injury Frequency Rates (LTIFR)[[4]](#footnote-4) | 72.6 | 71.6 | 59.9 |
| Number of standard claims per 100 FTE (Full Time Equivalent) staff[[5]](#footnote-5) | 8.0 | 6.6 | 5.3 |
| Number of standard claims per 1,000,000 hours worked[[6]](#footnote-6) | 50.6 | 40.3 | 32.3 |
| Average cost per WorkCover standard claim [[7]](#footnote-7), [[8]](#footnote-8), [[9]](#footnote-9) | $113,268 | $100,261 | $81,262 |
| Number of hazards/incidents reports lodged[[10]](#footnote-10) | 3,356 | 4,086 | 3,995 |
| Percentage of WorkCover Standard claims with a Return to Work plan initiated | 100% | 100% | 100% |
| Percentage of employees immunised against influenza (including ACO’s)[[11]](#footnote-11) | 54.4% | 93.8% | 86.9% |
| Number of health and safety representative positions filled[[12]](#footnote-12) | 376 | 294 | 274 |
| Number of employees immunised against COVID-19 Vax 1[[13]](#footnote-13), [[14]](#footnote-14) | 99.7% | 56.9% | n/a |
| Number of employees immunised against COVID-19 Vax 1 & 2[[15]](#footnote-15), [[16]](#footnote-16) | 99.3% | 34.4% | n/a |

# Occupational Violence

### Statistics

|  | 2021-22 | 2020-21 | 2019-20 |
| --- | --- | --- | --- |
| WorkCover accepted claims with an occupational violence cause per 100 FTE | 0.9 | 0.9 | 0.6 |
| Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked | 5.0 | 5.3 | 3.7 |
| Number of Occupational Violence HII’s reported | 564 | 631 | 696 |
| Number of Occupational Violence HII’s reported per 100 FTE | 9.2 | 11.4 | 13.1 |
| Percentage of Occupational Violence HII’s resulting in a staff injury, illness or condition | 9.40% | 7.77% | 4.74% |

#### Notes:

Definitions:

* 1. Occupational Violence – any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.
  2. HII’s – Occupational Health and Safety hazards/incidents/injuries (HIIs) reported in the health service incident reporting system (AV’s Health and Safety Claims System (HSCS)).
  3. Accepted WorkCover claims – accepted WorkCover claims that were lodged in the financial year.
  4. Lost Time – defined as greater than one day.

# Alcohol and Other Drugs

AV's Alcohol and Other Drugs (AOD) testing program consists of four distinct areas, with a key performance indicator set at 20 per cent (N=1470) of the AV workforce (N=7350).

* The AOD program achieved a figure of 22 per cent of the workforce tested (N=1639) for 2021-2022.
* Pre-employment testing for operational paramedic applicants (830).
* Random testing for the existing workforce via randomised AV locations (621).
* ‘For cause/post incident’ testing (35).
* Workgroup testing (153).

Pre-employment AOD testing is conducted as part of the medical selection process prior to being employed with AV. The total of 830 candidates tested returned negative results.

In workforce testing (Random, For Cause, Post Incident and Workgroup) programs in 2021-2022, AV conducted the following testing numbers: Random (N=621), For Cause (N=26), Post Incident (MVA) (N=9) and Workgroup (N=153).

All employees who test positive are given assistance through AV’s supportive framework and the AOD Specialist Welfare with referral to treatment facilities as required.

# Research Report

AV is an international leader in pre-hospital research. Research activities range from epidemiological analyses of key patient cohorts to review and refinement of systems of care, and world-first clinical trials. Results have been published in high-ranking, high-impact journals, disseminated throughout the wider health system, and translated into improvements in patient care internationally.

The primary goal of AV research is to strengthen the evidence base that underpins ambulance protocols and systems to allow the best and most efficient care for patients and staff.

As of June 2022, 120 active research projects were registered in the AV research governance system. Our research portfolio is highly collaborative, involving partnerships with key organisations, including universities, hospitals, and institutes such as the Turning Point Drug and Alcohol Centre. In 2021-2022, AV research continued to contribute substantially to pre-hospital literature despite the operational burden of the COVID-19 pandemic, with staff co- authoring a record-breaking 85 research articles in peer-reviewed medical journals.

The AV Centre for Research and Evaluation also continues to foster research education and mentorship through supervision of higher research degree students, many of whom are paramedics who have balanced research education with clinical duties. The AV Centre for Research and Evaluation has also supervised and mentored internationally based higher research degree students who have chosen to work with AV for our reputation for clinical and research excellence.

AV is proud to be a leading partner in some of the largest research collaborations in our region, including the National Health and Medical Research Council (NHMRC)-funded Centres for Research Excellence in Pre-hospital Emergency Care (PEC-ANZ) and the Australian Resuscitation Outcomes Consortium (Aus-ROC), which are administratively based at Monash University.

These research centres have helped to build capacity in pre-hospital and cardiac arrest research through collaborative projects between leading researchers, clinicians and ambulance services in Australia and New Zealand. The aims of the PEC-ANZ and Aus-ROC Centres for Research Excellence are to strengthen the evidence base underpinning pre-hospital emergency care and cardiac arrest treatment, policy and practice.

### Collaborations

AV has also engaged in new collaborative projects, such as contributing to the creation of the National Transfusion Dataset (NTD). The NTD will be administratively based at Monash University and has been developed to expand transfusion data coverage by integrating pre-hospital transfusion data with hospital transfusion data and linking the dataset with registry transfusion data. Ultimately, the NTD will create new research opportunities to inform national transfusion policy and practice, improve blood utilisation and patient management and outcomes.

Additionally, we are excited to engage with the National Centre for Healthy Ageing, a partnership between Monash University and Peninsula Health, to develop and test a nationally scalable, digital health solution to enable the sharing of consensus-driven critical point-of-care, primary healthcare information during transfer of people living in residential aged care to hospital and back again.

The provision of real-time, accurate and reliable patient information that can be shared across settings involved in the transfer of resident is expected to have numerous benefits for AV and other health service providers. This includes improved quality and safety of care for residential aged care residents across the transfer settings and health system savings through increased efficiencies.

### Clinical trials

Pre-hospital clinical trials at AV are world-leading and our paramedics are internationally recognised for their success in recruiting eligible patients. Enrolment into various clinical trials that had to be postponed due to the COVID-19 pandemic has now resumed, and we look forward to another productive year of pre-hospital clinical trial research.

The lignocAine Versus Opioids In myocarDial infarction (AVOID-2) trial was a phase II multi-centre randomised controlled trial, designed to examine whether lignocaine is an effective and safe alternative analgesic agent compared to fentanyl in patients with suspected ST-elevation myocardial infarction (STEMI). We successfully enrolled over 300 patients between October 2020 and July 2021, completing recruitment months ahead of schedule.

Trial results show that although lignocaine significantly reduced pain, it was not as effective as fentanyl for pain relief. Despite this, lignocaine was better tolerated than fentanyl, with fewer patients experiencing adverse events. AVOID-2 was undertaken during challenging times in the COVID-19 pandemic, and despite this, over 140 teams in the metropolitan region contributed to patient recruitment. Importantly, more than 80 per cent of patients had confirmed STEMI on coronary angiogram and there were very few protocol deviations. We are absolutely thrilled with this result and would like to congratulate AV paramedics for leading the world in evidence-based practice.

Despite several interruptions, the CPR, pre-Hospital ECMO and Early Reperfusion (CHEER-3) trial has now enrolled seven patients. CHEER3 is assessing the feasibility and impact of dispatching a paramedic with two Alfred Health intensive care physicians to eligible cardiac arrest patients to receive extracorporeal membrane oxygen (ECMO) therapy in the field. ECMO is similar to a heart and lung machine and provides support to patients who are refractory to standard resuscitation techniques.

Recently, the manual pressure AUGMENTation in defibrillation of Ventricular Arrhythmias: (AUGMENT-VA) randomised controlled trial began and has successfully enrolled over 20 patients as of June 2022. The primary aims of AUGMENT-VA are to determine the impact of manual pressure augmentation (MPA) on patient survival to hospital discharge and to assess the efficacy of MPA for successfully cardioverting shockable rhythms.

While use of MPA for successful conversion of atrial arrhythmias is well documented, the use of MPA for defibrillation of ventricular arrhythmias is novel. The first patient enrolment, resulting in successful rhythm conversion, was reported in the Resuscitation journal this year (Voskoboinik et al. Resuscitation. 2022; 174:31-32). We look forward to continuing to lead pre-hospital out-of-hospital cardiac arrest research.

We are also aiming to further increase survivability from out-of-hospital cardiac arrests (OHCA) by increasing access to early defibrillation. The First Responder Shock Trial (FIRST) is a cluster randomised controlled trial of smartphone-activated first responders equipped with ultraportable defibrillators in OHCA. This trial is a collaboration between AV and St John Ambulance New Zealand. For every minute that passes without defibrillation, survival from cardiac arrest falls by approximately 10 per cent.

Defibrillation by bystanders and GoodSAM responders using an AED halves the time to first defibrillation and can potentially triple survival rates. Although the GoodSAM app aims to increase visibility and access to AEDs in the community, the proportion of GoodSAM responders providing defibrillation remains low. New defibrillation technology has been developed to improve the cost-effectiveness and accessibility of AEDs significantly. We are looking forward to leading this exciting clinical trial.

The Safe Treatment of Atrial fibrillation in the communitY (STAY) trial has now commenced enrolment, already enrolling seven patients. This trial aims to develop a novel, integrated model-of-care and alternative clinical pathway for atrial fibrillation (AF) patients who contact Triple Zero (000) for acute presentations. Redirecting patients away from transport to and management within hospital emergency departments lessens the burden on ambulance and hospital resources.

This alternative care model is likely to be significantly lower in cost and clinically beneficial. Successful development of a community-based care system would have important implications for quality care and public health policy in the management of atrial fibrillation and other cardiovascular conditions presenting acutely in the community.

Phase two of the Paramedic Antibiotics for Severe Sepsis (PASS) trial is underway, investigating whether prehospital administration of antibiotics to patients with suspected sepsis reduces the time to antibiotic administration when compared with standard care in the emergency department. A total of 20 patients have been successfully enrolled in the trial so far, and we look forward to continuing to enrol patients in the coming year.

The Pre-hospital Freeze-Dried Plasma for critical bleeding after trauma pilot trial has now commenced enrolment. This trial involves a pilot feasibility trial of freeze-dried plasma versus standard therapy for patients with haemorrhagic shock receiving pre-hospital blood. The aim of this project is to fill an identified patient blood management knowledge gap on early and effective management of haemorrhage after trauma. This will build on evidence from two overseas trials examining pre-hospital plasma that reported contrasting results.

### Registries

Our clinical quality registries remain the lifeblood of AV and underpin our commitment to provide best care to the community. The VACAR has now captured over 120,000 cardiac arrest cases attended by AV paramedics since October 1999 and drives quality improvement in resuscitation practice, supports a large research agenda, and continues to inform key performance indicators at AV.

The VACAR also contributes to multiple research collaborations outside of AV, including the Unexplained Sudden Cardiac Death Registry (based at the Baker Institute). In 2020, the VACAR established routine post-resuscitation debriefing reports using improved functionality embedded into the registry. These reports (known as Team Performance Reports) are issued to paramedics present at the scene of resuscitation and involve 19 key metrics that align with current resuscitation guidelines.

The report utilises a traffic light system that benchmarks the team’s metrics against the previous 12-months of attempted resuscitations. The reports are supported by the collection of real-time monitoring of CPR quality during resuscitation which is now routinely captured by the VACAR.

This information has also been used to develop a service-wide bi-monthly newsletter aimed at increasing transparency between the VACAR and the wider AV workforce regarding key performance metrics, while encouraging engagement with high-performance CPR training.

The AV Centre for Research and Evaluation also maintains the Victorian Ambulance STEMI Quality Improvement (VASQI) Initiative, which focuses on paramedic diagnosis, treatment, and triage of patients with a heart attack.

In addition, the Centre for Research and Evaluation continues to provide data to the Victorian State Trauma Registry for all major trauma patients attended by ambulance paramedics; the Turning Point Drug and Alcohol Centre for all drug, alcohol and mental health related ambulance attendances; and, the Victorian Cardiac Outcomes Registry (VCOR), which is a state-wide population-based clinical quality registry aiming to improve the quality of care provided to patients with cardiovascular disease.

We have also provided pre-hospital data to the Australian Stroke Clinical Registry through a novel data linkage project. This project aims to examine the impact of pre-hospital diagnosis, treatment, and triage of stroke patients on long-term patient outcomes.

### Awards

The Director for the Centre of Research and Evaluation, Professor Karen Smith, was in 2021 recognised as the top publishing researcher in the world for pre-hospital emergency care research for 2000-2020, as well as the most-cited author internationally (2010- 2019) regarding paramedic related publications.

Dr. Ziad Nehme, an Advanced Life Support Paramedic and Senior Clinical Researcher with AV, was recognised as a 2021 Heart Foundation Future Leader Fellow, as well as receiving the Resuscitation Science Symposium (ReSS) Young Investigator Award and the Paul Dudley White International Scholar Award at the Resuscitation Science Symposium 2021 conference.

Dr Nehme has also been recognised in the 2022 Australia Day Honours list as a recipient of an Ambulance Service Medal in recognition of his significant contribution to pre-hospital research improving the evidence base for paramedic care and patient outcomes.

### AV presentations at key conferences

Despite continued interruptions to international travel AV staff or research was presented at key conferences including:

* American Heart Association Resuscitation Science Symposium, ‘ReSS2021’, virtually.
* Annual International Research Conference 2021: Global Developments in Paramedic Research, virtually.
* Australasian Resuscitation Outcomes Consortium (AUS-ROC) ECR Seminar ‘Resuscitation: The Future is Shocking’, virtually.
* Australasian Trauma Conference, virtually.
* EMS 2022, Glasgow Scotland.
* The 7th International Conference on Neurology and Epidemiology 2021, virtually.
* The Council of Ambulance Authorities Webinar series, virtually.
* The European Society of Cardiology's EuroPCR Meeting, Paris France.
* The European Resuscitation Council Congress 2022, Antwerp Belgium.

## Publications

1. Alqudah Z, Nehme Z, Williams B, Oteir A, Smith K. Survival outcomes in emergency medical services witnessed traumatic out-of-hospital cardiac arrest after the introduction of a trauma-based resuscitation protocol. Resuscitation. 2021;168:65-74.

2. Amminadab E, Smith, K, Kilkenny M, Kim J, Bagot, K, Andrew E, Cox S, Bladin C, Cadilhac D. Linking data from the Australian Stroke Clinical Registry with ambulance and emergency administrative data in Victoria. Inquiry In Press 2022.

3. Andrew E, Cox S, Smith K. Linking Ambulance Records with Hospital and Death Index Data to Evaluate Patient Outcomes. International Journal of General Medicine. 2022;15:567-72.

4. Andrew E, Nehme Z, Stephenson M, Walker T, Smith K. The Impact of the COVID-19 Pandemic on Demand for Emergency Ambulances in Victoria, Australia. Prehospital Emergency Care. 2021:1-7.

5. Andrew E, Nehme Z, Stephenson M, Walker T, Smith K. The Impact of the COVID-19 Pandemic on Demand for Emergency Ambulances in Victoria, Australia. Prehospital Emergency Care. 2022;26(1):23-9.

6. Beck B, Zammit-Mangion A, Fry R, Smith K and Gabbe B. Spatiotemporal mapping of major trauma in Victoria, Australia. Plos One. In Press 2022.

7. Bennett R, Williams B. Desirable non-technical skills for paramedicine: A Delphi study. Australasian Journal of Paramedicine. 2022;19.

8. Bernard S, Roggenkamp R, Delorenzo A, Stephenson M, Smith K, Augello M, et al. Use of intramuscular ketamine by paramedics in the management of severely agitated patients. EMA – Emergency Medicine Australasia. 2021;33(5):875-82.

9. Bernard SA, Hopkins SJ, Ball JC, Stub DA, Stephenson MW, Nanjayya VB, et al. Outcomes of patients with refractory out-of-hospital cardiac arrest transported to an ECMO centre compared with transport to non-ECMO centres. Crit Care Resusc. 2022;24(1):7-13.

10. Bivard A, Zhao H, Churilov L, Campbell BCV, Coote S, Yassi N, et al. Comparison of tenecteplase with alteplase for the early treatment of ischaemic stroke in the Melbourne Mobile Stroke Unit (TASTE-A): a phase 2, randomised, open-label trial. The Lancet Neurology. 2022;21(6):520-7.

11. Bivard A, Zhao H, Churilov L, Campbell B, Coote S, Yassi N, Yan B, Valente M, os Sharobeam A, Balabanski A, Dos Santos A, Ng J, Langenberg F, Easton D, Warwick A, Mackey E, MacDonald A, Stephenson M, Smith K, Anderson D, Choi P, Thijs V, Ma H, Cloud G, Wijeratne T, Olenko L, Italiano D, Davis S, Donnan G and Parsons M on behalf of the TASTE-A collaborators. The Melbourne Mobile Stroke Unit Tenecteplase versus Alteplase for Stroke Thrombolysis Evaluation Trial in the Ambulance (TASTE-A). The Lancet Neurology. In Press 2022.

12. Bivard A, Zhao H, Coote S, Campbell B, Churilov L, Yassi N, et al. Tenecteplase versus Alteplase for Stroke Thrombolysis Evaluation Trial in the Ambulance (Mobile Stroke Unit-TASTE-A): protocol for a prospective randomised, open-label, blinded endpoint, phase II superiority trial of tenecteplase versus alteplase for ischaemic stroke patients presenting within 4.5 hours of symptom onset to the mobile stroke unit. BMJ open. 2022;12(4):e056573.

13. Bloom JE, Andrew E, Dawson LP, Nehme Z, Stephenson M, Anderson D, et al. Incidence and Outcomes of Nontraumatic Shock in Adults Using Emergency Medical Services in Victoria, Australia. JAMA Network Open. 2022;5(1):e2145179-e.

14. Bloom J, Andrew E, Nehme Z, Beale A, Dawson L, Shi W, Vriesendorp P, Fernando H, Noaman S, Cox S, Stephenson M, Anderson D, Chan W, Kaye D, Smith K and Stub D. Gender disparities in cardiogenic shock treatment and outcomes; A population-based cohort study. American Journal of Cardiology In Press 2022.

15. Bloom JE, Andrew E, Nehme Z, Dinh DT, Fernando H, Shi WY, et al. Pre-hospital heparin use for ST-elevation myocardial infarction is safe and improves angiographic outcomes. Eur Heart J Acute Cardiovasc Care. 2021;10(10):1140-7.

16. Blusztein D, Dinh D, Stub D, Dawson L, Brennan A, Reid C, et al. Predictors of hospital prenotification for STEMI and association of prenotification with outcomes. Emerg Med J. 2021:emermed-2020-210522.

17. Bray J, Howell S, Ball S, Doan T, Bosley E, Smith K, et al. The epidemiology of out-of-hospital cardiac arrest in Australia and New Zealand: A binational report from the Australasian Resuscitation Outcomes Consortium (Aus-ROC). Resuscitation. 2022;172:74-83.

18. Broder JC, Gao CX, Abramson MJ, Wolfe R, Dimitriadis C, Ikin J, et al. Long-term impact of exposure to coalmine fire emitted PM2.5 on emergency ambulance attendances. Chemosphere. 2022;288:132339.

19. Buscot MJ, Chandra RV, Mainguard J, Nichols L, Blizzard L, Stirling C, et al. Association of Onset-to-Treatment Time with Discharge Destination, Mortality, and Complications among Patients with Aneurysmal Subarachnoid Hemorrhage. JAMA Network Open. 2022;5(1).

20. Cadilhac DA, Bagot KL, Demaerschalk BM, Hubert G, Schwamm L, Watkins CL, et al. Establishment of an internationally agreed minimum data set for acute telestroke. J Telemed Telecare. 2021;27(9):582-9.

21. Carroll M, Gao CX, Campbell TCH, Smith CL, Dimitriadis C, Berger E, et al. Impacts of coal mine fire-related PM2.5 on the utilisation of ambulance and hospital services for mental health conditions. Atmospheric Pollution Research. 2022;13(5).

22. Case R, Stub D, Mazzagatti E, Pryor H, Mion M, Ball J, et al. The second year of a second chance: Long-term psychosocial outcomes of cardiac arrest survivors and their family. Resuscitation. 2021;167:274-81.

23. Cole J, Beare R, Phan T, Srikanth V, Stub D, Smith K, et al. Modelling STEMI service delivery: a proof of concept study. Emerg Med J. 2021:emermed-2020-210334.

24. Coote S, Mackey E, Alexandrov AW, Cadilhac DA, Alexandrov AV, Easton D, et al. The Mobile Stroke Unit Nurse: An International Exploration of Their Scope of Practice, Education, and Training. J Neurosci Nurs. 2022;54(2):61-7.

25. Davis S, Olaussen A, Bowles KA, Shannon B. Review article: Paramedic pain management of femur fractures in the prehospital setting: A systematic review. EMA – Emergency Medicine Australasia. 2021;33(4):601-9.

26. Dawson LP, Andrew E, Nehme Z, Bloom J, Biswas S, Cox S, et al. Association of Socioeconomic Status With Outcomes and Care Quality in Patients Presenting With Undifferentiated Chest Pain in the Setting of Universal Health Care Coverage. Journal of the American Heart Association. 2022;11(7).

27. Dawson LP, Andrew E, Nehme Z, Bloom J, Liew D, Cox S, et al. Development and validation of a comprehensive early risk prediction model for patients with undifferentiated acute chest pain. IJC Heart and Vasculature. 2022;40.

28. Dawson L, Andrew E, Nehme Z, Bloom J, Okyere D, Cox S, Anderson D, Stephenson M, Lefkovits J, Taylor A, Kaye D, Smith K\* and Stub D\*. Incidence, diagnoses and outcomes of ambulance attendances for chest pain: A population-based cohort study. Annals of Epidemiology In Press 2022.

29. Dawson L, Andrew E, Stephenson M, Nemhe Z, Bloom J, Cox S, Anderson D, Leftovits J, Taylor A, Kaye D, Smith K and Stub D. Impact of ambulance off-load delays on mortality in patients with chest pain. Medical Journal of Australia. In Press 2022.

30. Dawson L, Smith K, Cullen L, Nehme Z, Leftkovits J, Taylor A and Stub D. Care Models for Acute Chest Pain that Improve Outcomes and Efficiency: JACC State-of-the-Art Review. Journal of the American College of Cardiology In Press 2022.

31. Delardes B, Chakraborty S, Smith K, and Bowles KA. Development of an electronic referral proforma from paramedics to general practitioners: a Delphi study. Australasian Journal of Paramedicine. In Press 2022.

32. Delorenzo A, Shepherd M, Andrew E, Jennings P, Bernard S, Smith K. Endotracheal Tube Intracuff Pressure Changes in Patients Transported by a Helicopter Emergency Medical Service: A Prospective Observational Study. Air Med J. 2021;40(4):216-9.

33. Eastwood K, Howell S, Nehme Z, Finn J, Smith K, Cameron P, et al. Impact of a mass media campaign on presentations and ambulance use for acute coronary syndrome. Open Heart. 2021;8(2):e001792.

34. Eliakundu AL, Cadilhac DA, Kim J, Andrew NE, Bladin CF, Grimley R, et al. Factors associated with arrival by ambulance for patients with stroke: a multicentre, national data linkage study. Australasian Emergency Care. 2021;24(3):167-73.

35. Fernando H, Duong T, Huynh K, Noonan J, Shaw J, Duffy SJ, et al. Effects of lignocaine vs. opioids on antiplatelet activity of ticagrelor: the LOCAL trial. Eur Heart J. 2021;42(39):4025-36.

36. Fernando H, Nehme Z, Dinh D, Andrew E, Brennan A, Shi W, Bloom J, Duffy S, Shaw J, Peter K, Nadurata V, Chan W, Layland J, Freeman M, Van Gaal, Barnard S, Lefkovits, Liew D, Stepehenson M, Smith K\* and Stub D\*. Impact of Pre-hospital Opioid Dose on Angiographic and Clinical Outcomes in Acute Coronary Syndromes. Emergency Medicine Journal. In Press 2022.

37. Fernando H, Nehme Z, Peter K, Bernard S, Stephenson M, Bray JE, et al. Association between pre-hospital chest pain severity and myocardial injury in ST elevation myocardial infarction: A post-hoc analysis of the AVOID study. IJC Heart & Vasculature. 2021;37:100899.

38. Fouche PF, Meadley B, St Clair T, Winnall A, Jennings PA, Bernard S, et al. The association of ketamine induction with blood pressure changes in paramedic rapid sequence intubation of out-of-hospital traumatic brain injury. Acad Emerg Med. 2021;28(10):1134-41.

39. Fouche PF, Meadley B, StClair T, Winnall A, Stein C, Jennings PA, et al. Temporal changes in blood pressure following prehospital rapid sequence intubation. Emerg Med J. 2021:emermed-2020-210887.

40. Gowens P, Smith K, Clegg G, Williams B, Nehme Z. Global variation in the incidence and outcome of emergency medical services witnessed out-of-hospital cardiac arrest: A systematic review and meta-analysis. Resuscitation. 2022.

41. Han M, Yeo A, Ong M, Smith K, Lim Y, Lin N, Tan B, Arulanandam S, Ho A, Ng Q. Cardiac arrest occurring in high-rise buildings: A scoping review. Journal of Clinical Medicine In Press 2021.

42. Haskins B, Nehme Z, Cameron PA, Smith K. Cardiac arrests in general practice clinics or witnessed by emergency medical services: a 20-year retrospective study. Medical Journal of Australia. 2021;215(5):222-7.

43. Haskins B, Nehme Z, Dicker B, Wilson MH, Ray M, Bernard S, et al. A binational survey of smartphone activated volunteer responders for out-of-hospital cardiac arrest: Availability, interventions, and post-traumatic stress. Resuscitation. 2021;169:67-75.

44. Holbery-Morgan L, Carew J, Angel C, Simpson N, Steinfort D, Radford S, et al. Feasibility of pulse oximetry after water immersion. Resusc Plus. 2021;7:100147.

45. Hook J, Smith K, Andrew E, Ball J, Nehme Z. Daylight savings time transitions and risk of out-of-hospital cardiac arrest: An interrupted time series analysis. Resuscitation. 2021;168:84-90.

46. Kearney J, Muir C, Smith K. Occupational injury among paramedics: a systematic review. Inj Prev. 2021:injuryprev-2021-044405.

47. Kearney J, Muir C, Smith K. Occupational injury among paramedics: a systematic review. Injury prevention : journal of the International Society for Child and Adolescent Injury Prevention. 2022;28(2):175-84.

48. Kempster K, Howell S, Bernard S, Smith K, Cameron P, Finn J, et al. Out-of-hospital cardiac arrest outcomes in emergency departments. Resuscitation. 2021;166:21-30.

49. Kwok JS, Fox K, Bil C, Langenberg F, Balabanski AH, Dos Santos A, et al. Bringing CT Scanners to the Skies: Design of a CT Scanner for an Air Mobile Stroke Unit. Applied Sciences (Switzerland). 2022;12(3).

50. Li C, Sotomayor-Castillo C, Nahidi S, Kuznetsov S, Considine J, Curtis K, et al. Emergency clinicians’ knowledge, preparedness and experiences of managing COVID-19 during the 2020 global pandemic in Australian healthcare settings. Australasian Emergency Care. 2021;24(3):186-96.

51. McGuinness SL, Johnson J, Eades O, Cameron PA, Forbes A, Fisher J, et al. Mental Health Outcomes in Australian Healthcare and Aged-Care Workers during the Second Year of the COVID-19 Pandemic. Int J Environ Res Public Health. 2022;19(9).

52. McManamny TE, Dwyer R, Cantwell K, Boyd L, Sheen J, Smith K, et al. Emergency ambulance demand by older adults from rural and regional Victoria, Australia. Australas J Ageing. 2022;41(1):e74-e81.

53. Meadley B, Horton E, Perraton L, Smith K, Bowles K and Caldwell J. The physiological demands of helicopter winch rescue in water and over land. Ergonomics In Press 2021.

54. Meadley B, Horton E, Pyne DB, Perraton L, Smith K, Bowles K-A, et al. Comparison of swimming versus running maximal aerobic capacity in helicopter rescue paramedics. Ergonomics. 2021;64(10):1243-54.

55. Meadley B, Wolkow AP, Smith K, Perraton L, Bowles K-A, Bonham MP. Cardiometabolic, dietary and physical health in graduate paramedics during the first 12-months of practice – a longitudinal study. Prehospital Emergency Care. 2021:1-19.

56. Mion M, Case R, Smith K, Lilja G, Blennow Nordström E, Swindell P, et al. Follow-up care after out-of-hospital cardiac arrest: A pilot study of survivors and families’ experiences and recommendations. Resuscitation Plus. 2021;7:100154.

57. Naccarella L, Saxton D, Lugg E, Marley J. It takes a community to save a life in cardiac arrest: Heart safe community pilots, Australia. Health Promot J Austr. 2022;33(1):99-105.

58. Nan Tie E, Fernando H, Nehme Z, Dinh D, Andrew E, Brennan A, et al. Sex differences in prehospital analgesia in patients presenting with acute coronary syndromes and their association with clinical outcomes. Catheter Cardiovasc Interv. 2022;99(4):989-95.

59. Nehme Z, Smith K. Gas asphyxiation precipitating out-of-hospital cardiac arrest: A call for more data and uniform definitions. Resuscitation. 2022;175:34-5.

60. Nehme Z, Stub D. Triage of post-cardiac arrest patients: To PCI or not to PCI, that is the question. Resuscitation. 2022;170:335-8.

61. Nguyen TP, Stirling C, Kitsos G, Nichols L, Chandra RV, Rehman S, et al. Barriers and facilitators to more timely treatment of aneurysmal subarachnoid haemorrhage across two tertiary referral centres in Australia: A thematic analysis. Australasian Emergency Care. 2022.

62. Nielsen S, Sanfilippo PG, Scott D, Lam T, Smith K, Lubman DI. Characteristics of oxycodone-related ambulance attendances: analysis of temporal trends and the effect of reformulation in Victoria, Australia from 2013 to 2018. Addiction. 2021;116(8):2233-41.

63. Ogeil RP, Scott D, Faulkner A, Wilson J, Beard N, Smith K, et al. Changes in alcohol intoxication-related ambulance attendances during COVID-19: How have government announcements and policies affected ambulance call outs? The Lancet Regional Health – Western Pacific. 2021;14:100222.

64. Olaussen A, Abetz J, Qin KR, Mitra B, O'Reilly G. Misleading medical literature: An observational study. EMA – Emergency Medicine Australasia. 2022;34(1):39-45.

65. Orman Z, Thrift AG, Olaiya MT, Ung D, Cadilhac DA, Phan T, et al. Quality of life after stroke: a longitudinal analysis of a cluster randomized trial. Quality of Life Research. 2022.

66. Paratz E, Rowe S , Van Heusden A , Smith K , Pflaumer A, Semsarian C, Parsons S , Stub D, Zentner D , La Gerche A. Clinical and pathologic features of out-of-hospital cardiac arrest in pregnancy: insights from a state-wide registry. JACC Advances In Press 2022.

67. Paratz ED, van Heusden A, Zentner D, Morgan N, Smith K, Ball J, et al. Predictors and outcomes of in-hospital referrals for forensic investigation after young sudden cardiac death. Heart Rhythm. 2022.

68. Paratz E, vn Heusden A, Zentner D, Morgan N, Smith K, Ball J, Thompson T, James P, Connell V, Pflaumer A, Semsarian C, Ingles J, Stub D, Parsons S and La Gerche A. Prevalence of Coronary Artery Anomalies in Young and Middle-Aged Sudden Cardiac Death Victims (From a Prospective State-Wide Registry). American Journal of Cardiology. In Press 2022.

69. Pfeiffer CK, Smith K, Bernard S, Dalziel SR, Hearps S, Geis T, et al. Prehospital benzodiazepine use and need for respiratory support in paediatric seizures. Emerg Med J. 2022:emermed-2021-211735.

70. Pilcher DV, Duke G, Rosenow M, Coatsworth N, O’neill G, Tobias TA, et al. Assessment of a novel marker of ICU strain, the ICU Activity Index, during the COVID-19 pandemic in Victoria, Australia. Crit Care Resusc. 2021;23(3):300-7.

71. Rehman S, Chandra RV, Lai LT, Asadi H, Dubey A, Froelich J, et al. Adherence to evidence-based processes of care reduces one-year mortality after aneurysmal subarachnoid hemorrhage (aSAH). Journal of the Neurological Sciences. 2021;428:117613.

72. Ross LJ, Eade A, Shannon B, Williams B. Out-of-hospital or pre-hospital: Is it time to reconsider the language used to describe and define paramedicine? Australasian Emergency Care. 2022.

73. Sharobeam A, Yan B. Advanced imaging in acute ischemic stroke: an updated guide to the hub-and-spoke hospitals. Curr Opin Neurol. 2022;35(1):24-30.

74. Sharrock MK, Shannon B, Garcia Gonzalez C, Clair TS, Mitra B, Noonan M, et al. Prehospital paramedic pleural decompression: A systematic review. Injury. 2021;52(10):2778-86.

75. Smith J, Andrew E, Smith K. Pre-hospital early warning scores are associated with requirement for medical retrieval services. Australasian Journal of Paramedicine. 2022;19:1-9.

76. Ting A, Smith K, Wilson CL, Babl FE, Hopper SM. Pre-hospital intraosseous use in children: Indications and success rate. Emerg Med Australas. 2022;34(1):120-1.

77. Voskoboinik A, Nehme Z, Kistler PM, Stub D, Smith K. First time use of manual pressure augmentation for ventricular fibrillation arrest in the community. Resuscitation. 2022;174:31-2.

78. Walker K, Jiarpakdee J, Loupis A, Tantithamthavorn C, Joe K, Ben-Meir M, et al. Emergency medicine patient wait time multivariable prediction models: a multicentre derivation and validation study. Emerg Med J. 2021:emermed-2020-211000.

79. Walker K, Jiarpakdee J, Loupis A, Tantithamthavorn C, Joe K, Ben-Meir M, et al. Emergency medicine patient wait time multivariable prediction models: a multicentre derivation and validation study. Emergency medicine journal : EMJ. 2022;39(5):386-93.

80. Walker KJ, Jiarpakdee J, Loupis A, Tantithamthavorn C, Joe K, Ben-Meir M, et al. Predicting Ambulance Patient Wait Times: A Multicenter Derivation and Validation Study. Ann Emerg Med. 2021;78(1):113-22.

81. Walker M, d'Arville A, Lacey J, Lancman B, Moloney J, Hendel S. Mass casualty, intentional vehicular trauma and anaesthesia. Br J Anaesth. 2022;128(2):e190-e9.

82. Watt A, Sherry N, Anersson P, Lane C, Johnson S, Wilmot M, Horan K, Sait M, Ballard S, Crachi C, Beck D, Marshall C, Kainer M, Stuart R, McGrath C, Kwong J, Bass P, Kelley P, Crowe A, Guy S, Macesic N, Smith K, Williamson D, Seemann T, Howden B.State-wide Genomic Epidemiology Investigations of COVID-19 in Healthcare Workers in 2020 Victoria, Australia: Qualitative Thematic Analysis to Provide Insights for Future Pandemic Preparedness. Lancet Regional Health – Western Pacific In Press 2022.

83. White M, O'Reilly GM, Mitchell RD, Noonan M, Hiller R, Mitra B, et al. Informing the Alfred Registry for Emergency Care Project: An analysis of presenting complaint documentation in an emergency department. EMA – Emergency Medicine Australasia. 2022.

84. Witt K, Pirkis J, Scott D, Smith K, Lubman D. Trajectories in suicide attempt method lethality over a five-year period: Associations with suicide attempt repetition, all-cause, and suicide mortality. PLOS ONE. 2021;16(1):e0245780.

85. Yassi N, Zhao H, Churilov L, Campbell BCV, Wu T, Ma H, et al. Tranexamic acid for intracerebral haemorrhage within 2 hours of onset: protocol of a phase II randomised placebo-controlled double-blind multicentre trial. Stroke and vascular neurology. 2022;7(2):158-65.

# Environment and Sustainability

Three years since the development of our Social and Environmental Responsibility Framework and Action Plan we continue to make great progress on improving social and environmental outcomes for our people and communities.

A focus on emissions reduction saw us continue to transition corporate and suitable response vehicles from internal combustion engines to hybrid vehicles. Our next stage of vehicle transition is to zero emission vehicles, which will include the trial of electric vehicles as part of the corporate fleet.

We were also able to avoid 4,330 tonnes of carbon dioxide equivalent (tCO2e) emissions from electricity usage from solar installations on our buildings and the purchase of green power throughout the year. The commencement of an LED lighting retrofit program will further support the reduction in energy consumption from our buildings and therefore contribute to emission reductions in future years.

Overall net emissions reduced by three per cent in 2021-2022 compared to the previous 12 months. While operational growth puts pressure on our emission reductions, we continue to target Net Zero emissions by 2045.

As a leader of sustainability in the healthcare sector we developed and delivered a climate literacy course for our employees, which was adapted into a module for training of directors by the Council of Ambulance Authorities (CAA). This was well received and viewed by 26 people within the CAA network.

We also collaborated with CAA on an emissions performance benchmarking study. As part of this a baseline dataset for Carbon per Case has been established and will be employed as a normalising indicator for greenhouse data going forward. AVs normalised data shows Carbon per Case has reduced by 14 per cent from 43.9 kilograms of carbon dioxide equivalent (kgCO2e) in 2014-2015 to 37.8 kgCO2e in 2021-2022. This reflects AV’s efforts in climate action and a transition towards a lower carbon model of care.

Waste is a significant challenge in the healthcare sector and this is no different for AV. In addition to segregating recycling from landfill, paramedics must also understand correct disposal of clinical waste. To support this, an online learning module was created for paramedics to understand best practice waste disposal. In this course paramedics learnt correct waste segregation practices for clinical and other related wastes in response to legislative changes introduced by the Victorian Environment Protection Authority.

Achieving both a positive social and environmental outcome, our partnership with Enable saw 15,000 kg of information technology waste, such as laptops and computers, responsibly recycled while also providing employment opportunities for people with a disability. And through our membership with Social Traders, a social enterprise certifying organisation, AV will be supported to identify further opportunities.

### Environmental Awards

AV received three awards for our efforts in climate action and sustainability in the Global Green and Healthy Hospitals (GGHH) Climate Champion Awards announced in February 2022.

AV was awarded gold in both the Climate Resilience and Climate Leadership categories, and silver in the Renewable Energy category. The awards recognise the steps we are taking to prepare for the impacts of extreme weather and the shifting burden of disease, as well as educating staff and the public by promoting policies that protect public health from climate change, and help reduce health care’s own carbon footprint.

AV is committed to reducing our key emissions from road vehicles, building energy usage, and air ambulance services.

We have set ambitious targets, and are making strong progress to meeting reduction targets for our Scope 1 and 2 emissions on our path towards zero net carbon emissions:

* 2025: 39 per cent emissions reduction
* 2030: 60 per cent emissions reduction
* 2045: Net zero emissions

By way of further commitment, AV participates in the Race To Zero, a global campaign to rally leadership and support from businesses, cities, regions, investors for a healthy, resilient, zero carbon recovery that prevents future threats, creates decent jobs, and unlocks inclusive, sustainable growth.

### Patient triage finding sustainable solutions

An investigation into the clinically appropriate use of alternative service providers has demonstrated improved social and environmental outcomes.

Patients across Victoria have benefited from increased flexibility and service choice made possible through recent developments in virtual care and connection to alternate service providers when safe and clinically appropriate.

Triage Services care has proven to be a cost effective, real-time and convenient alternative to the more traditional face-to-face way of providing paramedic care. This innovative program introduced by AV managed to avoid dispatch to lower acuity patients during COVID-19 and preserve emergency ambulances for time critical events.

This alternative care model, initially introduced to alleviate pressure on the number of ambulance call outs, was also studied for its environmental impact. The study found that across the year 395 tonnes of carbon pollution was avoided by diverting calls to a mix of alternate service providers.

Statistical analysis revealed:

* On average, 11 kilometres of travel and 5.8 kilograms of carbon pollution was avoided per diversion to an alternative service provider.
* Approximately 36 per cent of emissions reduced was by the provision of telehealth services.
* The use of a domestic vehicle in place of an ambulance can reduce emissions by more than 60 per cent.
* Provision of taxis instead of an ambulance where clinically appropriate for the patient reduced kilometres travelled on average by 40 per cent.

AV continues to investigate how programs like these can improve the delivery of care to unique cohorts which would have further environmental and social benefits.

# Environmental Report

## Environmental commitment

AV recognises that our everyday activities have direct and indirect impacts on the environment. Knowing that the environment we live in can impact our health and quality of life our aim is to minimise these impacts wherever possible. Our Social and Environmental Responsibility Framework 2020-2024 and associated Action Plan puts a focus on environmental improvements in our most material areas of climate change adaptation and mitigation, waste minimisation and sustainable design and procurement.

## Key achievements

This year, we commenced implementation of our Climate Adaptation Action Plan 2022-2025.

This plan spans four years and will help AV understand the risks to our operations under potential future climate scenarios. Using this knowledge we are planning for more frequent and extreme weather events. By preparing for these events, climate related impacts to our operations will be reduced and our ability to provide effective pre-hospital care can be better maintained.

In mitigating our contribution to climate change, a continued focus on energy efficiency projects saw carbon emissions associated with electricity reduce in 2021-2022 by 9 per cent compared to 2020-2021.

This was a significant contributor to our overall carbon emission reduction of two per cent in 2021-2022.

In recognition of our efforts in 2021-2022 we received the following awards:

* Leadership Prize in CAA Annual Excellence Awards (November 2021).
* Community Champion – Waste Reduction and the Circular Economy category of the Premier’s Sustainability Awards 2021.
* Climate Champion Awards from Global Green and Healthy Hospitals (GGHH) for action on climate change.
  + Climate Resilience – Gold
  + Climate Leadership – Gold
  + Renewable Energy – Silver

## Climate change

The Climate Adaptation Action Plan 2022-2025 commenced its first year of delivery, known as the ‘establish phase’.

Many of the actions were of a foundational and communicative nature to establish understanding, networks and process before moving into the longer-term strategic actions in the Scenario Plan stage in 2022-23. During this initial phase a strong relationship has been developed with the Department of Environment, Land, Water and Planning. This has helped us to understand potential future weather conditions and events specific to individual regions.

## Paper use

AV continued to see a significant reduction in paper usage falling by 54 per cent in 2021-2022 to 4,196 reams of paper.

This is a great effort and supported by the reduced presence of corporate staff on site, the use of DocuSign to sign formal documents and an improvement in utilities invoice payments which resulted in less paper use. The recycled paper content of all paper consumed remained relatively consistent at 71 per cent. Supporting social procurement priorities, our paper is sourced from a certified Aboriginal and Torres Strait Islander social enterprise.

## Electricity Greenhouse emissions

AV is proud to be one of the first health services to have an action plan that includes emissions reduction and climate adaptation commitments.

We have developed an emissions vision for net zero by 2045, including reduction pledges along the way. The first pledge is to achieve a 39 per cent reduction in emissions from the 2015 baseline by 2025. AV net emissions have been steadily decreasing since a peak observed in 2018-19. This has been strongly influenced by higher penetration of renewable energy into the electricity grid, reducing the overall emission factor, and entering into a Power Purchase Agreement in 2020-2021. As a result Scope 2 emissions (electricity) reduced by nine per cent and AV total emissions reduced by three per cent overall.

This reduction in emissions along with an increasing number of cases being responded to has seen emissions per case decrease since 2018-19 showing an improved emissions efficiency for service provided.

## Energy use (Stationary Energy)

Stationary energy use has remained relatively stable since 2020-2021, only reducing by two per cent in 2021-2022.

Larger fluctuations have occurred in sources such as liquified petroleum gas, however due to the small quantity reported this has not made a significant impact on the overall figure.

## Fuel use (Transport Energy)

Reducing energy use associated with our fleet continues to be challenging due to the nature of our work and our requirement for specific road vehicle and aircraft platforms.

The conversion to hybrid corporate vehicles has commenced however worldwide delays in supply of vehicles has limited the number of hybrids coming into Australia and hampered the transition. An increased road case load over recent years has resulted in increased diesel fuel consumption, which has been too significant to offset the reduction observed in aircraft energy consumption. With these challenges in mind, AV is pleased to report that transport energy increased by less than one per cent in 2021-2022.

## Water use

Water use increased by 12 per cent in 2021-2022 compared to 2020-2021 but remained well below the consumption levels observed pre-COVID-19.

Traditionally, the bulk of our water is consumed at corporate sites so this consumption is in line with reduced numbers of staff at these locations. AV regularly analyses water consumption trend information to identify possible leaks and improve our approach to water use.

## Reducing waste and maximising recycling

Waste generation rose in 2021-2022, however so did our recycling percentage rate, up from 41 per cent in 2020-2021 to 48 per cent in 2021-2022.

The continued focus on recycling at branches and further roll out of waste segregation bins has contributed to this increased recycling rate. The increased number of cases and PPE requirements of COVID-19 has had a negative impact on waste generation at AV.

We will continue to seek innovative ways to manage the waste we generate. One such example is the adoption of gloves that breakdown in landfill via a process of mineralisation.

The gloves are impregnated with an organic additive that attracts landfill bacteria which consume the nitrile glove leaving behind organic material, carbon dioxide and methane.

Another program AV has to reduce waste generation is the collection and re-use of paramedic uniforms that are no longer required.

The program, established and co-ordinated by ALS Paramedic and Team Manager Jo Algie, is able to re-distribute uniforms to current paramedics in need and was of benefit when needing to supply uniform to the COVID-19 surge workforce.

Uniforms that cannot be re-distributed are de-badged and donated to Uniforms for Kids, a not-for-profit organisation that, with the help of volunteers, creates new and unique outfits for disadvantaged children.

Jo was recognised in the Premier’s Sustainability Awards in the Community Champion – Waste Reduction and the Circular Economy category for her great efforts.

# Environmental Report

## Governance, reporting and targets

Regular progress reporting to the Executive Committee and AV Board contributes to the governance of our actions. The following table summarises our environmental results for this year and outlines targets set for 2022-2023.

| Environmental indicator | Target 2021-22 | Results 2021-2022 | Target 2022-2023 |
| --- | --- | --- | --- |
| Reduction in greenhouse emissions  Increased energy sourced from renewables  Increased fuel efficiency of road fleet | 2 per cent carbon reduction on 2015 baseline  Establish baseline carbon per case by service type | Carbon reduction  Emissions reduction achieved from renewables and projects: 3 per cent carbon reduction compared to 2020-2021 (788 tCO2e)  Carbon per case by service type established for:   * Total fleet * Fixed Wing * Rotary Wing * Emergency Road * AV Non Emergency Patient Transport | 8 per cent reduction compared to 2021-2022  Carbon per case <33kgCO2e/case |
| Improved waste behaviours | Rollout recycling trial to 40 branches | Rolled out recycling trial to 80 branches | Rollout recycling trial to a further 40 branches, 255 sites in total |

# Environmental Performance[[17]](#footnote-17)

|  | Unit of Measure | 2019-20 | 2020-21 | 2021-22 |
| --- | --- | --- | --- | --- |
| GREENHOUSE EMISSIONS[[18]](#footnote-18) | | | | |
| Scope 1 | tC02e- | 24,587 | 25,877 | 25,745 |
| Scope 2 | tC02e- | 9,091 | 8,205 | 7,439 |
| Total AV Greenhouse Emissions[[19]](#footnote-19) | tC02e- | 33,678 | 34,082 | 33,184 |
| GreenPower | tC02e- | -1,748 | -2,783 | -2,673 |
| Net AV Greenhouse Emissions[[20]](#footnote-20) | tC02e- | 31,930 | 31,299 | 30,511 |
| Emissions from Energy (Stationary) | tC02e- | 6,584 | 5,549 | 4,240 |
| Emissions from Transport | tC02e- | 24,464 | 25,751 | 25,611 |
| Carbon per Case | kgCO2e- | 43.15 | 40.27 | 37.78 |
| Carbon avoided per Case | kgCO2e- | 2.346 | 3.58 | 3.31 |
| Environmental Indicator | | | | |
| Stationary Energy[[21]](#footnote-21) |  |  |  |  |
| Diesel Oil | GJ | 174 | 135 | 154 |
| Electricity | GJ | 32,084 | 30,141 | 29,428 |
| Liquefied Petroleum Gas | GJ | 62 | 46 | 8 |
| Natural Gas | GJ | 2,090 | 2,224 | 2,391 |
| Total Consumption | GJ | 34,410 | 32,546 | 31,982 |
| Green Power purchased | % | 19 | 33 | 33 |
| Solar Power (installed) | GJ | 1,230 | 1,718 | 1,657 |
| Consumption per FTE[[22]](#footnote-22) | GJ per FTE | 6.47 | 6.37 | 5.24 |
| Transport Energy[[23]](#footnote-23) |  |  |  |  |
| Total Consumption | GJ | 333,353 | 364,785 | 365,404 |
| Consumption per FTE | GJ per FTE | 62.73 | 68.65 | 74.61 |
| Water[[24]](#footnote-24) |  |  |  |  |
| Total Consumption | KL | 35,137 | 25,066 | 35,137 |
| Consumption per FTE | KL per FTE | 6.61 | 4.72 | 5.76 |
| Waste[[25]](#footnote-25) |  |  |  |  |
| Total waste generated | Kg (clinical, general, liquid & recycled) | 291,205 | 225,806 | 381,883 |
| Total waste to landfill | Kg (clinical & general) | 206,624 | 160,270 | 245,395 |
| Recycling rate % | Kg (recycled / general & recycled) | 35 | 41 | 48 |
| Waste to landfill per FTE | Kg per FTE | 38.88 | 29.07 | 40 |
| Paper[[26]](#footnote-26) |  |  |  |  |
| Total Reams | Reams | 12,464 | 9,103 | 4.196 |
| Average Recycled Content | % | 71 | 70 | 71 |
| Reams per FTE | Reams per FTE | 2.35 | 1.71 | 0.69 |

# Social Procurement

Through our buying power, we generate social, economic and environmental outcomes that benefit the Victorian community and the environment. Our Social Procurement Framework provides the basis of our collaboration with our suppliers, to improve the social and environmental value of our purchasing decisions.

This Social Procurement Framework sets the governance requirements by which AV intends to apply social procurement to achieve its related enterprise performance objectives.

Our social procurement aligns with and supports the AV Strategic Plan 2017-2022 objective of operating in a financially and environmentally sustainable way.

AV’s approach to social procurement is grounded by nine key objectives, based on the Victorian Government’s Social Procurement Framework objectives. These objectives are considered in purchasing decisions to deliver the social and environmental value we strive for.

These objectives are:

* Providing opportunities for Victorian Aboriginal people.
* Providing opportunities to Victorians with disability.
* Promoting gender equality and women’s safety.
* Providing opportunities for disadvantaged Victorians.
* Supporting safe and fair workplaces.
* Engaging social enterprises, Australian disability enterprises and Aboriginal businesses where possible.
* Supporting sustainable Victorian regions.
* Consideration of a project’s environmentally sustainable outputs.
* Sustainable business practices adopted by suppliers.
* Implementation of the Victorian Government’s Climate Change Policy objectives.

Over the past 12 months, AV has delivered a range of work in line with the Framework. These include:

* Obtaining membership of Social Traders who aim to connect certified enterprises with business, creating a positive impact through jobs, community services and support for the most marginalised.
* Conducting an analysis of the AV procurement spend in conjunction with Social Traders, to identify social procurement opportunities.
* Delivering social procurement training to management groups within AV.
* Highlighting for AV to purchase social and sustainable products offered by our stationery provider (copy paper, bottled water, paper cups, etc).
* Establishing an attestation process for social procurement reporting.
* Providing an internal register of social providers on AV’s Intranet.
* Increasing numbers of social suppliers in AV’s supply chain.
* Continuing to integrate social and environmental responsibility requirements into tenders.
* Joining Supply Nation, which aims to help shape the emerging and rapidly evolving Indigenous business sector, to assist with growing our Indigenous spend and understanding.

Our 2021-2022 social procurement spend exceeded target. Total social spend with certified suppliers rose from $18.4 million to $27.7 million. This can be attributed to the increase in maintenance and operational services delivered by social procurement suppliers as part of AV’s health response to the COVID-19 pandemic, the addition of long-term AV suppliers that are now included within the Social Traders umbrella and increased AV staff awareness.

| Social Procurement | 2019-20 | 2020-21 | 2021-22 |
| --- | --- | --- | --- |
| Social procurement spend | $17.5M | $18.4m | $27.7m |
| Social procurement ‘addressable spend’[[27]](#footnote-27) | $269,000 | $654,000 | $3.4m |
| Number of social suppliers[[28]](#footnote-28) | 40 | 60 | 76 |

## Case Studies

In accordance with the Victorian Government’s Social Procurement Framework, AV actively seeks to use its buying power to generate social value above and beyond the value of the goods, services or construction being procured.

Social value refers to the benefits for all Victorians when social and sustainable outcomes are achieved through procurement activities. The below examples highlight opportunities that have been realised under AV’s Social Procurement Framework.

### Be Well Be Safe Program

Ambulance Victoria implemented the ‘Be Well Be Safe’ Healthcare Workforce Wellbeing Grant Program. Fruit boxes were delivered fortnightly by fruit2work across metropolitan Melbourne and to Geelong’s Regional Office. Fruit2work is a social enterprise that provides employment opportunities to those who have been involved with the justice system.

### Paramedic Refreshment Program

AV required a strategy to support paramedics and staff in combatting fatigue during the COVID-19 pandemic. Waverley Social Enterprises Catering and the Salvation Army were able to assist by supplying ‘after hours’ snack boxes at our premises at Wesley Court and the latter also at our Ballarat call centre. These were very well received by AV staff. Both suppliers felt a strong connection in supporting AV and in turn playing a part in assisting in the fight against the pandemic.

### Uniforms

AV contracted two uniform providers with social procurement practices embedded within their operations.

Thread Group Australia is an Indigenous owned business, registered with both Kinaway and Supply Nation. It is also a registered supplier on the Victorian Government Ethical Supplier Register and accredited to Ethical Clothing Australia.

Workwear Group is a registered supplier on the Victorian Government Ethical Supplier Register, accredited to Ethical Clothing Australia, members of Better Cotton Initiative (BCI) and, Signatory to the Australian Packaging Covenant Organisation (APCO). The group also partners with Career Trackers to build pathways for young Indigenous professionals.

# Donations Summary

General Donations and Bequests greater than or equal to $1,000

|  |  |
| --- | --- |
| Name of Donor | Donation Amount |
| Rotary Club of Wonthaggi | $65,500.00 |
| Lorne Community Opportunity Shop Inc. | $37,400.00 |
| Alma Sylvia & Carmen Figuerola Trust | $26,261.79 |
| Nicoll Bedford | $20,022.44 |
| Judith Stembridge | $20,000.00 |
| Heather Rae | $18,700.00 |
| Foundation for Rural & Regional Renewal | $17,928.00 |
| Magistrates Court of Victoria | $17,000.00 |
| Rodney McRae | $10,000.00 |
| Mildura Connected Community | $8,550.00 |
| Ritchies Stores | $6,438.16 |
| Mallacoota Fundraising Group | $5,835.00 |
| Edwards Foundation | $5,000.00 |
| Eildon Community Opportunity Shop Inc | $5,000.00 |
| Estate of Brian J Winfield | $5,000.00 |
| The AL Lane Foundation | $5,000.00 |
| The Gall Family Foundation | $5,000.00 |
| The Midfield Group | $5,000.00 |
| Towong Shire Council | $5,000.00 |
| McMahons Road Pty Ltd | $4,870.00 |
| Kathleen & Neal Gildea | $4,000.00 |
| John Brian Little | $3,000.00 |
| Tracey Kol | $3,000.00 |
| Omeo Rodeo Association Inc | $2,500.00 |
| Andrew Stevens | $2,000.00 |
| GOLF AUSTRALIA | $2,000.00 |
| Anonymous | $1,500.00 |
| Askra Consulting Pty Ltd | $1,500.00 |
| Blue Label Pty Ltd | $1,500.00 |
| Rotary Club of Warrandyte Donvale | $1,500.00 |
| The Big Trentham Thank You | $1,319.05 |
| Mount Beauty Foodworks | $1,292.81 |
| Andrew Cook | $1,000.00 |
| Ann & Peter Robb | $1,000.00 |
| Anonymous | $1,000.00 |
| Anonymous | $1,000.00 |
| Brown McComish Solicitors | $1,000.00 |
| Lloyd Thomson | $1,000.00 |
| Nhan Le | $1,000.00 |
| Salvatore Di Paola | $1,000.00 |
| Warrnambool Dog Training School Inc. | $1,000.00 |
| Total | $327,617.25 |
| General Donations and Bequests under $1,000 | $111,048.81 |
| Total General Donations and Bequests | $438,666.06 |

#### Auxiliary Donations greater than or equal to $1,000

| Name | Auxiliary | Amount |
| --- | --- | --- |
| Gippsland Wool Growers | Helimed 1 | $15,816.16 |
| ‘Greater Gippsland Fund’ Supported by Nationals MP Darren Chester & Department of Industry | Sale | $5,500.00 |
| Ritchies IGA Paynesville | Paynesville | $3,795.50 |
| Omeo Rodeo Association Inc | Helimed 1 | $2,500.00 |
| Exxon Mobil (ESSO) | Sale | $2,200.00 |
| Sale Greyhound Racing Club | Sale | $2,183.10 |
| Anonymous | Sale | $2,110.90 |
| Paynesville Uniting Church | Paynesville | $2,000.00 |
| Robinvale Op Shop | Robinvale | $2,000.00 |
| Maryborough Lions Club | Maryborough | $1,500.00 |
| Paul Okely | Warracknabeal | $1,500.00 |
| Bairnsdale Golf Club | Paynesville | $1,437.55 |
| Nhill Pharmacy | Nhill | $1,297.49 |
| Parkridge Social Club | Paynesville | $1,250.00 |
| Bendigo Bank | Romsey-Lancefield | $1,000.00 |
| Grantville Business & Ratepayers Association | Grantville | $1,000.00 |
| Anonymous | Woodend | $1,000.00 |
| Yarram Camp Draft | Helimed 1 | $1,000.00 |
| Total |  | $49,090.70 |
| Auxiliary Donation and Bequests under $1,000 |  | $296,979.47 |
| Total Auxiliary Donations |  | $346,070.17 |

# Governance

## AV Charter

AV aims to improve the health of the community by providing high quality pre-hospital care and medical transport. AV provides emergency medical response to almost 6.7 million people.

AV is a statutory authority required by the *Ambulance Services Act 1986* to provide state-wide emergency pre-hospital ambulance services to all Victorians. This includes to:

* respond rapidly to requests for help in a medical emergency.
* provide specialised medical skills to maintain life and to reduce injuries in emergency situations and while transporting patients.
* provide safe, patient-centred and appropriate services.
* provide specialised transport facilities to move people requiring emergency medical treatment.
* provide services for which specialised medical or transport skills are necessary.
* foster continuous improvement in the quality and safety of the care and services it provides.
* foster public education in first aid.

AV was established on 1 July 2008 following the merger of the Metropolitan Ambulance Service, Rural Ambulance Victoria and the Alexandra and District Ambulance Service.

AV reports to the Minister for Ambulance Services through the Department of Health. During this reporting period, two Ministers held the portfolio. The Hon. Martin Foley MP from 1 July 2021 to 27 June 2022, and the Hon. Mary-Anne Thomas MP from 27 June 2022 to 30 June 2022.

Appointed by the Governor in Council on the recommendation of the Minister, the Board of Directors (the Board) is responsible for the provision of comprehensive, safe and efficient ambulance services to the people of Victoria. While organisational operations and management is vested in the Chief Executive Officer and the Executive team, the Board is accountable to the Victorian Government and Minister for the overall and ongoing performance of AV.

The Board is responsible for the establishment of AV’s strategic direction, governance, material policies and frameworks. It oversees AV’s clinical, financial and organisational performance and operating efficiency. The Board is also responsible for ensuring the provision of safe working environment for our staff and enabling an inclusive and supportive organisational culture.

The Board operates in accordance with the AV By-Laws (approved by the Department of Health Secretary), as well as other Board and government policies and frameworks. These support AV to meet its statutory obligations and, in doing so, comply with appropriate standards of governance, transparency, accountability and propriety. All Board and committee members are independent, non-executive Directors.

The Board’s qualifications, skills and experience are diverse and extensive, with expertise across government (state and federal), emergency services, health; industrial relations, technology and transformation, finance, accounting, law, commerce, diversity, governance, not-for-profit settings, community engagement, and culture. The Board also ensures it maintains regular engagement with representatives of other health services, government department officers, various external specialists and other Board Chairs to ensure it remains connected to contemporary practices and initiatives in health, risk and governance.

The Board Chair works with the Department of Health and the Minister to ensure the Board has the requisite skills, competency and diversity mix to provide strong and insightful stewardship of the organisation. This includes ensuring the Board has the attributes required not only for today’s needs, but also for future years where the Board will need to respond to a more technologically, financially and socially complex environment.

## Board Committees

The Board continues to maintain three statutory committees, two advisory committees, and a Remuneration and Nominations Committee to support its functions.

All committees are governed by a Board-approved Terms of Reference, which sets out each forum’s role, responsibilities, membership, quorum and voting structures. The Board appoints all committee members (reviewed annually) and ensures annual performance and effectiveness reviews are conducted and reported.

Committee activities continue to be periodically reviewed, to ensure they remain fit-for-purpose, aligned to legislation and government frameworks and best practice governance, and advance the Board’s role and responsibilities under the Ambulance Services Act 1986.

### Finance Committee (section 18 requirement)

The Finance Committee advises the Board on AV’s financial and business plans, strategies and budgets to ensure the long-term financial viability of the organisation. The committee assists the Board in monitoring strategies that seek to maximise revenue, and the effective and efficient use of AV financial resources and assets. Specific responsibilities include:

* financial strategy
* financial reporting, and
* business and financial planning and performance.

The committee is assisted in its work by the extensive commercial, finance and accounting experience of its members. The committee continuously improves its insights into AV through regular presentations on key areas of the business which present both financial opportunity and challenge for the organisation. All of the committee’s members are also appointed to the Audit and Risk Committee.

### Audit and Risk Committee (section 18 requirement)

The Audit and Risk Committee assists the AV Board in fulfilling its responsibilities in the areas of compliance, internal control, financial reporting, assurance activities and contemporary risk management. Specific responsibilities include:

* financial risk and internal controls
* financial reporting and management
* internal and external audit
* AV’s compliance with laws, regulations, internal policies and industry standards
* enterprise risk management (sharing responsibility with the Quality and Safety Committee in overseeing clinical risks).

Throughout the year, the committee regularly engaged with AV’s internal auditors (Ernst &Young) and external auditors (Victorian Auditor General’s Office). This ensured the committee provided the Board and AV with robust and informed oversight of matters mandated by its Terms of Reference, the Department of Health, and the Department of Treasury and Finance.

The committee’s work is supported by a strong cross-section of skills and experience of its members in the areas of law, banking, finance, commerce, government, hospitals and insurance.

The committee continues to update and refine AV’s risk and risk appetite framework, as well as staying connected to internal and external emerging risks. In 2021-2022, the committee continued its oversight of material risks including, but not limited to, the COVID-19 pandemic and organisational culture.

### Quality and Safety Committee (section 18 requirement)

The Quality and Safety Committee is responsible to the Board for monitoring the performance of AV with regard to whether:

* effective and accountable systems are in place to monitor and improve the quality, safety and effectiveness of services provided by AV;
* any systemic problems identified with the quality, safety and effectiveness of ambulance services are addressed and the results reported in a timely manner; and
* AV continuously strives to improve the quality of the services it provides and to foster innovation.

The committee actively monitors the performance of quality care and service provision against the five domains of the Safer Care Victoria Clinical Governance Framework and AV’s own Best Care Framework.

Membership includes AV Directors (each with extensive health service and clinical governance experience), paramedic observers and Community Advisory Committee members.

The committee maintains an ongoing commitment to evolving its knowledge and consideration of new clinical governance practices and frameworks, comprehensive quality and safety reporting, and ways to effectively monitor and measure patient care, safety and experience. This is supported by the connection of its directors to emerging best practices across public health generally, as well as the advancements in data and clinical practices delivered by management.

Patient case examples remain a consistent part of this committee’s work plan, to provide members with a direct connection to patient experiences, AV clinical practices and clinical governance performance.

Members traditionally meet at least annually with the Audit and Risk Committee and the Community Advisory Committee on shared areas of interest and responsibility.

### People and Culture Committee

The purpose of the People and Culture Committee is to advise the Board on material policies and strategies to improve the health, safety, wellbeing, development and performance of AV employees. The committee monitors the development and implementation of strategies to ensure the organisation fosters and promotes a positive culture that enables delivery of high-quality patient care, and a safe and supportive environment for all staff.

The committee’s concentration points continue to align with: workforce health, safety, workplace cultural programs, staff engagement, operational structure reviews, emerging technology practices relevant to clinical performance and manual handling, strategic workforce planning, and other imperatives that collectively enhanced outcomes for our people.

In 2021-2022, the committee maintained a strong focus on the health, safety and wellbeing of AV’s workforce, which has included overseeing management’s development of various related strategies, plans and work programs. Management’s development of internal leadership capability has also been a key focus of this forum over the past year.

### Community Advisory Committee

The Community Advisory Committee (CAC) informs and guides the Board and Executive on key issues associated with AV’s work with the community.

Independent community members come from a diverse range of backgrounds, experience and education sets and have been an important part of the CAC’s successful contribution to service design planning and AV’s patient care commitments.

Chaired by an AV Board Director, the CAC reports regularly to the Board, including on the progress of AV’s Community and Consumer Engagement Plan 2020-2022. The CAC has become a valued source of patient, consumer, and community insights as to how we can better deliver our services.

In March 2021, the Board approved a new strategic direction for the CAC, requesting it to focus its expertise on community while allowing the consumer component to be overseen by other governance forums within the organisation and at Board level. However, many CAC activities, including the joint meeting, were not undertaken this year due to the pressures arising from the COVID-19 pandemic.

# Board Director Profiles

## BOARD CHAIR

### Mr Ken Lay AO APM

Ken Lay is a professional non-executive Director and was appointed AV Board Chair in December 2015.

Ken's career was with Victoria Police, concluding as the Chief Commissioner (2011-2015). He has since conducted a number of reviews for both state and federal governments concerning significant social policy, community safety, governance and leadership issues.

In 2021-2022, Ken’s Board portfolio continued to include the National Heavy Vehicle Regulator Board (Director), and chairing roles with Ambulance Victoria and the Victorian Institute of Forensic Mental Health (Forensicare). In July 2020, he was appointed by the Victorian State Government to lead a review into establishing a second supervised injecting room in Melbourne which remains ongoing.

Ken is an Officer of the Order of Australia and an Australian Police Medal recipient. He has also been admitted to the degree of Doctorate of Laws (Honoris Causa) by Monash University.

Ken attends a variety of Committee meetings in an ex officio capacity throughout the year and is a permanent member of the People and Culture Committee. He also chairs AV’s Remuneration and Nominations Committee.

## BOARD MEMBERS

#### Wenda Donaldson

Wenda Donaldson has been an AV Board Director since July 2020.

Wenda is a public sector and not-for-profit senior executive, combining her non-executive Board career with her role as a General Manager at Uniting Victoria/Tasmania. Previous executive roles have been held with the Australian Red Cross, Australian Department of Education and the Australian Sports Commission.

Wenda has proven expertise in advocacy for policy reform and investment to enhance outcomes for those experiencing vulnerability or disadvantage. She has also been involved in the establishment of inter-governmental and multi-sector partnership agreements to deliver on major public policy reforms.

Previous governance roles have included Chair of the Refugee and Asylum Seeker Reference Group, State Emergency Management Team, Panel Member – Bourke Street Mall Fund, Indigenous Reading Project, ACT Justice Reform Advisory Committee and the ACT One Canberra Reference Group.

Wenda is a member of the Board’s People and Culture Committee and the Quality and Safety Committee.

#### Dr Joanna Flynn AM

Dr Jo Flynn has been an AV Board Director since December 2015.

Jo is a medical practitioner and has held many governance and advisory roles in health at federal and state level over many years.

Jo is the President of Berry Street. She also chairs the Ministerial Advisory Committee advising the Minister for Health regarding Health Board appointments.

Across her significant governance career, Jo was Chair of Eastern Health (10 years) and the Medical Board of Australia (nine years). She has recently completed a term as a Board Director of Forensicare.

She is a member of the Order of Australia and in 2018 was recognised in the Victorian Public Sector’s Top 50 Public Sector Women Awards.

Jo has chaired AV’s Quality and Safety Committee since 2016 and is also a member of the Remuneration and Nominations Committee, and the Community Advisory Committee.

#### Ian Forsyth

Ian Forsyth has been an AV Board Director since December 2015.

After a private and public sector executive career including more than three decades’ experience developing and leading teams across complex, high profile and transitioning organisations, Ian recently retired as an executive, with the goal of assisting other companies as an adviser or board director.

Current Board Director appointments include the Australian Centre for the Moving Image (ACMI), the Emergency Services Foundation, and the Victorian Institute of Forensic Mental Health (Forensicare).

Most recently as managing director with one of Australia’s leading behaviour change communication consultancies, Ian’s executive roles included Deputy CEO, WorkSafe Victoria, Managing Director, Norwich Union Life Australia and Chief Information Officer, Transport Accident Commission (TAC).

In 2020-2021, Ian continued to chair Ambulance Victoria’s Finance Committee. He is also a member of the Audit and Risk Committee and the People and Culture Committee.

#### Colleen Furlanetto OAM

Colleen Furlanetto has been an AV Board Director since July 2020.

Colleen is a noteworthy advocate in the fields of disability and inclusion, authentically embodying the principle that ‘Diversity is a Fact, Inclusion is a Choice’ and carrying that concept into all her volunteer and business endeavours.

She lives a life of service, advocating strongly for connection, support, and inclusion for people with a disability. Believing that ‘Access and Inclusion are a Human Right’, she strives to ensure that all people have the opportunity to engage in active citizenship in their local communities and the wider world.

Awarded the Order of Australia Medal (OAM) in 2020 for Service to Community, Disability and Health, Colleen has also held various disability portfolios along with extensive committee roles regarding safety and inclusion for Victorians with a disability.

With significant networks across Victoria, including Local and State Government agencies, organisations, and departments, Colleen is currently a member of boards servicing community in Health, Disability, Emergency management, Community Services and Advocacy.

#### Michael Gorton AM

Michael Gorton has been an AV Board Director since December 2015.

Michael’s extensive commercial and public sector career has spanned more than 28 years, advising the health and medical sectors on all aspects of commercial law, corporate and clinical governance, and risk management.

In addition to his role as a senior partner of Russell Kennedy Lawyers, Michael remains the Chair of Alfred Health and Wellways Australia Ltd. Michael continues to Chair the Department of Health Information Sharing Legislation Reform Advisory Group and the Mental Health and Wellbeing Act Expert Advisory Group.

Michael is a founding member of the International Academy for Quality and Safety in Health Care and is also an Honorary Fellow of the Royal Australasian College of Surgeons (RACS) and the Australian and Aotearoa New Zealand College of Anaesthetists (ANZCA). In recognition of his substantial contributions to the community, Michael was awarded a Member of the Order of Australia.

Michael is a member of AV’s Audit and Risk, Quality and Safety, and Remuneration and Nominations committees.

#### Anna Leibel

Anna Leibel has been an AV Board Director since July 2019.

Anna was previously the Chief Technology and Delivery Officer with superannuation fund UniSuper and had earlier led Digital Transformations with PwC, Telstra, IBM and NAB. In 2020-2021, Anna co-authored and published her first book on cyber security risk governance for Boards. She also retains her private consulting firm 110% Consulting and continues as a partner within The Secure Board Advisory. In 2021-2022, Anna commenced as a Non-Executive Director with Alfred Health and Secure Electronic Registries Victoria.

In July 2021 Anna was appointed as the Chair of the Audit and Risk Committee. She also served as a member of the Finance and Remuneration and Nominations committees. Ms Leibel concluded her tenure with Ambulance Victoria on 30 June 2022.

#### Peter Lewinsky

Peter Lewinsky has been an AV Board Director since December 2015.

Peter has an extensive private and public sector career spanning investment banking, corporate and government advisory, and stockbroking both in Australia and internationally. Over the past 26 years, he has been appointed across various Victorian Government departments in governance roles, often as a finance, audit and risk specialist.

Peter’s appointments in 2021-2022 included Chair, Audit and Risk Committee, Department of Jobs, Precincts and Regions and Primary Compliance Officer, Victorian Independent Tribunal (DPC).

Peter continues to be Chair of Holmesglen Institute, TAL Superannuation Ltd, the Audit and Risk Committee (Department of Environment, Land, Water and Planning), Audit and Risk Committees of each of the Labour Hire Authority Victoria, Essential Services Commission and the Environment, Planning and Sustainable Development Directorate in the ACT.

Peter has been AV’s Chair of the Audit and Risk Committee and a member of the Finance Committee since January 2016. Previous appointments also included membership of the Remuneration and Nominations Committee and the People and Culture Committee.

#### Greg Smith AM

Greg Smith has been an AV Board Director since December 2015.

Greg has enjoyed an extensive career in conciliation and arbitration, both in Australia and overseas, through his previous roles with the Conciliation and Arbitration Commission, Industrial Relations Commission and Fair Work Commission. His skills in resolving industrial disputes across a range of industry sectors through conciliation, mediation and arbitration span over 30 years.

Greg retains his position as a Director on the Board of Zoos Victoria and as Chair of the State-wide Classification Committee for the Australian Nurses and Midwifery Federation and the Victorian Hospitals’ Industrial Association. New appointments this past year included his role as Chair of the ACT Government’s Disciplinary Appeals Panel and a member of the newly established Independent Review into the Culture of Victoria’s Prison System.

Greg holds the award of Member of the Order of Australia.

He remains Chair of AV’s People and Culture Committee (a role held since January 2016) and was a member of the Finance Committee from September 2021 through until the conclusion of his tenure with AV on 30 June 2022.

# Meetings

|  | Board | | Finance Committee | | Audit & Risk Committee | | Quality & Safety Committee | | People & Culture Committee | | Community Advisory Committee | | Rem & Nom Committee | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Chair: K Lay AO APM | | Chair:  I Forsyth | | Chair:  P Lewinsky | | Chair:  Dr J Flynn AM | | Chair:  G Smith AM | | Chair:  C Furlanetto OAM | | Chair:  K Lay AO APM | |
|  | H[[29]](#footnote-29) | A[[30]](#footnote-30) | H[[31]](#footnote-31) | A[[32]](#footnote-32) | H[[33]](#footnote-33) | A[[34]](#footnote-34) | H[[35]](#footnote-35) | A[[36]](#footnote-36) | H[[37]](#footnote-37) | A[[38]](#footnote-38) | H[[39]](#footnote-39) | A[[40]](#footnote-40) | H[[41]](#footnote-41) | A[[42]](#footnote-42) |
| Board of Directors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| K Lay AO APM (AV Chair) | 14 | 14 | Ex officio |  | Ex officio |  | Ex officio |  | 4 | 4 | Ex officio |  | 2 | 2 |
| C Furlanetto OAM | 14 | 14 | 7 | 6 |  |  | 1 | 1 |  |  | 3 | 3 |  |  |
| W Donaldson | 14 | 13 |  |  |  |  | 5 | 5 | 4 | 4 |  |  |  |  |
| Dr J Flynn AM | 14 | 14 |  |  |  |  | 5 | 5 |  |  | 3 | 3 | 1 | 1 |
| I Forsyth | 14 | 14 | 7 | 6 | 1 | 1 |  |  | 4 | 3 |  |  |  |  |
| M Gorton AM | 14 | 13 |  |  | 5 | 4 | 5 | 5 |  |  |  |  | 1 | 1 |
| P Lewinsky | 14 | 14 | 7 | 7 | 5 | 5 |  |  |  |  | 5 | 5 | 2 | 2 |
| A Leibel | 14 | 13 | 1 | 1 | 5 | 5 |  |  | 4 | 4 |  |  | 1 | 1 |
| G Smith AM | 14 | 13 | 7 | 5 |  |  |  |  | 4 | 4 |  |  | 1 | 1 |
| T Santo[[43]](#footnote-43) |  |  |  |  |  |  | 1 | 1 |  |  |  |  |  |  |
| Jessica Handley[[44]](#footnote-44) |  |  |  |  |  |  | 2 | 2 |  |  |  |  |  |  |
| James Shuttleworth[[45]](#footnote-45) |  |  |  |  |  |  | 2 | 2 |  |  |  |  |  |  |
| J Drake[[46]](#footnote-46) |  |  |  |  |  |  | 5 | 5 |  |  | 3 | 3 |  |  |
| S Porter[[47]](#footnote-47) |  |  |  |  |  |  | 5 | 4 |  |  | 3 | 2 |  |  |
| A Gardiner[[48]](#footnote-48) |  |  |  |  |  |  |  |  |  |  | 3 | 2 |  |  |
| P Kirkpatrick[[49]](#footnote-49) |  |  |  |  |  |  |  |  |  |  | 3 | 3 |  |  |
| R Coverdale[[50]](#footnote-50) |  |  |  |  |  |  |  |  |  |  | 3 | 3 |  |  |
| Hana Williamson[[51]](#footnote-51) |  |  |  |  |  |  |  |  |  |  | 3 | 3 |  |  |
| Kane Treloar[[52]](#footnote-52) |  |  |  |  |  |  |  |  |  |  | 1 | 0 |  |  |
| Zaineb Mourad[[53]](#footnote-53) |  |  |  |  |  |  |  |  |  |  | 1 | 1 |  |  |
| David McCarthy[[54]](#footnote-54) |  |  |  |  |  |  |  |  |  |  | 1 | 1 |  |  |

# Executive Group

### Chief Executive Officer

##### Professor Tony Walker ASM

(Medical leave from Mar 2022)

##### Elizabeth Murphy APM

(Acting Mar to Apr 2022)

##### Felicity Topp

(Interim from May 2022, seconded from Peninsula Health)

Responsible to the Board of Directors for the overall management and performance of AV.

### Chief Operating Officer

##### Mark Rogers ASM (Jul to Aug 2021)

##### Elizabeth Murphy APM (from Aug 2021)

Responsible to the CEO to ensure a collaborative approach to the delivery of integrated, effective and efficient state-wide operational services in line with organisational performance targets. This includes the management of response to the community and logistical services.

### Executive Director Clinical Operations

##### Associate Professor Mick Stephenson ASM

Responsible for the provision of quality state-wide emergency ambulance operations with Advanced Life Support (ALS) and Mobile Intensive Care (MICA) paramedics, Ambulance Community Officer (ACO) and Community Emergency Response Teams (CERT), and delivery of Ambulance Victoria’s specialist Complex Care services.

### Executive Director Corporate Services

##### Garry Button

Responsible for AV’s financial strategy, financial and management accounting services, including compliance with accounting standards, taxation, billing and debt collection, commercial and procurement services, property services, legal and Freedom of Information. Corporate Services is also responsible for asset management, privacy advice, audit and risk management, strategic planning, major projects as well as the Ambulance Victoria Membership Scheme.

### Executive Director Transformation and Strategy

##### Jill Fitzroy (until Dec 2021)

Division was dissolved in January 2022.

Previously responsible for the strategic design and delivery of digital and service transformation.

### Executive Director People and Culture

##### Rebecca Hodges

(Jul 2021 to Feb 2022)

##### Alison Goss

(Acting since Feb 2022)

Responsible for providing leadership and direction for the organisation’s workforce strategy, organisational development and cultural programs. This includes diversity and inclusion, professional conduct, and expertise and support in the areas of health and safety, wellbeing and support services, human resources, employee relations and payroll services.

### Executive Director Communication and Engagement

##### Rebecca Hodges

(acting until Jan 2022)

##### Nichola Holgate

(commenced Jan 2022)

Responsible for leadership of strategic internal and external communication; engaging our people, community and stakeholders with Ambulance Victoria’s contemporary role in Victoria’s public health system.

### Executive Director Quality and Patient Experience

##### Nicola Reinders

Responsible for providing leadership and direction for clinical governance, patient safety and quality systems, and supporting a culture of continuous improvement in the delivery of patient-centred care to ensure AV delivers Best Care every time.

### Executive Director Operational Communications

##### Anthony Carlyon

Responsible for coordinating and optimising state-wide emergency and non-emergency ambulance response, and the provision of patient care through telehealth services including Nurse on Call and Ambulance Victoria Referral Service.

### Executive Director Operational Strategy and Integration

##### Mark Rogers ASM

(commenced Aug 2021)

Operational Strategy and Integration focuses on delivery of priorities in relation to driving sustainability, operational strategy, service innovation and improvement to create a collaborative and integrated approach to support AV better to deliver Best Care and improving performance outcomes by using its resources as efficiently as possible.

### Executive Director Equality and Workplace Reform

##### Simone Cusack

(commenced Mar 2022)

Responsible for providing leadership of AV’s program of work to implement and oversee the long-term and meaningful reforms needed to make AV a safe, fair and inclusive organisation for our people and our patients. Established in 2022, the creation of the Equality and Workplace Reform division achieves implementation of Recommendation 11 arising from the VEOHRC Independent review into workplace equality in AV.

### Medical Director

##### Dr David Anderson MStJ FICICM

Responsible for providing expert medical advice, clinical research, and development of clinical practice guidelines.

### Chief Information Officer

##### Gavin Gusling

(commenced Sep 2021)

Accountable and responsible for ICT strategy, digital and technology innovation, security and policy setting. Development of systems architecture, ICT led project delivery, major system changes or introduction / integration of new systems, master data management and data governance. Also responsible for data sharing agreements, ongoing maintenance of applications and infrastructure and hardware, including real-time support for IT end-users consistent with our service level objectives.

# Executive Structure

Ambulance Victoria Board of Directors

* Chair Ken Lay
* Chief Executive Officer, Tony Walker – reporting to Chair Ken Lay
* Medical Director, Dr David Anderson– reporting to Chief Executive Officer Tony Walker
* Executive Director Strategy and Integration, Mark Rogers – reporting to Chief Executive Officer Tony Walker
* Executive Director Quality and Patient Experience, Nicola Reinders – reporting to Chief Executive Officer Tony Walker
* Executive Director Corporate Services, Garry Button – reporting to Chief Executive Officer Tony Walker
* Chief Operations Officer, Elizabeth Murphy – reporting to Chief Executive Officer Tony Walker
* Chief Information Officer, Gavin Gusling – reporting to Chief Executive Officer Tony Walker
* Executive Director Equality and Workplace Reform, Simone Cusack – reporting to Chief Executive Officer Tony Walker
* Executive Director People and Culture, Alison Goss (acting) – reporting to Chief Executive Officer Tony Walker
* Executive Director Communication & Engagement, Nichola Holgate – reporting to Chief Executive Officer Tony Walker
* Executive Director Operational Communications, Anthony Carlyon – reporting to Chief Operations Officer Elizabeth Murphy
* Executive Director Clinical Operations, Mick Stephenson – reporting to Chief Operations Officer Elizabeth Murphy

# Statement of Priorities

AV's Statement of Priorities is the key service delivery and accountability agreement between Ambulance Victoria and the Victorian Government. This agreement facilitates delivery of, or progress towards, the government’s commitments for the financial year.

### Part A Summary

| Strategic Priorities | Deliverables | Outcome |
| --- | --- | --- |
| COVID-19 READINESS AND RESPONSE | | |
| Maintain your robust COVID-19 readiness and response, working with my department to ensure we rapidly respond to outbreaks, if and when they occur, which includes providing testing for staff where necessary and if required. This includes participating in the implementation of our COVID-19 vaccine immunisation program rollout, ensuring the community’s confidence in the program. | AV will support the Victorian Government and community in ensuring readiness and response to COVID-19 through:   * Maintenance of the AV COVID-19 Pandemic SubPlan, including iteration as required to ensure appropriate response to the pandemic. * Maintaining a surge workforce to minimise the effects of unplanned leave during the pandemic. * Providing testing for AV personnel where necessary and if required. * Supporting implementation of the COVID-19 vaccine immunisation program to AV personnel. | The updated AV COVID-19 Pandemic SubPlan was in place since November 2021.  An additional 160 surge responders were trained and made available for operational duties since Quarter 3 (total 1314). This includes 30 Australian Defence Force (ADF) personnel, who were due to complete a duty rotation on 30 June 2022.  Revised AV COVID-19 Workplace Attendance Requirements remain in place, and are regularly reviewed against public health order requirements. COVID-19 surveillance testing via Rapid Antigen Test (RAT) remain in place for all operational staff, and staff working in critical areas.  On 10 January 2022, the Victorian Government announced that workers in key sectors including Emergency Services who were already required to be fully vaccinated (two doses) against COVID-19 would be required to get their third dose within the specified timeline. The final booster deadline for AV employees was 29 March 2022 (extended from 12 March 2022). All eligible staff are vaccinated or have an appropriate exemption, aside from a small number of employees who were issued with show cause notices on 4 June 2022 in relation to their vaccination status. This process is currently active. |
| HOSPITAL HANDOVER ENHANCEMENT | | |
| Work collaboratively with Emergency Departments to ensure improved and efficient handover processes. | AV will work collaboratively with Emergency Departments to improve handover processes through:   * Ongoing representation on the Ambulance Patient Transfer Taskforce. * Participation in the sector wide review of transfer times and implement Taskforce recommendations. | COVID-19 response continues to slow progress of the Taskforce recommendations.  Geographical catchments were removed at 7am on 22 June 2022 to enable better distribution of lower acuity patients to smaller metropolitan health services.  Ambulance Patient Offload Teams (APOT) and now Ambulance Victoria Offload (AVOL) have expanded at Health Services state-wide, with both Latrobe Regional Hospital and Bass Coast commencing. Ambulance managers continue to be rostered daily to assist with ramping, escalation and patient flow.  A joint three-week pilot program commenced for a daily 6pm Senior Consultant and Register led review of patients on stretchers at three sites (Austin, Box Hill and Sunshine).  There is continued daily and weekly engagement with Health Services state-wide to discuss strategies for improved patient transfer. Hospital capacity and internal patient flow remains restricted.  AV response performance is increasingly impacted by hospital transfer times.  AV has ongoing participation in the ‘Medical Emergency Response Times’ working group convened by Department of Premier & Cabinet (DPC). Progressive expansion of Victorian Virtual Emergency Department (VVED) state-wide for all patients is demonstrating benefits in reducing Emergency Department demand.  The Ambulance Victoria Offload (AVOL) strategy expansion demonstrates early improvement. |
| AMBULANCE PERFORMANCE IMPROVEMENT PLAN (APIP) | | |
| Commence delivery of the government’s $121 million Ambulance Improvement Plan (AIP) to update AV’s operating model to better meet the emergency health needs of Victorians. Progress and implementation of initiatives will be reported via the AIP steering committee. | The Ambulance Performance Improvement Program 2022-2025 will implement a suite of practical initiatives to deliver operational change to improve Code 1 response performance, in recognition of continued increase in Triple Zero (000) demand, as follows:   * Expand AVs secondary triage, which connects Triple Zero (000) callers who do not need an ambulance, with alternative care providers. * Recruit additional mental health staff to expand TelePROMPT to 24-hours. * Recruit additional staff to Operational Communication centres to support increased workload and demand. * Introduce a new medium acuity patient transport service across the state, including vehicles and staff to target medium acuity workload. * Convert four on-call locations to 24-hour coverage – Cobram, Mansfield, Yarrawonga and Korumburra. * Four rural Peak Period Units operating out of Moe, Bendigo, Warragul and Leongatha. | * The Ambulance Performance Improvement Program 2022-2025 Year 1 progress against deliverables is as follows: * The Secondary Triage Program has progressed recruitment of 31 Referral Service Triage Practitioners against a program target of 43 FTE. The program is on track for September 2022 completion, with the second recruitment campaign launched in April 2022. * Additional mental health staff have been engaged through mental health providers and the government funded TelePROMPT service now operates 24 hours a day, 7 days a week. * Following the introduction of additional Clinical Support Paramedics earlier in the year, the introduction of additional clinicians into both the metro and regional communications centres is on track for completion in August 2022. * 22 Medium Acuity Transport Units (MATS) continue to operate effectively across the state. The transition of our first MATS Graduate Bridging Paramedics (GBP) into the Graduate Ambulate Paramedic Program will occur in August 2022. As part of this process, a new group of MATS graduates will commence in the MATS pilot program. * Korumburra, Mansfield, Yarrawonga and Cobram have been successfully converted to 24-hour coverage. * Peak Period Units at Leongatha, Moe, Bendigo and Warragul have been implemented. |
| MENTAL HEALTH ROYAL COMMISSION REFORM | | |
| Work with the Department of Health, Department of Justice and Community Services, Victoria Police and the Emergency Services Telecommunications Authority to deliver initial planning and design for the implementation of Recommendation 10 of the Royal Commission into Victoria’s Mental Health System to enshrine health-led responses to mental health crises. | The Final Report of the Royal Commission into Victoria’s Mental Health System sets out the reform agenda to redesign Victoria’s mental health and wellbeing system including 65 recommendations. Specific to AV is recommendation 10, which details the requirements of emergency services when responding to mental health crises. AV will:   * Develop an implementation plan in response to the Royal Commission into Victoria’s Mental Health System Final Report. * Commence implementation of initiatives aligned to recommendation 10 of the report so that we can improve patient outcomes and experience, reduce emergency demand and create greater job satisfaction for paramedics. | In response to Recommendation 10 of the Final Report of the Royal Commission into Victoria’s Mental Health System, AV has progressed deliverables as follows:   * A detailed and dynamic Implementation Plan has been developed with our partner agencies and implementation initiatives have commenced. * The 'project initiation phase' nears completion with the development of project management tools, current state data and interdependency mapping. * Workstreams have commenced, including Legislation, Clinical Safety & Patient Experience (CSPE) and Service Design. * AV has provided critical input into the draft Mental Health & Wellbeing Bill comprising of 10 chapters and an addendum. |
| VICTORIAN EQUAL OPPORTUNITY AND HUMAN RIGHTS COMMISSION REVIEW | | |
| Develop a detailed plan to implement recommendations contained in Volumes 1 and 2 of the final report from the Victorian Equal Opportunity and Human Rights Commission’s independent review into workplace equality in Ambulance Victoria. | The Victorian Equal Opportunity and Human Rights Commission (VEOHRC) will conduct an independent review of AV, focused broadly on workplace equality. AV will:   * Support the Independent Review into Workplace Equality in AV. * Develop an implementation plan in response to VEOHRC’s final report and commence implementation of high priority recommendations. | AV developed a draft implementation plan – Safe Fair Inclusive: Your AV Roadmap 2022-27 – and consulted with the workforce, unions and other key partners on its critical elements. This included the proposed governance framework, sequencing and prioritisation of reforms to reflect AV’s response and the roadmap forward.  The Equality & Workplace Reform Division has been set up and recruitment for staff to join the division is well underway.  AV has also begun implementing the VEOHRC recommendations, including:   * Making work environments more secure by installing privacy locks across all regional and metro buildings. * Developing tender documents to engage a consultancy to support the redesign of AV’s organisational values. * Researching independent providers of restorative engagement schemes and the key elements of each scheme, which are now under consideration for AV to determine the way forward. * Identifying a service provider to administer ‘anonymous reporting pathways’; enabling staff to raise concerns about unlawful or harmful workplace conduct without providing identifying information. * Progressing work to create a fair report and complaint system. |
| ABORIGINAL AND TORRES STRAIT ISLANDER CULTURAL SAFETY FRAMEWORK | | |
| Embed the Aboriginal and Torres Strait Islander Cultural Safety Framework into our organisation. Build a continuous quality improvement approach to improving cultural safety, underpinned by Aboriginal self-determination, to ensure delivery of culturally safe care to Aboriginal patients and families, and to provide culturally safe workplaces for Aboriginal employees. | AV is committing to establishing an enduring partnership with Aboriginal and Torres Strait Islander communities to improve the cultural safety of our organisation and enhance the provision of culturally appropriate care for our patients. AV will:   * Establish a cross functional working group to support AV's work to embed the eight cultural safety framework principles across the organisation. The group’s program of work to be governed by the Diversity and Inclusion Council. * Continue to progress and deliver key actions outlined in AV's Cultural Safety & Equity Action Plan (Phase 3). * Endorse and include relevant cultural safety actions as part of AV's Reflect Reconciliation Action Plan. | AV continues its commitment to creating culturally safe environments for all who work and volunteer with us.  The establishment of the Equality & Workplace Reform Division includes a dedicated program lead with the remit for the program of work to lead cultural safety for Aboriginal and Torres Strait Islander peoples. With recruitment in progress, it is forecast for the team to be established by September 2022. In addition, a new governance structure has been established to oversee the Equality & Workplace Reform program of work, including a Steering Committee with employee representatives, senior leaders, external specialists, and union representatives. This governance of the work to embed Aboriginal and Torres Strait Islander Cultural Safety will formally transition to this Steering Committee.  The Cultural Safety & Equity Action Plan has continued to progress, including the engagement of a designer to prepare a cultural safety symbol for use across AV. An Aboriginal artist has been commissioned to design the cultural safety symbol artwork and it is expected to be released in conjunction with AV’s first Reconciliation Action Plan.  AV's draft Reconciliation Action Plan was submitted to Reconciliation Australia for second review and endorsement in May 2022 with feedback for further amendment received in June 2022. A third draft is in development to be submitted for further feedback. |

# Performance Priorities

## Statement of Priority Part B

|  | 2021-22 Target | 2021-22 Actual |
| --- | --- | --- |
| HIGH QUALITY & SAFE CARE | | |
| Accreditation | | |
| Certification to the ISO Standard ISO 9001:2015 | Certified | Certified |
| Infection prevention and control | | |
| Percentage of healthcare workers immunised for influenza[[55]](#footnote-55) | 90.0% | 54.4% |
| Quality and safety | | |
| Percentage of respondents who rated care, treatment, advice and/or transport received from the ambulance service as good or very good[[56]](#footnote-56) | 95.0% | 96.1% |
| Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly[[57]](#footnote-57) | 90.0% | 92.6% |
| Percentage of adult stroke patients transported to definitive care within 60 minutes[[58]](#footnote-58) | 90.0% | 98.3% |
| Percentage of major trauma patients that meet destination compliance[[59]](#footnote-59) | 85.0% | 94.8% |
| Percentage of adult cardiac arrest patients surviving to hospital[[60]](#footnote-60) | 50.0% | 54.7% |
| Percentage of adult cardiac arrest patients surviving to hospital discharge[[61]](#footnote-61) | 25.0% | 28.3% |
| Percentage of respondents who rated care and treatment received from paramedics as good or very good | 95.0% | 97.7% |
| STRONG GOVERNANCE, LEADERSHIP AND CULTURE | | |
| Organisational culture | | |
| People matter survey – percentage of staff with an overall positive response to safety and culture questions[[62]](#footnote-62) | 62.0% | 75.0% |
| TIMELY ACCESS TO CARE | | |
| Response times Statewide | | |
| Percentage of emergency Code 1 incidents responded to within 15 minutes[[63]](#footnote-63) | 85% | 67.5% |
| Percentage of emergency Priority 0[[64]](#footnote-64) incidents responded to within 13 minutes | 85% | 76.9% |
| Response times Urban | | |
| Percentage of emergency Code 1 incidents responded to within 15 minutes in centres with a population greater than 7,500[[65]](#footnote-65) | 90.0% | 71.9% |
| 40-minute transfer | | |
| Percentage of patients transferred from ambulance to ED within 40 minutes | 90.0% | 61.3% |
| Call referral | | |
| Percentage of triple zero cases where the caller receives advice or service from another health provider as an alternative to an emergency ambulance response – statewide | 15.0% | 19.8% |
| Clearing time | | |
| Average ambulance hospital clearing time[[66]](#footnote-66) | 20 mins | 29 mins |

# Statistical Summary

|  | 2021-22 | 2020-21[[67]](#footnote-67) | 2019-20 | 2018-19 | 2017-18 | 2016-17[[68]](#footnote-68) |
| --- | --- | --- | --- | --- | --- | --- |
| EMERGENCY ROAD INCIDENTS | | | | | | |
| METROPOLITAN REGIONS | | | | | | |
| Code 1 | 266,066 | 223,062 | 217,717 | 213,557 | 205,555 | 200,960 |
| Code 2 | 143,904 | 163,020 | 163,968 | 160,169 | 160,926 | 151,974 |
| Code 3 | 54,479 | 64,704 | 59,571 | 58,565 | 50,105 | 46,625 |
| Total Metropolitan Emergency Road Incidents | 464,449 | 450,786 | 441,256 | 432,291 | 416,586 | 399,559 |
| RURAL REGIONS | | | | | | |
| Code 1 | 111,320 | 100,504 | 92,373 | 87,779 | 81,776 | 78,372 |
| Code 2 | 73,210 | 77,816 | 72,965 | 70,722 | 69,755 | 66,533 |
| Code 3[[69]](#footnote-69) | 33,529 | 31,386 | 27,366 | 27,923 | 23,898 | 22,028 |
| Total Rural Emergency Road Incidents | 218,059 | 209,706 | 192,704 | 186,424 | 175,429 | 166,933 |
| ALL REGIONS | | | | | | |
| Code 1 | 377,386 | 323,566 | 310,090 | 301,336 | 287,331 | 279,332 |
| Code 2 | 217,114 | 240,836 | 236,933 | 230,891 | 230,681 | 218,507 |
| Code 3[[70]](#footnote-70) | 88,008 | 96,090 | 86,937 | 86,488 | 74,003 | 68,653 |
| Total Statewide Emergency Road Incidents | 682,508 | 660,492 | 633,960 | 618,715 | 592,015 | 566,492 |
| NON-EMERGENCY ROAD INCIDENTS | | | | | | |
| Total Metropolitan Non-Emergency Road Incidents[[71]](#footnote-71) | 263,112 | 258,798 | 254,020 | 246,594 | 235,627 | 229,921 |
| Total Rural Non-Emergency Road Incidents[[72]](#footnote-72) | 97,282 | 96,748 | 85,710 | 74,865 | 61,441 | 53,551 |
| Total Statewide Non-Emergency Road Incidents | 360,394 | 355,546 | 339,730 | 321,459 | 297,068 | 283,472 |
| Total Metropolitan Road Incidents[[73]](#footnote-73) | 727,561 | 709,584 | 695,276 | 678,885 | 652,213 | 629,480 |
| Total Rural Road Incidents | 315,341 | 306,454 | 278,414 | 261,289 | 236,870 | 220,484 |
| ROAD INCIDENTS (ALL REGIONS) | | | | | | |
| Emergency Code 1 | 377,386 | 323,566 | 310,090 | 301,336 | 287,331 | 279,332 |
| Emergency Code 2 | 217,114 | 240,836 | 236,933 | 230,891 | 230,681 | 218,507 |
| Emergency Code 3[[74]](#footnote-74) | 88,008 | 96,090 | 86,937 | 86,488 | 74,003 | 68,653 |
| Non-Emergency[[75]](#footnote-75) | 360,394 | 355,546 | 339,730 | 321,459 | 297,068 | 283,472 |
| Total Road Incidents[[76]](#footnote-76) | 1,042,902 | 1,016,038 | 973,690 | 940,174 | 889,083 | 849,964 |
| AIR INCIDENTS (ALL REGIONS) | | | | | | |
| Fixed Wing – Emergency | 1,962 | 2,017 | 1,771 | 2,235 | 2,437 | 2,298 |
| Fixed Wing – Non-Emergency[[77]](#footnote-77) | 3,320 | 3,048 | 2,693 | 2,661 | 2,255 | 2,253 |
| Total Fixed Wing Incidents[[78]](#footnote-78) | 5,282 | 5,065 | 4,464 | 4,896 | 4,692 | 4,551 |
| HELICOPTERS | | | | | | |
| Helicopter (HEMS 1 Essendon) | 563 | 612 | 554 | 617 | 591 | 392 |
| Helicopter (HEMS 2 Latrobe Valley) | 461 | 501 | 449 | 505 | 499 | 452 |
| Helicopter (HEMS 3 Bendigo) | 516 | 551 | 463 | 532 | 521 | 424 |
| Helicopter (HEMS 4 Warrnambool) | 361 | 355 | 331 | 342 | 345 | 282 |
| Helicopter (HEMS 5 Retrieval) | 575 | 623 | 546 | 591 | 593 | 578 |
| Total Helicopter Incidents (All Emergency) | 2,476 | 2,642 | 2,343 | 2,587 | 2,549 | 2,128 |
| Emergency Air Incidents | 4,438 | 4,659 | 4,114 | 4,822 | 4,986 | 4,426 |
| Non-Emergency Air Incidents[[79]](#footnote-79) | 3,320 | 3,048 | 2,693 | 2,661 | 2,255 | 2,253 |
| Total Air Incidents[[80]](#footnote-80) | 7,758 | 7,707 | 6,807 | 7,483 | 7,241 | 6,679 |
| ADULT RETRIEVAL | | | | | | |
| Cases handled | 6,365 | 5,587 | 4,833 | 5,172 | 5,178 | 4,897 |
| RETRIEVALS4 | | | | | | |
| Road retrievals – ARV Crew (Doctors  and/or Critical Care Registered Nurse | 829 | 571 | 474 | 546 | 652 | N/A |
| Road retrievals – paramedic only | 456 | 477 | 424 | 364 | 368 | 278 |
| Road retrievals – doctor & paramedic | 218 | 218 | 183 | 195 | 228 | 477 |
| Total road retrievals | 1,503 | 1,266 | 1,081 | 1,105 | 1,248 | 755 |
| Air retrievals – paramedic only | 1,217 | 1,161 | 1,023 | 1,221 | 1,144 | 1,183 |
| Air retrievals – doctor & paramedic | 376 | 531 | 476 | 542 | 549 | 493 |
| Total air retrievals | 1,593 | 1,692 | 1,499 | 1,763 | 1,693 | 1,676 |
| Total adult retrievals | 3,096 | 2,958 | 2,580 | 2,868 | 2,941 | 2,431 |
| CODE 1 RESPONSE TIME | | | | | | |
| Proportion of emergency (Code 1) incidents responded to in 15 minutes or less | 67.5% | 77.2% | 82.3% | 84.0% | 81.8% | 78.3% |
| Proportion of emergency (Code 1) incidents, located in centres with a population greater than 7,500, and responded to in 15 minutes or less[[81]](#footnote-81) | 71.9% | 82.5% | 87.6% | 89.3% | 87.2% | 83.7% |
| REFERRAL SERVICE | | | | | | |
| Percentage of Triple Zero (000) cases resulting in callers receiving health advice or service from another health provider as an alternative to emergency ambulance response[[82]](#footnote-82) | 19.8% | 17.6% | 17.6% | 15.5% | 14.9% | 15.3% |
| PATIENTS TRANSPORTED6 | | | | | | |
| ROAD TRANSPORTS (METROPOLITAN REGIONS) | | | | | | |
| Emergency Operations | 336,014 | 349,714 | 342,400 | 330,564 | 306,127 | 285,484 |
| Non-Emergency Operations Stretcher[[83]](#footnote-83) | 147,335 | 141,464 | 137,461 | 129,745 | 134,466 | 128,389 |
| Total Stretcher | 483,349 | 491,178 | 479,861 | 460,309 | 440,593 | 413,873 |
| Non-Emergency Clinic Transport Services[[84]](#footnote-84) | 93,710 | 99,104 | 100,234 | 97,033 | 89,647 | 82,293 |
| Total Metropolitan Regions | 577,059 | 590,282 | 580,095 | 557,342 | 530,240 | 496,166 |
| ROAD TRANSPORTS (RURAL REGIONS) | | | | | | |
| Total Rural Regions | 231,121 | 236,600 | 224,833 | 211,818 | 187,483 | 176,455 |
| Total Patients Transported by Road | 808,180 | 826,882 | 804,928 | 769,160 | 717,723 | 672,621 |
| AIR TRANSPORTS (ALL REGIONS) | | | | | | |
| Fixed Wing transports[[85]](#footnote-85) | 4,835 | 4,699 | 4,333 | 4,806 | 4,665 | 4,504 |
| HELICOPTERS | | | | | | |
| Helicopter (HEMS 1 Essendon) | 445 | 493 | 461 | 519 | 506 | 324 |
| Helicopter (HEMS 2 Latrobe Valley) | 365 | 405 | 370 | 416 | 428 | 382 |
| Helicopter (HEMS 3 Bendigo) | 431 | 452 | 389 | 446 | 424 | 349 |
| Helicopter (HEMS 4 Warrnambool) | 287 | 307 | 279 | 289 | 295 | 244 |
| Helicopter (HEMS 5 Retrieval) | 453 | 502 | 474 | 505 | 495 | 471 |
| Total Helicopter Transports | 1,981 | 2,159 | 1,973 | 2,175 | 2,148 | 1,770 |
| Total Air Transports[[86]](#footnote-86) | 6,816 | 6,858 | 6,306 | 6,981 | 6,813 | 6,274 |
| Total Patient Transports[[87]](#footnote-87) | 814,996 | 833,740 | 811,234 | 776,141 | 724,536 | 678,895 |
| ROAD PATIENTS TRANSPORTED (ALL REGIONS) – CHARGING CATEGORIES7 | | | | | | |
| COMPENSABLE TRANSPORTS | | | | | | |
| Veterans’ Affairs | 12,908 | 14,199 | 16,400 | 18,382 | 19,980 | 21,413 |
| Transport Accident Commission | 12,310 | 13,055 | 14,701 | 16,046 | 14,789 | 13,153 |
| WorkCover | 3,331 | 3,778 | 3,697 | 3,959 | 3,652 | 3,447 |
| Public Hospital Transfers[[88]](#footnote-88) | 31,246 | 30,306 | 27,949 | 28,441 | 26,732 | 24,712 |
| Private Hospital Transfers[[89]](#footnote-89) | 2,432 | 2,389 | 2,226 | 2,214 | 2,229 | 2,071 |
| Ordinary | 65,210 | 62,315 | 62,790 | 60,768 | 56,782 | 53,863 |
| Subscriber | 164,718 | 164,165 | 155,817 | 146,491 | 132,189 | 123,187 |
| Total Compensable Road Transports | 292,154 | 290,207 | 283,580 | 276,301 | 256,353 | 241,846 |
| Community Service Obligation Road Transports[[90]](#footnote-90) | 508,405 | 528,933 | 513,545 | 487,853 | 453,081 | 422,778 |
| Other[[91]](#footnote-91),[[92]](#footnote-92) | 7,499 | 7,749 | 7,804 | 8,107 | 8,289 | 7,997 |
| Total Patients Transported by Road[[93]](#footnote-93) | 808,058 | 826,889 | 804,929 | 772,261 | 717,723 | 672,621 |

## Code 1 First Response Performance by LGA, 2021-2022

| Local Government Area Name | % Responses <= 15 Minutes | Average Response Times Minutes | Total Number of First Responses |
| --- | --- | --- | --- |
| Interstate LGAs | 50.5% | 20:20 | 1,254 |
| Alpine (S) | 40.6% | 22:47 | 727 |
| Ararat (RC) | 57.5% | 17:49 | 772 |
| Ballarat (C) | 79.6% | 12:53 | 7,973 |
| Banyule (C) | 73.6% | 13:54 | 6,438 |
| Bass Coast (S) | 58.7% | 16:38 | 2,714 |
| Baw Baw (S) | 60.1% | 16:27 | 3,346 |
| Bayside (C) | 71.2% | 14:53 | 3,705 |
| Benalla (RC) | 55.9% | 17:52 | 965 |
| Boroondara (C) | 75.2% | 13:53 | 5,755 |
| Brimbank (C) | 69.0% | 14:40 | 12,190 |
| Buloke (S) | 32.7% | 27:33 | 358 |
| Campaspe (S) | 57.2% | 16:30 | 2,459 |
| Cardinia (S) | 54.8% | 17:09 | 6,337 |
| Casey (C) | 64.9% | 15:12 | 18,634 |
| Central Goldfields (S) | 53.1% | 19:13 | 989 |
| Colac-Otway (S) | 60.1% | 17:33 | 995 |
| Corangamite (S) | 48.9% | 18:30 | 947 |
| Darebin (C) | 76.7% | 13:34 | 8,691 |
| East Gippsland (S) | 53.2% | 19:00 | 3,576 |
| Frankston (C) | 74.4% | 13:30 | 9,361 |
| Gannawarra (S) | 42.8% | 22:02 | 533 |
| Glen Eira (C) | 74.9% | 13:48 | 6,163 |
| Glenelg (S) | 73.2% | 14:11 | 1,074 |
| Golden Plains (S) | 29.7% | 21:06 | 989 |
| Greater Bendigo (C) | 69.3% | 14:40 | 8,281 |
| Greater Dandenong (C) | 74.3% | 13:51 | 9,697 |
| Greater Geelong (C) | 73.3% | 13:38 | 17,186 |
| Greater Shepparton (C) | 71.7% | 14:20 | 5,379 |
| Hepburn (S) | 40.5% | 20:10 | 1,020 |
| Hindmarsh (S) | 52.0% | 20:17 | 400 |
| Hobsons Bay (C) | 67.2% | 14:37 | 5,139 |
| Horsham (RC) | 78.7% | 12:54 | 1,327 |
| Hume (C) | 61.2% | 16:00 | 18,680 |
| Indigo (S) | 28.2% | 23:21 | 749 |
| Kingston (C) (Vic.) | 71.3% | 14:13 | 7,802 |
| Knox (C) | 75.1% | 13:42 | 7,375 |
| Latrobe (C) (Vic.) | 73.3% | 13:07 | 7,164 |
| Loddon (S) | 24.8% | 25:29 | 501 |
| Macedon Ranges (S) | 56.6% | 16:36 | 2,539 |
| Manningham (C) | 67.4% | 15:16 | 5,179 |
| Mansfield (S) | 43.5% | 26:14 | 398 |
| Maribyrnong (C) | 73.1% | 14:12 | 4,282 |
| Maroondah (C) | 77.4% | 13:15 | 5,790 |
| Melbourne (C) | 79.3% | 12:31 | 10,298 |
| Melton (C) | 55.3% | 16:58 | 11,090 |
| Mildura (RC) | 76.6% | 13:30 | 3,908 |
| Mitchell (S) | 52.9% | 17:35 | 2,993 |
| Moira (S) | 46.4% | 20:19 | 2,292 |
| Monash (C) | 70.1% | 14:47 | 8,166 |
| Moonee Valley (C) | 70.4% | 14:36 | 6,326 |
| Moorabool (S) | 46.5% | 18:44 | 1,955 |
| Moreland (C) | 72.0% | 14:20 | 10,387 |
| Mornington Peninsula (S) | 65.5% | 14:48 | 10,307 |
| Mount Alexander (S) | 47.4% | 18:44 | 964 |
| Moyne (S) | 37.8% | 19:27 | 719 |
| Murrindindi (S) | 37.6% | 23:05 | 969 |
| Nillumbik (S) | 50.9% | 17:21 | 2,522 |
| Northern Grampians (S) | 62.1% | 17:30 | 885 |
| Port Phillip (C) | 76.3% | 13:15 | 5,498 |
| Pyrenees (S) | 36.8% | 21:55 | 470 |
| Queenscliffe (B) | 59.7% | 16:35 | 231 |
| South Gippsland (S) | 48.0% | 18:59 | 1,830 |
| Southern Grampians (S) | 63.5% | 16:14 | 816 |
| Stonnington (C) | 74.4% | 14:17 | 4,277 |
| Strathbogie (S) | 28.7% | 23:38 | 890 |
| Surf Coast (S) | 56.0% | 16:26 | 1,697 |
| Swan Hill (RC) | 65.7% | 16:11 | 1,266 |
| Towong (S) | 34.7% | 26:34 | 294 |
| Unincorporated Vic | 40.2% | 30:06 | 87 |
| Wangaratta (RC) | 71.8% | 14:39 | 2,022 |
| Warrnambool (C) | 85.6% | 11:12 | 2,077 |
| Wellington (S) | 51.8% | 18:49 | 2,719 |
| West Wimmera (S) | 34.8% | 24:07 | 201 |
| Whitehorse (C) | 76.2% | 13:27 | 6,849 |
| Whittlesea (C) | 64.5% | 15:22 | 13,511 |
| Wodonga (C) | 75.2% | 13:51 | 2,644 |
| Wyndham (C) | 67.7% | 14:54 | 12,935 |
| Yarra (C) | 79.4% | 12:44 | 4,757 |
| Yarra Ranges (S) | 59.7% | 16:08 | 7,871 |
| Yarriambiack (S) | 37.7% | 25:01 | 462 |
| Total | 67.5% | 15:02 | 363,018 |

The Moonee Valley LGA includes the airport to which a significant number of Code 2 inter hospital transfers (IHTs) arrive. IHTs often have extended response times due to the emergency road ambulance waiting at the airport for the patient to arrive by aircraft. Removing IHTs from the Moonee Valley Code 1 response time results in performance similar to surrounding LGAs.

## Code 1 First Response Performance by UCL > 7500, 2021-2022

| Urban Centre Locality Name >7500 | % Responses <= 15 Minutes | Average Response Times Minutes | Total Number of First Responses |
| --- | --- | --- | --- |
| Albury – Wodonga (Wodonga Part) | 79.2% | 13:21 | 2,411 |
| Bacchus Marsh | 53.8% | 17:23 | 1,137 |
| Bairnsdale | 72.4% | 14:35 | 1,175 |
| Ballarat | 81.2% | 12:39 | 7,517 |
| Benalla | 68.7% | 15:15 | 715 |
| Bendigo | 75.0% | 13:41 | 7,219 |
| Castlemaine | 67.4% | 15:37 | 552 |
| Colac | 78.2% | 13:55 | 624 |
| Drouin | 70.3% | 14:29 | 901 |
| Drysdale – Clifton Springs | 74.6% | 13:30 | 903 |
| Echuca – Moama (Echuca Part) | 80.8% | 12:23 | 898 |
| Geelong | 77.1% | 13:02 | 11,812 |
| Gisborne | 66.5% | 14:10 | 629 |
| Hamilton | 84.0% | 11:39 | 545 |
| Healesville | 65.4% | 15:41 | 685 |
| Horsham | 87.1% | 11:13 | 1,149 |
| Lara | 66.1% | 14:59 | 799 |
| Leopold | 81.9% | 11:36 | 679 |
| Maryborough (Vic.) | 65.2% | 16:51 | 658 |
| Melbourne | 70.9% | 14:21 | 236,137 |
| Melton | 56.9% | 16:36 | 4,993 |
| Mildura - Buronga (Mildura Part) | 86.6% | 11:29 | 2,790 |
| Moe – Newborough | 72.8% | 12:57 | 2,136 |
| Morwell | 86.0% | 11:11 | 1,888 |
| Ocean Grove – Barwon Heads | 73.0% | 13:53 | 1,032 |
| Portland (Vic.) | 83.8% | 11:29 | 618 |
| Sale | 81.2% | 11:47 | 889 |
| Shepparton – Mooroopna | 79.8% | 13:14 | 4,208 |
| Sunbury | 55.8% | 16:37 | 2,404 |
| Swan Hill | 85.9% | 11:15 | 700 |
| Torquay – Jan Juc | 63.6% | 15:11 | 976 |
| Traralgon | 77.2% | 12:30 | 2,005 |
| Wallan | 64.4% | 14:44 | 609 |
| Wangaratta | 83.3% | 12:23 | 1,616 |
| Warragul | 75.7% | 13:19 | 1,064 |
| Warrnambool | 86.1% | 11:04 | 1,986 |
| Wonthaggi | 78.6% | 12:52 | 720 |
| Yarrawonga– Mulwala  (Yarrawonga Part) | 65.8% | 17:04 | 687 |
| Total | 71.9% | 14:09 | 308,466 |

#### Notes

The Maryborough (Vic.), Wonthaggi and Yarrawonga - Mulwala (Yarrawonga Part) UCLs were redefined by the Australian Bureau of Statistics in the 2016 census as having a population greater than 7,500 people.

The Melbourne UCL was redefined by the Australian Bureau of Statistics in the 2016 census to include the area which was previously the Pakenham UCL. Ambulance Victoria has implemented 2016 census changes from 1st July 2018.

# Glossary

This glossary is applicable to the Performance Priorities, Statistical Summary and Public Reporting sections.

### Incident

An event to which one or more ambulances are dispatched.

### Emergency Incident

An incident to which one or more ambulances are dispatched in response to a Triple Zero (000) call from a member of the public, or a medical request for transport requiring an emergency ambulance (due to patient acuity or transport timeframe).

### Dispatch Codes

Priority 0 is a subset of our Code 1 caseload and indicates the most urgent events requiring a time-critical response. These usually involve patients with life-threatening conditions such as suspected cardiac arrest.

Code 1 incidents require urgent paramedic and hospital care, based on information available at time of call.

Code 2 incidents are acute and time sensitive, but do not require a lights and sirens response, based on information available at time of call.

Code 3 incidents are not urgent but still require an ambulance response, based on information available at time of call.

### Non-Emergency Incident

Request for patient transport where patient has been medically assessed and the transport is medically authorised; covered by the NEPT regulations and usually pre-booked.

### Compensable

Not funded by the Department of Health; patient or third party (e.g. hospital, Department of Veterans' Affairs, WorkSafe, Transport Accident Commission, Member Subscription Scheme) responsible for fee.

### Community Service Obligation

Partially funded by Department of Health – Pensioner or Health Care Card Holder exempt from fee.

### Retrieval

A retrieval is a coordinated inter-hospital transfer of a patient, who has a critical care or time critical healthcare need, which is unable to be met at the original health service. Retrieval services are provided by specialised clinical crews with advanced training in transport, retrieval and critical care medicine, operating within a structured system which ensures governance & standards. Cases handled by Adult Retrieval Victoria include the provision of adult critical care and major trauma advice, coordination of critical care bed access and retrieval of critical care patients state-wide.

### Referral Service

The AV Referral Service provides additional triaging of lower priority calls to Triple Zero (000) by a health professional; suitable calls are referred to other service providers as an alternative to an emergency ambulance dispatch. Referral options include locum general practitioners, nursing service, hospital response teams and non-emergency ambulance transport.

### Response Time

Response time measures the time from a Triple Zero (000) call being answered and registered by the Emergency Services Telecommunications Authority (ESTA), to the time the first AV resource arrives at the incident scene.

From 1 July 2013 all response times are based on data sourced from the Computer Aided Dispatch (CAD) system.

### % <= 15mins

This is the percentage of Code 1 first responses arriving in 15 minutes or less. This is calculated by dividing the number of Code 1 first responses arriving in 15 minutes or less by the total number of Code 1 first arrivals.

When AV respond to an incident, we sometimes dispatch multiple AV resources to that incident. ‘First response’ refers to the first AV resource to arrive at the incident scene.

### Average Response Time

The average response time is the average response time for the area being reported, which is calculated by dividing the sum of the response times by the number of response times within the area being reported. The average response time is provided in minutes and seconds.

### Number of First Responses

This is the total number of first arrivals within the reported time period.

### UCL (Urban Centres Localities)

Urban Centres and Localities (UCLs) are Australian Bureau of Statistics (ABS), statistical divisions that define urban areas and capture residential populations. AV reports performance for larger UCLs where population exceeds 7,500 persons.

### LGA (Local Government Area)

Local government in Victoria comprises of 79 municipal districts. They are often referred to as local government areas (LGAs). The number of LGAs and their boundaries can change over time. LGAs are as defined by Local Government Victoria, which is part of the Department of Transport, Planning and Local Infrastructure.

### Interstate LGAs

Incidents responded to by AV resources outside the Victorian LGA Boundaries.

# Statutory Compliance

### Freedom of Information

AV received 2,633 requests under the *Freedom of Information Act 1982 (Vic)* (the Act) in 2021-2022.

* Full access to documents was provided in 1,766 requests.
* Exemptions under the Act were applied to 523 requests.
  + Partial access was granted for 522 requests.
  + One request was denied in full.

The most common reason for AV seeking to partially exempt documents was the protection of personal privacy in relation to request for information about persons other than the applicant.

In terms of documents that were fully exempted the most common exemptions applied were that the document was an internal working document or contained matters communicated in confidence.

Most applications were received from members of the public and lawyers/solicitors.

Most applications were for access to patient care records (PCRs) by AV, their legal representatives or surviving next of kin.

AV collected $50,712.30 in application fees.

AV collected nil in access charge fees to facilitate access to documents.

In addition, the Freedom of Information team at AV processed 924 statute FOI requests.

These include:

|  |  |
| --- | --- |
| The Coroners Court of Victoria | 552 |
| Child Protection | 117 |
| Transport Accident Commission (TAC) | 228 |
| Other | 21 |
| Australian Health Practitioner Regulation Agency (AHPRA) | 6 |
| Total | 924 |

| Freedom of Information Requests | 2021-22 |
| --- | --- |
| Requests received during the year | 2,633 |
| Response not completed within the statutory period | 90 |
| Response completed within the statutory period | 2,543 |
| Request transferred to another agency | 4 |
| Request transferred from another agency | 1 |
| Requests not proceeded with by the applicant | 67 |
| Requests withdrawn with by the applicant | 3 |
| Access granted in full | 1,766 |
| Access granted in part (exemptions claimed) | 522 |
| Access denied in full (exemptions claimed) | 1 |
| Requests where no relevant documents could be located | 149 |
| Requests not deemed valid | 71 |
| Requests awaiting completion at the end of the financial year | 48 |

#### FOI Commissioner

| Freedom of Information Requests | 2021-22 |
| --- | --- |
| eviews/Complaints accepted by FOI Commissioner | 9 |
| VCAT appeals lodged | 1 |
| Outcome of Appeal |  |
| VCAT confirmed | 1 |
| VCAT varied original decision | 0 |

The Freedom of Information unit also processed:

* 1,563 requests on behalf of Victoria Police for Patient Care Records and/or Paramedic statements.
* 175 subpoenas.
  + 66 subpoenas were for paramedics to attend court.
  + 109 subpoenas were for AV to produce documents.

### National Competition Policy

The Government of Victoria is a party to the intergovernmental Competition Principles Agreement, which is one of three agreements that collectively underpin National Competition Policy. The Victorian Government is committed to the ongoing implementation of the National Competition Policy in a considered and responsible manner. This means that public interest considerations should be taken into account explicitly in any Government decisions on the implementation of this policy. We adhere to this, and AV complies, to the extent applicable, with the National Competition Policy.

### Building Standards

AV is compliant with Victoria’s legislative framework for building activity. All building construction activities carried out during the year were conducted in accordance with the requirements of the Building Act 1993, the Building Regulations 2018 and the relevant provisions of the National Construction Code. Maintenance and annual reporting of Essential Safety Measures was completed in accordance with requirements of the Building Regulations 2018.

### Code of Conduct

AV employees are subject to the Code of Conduct for Victorian Public Sector Employees. AV has policies and processes that are consistent with the Code. These documents contain the expected workplace behaviours specific to AV. The AV Code of Conduct is built on our values, professional and ethical standards, and the additional obligations we are required to adhere to as a Victorian Government Agency, and as such our policies are reviewed on a regular basis.

### *Carers’ Recognition Act 2012*

AV acknowledges and values the important contribution that people in care relationships make to the community, recognising differing needs and promoting the benefit that care relationships bring in accordance with the *Carers’ Recognition Act 2012*. AV is committed to ensuring its policies and procedures comply with the statement of principles in the Act and will work to ensure the role of carers is recognised within the organisation.

#### *Public Interest Disclosure Act 2012*

Under the *Public Interest Disclosures Act 2012*, complaints about certain serious misconduct or corruption involving public health services in Victoria should be made directly to the Independent Broad-based Anti-corruption Commission (IBAC) in order to remain protected under the Act. AV encourages individuals to make any disclosures which are protected disclosures within the meaning of the Act to IBAC.

#### *Local Jobs First Act 2003*

The *Local Jobs First Act 2003* applies to all projects valued at $3 million or more in metropolitan Melbourne or state-wide. The policy also applies to projects in regional Victoria valued at $1 million or more.

During 2021-2022 AV commenced five Local Jobs First Standard contracts totalling $28.38 million. All five contracts were state-wide and the Local Jobs First commitment outcomes expected are:

* An average of 90.66 per cent of local content committed.
* A total of 84.79 jobs (annualised employee equivalent) committed, including the creation of 34.47 new jobs and the retention of 50.32 jobs.
* A total of 3.04 positions for apprentices, trainees and cadets committed, including the creation of three new apprenticeships, traineeships and cadets, and the retention of 0.04 existing apprenticeships, traineeships and cadets.

During 2021-2022 AV commenced one Local Jobs First Strategic contract totalling $345.48 million. This project is state-wide, and the Local Jobs First commitment outcomes expected are:

* An average of 85.84 per cent of local content committed.
* A total of 46.83 jobs (annualised employee equivalent) committed, including the creation of 0.91 new jobs and the retention of 45.92 jobs.
* A total of 2.20 positions for apprentices, trainees and cadets committed, including the creation of 0.15 new apprenticeships, traineeships, and cadets and the retention of 2.05 existing apprenticeships, traineeships and cadets.

During 2021-2022 AV did not complete any projects subject to Local Jobs First policy outcomes.

#### *Gender Equality Act 2020*

As a defined entity under the *Gender Equality Act 2020*, AV has been progressively taking steps to meet three key obligations set out in the Act which came into effect on 31 March 2021. AV conducted a workplace gender audit to inform the development of its first Gender Equality Action Plan. This was submitted to the Gender Equality Commission on 20 June 2022. Additionally, AV has established processes to undertake a Gender Impact Assessment on any new or updated policies, programs, or services with a direct and significant impact on the public. To meet the consultation requirements set out by the Act, AV consulted with and sought input into the development of the Gender Equality Action Plan from the Board of Directors, Executive Committee, staff, and volunteers from across the organisation.

### DataVic Access Policy

Consistent with the DataVic Access Policy issued by the Victorian Government in 2012, the information on operational performance, workforce data and performance priorities included in this Annual Report will also be available at www.data.vic.gov.au in machine readable format.

## Additional information available on request

Details in respect of the items listed below have been retained by AV and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

* Declarations of pecuniary interests have been duly completed by all relevant officers;
* Details of shares held by senior officers as nominee or held beneficially;
* Details of publications produced by the entity about AV, and how these can be obtained;
* Details of changes in prices, fees, charges, rates and levies charged by AV;
* Details of any major external reviews carried out on the AV;
* Details of major research and development activities undertaken by AV that are not otherwise covered either in the report of operations or in a document that contains the financial statements and report of operations;
* Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
* Details of major promotional, public relations and marketing activities undertaken by AV to develop community awareness of AV and its services;
* Details of assessments and measures undertaken to improve the occupational health and safety of employees;
* A general statement on industrial relations within AV and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations;
* A list of major committees sponsored by AV, the purposes of each committee and the extent to which those purposes have been achieved;
* Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

The AV website at ambulance.vic.gov.au contains information about AV and is regularly updated with the latest statistics, developments and media releases.

# Consultancies

### Details of Consultancies (under $10,000)

AV did not engage any consultants where the total fees payable to the consultants was less than $10,000.

### Details of Consultancies (valued at $10,000 or greater)

In 2021-2022, there were seven consultancies where the total fees payable to the consultants were $10,000 or greater. The total expenditure incurred during 2021-2022 in relation to these consultancies was $1,677,000 (excluding GST). Details of individual consultancies are below.

AV secured the services of consulting firms to undertake the following consultancies that were valued at more than $10,000 and completed over one financial year.

* Property Services Department Functional Review
* Internal Cyber Incident Operational Review
* AV Demand Drivers and Demand Research Project
* Develop AV Restorative Justice Scheme
* Develop Data Literacy Improvement Program and Roadmap
* Major Projects Implementation Review
* Aviation Advisory Services for Fixed Wing Tender

#### Details of individual consultancies – Over One Year

| Consultant Name | Purpose of Consultancy | Start date | End  date | Total Approved Project Fee (excl GST) $’000 | Expenditure 2021-22 $’000 | Future Expenditure (excl GST) $’000 |
| --- | --- | --- | --- | --- | --- | --- |
| Grosvenor Performance Group Pty Ltd | Property Services Department Functional Review | Aug-21 | Mar-22 | 91 | 91 | 0 |
| IPSec Pty Ltd | Internal Cyber Incident Operational Review | Oct-21 | Jun-22 | 61 | 58 | 0 |
| KPMG Management Consulting | AV Demand Drivers & Demand Research Project | Jul-21 | Nov-21 | 248 | 248 | 0 |
| Article One Consulting | Develop AV Restorative Justice Scheme | May-22 | Jun-22 | 38 | 38 | 0 |
| Deloitte Consulting Pty Ltd | Develop Data Literacy Improvement Program and Roadmap | Jun-22 | Jun-22 | 195 | 195 | 0 |
| Price Waterhouse Coopers | Major Projects Implementation Review | Feb-22 | Jun-22 | 110 | 109 | 0 |
| AviPro - Resolution Response Pty Ltd | Aviation Advisory Services for Fixed Wing Tender | May-21 | Jul-21 | 27 | 27 | 0 |

AV secured the services of consulting firms to undertake the following consultancies that were valued at more than $10,000 and completed over two financial years.

* Workplace Equality Review
* Develop Transformation and Strategy Operating Model
* Develop AV Data Strategy
* Digitising the Paramedic Experience
* Aviation Advisory Services for Rotary Wing Tender

#### Details of individual consultancies over two years

| Consultant Name | Purpose of Consultancy | Start date | End date | Total Approved Project Fee (excl GST) $’000 | Expenditure 2021-22 $’000 | Future Expenditure (excl GST) $’000 |
| --- | --- | --- | --- | --- | --- | --- |
| Victorian Equal Opportunity & Human Rights Commission | Workplace Equality Review | Nov-20 | Nov-21 | 1,640 | 766 | 0 |
| Nous Group Pty Ltd | Develop Transformation and Strategy Operating Model | Mar-21 | Jul-21 | 199 | 49 | 0 |
| Nous Group Pty Ltd | Develop AV Data Strategy | Mar-21 | Jul-21 | 98 | 44 | 0 |
| Nous Group Pty Ltd | Digitising the Paramedic Experience | Mar-21 | Jul-21 | 30 | 30 | 0 |
| Heliport Design Group Pty Ltd | Aviation Advisory Services for Rotary Wing Tender | Jun-22 | Jun-24 | 250 | 22 | 228 |

# ICT Expenditure

### Details of Information and Communication Technology (ICT) expenditure

For the 2021-2022 reporting period, AV had a total ICT Expenditure of $48.57m (excluding GST) with the details shown below ($m).

| Business As Usual (BAU) ICT expenditure (Total) | Non Business As Usual (non BAU) ICT expenditure (Total = Operating expenditure and Capital Expenditure) | Non Business As Usual Operating expenditure | Non Business As Usual Capital expenditure |
| --- | --- | --- | --- |
| $34.94m | $13.63m | $1.27m | $12.36m |

# Financial Overview

## Key financial results

|  | 2021-22  $m | 2020-21  $m | 2019-20  $m | 2018-19  $m | 2017-18  $m |
| --- | --- | --- | --- | --- | --- |
| Operating Result[[94]](#footnote-94) | 23.396 | 10.701 | 14.265 | 33.476 | 8.215 |
| Net Result From Transactions[[95]](#footnote-95) | 28.287 | (10.660) | 13.322 | 56.189 | 16.205 |
| Net Result[[96]](#footnote-96) | 28.644 | 0.231 | (18.209) | 2.010 | (9.692) |
| Comprehensive Result[[97]](#footnote-97) | 46.664 | 15.000 | (18.209) | 10.153 | (9.692) |

## Summary results

AV generated a $23.4m Operating Result surplus for 2021-2022. While this result is the key measure used to monitor health services financial performance, it excludes bad and doubtful debts, of which AV incurred $21.5m during the year and is included in Other Economic Flows/Net Result. The doubtful debt expense within Other Economic Flows was largely offset by a significant decrease in the value of AV’s long service leave provision to reflect lower expected future payments following increases to the Department of Treasury and Finance’s discount rate, resulting in AV’s $28.6m Net Result surplus. AV’s $46.7m Comprehensive Result surplus was impacted by an $18.0m increase in the fair value of AV land.

## Total revenue increased by 15 per cent

AV’s total revenue comprises operating and capital income. While the global COVID-19 pandemic continues to have a material impact on the health sector, including AV, government continued to provide funding to support expenditure incurred in AV’s COVID-19 response. This included implementation of safety and precautionary activities, additional resourcing to support AV’s response to the pandemic, and provision of medical and personal protective equipment. Additional government funding was also received to expand service capability and meet increases in demand.

AV’s workload continued to increase, together with an increase to chargeable transports, resulting in a 6 per cent increase in transport fees.

## Total expenditure from transactions increased by 12 per cent

Overall service delivery expenditure increased in 2021-2022, driven by workload growth, additional COVID-19 activities, and implementation of performance improvement programs. The increases included more ambulance services (both emergency and non-emergency, including new Medium Acuity Transport Services), recruitment of additional paramedics and surge workforce for COVID-19, and increased supplies and consumables.

## Comprehensive Result

Property market values continued to increase significantly in 2021-2022, triggering a management valuation resulting in a $18.0m increase to the fair value of AV land, and Net Assets, in 2021-2022.

|  | 2021-22 $000 | 2020-21 $000 | 2019-20 $000 | 2018-19  $000 | 2017-18  $000 |
| --- | --- | --- | --- | --- | --- |
| Summary of Financial Results | | | | | |
| Total Income from Transactions | 1,481,874 | 1,288,269 | 1,188,563 | 1,140,919 | 1,046,405 |
| Total Expenses from Transactions | (1,453,587) | (1,298,929) | (1,175,241) | (1,084,730) | (1,030,200) |
| Net Result from Transactions | 28,287 | (10,660) | 13,322 | 56,189 | 16,205 |
| Total Other Economic Flow | 357 | 10,891 | (31,531) | (54,180) | (25,897) |
| Net Result | 28,644 | 231 | (18,209) | 2,010 | (9,692) |
| Total Assets | 1,065,675 | 1,051,955 | 1,009,164 | 739,909 | 682,088 |
| Total Liabilities | 716,849 | 749,793 | 721,527 | 430,223 | 382,555 |
| Net Assets | 348,826 | 302,162 | 287,637 | 309,686 | 299,533 |
| Financial Indicators | | | | | |
| Current Assets Ratio | 0.39 | 0.40 | 0.36 | 0.52 | 0.49 |
| Debtors Turnover (Days) | 77 | 73 | 71 | 72 | 84 |
| Creditors Payable Turnover (Days) | 58 | 46 | 38 | 64 | 50 |
| Bad & Doubtful Debt Provision/YTD Billings Ratio | 0.13 | 0.10 | 0.08 | 0.07 | 0.07 |
| Actual Cost Per Road Incident ($) | $1,065 | $1,059 | $1,006 | $969 | $986 |
| Liability Ratio | 0.67 | 0.71 | 0.71 | 0.58 | 0.56 |
| Asset Turnover Ratio | 1.41 | 1.25 | 1.36 | 1.60 | 1.55 |

|  | 2021-22 |
| --- | --- |
| Reconciliation between Net Result from Transactions & Statement of Priorities | |
| Operating Result | 23,396 |
| Capital and Specific Items |  |
| Capital Purpose Income | 127,469 |
| Specific Income | – |
| COVID-19 State Supply Arrangements |  |
| * Assets and Supplies Received Free of Charge or for Nil Consideration | 3,577 |
| * State Supply Items Consumed up to 30 June 2022 | (3,577) |
| Assets Received Free of Charge | – |
| Assets Provided Free of Charge | – |
| Expenditure for Capital Purpose | (4,512) |
| Depreciation and Amortisation | (112,707) |
| Impairment of Non-Financial Assets | – |
| Finance Costs | (5,359) |
| Net Result from Transactions | 28,287 |

# Disclosure Index

The annual report of Ambulance Victoria is prepared in accordance with all relevant Victorian legislation. This index has been prepared to facilitate identification of the Department’s compliance with statutory disclosure requirements. The page numbers referenced are as they appear in the printed pdf version of this document, not the word file.

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# Financial Report for the year ending 30 June 2022

## Board Chair’s, Chief Executive Officer’s and Chief Financial Officer’s Declaration

The attached financial statements for Ambulance Victoria have been prepared in accordance with Direction 5.2 of the Standing Directions of the Assistant Treasurer under the *Financial Management Act 1994*, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2022 and the financial position of Ambulance Victoria at 30 June 2022.

At the time of signing, we are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

We authorise the attached financial statements for issue on 7 October 2022.

Signed by Shelly Park, Chair of the Board

Melbourne, 7 October 2022

Signed by Professor Tony Walker ASM , Chief Executive Officer

Melbourne, 7 October 2022

Signed by Garry Button FCPA , Chief Financial Officer

Melbourne, 7 October 2022

## Independent Auditor’s Report and Financial Statements

This section is not available in an accessible format. Please refer to the PDF version of the Annual Report published on the Ambulance Victoria website [www.ambulance.vic.gov.au/about-us/our-performance](https://www.ambulance.vic.gov.au/about-us/our-performance/) or email [corporatecommunications@ambulance.vic.gov.au](mailto:https://www.ambulance.vic.gov.au/about-us/our-performance/) for assistance.

## The End

1. On road Clinical Staff – includes but not limited to Paramedics, Team Managers, Patient Transport Officers, Retrieval Registrars, Clinic Transport Officers and Clinical Instructors. [↑](#footnote-ref-1)
2. Operation Support and Managerial Staff – includes but not limited to Senior Team, Area and Regional Managers, Rosters staff, Communications staff, Rehab Advisors, OHS Advisors, Logistics staff, Fleet staff, Duty Team Managers, Telecommunication staff and Clinical Practice staff. [↑](#footnote-ref-2)
3. Other Managerial, Professional include all other staff who do not fall into the above two categories. [↑](#footnote-ref-3)
4. An increased number of Standard WorkCover claims in 2021-2022 negatively impacted the LTIFR, the average number of Standard Claims per 100 FTE and the average cost per WorkCover Standard Claim rates. The average number of Standard WorkCover claims per 1,000,000 Hours Worked has been included to show the impact of the increasing number of claims on the AV workforce environment based on the number of productive hours worked. [↑](#footnote-ref-4)
5. An increased number of Standard WorkCover claims in 2021-2022 negatively impacted the LTIFR, the average number of Standard Claims per 100 FTE and the average cost per WorkCover Standard Claim rates. The average number of Standard WorkCover claims per 1,000,000 Hours Worked has been included to show the impact of the increasing number of claims on the AV workforce environment based on the number of productive hours worked. [↑](#footnote-ref-5)
6. An increased number of Standard WorkCover claims in 2021-2022 negatively impacted the LTIFR, the average number of Standard Claims per 100 FTE and the average cost per WorkCover Standard Claim rates. The average number of Standard WorkCover claims per 1,000,000 Hours Worked has been included to show the impact of the increasing number of claims on the AV workforce environment based on the number of productive hours worked. [↑](#footnote-ref-6)
7. An increased number of Standard WorkCover claims in 2021-2022 negatively impacted the LTIFR, the average number of Standard Claims per 100 FTE and the average cost per WorkCover Standard Claim rates. The average number of Standard WorkCover claims per 1,000,000 Hours Worked has been included to show the impact of the increasing number of claims on the AV workforce environment based on the number of productive hours worked. [↑](#footnote-ref-7)
8. The average cost per WorkCover claim has been updated to reflect current data. This captures average costs as they have matured since the last annual report. The 2021-2022 result is based on the cost of claims as received by AV's workers compensation claims agent as at the end of June 2022, divided by the total number of Standard WorkCover claims lodged in 2021-2022. [↑](#footnote-ref-8)
9. Occupational Violence AV is committed to preventing injuries, both physical and psychological, arising from occupational violence. While the overall number of occupational violence hazards/incidents/injuries (HIIs) reported and the number of HIIs reported per 100 FTE are the lowest they have been in three years, the percentage of reports that ultimately result in injury is rising. [↑](#footnote-ref-9)
10. The number of hazards/incidents/injuries (HIIs) as lodged in AV's Health, Safety and Claims System (HSCS). [↑](#footnote-ref-10)
11. The result reflects the uptake of the 2021 Influenza Vaccination Program from 14 April to 14 August 2021. [↑](#footnote-ref-11)
12. HSRs have increased in number over the past three years and align with the growth in the paramedic workforce and the number of AV locations. [↑](#footnote-ref-12)
13. COVID-19 vaccination rates as at 30 June 2022. [↑](#footnote-ref-13)
14. COVID-19 vaccination rates represent a point in time rate at the end of the financial year and are not discrete annual program rates. [↑](#footnote-ref-14)
15. COVID-19 vaccination rates as at 30 June 2022. [↑](#footnote-ref-15)
16. COVID-19 vaccination rates represent a point in time rate at the end of the financial year and are not discrete annual program rates. [↑](#footnote-ref-16)
17. All figures have been forecast and adjusted to include the most up-to-date information, available at the time of preparation. Where data was not available or estimated in prior years but has since become available, the data has been adjusted to reflect actual figures representing the reported portfolio as at 30 June 2022. [↑](#footnote-ref-17)
18. Greenhouse emissions are reported for Scope 1 (direct emissions from owned or controlled sources) and Scope 2 (indirect emissions from the generation of purchased electricity). Emission factors for calculation of greenhouse impact are taken from Department of Climate Change and Energy Efficiency, National Greenhouse Account Factors, August 2020 at <https://www.industry.gov.au/data-and-publications/national-greenhouse-accounts-factors> [↑](#footnote-ref-18)
19. Total greenhouse emissions figures incorporate all Scope 1 and 2 emissions produced (not including any offsets). [↑](#footnote-ref-19)
20. Net greenhouse emissions figures incorporate an offset for the purchase of accredited GreenPower. For carbon per case, case is an event that results in one or more responses by an ambulance service. [↑](#footnote-ref-20)
21. Stationary Energy use incorporates electricity and natural gas consumption for all sites including offices and branches. Consumption data that is unavailable, for example at sites that are co-located with hospitals or other emergency services is estimated. [↑](#footnote-ref-21)
22. Official Full Time Equivalent staff as at the end of the financial year. [↑](#footnote-ref-22)
23. Transport Energy incorporates all AV road vehicles and air fleet. Due to lag in data collation, road-based fuel is calculated using the 12 month period from June 2021 to May 2022. [↑](#footnote-ref-23)
24. Metered potable water used for all sites including offices and branches. Consumption data that is unavailable, for example at sites that are co-located with hospitals or other emergency services, is estimated. [↑](#footnote-ref-24)
25. In 2021 waste data was re-baselined to align with Department of Health Waste Reporting Tool for 2020-2021 and previous years of data. Assumed weights are used for waste where no weight was recorded at time of collection. [↑](#footnote-ref-25)
26. One ream is equivalent to 500 sheets of A4 paper. Recycled content is the average percentage of recycled content purchased. Paper count includes paper used for patient care record (VACIS) printing but does not include AV pre-printed letterhead. [↑](#footnote-ref-26)
27. Addressable spend excludes DEBIT & AV patient transport services. [↑](#footnote-ref-27)
28. Cumulative year on year total. [↑](#footnote-ref-28)
29. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-29)
30. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-30)
31. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-31)
32. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-32)
33. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-33)
34. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-34)
35. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-35)
36. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-36)
37. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-37)
38. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-38)
39. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-39)
40. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-40)
41. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-41)
42. H = Meetings eligible to attend (excludes those held by circular resolution) vs A = meetings attended [↑](#footnote-ref-42)
43. Paramedic representative (no voting rights). [↑](#footnote-ref-43)
44. Paramedic representative (no voting rights). [↑](#footnote-ref-44)
45. Paramedic representative (no voting rights). [↑](#footnote-ref-45)
46. J Drake, S Porter are also voting members of Quality & Safety Committee. [↑](#footnote-ref-46)
47. J Drake, S Porter are also voting members of Quality & Safety Committee. [↑](#footnote-ref-47)
48. Community members of the Community Advisory Committee. [↑](#footnote-ref-48)
49. Community members of the Community Advisory Committee. [↑](#footnote-ref-49)
50. Community members of the Community Advisory Committee. [↑](#footnote-ref-50)
51. Community members of the Community Advisory Committee. [↑](#footnote-ref-51)
52. Community members of the Community Advisory Committee. [↑](#footnote-ref-52)
53. Community members of the Community Advisory Committee. [↑](#footnote-ref-53)
54. Community members of the Community Advisory Committee. [↑](#footnote-ref-54)
55. Includes all AV staff. Results reﬂect the 2021 Inﬂuenza Immunisation Program which ended in August 2021, as required by business rules. [↑](#footnote-ref-55)
56. Based on results of VHES survey conducted in 2022 (excludes missing/don’t know/cant say from total responses). [↑](#footnote-ref-56)
57. Includes patients of all ages with traumatic pain and patients aged 15 years or greater with cardiac pain who presented with GCS (Glasgow Coma Scale) of 9 or more, were not intubated, had an initial pain score of 8 or more and a pain reduction of 2 or more points. Provisional ﬁgures are provided. [↑](#footnote-ref-57)
58. Includes patients aged 15 years or greater whose ﬁnal paramedic assessment was stroke and who were transported to a hospital with stroke unit and thrombolysis or telemedicine services within 60 minutes. Excludes inter-hospital transports. Provisional ﬁgures are provided. [↑](#footnote-ref-58)
59. Includes major trauma patients, as deﬁned by the Victorian State Trauma Registry, who were transported directly to a Major Trauma Service, and patients transported to the highest level of Trauma Service within 45 minutes, where travel time to a Major Trauma Service was > 45 minutes. Excludes inter hospital transports. Results based on data available from July 2021 – December 2021. [↑](#footnote-ref-59)
60. Adult (≥15 years) cardiac arrests where resuscitation was attempted by EMS (excluding those cases where resuscitation was commenced but ceased when a Do Not Resuscitate was discovered) and the arrest rhythm on ﬁrst ECG assessment was Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT). VF/VT events include cases that were deﬁbrillated prior to the arrival of EMS. EMS denotes Ambulance Victoria, Fire Services (Metropolitan Fire Brigade (MFB), Country Fire Authority (CFA)) and Community Emergency Response Teams (CERT). Excludes cardiac arrests witnessed by a paramedic. Cardiac arrest data is sourced from the Victorian Ambulance Cardiac Arrest Registry (VACAR) which is subject to ongoing quality control and is continually updated. Survival to hospital percentage calculation excludes cases where rhythm on arrival at hospital was unknown. Survival to hospital discharge percentage calculation excludes cases where hospital outcome data is unavailable. The data provided is provisional. Results based on data available from July 2021 to May 2022. [↑](#footnote-ref-60)
61. Adult (≥15 years) cardiac arrests where resuscitation was attempted by EMS (excluding those cases where resuscitation was commenced but ceased when a Do Not Resuscitate was discovered) and the arrest rhythm on ﬁrst ECG assessment was Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT). VF/VT events include cases that were deﬁbrillated prior to the arrival of EMS. EMS denotes Ambulance Victoria, Fire Services (Metropolitan Fire Brigade (MFB), Country Fire Authority (CFA)) and Community Emergency Response Teams (CERT). Excludes cardiac arrests witnessed by a paramedic. Cardiac arrest data is sourced from the Victorian Ambulance Cardiac Arrest Registry (VACAR) which is subject to ongoing quality control and is continually updated. Survival to hospital percentage calculation excludes cases where rhythm on arrival at hospital was unknown. Survival to hospital discharge percentage calculation excludes cases where hospital outcome data is unavailable. The data provided is provisional. Results based on data available from July 2021 to May 2022. [↑](#footnote-ref-61)
62. Reinstatement following removal in 2020–21 due to optional participation in the People Matter Survey in response to COVID-19. Business rule change to align with Victorian Public Sector Commission reporting has affected performance levels – Target rebased to 62% to provide consistency in performance thresholds relative to past years. Single summary KPI to be reinstated as the sole indicator of ‘Strong governance, leadership and culture’ domain while all KPIs under this domain are reviewed. Supporting eight underlying KPIs will continue to be monitored through regular reporting in PRISM. [↑](#footnote-ref-62)
63. From 1 July 2014 Statewide response times are based on data sourced from the Computer Aided Dispatch system. [↑](#footnote-ref-63)
64. Priority 0 is a subset of our Code 1 caseload and indicates the most urgent events requiring a time-critical response. These usually involve patients with life-threatening conditions such as suspected cardiac arrest patients. [↑](#footnote-ref-64)
65. Based on the Australian Bureau of Statistics Urban Centre boundaries (2016 census) and resident population data. [↑](#footnote-ref-65)
66. Based on all emergency transports with recorded times. From 1 July 2019, minor data quality issues were resolved. [↑](#footnote-ref-66)
67. Figures for 2020-2021 have been updated where applicable to include data received after the completion of last year's report. [↑](#footnote-ref-67)
68. In May 2016, AV commenced rolling out changes to event priorities to better match resource allocation to patient need. This program, included within the Ambulance Policy and Performance workload, including the Code 1 subset of Consultative Committee ﬁnal report, sees a progressive increase in the number of Triple Zero calls receiving secondary triage by AV. Overall Emergency Ambulance workload, shows lower annualised growth than Triple Zero call volume for May and June 2016 as a result of this program. [↑](#footnote-ref-68)
69. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016. [↑](#footnote-ref-69)
70. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016. [↑](#footnote-ref-70)
71. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016. [↑](#footnote-ref-71)
72. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016. [↑](#footnote-ref-72)
73. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016. [↑](#footnote-ref-73)
74. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-74)
75. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-75)
76. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-76)
77. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-77)
78. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-78)
79. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-79)
80. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-80)
81. Based on the Australian Bureau of Statistics Urban Centre boundaries (2016 census) and resident population data. [↑](#footnote-ref-81)
82. Referral results have been updated to include doctor request (CLINMRT) and referral welfare check cases that were diverted from emergency dispatch. This change has been implemented to correct an inconsistency between Emergency and Referral Services reporting. Figures prior to 2019/2020 are incomparable. [↑](#footnote-ref-82)
83. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-83)
84. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and ﬁnished in April 2016 [↑](#footnote-ref-84)
85. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-85)
86. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-86)
87. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-87)
88. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-88)
89. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-89)
90. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-90)
91. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-91)
92. The ‘other’ category includes the road components of multi-legged road transports which have not been assigned a charge class.

    The ‘Other’ category also includes road transports not yet assigned a charge class. [↑](#footnote-ref-92)
93. Revised patient transport charging guidelines were introduced on 1 July 2014. The revisions have impacted demand for AV services, resulting in changes in Air Ambulance transports, Non-Emergency road transports, public hospital transfers, and the creation of a new charging category ‘Private Hospital Transfers’. At times this has created a decline in demand, and is predominantly a result of a reduction in booked non emergency transports due to changes in non emergency fees introduced from July 2014 and the impact of the NEPT Pilot which began in November 2015 and finished in April 2016. [↑](#footnote-ref-93)
94. Statement of Priorities financial result performance measure (also refer reconciliation below) [↑](#footnote-ref-94)
95. Includes capital income and depreciation. [↑](#footnote-ref-95)
96. Includes capital income, depreciation, and movements in financial instruments, and other economic flows. [↑](#footnote-ref-96)
97. Reflects the movement in Net Assets for the period. [↑](#footnote-ref-97)