Part C: Service Specification for Ambulance Communications Services

This Agreement will commence on 1 August 2012 or when duly executed by the parties and will, unless lawfully terminated earlier continue for a period of 18 months to 31 January 2014.

1 Overview

1.1 Emergency Ambulance Services (EAS) respond in a timely manner to calls for assistance made through the Ambulance Communications Centres in order to provide appropriate care, treatment and, where necessary, transportation to people requiring urgent assistance as a result of injury, illness or a maternity emergency.

1.2 The Ambulance Communications Centres provide the telecommunication interface between the 111 caller and the Emergency Ambulance Provider (EAP), which allow ambulances to be dispatched to the scene of medical or accident emergencies.

1.3 The type of resources available to the Ambulance Communications Centres for dispatch are:

a. Emergency Road Ambulance including water ambulances[1]

b. Rapid Response Units, Urgent Community Care and other clinicians such as Extended Care Paramedics (ECPs)

c. Emergency Air Ambulances

d. Primary Response in Medical Emergency (PRIME) doctors and nurses

e. First responders

2 Background

2.1 Roadside to Bedside

2.1.1 The framework for the delivery of EAS is set out in Roadside to Bedside.[2] EAS includes EAPs and Ambulance Communications Services. Roadside to Bedside outlines the framework necessary to provide the best possible outcomes for people who need to access emergency services by ensuring that people get 'the right care, at the right time, in the right place, from the right person'.[3]

2.1.2 *Roadside to Bedside* identifies eight features necessary to provide a quality emergency service to New Zealand citizens:

a) "establishment of regional networks;

b) delivering patients to the nearest hospital capable of providing definitive care;

c) capability for 'rescue';

d) integration of all services;

e) appropriate emergency transport systems;

f) agreed protocols, guidelines and standards;

[1] Services usually organised through EAPs and provided by Coast Guard services
[2] *Roadside to Bedside – A 24-hour Clinically Integrated Acute Management System for New Zealand*; ACC/Health Funding Authority/Ministry of Health and Council of Medical Colleges; 1999. Available from http://www.health.govt.nz/
[3] Ibid.

g) workforce development; and

h) access to telecommunications and emergency response".

2.1.3 The EAS is constructed to ensure that all eight elements identified in Roadside to Bedside are in place to ensure that the goals of right care, right time, right place and right person are met.

2.2 Ambulance Communications Service and EAP Interface

2.2.1 Appendix 3 outlines the points where time based measurements are recorded. Some of these points are the performance measurement requirements of EAPs and some are the performance measurement requirements of the Ambulance Communications Service, the latter being responsible for the call-taking, dispatching and pre-arrival clinical advice for an incident.

2.2.2 As the data retrieval for most reporting requirements on the EAPs is a function of the Ambulance Communications Service by virtue of the systems infrastructure, reporting the raw data on Performance Measurement Points is the responsibility of the Provider. This is purely a function of providing data to the funders in order for the funders to analyse and make assumptions about the actual performance of providers.

2.3 [reserved]

2.4 [reserved]

2.5 Emergency Care Coordination Teams

2.5.1 There are five regional acute care networks based in Auckland, Hamilton, Wellington, Christchurch and Dunedin.

2.5.2 Each region (with the current exception of Auckland) has an Emergency Care Co-ordination Team which acts in a networking, monitoring and advisory role to the regional emergency care system. All EAPs and Ambulance Communications Service providers must be participating members of the appropriate regional Emergency Care Coordination Team, where they exist.

2.6 EAS are configured to:

2.6.1 meet the needs of the regional network based on the five tertiary centres outlined in Roadside To Bedside (Dunedin, Christchurch, Wellington, Hamilton and Auckland);

2.6.2 provide a range of service and capability levels to most appropriately meet the needs of their communities within available resources; and

2.6.3 ensure that all emergency ambulance services are supplied according to the Ambulance and paramedical services Standard (NZS 8156).[4]

[4] Note the minimum crewing for Basic Life Support ambulances in this service specification is a single crew compared with full crewing in NZS 8156. Available from www.standards.co.nz.

2.7 [reserved]

2.8 ACC Responsibilities

ACC is responsible for the funding of EAS for certain eligible people who have suffered personal injury in terms of the AC Act for which a claim for cover has been accepted, or is likely (in the provider's experience) to be accepted. Eligible people are those for whom the EAS starts within 24 hours of suffering a personal injury or within 24 hours of being found after suffering a personal injury (whichever is the later), and for whom the emergency transport is necessary for the purpose of obtaining treatment urgently for the claimant's personal injury. Those eligible are all those resident in New Zealand and visitors to New Zealand.

2.9 Ministry Responsibilities

2.9.1 The Ministry funds EAS for all Eligible People (who have a need for emergency medical attention. For the purposes of this service specification emergency medical attention means services provided to a patient who requires medical attention (not caused by trauma) from the time of the EAS being notified (via the Ambulance Communications Centre) of the need for services; to the time the patient arrives at a place of definitive care.

2.9.2 Transport between public hospital emergency departments within three hours of arriving by ambulance is included in the service provided under this agreement.

2.9.3 In this specification, "emergency" means those cases triaged as life threatened or potentially life threatened as determined by the triage system used in the Ambulance Communications Centres.

2.9.4 The EAS is capacity funded to meet this urgent demand and may be used to respond to non-emergency situations but non-emergency volumes are not considered a basis for changes in funding levels.

2.9.5 The use of funded capacity to respond to non-emergency situations must not impact on the ability to respond to emergency situations.

3 Service Description

3.1 General

3.1.1 The Ambulance Communications Centres must supply a communication service for people requiring emergency assistance as a result of injury, illness or a maternity emergency, in order to provide service users with a timely emergency ambulance response.

3.1.2 The Ambulance Communications Centres must provide the service 24 hours a day and 7 days a week inclusive of statutory and public holidays, and must have contingency services in place, including the concept of a "virtual single system" between all three centres in the event of failure or overload in the case of unprecedented demand.

3.1.3 The Provider must have a Clinical Support Desk, as described in Appendix 6, in each of the Ambulance Communications Centres. The Clinical Support Desk will provide the following:

a. clinical support and advice to call takers and dispatchers within the Ambulance Communications Centres to enhance the most appropriate dispatch decision making process, for all levels of patient acuity, especially high acuity;

b. clinical support and advice to all field personnel (including road and air), thereby facilitating use of the most appropriate pathways of care;

c. real time clinical advice to support decisions on air or land transport options and;

d. support clinical audit and quality improvement in the Ambulance Communications Centres.

3.2 Call-Taking

3.2.1 The Ambulance Communications Centres must provide a service which links continuously to the 111 phone system operated by Telecom on behalf of all New Zealand emergency services that:

a. provides timely and seamless access to EAS triage advice for members of the public when the need arises;

b. prioritises all calls for service;

c. provides Caller Line Identification as available;

d. efficiently transfers the relevant information from the Emergency Medical Dispatcher (refer Appendix 1), should an emergency ambulance response be required;

e. demonstrates that those incidents that do not require an emergency ambulance response are being dealt with in an appropriate manner (inappropriate directions are to be reviewed internally), such as referral to an Alternative Care Pathway.

3.3 Dispatching

3.3.1 The Ambulance Communications Centres must:

a. Prioritise all calls using the approved Medical Priority Dispatch System to determine:
   i. category of incidents: life threatening, potentially life threatening or non-emergency and
   ii. mode of transport (i.e. road, air or water);
   iii. the Service Capability Level response as defined in the NZS 8156.
   iv. incidents appropriate for an Alternative Care Pathway.

b. dispatch the necessary resources to those calls for assistance that do require an emergency response, using the approved Medical Priority Dispatch System available in the supplied computer software;

NOTE: The Ambulance Communications Centres must use the Service Level Capability terminology used in NZS 8156 when dispatching an ambulance resource but will not be responsible for guaranteeing the crewing matches these definitions, that being the responsibility of EAPs.

c. guarantee that dispatching decisions will take into account the following
   i. approved Medical Priority Dispatch Systems (refer Appendix 1);
   ii. availability of resources;
   iii. appropriateness of available resources;
   iv. distance;
   v. geography;
   vi. route conditions etc (as they are known); and

d. understand that there will be no obligation or expectation that the Ambulance Communications Centre will initiate an emergency ambulance response to the scene for all calls, when the Medical Priority Dispatch System indicates an emergency ambulance response is not required.

3.4 Equipment

3.4.1 The Ambulance Communications Centres must have and use the following equipment:

a. call handling technology that is capable, reliable and able to meet the demands on the service as measured by a low abandoned call rate)

b. Computer Aided Dispatch (CAD) system;

c. radios connected through a national network;

d. technology that provides fail-over and business continuity provisions (referred to as a virtual single system) (refer Appendix 1) at all times;

e. Automatic Vehicle Location (AVL) systems;

f. Mapping linked to AVL/CAD;

g. direct telephone lines and/or radio links to other emergency service providers including the Fire Service, Police; the Rescue Coordination Centre operated by Maritime New Zealand, EAPs in the field and hospital Emergency Departments;

h. an uninterrupted power supply.

3.5 Process

3.5.1 The Provider must:

a. warrant that all call taking staff are appropriately trained and qualified;

b. warrant that all dispatchers are appropriately trained in resource deployment in line with agreed protocols and processes;

c. establish and maintain, jointly with all Ambulance Communications Centres and contracted EAPs, up-to-date information in the Computer Aided Dispatch software that:
   i. establishes standards of dispatch decision-making using pre-developed local response plans to ensure the patient is transported to the right place in the right time;
   ii. ensures an emergency resource with the appropriate Service Capability Level is dispatched to the emergency situation;

iii. aligns to the computerised Medical Priority Dispatch System (refer Appendix 1) software; and
iv. has aspects of the manual that pertain to 'local issues and local solutions',' consulted for appropriateness and feasibility with the relevant Emergency Care Coordination Team.

d. manage an internal quality assurance system which includes, but is not limited to, review of the processes mandated by contract with the Ministry and ACC;

e. coordinate with one-another when inter-regional incidents occur;

f. maintain systems to provide ambulance officers with clinical advice as required that includes a record of the advice requested and the response provided. Such records are to be kept for a period of time as specified in the Ambulance Communications Centres Operations Manual, taking into account any legal requirements;

g. maintain system compatibility between the three Ambulance Communications Centres particularly in matters relating to call handling, triage and dispatch systems;

h. upon reasonable notice (not less than 10 days), collate and provide information for audit to the National Ambulance Sector Office[5] (NASO);

i. use EAS operational resources available to best reach their response time targets (Refer to Appendices 1&2);

j. have;
   i. Service Level Agreements with EAPs contracted by the Ministry and ACC (refer to Appendix 5 for a list of contracted providers);
   ii. agreements with all non-ambulance First Response unit providers (refer Appendix 1); and
   iii. agreements (as above) with any local alternative health care providers such as health advice telephone lines (in order to provide efficient redirection of calls not requiring an EAS response).

k. have documented procedures for backup arrangements for each ambulance station with other ambulance stations and with PRIME practitioners;

l. have a documented inventory of the resources (i.e. ambulances, vehicles, helicopters, other modes of delivery/transport, staff, equipment, etc.) of the network for all NZ territories as required by the fail-over and business continuity provisions;

m. operate to the best practice guidelines described in NZS 8156;

n. have plans, processes, staff and technology to ensure continued ability to activate and manage resources for emergency callouts, in the event of unexpected service failure or overload in the case of unprecedented call demand, of any Ambulance Communications Centre in the network; and

o. clearly advertise, particularly to health care professionals, that priority will always be given to calls made through the 111 system.

[5] NASO is a joint ACC and Ministry team which manage all EAS contracts including Ambulance Communications Services and EAP contracts, on behalf of the two Crown Agencies.

4 Maori Health

4.1 Ambulance Communications Centres will provide services in a culturally appropriate way and will comply with relevant cultural requirements as prescribed by the Ministry and ACC from time to time.

5 Exclusions

5.1 Ambulance Communications Services will not be provided by an organisation with an ownership interest in an emergency air ambulance service without prior written approval from both ACC and the Ministry.

6 [Reserved]

7 Service Linkages

7.1 The purpose of key linkages is to maintain a working relationship of communication, consultation and inclusion. Those organisations identified at Clause 7.2 are not exclusive and the Provider is encouraged to explore opportunities to develop and maintain key linkages with other organisations nationally, and within the respective Ambulance Communications Centre coverage areas, that enables and/or promote effective service delivery and achievement of the outcomes of this service specification.

7.2 The Provider must maintain key linkages with the following organisations or entities in order to provide an efficient and effective emergency ambulance service:

a. EAPs (road and air) in the region and neighbouring regions;

b. PRIME providers;

c. Other Ambulance Communications Centres;

d. receiving District Health Boards (DHBs) which have an involvement in emergency care as well as DHBs which provide specialist services on a national or sub national basis (e.g burns, spinal injury);

e. the ECCT for the region;

f. the Ministry;

g. ACC;

h. NASO;

i. other emergency services including New Zealand Police, Fire, Search and Rescue;

j. relevant national Sector and Stakeholder groups e.g. Ambulance New Zealand;

k. other local organisations with a direct interest in the provision of emergency care including Primary Health Organisations and private emergency medical clinics.

8 Quality Requirements

8.1 General Quality Requirements

The Provider:

a. Will comply with NZS 8156

b. Will meet the requirements of ISO 9001

c. In addition to the Performance Indicators outlined in Clause 8.2, will comply with the quality requirements in the overarching agreement including specific cultural requirements.

d. will work with EAPs to ensure that the data stored by Ambulance Communications Centres is accurate and reliable.

e. Will work with EAPs to ensure that the classifications (ie Urban, Rural and Remote) that are applied to each Service Area are aligned with the latest Census data available.

f. Will ensure there is agreement with the EAP, the Ambulance Communications Centres Provider and NASO to apply a classification to a Service Area(s) that is not in line with the latest census data available. The reason for the change must be documented and reported in the next Quarterly Report.

g. Will ensure the Disaster Recovery Plan is outlined in the Ambulance Communications Centres Business Continuity Plans and this Disaster Recovery plan will be tested at least every six months.

8.2 Performance Indicators

8.2.1 Background

a. Answer times (T1-T2 - refer Appendix 3) reflect the ability of the Ambulance Communications Centres to answer and process a call in order to determine the needs of the caller and dispatch an emergency ambulance provider if appropriate.

b. The Response Time Targets (refer Appendix 2) for Emergency Road Ambulance Providers arrival at scene (T4-T7 – refer Appendix 3) reflect the ability of that Emergency Road Ambulance Provider to supply a service that is responsive to the level of emergency indicated by categorisation. The targets used vary according to the level of emergency in the situation and the nature of the area where the patient is located.

c. Response times are further defined in the Service Specification for Emergency Road Ambulance. The Ambulance Communications Centres are not responsible for delivery on these Service Specifications.

d. Response times acknowledge the necessity for an efficient and effective relationship between the Ambulance Communications Centres and the EAPs, First Response unit or PRIME practitioner service.

e. The response time targets provided in Appendix 3 are not currently separated into specific performance requirements for the Ambulance Communications Centres and the EAPs.

f. The area types to which the response time targets apply recognise the impact of population distribution on the ability of the EAP to respond.

8.2.2 Quality Measures

In relation to the performance requirements for the call-taking portion of the response times (refer Appendix 3) the Ambulance Communications Centres will make best endeavours to ensure that:

a. 95% of calls are answered within 15 seconds (T1-T2);

b. 95% of calls move between T2 and T4 (Call registered to Job on Dispatcher screen) within 3 minutes;

c. Audited calls[6] reach a minimum compliance level of 90% as per the Medical Priority Dispatch System performance indicators guidelines

9 Reporting

The Ambulance Communications Centres will provide data to NASO in electronic format.

9.1 [Reserved]

9.2 Quarterly Reporting

Quarterly Reports are to be received by the 20th calendar day of the month following the end of each financial quarter in the format agreed with NASO.

9.2.1 The following information for Ambulance Communications Services must be submitted electronically to NASO.

a. total number of calls received by call type;

b. total number of emergency incidents to which a service (ambulance, First Responder or PRIME) was dispatched;

c. total number of non-emergency incidents to which a service (ambulance, First Responder or PRIME) was dispatched;

d. total number of calls referred by the Ambulance Communications Centres to an Alternative Care Pathway;

e. performance against each of the quality measures in clause 8.2.2 (National Summary and by each Ambulance Communications Centre);

f. median time for all “Echo determinant” (refer to Appendix 1) calls (which have required a scene response) to be activated, by each Ambulance

[6] Audited Calls – the number of calls to be audited is dependent on the total number of incidents received by the EACCs

Communications Centre. The time recorded will be T4 – T5 as indicated in Appendix 3;

g. median time for other life-threatening calls (which have warranted a scene response) to be activated, by each Ambulance Communications Centre. The time recorded will be T4 – T5 as indicated in Appendix 3;

h. abandoned call rate.

9.2.2 The following information must be submitted electronically for PRIME Services

a. number of PRIME notifications;

b. number of PRIME responses (as system improvements allow);

9.2.3 The following information must be submitted electronically for Air Ambulance Services. This information must also be copied to the Air Ambulance providers.

a. number of incidents to which an Air response was dispatched by volume, provider and Dispatch Categories (refer to Appendix 1);

b. Median activation times (T4-T6) for Air Providers against the following targets:

Day time (0600 – 1800)	Within 10 minutes of dispatch time
Night time (1800 – 0600)	Within 20 minutes of dispatch time

9.2.4 National Performance data against response time targets (T4-T7) (refer Appendix 3) must be submitted

9.2.5 For informational purposes, Emergency Road Ambulance Providers submit reports on their performance, directly to NASO.

9.3 Financial Reporting

9.3.1 Financial accounts for each Provider must be forwarded to NASO within three months of the end of each financial year. These reports should reflect the accounts of all funds paid to the contractors who provide Ambulance Communications Services under this contract and should include:

a. statement of comprehensive income

b. statement of changes in equity

c. statement of Financial Position; and

d. statement of cash for the period.

9.3.2 From 01 July 2012 the Provider must report annually on the breakdown of revenue and expenditure allocated to that revenue stream for the following services:

a. 111 services;

b. Patient Transport Services (refer Appendix 1);

c. Events (refer Appendix 1);

d. Alarm Monitoring (refer Appendix 1); and

e. Privately funded services (refer Appendix 1).

9.3.3 Statements from independent auditors must be provided to NASO on an annual basis.

9.4 Other Reporting

9.4.1 By 20th July of each year the Providers must submit the following national volumes data for the previous financial year to NASO:

a. Number of calls received by the Ambulance Communications Centres

i. Via 111
ii. Via other methods

b. Number of emergency incidents

i. registered by the Ambulance Communications Centres
ii. with at least one vehicle dispatched (T5)
iii. with at least one vehicle mobilised (T6)
iv. with at least one vehicle arriving at scene (T7)
v. with a transport to a medical facility (T9)

c. Number of vehicles

i. Mobilised
ii. Arriving at Scene (T7)
iii. Transporting to a medical facility (T9)

9.4.2 The following information must be made available to the funders upon reasonable request:

a. evidence that a comprehensive quality management system is in place

b. evidence of the level of the Ambulance Communications Centre's compliance with NZS 8156.

10 Monitoring and Evaluation

10.1 NASO retains the right to evaluate the Provider's performance and demonstration of the delivery of a consistent, quality service. This evaluation by either NASO (or auditor nominated by the NASO) is not restricted to the above reporting areas. At least 10 days notice will be given of any evaluation audit.

10.2 Prior to the regular performance monitoring meetings, the Provider will provide NASO with written commentary/explanations regarding

a. Changing trends and exceptions identified in the reports

b. Performance issues

c. Activities planned and being undertaken to improve performance

11 Access to Information

NASO retains the right to make reasonable requests for ad-hoc information relating to the provision of EAS in the region and the Provider must accommodate such requests within a reasonable and agreed timeframe.

APPENDIX 1: Definitions

In this Service Schedule, unless the context otherwise requires, the following terms have the meaning in the corresponding definition:

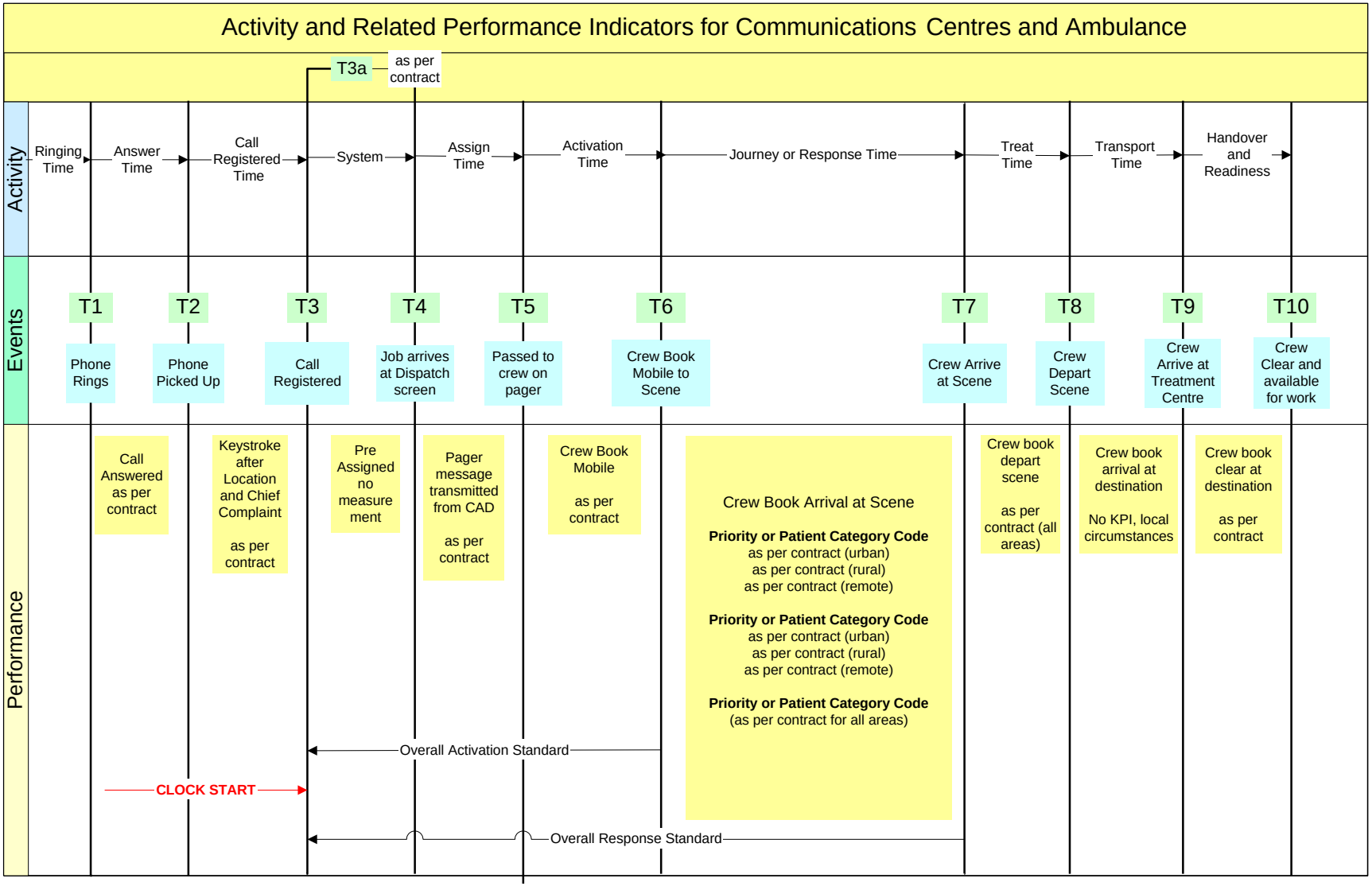
Term	Definition
Abandoned Call Rate	The number of calls abandoned by the caller before it has been answered by the Ambulance Communications Centre.
Activated	The point at which the dispatcher notifies the EAP crew to respond to an incident
Activation Times	The time between when an emergency resource, whether road, air or other is assigned by the Ambulance Communications Centre until that emergency resource is mobile, airborne, or other (T3-T6). The activation is linked to the Assign Time see below.
Alarm Monitoring	The receipt of automated alarm signals from remote devices via line receivers connected to the Ambulance Communications Centre. and subsequent response assessment. Note this does not include the management of non-triaged emergency calls forwarded from medical alarm companies.
Assign Time T5	The exact time that an ambulance resource whether road, air or other is provided with sufficient information to begin to make a response to an emergency call. (Refer Appendix 3)
Automatic Vehicle Location	A system that can track ambulances or vehicles and display them on a digital map.
Business Continuity	All aspects of strategic and operational areas of an organisation.
Call Answer Time T1-T2	Means the interval of time from when the phone begins to ring until the Ambulance Communications Centre answers. (Refer Appendix 3)
Call Registered	The first keystroke after the call has been transferred to the dispatcher.
Call Type	Calls arriving at the Ambulance Communications Centre via; over-flow from another Ambulance Communications Centre, the 111 system, a clinician, through a public access line, from other emergency services, via medical alarms or by other means.
Caller Line Identification	The ability for a 111 caller's landline number to automatically populate onto the computer screen of the call-taker. Only available for Telecom subscribers.
Computer Assisted Dispatch (CAD)	An emergency ambulance dispatching system that is aided by a computer.
Dispatch time T4-T6	Means the interval of time from when a call is received by the Ambulance Communications Centre (after sufficient information is obtained as to the location and nature of the call) until an ambulance or First Responder departs to attend that call. (Refer Appendix 3)
Emergency Medical Dispatcher	A call-taker or dispatcher who is registered with the International Academy of Emergency Medical Dispatchers levels 1 to 4.
First Responders	A response which may have a qualification of less than BLS and is the first resource available to respond to an incident. This may or may not be a response in a vehicle with patient carrying capability. This may include the fire service.

Term	Definition
Medical Priority Dispatch System	A software system used to prioritise the potential severity of a patient's condition in order to determine the relative need for emergency ambulance services.
Medical Priority Dispatch System Compliance Targets	The key performance indicators outlining compliance performance with the Medical Priority Dispatch System's expectations.
Mobile data transfer mapping	The ability to supply a geo-verified address to ambulance crews as part of total job information.
Patient Transport Services	Transport of non-emergency inter-hospital patients by EAPs under contracts with DHBs.
Rapid Response Unit	A response is a non-transport capable vehicle. This response is designed for early arrival at cases where immediate intervention is required and can also be used for back up for lower skilled crew levels.
Registered	The first keystroke after the call has been transferred to the dispatcher.
Registrar	A health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand (established by the Health Practitioner Competence Assurance Act 2003) and who is eligible to be enrolled in a vocational training programme.
Response Time **T4 – T7**	Means the interval of time from when a call is received by the Ambulance Communications Centre after sufficient information is obtained as to the location and nature of the call, until an ambulance (road or air) or First Responder or PRIME practitioner arrives at the place for which it was requested. (Refer Appendix 3)
Unit Hour	An ambulance (i.e. not a First/Rapid Response Unit or manager vehicle) available to attend a call for an hour.
Urgent Community Care (UCC)/Extended Care Paramedics (ECP)	A response with a skill level of ECP/UCC who are trained to assess patients conditions to determine the best patient care pathway, which may typically involve treatment at home or referral to other care pathways, rather than direct transport to ED.
Virtual Single System	The ability of the three Ambulance Communications Centres to be in a constant and active network that allows for the overload of calls to be managed in an alternative Ambulance Communications Centre and to provide backup in the event of a systems failure in one Ambulance Communications Centre.

APPENDIX 2: Response Time Targets for Road Ambulances

	Type of Area					
Type of Incident	**Urban Service Area** (Main urban centres > 15,000 population – responses within city boundary as specified on service area map)		**Rural Service Area** (Rural areas surrounding urban cities, or non-remote rural areas, or minor urban/provincial town centres <15,000 population as specified on service area map)		**Remote Rural Service Area** (Very rural and remote locations as specified on service area map)	
Immediately Life Threatening Emergency Incidents	Arrive at request point within 8 minutes from time of sufficient information collected for the call to be entered into the queue for 50% of calls	Arrive at request point within 20 minutes from time of sufficient information collected for the call to be entered into the queue for 95% of calls	Arrive at request point within 12 minutes from time of sufficient information collected for the call to be entered into the queue for 50% of calls	Arrive at request point within 30 minutes from time of sufficient information collected for the call to be entered into the queue for 95% of calls	Arrive at request point within 25 minutes from time of sufficient information collected for the call to be entered into the queue for 50% of calls	Arrive at request point within 60 minutes from time of sufficient information collected for the call to be entered into the queue for 95% of calls
Potentially Life Threatening Emergency Incidents	Arrive at request point within 20 minutes from the time of sufficient information collected for the call to be entered into the queue for 80% of calls		Arrive at request point within 30 minutes from the time of sufficient information collected for the call to be entered into the queue for 80% of calls		Arrive at request point within 60 minutes from the time of sufficient information collected for the call to be entered into the queue for 80% of calls	
Non Emergency Incidents	Time out as requested or specified by control and within normal road restrictions		Time out as requested or specified by control and within normal road restrictions		Time out as requested or specified by control and within normal road restrictions	

APPENDIX 3: Time Intervals



APPENDIX 4: Reporting Categories

Where information is requested by volume categories, the following categories are to be used:

1. ACC Road – trauma cases with road ambulance response only, funded by ACC, patient transported
2. ACC Air – trauma cases with air ambulance response (with or without road ambulance assistance), funded by ACC, patient transported
3. Accident, Treatment Only – trauma case, emergency only, patient not transported
4. Accident, Transfer, Road – trauma case, funded by ACC, inter-hospital transfer by road
5. Accident, Transfer, Air – trauma case, funded by ACC, inter-hospital transfer by air
6. Medical, Road – non-trauma case with road ambulance response only, MPDS echo or Category A calls, patient transported
7. Medical, Road – non-trauma case with road ambulance response only, MPDS Category A, non-echo, patient transported
8. Medical, Air – non-trauma case with air ambulance response (with or without road ambulance assistance), emergency only, patient transported
9. Medical Treatment Only – non-trauma case with road ambulance response only, emergency only, patient not transported
10. Other, Road – not emergency, road response only
11. Other, Air – not emergency, air ambulance response (with or without road ambulance assistance).

Note that, for the purposes of establishing reporting categories, the terms ‘medical’, ‘accident’ and ‘other’ relate to the status as determined by ProQA with ‘other’ including standby, false alarms and assistance dispatches.

Where information is requested by provider categories, the following categories are to be used:

1. Own District – a provider physically based within the District of the scene
2. Other District – a provider physically based outside of the District of the scene

APPENDIX 5: Contracted and Sub Contracted Emergency Ambulance Service Providers

Road
Order of St John
Wellington Free Ambulance
[reserved]
[reserved]
Air (for ACC)
Auckland Rescue Helicopter Trust
Eastland Helicopter Rescue Trust
Hawkes Bay Helicopter Rescue Trust
Taranaki Rescue Helicopter Trust
Philips Search & Rescue Trust
The Life Flight Trust
Garden City Helicopters
Otago Rescue Helicopter Trust
Subcontracted
Lakes District Air Rescue Trust
Northern Emergency Services Trust

APPENDIX 6: Clinical Support Desk Service Description

1. OVERVIEW

1.1 The National Ambulance Services Strategy (the Strategy) was released in June 2009. The Strategy is built around 10 initiatives. Initiative 10 related to ensuring that response and resolution of call out is clinically appropriate for each patient.

1.2 A Clinical Support Desk function will support the following actions under initiative 10 of the Strategy:

a. Improve clinical decision making support within Ambulance Communications Centres

b. Use technology and clinical expertise to increase capabilities within the Ambulance Communications Centres' system.

2 AIM

2.1 The Clinical Support Desk will provide the following:

a. clinical support and advice to call takers and dispatchers in the Ambulance Communications Centres to enhance the most appropriate dispatch decision making process, for all levels of patient acuity, especially high acuity

b. clinical support and advice to all field personnel (including road and air), thereby facilitating the use of the most appropriate pathways of care

c. real time clinical advice to support decisions on air or land transport options

d. support clinical audit and quality improvement in Ambulance Communications Centre processes

e. clinical support and guidance for Ambulance Communications Centre call takers and dispatchers.

3 SERVICE REQUIREMENTS

3.1 A Clinical Support Desk function will:

a. operate 24 hours per day, seven days per week in each of the Ambulance Communications Centres

b. be provided in each Ambulance Communications Centres (physical presence or available remotely from another Ambulance Communications Centre

c. be staffed by Advanced Life Support (ALS) paramedics who are employed by a contracted emergency ambulance service provider (Emergency Ambulance Provider)

d. be supported by a Clinical Support Desk Policy, common to all three Ambulance Communications Centres

e. provide advanced clinical advice to Ambulance Communications Centre staff, and ambulance staff in accordance with the Ambulance Communications Centres Clinical Desk Protocols[7] including red flags and clinical conditions

f. support ambulance crews in accessing the most appropriate care pathway for their patients

g. ensure that robust processes are followed to ensure priority is given to the incident with the highest acuity

[7] The Ambulance Communications Centre Clinical Desk Protocols as agreed by the Clinical Desk Steering Group.

h. ensure complete and accurate records are documented for each patient in compliance with relevant legislative requirements

i. actively engage and participate in clinical reviews.

3.2 The benefits of the Clinical Support Desk will include:

a. patient outcomes for high acuity patients may be improved by clinical determination of increased skill sets and/or additional resources being required

b. patient outcomes for low acuity patients may be improved by ensuring that the appropriate pathways are accessed in the most timely manner

c. potential increase in the availability of ambulances (and staff) to attend higher acuity call outs by avoiding the dispatch of an ambulance when it is not required

d. all field staff (including Primary Response in Medical Emergency practitioners) will have immediate access to clinical advice to assist with the facilitation of appropriate treatment/transport regimes

e. reduction of inappropriate transports to emergency departments

f. improved utilisation of existing alternative care pathways and health resources to support alternative care for patients.

3.3 The Provider will enter into a Service Level Agreement (SLA) with each Emergency Ambulance Provider to ensure clarity around governance, accountabilities and reporting lines. A copy of the signed SLA and variations to the SLA will be provided to the National Ambulance Sector Office (NASO).

4 SERVICE CAPABILITY LEVELS

4.1 The service capability levels describe the skill level required for the Clinical Support Desk function. The staff will be advanced life support paramedics with a high level of clinical competency with excellent oral and written communication, technological and leadership skills.

4.2 The staff will have access to the appropriate tools eg software to enable them to fulfil the role of the Clinical Desk Support Function.

5 CLINICAL OVERSIGHT

5.1 The staff providing the clinical desk function will do so under the delegated authority to practice and clinical oversight provided to him/her by the medical director of their Emergency Ambulance Service employer.

6 REPORTING

6.1 The Provider will report quarterly to NASO with regard to the Clinical Support Desk function and performance.

6.2 The reporting parameters are agreed by the Clinical Desk Steering Group[8] with advice provided by Subject Matter Experts in the Emergency Ambulance and Ambulance Communications Centre environments, if required.

[8] Membership of this Group includes representatives from the National Ambulance Sector office, St John, Wellington Free Ambulance, Air Ambulance Sector and Ambulance New Zealand

6.3 The quarterly reports are due by the 20th of the month following the end of the reporting period. Quarters end 31st March, June 30th, September 30th and December 31st.

Period	Report is due by	Report Content
1 July to 30 September	20 October	Regular reporting parameters agreed (as per clause 6.2 of this service specification).
1 October to 31 December	20 January	
1 January to 31 March	20 April	
1 April to 30 June	20 July	
1 July to 30 September	20 October	
1 October to 1 December	20 January	
1 January to 31 January	20 February	

7 QUALITY REQUIREMENTS

The Provider will:

a. comply with the quality requirements in the current overarching Agreements(s)

b. develop and implement a clinical desk support quality improvement programme and provide a copy to NASO if requested.