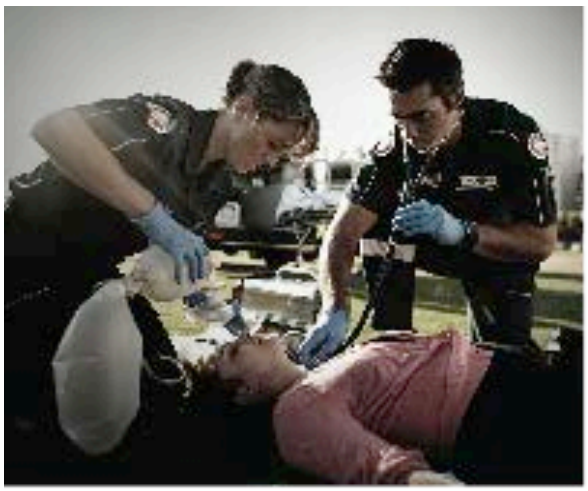

The Council of Ambulance Authorities

Annual Report 2011-12

Providing leadership for the provision of Ambulance Services

Contents

Chairman's Introduction

In this, the 50th year of the Council of Ambulance Authorities (CAA), it is pleasing to report on the work of the CAA, our ongoing achievements and those of our member organisations.

This is my second year as Chair and it has been a year of change again for the CAA as we continue to implement the new directions set for the organisation last year.

Our conference in 2011 was in Sydney. Our Rural and Remote Symposium was combined with the 7th Annual Meeting of the International Roundtable on Community Paramedicine and it was good to see ambulance colleagues from around the world at this event. I, and a number of my colleagues were also able to attend the 8th Annual IRCP meeting in Vancouver in June 2012. The opportunity for international dialogue with services dealing with similar issues to our own is very valuable and continues to add value to our own operations. Ambulance services around the world are grappling with many of the same pressures and we can learn valuable lessons from each other's responses.

The 2011 Open Conference focussed on the role of ambulance services in emergency management and in responding to natural and man-made disasters, of which there has been no shortage. As is our usual practice we presented our annual Ambulance Awards at a special dinner during the conference. I would like to congratulate the winners and the runners up for their creativity and achievements in the continuing advancement of ambulance services in Australia and New Zealand.

On behalf of the CAA I would like to thank all of the representatives from our member services who contribute so much as members of the CAA Board and its sub-committees to continually progress the work of the CAA and the development of our sector.

I would also like to thank my Board colleagues for their support and collegiality throughout the year and the CEO and CAA Secretariat team for their support for the Board and its committees and the ongoing work of the CAA.

Tony Ahern
Chairman

Council of Ambulance Authorities

The Council of Ambulance Authorities Inc. (CAA) is the peak body representing the principal statutory providers of ambulance services in Australia, New Zealand and Papua New Guinea. The CAA formally incorporated in December 2002, having operated as an informal grouping of the ambulance services of Australia, New Zealand, and Papua New Guinea since 1962.

Intent

The intent of the Council of Ambulance Authorities is to influence, advise and develop superior pre-hospital care and ambulance services in the Asia Pacific Region.

Purpose

Policy	Actively contribute to the development of public policy;
Knowledge	Develop a body of knowledge through research, exchange of information, monitoring and common KPI reporting;
Quality	Develop and implement standards for improved quality of care and services;
Synergies	Develop common systems and processes;
Leverage	Jointly fund initiatives for common outcomes.

Membership

Membership of the CAA includes the principal providers of ambulance services in each State and Territory of Australia, New Zealand and Papua New Guinea. The Board of the CAA consists of the Chief Executives of each member service.

Members of the CAA are:

- A.C.T Ambulance Service (Emergency Services Agency, ACT Department of Justice and Community Safety)
- Ambulance Service of New South Wales
- Ambulance Tasmania (a Division of the Department of Health and Human Services)
- Ambulance Victoria
- Queensland Ambulance Service (a Division of the Department of Community Safety)
- SA Ambulance Service
- St John Ambulance Australia (NT) Inc.
- St John Ambulance Australia (Western Australia) Inc.
- St John New Zealand
- Wellington Free Ambulance

Associate Members are:

- Ambulance New Zealand
- St John Ambulance Papua New Guinea

Celebrating 50 Years of the CAA

The Council of Ambulance Services turned 50 this year and we took time in Hobart to celebrate the fact. A special dinner was held at The Source restaurant, part of Hobart's famous Museum of Old and New Art (MONA) where guests were presented with an updated edition of the *History of the Council of Ambulance Authorities* The original work written and illustrated by Ian Kaye-Eddie, formerly of St John Ambulance (WA), covered the period from 1962 to 1996 starting with the initial meeting held in December 1962 in Canberra. This was updated to the present day by former CAA Executive Director Lyn Pearson, who wrote a postscript covering the period 1996-2012. Many at the dinner had their heads in this publication between courses and many copies were autographed by the authors who were both present.

The publication highlights some of the progress that has been made by the ambulance sector and by the CAA as its representative over the past half century. The CAA's role in helping to achieve a single telephone number (000) for emergency calls throughout Australia is but one highlight among many. Developing a system of accreditation for degree courses in paramedicine is another.

Australia's famous ambulance man, John Simpson, and his donkey carrying a wounded soldier in Shrapnel Valley, Gallipoli – April 1915

The CAA's most profound contribution in many ways though is the ongoing culture of collegiality, cooperation and mutual support which has helped to facilitate the development of modern ambulance services in every jurisdiction that has a CAA member. As Tony Ahern, the current chair of the CAA put it in his Foreword to the 2012 edition;

Fifty years has seen transformational change in the ambulance sector, not least in the last ten years. The pace of change throughout has been facilitated and even accelerated, by the collegiate exchange of knowledge experience and insights between CAA members. The ambulance sector has come a long way in the last fifty years and the CAA has played a key role in that development. Long may it continue.

2011-12 Disasters and Ambulance Response

Ambulance services are not only rapid response emergency health services, but also part of the array of resources needed in times of natural (or other) disaster. When a large number of people face a health threat together – as in an emergency situation – then the capacity of ambulance services to deliver critical care in the field; to manage the logistics of operating in an unstructured environment; transport patients to hospital and to move vulnerable people out of harm's way is a vital resource. Scaling up from our daily business of saving of lives one at a time to saving the lives of many people affected at once by a disaster is part of the challenge for ambulance's role in emergencies. Ambulance services must be able to maintain their normal, busy volumes of emergency services while also responding to major disasters.

Sharing resources between states and sending teams between states is one response to the challenge of scaling up. Smaller services are able to support the larger states by embedding staff into larger teams.

Significant events in 2011-12 included:

The NSW Ambulance Service (ASNSW) committed a significant number of resources to the flood emergency in NSW during early 2012, in addition to the impact of the flooding on normal operations. Resources allocated included helicopter placement in strategic locations, ambulance managers on a 24 hour roster to the State and District Emergency Operation Centres and assistance to the local health districts with the transporting of patients due to flood inundation at various locations.

A number of teams of ASNSW Special Operations Unit Swift Water Technicians were deployed to affected areas and tasked by the SES as the combat agency. This allowed for the SES to have a greater swift water technician capability and to also assist in fatigue management of SES crews.

In response to the March 2012 floods which affected 20 municipalities in north-east Victoria, Ambulance Victoria (AV) assisted with an emergency evacuation of the Numurkah hospital and aged care facilities in the affected area. AV established a Temporary Urgent Care Centre and provided ongoing support to the Numurkah District Health Service.

Queensland too experienced wide spread flooding in the south west of the state, resulting in several towns being isolated. The Queensland Disaster Management Centre, co-located with Queensland Ambulance Service was activated to assist the community with evacuations, flood recovery and relief.

In late 2011, significant bushfires in the South West region of Western Australia burnt 3,620

hectares, destroyed 45 houses, nine chalets and five large sheds, and partially destroyed three more homes. The multi-agency response was managed by the Department of Environment and Conservation, with assistance from emergency management partners. St John WA also sent support staff to Christmas Island following the capsizing of a boat carrying 200 asylum seekers which resulted in significant loss of life with 90 passengers dying.

In New Zealand a measles epidemic required additional planning in response to the threat and to ensure resilience. This included additional screening by 111 call takers and preparedness of crews to ensure St John NZ remained capable to attend to increased workloads as well as day to day work. Similar plans have been instigated with seasonal influenza responses. Recovery work relating to the 2011 Christchurch earthquake continued into 2011-12.

Over the past few years New Zealand has seen a number of volcanos experience increased activity with some eruptions including Tongariro. At the time of eruptions St John NZ works in with Civil Defence and other agencies to ensure public in the local area have been evacuated and are safe.

Chief Executive Officer's Report

2011-12 was my first full year as CEO of the Council of Ambulance Authorities. My first priority, after setting up our new office in St Kilda Road, was to begin the task of introducing the ambulance sector and the CAA to the key stakeholders at the national level in health and emergency services. I met with the Secretary and senior officials of the federal Health Department in Canberra; with the Director-General and senior staff of Emergency Management Australia and with the heads of many of the new national health reform agencies. Contact was made or renewed with key stakeholder organisations such as the National Heart Foundation and the Stroke Foundation and with key ambulance sector bodies such as Paramedics Australasia.

I found people receptive to the ambulance story and interested in the capability our sector brings to the health and emergency management fields.

I also made a point of visiting each of our ten member services and started to develop a good appreciation of their distinctive character and strengths.

The CAA Annual Conference in Sydney was a highlight for me and the high quality of the program, focussed on the ambulance role in emergency management, reinforced my confidence in the capability and resourcefulness of our sector and my admiration for the life-saving and life-changing work that our services do.

The Rural and Remote workshop, held in conjunction with the International Roundtable on Community Paramedicine (IRCP) introduced me to the creative responses used to meet the needs of the significant proportion of the Australian and New Zealand populations who live outside of urban centres. Rural service delivery was the focus of one of the submissions we made in 2011, to the Senate Inquiry into rural health service delivery and workforce issues. This submission also gave me the opportunity to present to the Senate Community Affairs Committee at hearings in Albury New South Wales. As with the senior officials I met with in Canberra, the Senators were interested to hear the ambulance story and to be briefed on the important role our members play in supporting the health of people in rural and remote communities and, not least, the vital role played by volunteers in these settings.

The CAA also made a submission on the development of an Activity-Based Funding (ABF) system for Australia's hospital sector and met with the consultants working on this project.

In May 2012 we were able to incorporate an ambulance display in the Health Informatics Conference at Sydney's Darling Harbour showcasing the data and communications capability of modern ambulance services and the connectivity with other parts of the health system. Ambulance services belong in the room

with other health services at forums such as this and it is part of my aim to get the organisers of and participants at such events to expect us to be there on a regular basis. I would like to thank ASNSW for mounting and staffing this display - and the young fellow from a visiting school party who managed to locate the switch for the ambulance's siren.

As well as our quarterly CAA Board meetings I attend most of the meetings of the formal sub-committees and forums established by the Board to develop and promote the collective wisdom of our sector. More detail on each of these is provided elsewhere in this Annual Report. Exchanging ideas between our member services was the whole point behind the establishment of the CAA, now 50 years ago, and is a source of our strength as an organisation. Bringing together senior managers from each service to discuss a focussed agenda of current and developing issues allows us to consolidate and coordinate effort on strategically-chosen issues and to keep abreast of the variety and diversity of our member organisations on others.

I very much appreciate the knowledge, experience and collegiality of the members of these groups which in many ways are the engine room driving the collective forward movement of the ambulance sector in Australia and New Zealand. We have world class quality ambulance services in Australasia and the involvement of the CAA bringing people together since its first meeting in December 1962 has helped us get to this point. I know that this appreciation is shared by the other CAA Secretariat staff who attend some of these meetings.

Overall, 2011-12 saw real progress in terms of putting the ambulance sector on the policy makers' radar. There's more to come in 2012-13!

Greg Mundy
Chief Executive Officer

CAA Committees and Working Groups

Ambulance Education Committee (AEC)

The AEC provides a focal point on ambulance education programs and professional practice in the sector and considers education matters relevant to the provision of quality ambulance services, providing recommendations on specific matters when requested by the CAA Board.

The AEC oversees the work of the Paramedic Education Accreditation Program (PEAP), which reviews and accredits entry-level university degree courses for paramedics. It also looks at new methods of delivering education including simulation and e-learning.

In 2011-12 the Committee met on 9 December 2011 and 15 May 2012.

The AEC continues to be a key vehicle for stakeholder engagement between the Universities, Paramedics Australasia (PA) and the CAA in the development of the higher education accreditation program agenda.

Emergency Management Committee (EMC)

The Emergency Management Committee's activities include the ongoing provision of advice to the Board relating to ambulance involvement in emergency management including such issues as: resource capacities and development; national standards and technical advice. The EMC looks at the involvement of ambulance services in major emergencies with a view to distilling the lessons to be applied to future events. In 2011-12 a report was commissioned from Monash University on these issues and the EMC is currently working on responses to this work.

The EMC provided considerable input to CAA's 2011 Conference, which focused on emergency management, and gave valued assistance in sourcing high quality speakers.

In 2011-12 the EMC met on 25 November 2011 and on 10-11 July 2012.

Strategic and Business Advisory Committee (SBAC)

The SBAC provides a national focus and acts as the key advisory group to the CAA on matters relating to the strategic direction and development of business, resourcing, planning, reporting and operational matters within the sector.

In 2011-12 the Committee met on 13 September 2011 and 9 March 2012.

SBAC has provided data for the 2012 ROGS and is continuing to work on 2013 ROGS data.

- The 2012 ROGS has seen some changes to the layout of Chapter 9 where ambulance data is located. The chapter has received an Emergency Management sector overview with the traditional Chapter 9 'Fire, Road rescue and Ambulance Event' following. The sector overview provides an introduction and the policy context for the government services reported in Chapter 9.
- There are a few bigger changes planned for the 2013 ROGS for ambulance section, such as a mini case study focusing on one of ambulance service project, data quality statements for a few ambulance indicators and a review of the ambulance framework. The Triple 000 Call Answer Time and Pain Management indicators are being trialled in the 2011-12 collections for possible publication in the 2014 ROGS.

Work is being progressed on the following SBAC priorities:

- The CAA Board and SBAC have allocated a dedicated resource for the Product Costing project and initial analyses are being completed.
- A demand management paper is looking at trends and data from past 10 years to identify policies and their outcomes on demand growth.
- Health Workforce Australia has approached the CAA to co-operate on the HWA Workforce Planning project. The SBAC has been working with HWA to arrange a collection for the report.
- The SBAC has been reviewing ambulance key performance indicators and has set up a project plan to analyse current indicators and prepare a proposal for an improved set of indicators, nationally and internationally comparable between services.

Forums and Working Groups

Rural and Remote Group

The Rural and Remote Working Group (RRG), provides a national focus and acts as the key advisory group to the CAA on matters relating to the strategic direction and development of ambulance services in rural and remote areas. Key issues include models of service delivery and strategic issues that affect the delivery of volunteer ambulance services. The RRG acts as the CAA's representative on the National Rural Health Alliance.

The RRG provided valued support to CAA's submission to the Senate Community Affairs Committee's inquiry into rural health workforce and service provision. RRG members also assisted with providing responses to questions raised by Senators in the hearings held in May 2012.

When required, the RRG assists the host jurisdiction in planning a rural and remote symposium in conjunction with CAA's Annual Conference. The 2011 Rural and Remote Symposium was held in Sydney jointly with the 7th meeting of the International Roundtable on Community Paramedicine. A brief report on this event is included in this Annual Report.

Clinical Forum

The re-constituted Clinical Forum met after the end of the 2011-12 reporting period and will report in next year's Annual Report.

Accreditation Project Update

The CAA has established the Paramedic Education Programs Accreditation Program (PEPAP) working in conjunction with professional bodies and the university sector to ensure graduates are equipped to meet the challenges of today's ambulance services.

The PEPAP project is well established and at the end of 2011-12 financial year 16 (sixteen) universities are involved at various stages of accreditation or evaluation of their program/s.

The Accreditation of entry-level paramedic education programs has 3 stages:

Preliminary approval

Preliminary approval of a new entry-level paramedic education program is sought prior to the commencement of teaching the course and approval is normally granted prior to, or commensurate with, the entry of the first cohort into the program.

Provisional accreditation

A new program that has been granted preliminary approval will be eligible for provisional accreditation after the first year of teaching, subject to successful annual review. Provisional accreditation may also be granted where conditions are attached following assessment for full accreditation.

Full accreditation

A program is eligible for full accreditation for a period of 5 years after the first cohorts of graduates have at least 12 months of practice experience following graduation.

In 2011-12 the Accreditation project Site Evaluation Team (SET) completed 8 (eight) visits.

The following Universities (programs) hold provisional/full accreditation:

- Monash University: Bachelor of Emergency Health (Paramedic); Bachelor of Nursing / Emergency Health (Paramedic)
- Flinders University: Bachelor of Paramedic Science
- Victoria University: Bachelor of Health Science (Paramedic)
- Queensland University of Technology: Bachelor of Health Science (Paramedic)
- Edith Cowan University: Bachelor of Science (Paramedical Science)
- Charles Sturt University: Bachelor of Clinical Practice (Paramedic)/ Bachelor of Nursing / Bachelor of Clinical Practice (Paramedic)
- Auckland University of Technology NZ: Bachelor Health Science (Paramedicine)
- Whitireia Polytechnic NZ: Bachelor of Health Science (Paramedic)
- Australian Catholic University: Bachelor of Nursing / Bachelor Paramedicine; Bachelor Paramedicine Central Queensland University: Bachelor of Paramedic Science

- University of Tasmania: Bachelor of Paramedic Practice
- University of Queensland: Bachelor of Paramedic Science

The following university programs are being evaluated for provisional/full accreditation or hold preliminary approval:

- University of Sunshine Coast; Bachelor of Paramedic Science
- University of Ballarat; Graduate Diploma of Paramedicine
- Curtin university; Bachelor of Science (Health sciences)
- LaTrobe University; Bachelor of Health Sciences Paramedic Practice

Paramedic Education Program Accreditation Scheme Enrolments

The below table provides an overview of the total number of enrolments for 2012 per state in Australia and in New Zealand.

Location	Total Enrolments
New Zealand	470
Australian Capital Territory	53
New South Wales	405
Queensland	1339
South Australia	400
Tasmania	164
Victoria	1861
Western Australia	274
TOTAL	**4966**

2011 CAA Conference

The 43rd annual Council of Ambulance Authorities Convention held in Sydney from 9th to 13th October 2011 was a great success with stimulating speakers, lively panel discussions and interactive working groups.

Presentations and discussion focussed on volunteers and volunteer management; rural workforce issues and ambulance service models in rural areas. Speakers from the US, Canada, Australia and New Zealand provided a rich and diverse picture of community paramedicine and the vital roles it can play for patients in rural areas. The presentations made it clear that service models are diverse, fitting with the characteristics of their local areas rather than being a 'one size fits all' template, but that there are many issues in common between the various locations featured.

Photos: Left - delegates at CAA 2011 Convention and Right Keynote Speaker, Mr Rick Patrick, Director, First Medical Responder Coordination, Office of Health Affairs, Homeland Security, USA.

Rural Ambulance Services - Their role in delivering quality out of hospital health care

This was the theme of a two day event auspiced jointly by the Council of Ambulance Authorities and the International Roundtable on Community Paramedicine (IRCP) which has members in the United States and Canada in addition to the CAA. On behalf of the IRCP, Gary Wingrove, from Minnesota, welcomed delegates before they heard keynote presentations from Jenny May, the former Chair of the (Australian) National Rural Health Alliance and Rick Patrick, Director of Medical First Responders within the Office of Health Affairs in the US Department of Homeland Security.

Disaster Management and Resilience

Disaster Management and Resilience was the theme of the Open Conference, held on October 12th. Prominent national and international keynote speakers from Australia, New Zealand, Canada and the United States provided delegates with additional knowledge and key learnings from recent worldwide disasters including the Christchurch Earthquakes, Queensland Floods and Cyclone Yasi, London Bombings, Alberta Wildfires, Victorian Black Saturday Fires and the preceding heatwave.

Michael Brooke, Operations Director, St John New Zealand, took delegates on a journey following the paramedics response to the numerous earthquakes experienced in Christchurch. Setting the scene, Christchurch has a population of 400,000 people, 8 ambulances during the day and one major hospital. When the quake of 22 February 2011 hit, it devastated the city with 181 people killed, hundreds more injured, buildings collapsed including 2 ambulance stations and the South Island Communications Centre inoperable, power outage, sewerage outage and collapsed infrastructure including roads and bridges. Mr Brooke went on to explain how St John responded and how they managed the work of an ambulance service in a destructed environment, praising his staff including volunteers and the assistance of agencies from regions including Wellington. He explained the set-up of Welfare Centres, which included the presence of paramedics assisting to prevent unnecessary emergency calls; the big focus on moving people and the importance of integration with the Royal New Zealand Air Force. He said in the days following, their attention also turned to the management of at-risk people living in the community, service filling the gaps in cases where regular Home and Community Carers did not show up.

Gerard Lawler, Assistant Commissioner, State Operations with the Queensland Ambulance Service discussed how his service prepared for and responded to the recent natural disasters of Cyclone Yasi and the Queensland floods - an unprecedented series of events by scale and nature managed by a high level of commitment, innovation, resilience & resourcefulness prior and during the events. He highlighted the importance of the strong links established with the Disaster Management Framework at state, regional and local levels including the importance of preparedness – establishing special response teams at regional level supported by the state, confirmation of exercises related to cyclones focusing again on preparedness, communication and response. Mr Lawler warned that history has a habit of repeating itself and outlined the importance of capturing and exercising the

lessons learnt including business continuity plans, resource deployment, staff welfare, regional incident management teams (at local level with support from state level) and patient transfer including records management. The importance of the value was stressed, along with communications including early engagement with stakeholders, the use of the media, good processes and last, but importantly not least, the value of personal contacts.

Photo: (Left) Mr Gerard Lawler, Assistant Commissioner, State Operations, Queensland Ambulance Service and Right: Mr Ray Creen, CEO, South Australian Ambulance Service.

Intrastate, interstate and international support and operability was discussed throughout the day. A key presentation address from Chris Collett, Assistant Secretary, Emergency Management Policy Branch of the Commonwealth's Attorney-General's Department discussed the Commonwealth's role in national leadership, support during national disasters and funding in recovery. Mr Collett outlined the current and new thinking of how our nation responds in the Emergency Management space outlining Preparedness, Response and Recovery. He provided an overview of the National Strategy for Disaster Resilience Plan. He also spoke of the different ways in which Australians are now living, travelling further distances to work, and where we are living- the tree change and sea changers bringing city expectations to rural areas. His department is currently working with communities with their role of minimising risk.

Sponsors

The Convention was sponsored by Platinum sponsors ETT and Lightfoot Solutions and Ruby sponsors Laerdal and Rapp Australia.

The CAA 2011 Ambulance Awards Dinner was sponsored by SDSI.

The CAA acknowledges and thanks the above organisations as our Convention and Awards Dinner would not be possible without their support.

Service Reports

This section presents the 2011-12 annual reports of the Council of Ambulance Authorities jurisdiction members.

- A.C.T. Ambulance Service
- Ambulance Service of New South Wales
- Ambulance Tasmania
- Ambulance Victoria
- Queensland Ambulance Service
- SA Ambulance Service
- St John Ambulance Australia (NT) Inc
- St John Ambulance Australia (Western Australia) Inc
- St John Ambulance Papua New Guinea
- St John New Zealand
- Wellington Free Ambulance

A.C.T. Ambulance Service

Contact Details

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Our Vision:

A prepared community supported by an expert and timely emergency service response.

Our Mission:

Protection and preservation of life through professional ambulance services.

Jurisdiction

The ACT Emergency Services Agency (ESA) provides emergency management arrangements for the ACT under the *Emergencies Act 2004.* The four operational services within the ESA include the ACT Ambulance Services, ACT Fire & Rescue, ACT Rural Fire Service and the ACT State Emergency Service which, through collaborative working arrangements, play a significant role in preparing for, preventing and responding to emergency incidents within the Australian Capital Territory.

As a response agency of the ESA, the ACT Ambulance Service (ACTAS), holds legislated responsibility within the ACT for the provision of emergency, non emergency, specialist ambulance services and aero-medical services to the surrounding region of south east NSW.

The Australian Capital Territory is the smallest territory of the Australian States and Territories. It occupies an area encompassed by the South East New South Wales and covers approximately 2,360 square kilometres. The resident population of the Australian Capital Territory is approximately 365,600[1] primarily spread across various town centres of Civic, Woden, Belconnen, Tuggeranong and Gungahlin. The capital city of Canberra occupies an area of approximately 300 square kilometres.

([1] 3218.0 – Regional Population Growth, Australia, 2010-11 ABS)

The Year in Review

Activity & Performance

In 2011-12, ACTAS managed 39,112 incidents involving 39,908 responses by operational crews. This was achieved with a patient satisfaction survey result of 97% of patients satisfied or very satisfied with the level of service provided.

ACTAS attended 50% of emergency incidents in 9.25 minutes or less (performance target 8 minutes) and 90% in 14.83 minutes or less (performance target 12 minutes 30 seconds). Improvements were achieved in emergency response time performance at the 50th and 90th percentile. This is despite ACTAS reporting response times commencing from the first keystroke on the Computer Aided Dispatch system and increased work load.

Emergency Planning and Preparedness

ACTAS emergency planning took centre stage in October 2011 when Her Majesty Queen Elizabeth and Prince Phillip spent 10 days in the Territory closely followed in November by the President of the United States with ACTAS providing 24/7 paramedical coverage to both events.

ACTAS was also again responsible for developing and implementing the Directorate influenza vaccination program. This program continues to be viewed as a valuable strategy in increasing the participation of salaried and volunteer

staff in the vaccination program, reducing the impact of seasonal influenza on staff absenteeism, and increasing preparedness in the event of pandemic influenza. In 2011-2012, the program involved 694 departmental officers from ESA, ACT Corrections, ACT Magistrates Court and the Justice and Community Safety Directorate receiving flu vaccinations.

Work commenced via the Territory emergency management framework to review and update Mass Casualty Incident Planning arrangements and a new Concept of Operations document is planned for development between ACTAS and ACT Fire & Rescue.

Capital Works

Feasibility and due diligence studies, design, and community consultation was undertaken linked to the construction of a new emergency services facility in West Canberra that will house ACTAS and ACT Fire & Rescue under co-located arrangements. Construction, due to commence in September 2012, is supported by $24.6m in funding announced in the 2012-13 budget which will also support further design work for a second facility and significant upgrades to existing premises.

Key Achievements

In the 2011-12 budget, ACTAS was allocated $21.1m over 4 years to implement Stage I of a 3 year Sustainable Front Line Resourcing Plan. Year 1 of this strategy, developed with the assistance of ORH, a UK based modelling firm resulted in front line resourcing of the ACTAS increasing by 30 FTE, the establishment of a Quality, Safety and Risk Management Unit and the strengthening of Educational services.

Five additional emergency ambulances were commissioned and base line crewing numbers increased from 7 crews 24/7 to 9, complementing demand crewing of 2 additional crews, which operate between 0700 – 2300. An 18 month Funding Agreement was signed with Health Workforce Australia to progress the trial and evaluation of an Extended Care Paramedic program due to commence in 2012-13. Due diligence work was completed linked to a front line trial and evaluation of new cardiac /monitor defibrillators and work continued on the design of new front line facilities to be co-located with ACT Fire & Rescue in West Canberra.

Key Targets for 2012-13

In May 2012, the ACT Government in announcing the 2012-2013 budget committed further funding of $9.5m for ACTAS over 4 years to implement Stage 2 of the 3 year Sustainable Front Line Resourcing Plan. Commencing in January 2013, ACTAS will recruit an additional 15 staff to front line crewing.

Capital funding of $4.3m will see the ACTAS replace all cardiac monitor/defibrillators on front line units and commission two additional emergency ambulances. January 2013 will also see the commencement of the operational phase of the Extended Care Paramedic program funded by Health Workforce Australia.

See www.ambulance.act.gov.au for further information.

Ambulance Service of New South Wales

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Our Vision:

Excellence in care.

Our Mission:

To provide quality emergency medical care to the NSW community.

Our Values:

- *Professionalism*
- *Responsibility*
- *Accountability*
- *Teamwork*
- *Respect*
- *Care*

Jurisdiction

The Ambulance Service of NSW provides high quality clinical care and health related transport services to more than 7.25 million people in NSW, distributed across an area of 801,600 square kilometres.

We employ over 4,000 people, with 90 per cent being operational staff involved in the front line delivery of services. This includes paramedics, patient transport officers and specialised areas such as intensive care and extended care paramedics, special operations, counter disaster, aeromedical and medical retrieval.

The year in review

Activity

Total activity

- In 2011/12 we provided over 1,183,795 emergency and non-emergency and non-emergency responses.
- There were an average of 3234 responses per day, a call for help every 26.7 seconds.
- Emergency responses increased 3.4 per cent to 865,725 from 837,070 in 2010/11.
- Non-emergency responses totalled 318,070 an increased of 1.7 per cent compared with 2010/11.

Response Times

- Fifty per cent of potentially life-threatening cases were responded to within 10.93 minutes, compared to 10.6 minutes the previous year.
- The change in response performance is primarily due to higher demand and longer off stretcher times which limited the overall availability of ambulances to respond.

Chief Executive's Year in Review

2011/12 saw the Ambulance Service of NSW (Ambulance) continue to focus on improving the patient experience and developing a strong workforce.

Operational developments have included engaging our volunteer network through the Volunteers Conference in Bathurst and strengthening the partnership between communities, volunteers and organisations delivering ambulance services on our behalf.

The State Cardiac Reperfusion Program continued to be rolled out across the state with additional paramedics receiving reperfusion training. Since the program commenced, 764 patients have received accelerated cardiac reperfusion, and pre-hospital thrombolysis is well established in the Hunter and New England zones, with 115 patients receiving this life saving intervention.

The Ambulance Management Qualification was recognised for its outstanding development program for current and aspiring managers. Having now qualified 475 staff, this ambulance specific training enhances our frontline managers, strengthens organisational capabilities and our vision of Excellence in Care.

The Healthy Workplace Strategy team continued to build on the positive cultural changes across Ambulance by implementing Phase 2 of the Respectful Workplace Training program, which provides staff with practical steps to identify and minimise behaviours relating to workplace concerns and prevent bullying.

Capital works enhancements included the arrival of two new Beechcraft KingAir 350s that are capable of supporting the inter-hospital transfer of patients requiring specialised medical treatment and the replacement of Batemans Bay, Byron Bay, Coonamble, Cessnock and Narrabri Ambulance stations.

The implementation of standardised rostering processes and myShift has streamlined paramedic rostering, increased efficiency across NSW and positioned Ambulance as an early adopter of the electronic rostering system.

Top 10 Achievements 2011-12

1. As part of the State Cardiac Reperfusion Program (a collaborative clinical redesign initiative between Ambulance and the Ministry of Health) reperfusion training was provided to 394 paramedics; 98 monitors /defibrillators were equipped to transmit 12 lead ECGs to specialist receiving hospitals; and the provision of pre-hospital administration of thrombolytic therapy to communities within the Hunter New England Local Health District footprint commenced.

2. The stroke training package was developed for inclusion in the scheduled paramedic education program across regional NSW. This package forms part of the Stroke Project, a collaboration with the Ministry of Health and NSW Agency for Clinical Innovation and aims to improve patient access to stroke services across the hospital network, in particular to early stroke thrombolysis at an Acute Thrombolytic Centre.

3. An Operational Support Manager for Ambulance Volunteers and Community First Responders was appointed to deliver a standardised approach to volunteering in Ambulance across the state. This role is based in the new State Coordination Centre in Bathurst. Volunteers completing Ambulance training will now receive Certificate II Medical First Response, a nationally recognised qualification.

4. Establishment of an online learning program on suicide risk assessment and management for frontline staff. The interactive learning program builds on training provided in the Ambulance generic mental health training program and is in response to a recommendation from the NSW Suicide Prevention Strategy.

5. The Phase 2 Respectful Workplace Training program was developed and rolled-out across Ambulance to further improve workplace culture for all 4300 staff. This program reinforces and builds on the key messages from Phase 1, providing staff with practical steps to identify and minimise behaviours relating to workplace concerns and prevent bullying.

6. A number of significant Workforce programs were recognised, including: *Ambulance Management Qualification* awarded the 2011 Australian Human Resource Institute National Award for Outstanding Talent, *Healthy Workplace Strategies* awarded the 2011 TMF Risk Management Leadership Award, *the Ambulance bariatric truck* awarded the 2011 TMF Occupational Health and Safety and Injury Management Risk Management award, and the 2012 NSW Aboriginal Health Award for Closing the Gap Through Innovation and Excellence in Workforce.

7. Air Ambulance introduced the first of its new fixed wing fleet. The new Beechcraft KingAir 350 can transport two stretchers and up to three ambulant patients or larger retrieval teams. With a greater payload capacity, it can transport heavier patients and those requiring more complex heart/lung bypass equipment.

8. Implemented standardised rostering protocols and procedures, supported by a paramedic rostering manual, to streamline Ambulance rostering processes and improve efficiency throughout the state. The statewide roll-out of the myShift website also provided a simpler, efficient and more transparent process for paramedics to request and allocate overtime for backfilling of shifts and shift swaps.

9. The Capital Works Program saw the replacement of the Batemans Bay, Byron Bay, Coonamble and Cessnock Ambulance stations, with Cessnock subsequently winning a Regional Master Builders Association award. Narrabri Station was also completed as part of the new Narrabri Hospital and Murrurundi Station was officially opened in May.

10. Continued roll-out of the Clinical Outreach Program Phase II – Wide Area Network (WAN) Re-architecture. The project has upgraded the WAN data bandwidth by as much as a 50 fold increase, deployed new networking devices and deployed new routers, including 3G backups to approximately 260 Ambulance stations across the state.

Future Directions 2012-13

- Ambulance will continue to upgrade its facilities with plans already underway for a new ambulance station at Bundeena and a replacement station for Albury.
- The Medical Equipment Replacement program for 2012/13 includes the roll out of new defibrillators with 12 lead ECH transmissions capable of transferring data directly to hospitals and cardiology units.

- The Aeromedical Operations Centre (AOC) will develop a tailor-made clinical education course and establish agreed standards for all AOC staff.

- A comprehensive Health and Wellness Program in particular a Health Assessment Program for Paramedics will be fully implemented during the year.

- Ambulance will continue to make significant improvements in the recruitment and retention of Aboriginal employees to include Trainee Paramedics (VET and graduate entry), Patient Transport Officer and Trainee Control Centre Officer.

- A major project will be the compliance with the Australian Communications and Media Authority (ACMA) change to 400 MHz radio band and the replacement of analogue radio systems with digital radio systems.



Ambulance Victoria

Contact Details

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Our Vision:

Ambulance Victoria's role is to: Improve the health of the Victorian community by providing high quality pre-hospital care and medial transport.

Our Mission:

Ambulance Victoria (AV) commenced operation on 1 July 2008. AV currently has four areas of focus that guide the development of its strategic direction:

1. *Service qualiy, efficiency and innovation*
2. *Staff development, safety and welfare*
3. *Organisational support systems and resources*
4. *Health system and community intergration*

Jurisdiction

AV reports through the Department of Health to the State Minister for Health, the Hon. David Davis, MP. The Board of Directors, appointed by the Governor in Council on the Minister's recommendation, is responsible for the provision of comprehensive and efficient ambulance services. The organisation is managed by the Chief Executive Officer, (who reports to the Board), and the executive team.

The year in review

Emergency Road Services

Responding to over 451,000 emergency and urgent road incidents, the Regional Services Division experienced only moderate growth in 2011/12 (1.7%), following on from large increases in the previous two years. The Referral Service was instrumental in keeping growth to a minimum, handling over 9% of '000' cases in the metropolitan area without an emergency dispatch. The percentage of Code 1 cases responded to within 15 minutes declined from 77.2% in 2010/11 to 74.8%.

A number of new response units were established during 2011/12 including a peak period unit at Cranbourne, and upgrades/additional shifts implemented at 13 other metropolitan and rural locations.

A pilot project funded by the Department of Health commenced during the year to trial a paramedic motorcycle unit in Melbourne. The unit aims to reduce response times in the city centre.

A plan to transition five rural call-taking and dispatch centres from AV to a single centre in Ballarat managed by the Emergency Services Telecommunications Authority (ESTA) was finally completed in August 2011. This has delivered a virtual statewide CAD capability and has provided the basis for coordinating work between emergency and contracted non-emergency activities within the state.

Work continued throughout 2011/12 to further integrate metropolitan and rural operational processes and systems including establishing a statewide rostering function and a rural paramedic reserve similar to the model used in the metropolitan area.

Non-Emergency Road Services

With just over 343,000 cases, non-emergency/urgent caseload grew by 1.7%, also following on from a period of stronger growth the previous year. A longer term non-emergency patient transport strategy for AV was also developed, in conjunction with the CAD development.

Air Ambulance

Air Ambulance incidents increased by 3.2% over 2011/2012 to just over 7,000. VACIS was implemented in air ambulance, and a new contract executed for the provision of fixed wing aircraft.

Information Management & Communications

The focus for information systems and communications remains on integration of metropolitan and rural platforms for key systems. In 2011/12, work was also undertaken on developing and implementing a new intranet system, a new business intelligence tool, developing a new interface for VACIS, and upgrading the records system.

The Learning Management System also went live in December 2011 aimed at improving the management of staff development and providing another vehicle for the delivery of training programs.

Research & Development

Work continued on upgrading the Victorian Cardiac Arrest Register database. Additionally, work progressed throughout the year on understanding the variation in cardiac arrest outcomes statewide.

Staff Development

A Leadership and Management Capability Framework was finalized in 2011/12, as well as a program to further develop frontline managers. Additionally, a new Performance Assessment tool was developed as well as supporting material. Programs to attract and retain staff in rural areas have also been developed further.

Health & Safety

A number of on-going health and safety initiatives continued to be implemented, including a fatigue management strategy. Work also commenced on developing an OHS information system to better meet AV's needs.

Future Directions 2012-13

With the process of organisational consolidation, now largely complete, AV can now begin to refocus on developing and implementing a range of new initiatives to improve services. With that in mind, work has commenced on developing the next long-term Strategic Plan for AV, including workshops, consultation and engagement with staff, stakeholders and the community. It is expected that the new draft Strategic Plan 2013-16 will be completed by the end of 2012.

Emergency road services

In 2010, the Government announced a boost to paramedic resources in Victoria over the next 4 years. In 2012/13, AV will implement the following resources to its emergency road response:

Metropolitan:

1. Clayton - new 12 hour peak period unit
2. Caroline Springs - new 12 hour peak period unit
3. Tarneit - new 12 hour peak period unit
4. Rockbank - add night shift
5. Officer - add night shift
6. Endeavour Hills - new 24 hour branch
7. Mount Eliza - new 24 hour branch

Rural Resources

1. Geelong - new 24 hour branch
2. Beaufort - new SO branch (from ACO)
3. Wallan - new 24 hour branch
4. Bairnsdale - introduce MICA single responder peak period unit
5. Sale - introduce MICA single responder peak period unit
6. Horsham - introduce MICA single responder peak period unit
7. Swan Hill - introduce MICA single responder peak period unit
8. Castlemaine - upgrade multiple officer branch to 24 hour

Additionally, a second paramedic motorcycle will be implemented as part of the ongoing 3-year trial.

Trialling in-field referrals by paramedics, increasing the call-taking capacity of the Referral Service, and introducing the latter to a rural region will enhance the work of the Service in managing emergency demand appropriately.

2011/12 will also see renewed focus on working with hospitals and the Department of Health to improve patient flow and reduce at-hospital times.

Non-Emergency road services

In the area of non-emergency services, a tender process will be undertaken for the provision of non emergency patient transport services statewide. Additionally, there will more work on developing appropriate KPIs and improving the reporting around the provision of NEPT services.

Air Ambulance

The focus for Air Ambulance will be the development and implementation of a 5-year rotary wing strategy, including procurement.

System integration

Improving coordination with other healthcare providers to improve patient outcomes remains a priority for AV. In 2012/2013, AV will continue to develop and implement a State-wide Cardiac Care program including extending the use of 12-lead ECG monitors and transmission to selected regional hospitals.

Information management & communications

In the area of IT, AV will focus on upgrading VACIS, implementing a new business intelligence tool, and improving the functionality of its intranet.

Research & Development

Subject to funding, AV will also continue to roll out thrombolysis to regional Victoria.

Staff capability & development

In the development of staff, AV remains focused on developing a high-level workforce plan, implementing enhancements to the CHRIS (HR management) system, and rolling out a targeted Team Manager development program.

Health & safety

Staff health, safety and welfare remain a high priority. In 2012/13, AV will continue implementation of the Fatigue Risk Management Framework, implement a plan to minimise musculoskeletal disorders resulting from manual handling, develop a Psychosocial Risk management Strategy, and expand the SMART program aimed at improving staff's psychological well-being.

Funding

AV continues to work with the Department of Health to ensure its funding is financially sustainable into the future.

Ambulance Tasmania

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Our Vision:

Ambulance Tasmania's vision is excellence in ambulance and health transport by providing optimal care integrated across all aspects of health and community transport.

Jurisdiction

Ambulance Tasmania (formerly Tasmanian Ambulance Service) was established under the *Ambulance Service Act (1982).* It is a statutory entity, which is part of the Department of Health and Human Services. Ambulance Tasmania (AT) has:

- 5 Divisions including Emergency and Medical Services, Health Transport Service, Aero-Medical and Medical Retrieval, Clinical Services and Operational Support Services.
- Emergency and Medical Service (AT-EMS) has 3 operational regions, a state-wide communications centre and volunteer coordination unit.
- The Health Transport Division manages the state wide coordination of Non Emergency Patient Transport Services (AT-NEPTS) for DHHS.
- The Aero-medical and Medical Retrieval Division is also now an integrated service of Ambulance Tasmania.

Under the *Ambulance Service Act (1982),* the Director of Ambulance Services is responsible for co-ordinating all ambulance services for AT, and all independent services, which ostensibly operate under the Director's consent and this includes a commercial sector providing non-urgent patient transport and safety coverage at sporting events.

Tasmanian residents continue to enjoy free ambulance transport within Tasmania. Some reciprocal arrangements exist with mainland services but not all.

The year in review

The highlights for the year have included:

- Bridgewater station on the urban fringe of Hobart was converted to a full urban station with 24/7 dual paramedic crewing as a result of Commonwealth funding, till 1 July 2012 and State Government recurrent funding thereafter.
- Roll out of 13 new Class 1 ambulance vehicles across the state.
- Established the Community Emergency Response Team (CERT) Programme at 4 locations in rural Tasmania.
- Commenced development of "Alternative Referral Pathway" Clinical practice Guidelines (CPGs) funded through an Australian Government National Partnership Agreement.
- Release of new paramedic and intensive care paramedic CPGs, acquisition of syringe drivers, CPAP and substantially completed roll out training across the state.
- Appointment of four new Paramedic Duty Manager positions providing 24/7 management in State Communications Centre.
- Publication and submission of a five year Staffing and Infrastructure Study to the State Government.
- Ongoing renewal program upgrading of ambulance equipment including monitor defibrillators, major incident support, frontline response kits and vehicles.
- Completion of ambulance vehicle tender for the fit out of new fleet for

the next five years as part of Ambulance Tasmania's fleet replacement program.

- Signed contract for ambulance on board computer system including 3G duress function, Automatic Vehicle Location, Satellite Navigation, Mobile Data Terminal funded through $1.5 million over two financial years.
- Held the two Staff Awards and Recognition Ceremonies in the state.
- Released tender for Stage 2 redevelopment of Hobart Station, Education Professional Development Unit upgrade and Southern Administration.
- Completed training and roll out of $750 000 new generation stretchers.
- Commenced operational jumpsuit uniform trial as well as additional purchase of Specialist Paramedic Helmets with eye protection, which meet Australian Standards for all salaried staff
- Gained funding under the Bass Strait Island Agreement for the clinical coordination system under the Aero-medical and Medical Retrieval Division for 2011-12.
- Established the first online "Wiki" for staff consultation in policy development.

YEAR IN PROSPECT

The year ahead will no doubt present challenges. At the point of writing, the 2012/13 budget has not been finalised. There is a risk that Ambulance Tasmania will be required to fund helicopter use without a suitable funding base.

Against this backdrop, the Government has announced an additional $2 million package of initiatives for 2012/13 which will provide full year funding for initiatives commenced in the previous years as well as:

- Continuing upgrade of medical and training equipment.
- Continuation of a routine property maintenance program.
- Ongoing improvement of information systems.
- Continuation of a cyclical ambulance replacement program.
- Conversion of Kingston station on the Hobart urban fringe to a full 24/7 two paramedic urban model.
- Provision of ongoing funding for the 6 additional staff at Bridgewater which was converted to an urban station through Australian Government funding in 2011/12.

Ambulance Tasmania acquired Australian Government funding towards investment in on board computer systems, which will

- Improve efficiency by linking into the Computer Aided Despatch system and
- Pre-populate the electronic patient report form with patient details, as well as
- Contributing to officer safety through its duress and automatic vehicle location capacity.

AT secured additional Australian Government funding under Health Workforce Australia to extend the role of Paramedics in the rural community. This will be initiated in 2012/13 and continue the year after.

Queensland Ambulance Service

Contact Details:

Title: Commissioner

Incumbent: **Russell Bowles** ASM

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Our Vision:

Safe and secure communities

Our Mission:

To provide timely and quality ambulance services, which meet the needs of the community

Our goals:

- *Focus on front-line service delivery*
- *Strengthen community resilience and partnerships*
- *Support volunteer organisations*
- *Build organisational performance and capability*

Jurisdiction

The Queensland Ambulance Service (QAS) operates under the authority of the *Ambulance Service Act 1991.* The QAS is a Division of the Department of Community Safety (DCS), which was created in March 2009 following Machinery of Government changes that resulted in the amalgamation of the Department of Emergency Services and the Department of Corrective Services.

The DCS is responsible for the provision of ambulance services, fire, search & rescue, counter disaster, hazardous materials services and corrective services.

The QAS serves over 4.5 million Queenslanders and approximately 158,000 visitors per day across a vast state of 1.77 million square kilometres, including about 1,000 offshore islands. Queensland is Australia's most decentralised state and accounts for 22.5% of Australia's land mass.

The QAS provides essential emergency medical services including pre-hospital care and related services across Queensland. The QAS aims to improve the health, safety and well being of individuals and the community by continuing to strive for excellence through innovation.

Services include:

- Providing pre-hospital paramedical response services to patients who suffer sudden illness or injury;
- Emergency and routine pre-hospital patient care;
- Coordination of aeromedical services;
- Inter-facility ambulance transport;
- Planning and coordination of major events, multi-casualty incidents and disasters;
- Community services such as community education and baby capsule hire and installation services; and
- Pre-hospital care research.

The QAS provides its services through 3,895 full-time equivalent employees and 354 volunteers, which includes Ambulance Attendants, Community First Responders and Volunteer Drivers.

The year in review

Response Performance

In 2011-12, QAS provided services in response to 833,243 incidents (Codes 1-4 & Casualty Room) across Queensland. This compares with the 2010-11 figure of 801,308 incidents.

For 2011-12, overall demand increased by 3.99% compared to 2010-11.

The combined Code 1 (emergency) and Code 2 (urgent) incidents increased by 6.47%.

In spite of a growth in demand for ambulance services, fifty percent of Code 1 life threatening incidents were attended within 8.3 minutes, and ninety percent of Code 1 life threatening incidents were attended in 17.0 minutes against a target

of 8.2 minutes and 16.5 minutes, respectively for 2011-12.

In 2011-12, the QAS was funded for an additional 52 ambulance officers above attrition.

State Operation Centres

The QAS manages seven Operations Centres across the State located in Cairns, Townsville, Rockhampton, Maroochydore, Toowoomba, Brisbane, and Southport.

- During 2011/12 the QAS Operation Centres received 577,689 Triple Zero (000) calls for assistance.
- In 2012 the Brisbane Operation Centre and the QCC Aeromedical & Referral Services relocated to the new Queensland Emergency Operations Centre (QEOC), Kedron Park complex. The QEOC houses the State Disaster Coordination Centre, 24 hour Emergency Management Queensland Watch Desk, QAS & QFRS communications facilities,the Queensland Clinical Coordination Centre (QCC) and the Department's Geographic Information Service.The QEOC building, technology and infrastructure provides enhanced telemedicine, telephony, video conferencing, radio, communication and redundancy capability.

Clinical Advances

In 2011-12, QAS released the updated Clinical Practices Manual (CPM) and accompanying Paramedic Field Reference Guide (FRG). These reference documents represent a major change in layout design with the ability to update individual sections without requiring entire reprints. Additionally, a free application (App) suitable for Apple iPhone/iPad and Android smart phone/tablet was made available to staff providing officers with electronic access to selected CPM titles via personal devices. The Office of the Medical Director has assisted in the development of numerous new clinical indicators for paramedic practice.

A number of clinical advancements to paramedic practice occurred in 2011-12, including:

- Introduction of the Ondansetron for the safe treatment nausea/vomiting;
- Introduction of intranasal Fentanyl for the treatment of severe pain;
- Introduction of Ipratropium Bromide for the treatment of severe bronchospasm;
- Introduction of Hydroxocobalamin for the treatment of cyanide toxicity (currently restricted to Mt Isa staff);
- Introduction of Noradrenaline as an inotrope for Intensive Care Paramedics undertaking Extended Scope of Role Aeromedical training.
- Introduction of Magnesium Sulphate for the treatment of Irukandji Syndrome by Advanced Care Paramedics (ACPs);
- Introduction of the Mucosal Atomization Device (MAD) for the administration of intranasal fentanyl;
- Introduction of coloumetric CO_2 detectors for paramedics operating in environment where waveform $EtCO_2$ is unable to be accurately obtained (underground mining operations at depths below 380m);
- Introduction of arterial tourniquets for life threatening arterial haemorrhage.

- Expansion of the existing Coronary Artery Reperfusion Clinical Practice Procedure allowing Intensive Care Paramedics to refer patient post lysis directly to the Coronary Care Unit at Cairns Private Hospital.
- Introduction of "Patient's own medication bags" to safely manage medicines when patients are transported by QAS to a health facility ensuring the patient's entire medications are stored together in one place:
- Removal of the adult total maximum Morphine dose for Advanced Care Paramedics.
- Planned introduction of intravenous Fentanyl for Advanced care Paramedics
- Introduction of a 24-hour dedicated medical consult line providing paramedics with rapid access to medical clinical advice. All physicians have an association with QAS therefore are well-versed in pre-hospital call and the challenges paramedics may face.

In 2011-12, QAS continued its rapid trauma response vehicle program, staffed by the Medical Director or a QAS Senior Pre-Hospital Registrar and an ICP – trialling new modalities including modified RSI, prehospital ultrasound and damage control resuscitation with blood products.

Vehicles

In 2011-12, $20.4 million was allocated for the commissioning of 140 new and replacement ambulance vehicles. With the establishment of a Standing Offer Arrangement for the design, tender and development of two new vehicle designs in 2010-11, the QAS continued with the production and rollout of these vehicles in 2011-12. This included a two stretcher Mercedes 519 cab chassis with a manufactured patient care compartment and a single stretcher Toyota LandCruiser cab chassis with a manufactured patient care compartment.

Research

The Clinical Performance and Service Improvement Unit (CPSI) provides the QAS with analysis and research services to support evidence-based clinical, operational and strategic decision making. During 2011-12 the CPSI Unit has delivered a number of key initiatives, including:

- Development of clinical performance indicators. An initial suite of outcome indicators has been developed, including pain management (clinically meaningful reduction in pain of cardiac and traumatic origin, % patients administered analgesia); asthma treatment (% patients with return of oxygen levels to within optimal range); management of acute hypoglycemia (% patients with final BSL in normal range); and several cardiac-related outcome measures (including % 12-lead ECG administration by Advanced Care Paramedics).
- Review of the current QAS Intensive Care Paramedic educational framework and course structure;
- Analysis of the impact of conversion from MPDS V11.3 to MPDS V12.1 on eventual dispatch priority;
- Continued development and reporting on longitudinal cardiac outcomes, including the reperfusion project;

- Supervision of paramedic-lead research projects under the QAS Kenneth James McPherson Research Foundation auspice;
- Contribution to a range of externally funded studies investigating ambulance demand and ramping,

Capital Works

The QAS had 19 major projects listed in the 2011-12 State Budget Paper 3, of which nine have been completed and 10 are in progress.

Education

- As at 30 June 2012 the QAS as an RTO had 292 officers enrolled in HLT50407 Diploma of Paramedical Science (Ambulance).
- The number of officers who completed this qualification in the previous financial year was 164.

FUTURE DIRECTIONS

New Structure

The restructure will realign existing QAS regions to match the 17 QHealth HHS boundaries. The net effect will be the abolition of the existing seven QAS regions and the 21 operational areas, which will be replaced by the establishment of 16 Local Ambulance Service Networks (LASNs). State communications will operate as its own LASN with the Assistant Commissioner State Operations Centres maintaining oversight of the individual communication centres.

There will be several benefits of the restructure, which include:

- Operational staff being redirected back to frontline positions
- Redistribution of existing administrative support staff to roles that provides essential support to the delivery of frontline services.
- Introduction of LASNs that focus QAS operations on core local service delivery issues and geographically aligns QAS to the HHS boundaries.
- LASN managers will have direct reporting relationships with Officers-in-Charge and will also be directly connected to the community through smaller more locally focused management structures
- Providing a central "State Headquarters' structure in line with the "System Manager' concept QHealth has adopted, to ensure ongoing coordination of all QAS resources and patient care and transport activities on a state-wide basis as part of Queensland Emergency Medical System (QEMS) for disaster management and mass casualty response across multiple LASNs.
- Allows a reduction in leased premises across the State allowing current regional leadership positions to be incorporated into existing frontline operational facilities with a strengthened proximal interface with frontline service delivery.

Managing Demand for Services

Demand for emergency ambulance services continues to grow, particularly in the south-eastern corner of the state, which includes some of the nation's fastest growing areas. Queensland's population growth rate remains higher

than the national average and the highest of all Australian states.

Population growth and ageing continue to be the main drivers of demand for health services. Demand has increased from 362,557 incidents in 2003-04 to 595,644 incidents in 2011-12. This is an increase of 64.29% or an annual average increase of 6.4%.In the year 2008-09 there is a plateau in demand compared to the period 2003-04 to 2007-08. In 2010-11 demand increased by 8.36% and in 2011-12 demand increased by 6.47%.

The increase in demand in codes 1 and 2 is associated with the significant increase in patient presentations at hospital emergency departments for the higher acuity patients in triage categories 1, 2 & 3.

In order to meet future challenges, QAS will employ an additional 60 ambulance officers across the state in 2012-13, bringing the total staff increase to 742 for the period 1 July 2007 to 30 June 2013.

Research

Whilst significant reform is implemented throughout 2012-13, it is expected that the CPSI Unit will continue to provide on-going analytical support in the development and implementation of new systems and strategies. Planned projects for the coming year include the development of a demand monitoring system (that includes geographic, demographic and socio-economic profiling using ABS data); and the analysis and evaluation of alternative management strategies for low-acuity patients.

Capital Works

Three new ambulance stations and six replacement, redeveloped or refurbished ambulance facilities will be commenced, progressed or completed in 2012-13. In addition, continuation of the design and redevelopment of the Spring Hill complex and ambulance station.

Vehicles

The QAS will commission 130 new or replacement ambulance vehicles in 2012-13 to ensure the ambulance fleet is effectively maintained to meet increasing community needs.

Enterprise Bargaining

QAS is currently involved in Enterprise Bargaining negotiations with United Voice Queensland, the representative union for QAS operational employees, with the *QAS Determination 2010* due to expire 30 September 2012. The QAS is committed to providing high quality and responsive paramedic services to Queensland communities, and to working with UVQ to ensure safe working environments and the necessary level of managerial responsibility for the QAS to meet community needs. The QAS remains committed to negotiating fair wages and conditions for all QAS employees and as such current negotiations incorporate a fair wage increase of 2.2% per annum for the life of the agreement.

Metropolitan Emergency Department Access Initiative (MEDAI)

MEDAI was established in October 2011 and was a key initiative focus for Queensland Health in addressing the issue of access block and ambulance ramping.

MEDAI report sets out 15 recommendations that aim to improve the way in which issues in relation to ambulance ramping and bypass are managed across all Queensland public hospitals. The report identified that issues of access block and ambulance ramping.

A high-level committee Emergency Services Management Committee (ESMC) has been established and their purpose is to provide policy advice to the Minister and to monitor implementation of the recommendations of the review in their entirety.

MEDAI report recommendations - all of which have the ability to impact on QAS. However of these recommendations, three (3) have been identified to have direct impact for QAS with a further three (3) recommendations that require direct engagement and consultation on QAS behalf.

Implementation of the MEDAI recommendations in their entirety across the State is to be effective by the 01 January 2013.

SA Ambulance Service

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Incumbent: **Ray Creen**

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Our Vision:

The community of South Australia is secure in the quality of service provided by their ambulance service.

Our Mission:

To save lives, reduce suffering and enhance quality of life, through the provision of accessible and responsive quality patient care and transport.

Our Values:

We value our reputation and professional profile and these values influence the way our business is conducted and how our organisation is managed.

We do this with accountability, integrity and innovation. We value the passions, effectiveness and potential of our people, and their need to feel valued and respected.

Jurisdiction

Our purpose and objectives

SA Ambulance Service (SAAS) is the principal provider of emergency ambulance services in South Australia. This provision of ambulance service comprises:

- Triple zero (000) call receipt and patient triage
- Emergency patient care transport
- Non-emergency patient care and transport
- Emergency and major event management
- MedSTAR emergency medical retrieval services.

To complement the provision of ambulance services, SAAS also:

- Coordinates the State Rescue Helicopter Service
- Manages the Royal Flying Doctor (RFDS) contract for fixed wing inter-hospital air transfers
- Collaborates with Flinders University to deliver the Bachelor of Health Sciences (Paramedic), the Master of Health Sciences (Pre-Hospital and Emergency Care) and the Masters of Retrieval Practitioner program
- Collaborates with James Cook University to deliver the Post Graduate Certificate in Aeromedical Retrieval and Masters in Public Health
- Operates as a registered training organisation providing in-house, nationally accredited training to its staff
- Promotes and administers the Ambulance Cover subscription scheme
- Promotes and manages Call Direct—a 24-hour personal monitoring emergency service.

Legislation

SAAS is constituted by the *Health Care Act 2008* under which it is an identifiable incorporated entity. In accordance with the Act, SAAS is managed by a Chief Executive Officer who reports to the Chief Executive of SA Health.

Workforce

SAAS has a total number of 1,281 personnel, which includes patient services paid employees and support services paid employees. In addition to this there are 1437 volunteers.

Reporting relationships

The Chief Executive of SA Health is responsible for the administration of SAAS and has appointed and delegated appropriate managerial powers to the Chief Executive Officer of SAAS.

At a corporate level, SAAS ultimately reports through SA Health to the Minister for Health. However, it continues to maintain its status as a separate entity for the purposes of reporting to the Department of Treasury and Finance.

For operational matters, SAAS has a close relationship with the Operations Division of SA Health. Issues that have an impact on the operations of the health system are therefore reported through to the chief executive of SA Health via the Executive Director, Operations Division of SA Health.

The year in review

Highlights for the 2011-12 year include:

Our people

- A new education facility was opened housing a clinical simulation laboratory which enables realistic simulation training in a range of complex clinical, patient and operational scenarios.
- SAAS achieved the best performance across the health portfolio with the number of safety performance targets met; 10 out of 13 targets were achieved, compared with eight the year before.
- SAAS continued to reward and recognise its staff for their achievements throughout the year. This year 112 staff were recognised at the annual graduation and presentation ceremony. Three SAAS personnel were also awarded with the prestigious Ambulance Service Medal.
- Enhanced driver training (10 days up from four) was developed and rolled out ensuring SAAS staff are even safer on the road.

Leadership

- SAAS leaders developed the *SAAS Leadership Philosophy,* formalising the behaviours, attributes and traits of all leaders in the ambulance service.
- Fifteen SAAS staff—both operational and support—participated in the SA Health LEADS management development program.
- SAAS was recognised on a national stage as a leader in technical capability for the development and roll out of its Automatic Vehicle Location (AVL) system which assists ambulance dispatchers to identify and respond ambulance fleet to incidents.
- SAAS's Mental Health Escort Team led the way as experts in safe restraint and de-escalation procedures for mental health clients, providing advice to a number of health units including emergency departments and specialist wards.

Service Delivery

- Almost 90 per cent of triple zero (000) were answered in 10 seconds or less.
- Extended Care Paramedics (ECPs) responded to 4706 cases with 64.5 per cent resulting in emergency department avoidance, up from 58.5 per cent last year.
- In September 2011, SAAS introduced the new South Australian Computer Aided Dispatch (SACAD) system, a new emergency call receipt and dispatch system. SAAS was the first emergency service in the state to roll out the new system.
- Sixteen new members were recruited to the Bicycle Response Unit (BRU), increasing SAAS's ability to respond to pedestrian-denser areas in an emergency.
- Commenced operation of the new SAAS REMOTE (Rural remote, Environment, Medical assist, Optimal treatment and Evacuation) pilot program. The program sees SAAS staff in country SA equipped with the skills and equipment to provide early medical assistance to patients in rural areas in challenging medical emergencies, whilst minimising risks associated with accessing patients who are difficult to reach.

Community

- Following consultation with the local council, medical professionals and the local community, a Community Emergency Response Team was established in Beachport. This year nine new recruits joined the team.
- Seventeen new recruits joined the Community Regional Response Team to support country communities respond to emergencies, with an additional 10 recruits to complete their training in 2012-13.
- During National Volunteer Week, more than 75 events were held across the state to recognise SAAS volunteers in their local country communities.
- SAAS, together with the Country Health SA Local Health Network (CHSALHN) Falls Steering Committee, developed and piloted a new referrals pathway for falls patients in the Limestone Coast.

Future directions (2012-13)

- The continued expansion of the successful ECP program, with an additional six members to join in 2012-13.
- SAAS will complete construction of a new ambulance station in Warooka and commence the new Mount Gambier ambulance station.
- Completion of the introduction of Mobile Data Terminals to SAAS operational vehicles. MDTs will increase the efficiency, speed and quality of information shared across the ambulance service.

SAAS will take a lead role in addressing issues with patient flow blockages experienced at metropolitan hospital emergency departments during periods of peak demand. This is through the introduction of a new position in the Emergency Operations Centre called a health network coordinator who is responsible for monitoring patient flow and resolving any issues as they arise.

St John Ambulance Australia (NT) Inc

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Our Vision:

The vision for the Service is to promote health and wellbeing to all Territorians and to form an integral part of the total Health deliver continuum. A key objective for us is to make 'First Aid a part of every Territorian's Life'.

Our Mission:

To be the leading provider of first aid, ambulance, and related health services in the Northern Territory.

Jurisdiction

St John Ambulance Australia (NT) Inc is a not-for-profit organisation that operates under contract to the NT Government to provide the Ambulance Service throughout the Northern Territory. The organisation comprises of essentially two separate entities – one delivering contracted Ambulance and associated services – and the other operating the traditional St John volunteer services, first aid training, first aid kit sales and contract paramedical services and vehicle fit-out activities, which allow us to provide for all of our Volunteers, Territory wide, at no cost to the volunteer.

Territorians form approximately 1% of the nation's population but currently have the highest growth percentages in population with 30% of the population being indigenous. The Northern Territory sits in the central north of Australia, between Western Australia and Queensland, directly above South Australia. It covers an area in excess of 2.16 million square kilometres and the total population – around 232,000 – tends to be concentrated around two major centres – Darwin (including Palmerston) and Alice Springs.

There are many challenges in the NT with the expanse we face, the large indigenous population and the average age being 31 years. The approach to Ambulance Services is certainly unique and at times can be challenging and reflects an understanding of the cultural extremities, and activities of the young, which exist.

The year in review:

Activity and Performance

During 2011-2012, St John Ambulance NT, experienced increases in activity, with Ambulance vehicles travelling 1,005,098 kilometres (up 14.7%), whilst in the process of transporting 35,906 patients (an increase of 9.3%), on 44,454 cases (up 9.4%). These increases certainly reflect the workload pressures being identified in all Regions and in our Communications Centres.

In the Urban setting 50% of emergency cases are being responded to within 8.6 minutes and 90% of cases are being responded to within 15 minutes. In the rural setting 50% of emergency cases are being responded to within 9.6 minutes with 90% being responded to within 22.5 minutes.

Key achievements

The dedication to duty and the professionalism of one of our longstanding members was recognised earlier this year with the award of the Ambulance Service Medal (ASM) to Mr. Michael McKay. The first such award to be presented in the Northern Territory.

Education

The Bachelor of Science (Paramedical Science) commenced in January 2012 in a collaborative tertiary program between the Paramedic Training College (PTC) and the Edith Cowan University of Western Australia (ECU).

The PTC and its Educators are primarily responsible for the delivery of 7 Units of the Degree in a unique "Work Integrated Learning Program" with PTC Educators being appointed as ECU Adjunct Lecturers. The inaugural program commenced in January with ten undergraduate students attending a three month "Induction Course" prior to their full time employment as trainee Paramedics.

The Induction course also contained specific service required training such as "Rescue" and "Driving" utilising resources of PTC and specialist external providers.

Work Health and Safety

In October 2011 St John engaged an external consultant to audit the St John Ambulance NT Occupational Health and safety System. The findings of the audit identified that a number of changes had to occur to ensure compliance with the new Health Work Act 2011. St John have engaged the services of the consultant to revise and update the Occupational Health and Safety system, this has lead to the creation of a new position of Health, Safety and Wellbeing Manager.

Clinical advances

St John NT recently reviewed Pharmacology & Patient Management Procedures, by preparing a new 2012 Clinical Practice Manual (CPM).

This is the first full review of pharmacological agents, skills and procedures since 2006. The CPM allows increases in paramedic scope through all ranks and affords SJANT leading methodologies in Paramedicine.

The CPM is divided into three (3) sections: drug therapy protocols (DTPs), clinical practice guidelines (CPGs) and clinical practice procedures (CPPs).

Community Education

Our volunteer Community Education Program has grown significantly this year, increasing participation numbers by 84% from 1706 to 3142 recipients. This initiative is in line with our desire to make First Aid a part of every Territorians' life and to build the brand name of St John within the Territory Community. Further to enhance this, St John NT has developed "First@scene" an online Learner Driver First Aid program, which aims to provide learner drivers with the basics in First Aid, should they be first on the scene of an accident. The program was implemented in May into the new NT Government DriveSafe NT Learner Driver program. Work is currently underway to convert this online program into an 'application' suitable for iPads and iPhones.

Workforce

St John Ambulance NT employed 119 females and 109 males in 2011/2012.

Recruitment	
Corporate Services	11
Emergency Dispatch	6
Intensive Care Paramedic	1
OIC	2
Paramedic training College	2
Patient transport	4
Qualified paramedic	3
Student Paramedic	10
Trainee Paramedic	9
Vehicle maintenance	1
Apprentice – Mechanic	2

Terminations	
Corporate Services	5
Emergency Dispatch	2
Intensive Care Paramedic	1
Officer in Charge	2
Patient Transport	1
Qualified Paramedics	4
Student paramedics	6
Trainee paramedics	1

FUTURE DIRECTIONS (2012/13)

Communications

The implementation of a virtual communications concept across the Darwin and Alice Springs Region is scheduled for October 2012. The construction of a new communications room in Alice Springs is complete with computer infrastructure in the final stages of implementation. Included will be the new version of ICAD, which has been redesigned to allow easier inputting of information and allow seamless data flow between the two communications centres in Darwin and Alice Springs, including links to Police and Fire Services.

GPS tracking and mobile data terminals

Currently being evaluated is an integrated mobile data terminal and tracking system for all response vehicles, this will allow the communications centre to track vehicles in real time, upload case details onto a terminal in the vehicle as well as record data on vehicle and fuel usage, servicing and driver behaviour. It is expected that this system will improve response times, improve officer safety, reduce overtime and reduce wear and tear on vehicles.

St John Ambulance Australia

(Western Australia) Inc

Contact Details

Title: Chief Executive Officer

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Our Vision

For the service of humanity.

Our Mission:

To serve the Western Australian community through the provision of high quality and cost effective first aid and ambulance services.

Jurisdiction

St John Ambulance WA (SJAWA) contracts with the State Government through the Department of Health (DoH) to provide the State's ambulance service. SJAWA is a charitable, non-profit organisation that has been teaching first aid in WA for 120 years and has provided the state's ambulance service for 90 years.

The organisation covers the largest single ambulance territory in the world, with an area of more than 2.6 million square kilometres. The metropolitan ambulance service is provided by paid paramedics, ambulance officers and patient transport officers. The country ambulance service is provided by a mixture of paid and volunteer staff in larger regional hubs, with smaller sub centres run entirely by volunteers. These volunteers contribute roughly 3.25 million hours of service annually

The year in review

2011/12 was an incredibly exciting year for St John Ambulance WA as the organisation continued to build on increased resourcing to deliver a more efficient ambulance service, as well as first aid training to more people than ever before.

This year was the second of SJAWA's three-year contract with DoH, and was a year of consolidation in terms of resources, staffing and infrastructure.

More than 300 new staff members – both operational and administrative – were hired over the course of the year, with more than 300 new volunteers also signing up across regional WA.

Across the State, SJAWA attended to 243,573 ambulance cases – a 13 per cent increase on the previous year. 192,500 of these cases occurred in the Perth metropolitan area and the remaining 51,073 cases were attended by a mixture of country career and volunteer sub centres

The organisation also took a significant step towards its goal of having one person in every WA household trained in first aid, with 169,314 people trained across the State during 2011/12. With this backdrop of growth in activity, the ambulance service achieved significant improvements in response times over the course of the year. Increased resources and improvements in business operations resulted in improved response times every month of 2011/12, compared to the same period in 2010/11. In the second half of the year, SJAWA consistently achieved its response time targets, with some months showing an improvement of almost five per cent compared to the same period in 2010/11. The year finished on a high with 92 per cent of all Priority One incidents being attended to in under 15 minutes during June 2012.

The number of Event First Aid Services volunteers rose dramatically over the course of the year, with more than 400

new members signing up between January and June 2012. The 1034 volunteers in total attended to 1288 events in and around Perth, donating a combined total of 41,470 duty hours. SJAWA's regionalisation program saw continued investment over the course of 2011/12, with an increase of 14 per cent in the number of ambulance paramedics deployed to career sub centres in country areas. Community paramedic (CP) numbers also received a significant boost, with the number of CPs in regional areas rising from three to 14. The CP role provides invaluable support and training to volunteer ambulance officers and the volunteer model around the State.

During the year a wide ranging review of the organisation's clinical practice guidelines (CPGs) was undertaken. The number of clinical audits also increased drastically throughout the year – from 280 to 1680 – and were expanded to include Industrial Health Services, Country Ambulance and Event First Aid Services.

On top of the increases to volunteer, staff numbers and resourcing, a number of unique initiatives were rolled out over the course of 2011/12 to improve the services offered to the WA community. One key initiative was the rollout of the electronic patient care record (ePCR) system across the metropolitan Ambulance Service. The rollout began in October 2011 and, by February 2012, was complete across Perth. The ePCR program involved the development of a specific patient record application and issuing all SJAWA's onroad staff with an iPad. Once patient records are completed, the data is simultaneously sent to head office and the receiving hospital.

A new Performance and Planning structure was also announced in 2011/12. The new directorate has a focus on equipping the organisation with new performance tools and planning our future activities and operational needs. A partnership with international organisation Lightfoot Solutions was unveiled at the end of 2011/12 and will engage with staff and volunteers across the organisation to support performance improvements in many areas.

Strong initiatives like ePCR and the Lightfoot Solutions partnership were made all the more significant against the backdrop of an important historical milestone for the organisation. 2011/12 marked 120 years since

St John in WA first began teaching first aid. The first committee meeting was held on 15 March, 1892, and since then more than two million Western Australians have been trained in first aid by SJAWA.

Future Directions 2012-13

2012/13 will see St John Ambulance WA enter the final year of its three-year contract with DoH, as well as the final year of its unprecedented $54 million capital works program. A raft of major projects that took significant steps forward this year will begin construction in 2012/13, including seven depots across metropolitan and regional areas.

The rollout of ePCR to regional areas will begin in 2012/13, with career sub centres the first to be connected and volunteer sub centres to follow. The partnership with Lightfoot Solutions will begin to engage with staff and volunteers to help deliver some exciting outcomes and build on the successes of the past few years.

Continued recruitment of operational and administrative support staff – as well as planned increases in Volunteer numbers across the State – will ensure St John Ambulance WA has the staffing and resources in place to deliver even stronger first aid and ambulance service to the people of WA.

St John Ambulance Papua New Guinea

Contact Details

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Incumbent: **Douglas J Kelson** MES, MBE, OStJ

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Our Vision

St John Ambulance Service Papua New Guinea will provide a quality and sustainable Ambulance Services within the framework of the National Health Plan of Papua New Guinea.

Our Mission

St John Ambulance Service Papua New Guinea will achieve our Vision by providing pre-hospital emergency care within a reasonable timeframe, to the community of Papua New Guinea under our agreements with the Department of Health.

St John New Zealand

Contact Details

Title: Chief Executive

Incumbent: **Jaimes Wood (check re: PB with GM)**

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Our Vision

Enhanced health and well-being for all New Zealanders.

Our Mission

The mission of St John is to prevent and relieve sickness and injury, and act to enhance the health and well-being of all people throughout New Zealand.

Jurisdiction

St John has provided ambulance services in New Zealand since 1885. St John is a community-based charitable organisation with a national office in Wellington and a national trust board, which delegates responsibility for oversight of service delivery to three regional trust boards; the organisation comprises more than 17,000 volunteer and paid members.

St John provides emergency ambulance services for nearly 90% of the country's population and to 97% of New Zealand's geographical area. Ambulance services in Wellington are provided by Wellington Free Ambulance and services in the Wairarapa region are operated by the District Health Board.

The year in review

The number of patients treated increased by 7,530 in the last year – 2%

St John members attended more than 350,000 incidents last year – a 4.2% (or 14,000) increase

The volume of 111 calls for an ambulance was up 3.8% on last year to 366,509

St John paid and volunteer ambulance officers work in reactive and stressful health emergency and accident environments. Our members give first aid care at community and corporate events, we transfer patients between hospitals or from hospitals to home, and we coordinate and staff air ambulance flights and connections working with rescue helicopter services.

To do all of this we support our ambulance officers by offering the best possible clinical education.

The current environment and challenges

We operate in a dynamic and – by its very nature – reactive environment. The Operations function of St John – ambulance, events, clinical development and communication centres – is a critical component of the New Zealand health system. We base our activity on the needs of New Zealanders.

The healthcare environment is changing rapidly to meet the demographic and economic challenges we face now and will continue to face in the future – that will require a level of resourcing that cannot be sustained with the current delivery model.

If St John is to stay vital and relevant in that environment we need to change our operating model to anticipate and accommodate those changes and the increasing demand for our services. Acting primarily as a transport service taking patients to hospital is arguably too costly for the healthcare system as a whole and does not always provide the best outcome for patients.

Transforming ambulance services

Transforming our ambulance service operations to meet the challenges in our health system has been a key focus for us this year. Recognising that we must innovate our services and processes and better integrate with our health partners, this year we progressed a five-year Operations Plan using ideas from St John members – through an innovative 'IDeAs' process (nearly 700 were submitted by 30 June 2012) – and health partners, to address how we establish a new model of service delivery. The process used has resulted in significant buy in from both internal and external audiences for the changes we intend to make in the coming years. It has also set a benchmark for consultation and collaboration for St John in New Zealand.

The framework for this Plan is to understand community; stakeholder, customer and patient needs, remotely assess patient needs and effectively manage referrals, assess patients and deliver effective treatment, promote health, well-being and the role of our teams, and connect patients to care. The plan details a large number of changes. Some of the most significant changes are:

- Electronic patient report forms
- Remote triage capability
- Alternative care pathways
- New response and transport options
- New treatment options
- Different models for different communities
- Hub and spoke networks
- Integration and partnerships

Initiatives in 2011/12

With this transformation programme of work we intend to maximise efficiency and effectiveness in services we deliver, optimise our resources, and deliver more value added services to the health system. Examples of this in 2011/12 included improving our resource forecasting, better, more informed winter planning, rosters and consumables stocking policies. A key initiative worked on in 2011/12 (to be launched in August 2012) was the new response system for ambulance services. The key objective here is to provide the most appropriate response to patients and make the best use of our resources. With the new system we are assigning ambulance resource based on getting the quickest response to immediately life threatening incidents – to the patients where response time is critical. This enables better use of resources and – most importantly – will provide the best outcome for patients.

Response time targets

By June 2012, 88.7% of ambulance responses were with a fully crewed ambulance (i.e. double crewed) – this is a 0.7% decrease on the previous year and is due to increasing demand in areas reliant on volunteers In 2011/12 we hit the targets for potentially life threatening call in both rural and remote areas and the 25 minute target for life threatening calls in remote areas. While the other targets were not achieved significant progress has been made against all targets, despite increasing levels of demand. St John has nine contracted ambulance response time targets, agreed with the Ministry of Health and with the Accident Compensation Corporation (ACC) and in

line with New Zealand ambulance standards.

For immediately life-threatening calls St John is contracted to arrive at:

- 50% of calls in urban areas within 8 minutes and 95% of calls within 20 minutes
- 50% of calls in rural areas within 12 minutes and 95% of calls within 30 minutes
- 50% of calls in remote areas within 25 minutes and 95% of calls within 60 minutes.

Ambulance Communication Centres

In the last year Telecom directed 1.14 million 111 calls to New Zealand's three emergency agencies. Of those calls 366,509 (32%) were 111 emergency calls for an ambulance. This is a 3.8% increase on the previous year. These calls were managed by 144 call takers and dispatchers.

Supporting Rugby World Cup

Rugby World Cup 2011 ran for 45 days in September and October 2011. St John played a vital role in the success of the tournament. We developed strategic resourcing plans for the event, worked closely with health and emergency services, and participated in a number of 'match fitness' training exercises.

For the tournament, we deployed specialist units including golf carts, Segways, bicycle paramedics, motorcycle and mobile first aid units. During the opening weekend St John was on duty at seven game venues and several fan zones, we treated 213 patients and transported 37 people to hospital. That Friday was one of the busiest days ever for our frontline teams in Auckland with a 32% increase in normal workload. Between 6.00pm Friday and 1.00am Saturday our Auckland Ambulance Communication Centre took more than 400 calls – twice the number they usually receive in that period on a Friday night.

Clinical developments

New ambulance sector clinical practice guidelines were released at the end of 2011. New books and educational material were developed and distributed, and incorporated into our learning modules. We have been working with the councils of the various medical colleges to incorporate their feedback into the new guidelines.

In 2011 we also reviewed and made changes to the Clinical function in St John to ensure clinical excellence is validated and supported by our clinical structure. We believe we have achieved that. Training to complete a National Diploma in Ambulance Practice (Level 5) typically takes about two years part-time, involves 300 hours of online and classroom time, followed by clinical placement spent in the field. As part of our commitment to training and best practice St John covers the cost of training and uniforms for volunteers and paid staff up to Paramedic level.

In March we introduced the first Clinical Desks into our Auckland Ambulance Communication Centre.

By July all three Communication Centres had Clinical Desks staffed by ALS (Advanced Life Support) Paramedics whose role is to support ambulance officers with clinical decisions. They also

support Communication Centre staff by reviewing jobs and recommending when a change in response or resource level would be appropriate.

CPR card world first

In a global first we piloted a CPR card developed by Laerdal to help improve cardiopulmonary resuscitation. The CPR card device is placed on the patient's chest, under the hand of the user and gives real-time visual feedback on the quality of CPR depth and rate of compressions. More than 1,400 St John members from 44 ambulance stations piloted the CPR card over four months from December 2011 to March 2012, picked because they responded to the most cardiac arrests in the previous 12 months.

A very busy summer

During summer 2011/12 the number of incidents we responded to peaked at 1,186 on 31 December and 1,374 on 1 January. Some locations had exceptionally higher emergency workloads, in the Bay of Plenty and East Cape (up 80%), in Northland (up 60%), and in Central Otago (up 75%). Sadly, the biggest surge over the New Year period involved attending the results of assaults. St John attended 77 assaults over the New Year period and we provided care at 319 events during 23 December 2011 to 8 January 2012.

Urgent community care

The Urgent Community Care (UCC) service in Horowhenua that started in December 2010 as a trial has proved successful by reducing hospital admissions and being better for patients. In June this year Government extended funding for the scheme until January 2014.

This service focuses on treating people in their own home – resulting in fewer people needing to make what can be a stressful and unnecessary trip to hospital. The UCC service provides a 24 hour seven day a week response in the community via a team of specially trained St John paramedics with extended assessment and treatment skills. They work alongside MidCentral District Health Board, the local Primary Healthcare Organisation, doctors, district nurses, pharmacists, physiotherapists, and care facilities. We believe that this model of healthcare is an exemplar for the rest of the country.

Wellington Free Ambulance

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Our Vision

To be pioneers of change for a better patient experience.

Our Mission

To be the leading New Zealand ambulance service provider, passionate about delivering our free-to-patient high quality, community-focused model of care.

Our Values

Passion – energy, enthusiasm and belief
Openness – open-minded, receptive and inclusive
Caring – respectful and empathetic
Integrity – genuine, consistent and trustworthy
Learning – strive for excellence.

Jurisdiction

Wellington Free Ambulance has a long and proud history as a free-to-the-patient emergency ambulance service, providing emergency care to the people of the Greater Wellington Region.

The Wellington Free Ambulance Service is an Incorporated Society.

The object of the Society is to make the best possible provision for the rendering of emergency care and transport for sick and injured persons; and subject to the constitution, undertake any other healthcare business, which will benefit society.

Wellington Free Ambulance serves a population of 483,000 residents.

The service responds to 50,000 urgent and non-urgent calls on average every year from New Zealand's capital city and outlying regions.

We're right here, every eight minutes, of every day responding to a call for help.

THE HEALTH LANDSCAPE - WELLINGTON, NEW ZEALAND

Wellington, along with many other parts of the world, is experiencing a significant change in the healthcare landscape. These changes are primarily driven by:

- An aging population – the percentage of the population over the age of 65 is set to significantly grow over the next 20 years. For the Wellington Free Ambulance Service this will see the likely number of patients over the age of 65 double by the year 2021.

- Increase in chronic illness - as the population ages and lives longer, it is anticipated that more patients will present with chronic illness and co-morbidities. WFA is already starting to experience this with increased numbers of patients suffering from long term respiratory and cardiovascular illness.

- Increased public expectation - public expectations of the healthcare system are increasing.

- Increase in demand – as a result of a combination of the above, WFA is seeing an increase in demand year on year of 7%, with the total number of 44,050 urgent and non-urgent incidents responded to in 2011/12.

The year in review

During the 2011/12 year WFA achieved a number of key objectives in order to help achieve its strategic goals:

- Following a tendering process, WFA was awarded the contract for the provision of emergency ambulance services to the Wairarapa area. This now sees WFA providing services to the whole greater Wellington area.

- WFA has increased its provision of patient transport services to include the transport of dialysis patients in the Porirua basin. This is set to further increase during 2012/13 to include the capital city as well.

- The Rugby World Cup visited New Zealand in October 2011 and WFA played a significant role in ensuring the safety of fans visiting the capital city, providing medical cover to both world cup matches and pre-determined fan zones. The medical cover provided by WFA was a success, with extremely low numbers of patients needing transporting to hospital.

- During the World Cup, WFA trialled a triage and treatment centre based in Wellington city's main entertainment area. This was a pilot to establish if the numbers of alcohol incidents transported to hospital could be reduced. The pilot proved to be a huge success. This initiative is now known as 'Safer City' and is collaboration between WFA, Wellington City Council and the Accident Compensation Corporation. This is now a regular feature during the busy weekend period.

- A new initiative for the management of diabetic patients was implemented. WFA paramedics treat diabetic patients suffering a hypoglycaemic episode being referring them to diabetic specialist nurses for their ongoing care. This allows patients whose diabetes has become unstable to remain in the community for their ongoing care.

- WFA has embarked upon an initiative to improve the number of patients surviving sudden cardiac arrest. This is known as 'Operation Heartbeat'. During the year 2011/12 the total number of the general public trained in CPR by WFA surpassed 10,000. Bystander CPR and early defibrillation are two key elements to help improve survival rates. Alongside teaching the public CPR and increasing the number of defibrillators in public places, WFA focused on managing the quality of advanced resuscitation conducted by its paramedics through the use of a quality and feedback process for all resuscitation events.

See below, WFA's survival rate from sudden cardiac arrest for 2011/12.

	July 1 - 30 June 2012		
	Total Cases	Survival to discharge	Survival to discharge %
Shockable - Witnessed	55	20	36.36%
Shockable - Non-Witnessed	17	4	23.53%
Non Shockable - Witnessed	50	0	0.00%
Non Shockable - Non-Witnessed	41	1	2.44%
Combined - Witnessed	105	20	19.05%
Combined - Non - Witnessed	58	5	8.62%
Total	163	25	15.34%

A NEW STRATEGIC PERIOD – 2012 TO 2017

In 2009 WFA delivered its three year strategic plan which reflected the organisation's vision to be pioneers of effective change for a better patient experience. Viewed by many at the time as a courageous plan, it drew upon WFA history as a progressive service to deliver on a number of innovations. In the last three years, this has allowed WFA to achieve its strategic goals.

The journey undertaken by WFA during this time now advocates for a review of the way we deliver our service; one that better recognises the needs of the patient, supports staff in meeting those needs and aligns WFA with national health strategy.

Five main outcomes have been identified that, through modernising the ambulance service, will achieve this:

1. Continue to deliver a high performing ambulance service
2. Coordinate healthcare through a single point of access
3. See and treat more patients at home or in their local community
4. Separate the response from transport requirements
5. Be more involved in primary healthcare, including the delivery of after hour services

WFA is now in a position to undertake the transformational change required to become a modern ambulance service in New Zealand and establish itself as an essential healthcare provider.

Comparative Data 2011-2012

The following section includes data collected for the financial year 2010-11. Data is presented in descending order based on population served by each service.

Please note the financial results have been adjusted by the Australian Bureau of Statistics (ABS) gross domestic product (GDP) price deflator where appropriate. Therefore financial results relating to previous years may not appear as first published.

The CAA thanks the Productivity Commission for assistance in producing the tables and associated footnotes in this section. Benchmarking information is published annually in the Report on Government Services and further information regarding annual reports can be found at www.pc.gov.au.

For further information regarding definitions, please refer to the CAA data dictionary which can be found at www.caa.net.au.

Ambulance Activity

Reported ambulance incidents, responses, patients and transport (a)

	Unit	NSW	Vic (b)	Qld	WA (c)	SA	Tas	ACT	NT (d)	Aust (e)	St John	WFA	NZ
Incidents													
Emergency incidents	'000	548	293	289	87	141	34	15	na	1 407	230	32	262
Urgent incidents	'000	139	158	307	44	57	22	16	na	743	101	11	111
Non-emergency incidents	'000	287	343	233	98	58	12	8	na	1 039	86	28	114
Casualty room attendances	'000	–	–	5	–	–	–	–	–	5			
Total incidents	'000	**973**	**795**	**833**	**230**	**256**	**68**	**39**	**–**	**3 194**	**416**	**71**	**487**
Population	million	7.2	5.6	4.5	2.4	1.6	0.5	0.4	0.2	22.5	3.9	0.5	4.4
Incidents per 1 000 people	no.	134	143	185	96	155	134	106	–	142	107	142	111
Responses													
Emergency responses	'000	695	428	368	93	191	42	16	13	1 847	286	30	316
Urgent responses	'000	171	203	336	45	74	25	16	21	891	118	10	128
Non-emergency responses	'000	318	386	227	103	63	13	8	10	1 128	92	27	119
Total responses	'000	**1 184**	**1 017**	**931**	**241**	**328**	**80**	**40**	**44**	**3 866**	**496**	**67**	**563**
Population	million	7.2	5.6	4.5	2.4	1.6	0.5	0.4	0.2	22.5	3.9	0.5	4.4
Responses per 1 000 people	no.	163	182	206	101	200	157	108	191	172	127	134	128
Patients													
Transported	'000	801	650	701	221	197	55	27	36	2 689	346	50	395
Treated not transported	'000	130	68	81	20	46	12	6	9	372	44	17	61
Total patients	'000	**931**	**718**	**782**	**241**	**243**	**67**	**33**	**44**	**3 060**	**389**	**67**	**456**
Population	million	7.2	5.6	4.5	2.4	1.6	0.5	0.4	0.2	22.5	3.9	0.5	4.4
Patients per 1 000 people	no.	128	129	173	101	148	131	89	191	136	100	134	104
Transport													
Total fleet road	m km	0.1	0.0	0.0	0.0	0.0	–	0.0	na	na	18.9		18.9
Flying hours fixed wing	'000 hrs	29.3	18.0	41.6	5.3	10.7	–	2.8	–	107.7			
Flying hours rotary wing	'000 hrs	1.9	6.5	1.2	3.6	0.1	–	0.2	–	13.5			
Growth over last year													
Incidents	%	3.1%	1.9%	4.0%	11.2%	-8.2%	-9.1%	8.3%	n/a	2.3%	4.8%	3.3%	4.6%
Responses	%	3.0%	3.7%	4.2%	12.2%	1.6%	-0.1%	11.3%	9.4%	3.9%	5.2%	6.1%	5.3%
Patients	%	3.0%	1.5%	6.3%	12.0%	3.6%	5.7%	6.9%	22.2%	4.5%	4.6%	6.1%	4.8%

(a) An incident is an event that results in a demand for ambulance resources to respond. An ambulance response is a vehicle or vehicles sent to an incident. There may be multiple responses/vehicles sent to a single incident. A patient is someone assessed,

(b) Vic: Victorian incidents and responses are for road ambulances only (excludes air ambulance).

(c) WA: Does not have a policy of automatically dispatching more than one unit to an incident unless advised of more than one patient. Separate statistics are not kept for incidents and responses. Numbers shown under incidents are cases.

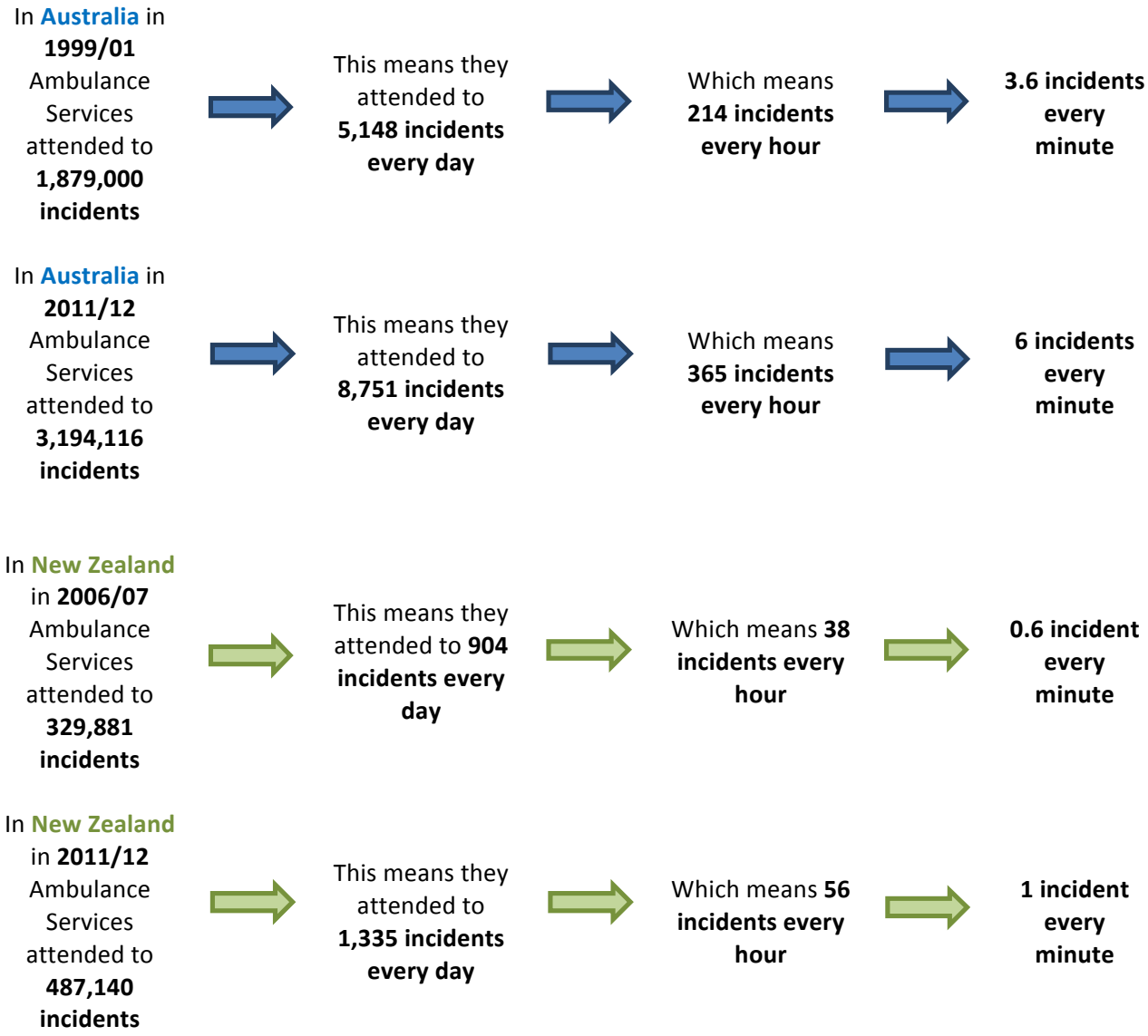
(d) NT: Incident data are unavailable as data are not recorded on the JESC system and all cases are considered an incident. A response is counted as an incident, therefore, data for incidents are not included in the rates for Australia.

(e) Aust: Australian incidents data exclude NT.

na = Not available. .. = Not applicable. – = Nil or rounded to zero.

Incidents, responses and patients are different as multiple vehicles (responses) can be sent to a single incident, and there may be more than one patient per incident. Ambulance services may also respond to incidents that do not have patients requiring treatment or transport.

In 2011-12 ambulance services in Australia and New Zealand attended 3.7 million incidents. Nearly 70% of ambulance work involved attending emergency and urgent incidents with 45% of incidents categorised as emergency, 23% urgent and 31% non-emergency.



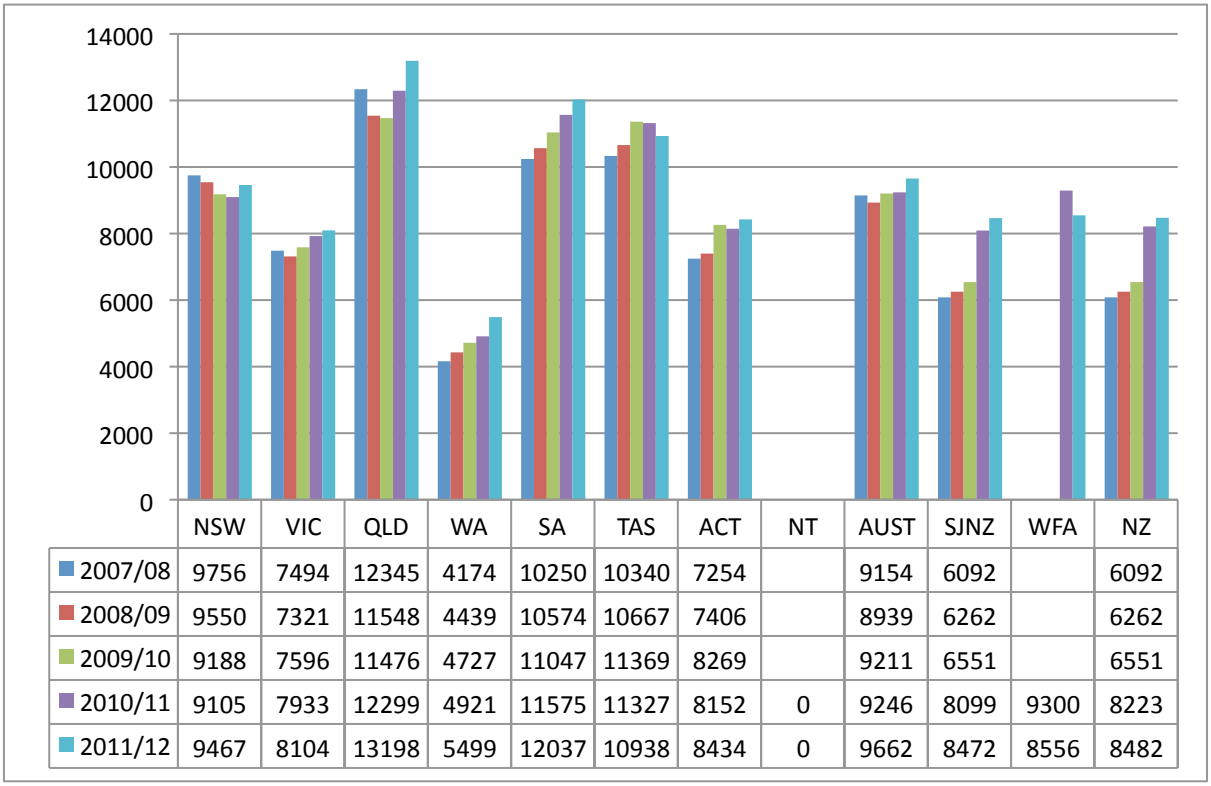
Incidents in Australia have had a combined growth of 70% between 1999 and 2012, with an average growth per annum of 4.5%. Looking at numbers, the growth means an extra 1.3 million incidents per year. In 1999 Australian ambulance services reported 1.9 million incidents by 2012 there were 3.2 million incidents. *

In New Zealand the number of incidents has grown by 47.7% between 2006 and 2012. The number of incidents has gone from 329,881 in 2006 to 487,140 in 2012. Average annual growth was 8.4%. *

- *Data for 6 and 10 years analysis is from the CAA Demand Management document, January 2013.*

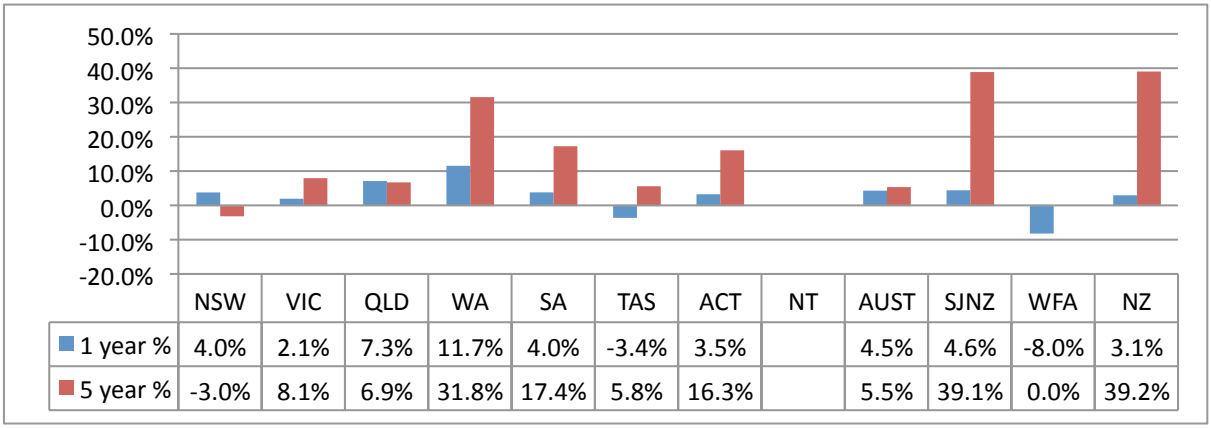
Incidents

Figure 1: Emergency and Urgent Incidents per 100,000 people



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	9756	7494	12345	4174	10250	10340	7254		9154	6092		6092
2008/09	9550	7321	11548	4439	10574	10667	7406		8939	6262		6262
2009/10	9188	7596	11476	4727	11047	11369	8269		9211	6551		6551
2010/11	9105	7933	12299	4921	11575	11327	8152	0	9246	8099	9300	8223
2011/12	9467	8104	13198	5499	12037	10938	8434	0	9662	8472	8556	8482

Figure 2: Emergency and Urgent Incidents per 100,000 people – 1 and 5 year growth



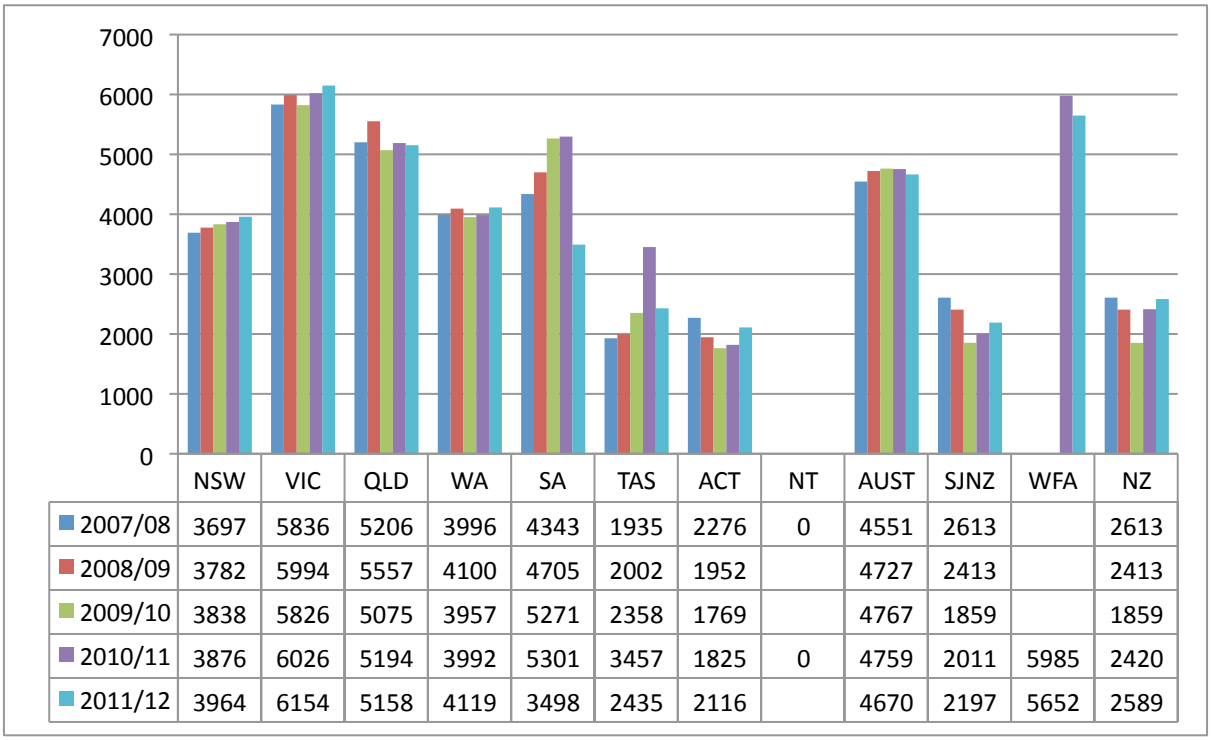
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	4.0%	2.1%	7.3%	11.7%	4.0%	-3.4%	3.5%		4.5%	4.6%	-8.0%	3.1%
5 year %	-3.0%	8.1%	6.9%	31.8%	17.4%	5.8%	16.3%		5.5%	39.1%	0.0%	39.2%

In Australia over the past year the rate of emergency and urgent incidents per 100,000 people has increased by 4.5%; with the only decrease of -3.4% recorded in Tasmania and increases in the rest of the states and territories ranging from 2.1% in Victoria to 11.4% in Western Australia.

In New Zealand the emergency and urgent incidents rate per 100,000 people has increased by 3.1% over the past year. WFA recorded a decrease of -8% and St John recorded an increase of 4.6%.

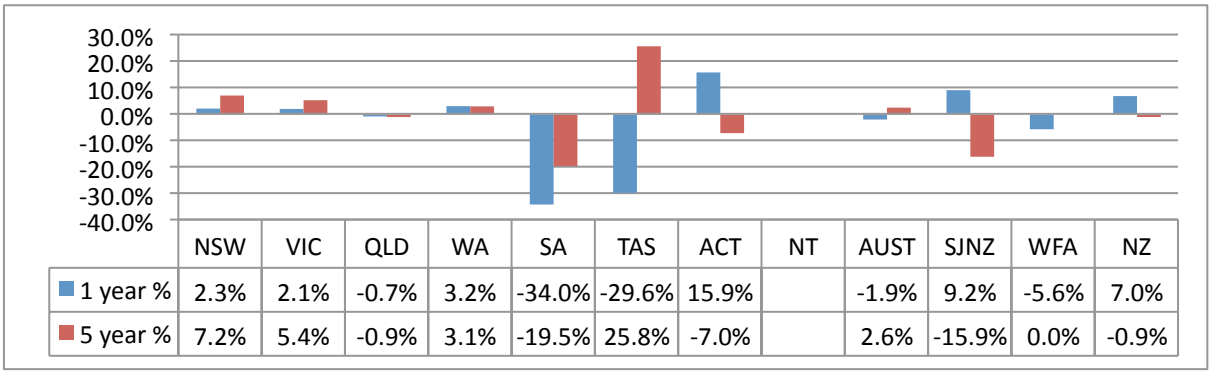
Over the past five years, emergency and urgent incidents per 100,000 people have increased both in Australia and New Zealand, 5.5% and 39.2% respectively. New South Wales is the only state that records a decrease of -3% over the last 5 years.

Figure 3: Non-emergency Incidents per 100,000 people



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	3697	5836	5206	3996	4343	1935	2276	0	4551	2613		2613
2008/09	3782	5994	5557	4100	4705	2002	1952		4727	2413		2413
2009/10	3838	5826	5075	3957	5271	2358	1769		4767	1859		1859
2010/11	3876	6026	5194	3992	5301	3457	1825	0	4759	2011	5985	2420
2011/12	3964	6154	5158	4119	3498	2435	2116		4670	2197	5652	2589

Figure 4: Non-emergency Incidents per 100,000 people – 1 and 5 year growth



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	2.3%	2.1%	-0.7%	3.2%	-34.0%	-29.6%	15.9%		-1.9%	9.2%	-5.6%	7.0%
5 year %	7.2%	5.4%	-0.9%	3.1%	-19.5%	25.8%	-7.0%		2.6%	-15.9%	0.0%	-0.9%

In Australia in 2011-12 non-emergency incidents per 100,000 people have decreased by -1.9%. This is a change from 2010-11 when Australia recorded an increase of 12.6%. In 2011-12 Queensland (-0.7%), South Australia (-34%) and Tasmania (-30%) recorded a decrease and other states recorded fairly small increases, between 2.1% and 3.2% with the exception of ACT who recorded a statistically significant increase of 16%.

New Zealand has this past year seen an increase in non-emergency incidents per 100,000 people of 7% which is in turn a change from 2010-11 recorded decrease of -8.3%. In this year St John recorded an increase of 9.2% and WFA recorded a decrease of -5.6%.

Over the past five years, Australia has recorded an increase of 2.6% in non-emergency incidents per 100,000 people; New Zealand has recorded a decrease of 1%. Queensland, South Australia, ACT and St John NZ have all recorded a decrease in growth over the last 5 years.

Figure 5: Non-emergency incidents as a % of total incidents

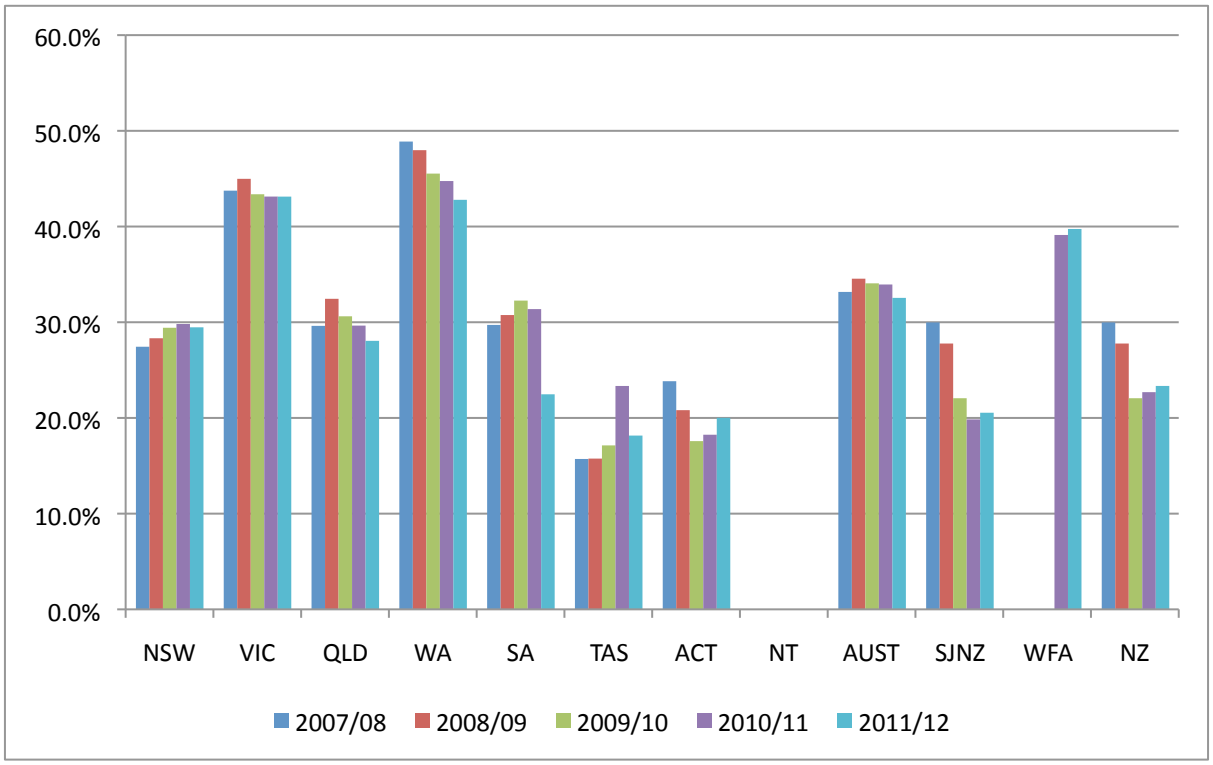
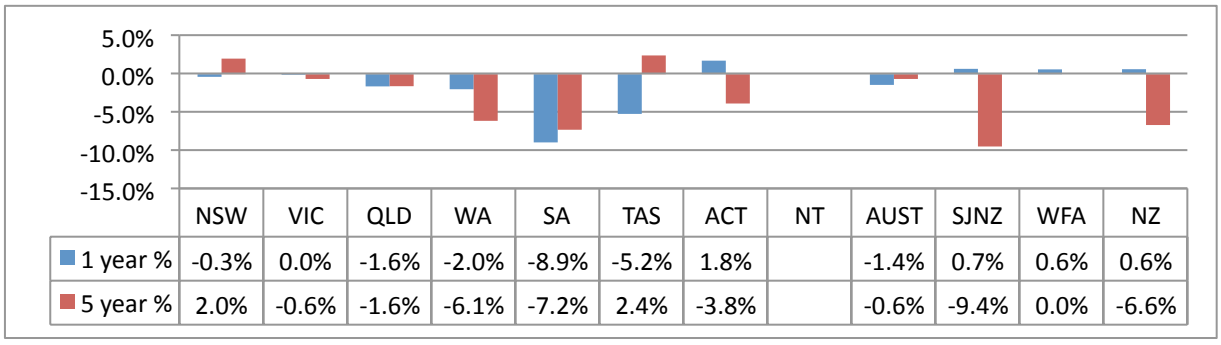


Figure 6: Non-emergency incidents as a % of total incidents – 1 and 5 year growth

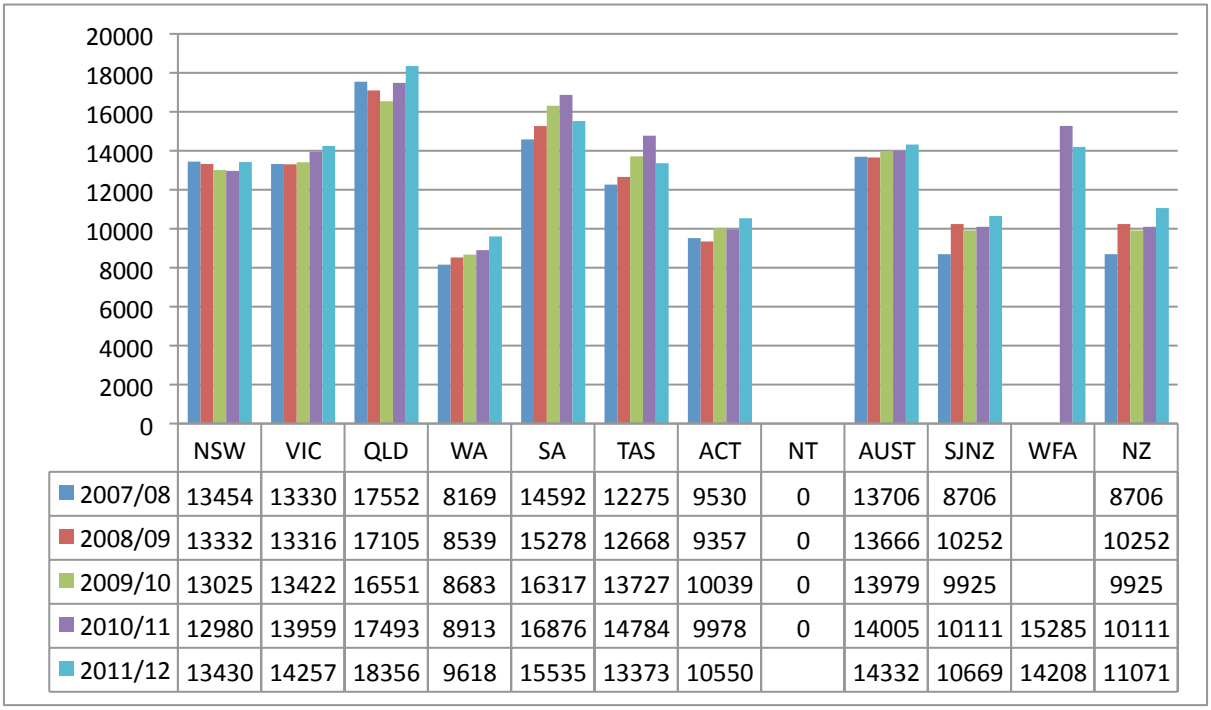


	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	-0.3%	0.0%	-1.6%	-2.0%	-8.9%	-5.2%	1.8%		-1.4%	0.7%	0.6%	0.6%
5 year %	2.0%	-0.6%	-1.6%	-6.1%	-7.2%	2.4%	-3.8%		-0.6%	-9.4%	0.0%	-6.6%

In 2011-12, non-emergency incidents accounted for 33% of all incidents across Australia. This ranged from 18% in Tasmania to 43% in Queensland. Overall Australia has seen a decrease of -1.4% in non-emergency incidents as percentage of all incidents.

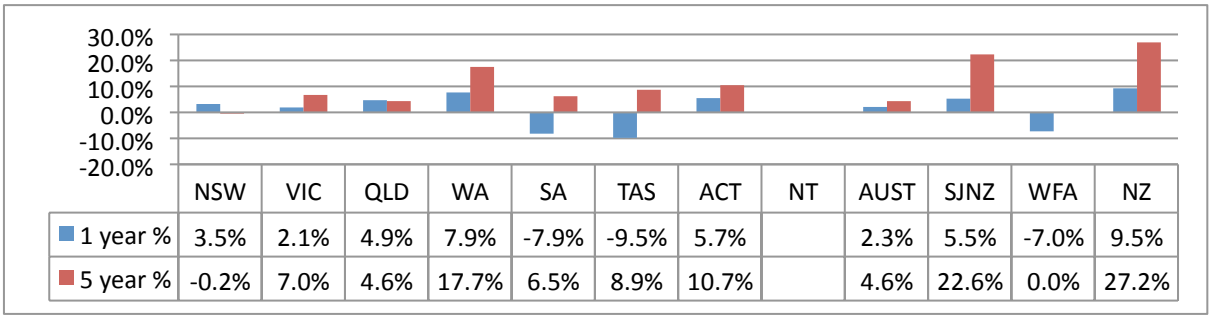
In New Zealand non-emergency incidents represent 23% of all incidents which increased by 0.6%.
Over the last five years, non-emergency incidents as a percentage of all incidents in both Australia and New Zealand have seen a decrease, -0.6% and -6.6% respectively.

Figure 7: All incidents per 100,000 people



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	13454	13330	17552	8169	14592	12275	9530	0	13706	8706		8706
2008/09	13332	13316	17105	8539	15278	12668	9357	0	13666	10252		10252
2009/10	13025	13422	16551	8683	16317	13727	10039	0	13979	9925		9925
2010/11	12980	13959	17493	8913	16876	14784	9978	0	14005	10111	15285	10111
2011/12	13430	14257	18356	9618	15535	13373	10550		14332	10669	14208	11071

Figure 8: All incidents per 100,000 people – 1 and 5 year growth



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	3.5%	2.1%	4.9%	7.9%	-7.9%	-9.5%	5.7%		2.3%	5.5%	-7.0%	9.5%
5 year %	-0.2%	7.0%	4.6%	17.7%	6.5%	8.9%	10.7%		4.6%	22.6%	0.0%	27.2%

Overall the rate of incidents per 100,000 people in Australia has increased by 2.3% in 2011-12. Decreases were recorded in South Australia (-8%) and Tasmania (-9.5%), and increases ranged in other states and territories from 2.1% in Victoria to 7.9% in Western Australia.

In 2011-12 the New Zealand incidents rate per 100,000 people increased by 9.5%. St John saw an increase of 5.5% and WFA recorded a decrease of -7%.

Over the last five years both Australia and New Zealand have been experiencing an increase in all incidents per 100,000 people. Australia has had an overall increase of 4.6% with ranges from a small decrease of -0.2% in New South Wales to 17.7% in Western Australia, and New Zealand has had a 27.2% increase.

Patients

Patient numbers in Australia over the last decade have grown on average 4.2% per annum, totalling in 50.2% growth in 10 years. Over last 10 years ambulance services in Australia have gone from seeing 4 patients every minute in 2001 to today seeing 6 patients every minute. *

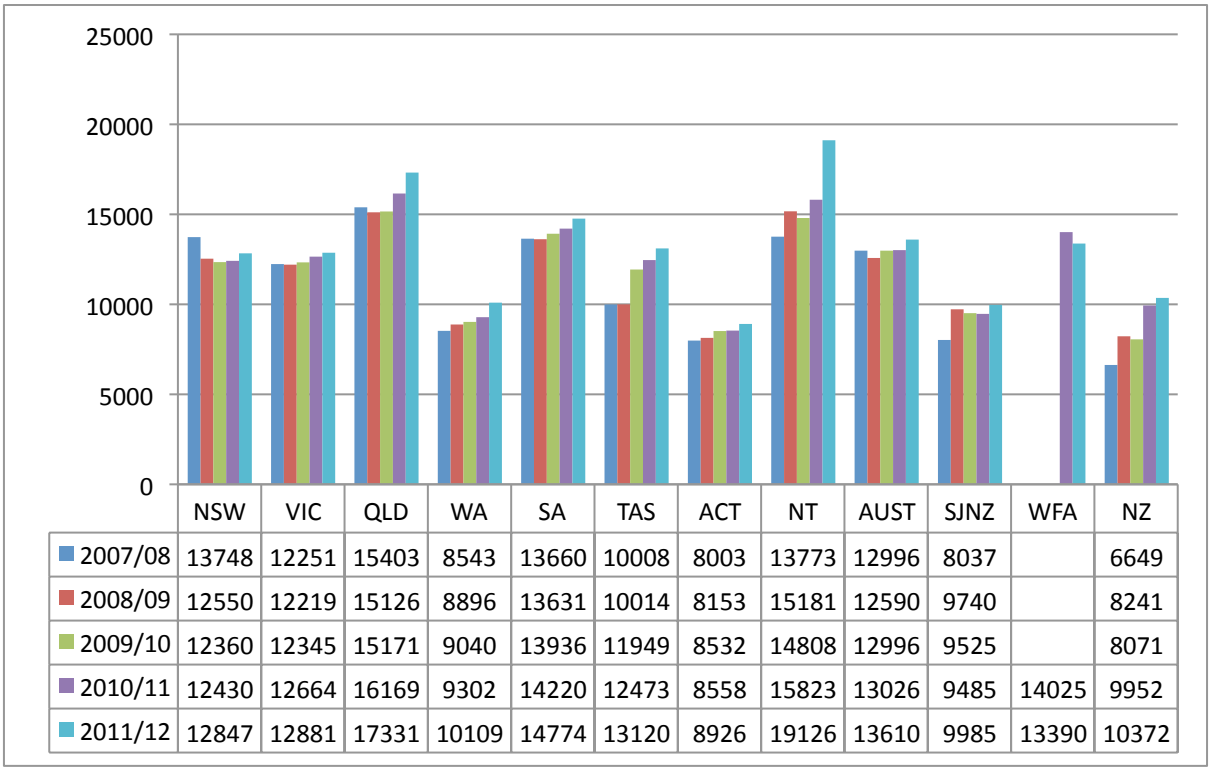
In **Australia** in **2001/02** Ambulance Services attended to **2,037,106 patients**	This means they attended to **5581 patients every day**	Which means **233 patients every hour**	**4 patients every minute**
In **Australia** in **2005/06** Ambulance Services attended to **2,432,879 patients**	This means they attended to **6665 patients every day**	Which means **278 patients every hour**	**5 patients every minute**
In **Australia** in **2011/12** Ambulance Services attended to **3,060,339 patients**	This means they attended to **8385 patients every day**	Which means **349 patients every hour**	**6 patients every minute**

Patient numbers in New Zealand have grown by 32.6% in the last 6 years with an average growth of 6.2% per year. There was a bigger growth reported in 2008/09 with 23.5%, following a year where NZ recorded a decrease in growth of patient numbers, by -6%. *

In **New Zealand** in **2006/07** Ambulance Services attended to **344,072 patients**	This means they attended to **943 patients every day**	Which means **39 patients every hour**	**0.7 patient every minute**
In **New Zealand** in **2011/12** Ambulance Services attended to **456,379 patients**	This means they attended to **1250 patients every day**	Which means **52 patients every hour**	**1 patient every minute**

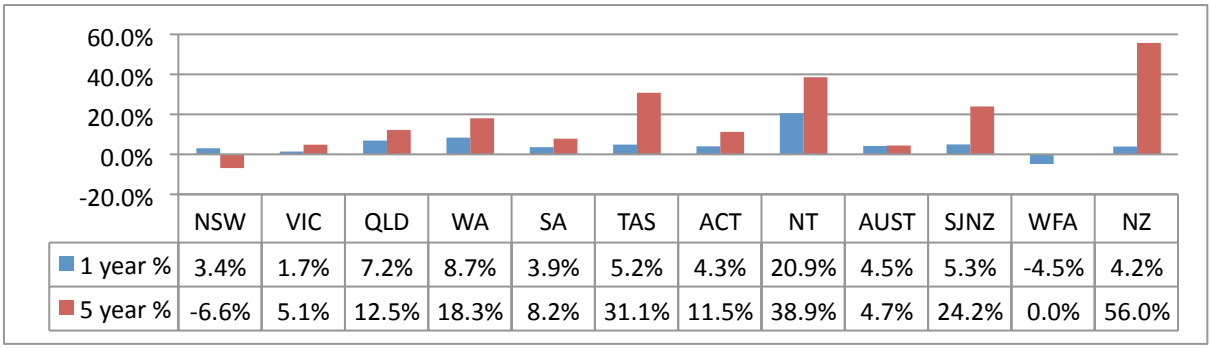
** Data for 6 and 10 years analysis is from the CAA Demand Management, January 2013 document.*

Figure 9: Patients per 100,000 people



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	13748	12251	15403	8543	13660	10008	8003	13773	12996	8037		6649
2008/09	12550	12219	15126	8896	13631	10014	8153	15181	12590	9740		8241
2009/10	12360	12345	15171	9040	13936	11949	8532	14808	12996	9525		8071
2010/11	12430	12664	16169	9302	14220	12473	8558	15823	13026	9485	14025	9952
2011/12	12847	12881	17331	10109	14774	13120	8926	19126	13610	9985	13390	10372

Figure 10: Patients per 100,000 people – 1 and 5 year growth



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	3.4%	1.7%	7.2%	8.7%	3.9%	5.2%	4.3%	20.9%	4.5%	5.3%	-4.5%	4.2%
5 year %	-6.6%	5.1%	12.5%	18.3%	8.2%	31.1%	11.5%	38.9%	4.7%	24.2%	0.0%	56.0%

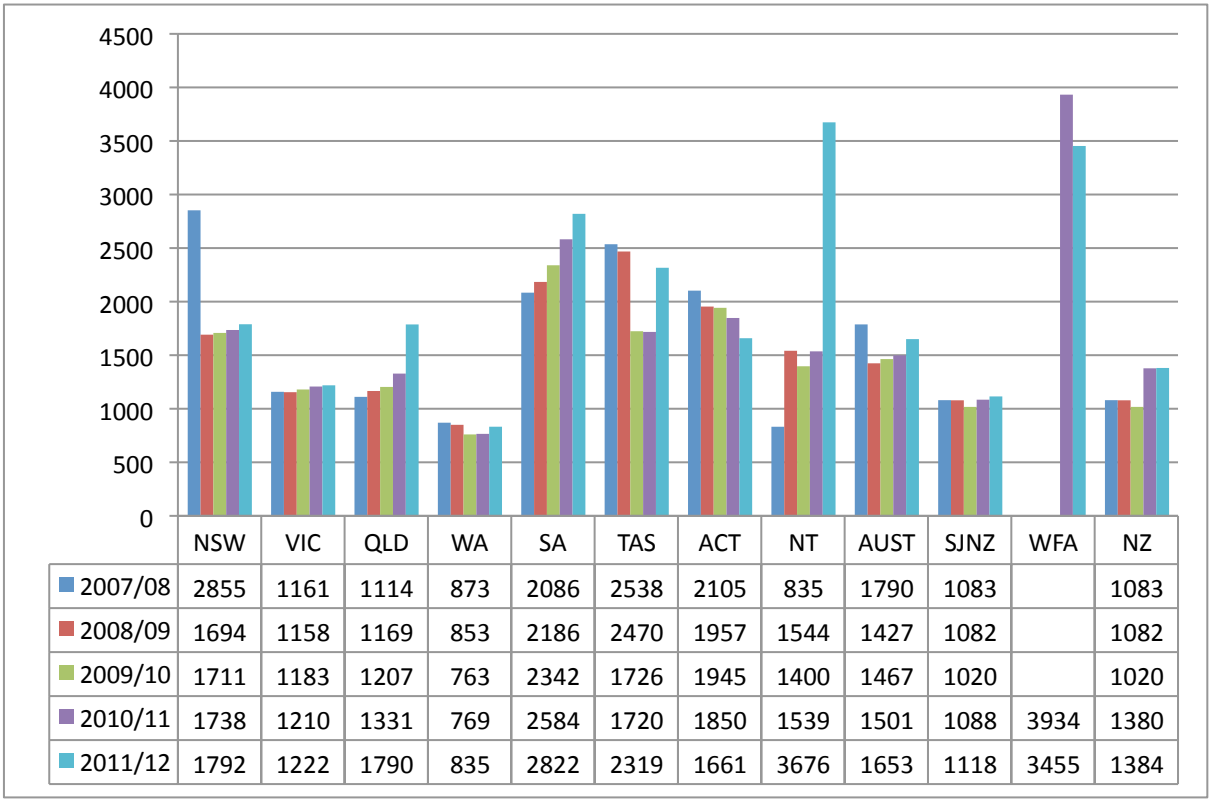
Australian ambulance services have in 2011-12 attended to 3 million patients and New Zealand has attended to 456,000 patients.

In the past year patients per 100,000 people increased by 4.5% in Australia. Increases were recorded in most states and territories ranging from 1.7% in Victoria to 20.9% in NT.

New Zealand saw an increase of 4.2% in number of patients per 100,000 people in the past year. St John recorded an increase of 5.3% and WFA reported a decrease of -4.5%.

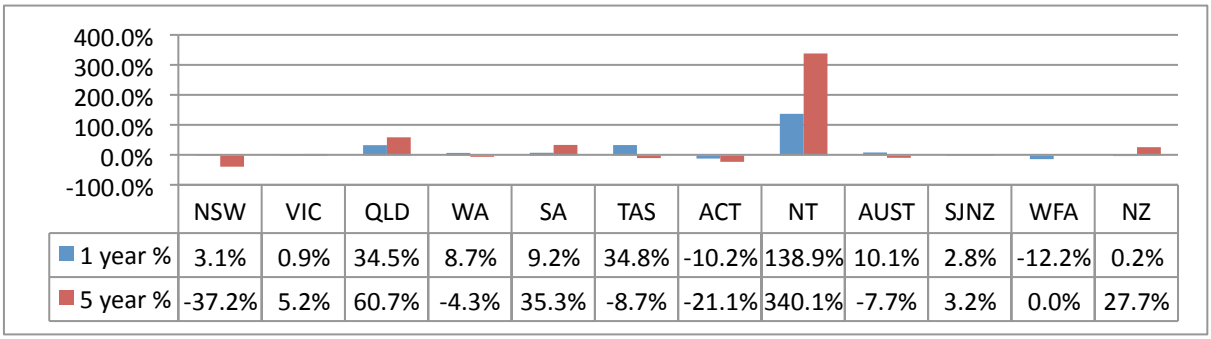
Over the last five years, patients per 100,000 people have increased in Australia by 4.7% and 56% in New Zealand.

Figure 11: Patients treated not transported per 100,000 people



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	2855	1161	1114	873	2086	2538	2105	835	1790	1083		1083
2008/09	1694	1158	1169	853	2186	2470	1957	1544	1427	1082		1082
2009/10	1711	1183	1207	763	2342	1726	1945	1400	1467	1020		1020
2010/11	1738	1210	1331	769	2584	1720	1850	1539	1501	1088	3934	1380
2011/12	1792	1222	1790	835	2822	2319	1661	3676	1653	1118	3455	1384

Figure 12: Patients treated not transported per 100,000 people – 1 and 5 year growth



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	3.1%	0.9%	34.5%	8.7%	9.2%	34.8%	-10.2%	138.9%	10.1%	2.8%	-12.2%	0.2%
5 year %	-37.2%	5.2%	60.7%	-4.3%	35.3%	-8.7%	-21.1%	340.1%	-7.7%	3.2%	0.0%	27.7%

In Australia in 2011-12 patients treated and not transported made up 12.2% of all patients. Overall Australia saw an increase of treated but not transported patients, by 10.1%. Increases ranged from 0.9% in Victoria to 139% in NT; ACT recorded a decrease of -10.2%.

New Zealand saw a small increase of patients treated and not transported, by 0.2%. These patients made up 13.3% of all patients in New Zealand.

The last five years have seen a decrease in treated patients not transported in Australia of -7.7% and an increase in New Zealand of 27.7%.

Ambulance Staff

Ambulance service organisations' human resources

	Unit	NSW	Vic (a)	Qld (b)	WA (c)	SA	Tas	ACT	NT	Aust	St John	WFA	NZ
Salaried personnel													
Ambulance operatives	%	84.9	82.1	84.3	69.8	75.1	78.1	75.7	81.4	81.8	62.3	82.2	64.5
Ambulance operatives	FTE	3 702	2 831	3 284	786	909	279	170	136	12 095	1062	176	1238
Patient transport officers	FTE	219	63	182	67	52	19	13	8	622	63	22	84
Students and base level ambulance officers	FTE	510	283	352	193	74	33	26	55	1 527	-	16	16
Qualified ambulance officers	FTE	2 600	2 421	2 326	441	655	197	109	51	8 801	882	97	979
Clinical other	FTE	53	12	–	–	39	3	–	–	107			
Communications operatives	FTE	319	52	424	84	89	27	21	22	1 039	117	41	158
Operational support personnel	FTE	390	262	301	156	164	47	30	12	1 362	223	16	239
Corporate support personnel	FTE	269	356	310	184	137	31	24	19	1 331	421	22	443
Total salaried personnel	FTE	**4 360**	**3 449**	**3 895**	**1 126**	**1 210**	**357**	**224**	**167**	**14 788**	**1705**	**214**	**1919**
Population (i)	million	7.2	5.6	4.5	2.4	1.6	0.5	0.4	0.2	22.5	3.9	0.5	4.4
Per 100 000 people													
Students and base level ambulance officers	FTE	7.0	5.1	7.8	8.1	4.5	6.4	7.0	23.7	6.8	0.0	3.2	0.4
Qualified ambulance officers	FTE	35.9	43.4	51.5	18.5	39.8	38.5	29.4	21.9	39.1	22.6	19.4	22.3
Total	FTE	**42.9**	**48.5**	**59.3**	**26.6**	**44.3**	**45.0**	**36.4**	**45.6**	**45.9**	**43.7**	**42.7**	**43.6**
Volunteers													
Ambulance operatives	no.	285	505	118	2 704	1 255	488	–	–	5 355	2 863		2 863
Operational / corporate support	no.	23	–	–	452	182	–	–	–	657			
Total volunteers	no.	**308**	**505**	**118**	**3,156**	**1,437**	**488**	**–**	**–**	**6 012**	**2,863**		**2,863**
Community first responders													
Total Community first responders	no.	**198**	**411**	**236**	**750**	**37**	**38**	**–**	**–**	**1 670**	**130**		**130**

(a) VIC: Data on volunteers includes some renumerated volunteers. These volunteers were remunerated for some time (usually response), but not for other time (usually on-call time). Data on community first responders includes 50 CERT and 30 Hatzolah responders.
(b) QLD: Volunteer numbers may fluctuate as members leave the service, new members are recruited and data cleansing occurs.
(c) WA: Operational and corporate support volunteers are the total of volunteers who perform a support role and do not undertake ambulance rosters.
FTE Full time equivalent na = Not available. .. = Not applicable. – = Nil or rounded to zero.

In 2011-12 Australia had 14,788 full time equivalent (FTE) salaried personnel employed by ambulance services. 82% of all staff were employed primarily for operational purposes. New Zealand had 1,919 full time equivalent salaried personnel, of which 64.5% were operational.

Volunteers are counted in numbers and not FTE. Australian ambulance services in total had 6,012 volunteers, of these 89% were involved in operations in 2011-12. New Zealand had 2,863 volunteers, who were all involved in operations.

In 2011-12 there were 1,670 first responders in Australia and 130 in New Zealand. These are the type of volunteers that provide an emergency response (with no transport capacity) and first aid care before ambulance arrival.

Figure 13: Ambulance service volunteers/first responders

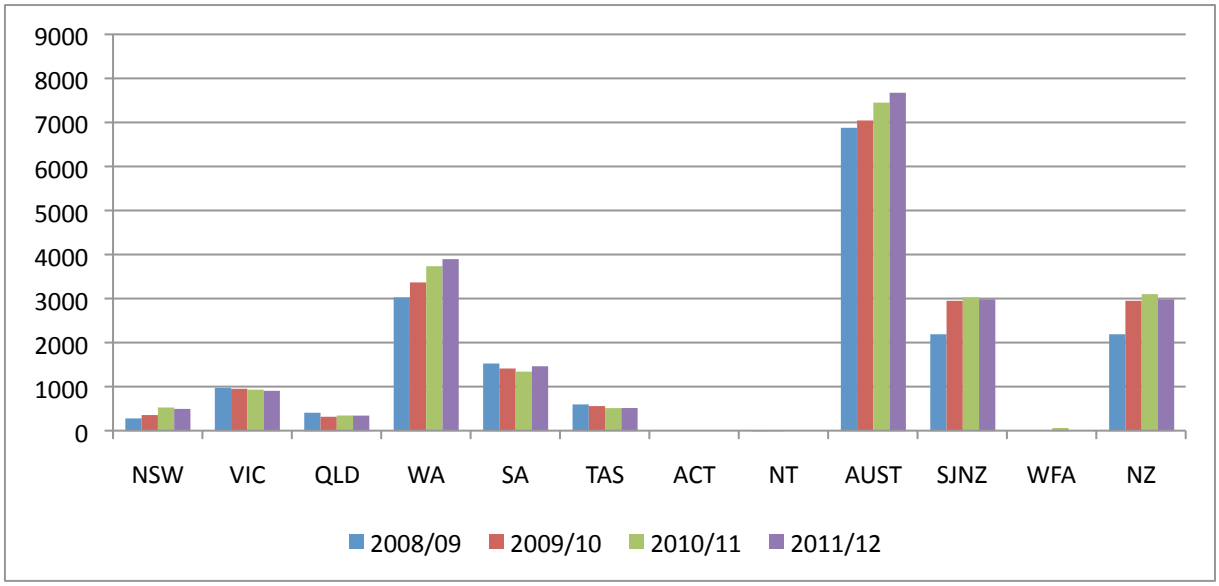
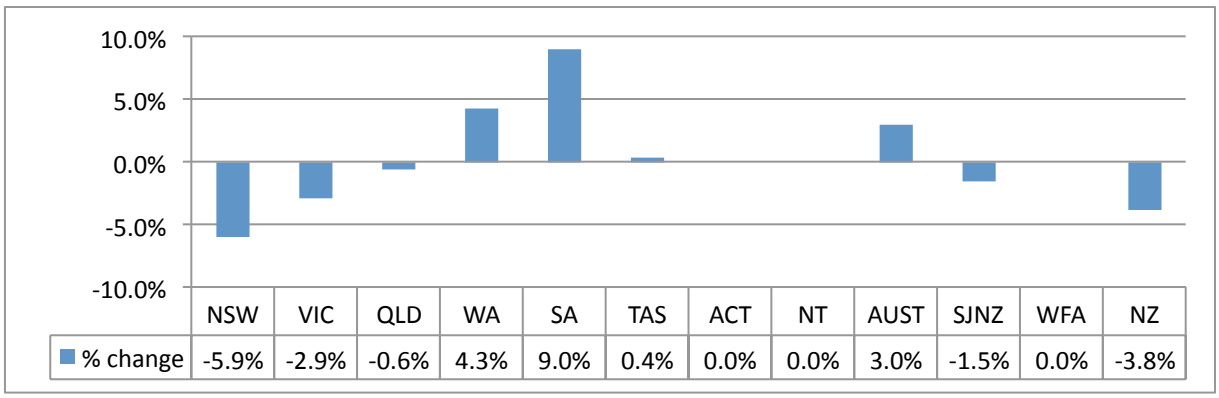


Figure 14: Ambulance service volunteers/first responders – annual growth



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
% change	-5.9%	-2.9%	-0.6%	4.3%	9.0%	0.4%	0.0%	0.0%	3.0%	-1.5%	0.0%	-3.8%

Ambulance volunteers in Australia and New Zealand represent a substantial proportion of the workforce, particularly in Western Australia, South Australia, Tasmania and New Zealand. Ambulance services deeply value the significant contribution volunteers make to Australian and New Zealand communities and the many sacrifices and challenges volunteers face in their duties, particularly in rural and remote areas.

Nationally in Australia in 2011-12 ambulance services consisted of 7,682 volunteers, including community first responders. Volunteer and first responder numbers have increased by 3% over the last year.

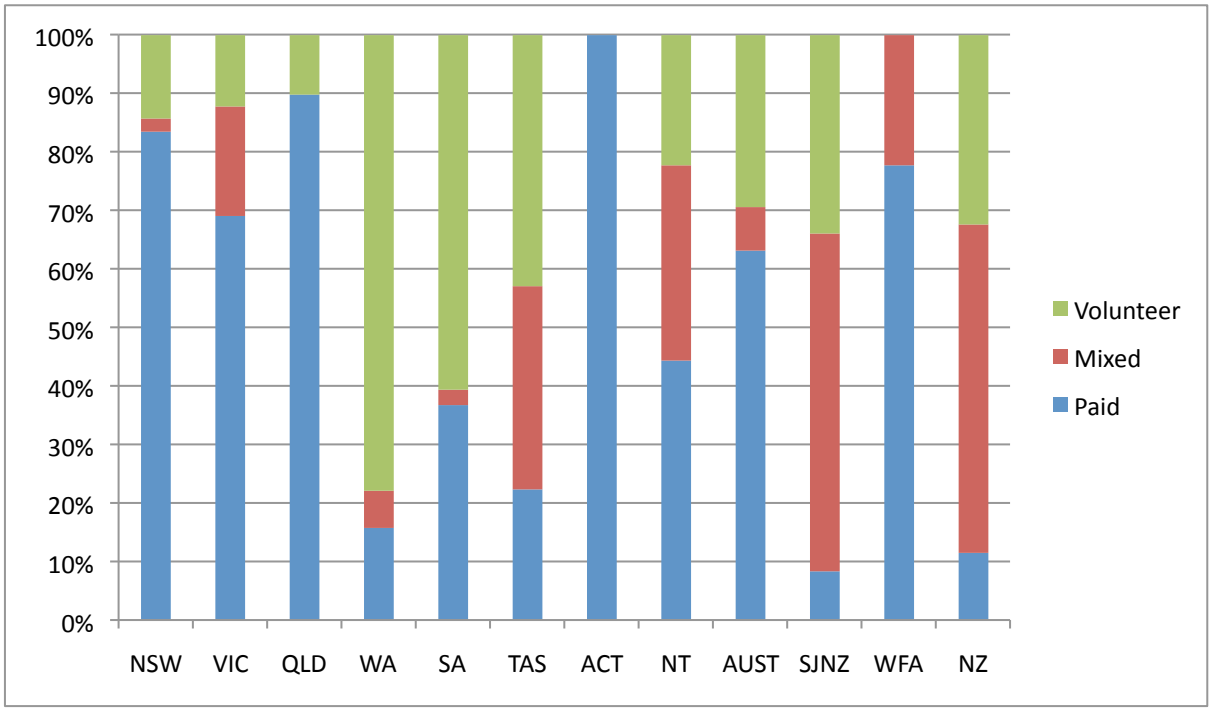
New Zealand had a total of 2,993 volunteers and first responders in the last year, which represented a -3.8% decrease from the previous year.

Ambulance stations and locations, by staff type (a)

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	St John	WFA	NZ
Ambulance stations and locations													
With paid staff only	no.	223	159	239	30	42	11	7	4	715	16	7	23
With mixed paid and volunteer staff	no.	6	43	–	12	3	17	–	3	84	109	2	111
With volunteer staff only	no.	38	28	27	147	69	21	–	2	332	64		64
Total	no.	**267**	**230**	**266**	**189**	**114**	**49**	**7**	**9**	**1 131**	**189**	**9**	**198**
Population (a)	million	7.2	5.6	4.5	2.4	1.6	0.5	0.4	0.2	22.5	3.9	0.5	4.4
Per 100 000 people													
With paid staff only	no.	3.1	2.9	5.3	1.3	2.6	2.1	1.9	1.7	3.2	0.4	1.4	0.5
With mixed paid and volunteer staff	no.	0.1	0.8	0.0	0.5	0.2	3.3	0.0	1.3	0.4	2.8	0.4	2.5
With volunteer staff only	no.	0.5	0.5	0.6	6.2	4.2	4.1	0.0	0.9	1.5	1.6	0.0	1.5
Total	no.	**3.7**	**4.1**	**5.9**	**7.9**	**6.9**	**9.6**	**1.9**	**3.9**	**5.0**	**4.8**	**1.8**	**4.5**

na = Not available. .. = Not applicable. – = Nil or rounded to zero.

Figure 15: Ambulance stations and locations by staff type per 100,000 people

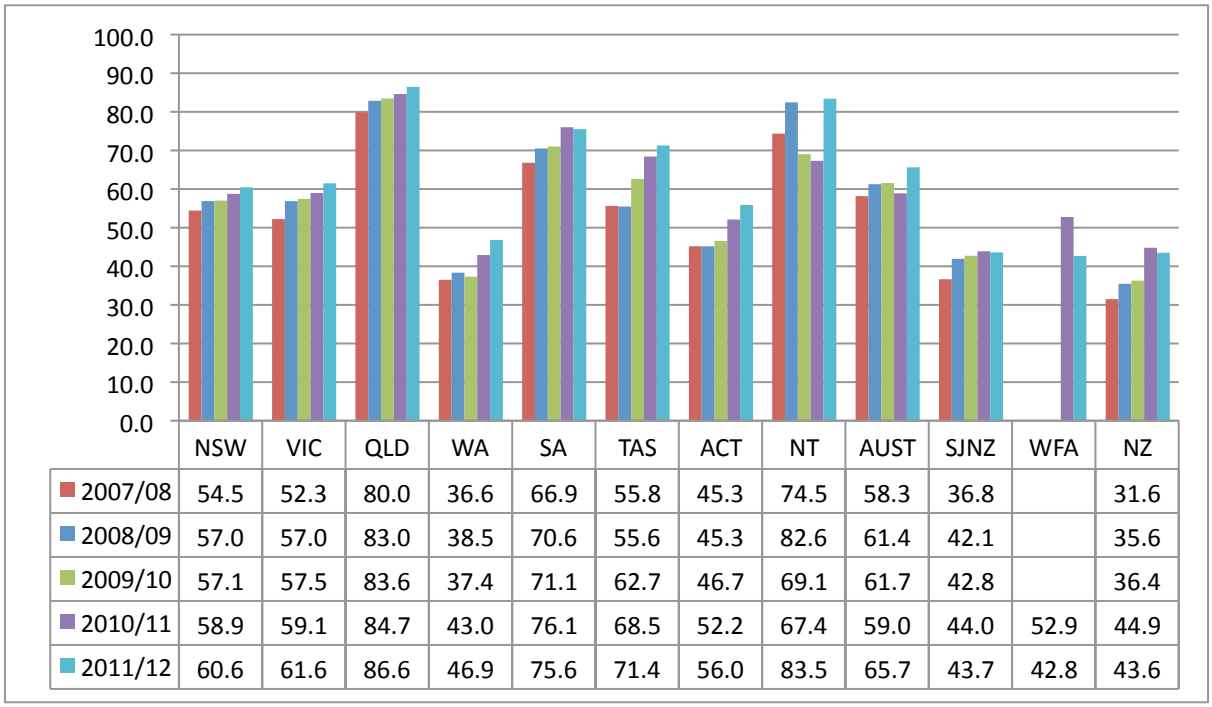


In 2011-12 there were 1,131 ambulance response locations Australia wide, 63% with paid staff only, 7% combination of paid and volunteer staff and 29% fully volunteer supported. The distribution varies between states and territories, with Western Australia, South Australia and Tasmania heavily relying on volunteer based response locations in rural and remote areas.

New Zealand had 198 response locations in 2011-12. 12% were paid staff supported, 56% were supported by paid and volunteer staff and 32% were fully volunteer supported.

Ambulance services provide volunteers with quality education and ongoing training and support to ensure volunteer ambulance personnel are well prepared to meet the needs of their communities. Ambulance services continue to develop new initiatives to support the development of current volunteers and the recruitment of new volunteers.

Figure 16: Ambulance service salaried personnel per 100,000 population



	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	54.5	52.3	80.0	36.6	66.9	55.8	45.3	74.5	58.3	36.8		31.6
2008/09	57.0	57.0	83.0	38.5	70.6	55.6	45.3	82.6	61.4	42.1		35.6
2009/10	57.1	57.5	83.6	37.4	71.1	62.7	46.7	69.1	61.7	42.8		36.4
2010/11	58.9	59.1	84.7	43.0	76.1	68.5	52.2	67.4	59.0	44.0	52.9	44.9
2011/12	60.6	61.6	86.6	46.9	75.6	71.4	56.0	83.5	65.7	43.7	42.8	43.6

In 2011-12 the number of ambulance service salaried personnel per 100,000 population in Australia has increased, from 59.0 in 2010-11 to 65.7 in 2011-12. In New Zealand they experienced a slight increase from 44.9 in 2010-11 to 43.6 in 2011-12.

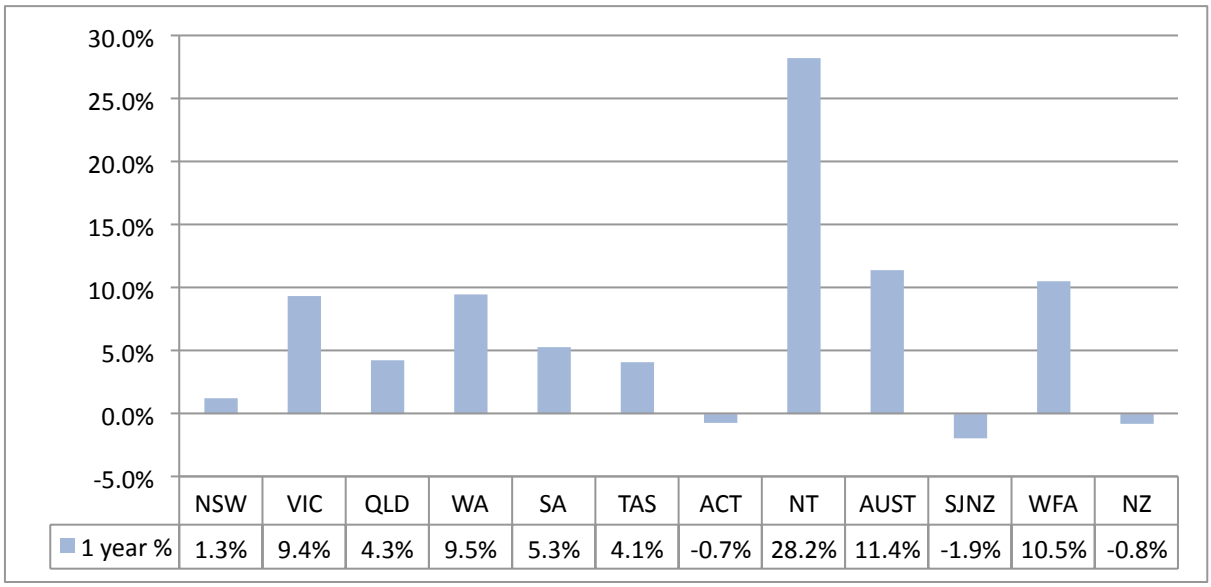
In Australia the number of ambulance service salaried personnel per 100,000 population varies from 46.9 in WA to 86.6 in Queensland.

In New Zealand St John records 43.7 ambulance service salaried personnel per 100,000 population and WFA has 42.8 in the 2011-12 financial year.

Figure 17: Availability of paramedics/ambulance officers per 100,000

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
2007/08	40.2	39.8	52.4	22.5	40.2	41.3	32.0	52.4	40.8	19.0		16.3
2008/09	42.1	43.4	55.9	23.1	42.9	40.7	30.4	51.9	43.2	19.6		16.6
2009/10	41.9	43.8	56.6	22.5	42.7	44.3	31.7	46.4	43.3	22.4		19.1
2010/11	42.7	44.1	57.1	24.1	43.3	44.2	34.0	41.3	41.2	23.1	20.4	22.8
2011/12	43.2	48.3	59.5	26.4	45.6	46.0	33.8	53.0	45.9	22.6	22.6	22.6

Figure 18: Availability of paramedics/ambulance officers per 100,000 – annual growth



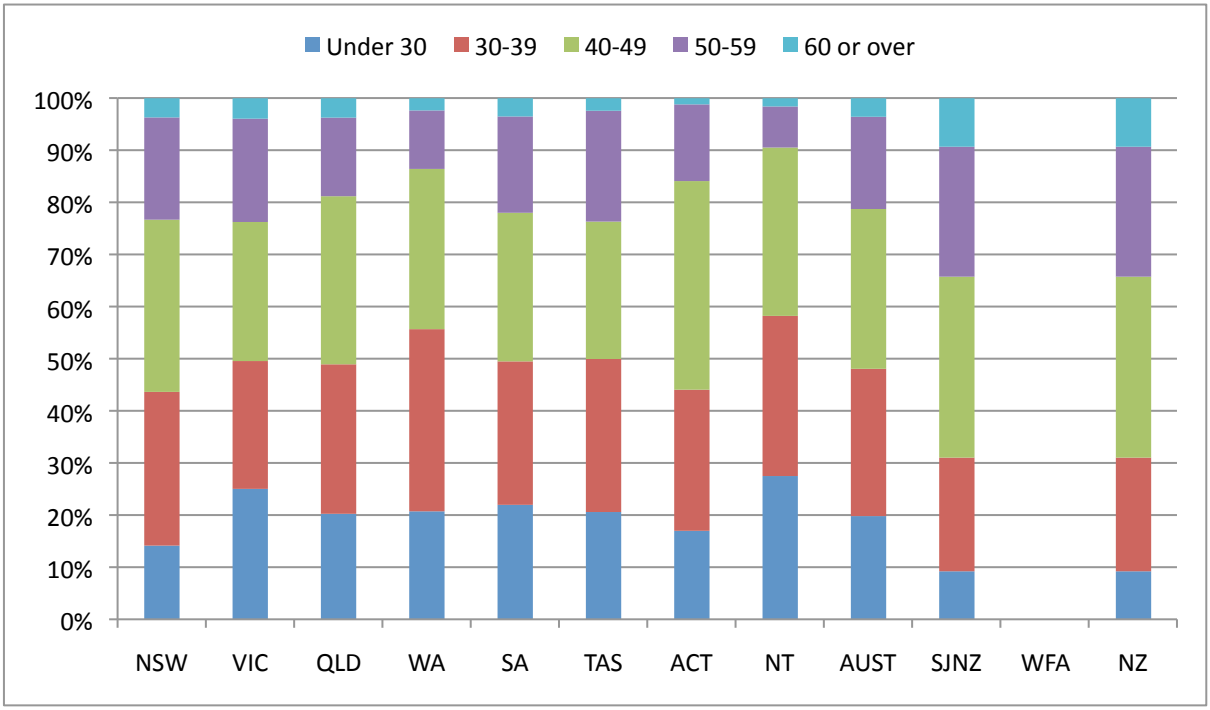
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUST	SJNZ	WFA	NZ
1 year %	1.3%	9.4%	4.3%	9.5%	5.3%	4.1%	-0.7%	28.2%	11.4%	-1.9%	10.5%	-0.8%

The figures for ambulance officers/paramedics include student and base level ambulance officers and qualified ambulance officers, but exclude patient transport officers.

Overall, Australia experienced an increase of 11.4%. Increases were highest in WA, 9.5% and Victoria 9.4%. The only decrease was recorded in the ACT with -0.7%.

New Zealand saw a small decrease of -0.8% in ambulance officers/paramedics availability per 100,000 people. St John recorded a decrease of 2% and WFA saw a significant increase of 10.5%.

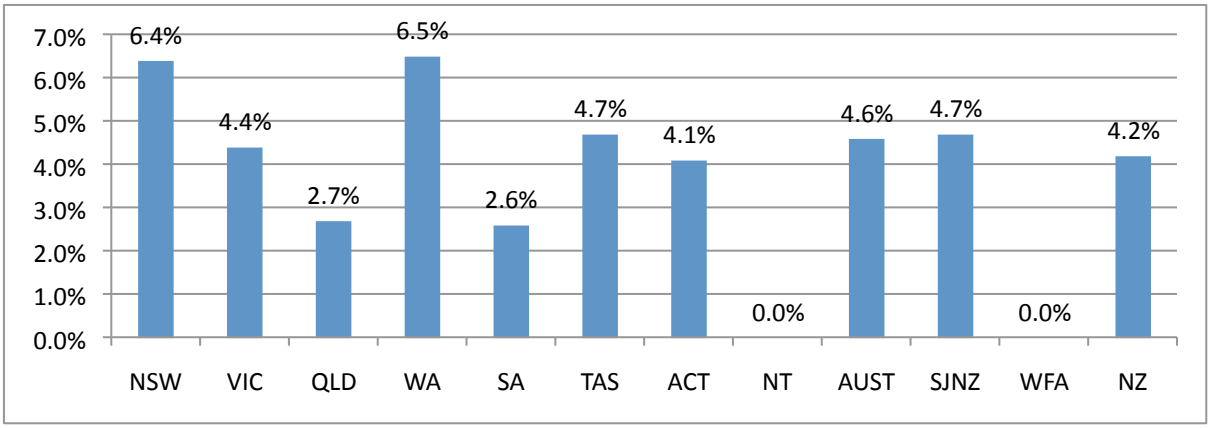
Figure 19: Operational ambulance workforce by age group



Operational workforce by age group and is identified as staff with paramedic qualifications desirable or essential to the role. The larger the proportion of operational workforce closer to retirement, the more likely sustainability problems will arise in the future.

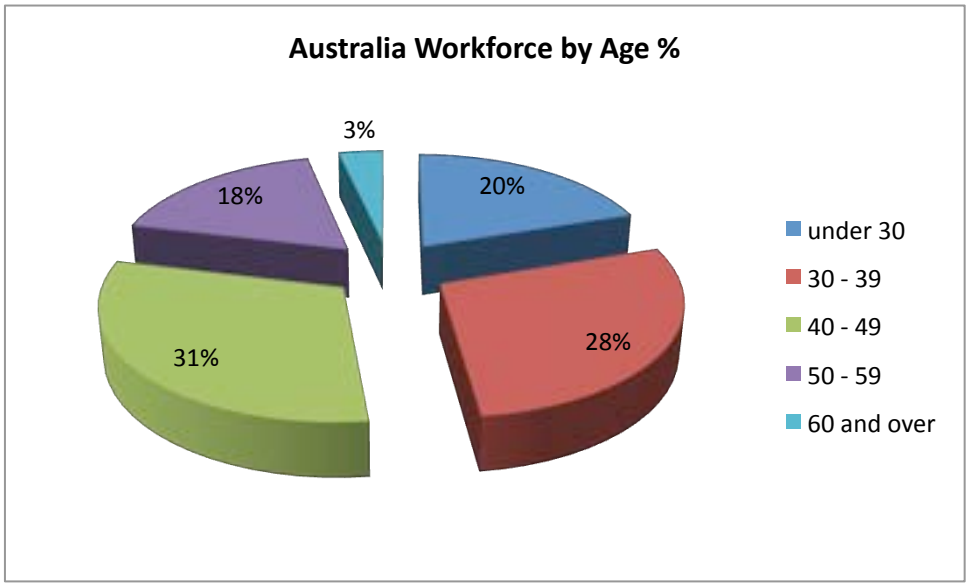
In Australia 79% of the workforce was aged under 50, in New Zealand (data for St John only) the percentage was 66%. These numbers have slightly decreased from the previous year (Australia 80%, NZ (St John and WFA) 70%).

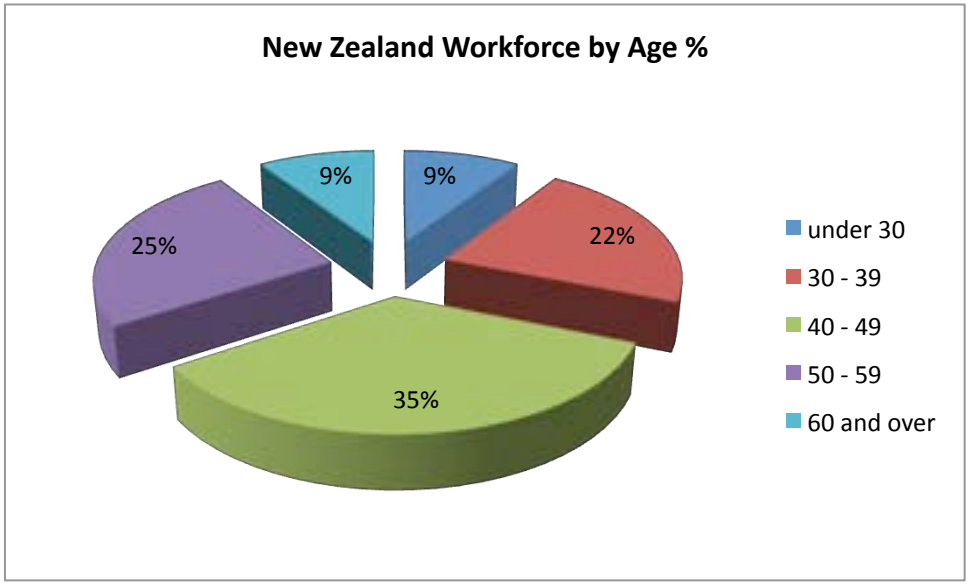
Figure 20: Operational ambulance staff attrition (FTE)



In 2011-11 staff attrition, which is calculated as the proportion of FTE employees who exit the organisation during the year, for Australia was 4.6% and varied between states and territories from 6.5% in WA to 0% in NT. New Zealand recorded a 4.2% staff attrition rate, with St John reporting 4.7% attrition rate and WFA 0%.

Figure 21: Total workforce by age Australia and New Zealand*





** New Zealand data only includes St John data.*

Assets

Ambulance assets (number) (a) (b)

	Unit	NSW	Vic (c)	Qld	WA	SA	Tas	ACT	NT (c)	Aust	St John	WFA	NZ
Ambulance stations and locations													
Response locations	no.	267	230	266	189	114	49	7	9	1 131	189	9	198
Communication centres	no.	5	7	7	1	1	na	1	1	na		1	1
Other locations	no.	60	34	25	113	23	6	4	1	266	34	7	41
Total	no.	**332**	**271**	**298**	**303**	**138**	**55**	**12**	**11**	**1 397**	223	17	240
First responder locations													
Ambulance	no.	16	31	30	254	8	4	–	–	343	42		42
Third party	no.	6	68	na	na	7	5	na	na	na	93		93
Ambulances and other vehicles													
Ambulance general purpose	no.	914	527	816	458	226	108	25	31	3 105	506		506
Patient transport vehicles	no.	122	57	105	29	15	14	4	3	349	54	19	73
Operational support vehicles	no.	309	310	210	24	104	30	12	12	1 011	73		73
Special operations vehicles	no.	94	16	18	11	15	3	na	1	na	57	6	63
Administrative vehicles	no.	68	150	47	53	27	3	1	6	355	215	3	218
Other vehicles	no.	67	32	48	22	12	6	4	5	196	8	2	10
Total	no.	**1 574**	**1 092**	**1 244**	**597**	**399**	**164**	**46**	**58**	**5 016**	**913**	**30**	**943**

(a) Differences in geography, topography and operational structures require different resourcing models across jurisdictions.

(b) VIC: General purpose ambulances exclude contractors' nonemergency vehicles and special operations vehicles include four fixed wing and three rotary wing aircraft under contract.

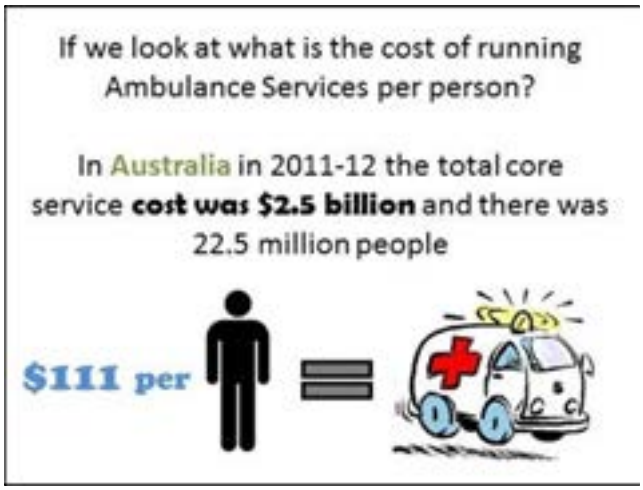
na = Not available. .. = Not applicable. – = Nil or rounded to zero.

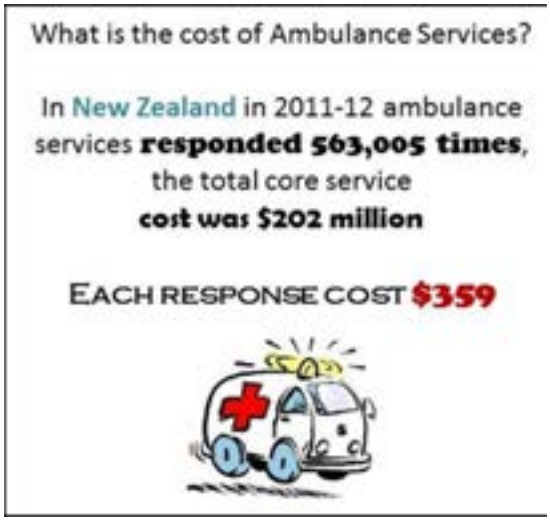
Costs

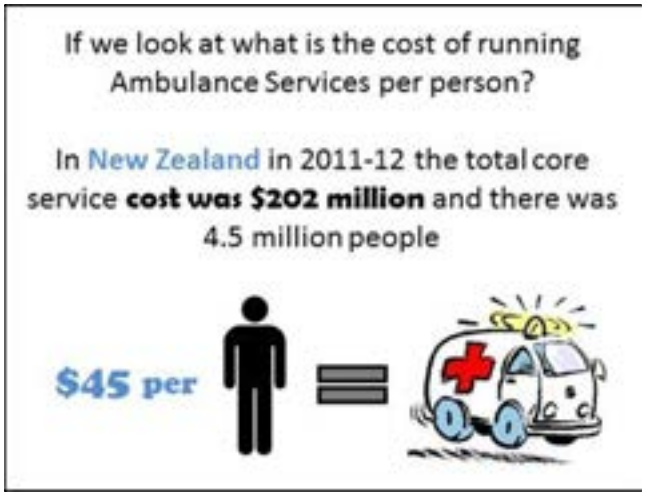
Ambulance service costs ($'000) (2011-12 dollars) (a), (b)

	NSW	Vic	Qld	WA (c)	SA	Tas (d)	ACT	NT (e)	Aust (c)	St John	WFA	NZ
Labour costs - Salaries and payments in the nature of salaries	504 572	376 308	380 481	97 222	186 448	37 782	23 860	17 048	1 623 720	125,585		125,585
Capital costs												
Depreciation	19 557	28 800	39 246	9 959	8 443	3 044	859	1 460	111 368	14,750		14,750
User cost of capital - Other assets	13 017	15 449	27 022	6 427	4 340	2 152	562	320	69 290	7,445		7,445
Other costs	205 276	189 696	120 481	58 103	54 944	14 610	12 031	4 516	659 657	51,314		51,314
Total expenditure (i)	**742 422**	**610 253**	**567 230**	**171 711**	**254 175**	**57 588**	**37 312**	**23 344**	**2 464 036**	**199,094**		**199,094**
Other costs												
Payroll tax	–	–	16 081	–	–	2 197	–	–	18 278			
User cost of capital - Land	7 316	4 179	8 672	935	944	582	453	21	23 103	2,916		2,916
Interest on borrowings	–	–	–	–	124	–	–	–	124	271		271

(a) Payroll tax is excluded from labour costs.
(b) Total expenditure excludes the user cost of capital for land, interest on borrowings and payroll tax.
(c) WA: WA use a contracted service model for ambulance services.
(d) TAS: The service is part of the Department of Health and Human Services and sources corporate support services from the Department. Other assets includes $3 million funded through recurrent operational funds (land and buildings, medical equipment) subsequently transferred to capital.
(e) NT: NT use a contracted service model for ambulance services. All property holding assets are held under a separate entity to St John Ambulance NT.
na = Not available. .. = Not applicable. – = Nil or rounded to zero.







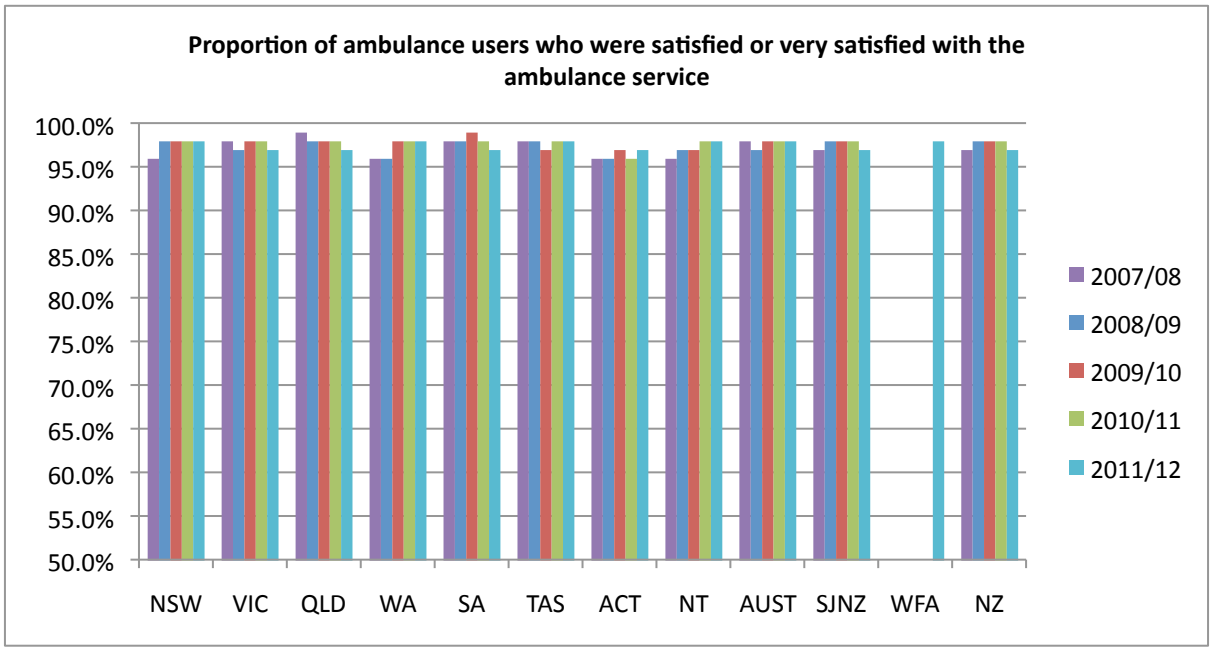
Patient Satisfaction

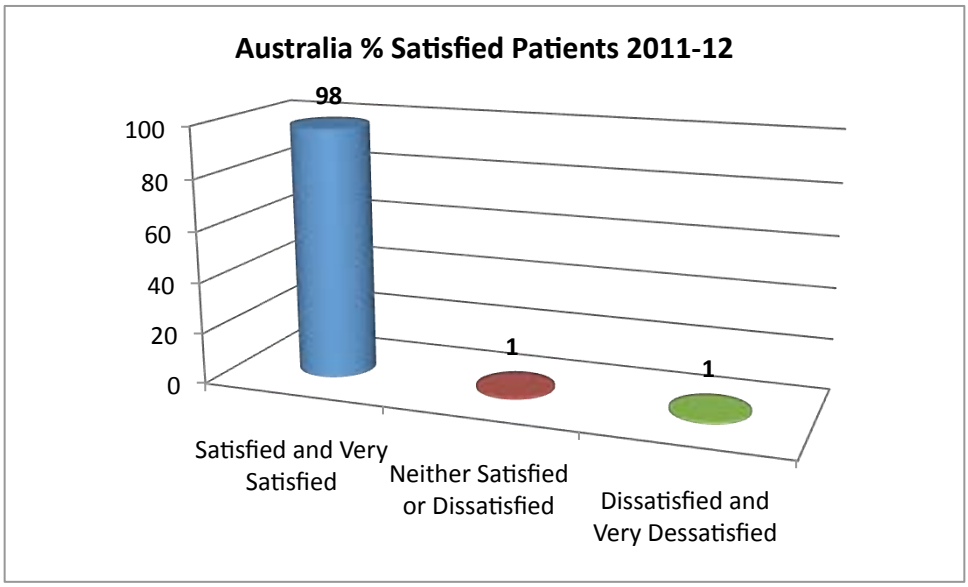
Satisfaction with ambulance service organisations (a)

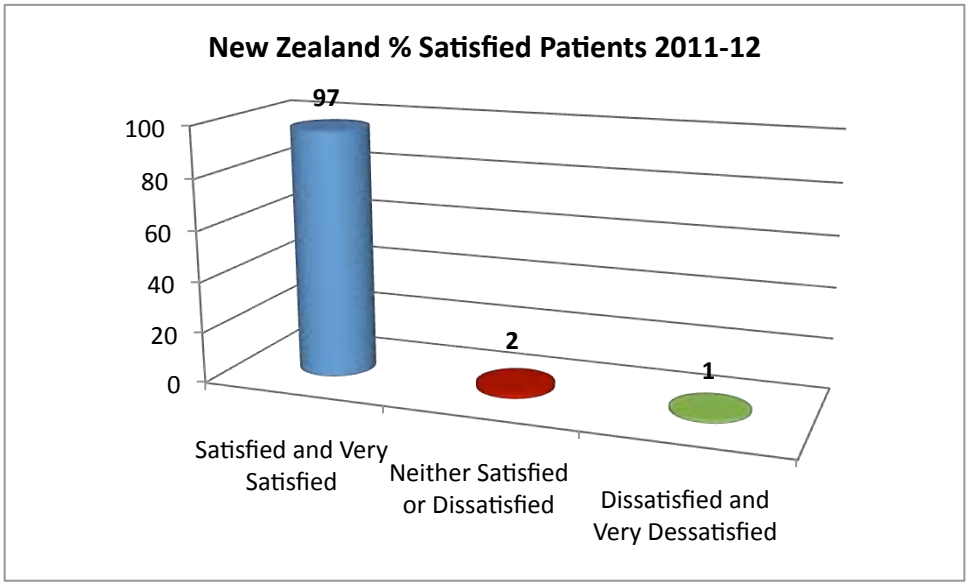
	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	St John	WFA	NZ
Number of patients surveyed	no.	1 300	2 600	1 300	1 300	1 500	1 300	1 300	1 300	12 100			
Usable responses	no.	458	996	453	406	579	555	478	198	4 123		368	
Overall satisfaction (c)													
Very satisfied or satisfied	%	98	97	97	98	97	98	97	98	98	97	98	97
95% confidence interval	±	1.2	1.0	1.6	1.4	1.4	1.1	1.6	2.0	0.5			1.1
Neither satisfied / dissatisfied	%	1	1	2	1	2	1	1	2	1	2	2	2
Dissatisfied / very dissatisfied	%	1	2	1	1	1	1	2	–	1	1	1	1
Phone answer time													
Very satisfied or satisfied	%	99	98	97	98	98	99	99	97	98	98	99	99
Neither satisfied / dissatisfied	%	1	1	1	–	2	–	–	1	1	2	–	1
Dissatisfied / very dissatisfied	%	–	1	2	2	–	1	1	2	1	–	1	–
Ambulance arrival time													
Very satisfied or satisfied	%	96	92	96	96	96	97	94	90	95	95	93	94
Neither satisfied / dissatisfied	%	1	4	3	1	2	1	3	4	2	3	3	3
Dissatisfied / very dissatisfied	%	3	4	1	3	2	2	3	6	3	2	5	3
Satisfaction with treatment													
Very satisfied or satisfied	%	99	98	98	98	98	98	97	97	98	99	99	99
Neither satisfied / dissatisfied	%	–	1	1	2	1	1	2	1	1	1	–	1
Dissatisfied / very dissatisfied	%	1	1	1	–	1	1	1	2	1	–	1	1
Satisfaction with paramedic attitude													
Very satisfied or satisfied	%	99	97	98	97	98	99	96	98	98	98	99	99
Neither satisfied / dissatisfied	%	–	1	1	1	2	–	2	2	1	1	1	1
Dissatisfied / very dissatisfied	%	1	2	1	2	–	1	2	–	1	1	–	1
Total patients (est.) (b)	'000	**931**	**718**	**782**	**241**	**243**	**55**	**33**	**44**	**3 048**	**389**	**67**	**456**

(a) These results are from a survey distributed to code 1 and code 2 patients (Emergency and Urgent), per jurisdiction, per year.
(b) Total patients is equal to the sum of the number of patients transported plus the number treated and not transported.
(c) Overall satisfaction rates from 2009 include standard errors for the 95 per cent confidence interval (for example, X per cent ± X per cent). Confidence intervals for prior years are not available.
na = Not available. .. = Not applicable. – = Nil or rounded to zero.

Figure 22: Proportion of ambulance users who were satisfied or very satisfied with the ambulance service







In 2011-12 the overall satisfaction with ambulance services in Australia and New Zealand was again high at 98% and 97% respectively.

The satisfaction levels have not changed from last year, for NSW, WA and TAS recording the same results in the percentage of people who were 'satisfied' or 'very satisfied' with overall ambulance services. Victoria, Queensland, South Australia and St John NZ recorded a small decrease and the ACT recorded a small increase from last year.

Response Times

Ambulance code 1 response times (minutes) (a), (b)

	Unit	NSW	Vic (c)	Qld (d)	WA	SA	Tas (e)	ACT	NT	St John	WFA
Statewide 50th percentile	min	10.9	11.0	8.3	9.8	9.8	11.2	9.3	9.6	10.8	9.1
Statewide 90th percentile	min	22.5	22.1	17.0	18.1	17.4	23.1	14.8	22.5	23.8	19.5
Capital city 50th percentile (f)	min	10.7	10.6	8.5	9.4	9.7	10.3	9.3	8.6	10.9	8
Capital city 90th percentile (f)	min	19.7	18.7	15.7	15.7	15.5	16.2	14.8	15.0	21.2	15.4
Urban centre (a)											
Population ('000)	"000	3 641.4	3 371.9	1 676.4	1 256.0	1 040.7	128.6	322.0	66.3	3925	450
Area (sq km)	sq km	1 788.1	2 152.8	1 825.9	1 035.2	754.5	125.1	297.7	78.5		
Population per sq km	no.	2 036.4	1 566.3	918.1	1 213.3	1 379.3	1 028.0	1 081.7	844.6		

(a) Response times commence from the following time points: Vic (AV rural) receipt of call; Vic (AV metro), SA and Tas first key stroke; NSW, Qld (QAS) and WA transfer to dispatch; and the NT crew dispatched. In 2007-08 the ACT response times commence from the first key stroke, wheras, in 2006-07 response times commenced from incident creation. Therefore, ACT data across years are not directly comparable.

(b) Urban centre response times are currently measured by the response times within each jurisdictions' capital city — boundaries based on the ABS Urban Centres Localities structure. Capital cities are Sydney, Melbourne, Brisbane, Perth, Adelaide, Hobart, Canberra and Darwin.

(c) VIC: Metropolitan response and case times data are sourced from Computer Aided Dispatch system. Rural response times are sourced from Patient Care Records completed by paramedics.

(d) QLD: Casualty room attendances are not included in response count and, therefore, are not reflected in response times data. Response time calculations for percentiles for both Capital City and State sourced from Computer Aided Dispatch (CAD) system.

(e) TAS: The highest proportion of population is in small rural areas, relative to other jurisdictions, which increases average response times.

na = Not available. .. = Not applicable. – = Nil or rounded to zero.

Cardiac Arrest

Cardiac Arrest Survived Event Rate (a), (b), (c), (d), (e), (f), (g), (h)

	Unit	NSW (i)	Vic (j)	Qld	WA	SA	Tas	ACT	NT	St John	WFA
Paramedic witnessed adult cardiac arrests											
Incidents	no.	na	397	340	67	73	11	16	16		24
Survival incidents	no.	na	196	150	29	28	3	11	11		8
Survival rate	%	na	49.4	44.1	43.3	38.4	27.3	68.8	68.8		33.3
Adult cardiac arrests where resuscitation attempted (excluding paramedic witnessed)											
Incidents	no.	na	1 970	1 634	545	538	167	46	123		163
Survival incidents	no.	na	634	392	125	142	56	11	24		59
Survival rate	%	na	32.2	24.0	22.9	26.4	33.5	23.9	19.5		36.2
Adult VF/VT cardiac arrests (excluding paramedic witnessed)											
Incidents	no.	na	650	445	132	167	40	19	39		71
Survival incidents	no.	na	342	167	45	75	23	6	13		38
Survival rate	%	na	52.6	37.5	34.1	44.9	57.5	31.6	33.3		53.5

(a) Rates are the percentage of patients aged 16 years or over who were in out-of-hospital cardiac arrest (excluding paramedic witnessed) for:

(i) all paramedic witnessed adult cardiac arrests where any chest compressions and/or defibrillation was undertaken by ambulance/EMS personnel, where the patient has a return of spontaneous circulation (ROSC) on arrival at hospital; and

(ii) all adult cardiac arrests (excluding paramedic witnessed) where any chest compressions and/or defibrillation was undertaken by ambulance/EMS personnel, where the patient has a return of spontaneous circulation (ROSC) on arrival at hospital; and

(iii) adult VF/VT cardiac arrests (a further breakdown of cardiac arrest data) the arrest rhythm on the first ECG assessment was either Ventricular Fibrillation or Ventricular Tachycardia, where the patient has a ROSC on arrival at hospital.

(b) For each of the indicators used a higher or increasing rate is a desirable outcome.

(c) Successful outcome is defined as the patient having return of spontaneous circulation (ROSC) on arrival to hospital (i.e. the patient having a pulse). This is not the same as the patient surviving the cardiac arrest as having ROSC is only one factor that contributes to the overall likelihood of survival.

(d) The indicators used to measure outcomes for cardiac arrests are not directly comparable as each are subject to variations based on differing factors used to define the indicator which are known to influence outcome. A recent review of the data across jurisdictions has highlighted a level of uncertainty that all jurisdictions are utilising a consistent definition in the denominator presented within the Cardiac Arrest data. These discrepancies are currently the subject of further review by the Council of Ambulance Authorities.

(e) The indicator 'Adult cardiac arrests where resuscitation attempted' provides an overall indicator of outcome without specific consideration to other factors known to influence survival.

(f) Patients in Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT) are more likely to have better outcomes compared with other causes of cardiac arrest as these conditions are primarily correctable through defibrillation.

(g) Paramedic witnessed cardiac arrests are analysed separately in the indicators reported as these cardiac arrests are treated immediately by the paramedic and as such have a better likelihood of survival due to this immediate and rapid intervention. This is vastly different to cardiac arrests occurring prior to the ambulance arriving where such increasing periods of treatment delay are known to negatively influence outcome.

(h) Cardiac arrest data is not comparable between jurisdictions due to different methods of reporting. Data is only comparable between years for each individual jurisdiction (unless caveats say otherwise).

(i) NSW: Data consistency issues mean that this measure is unable to be reported. NSW is awaiting the development of a national methodology for calculation of this measure prior to revising its internal processes.

(j) VIC: Excludes patients with unknown rhythm on arrival at hospital.

na = Not available. .. = Not applicable. – = Nil or rounded to zero.


If you suffer a Cardiac Arrest
in Australia and somebody
(other than a paramedic)
attempted resuscitation
your chances of survival
are 28%
This means only 3 of 10 will survive
But if a Paramedic
witnesses
the Cardiac Arrest
your chances of survival
improve by almost half
and are 47%
This now means 5 of 10 will survive