



The Council of Ambulance Authorities



Annual Report 2012-13

*Providing leadership for the
provision of Ambulance Services*

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Chairman's Introduction

This year, 2012-13, is the final year of my current term as Chair of the CAA. Ray Creen, who has been Deputy Chair, will take over the role after the 2013 Annual General Meeting. It has been an eventful three years for the CAA and a very satisfying period in which to have been its chair. In this period, we completed a strategic review of the CAA: appointed our first CEO, Greg Mundy; celebrated our 50th Anniversary; and continued to advance the ambulance sector in Australia and New Zealand through our collective work in committees, our representation to Governments and other decision makers and the exchange of ideas and perspectives between members.

The Strategic Directions adopted by the Board for the CAA in 2010-11 included a stronger focus on influencing health policy and a stronger profile for the CAA was identified as one of the means to this end. Showcasing the work of our sector both internally and to our external stakeholders is important in achieving this stronger profile and our 2012 conference in Hobart signalled the arrival of a new look CAA. For the first time we staged a full two day conference with a formal trade exhibition as part of it. We more than doubled the number of delegates from the previous year's event and we used the event to mark our 50th birthday with the launch of an updated history of the CAA.

The conference focussed on *Shaping the Future* asking the question 'what will ambulance services in Australia and New Zealand look like 10-20 years from now' in areas such as patient care, workforce including volunteering and technology. Looking ahead has been a feature of the CAA throughout its history and I look forward to seeing that continue.

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.

We have been pleased to see the emergence of a similar body to the CAA in England with the formation there of the Association of Ambulance Chief Executives (AACE) in 2011. Meeting with the AACE members at their Ambulance Leadership Forum (ALF) in May 2013 served to reinforce the importance of maintaining links with international colleagues and to learn from their approaches to the similar issues facing all of us in the ambulance sector.

We learned about the changes to emergency medical services in the National Health Service and the performance to date of their alternative phone service for non-emergency assistance (111 as opposed to 999). I shared with the ALF delegates our experiences in Western Australia of building a data rich organisation and our CEO, Greg Mundy, provided an overview of ambulance services in Australia and New Zealand. We look forward to an ongoing relationship with AACE, alongside that which we enjoy with the Paramedic Chiefs of Canada and the International Roundtable on Community Paramedicine.

I would like to thank my Board colleagues for their support and collegiality throughout my term as CAA Chair; the CEO and CAA Secretariat team for their hard-working support for me and the Board; and the representatives from our member services who contribute so much to the work of the CAA. I have enjoyed my three years as Chair of the CAA, we have achieved much and I look forward to the future of the ambulance sector and its Association with optimism.



Tony Ahern
Chairman
Council of Ambulance Authorities

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.

Chief Executive Officer's Report

2012-13 saw a consolidation of our efforts to establish and maintain a presence for the ambulance sector and the CAA at the national level in health and emergency services, building on the introductory contacts made in my first year as CEO.

One of the key policy issues facing the ambulance sector in Australia and New Zealand is the question of the regulation of paramedics. Agreement to introduce professional registration in New Zealand has already been reached though not yet implemented. In Australia, where eight jurisdictions need to find common ground, progress has been slower.

This question has been in front of Australian Health Ministers for some time and a formal consultation process on their behalf took place in 2012-13. The CAA and individual ambulance services attended a number of the face-to-face consultation sessions and we made a formal written submission responding to the formal Consultation Paper issued by the Australian Health Ministers' Advisory Council on this issue. The CAA supports the concept of professional registration for paramedics; it is consistent with the profound changes in our sector in recent decades and will assist with the development of a culture to support its continued development. We followed our submission up with meetings and correspondence with key decision makers including Commonwealth and State Ministers and senior officials. At the time of writing, consideration of this issue by Ministers is ongoing.

In last year's Annual Report, I wrote about the emerging interest in community paramedicine, often referred to as 'Extended Care Paramedicine', not least in supporting the health of people in rural and remote communities. We were pleased in 2012-13 when Health Workforce Australia (HWA) announced a project, as part of their Expanded Scope of Practice initiative, to conduct pilots of new models of paramedic care in a range of sites around Australia and invited the CAA to be a member of their reference group for this project. Five projects were funded for approximately 18 months, finishing in mid-2014. A formal evaluation forms part of the process, which will assist decision making about the future of these projects and other work in this area. There are services of this type now in many parts of the world and other CAA members, in addition to those participating in the HWA project, also provide such services. The geographical spread of the International Roundtable of Community Paramedicine (IRCP), whose conference the CAA hosted in Sydney in 2011 has now expanded to include the United Kingdom, reflecting the international interest in this particular frontier. The Association of Ambulance Chief Executives (AACE, our UK equivalent) were the hosts of IRCP in May 2012.

Our annual conference was in Hobart in October 2012 and I am pleased to see it developing into the feature event on the ambulance calendar in Australia and New Zealand. Our record number of delegates enjoyed a rich program of international and local speakers, supported by our increasing numbers of sponsors. Our partnership with Ambulance Tasmania in planning and staging the 2012 conference was a rewarding and productive one and we now have a sustainable model for future CAA conferences.

The links between our sector and other parts of the national health and emergency services system continue to be important and continue to grow. As I noted in my report last year, Australia has taken the first steps on a path towards uniform, Activity-Based, funding for public hospitals; has established a network of new coordinating agencies in primary health care – the Medicare Locals – and there is now, more than ever a need for our sector to maintain strong links with the stakeholders and policy makers, especially in the areas likely to directly impact on ambulance services. We need to know what is happening on the national stage in Australia and to seek to influence it where we need to. This is why we participate in the activities of organisations such as the National Rural Health Alliance (NRHA), the Australian Healthcare and Hospitals Association (AHHA) and the National Primary Health Care Partnership (NPHCP). As well as providing two-way channels of communication, participating in such networks helps to ensure that the ambulance perspective is heard, understood, and sought out when it is relevant or needed.

The development of the sector's information and policy base continued in 2012-13, through the work of our committees and working groups, including this year a re-vamped Clinical Forum. CAA's Emergency Management Committee commissioned a report from consultants on the role of ambulance services in

Emergency Management and work commenced this year on a CAA Position Statement on this subject for launching at our 2013 Conference. The Ambulance Education Committee continued its role of overseeing the Paramedic Education Programs Accreditation Scheme (PEPAS) together with many other aspects of professional education. Lilia Sher joined the CAA Secretariat this year as PEPAS Coordinator, providing valued support for this important function.

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. 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. We have world-class quality ambulance services in Australia and New Zealand 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 CAA Board, the members of our committees and CAA Secretariat staff who contribute to our work.

I look forward to another productive year in 2013-14.

A handwritten signature in black ink, appearing to read 'Greg Mundy', with a stylized flourish at the end.

Greg Mundy
Chief Executive Officer
Council of Ambulance Authorities

CAA Committees and Working Groups

Ambulance Education Committee (AEC)

The AEC provides a focal point on ambulance education programs and professional practice and considers education matters relevant to the provision of quality ambulance services.

The AEC oversees the work of the Paramedic Education Programs Accreditation Scheme (PEPAS), 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. The AEC is a key vehicle for stakeholder engagement between the universities, professional bodies and the CAA in this context.

Emergency Management Committee (EMC)

The Emergency Management Committee provides advice to the Board relating to ambulance involvement in emergency management including such issues as: resource capacities and development; national standards and technical matters. 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.

Strategic and Business Advisory Committee (SBAC)

The SBAC is 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. The SBAC provides oversight for the CAA's data collections and their development including data for the annual Report on Government Services (ROGS).

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. When required, the RRG assists the host jurisdiction in planning a rural and remote symposium in conjunction with CAA's Annual Conference.

Clinical Forum

The Clinical Forum provides an opportunity for the clinical directors of each service to exchange information, issues, and perspectives on clinical matters. Its agenda covers clinical practice, current clinical research projects, and related matters.

Accreditation Scheme Update

The CAA administers the Paramedic Education Programs Accreditation Scheme (PEPAS) in cooperation with professional bodies and the tertiary sector to ensure paramedic graduates are equipped to meet the challenges of today's ambulance services.

The PEPAS scheme is accepted as the industry standard; at the close of 2012-13 financial years 16 (sixteen) universities were 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 up to 5 years after the first cohorts of graduates have at least 12 months of practice experience following graduation.

The following Universities hold provisional/full accreditation as at June 30 2013:

- 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); Graduate Diploma 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.
- University of Sunshine Coast; Bachelor of Paramedic Science.

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

- University of Ballarat (*now Federation University of Australia*); Graduate Diploma of Paramedicine.
- Curtin University; Bachelor of Science (Health Sciences).
- La Trobe University; Bachelor of Health Sciences Paramedic Practice.

Enrolments in Accredited Courses

The below table provides an overview of the total number of enrolments for 2013 by location in Australia and New Zealand.

Location	Total Enrolments
New Zealand	373
Australian Capital Territory	108
New South Wales	736
Queensland	1796
South Australia	417
Tasmania	100
Victoria	2043
Western Australia	671
TOTAL	6244

Service Reports

This section presents the 2012-13 annual reports received from the Council of Ambulance Authorities member services.

- 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.

Australian Capital Territory Ambulance Service

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Our Vision and Mission

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 Service, 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 South East New South Wales and covers approximately 2,360 square kilometres. The resident population of the Australian Capital Territory is approximately 382,900¹ 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 Preliminary Data Population at end Sept qtr 2013_ABS

The Year in Review

Activity & Performance

In 2012-13, ACTAS managed 41,346 incidents involving 41,560 responses by operational crews. This was achieved with a patient satisfaction survey result of 98% of patients satisfied or very satisfied with the level of service provided.

ACTAS attended 50% of emergency incidents in 8.7 minutes or less (performance target 8 minutes) and 90% in 13.7 minutes or less (performance target 12 minutes 30 seconds). The 2012-13 results showed a continued improvement compared to the 2011-12 outcome for these indicators of 9.3 minutes and 14.8 minutes respectively. This is a notable achievement when considering that ACTAS reporting response times commence from the first keystroke on the Computer Aided Dispatch system and increased workload.

Emergency Planning and Preparedness

As with previous years, ACTAS administered the Directorate influenza vaccination program. This annual exercise 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 2012-13, the program involved 781 departmental officers from ESA, ACT Corrections, ACT Magistrates Court and the Justice and Community Safety Directorate receiving flu vaccinations.

A new Concept of Operations targeted at strengthening the cohesiveness in joint operations between the ACTAS and ACT Fire & Rescue was finalised and endorsed by the Emergency Services Agency Commissioner as a “Notifiable Instrument” under the Emergencies Act 2004 in March 2013.

Key Achievements

In the 2012-13 Budget, the ACTAS was allocated \$13.347m over four years. This funding, which supports Stage II of the ACTAS Sustainable Frontline resourcing model delivered 15 additional frontline staff, commissioned two additional ambulance vehicles to support additional staffing and replaced cardiac monitor/defibrillators on all frontline intensive care ambulances and semi-automatic external defibrillators on supporting emergency response vehicles.

In October 2013, the ACT hosted the annual Council of Ambulance Authorities conference titled “Exploring the Frontiers, Paramedicine of Tomorrow”. The conference, which was formally opened by the ACT Minister for Police & Emergency Services Mr Simon Corbell MLA, attracted, in excess of 200 delegates and included keynote national and international speakers, some of which included Deputy Superintendent Michael Bosse from Boston Emergency Medical Services (EMS), who captivated the audience with his role in leading the tactical response to the Boston bombings, and Professor Russell Gruen from the Victorian National Trauma Research Institute.

A 2012-13 mental health training initiative focused on staff working within the ESA’s Communications Centre and ACTAS recruits. Forty-eight staff members were involved in this initiative. Adjustments will be made to the existing program in 2013 in anticipation of changes to the Mental Health (Treatment and Care) Act 1994, which proposes to extend legal powers to ACTAS officers to authorise an emergency detention order in the pre-hospital environment as announced by the ACT Chief Minister on 26 April 2013.

The aeromedical service (Snowy Hydro SouthCare) operated by the ACTAS on behalf of the ACT and NSW Governments flew 498 missions. The previous establishment of dedicated training and accommodation facilities at the helicopter base supported the service being awarded training accreditation from the colleges of Intensive Care Medicine, Australasian College for Emergency Medicine, and Australia and New Zealand College of Anaesthetists.

Four Intensive Care Paramedic officers were selected and travelled to South Australia to undertake Extended Care Paramedic training with the South Australian Ambulance Service. The trial, funded by Health Workforce Australia, will see ACTAS deploying four Extended Care Paramedics on 12-hour shifts into front line operations over the next twelve months. A Steering Committee established to oversight the trial includes representation from Medicare Local, a number of areas of ACT Health including Community Nursing and Aged Care, ACT Government Solicitors, the ACTAS Medical Advisor and senior management.

Key Targets for 2013-14

In 2012, the NSW Ministry for Health commenced a statewide review of aero-medical (rotary wing) ambulance services. The review has been used by the NSW Government to inform a ten (10) year plan for the configuration and future development of aero-medical services in NSW. The ACTAS will be contributing personnel to the ongoing works coming out of the review, based on the role of the ACT aeromedical service in the statewide retrieval system.

The Service, in consultation with a number of stakeholders, will also commission a follow up review to the 2010 “Lennox Report” and undertake a review of organisational culture with both strategies aimed at further strengthening corporate, clinical and operational governance and engagement at all levels of the Service.

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



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Our Vision

Excellence in Care

Activity

The average daily number of ambulance responses increased by 3.3 per cent over the past year. NSW Ambulance provided over 1,219,262 total responses (both emergency and non-emergency), compared to 1,183,795 total responses in 2011/12.

On average, there were 3,340 responses per day – equivalent to a response every 25.9 seconds. The total number of emergency responses was 898,132, compared with 865,725 in 2011/12.

The average number of emergency responses per day increased by 4 per cent from 2365 in 2011/12 to 2461 in 2012/13.

NSW Ambulance provided 321,130 non-emergency responses compared with 318,070 in 2011/12.

The Year in Review

2012/13 has been a year of major change for NSW Ambulance, with the appointment of a new Chief Executive and the launch of the Reform Plan for NSW Ambulance released by the Minister for Health in December 2012. The plan outlines five strategic directions aimed at improving ambulance services for the NSW community:

- Integrating NSW Ambulance into the broader health system.
- Separating non-emergency patient transport (NEPT) from urgent medical retrieval patient services so NSW Ambulance is able to focus on its core role of attending to emergencies.
- Developing new models of care and investing in new providers to effectively manage demand, and response times, reduce paramedic fatigue and improve the operating costs of NSW Ambulance.
- Ensuring that NSW Ambulance has effective infrastructure, and a funding model, that will ensure financial sustainability in the future.

- Strengthening the leadership, workforce and governance structure of NSW Ambulance and embracing the CORE values of Collaboration, Openness, Respect, and Empowerment.

NSW Ambulance has formed a high level Steering Committee comprising key stakeholders from across the health system who are working together to implement the reforms. As at June 2013, 11 of the 34 reforms contained in the plan are complete and the remaining 23 are on track, with the majority expected to be completed by the end of 2013.

The implementation of the Reform Plan will assist in ensuring that patient care is delivered in a coordinated way across the entire health system, increasing the ability of ambulances to respond to urgent life threatening emergencies. The leadership capability across the organisation will be strengthened by the realignment of the executive structure, recruitment to vacant positions and enhanced training opportunities.

Top 10 Achievements 2012-13

1. Non-Emergency Patient Transport (NEPT) project improving efficiencies in transporting non-emergency patients, splitting them from the emergency services tier of NSW Ambulance. A dedicated NEPT booking hub will be established at Regent's Park in July.
2. Implementation of the Aeromedical Reform Plan. Initiated by the NSW Government in 2012, a detailed review of Aeromedical Services was established, aimed at improving the quality of service provided statewide.
3. 24 hour secondary triage with Healthdirect Australia. Patients phoning Triple Zero (000) who meet certain criteria are transferred to Healthdirect Australia, which undertakes secondary triage to provide referral services and self-care instructions.
4. Work continues on transitioning NSW Ambulance to StaffLink Human Resource Information System (HRIS) and implementing HealthRoster, bringing NSW Ambulance human resource systems in line with NSW Health.
5. Ambulance Operational Showcase was conducted in April 2013, giving Local Health District representatives the opportunity to view the tools used to manage demand and optimise availability of ambulance resources.
6. Turnaround delays reduced through collaboration between NSW Ambulance's Hunter New England Sector and the Hunter New England Local Health District. Various initiatives significantly reduced off- stretcher delays – from 1555 hours of lost productivity in July 2012 (due to crews waiting in excess of 30 minutes to off-load patients) down 48 per cent to 748 hours in June 2013.
7. Stroke Reperfusion Program launched in January 2013, improving patient access to stroke services, specifically to early stroke thrombolysis at an Acute Thrombolytic Centre (ATC). By June 2013, paramedics had transported 550 patients to ATCs with an average patient thrombolysis rate of 12 per cent.
8. Cardiac Care Program. Patients who present to NSW Ambulance with ST Elevation Myocardial Infarction (STEMI) are provided the most appropriate treatment pathway, either Pre-Hospital

Assessment for Primary Angioplasty (PAPA) or Pre-Hospital Thrombolysis (PHT). In 2012/13, 1159 patients were enrolled in the PAPA pathway and 49 patients received PHT.

9. Implementation of the New Emergency Response Grid, increasing the safety of paramedics with fewer requirements for lights and sirens responses. It also decreases response time to Priority 1 incidents, meaning the sickest patients receive more expedited care.
10. Expand the Frequent User Program. Over the past three years, NSW Ambulance has seen a year on year rise in the number of responses to patients who use NSW Ambulance more than 10 times per year. The frequent user project aims to develop a strategy to work with this patient group to ensure they are able to access health care interventions appropriate to their needs without the repeated use of emergency services. Key components of the model include patient identification, review of patient acuity and implementation of a range of interventions developed in consultation with Local Health Districts and other care providers.

Future Directions 2013-14

Top 10 Planned Activities and Outcomes

1. NSW Ambulance restructure. The Reform Plan for NSW Ambulance acknowledged the current structure could be improved by better aligning and grouping 'like' functions across the organisation, reducing the number of direct reports to the Chief Executive, creating a business improvement directorate and grouping executive services and public affairs. These changes will enhance communication across the organisation and improve NSW Ambulance's ability to meet current and future workforce and patient needs.
2. The Reform Plan for Aeromedical (Rotary Wing) Retrieval Services in NSW was announced in mid-2013, with the Government committing an additional \$39 million over the next three years which will result in improved quality of care and access to critical care services for NSW patients. Aeromedical clinical and aviation crews will benefit from improved safety, training and education.
3. StaffLink Human Resource Information System is a human resource and payroll system rolled out across NSW Health since 2009. In line with the Reform Plan to be more closely integrated with NSW Health, NSW Ambulance commenced implementation of StaffLink in February and will use the system for HR, finance, salary packaging, workers' compensation and clinical administration, with the go-live scheduled for early 2014.
4. HealthRoster is the integrated electronic rostering system being introduced across NSW Health, with NSW Ambulance one of the first to implement the eRostering system. HealthRoster has now been configured to meet NSW Ambulance requirements and roll-out has commenced to operational staff. This roll-out will be extended to corporate and other staff over the next 12 months.
5. Non-Emergency Patient Transport (NEPT). One of the five key strategic directions set out in the Reform Plan for NSW Ambulance is that NEPT be split from the emergency medical retrieval tier. This will reduce the demands on the NSW Ambulance fleet and resources throughout the state,

enabling us to respond more quickly to priority patients. It will also improve the flow of non-emergency patients to and from scheduled hospital and other medical appointments.

6. Fire and Rescue NSW Emergency First Responder Trial. The Reform Plan for NSW Ambulance outlined strategic directions for improving emergency out-of-hospital care for the NSW community, including developing new models of care. NSW Ambulance is working with Fire and Rescue NSW on the Emergency First Responder Trial, to be held in the Northern Beaches in early 2014. Arising from the reform, this initiative aims to improve patient outcomes and enhance service delivery by dispatching firefighters with paramedics to life threatening emergencies.
7. Fleet improvements. The phasing out of the Volkswagen T5 and Crafter ambulance and patient transport vehicles has commenced and all vehicles will be replaced over the next three years. Three additional bariatric ambulances have been introduced and can be used to transport morbidly obese patients (weighing up to 300 kg) and critically ill patients in a state of high-dependency.
8. InterCAD Emergency Messaging System (ICEMS). NSW will introduce ICEMS, which will facilitate the exchange of recorded mission critical information between emergency service organisations in a more accurate and timely manner, strengthening the notification protocols.
9. New and revised NSW Ambulance Clinical Protocols and Pharmacology were released in October 2012, marking two significant milestones – the implementation of a Protocol Governance System, and the first suite of protocols reflecting paramedic feedback on format and distribution. While the initial review of all Clinical Protocols and Pharmacology is scheduled for completion by 2015, the ongoing systematic review and identification of new initiatives is a continual process, which will ensure patients receive the best possible treatment.
10. New staff medals were introduced in 2012. A new bravery award, the Conspicuous Service Medal, was introduced to bridge the gap between the highest NSW Ambulance bravery award, the Distinguished Service Medal and the Meritorious Service Medal, and recognises acts of conspicuous bravery by employees in circumstances of great peril. The Chaplain and Volunteer Long Service and Good Conduct Ribbon Drop was replaced by a new medal, in line with the NSW Ambulance staff Long Service and Good Conduct Medal, recognising the contributions made by members of our chaplaincy and volunteer units.



Ambulance Tasmania

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Our Vision

Ambulance Tasmania's vision is excellence in ambulance and out of hospital care.

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 statewide 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.
- The Clinical Services Division is responsible for providing advice and guidance on research clinical practice and providing RTO compliant educational and professional development services.
- Operational support services division provides all of ATs corporate services.

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:

- Kingston station on the urban fringe of Hobart was converted to a full urban station with 24/7 dual paramedic crewing as a result of combined Commonwealth State funding.
- Roll out of the first 18 of the new ETT Sprinter vehicles at a cost of \$1.76 million.
- Established a fifth Community Emergency Response Team (CERT) at Ellendale in rural Tasmania.
- Completed the rollout of new Clinical Practice Guidelines, medications and equipment and training.
- Completed Hobart Complex Stage 2 redevelopment completing the full construction of the State Operations Centre and Hobart redevelopment over 4 years at approximately \$7.9 Million.
- New Ambulance Tasmania fixed wing aircraft commenced operations.
- Implemented new \$300,000 Zetron (Acom) switching system for radio and telephony integration into state communications centre.
- Implementation of \$100,000 voice logger hardware and software to the state communications centre.
- Successfully completed the Hobart First intervention Vehicle trial.
- Implemented Extended Care Paramedic trial into Launceston after a \$750 000 successful bid for Australian Government funding.
- Held two Staff Awards and Recognition Ceremonies in the state.
- Implementation of Hobart First Intervention Vehicle (FIV) Trial and first change over.
- Recruitment of twelve additional paramedic staff and seven new graduate paramedics.
- Implementation of stand-alone redundancy arrangements for duress device monitoring into communications centre.
- Commencement of Technical Radio Communications Consultant to establish radio communications strategic plan.
- Launched new Volunteer Manual, Policies and Procedures.
- Developed the 2013-2016 Ambulance Tasmania Business Plan.

Future Directions 2013-14

The year ahead will no doubt present challenges. AT is required to deliver on further Efficiency Dividends in difficult economic times. AT will however continue to fund initiatives commenced in the previous years as well as:

- Continuing upgrade of medical and training equipment.
- Continuation of a routine asset and property maintenance program.
- Ongoing improvement of information systems.
- Continuation of a cyclical ambulance replacement program.

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.

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

Ambulance Victoria (AV)

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Our Vision and Mission

Ambulance Victoria's Mission Statement:

We improve the health of our community by delivering innovative, high-quality ambulance services
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. Our Services: Co-ordinate and deliver safe and efficient patient-centred care.*
- 2. Our People: Work collaboratively to achieve a safe, capable, accountable, and engaged workforce.*
- 3. Our Partners & Community: Partner with key stakeholders to deliver improved health outcomes, enhanced community safety and resilience.*
- 4. Our Financial Sustainability: Ensure Ambulance Victoria's business model can resource current service needs and investment in service improvements.*

Jurisdiction

Ambulance Victoria (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 management team.

The Year in Review

Emergency Road Services

Responding to over 476,000 emergency and urgent road incidents, AV experienced strong growth in 2012/13 (5.1%), following on from a moderate increase (2.1%) in the previous year. Despite the large increase in demand, the percentage of Code 1 cases responded to within 15 minutes only declined slightly from 74.8% in 2011/12 to 73.0%.

The Referral Service, established in 2003, managed a record 50,613 emergency calls in the metropolitan area during the year, an increase of more than 5.0 per cent over the previous year. This service was responsible for significantly reducing demand for emergency ambulance dispatching, thereby increasing the availability of ambulances to respond to more urgent emergency calls.

The Referral Service was also successfully introduced outside the metropolitan area to the Barwon South West region (including Geelong). At the same time, preparations were made to increase call-taking capacity prior to expanding the Service to the rest of the state.

A number of new response units were established during 2012/13 including 4 new 24 hour branches, and upgrades/additional shifts and peak period units were implemented at 11 other metropolitan and rural locations. AV continues to work closely with the Department of Health and hospitals to reduce patient transfer time. Additionally a pilot project to trial a paramedic motorcycle unit in Melbourne's city centre continues.

Work continued throughout 2012/13 to further consolidate metropolitan and rural operational processes and systems; an integrated statewide rostering function was implemented.

Non-Emergency Road Services

With just under 340,000 cases, non-emergency caseload declined by 1.0%, following on from a period of strong growth in the previous two years. A statewide tender for the provision of non-emergency services statewide was also undertaken during the year.

Air Ambulance

Air Ambulance incidents increased by 3.9% over 2012/13 to 7,359.

Information Management & Communications

In 2012/13, the focus for information systems and communications was on improving existing platforms for key systems, including developing and implementing a new intranet system, a new business intelligence tool, and developing an upgrade and a new interface for VACIS which is now Windows based.

Research & Development

Work progressed throughout the year on understanding the epidemiology and outcomes of key patient groups such as cardiac arrest and major trauma. Additionally, three key randomised controlled trials, RINSE (cooling during CPR), AVOID (air versus oxygen for STEMI patients), and POLAR (induced hypothermia for head injured patients), progressed with no complications.

Staff Development

A major program to introduce cultural change was developed during 2012/13. Additionally a new Learning and Development framework was introduced as well as an implementation strategy.

Health & Safety

A number of on-going health and safety initiatives continued to be implemented, including a fatigue management strategy, and a plan to reduce manual handling injuries. In the mental health space, a psychosocial risk management framework was also agreed and developed, and the SMART program further expanded.

Future Directions 2013-14

With the activity of infrastructural and process consolidation now complete, AV has refocused on developing and implementing a range of new initiatives to improve services and deal with the key issues it faces.

Our Services

In 2013/14, work will continue to design a new service model in order to provide more appropriate and safe care for patients whilst optimising the use of existing resources. This increase to our demand management initiatives will significantly increase our capacity to provide rapid responses to the most urgent cases.

A major program of works is underway. Key deliverables for 2013/14 are:

- Statewide expansion of the successful Referral Service beyond Melbourne and the Barwon South West Regions.
- Plan to undertake a high-volume in-field referral trial, whereby attending paramedics would be able to refer relevant low-acuity patients to more appropriate health providers and care.
- Investigate improvements to triage processes and alternative care providers for low-acuity patients, including further enhancing the relationship with Medicare locals.

In parallel with this work, AV will also implement 16 new government-funded units across the state. Additionally, processes will continue to be developed to improve ambulance availability, including standardising processes for paramedics at hospital and opportunities to review the status of crews at hospital. The Ambulance Arrivals Board, exchanging real-time information between AV and EDs to better manage arrivals and patient flow, will also be extended to a number of key hospitals.

Our People

Building an inclusive culture is an important focus for AV in 2013/14, with increased engagement, more effective communication, and increased decision-making ability. Key deliverables for the coming year include:

- Implementing Culture Change Working groups.
- Implementation and communication of AV agreed Values and Behaviours.
- Building a new Reward & Recognition Framework.
- Developing and understanding of staff engagement.

Enterprise Agreements are also due this year with both paramedics and non-operational staff.

Programs will also be rolled out to support the professional and ongoing development of our people and leaders. In 2013/14, AV will:

- Implement the Operational Frontline Management Model.
- Implement targeted Development Programs for Senior Leaders and managers/team leaders.
- Complete 360 Degree feedback process for current and future leaders.

Our Financial Sustainability

AV will continue to work with the Department of Health and Government to ensure it's funding is financially sustainable into the future and is better aligned to the revised operating model. At the same time, our analytical and forecasting capability will be further developed through the Analytics and Reporting Program and a new business intelligence tool.

In 2013/14, AV will also finalise the tender arrangements for the supply of rotary wing aircraft.

Other

Work will continue on developing VACIS 3.0 in the coming year to a redesigned and updated version. At the same time, work will commence to install VACIS throughout the non-emergency provider fleet.



Queensland Ambulance Service

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Our Vision and Mission

Blueprint for better healthcare in Queensland

- Health services focused on patients and people
- Empowering the community and our health workforce
- Providing Queenslanders with value in health services
- Investing, innovating and planning for the future

Queensland Public Service Values



Customers first



Ideas into action



Unleash potential



Be courageous



Empower people

Jurisdiction

The Queensland Ambulance Service (QAS) operates under the authority of the *Ambulance Service Act 1991*. On 1 October 2013, the QAS became a Division of the Department of Health, following Machinery of Government changes.

The QAS serves over 4.6 million Queenslanders and 162,000 tourists per day across a vast state of 1.73 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.
- Inter-facility ambulance transport.
- Planning and coordination of major events, multi-casualty incidents and disasters.
- Community services such as community education.
- Pre-hospital care research.

The QAS provides its services through 3,878 full-time equivalent employees and approximately 357 volunteers, which includes Ambulance Attendants, Community First Responders and Volunteer Drivers.

The Year in Review

On 2 November 2012, the QAS underwent its most significant structural reform process since the organisation was formed in 1991.

The formation of 16 Local Ambulance Service Networks (LASNs) and the reporting arrangements implemented as part of this structural reform have been undertaken with the primary goal of ensuring that frontline operations receive the support they need to deliver effective pre-hospital care and transport services to the Queensland community.

The ambulance service delivery model is now closely aligned with the Department of Health Hospital and Health Services (HHS) boundaries and changes focus on enabling local accountability and local solutions to be achieved.

Response Performance

In 2012-13, QAS provided services in response to 870,213 incidents across Queensland compared to 833,243 incidents in 2011-12.

For 2012-13, overall demand increased by 4.44% compared to 2011-12. The combined Code 1 and 2 incidents (emergency) increased by 6.43% with Code 3 and 4 (non-emergency) incidents increasing by 0.46%.

In spite of a growth in demand for ambulance services, fifty percent of Code 1 life threatening incidents were attended within 8.2 minutes, and ninety percent of Code 1 life threatening incidents were attended in 16.5 minutes achieving the Queensland Governments Service Delivery Statements targets/estimates of 8.2 minutes and 16.5 minutes respectively.

In 2012-13, QAS employed an additional 60 ambulance officers above attrition.

State Operations Centres

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

During 2012-13, QAS Operations Centres received 617,729 Triple Zero (000) calls for assistance. The State Operation Centres answered 90.64 % of Triple Zero (000) calls in less than 10 seconds.

Metropolitan Emergency Department Access Initiative

The Metropolitan Emergency Department Access Initiative (MEDAI) project was established in October 2011 to identify solutions to ambulance vehicle ramping in Queensland metropolitan hospitals. The primary aim of the MEDAI project was to improve timely access to emergency care for the people of Queensland. The Minister for Health, tabled the MEDAI report in Parliament on 2 August 2012. The final report set out 15 recommendations (two relating to QAS) that aimed to improve the way in which issues in relation to ambulance ramping and access block are managed across Queensland public hospitals. The MEDAI recommendations pertaining to QAS were implemented by 1 January 2013. Following MEDAI and other QAS renewal processes, patients are now receiving hospital care faster and ambulances are being available sooner to respond to the next call for assistance.

Clinical Advances

In 2012-13, QAS implemented the Clinical Support Officer (CSO) Field Audit. These real-time in-field audits of authentic clinical cases provide a far superior model of clinical support and governance than the previous model, and allows our clinical support officers to facilitate a more evidence-based clinical support mechanism. Overall the QAS audits approximately 13% of acute cases attended by ambulance.

A number of clinical advancements to paramedic practice occurred in 2012-13, including:

- Introduction of the o_{two}® Continuous Positive Airway Pressure (CPAP) to Intensive Care Paramedics for the treatment of acute cardiogenic pulmonary pressure. QAS is the first service in the world to use this particular type of CPAP, which is smaller, less expensive and uses less oxygen. To date it has had overwhelmingly good results.
- Introduction of the CT-6 femoral traction splint. This is a large investment in updated technology and brings QAS to the forefront of contemporary pre-hospital long bone fracture management.
- Rollout of flight paramedic course which allows our paramedics to be better skilled in critical care and will prepare them to undertake more cases without the need for medical officers.
- Introduction of the Public Hospital Clinical Matrix, which aids paramedics in decision making regarding appropriate patient disposition.
- Introduction of a dedicated centralised Intensive Care Paramedic primary percutaneous coronary intervention (pPCI) referral line. This recorded telephone line provides ICPs with direct access to any state-wide pPCI facility by means of a tiered menu system, negating the need for ICPs to maintain the contact details of individual facilities.
- Analgesic practice has been expanded to allow Advanced Care Paramedics to administer IM/IV fentanyl to adult patients, and Intensive Care Paramedics to administer IV fentanyl to paediatric patients.
- Introduction of finger pulse oximetry to QAS First Responders.
- The QAS 24 hour Medical Consultation Line number was changed to a 1300 number, which is now recorded and available for review, by the Medical Director to enhance consistency and quality of clinical advice provided to QAS paramedics.

In 2012-13, QAS continued its rapid trauma response vehicle program, staffed by a QAS Senior Pre-Hospital Registrar and an Intensive Care Paramedic – trialling new modalities including RSI, pre-hospital ultrasound and damage control resuscitation with blood products. This program will evolve in 2013-14 to being paramedic driven, with the physicians moving to a professional development role on selected shifts.

Vehicles

In 2012-13, 130 new and replacement ambulance vehicles were commissioned. Highlights of the 2012-13 build were ongoing production of the single stretcher Toyota Landcruiser cab chassis with a manufactured patient care compartment and the Mercedes Sprinter LWB Patient Transport vehicles, which are configured for two stretchers and five seated patients.

Research

The Clinical Performance and Service Improvement Unit (CPSIU) carries out an expansive work program, providing an evidence base for QAS clinical practice and operations. The Unit aims to facilitate interaction between industry, paramedics and academics to develop the pre-hospital profession and the evidence base for pre-hospital care.

Key activities of the CPSIU in 2012-13 include:

- Facilitation of QAS participation in an international trial (ATLANTIC) of antiplatelet drug Ticagrelor (conducted by Astra Zeneca).
- Participation in a national study to examine rates of mental health, suicide, drug and alcohol involvement in patients presenting to ambulance services (Department of Health and Ageing, Turning Point Victoria).
- Development and refinement of clinical and system performance indicators to inform continuous clinical quality improvement.
- Undertake a range of analyses to support the significant reform agenda in emergency health service delivery across Queensland, including new initiatives to effectively manage service demand, patient distribution, and the growth of lower acuity patient cohorts.

Capital Works

The QAS had 10 major projects listed in the 2012-13 Budget Paper 3, of which three have been completed and seven are in progress.

Education

The QAS continued its partnerships with five Queensland Universities for the provision of pre-employment Bachelor of Paramedicine and dual Bachelor of Paramedicine/Bachelor of Nursing degrees. The participating Universities are Queensland University of Technology (Kelvin Grove Campus), University of Queensland (Ipswich Campus), University of Sunshine Coast (Sippy Downs Campus), Australian Catholic University (Banyo Campus) and Central Queensland University (Rockhampton Campus).

Future Directions 2013-14

QAS transition to Queensland Health

On 1 October 2013, following the outcome of the Police and Community Safety Review commissioned by the Minister for Police and Community Safety, the QAS was transferred to the Queensland Health portfolio as a discreet Division of the Department of Health.

The transfer recognises the longstanding close positive long term working relationship that exists between QAS and Queensland Health as partners in identifying a broad range initiatives to improve health service delivery to Queensland communities including more recently, reducing ambulance ramping and improving timely access to emergency care.

Further opportunities also exist as a result of the portfolio change to enhance clinical procedures for paramedics, access to patient information and to develop a greater understanding of the effect of pre-hospital care on patient outcomes through the closer health relationship.

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. Over the last nine years, the growth in Code 1 and Code 2 incidents has averaged 6.4% annually.

In order to meet future challenges, QAS will employ an additional 60 ambulance officers across the state in 2013-14, bringing the total staff increase to 802 for the period 2007-08 to 2013-14.

Research

The Clinical Performance and Service Improvement Unit is committed to the conduct of high quality research, and detailed analysis, which supports and informs the ongoing quality improvement strategies of QAS in all aspects of its operational and strategic development activities. Planned projects for the coming year include the pilot and evaluation of targeted strategies to effectively and efficiently deliver care to both lower and high acuity patients, an examination of the mortality and morbidity of serious trauma patients transferred within the Queensland trauma system, and an evaluation of the feasibility of Advanced Care Paramedic-led thrombolysis in regional areas.

Capital Works

Eleven replacement, redeveloped or refurbished ambulance facilities will be commenced, progressed or completed in 2013-14. In addition, continuation of the design and redevelopment of the Spring Hill complex and ambulance station.

Vehicles

The QAS will commission 155 new or replacement ambulance vehicles in 2013-14 to ensure the ambulance fleet is effectively maintained to meet increasing community needs.



SA Ambulance Service

Contact Details

Title: Chief Executive Officer

Incumbent:

Ray Green (to 15 March 2013)

Aaron Chia (acting from 15 March to 28 July 2013)

Robert Morton (commenced 29 July 2013)

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Our Vision, Mission and Values

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 passion, 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.
- Pre-hospital 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 Paramedic Science, 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 degree.
- 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 1,340 personnel, which includes patient services paid employees and support services paid employees. In addition to this, there are 1503 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 and Ageing. 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 System Performance 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 Deputy Chief Executive, Systems Performance of SA Health.

The Year in Review

Highlights for 2012 - 13 include:

Our people

- Implementation of a new operational safety training program as part of induction and professional development education schedules for all operational staff. The program provides theoretical and practical training to equip staff with appropriate responses when confronted by aggressive or violent patients and/or bystanders.
- Achievement of the best work health and safety (WH&S) performance across the SA Health portfolio for the second year in a row - SAAS achieved 11 out of the 13 safety performance targets.
- Successful completion of SAAS's Aboriginal Traineeship Program by one trainee, resulting in a Certificate III in Business.
- Recognition of SAAS staff achievements at the annual Graduation and Presentation Ceremony - 289 staff members/teams were recognised and four staff members were honoured with the prestigious Ambulance Service Medal.
- Contribution to the development and launch of an innovative vehicle crash simulator, as well as simulator training rooms. Both greatly enhance SAAS's educational facilities and program.

Leadership

- The State Leadership Conference provided managers from all organisational levels the opportunity to review and contribute to the development of SAAS's next strategic plan.
- SAAS was awarded the Educational Performance Award (part of the CAA Australasian Ambulance Awards for Excellence) for developing the *'eBooks for Rural Volunteer Ambulance Recruits'* project.

Service delivery

- Launch of the MedSTAR Kids ambulance by the Minister for Health and Ageing to improve service delivery to neonatal and paediatric patients.
- Installation and activation in April 2013 of new mobile data terminals (MDTs) into operational vehicles across the organisation.
- Following the success of SAAS's Extended Care Paramedic (ECP) Program in the metropolitan area, SAAS commenced a trial of this in the regional areas of Mount Gambier and Port Lincoln.
- Implementation of the 'Lightfoot' trial in the southern metropolitan area (title based on the name of the external specialist consultancy employed by SAAS) to address issues around data availability, resourcing, utilisation and operational performance. The trial aimed to ensure the application of best-practice performance management.

Successes included:

- Improvement in Priority 1 response times.
- Reduced case-work load for area clinical team leaders.
- Reduction in non-emergency inter-hospital transfers.
- Ambulance crew call-on-air times brought close to the benchmark.
- Answering more than 90 per cent of the total of 177 752 triple zero calls received within 10 seconds.
- Establishment of the Upper Murray Mallee Volunteer Regional Response Team (UMMVRT) to assist with volunteer roster coverage for the Lameroo, Pinnaroo, Swan Reach and Morgan teams.
- A 310 per cent increase in Special Operations Team (SOT) responses to incidents.

Community

- SAAS was involved in the planning of over 427 public events. SAAS personnel attended and supported 84 of these.
- Establishment of a second Country Regional Response Team (CRRT) - this increased the CRRT numbers by 40.5 per cent. The CRRT are a group of volunteers based in the metropolitan area who provide regional areas with short-notice roster coverage across the State when required.
- During National Volunteer Week, 68 events were held across the State to recognise the contribution of SAAS volunteers for their local regional communities.
- All of these activities occurred while SAAS experienced a 2.74 per cent overall increase in the number of cases compared to the previous year.
- Of the total incidents, 129 142 were emergency cases (priorities 1 and 2), 73 725 were urgent cases (priorities 3, 4 and 5) and 59 687 were non-urgent/routine (priorities 6, 7 and 8).

Northern Territory St John Ambulance Australia (NT) Inc

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Our Vision and Mission

VISION

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

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.

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 235,000 – 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 reflects an understanding of the cultural extremities, and activities of the young, which exist.

The Year in Review

Operations

Activity and Performance

The 2012-2013 year saw an increase in workload across the Territory. Paramedics transported 36,578 patients, (up 1.9%) with ambulance vehicles travelling 1,123,656km an increase of 11.8% on the previous year. The increase in kilometres travelled versus patient kilometres (402695, an increase of 3.6%) can be attributed to the introduction of the ECP program and on-road supervision. This has alleviated the presentations at hospital, with the ECP's ability to ANR patients who would normally require transport.

The 000 call centres received 44,985 calls in the 2012-2013 year.

Key Achievements

St John NT was again a proud finalist in the Northern Territory Training Awards for the second year in a row, against some very strong competition.

We were extremely honored to have three members nominated in the local round of the Pride of Australia medal awards; Warren Purse - ICP; Anthony Kleidon - Volunteer; and Ben Hankin - Cadet. Congratulations to the three nominees.

We invested a significant amount of time in updating our website and in February launched our new look, with a measurable increase in traffic to the site.

The NT was host to the St John Ambulance National Member Convention in May, which saw delegates from around the country attend a well presented and informative event.

Education

The Paramedic Training College continues to work with Edith Cowan University (ECU) to deliver the Paramedic Graduate Program, whilst transitioning the last of our in-house trained students.

The HWA Extended Care Paramedic (ECP) Program is in full play and the results of reductions in emergency department admissions growth is clearly evident. With the issue of non-funding for this program post 30 June 2014 by HWA and at a Territory level, the benefits now being achieved could potentially be lost.

Communications

Siren implementation was completed mid-year, with trials undertaken in July. With the commencement of this platform, we are now in a position to report and track accurate and individual clinical data.

The upgrade of the Alice Springs Communications centre, now means that the ICAD system, is in use in both the Northern and Southern regions, allowing for implementation of a virtual communications system across the whole of the Territory.

Clinical Advances

Our education focus has increased emphasis on underpinning knowledge, supporting evidence based practice. To support this move, we have introduced a Clinical Practice Manual, comprising of 3 elements: Drug Therapy Protocol, Clinical Practice, Guidelines, Clinical Practice Procedures.

To improve our Clinical Governance structure, we introduced Annual photographic Authority to Practice cards for all levels of operational staff.

Workforce

Staffing numbers have remained static over the past 12 months, with little turnover of operational staff.

There has been a significant number of staff presented with awards for significant years of service. We acknowledged 17 members who achieved 5 years of service, 6 members with 10 years of service and 1 member with 15 years of service.

We have recently signed off on a community engagement program with Bendigo Bank, which aims to place AED's into the community. It is envisaged that by the end of 2013, an additional 8 units will be placed around the Darwin Community.

Community Education

In the past 12 months, there has been significant growth in the Community Education program, with the addition of a dedicated community educator and vehicle for the Central Australia region. Our aim is to reach 5000 students over the next 12 months, upholding our value of "making first aid a part of all Territorians' lives".

Future Directions 2013-14

In the second half of 2013, we are aiming to release a personal issue Amicroe Touch TAB S 7" tablet, to all operational ambulance staff, which will enable the staff to have immediate access to the Clinical Practice Manual, issued at the start of the year.

The Siren Electronic case card (ePCR) system will be operational in all centres and vehicles prior to Christmas.

Data from the ECP program will be fully accessible by the end of 2013. We believe this will confirm what has already been indicated in that the program has been an effective project in the Darwin area.

The Enterprise Agreement discussions for the 1 July 13-commencement date are still ongoing with a number of issues to be resolved prior to the year-end.

With the recent appointment in the Marketing/PR area of the business, a significant positive profile building exercise centered around the work of Paramedics and Community assistance prior to the arrival of a paramedic, will be embarked upon.



St John Ambulance WA Inc

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Our Purpose

Our purpose for being in Western Australia is for the unique contribution that we make in serving humanity and developing resilient communities in this State. We achieve our purpose when we make first aid a part of everyone's life, and deliver high quality, cost-effective ambulance services to the people of Western Australia.

Jurisdiction

Responsibility for providing ambulance services across 2.5 million square miles – the largest area in the world covered by a single ambulance service – comes with its challenges, but also opportunities: to innovate, reform, and work more effectively with partners in healthcare. For St John Ambulance in Western Australia, 2012/13 was a year of considerable achievement across all areas of operation, providing a solid platform for the negotiation of a future long-term contract with State Government, and proving the benefits of an integrated, streamlined, and employee-engaged approach to pre-hospital care.

The Year in Review

Activity and response times

Overall ambulance activity increased by over 12,000 cases (a rise of over 5%) from the previous financial year, with our metropolitan and country crews responding to 194,445 and 57,772 cases respectively. Despite this increase in activity, our ability to meet response time targets also increased across all categories (emergency, urgent, and non-urgent). On average, over 93% of all cases were responded to within the required time target, compared to the previous year's average of 90%.

Better response times have been achieved through an increase in standby capacity, which is measured as that percentage of the total number of crews, which are able to respond to a call-out at any given time. In 2012/13, our standby capacity was 54.6%, an increase of 1.5% on last financial year's figure of 53.5%.

Resources

Underpinning our improved capacity and response times was the increased resources funded through the Department of Health's contract. Our fleet of ambulance vehicles has increased by 8 to 466 and our full time (paid) staff establishment has grown by 152 to 1286. Much of this increase is attributable to an increase in the number of paid metropolitan staff who work in operational or operational-support roles. Volunteer numbers have remained constant and during the year, they contributed over three million hours of voluntary service to the community through St John.

Alleviating pressure on public health system

A great success for the service this year has been in establishing, in partnership with other healthcare providers, alternative pathways for patients whose conditions are such that presentation at an Emergency Department is not essential. Together, these pathways help alleviate the pressure on the State's public health system and, according to our estimates, have saved the government hundreds of thousands of dollars in public healthcare expenses.

Ambulance Surge Capacity Unit (ASCU)

Located in a ward at Hollywood Private Hospital, and launched in May as a trial and operational when ramping occurred outside Perth's emergency departments, ASCU accommodated up to 15 low acuity patients. Rather than being ramped, patients could be assessed and cared for by St John employed medical staff (including a paramedic, GP, and RN) in a safe, more comfortable, hospital environment, and then either diverted to an alternative care provider, admitted into a private hospital, or transported back to the ED when ramping had eased. In May and June 2013, 221 patients were admitted to ASCU, of whom 30% were diverted to an alternative care provider. Importantly, our paramedic crews were able to "reclaim" several hundred hours on the road - a contributing factor in our higher standby capacity and improved response times.

Silver Chain Priority Response Assessment (PRA)

Paramedics who attend patients with non-urgent symptoms can refer those patients to Silver Chain's PRA service, which sees a Registered Nurse visit the patient's home within four hours to provide low-level treatment and monitoring. Of the over, 150 cases referred to PRA within the reporting period, only a small percentage have required eventual admission to hospital.

Salvation Army's Bridge House

Paramedics who attend patients experiencing the effects of drugs and alcohol, but who do not require treatment at an Emergency Department, can transport those patients to the Salvation Army's Bridge House. 48 patients were transported to this facility in 2012/13.

Medicare Local

Towards the end of the reporting period, St John entered into discussions with Medicare Local (Perth Central & East Metro) to establish a GP-referral system, where low acuity patients can be referred to a GP rather than be admitted to an ED. This pathway is expected to become operational during the 2013/14 Financial Year.

Technology driven performance

Embracing technology and adapting it to suit operational environments is essential if performance is to become optimal. Achievements in 2012/13 have cut across operational and clinical areas, and have included:

- The development of a 'Metropolitan Operations Dashboard' – a screen-sized data-board providing area managers a real time overview of response time performance, crew availability, and emergency department capacity.
- The rollout of Electronic Patient Care Records across the volunteer service (EPCR having previously been rolled out to all metro paramedics), replacing the paper-based system. Patient care records are what on-

road staff use to record patient and treatment information; this information can also be viewed by the hospitals, as the patient is en route.

- Rollout of the MRX HeartStart defibrillator across all metropolitan ambulances and in career (country) sub-centres. The MRX provides 12 lead ECH capability and protocols.

Regionalisation

The Country Ambulance Service entered its third of year of the regionalisation program, in 2012/13, with the focus of this program largely being on decentralisation and strengthening support for locally based crews. Throughout the year, an additional four community paramedics (CPs) were employed in country WA, bringing the total to 20; these CPs are based at one centre but spend much time visiting other centres within the same region and supporting local volunteer training and recruitment efforts and better integration with the local health system. In addition to community paramedics, another five ambulance paramedics were also employed, bringing the total number of paid paramedics in the country to 74, with an additional complement of six paramedics expected to be employed in Karratha, Kununurra and Busselton during 2013/14.

Staff engagement

Our staff and volunteers played a key role in the task of deciding the strategies needed to achieve the organisation's vision as to where it wants to be by 2017. Staff have also been empowered to take responsibility for continual operational improvement through attendance at dedicated workshops during which data is examined and analysed to see where performance might be improved. If issues have been identified through the standard analytical and reporting process, then a review team engages in team-based problem solving to initiate, implement, and monitor the effectiveness of solutions.

First aid

St John Ambulance WA trained over 190,226 students in first aid throughout the financial year – a 12.3% increase on the previous year – and in doing so became the first organisation in Australia to teach over 190,000 people in a year; a strong demonstration of the organisation's aim to make first aid a part of every Western Australian's life, and to build more resilient, first-aid aware communities.

Future Directions 2013-14

2012/13 marked the third year of a four-year contract between St John Ambulance WA and the WA Government to provide the state's ambulance service. During 2013/14, both parties (SJA & DoH) will be working on a long-term contract for the period beginning July 2014. Excellent achievements in 2012/13 combined with a record of providing a very cost-effective service to government position us well to secure a favourable outcome, although we acknowledge that competing pressures on government finances will present challenges for both parties.

We will be increasing our efforts to develop alternative pathways for low-acuity patients, and to work collaboratively with stakeholders to achieve this; to continue promoting our first aid training services so that the number of students who are taught first aid, rises even more; to increase our footprint and market positioned in industrial health; and to establish our Patient Transfers Service as a strong, stand-alone, commercially oriented business unit completely separate from the Emergency Ambulance Service.

St John Ambulance New Zealand

Contact Details

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Incumbent: Peter Bradley (from 24 September 2012)

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Our Vision and Mission

VISION

Enhanced health and well-being for all New Zealanders

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 headquarters in Auckland and a national trust board, which delegates responsibility for oversight of service delivery to three regional trust boards. The organisation comprises more than 17,600 volunteer and paid staff.

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 and the Wairarapa are provided by Wellington Free Ambulance. St John offers other services in these regions (first aid training, medical alarms, event medical services, and Youth programmes).

The Year in Review – Changing our Service to meet the needs of the future.

St John staff treated over 415,000 patients in the last year. The volume of 111 calls for an ambulance was up 3.8% on last year to 380,785.

In the changing and challenging New Zealand healthcare environment, we have continued over the last 12 months to focus on adapting our operating model to anticipate and accommodate those changes and the increasing demand for our services over the next five years.

In response to a growing, ageing population, with more chronic health needs we have been creating models and initiatives that are better for our patients, increase our effectiveness and our efficiency, and that ultimately are better for the wider New Zealand health system.

We are ensuring our resources are directed at providing the right care at the right time – with an increasing focus on taking care to people, rather than people to care. We have looked in particular at the best ways to respond to low acuity 111 calls for an ambulance.

Future Focus

In support of the five year integrated business plan for St John, has been the development of an Operations Plan. This has been a ‘bottom up’ development – based on ideas from St John staff and health partners and focused on addressing the challenges we face, delivering a good value, sustainable, service delivery model and improving the quality and safety of our care and services.

The Operations Plan details key initiatives and planning for a new service delivery model; several initiatives began in 2012/13.

Key Initiative – Right Care, Right Time

In August 2012 we introduced a new response system for ambulance services (St John and Wellington Free Ambulance), to ensure we focus on connecting patients to the right care at the right time. Since its introduction we have seen a significant reduction in the time it takes us to get to an urban immediately life threatening (cardiac / respiratory arrest) incident.

We receive over 1,000 emergency 111 calls for ambulance every day. We used to respond to approximately two-thirds of those as immediately life threatening (i.e. sending an ambulance, lights and sirens). Yet up to 80% of these can be later diagnosed as mid to low acuity.

The motivator for the change to the new response system was to enable us to better triage the incoming calls to our Communication Centres and our response to incidents – focussing on those incidents where getting to the patient faster will make a difference. It has assisted us in identifying those incidents where it may be better to redirect a patient to other parts of the health system.

With the new response system the terms Priority 1, 2, 3 are no longer used when responding, replaced by a five colour coded response system (purple, red, orange, green and grey) based on international best practice.

The new response system has produced better outcomes in the community, particularly for high acuity patients. Since August 2011 nationally we have achieved a 10.3% reduction in the time it takes to get to

an urban purple incident (immediately life threatening (cardiac / respiratory arrest)). This is now averaging 6 minutes and 7 seconds.

Key Initiative – Sierra Cars

To help meet the challenge of demand, we have looked at all aspects of how we can best deliver unscheduled care to match patient needs. Our goal is to use our expertise to have more New Zealanders treated in their homes and communities where this is appropriate and right for the patient.

In Auckland, Hamilton and Christchurch we trialled single crewed vehicles to attend low acuity calls that have a high probability of resulting in non-transport to an ED – freeing up resources to focus on life threatening emergency incidents. It is called a “sierra” car because of the Communication Centre call sign given to them.

Since the introduction of the sierra cars in January 2013, they have proven to be an effective alternative care option and will continue in Auckland and Christchurch, with some adjustments being made to ensure we are running them as efficiently as possible.

Key Initiative – Clinical Telephone Advice

In October 2012 we worked with our Canterbury (South Island) health partners to launch Clinical Telephone Advice (CTA). This is a process where a clinician takes an incident from when someone has called 111 for an ambulance, that has been triaged as not serious or immediately life threatening (i.e. low acuity) and re-triages the patient by gathering additional information to ensure the patient gets the most appropriate care, via the most appropriate pathway. That may or may not involve sending an ambulance.

The objectives are to improve patient outcomes by providing an enhanced secondary clinical triage service, to free up St John resources to respond effectively to life threatening priority calls, and gives us the ability to link lower acuity patients to care that’s most appropriate for them – which is not always an ED.

The pilot has a resolution rate of around 3% of eligible (i.e. lower acuity) calls managed through telephone based triage and advice. Overall, we believe that 9% of our total incidents can be managed through CTA.

Key Initiative – Demand Resource Profiling

Over the last 12 months we have completed a detailed analysis of every district St John operates in nationwide, in order to understand any gaps between the level of patient demand and the current resources available in that area. The objective being that we have the right resources at the right place at the right time to best meet our patient demand.

At 2012/13 year end, we have a better understanding of the level of demand for emergency ambulance service (EAS) transport, EAS non-transport and patient transfer service (PTS) and we are able to match the resource type to the demand type.

With the demand-resource profile recommendations we expect be able to improve/ increase the efficiency of our responses e.g. we expect to respond to 4,400 more high acuity patients (with life threatening symptoms) a year within 8 minutes in urban areas.

Key Initiative – Leading Safe and Effective Services

To ensure we have a fit for purpose, future focused management structure to allow us to adapt to meet our changing environment, a review of Operations Team Leader, Team Manager and Rural Support Officer roles was managed in 2012/13. The result was a new structure aimed to ensure the right roles with the right people, that we have managers with the right skills with clear responsibilities and that teams are well led and motivated to deliver safe and effective clinical services.

The key change was the introduction of 41 new Territory Manager roles. Overall there was an increase of 14 additional first line staff. We also changed Operations senior management structure – to give more support to the Operations Director.

Key Initiatives – Electronic Patient Report Forms (EPRF)

This transformational project kicked off in 2012/13. ePRFs will improve the quality and safety of our care and services and patients' experiences – because we'll have clear information that we can link up with other health providers and rich information which we can share with Health and use to inform and improve our services.

St John ambulance officers currently manually fill in around 2 million pages of paper patient report forms each year. The ePRF project will see these paper forms replaced with electronic records completed on a portable tablet device. And that electronic record can be shared with health partners (GPs, DHBs) to help with the treatment of patients.

The rollout of electronic patient report forms will be phased and is due to start 1 June 2014 and be completed by June 2015.

Ambulances Communication Centres

In the last year Telecom directed 1.16 million 111 calls to New Zealand's three emergency agencies. Of those calls 380,785 (33%) were 111 emergency calls for an ambulance. This is a 3.8% increase on the previous year.

In 2012, we began key projects to ensure the critical systems and technologies we use to in our frontline responses are fit for purpose, robust and up to date. In 2013/14, we will complete the upgrade of our computer aided dispatch (CAD) system and the replacement of radio control terminals in the Communication Centres.

In another significant project, from April 2014 we will start to equip each ambulance and operational vehicle with a new mobile data terminal (MDT). Staff use the MDT to communicate their status during a response and whether they're available or not to accept jobs; it provides location information to the CAD system and critical data for us to manage our service.

Current Performance – Response Times

St John has nine contracted ambulance response time targets, agreed with the Ministry of Health and with ACC and in line with New Zealand ambulance standards.

Compared to the 2011/12 financial year, three of the previously missed targets in urban and rural were achieved, despite increasing levels of demand.

Embedding a Performance and Improvement Culture

Over the last 12 months, we have continued to reinforce that all Operations staff have a role to play in improving performance. This has been reflected through the 'IdeAs' process where staff have continued to tell us ideas to improve our operation – over the last 12 month 410 ideas have come through and 78 have been implemented. We have also achieved this by setting targets nationally that we need to achieve, and through the use of storyboarding and good analytical data to work on the areas that make a real difference to patient outcomes and performance.

Clinical Focus

In July 2013, St John welcomed Norma Lane to the new role of Clinical and Community Programmes Director. Norma is focused on setting out the clinical strategy for the next five years. That focus is on delivering a suite of clinical key performance indicators that will expand on our current cardiac arrest data/return of spontaneous circulation (ROSC), to capture clinical outcomes and care given in the areas of STEMI (ST segment elevation myocardial infarction), stroke, diabetes, asthma and pain management. This will influence our education and training programme.

Future Directions 2013-14

We have identified what we think are the key components of the new service delivery model for St John and now need to work with whole of Health to implement it. The fundamental issue is looking at what we can do differently to manage low acuity patients.

We can treat more people at home. When we do transport, we can look at options other than just transport to an ED. We need to work with Health to identify what will make a difference – for all of us.

Another key focus for 2013/14 will be working with Health on demand management initiatives, looking in particular at how best to manage individuals who call us often, chronic obstructive pulmonary disease (COPD) patients and high risk falls patients. We will also continue supporting appropriate public health campaigns like blood pressure awareness week, men's health week, and immunisation programmes, to generally improve the health of the population.

Over the next 12 months, we will be implementing the resourcing plans resulting from our demand profile work. We will also be focussing on full crewing and on the need for more frontline resource – in Auckland and Christchurch in particular.

Wellington Free Ambulance

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Our Vision and Mission

Our Goal is to provide:

World-class free paramedic care for the people of greater Wellington and Wairarapa

Our Strategic Intentions are to:

Be a recognised key player in the New Zealand Sector

Be a high profile, dynamic, sustainable organization

Provide leading edge patient care

Be a great place to work

We value:

Passion Openness

Caring

Integrity

Learning – strive for excellence

Jurisdiction

Wellington Free Ambulance serves the people of Greater Wellington and the Wairarapa and is the only free emergency ambulance service in New Zealand.

Throughout the year we have provided the high-quality service that the people of our region have come to expect. We answered close to 75,000 calls for help with 5,500 calls in the Wairarapa. Wellington Free's patients reported an overall satisfaction rating of 99%² satisfied or very satisfied, based on their experience of our service.

We are proud to play a vital role in the communities in which we work and are excited about developing our model of care to reflect the changing needs of all people across our region.

The Year in Review

During the 2012/13 year, WFA achieved a number of key objectives in order to help achieve its strategic goals:

- WFA Board appointed a new chief executive, Diana Crossan.
- The establishment of a Clinical support desk introduced paramedics into communications centres early in the year. The immediate provision of clinical advice and support to despatchers and call takers, and to road staff when needed, has further strengthened the delivery of care to our patients and helps create more positive patient outcomes.
- In New Zealand, a new emergency response system was introduced across the ambulance sector on the 15th of August. Emergency calls are now prioritised using a colour coded response system. The changes help better differentiate low acuity incidents from time critical and life threatening incidents. The system also enhances our ability to make appropriate decisions, including using secondary triage.
- Secondary Triage is used internationally to help meet the needs of patients who do not have an immediate or life threatening emergency. When a paramedic or registered nurse advises a patient by phone this is referred to as a 'hear and treat' model. A 'see and treat' model is when a paramedic and ambulance physically attend a patient. Wellington Free participated in a pilot to trial secondary triage to understand how the model might look like for us. We found that the benefits included reducing inconvenience to our patients who didn't need to go to hospital as well as more effective use of our resources. It is remarkable to consider that over the year around over 2,000 people were helped without the need to send an ambulance, which could then be called on for a much needed emergency. These learnings enable us to transition alternative management of low-acuity work into our day-to-day business. The overall value of evolving our services in this way is that from the very first interaction with us, our patients can expect efficient and effective patient focused service delivery.
- Our involvement with regional and national health organisations across the broader health sector is crucial. An ambulance service relies on positive interactions with a range of providers and we can add value through inputting into the future shape of integrated community based medicine. In this regard, our expertise has been recognised across a range of clinical areas with five papers published in academic journals this year. Topics have included ambulance triage at major events, extended care paramedicine and resuscitation.

² Council of Ambulance Authorities Patient Satisfaction Survey 2013. 2 August, 2013. Ehrenberg-Bass. University of South Australia.

Comparative Data 2012-2013

The following section includes data collected for the financial year 2012-13. Data is presented in descending order based on population served by each service.

Please note the financial results for Australian Services 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 would like to thank the Productivity Commission for assistance in producing the tables and associated footnotes for Australian Services in this section.

Benchmarking information for Australian Services 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	312	310	92	129	38	14	-	1 443	169	24	192
Urgent incidents	'000	159	165	324	51	74	20	19	-	812	113	15	128
Non-emergency incidents	'000	287	339	234	104	60	12	8	-	1 043	128	40	168
Casualty room attendances	'000	-	-	2	-	-	-	-	-	2			
Total incidents	'000	994	816	870	246	263	71	41	-	3 300	409	79	489
Population	million	7.3	5.7	4.6	2.5	1.7	0.5	0.4	0.2	22.9	3.9	0.5	4.4
Incidents per 1 000 people	no.	135	144	189	100	158	138	109	-	144	105	159	111
Responses													
Emergency responses	'000	699	470	409	106	179	47	15	15	1 941	212	24	236
Urgent responses	'000	199	218	358	62	100	24	18	22	1 001	133	15	148
Non-emergency responses	'000	321	391	229	118	73	13	8	11	1 165	143	35	178
Total responses	'000	1 219	1 079	997	286	353	85	42	48	4 107	488	74	562
Population	million	7.3	5.7	4.6	2.5	1.7	0.5	0.4	0.2	22.9	3.9	0.5	4.4
Responses per 1 000 people	no.	166	190	216	116	212	165	109	201	179	125	148	128
Patients													
Transported	'000	816	660	736	219	202	58	30	37	2 757	332	64	396
Treated not transported	'000	141	79	88	24	32	13	7	10	394	53	19	72
Total patients	'000	958	739	824	243	234	71	37	47	3 152	385	83	468
Population	million	7.3	5.7	4.6	2.5	1.7	0.5	0.4	0.2	22.9	3.9	0.5	4.4
Patients per 1 000 people	no.	130	130	179	98	141	138	97	200	138	99	166	106
Transport													
Total fleet road	m km	36.3	34.1	34.1	7.0	11.5	2.9	1.3	-	-	18.8		18.8
Flying hours fixed wing	'000 hrs	9.0	4.9				1.4	-	-	15.3			
Flying hours rotary wing	'000 hrs	6.3	3.5				0.1	0.8	-	10.7			
Growth over last year													
Incidents	%	2.1%	2.7%	4.4%	7.2%	2.7%	3.0%	5.7%	n/a	1.9%	-1.6%	11.6%	0.3%
Responses	%	3.0%	6.1%	7.0%	18.4%	7.5%	5.7%	4.1%	7.0%	6.2%	-1.6%	10.4%	-0.2%
Patients	%	2.8%	2.9%	5.4%	0.5%	-3.8%	5.4%	11.4%	6.8%	3.0%	-1.1%	23.8%	2.5%

(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 any patients requiring treatment or transport.

In 2012-13, ambulance services in Australia and New Zealand attended 3.8 million incidents. Nearly 70% of ambulance work involved attending emergency and urgent incidents with 43% of incidents categorised as emergency, 25% urgent, and 32% non-emergency.

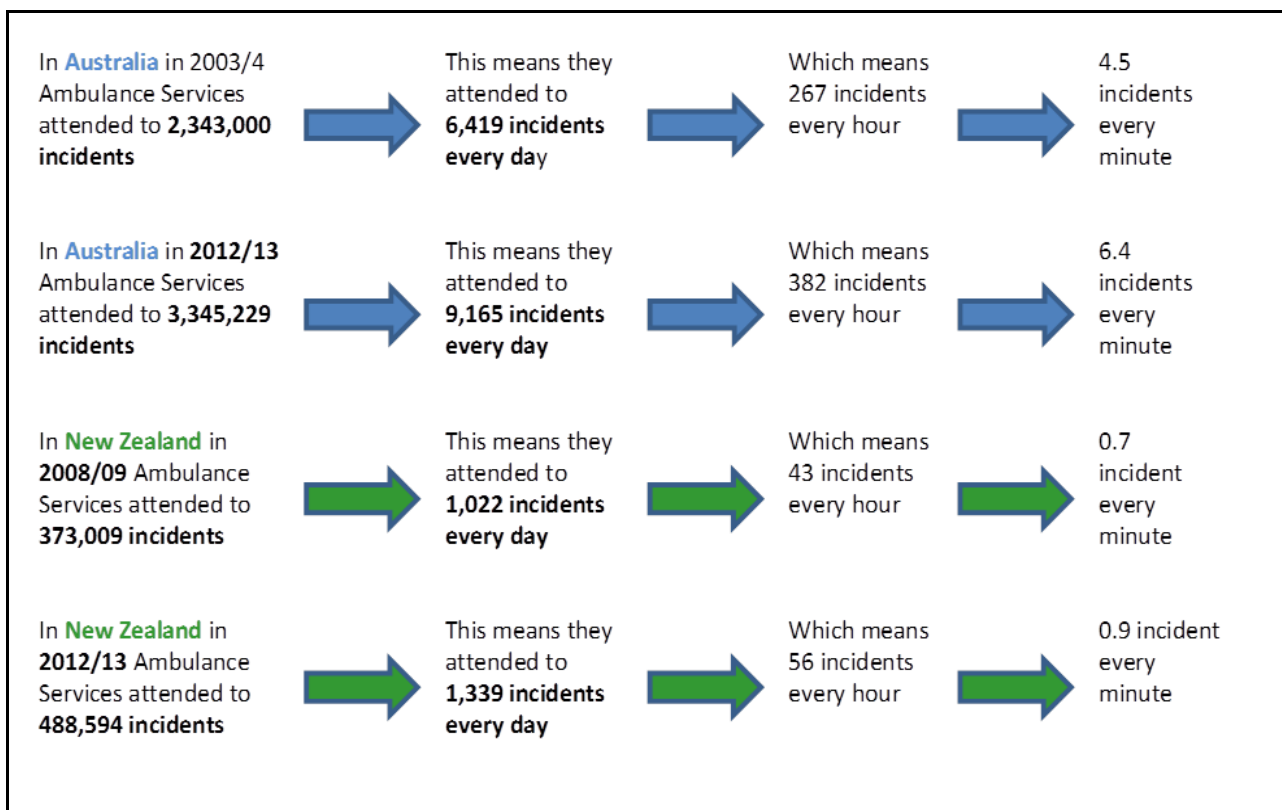


Figure 1 Incidents per day; hour; minute

Incidents in Australia have had a combined growth of 43% between 2003 and 2013 with an average growth per annum of 4.1%. In 2003, Australian ambulance services reported 2.3million incidents by 2013 there were 3.3 million incidents.

In New Zealand, the number of incidents has grown by 31% between 2008 and 2013. The number of incidents has gone from 373,009 in 2008 to 488,594 in 2013. Average annual growth was 6.2%.

Incidents

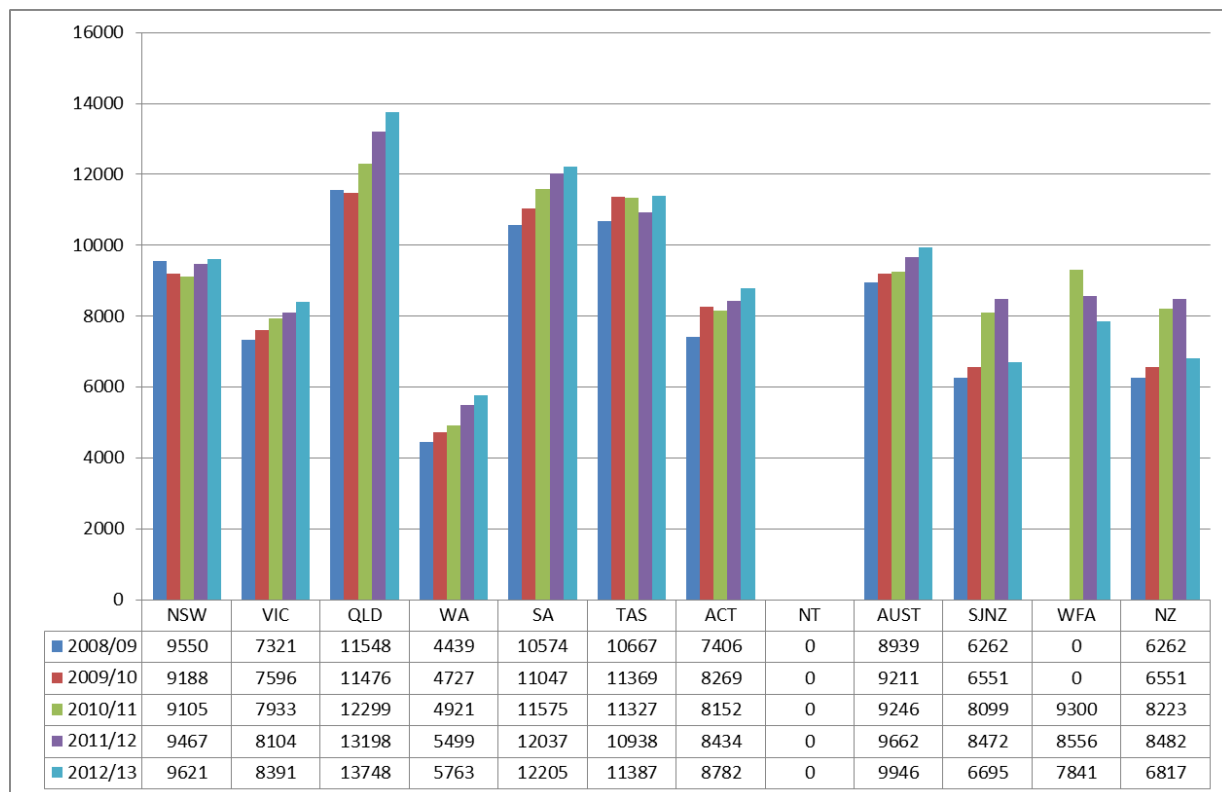


Figure 2 Emergency and Urgent Incidents per 100,000 people

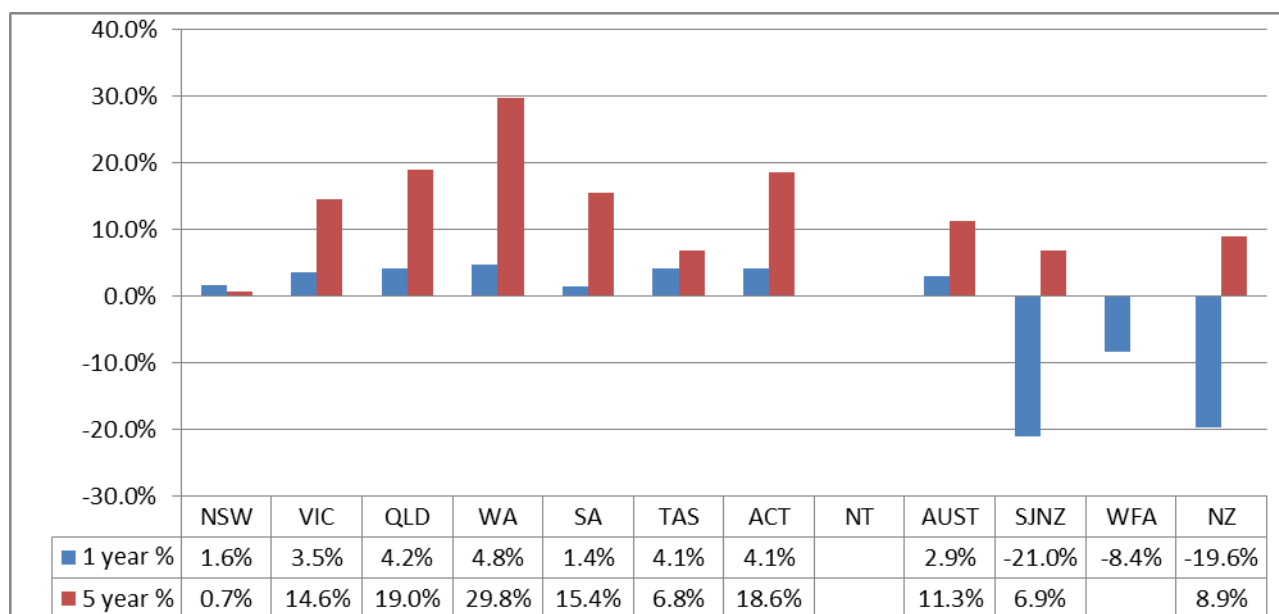


Figure 3 Emergency and Urgent Incidents per 100,000 people – 1 and 5 year growth

In Australia over the past year, the rate of emergency and urgent incidents per 100,000 people has increased by 2.9%; with the increase range from 1.4% to 4.8% recorded.

In New Zealand the emergency and urgent incidents rate per 100,000 people has decreased by -19.6% over the past year. WFA recorded a decrease -8.4% and St John NZ recorded a decreased amount -21%. Over the past five years, emergency and urgent incidents per 100,000 people have increased both in Australia and New Zealand, 11.3% and 8.9% respectively.

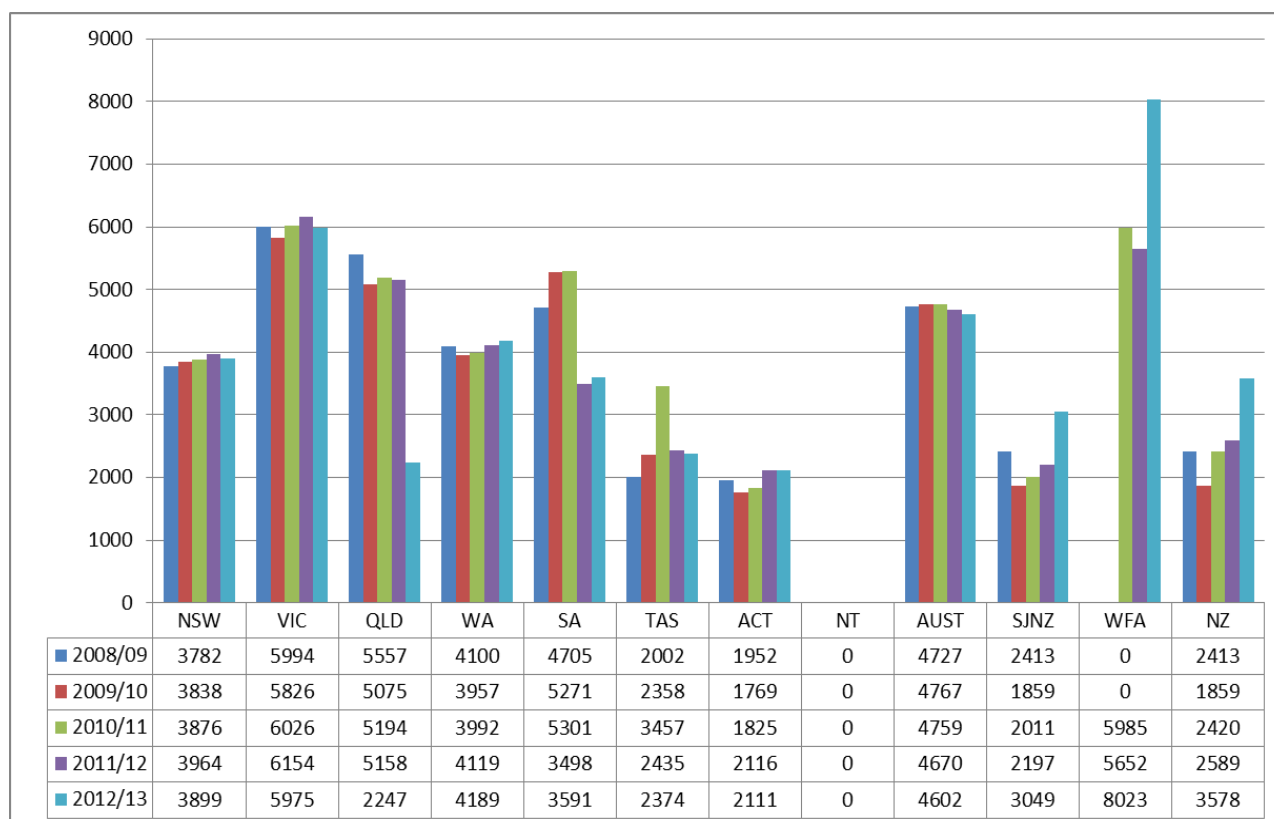


Figure 4 Non-emergency Incidents per 100,000 people

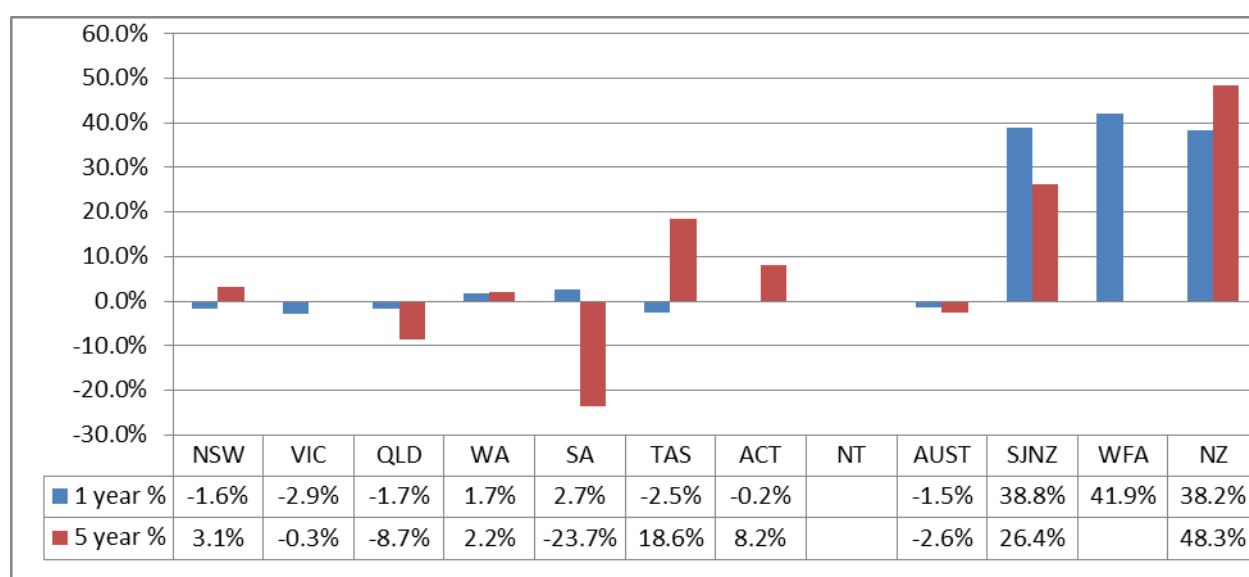


Figure 5 Non-emergency Incidents per 100,000 people – 1 and 5 year growth

In Australia in 2012/13 non-emergency incidents per 100,000 people have decreased by -1.5%. This is a slight difference from 2011/12 when Australia recorded a decrease of -1.9%. All states with exception of WA (1.7%) and SA (2.7%) decreased between minus 0.2% and minus 2.9%.

New Zealand has this past year seen an increase in non-emergency incidents per 100,000 people of 38.2%, which is a higher rise from 2011/12 of 7%. Both services recorded increases St John 38.8% and WFA 41.9%.

Over the past five years, Australia has seen a decrease to minus 2.6% in non-emergency incidents per 100,000 people; New Zealand has recorded an increase in growth over the past five years.

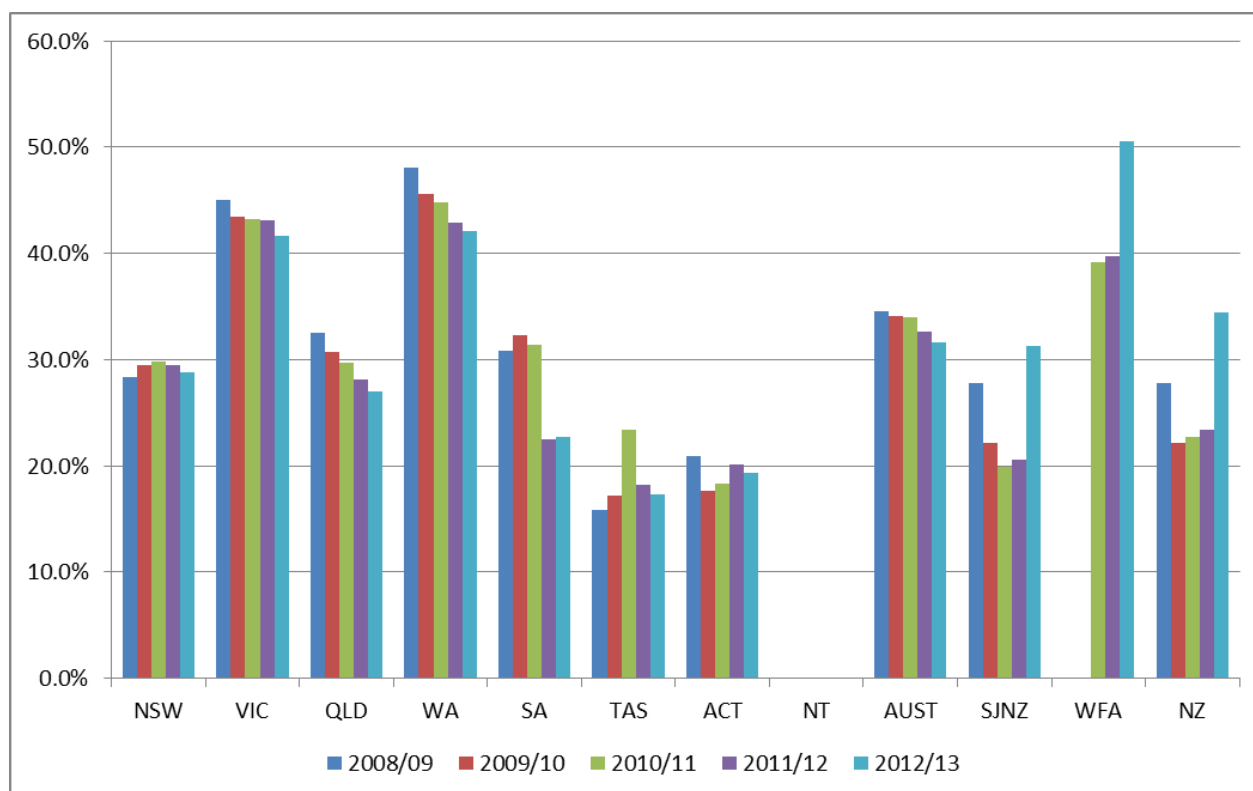


Figure 6 Non-emergency incidents as a % of total incidents

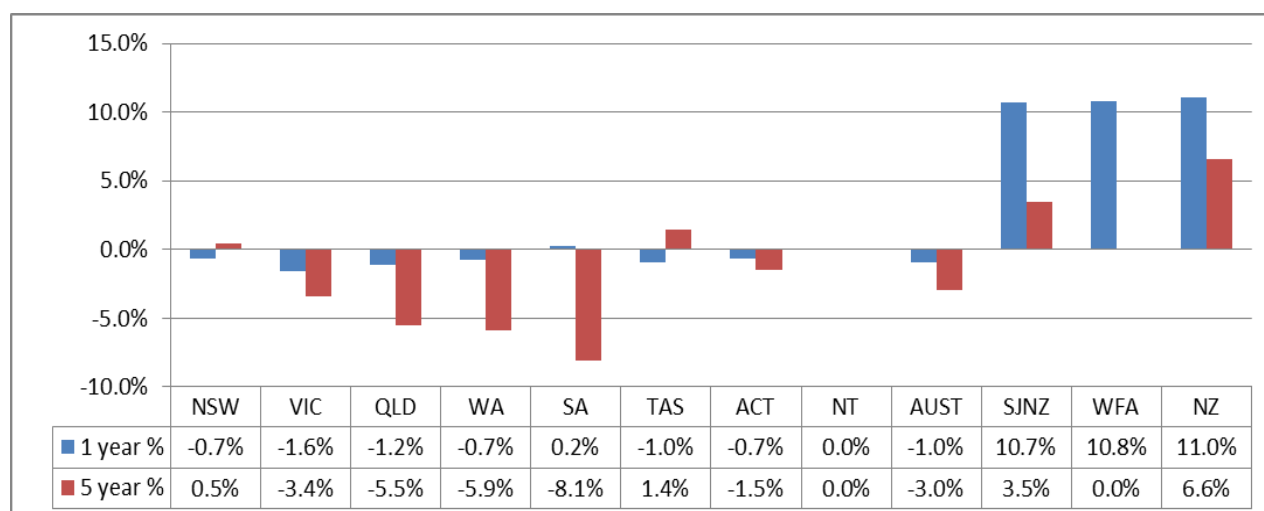


Figure 7 Non-emergency incidents as a % of total incidents – 1 and 5 year growth

In 2012-13, non-emergency incidents accounted for 32% of all incidents across Australia. This ranged from 17% in Tasmania to 42% in WA & VIC. Overall Australia has seen a decrease of minus 1.0% in non-emergency incidents as percentage of all incidents.

In New Zealand non-emergency incidents represent 34% of all incidents which increased by 11%. Over the past five years, non-emergency incidents as a percentage of all incidents in Australia have seen a decrease of minus 3% while New Zealand has seen an increase to 6.6%.

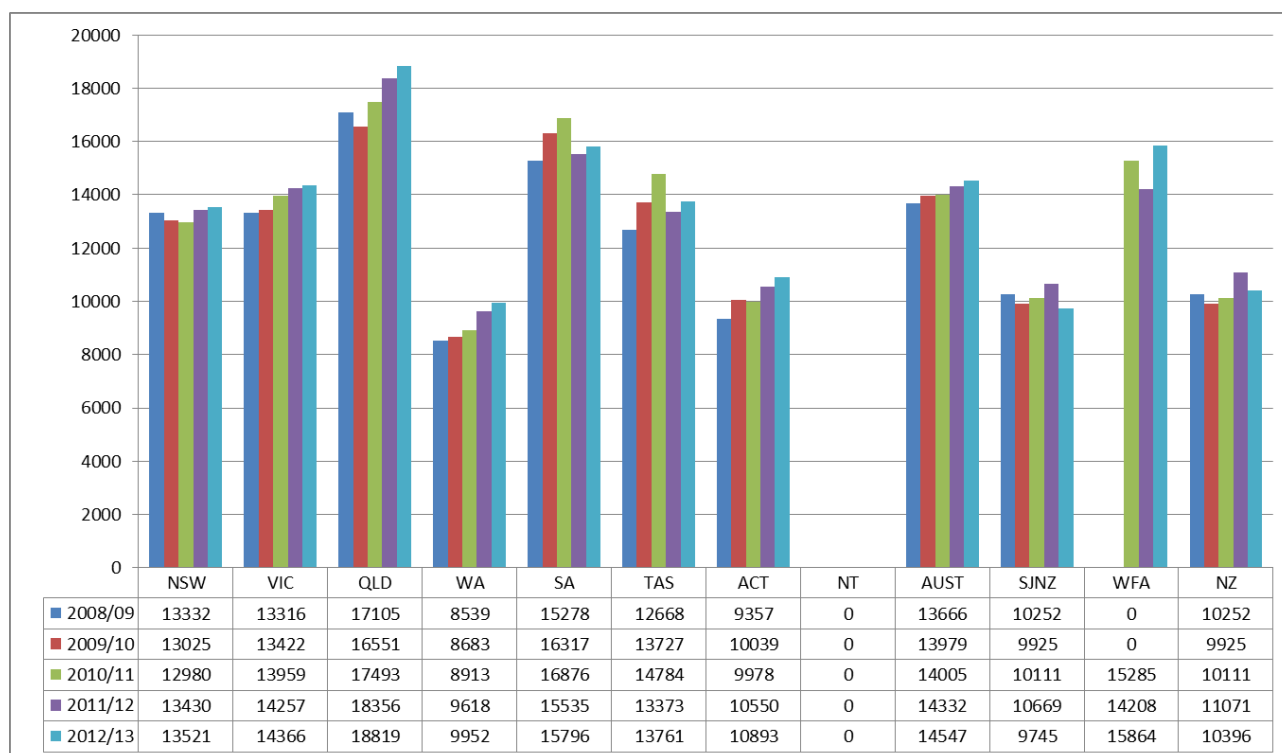


Figure 8 All Incidents per 100,000 people

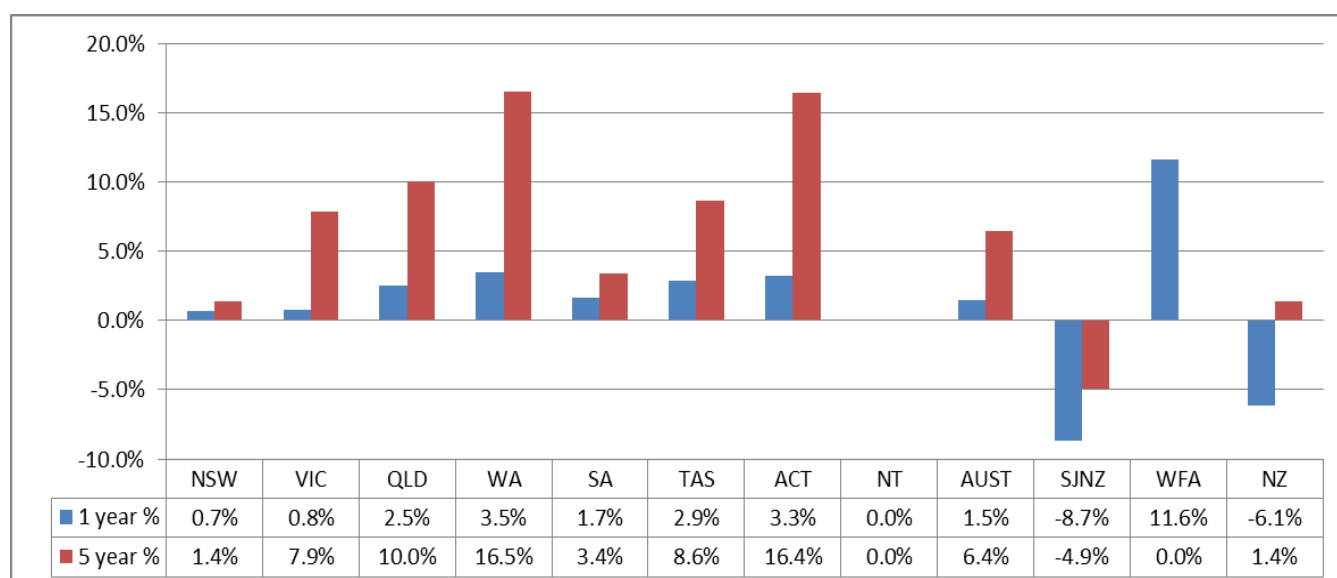


Figure 9 All incidents per 100,000 people – 1 and 5 year growth

Overall, the rate of incidents per 100,000 people in Australia has increased by 1.5% in 2012-13. Increases ranged 0.7 in New South Wales to 3.5% in Western Australia.

In 2012-13, the New Zealand incidents rate per 100,000 people decreased by minus 6.1%. WFA saw an increase of 11.6% and St John recorded a decrease of minus 8.7%. Over the past five years both Australia and New Zealand have been experiencing an increase in all incidents per 100,000 people. Australia had an overall increase of 6.4% while New Zealand showed small increase of 1.4%. Only 3 years of data collected from WFA.

Patients

Patient numbers in Australia over the past decade have grown on average 4% per annum, totalling in 44% growth in 10 years. Over last 10 years, ambulance services in Australia have gone from seeing four patients every minute in 2003 to today seeing six patients every minute.

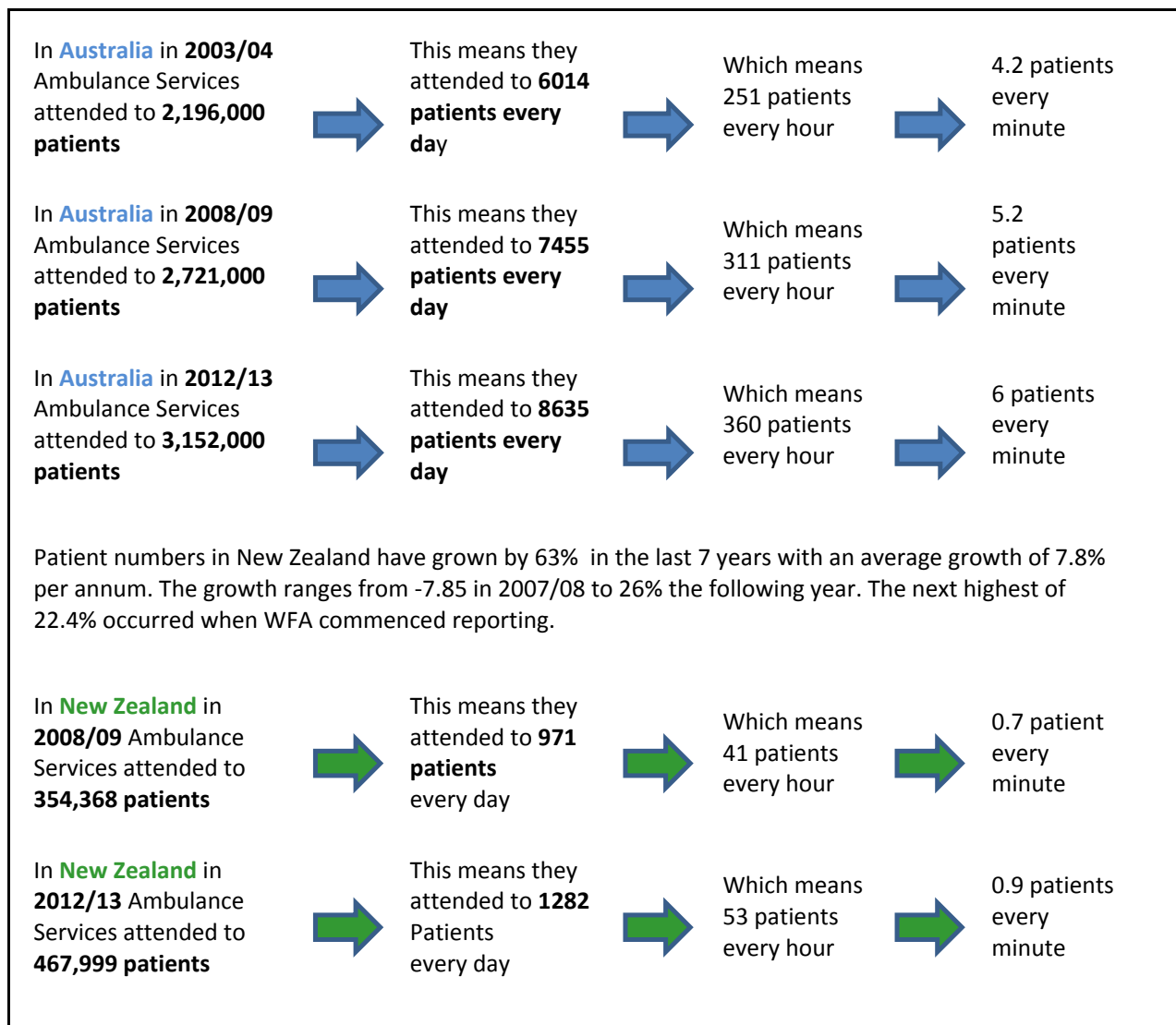


Figure 10 -Patients per day; hour; minute

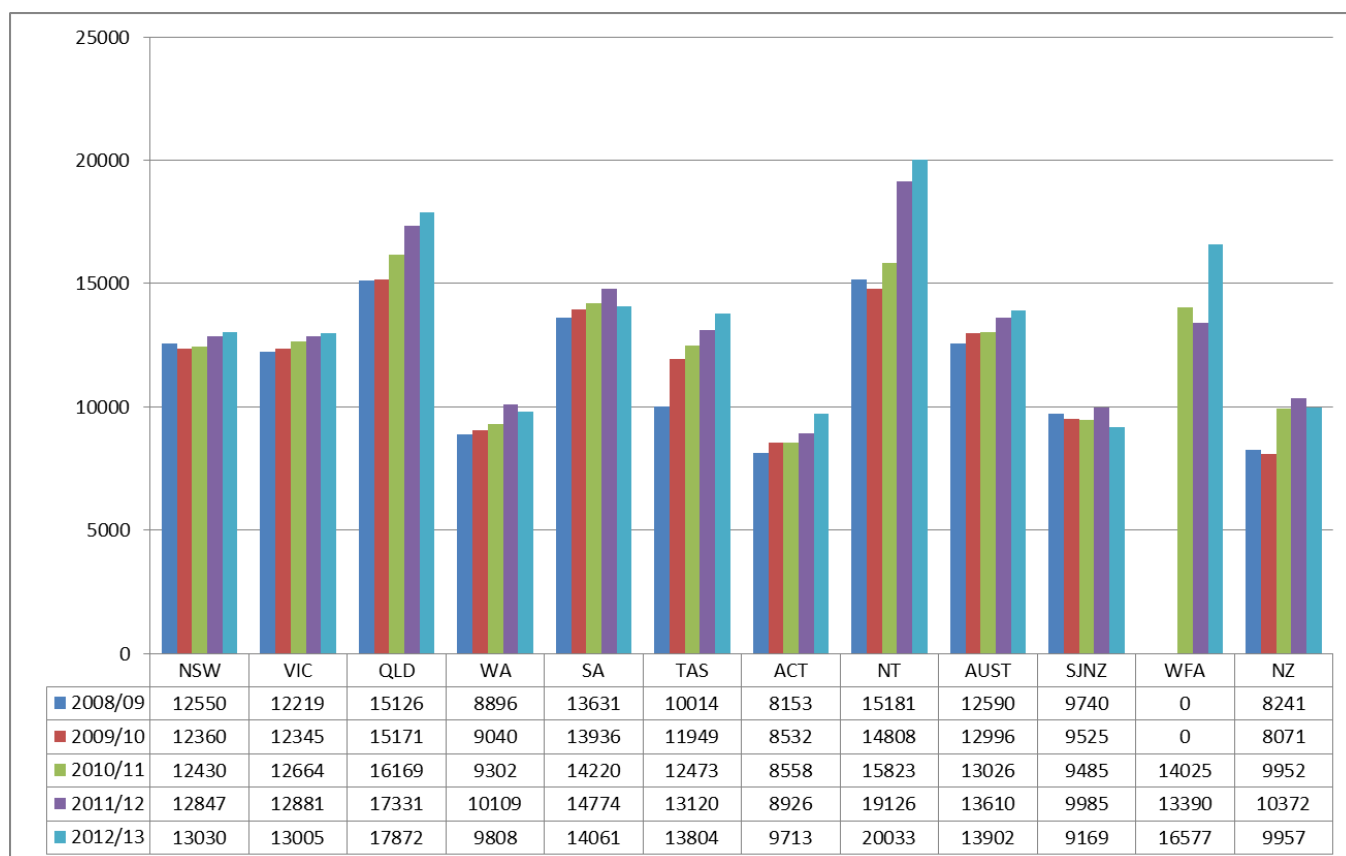


Figure 11 Patients per 100,000 people

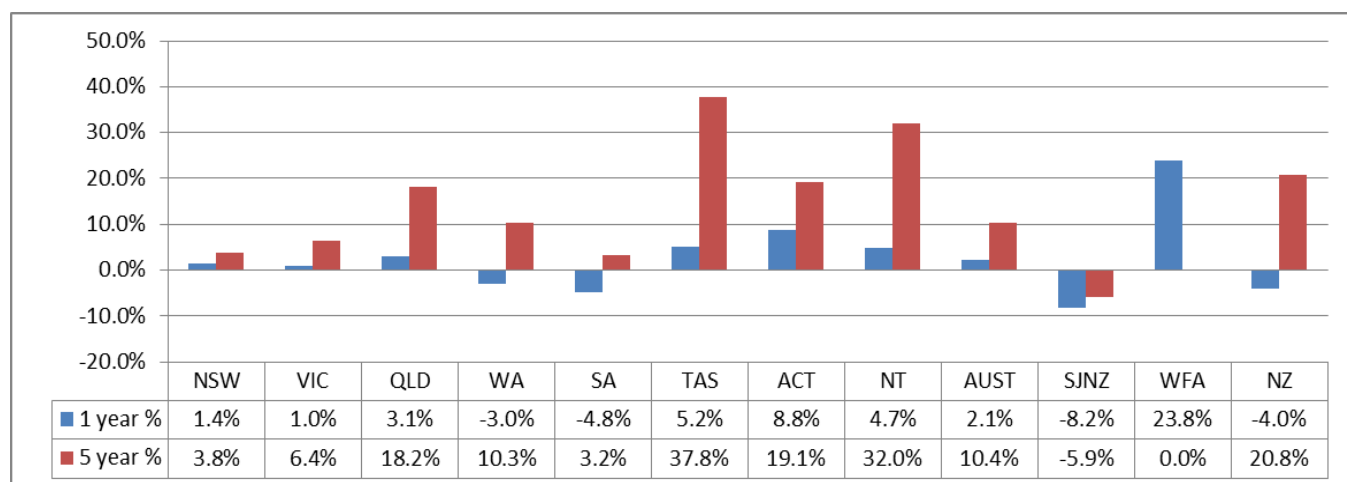


Figure 12 Patients per 100,000 people – 1 and 5 year growth

Australian ambulance services have in 2012-13 attended to 3.2 million patients and New Zealand has attended to 468,000 patients.

In the past year patients per 100,000 increased by 2.1% in Australia. Most states recorded an increase with the exception of Western Australia minus 3% and South Australia minus 4.8%.

New Zealand saw an overall decrease to minus 4% in number of patients per 100,000 people in the past year with St John recording minus 8.2% while WFA saw an increase of 23.8%. WFA has had less than five years data collected.

Overall the last five years has seen the increase in Australia and New Zealand 10.4% and 20.8% respectively.

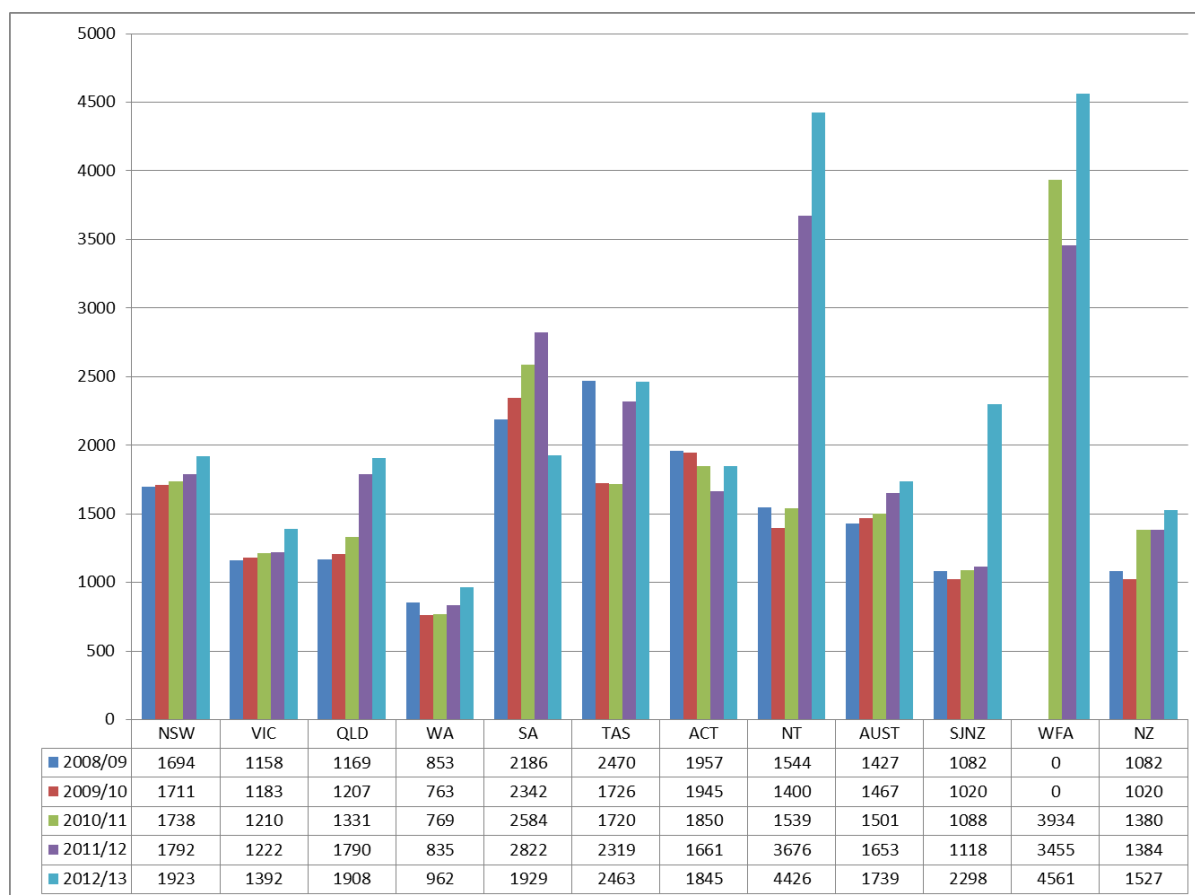


Figure 13 Patients treated not transported per 100,000 people

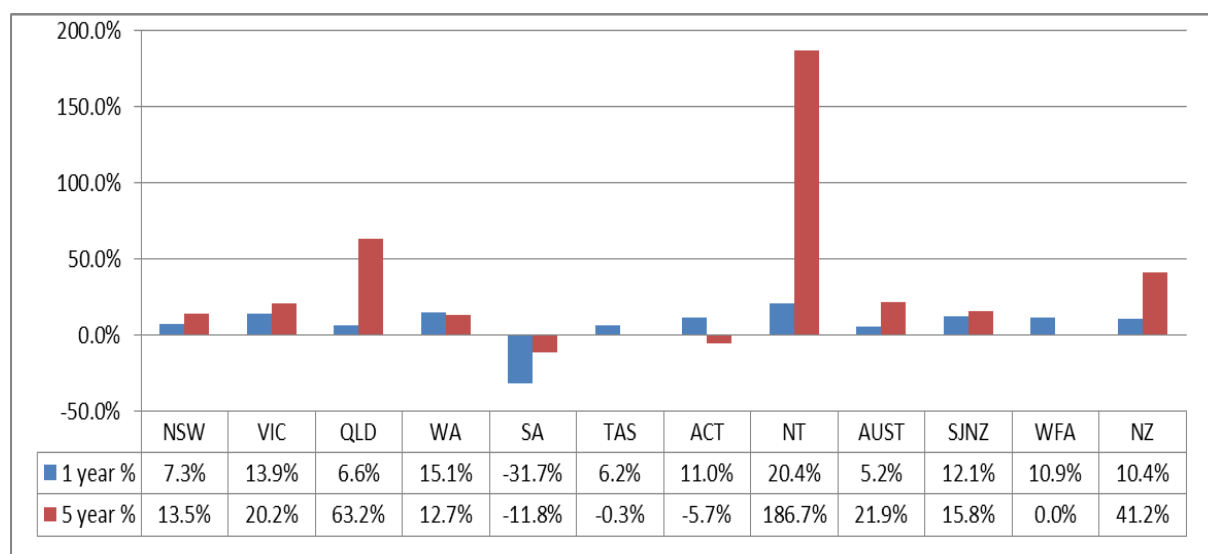


Figure 14 Patients treated not transported per 100,000 people – 1 and 5 year growth

In Australia in 2012-13, patients treated and not transported made up 12.5% of all patients. Overall Australia saw an increase of treated but not transported patients, by 5.2%. Increases ranged from 6.2% in Tasmania to 186% Northern Territory; with South Australia recording a decrease of minus 31.7%.

New Zealand saw an increase of patients treated but not transported by 10.4%. These patients made up 15.3% of all NZ patients.

The past five years have seen an increase in treated not transported patients in Australia of 5.2% and NZ 10.4%.

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	%	85.6	80.2	86.3	68.8	75.3	77.5	77.9	76.2	81.8	62.3	80.6	64.7
Ambulance operatives	FTE	3 715	2 940	3 346	877	960	285	190	131	12 444	1107	216	1322
Patient transport officers	FTE	226	59	179	83	57	19	11	7	642	70	29	98
Students and base level ambulance officers	FTE	518	345	234	220	53	31	28	46	1 475	-	20	20
Qualified ambulance officers	FTE	2 599	2 453	2 504	481	724	207	129	56	9 152	911	123	1034
Clinical other	FTE	53	16	1	1	35	2	-	-	107	1	-	1
Communications operatives	FTE	318	67	428	92	92	27	22	22	1 068	125	44	169
Operational support personnel	FTE	383	340	229	182	163	49	32	20	1 399	243	30	273
Corporate support personnel	FTE	244	387	303	216	152	34	22	21	1 378	427	22	449
Total salaried personnel	FTE	4 342	3 667	3 878	1 275	1 274	368	244	172	15 220	1777	268	2045
Population (i)	million	7.3	5.7	4.6	2.5	1.7	0.5	0.4	0.2	22.9	3.9	0.5	4.4
Per 100 000 people													
Students and base level ambulance officers	FTE	7.0	6.1	5.1	8.9	3.2	6.0	7.4	19.4	6.4	-	4.0	0.5
Qualified ambulance officers	FTE	35.4	43.2	54.3	19.4	43.5	40.3	33.9	23.6	40.0	23.3	24.6	23.5
Total	FTE	42.4	49.3	59.4	28.3	46.7	46.3	41.3	43.1	46.4	45.6	53.5	46.5
Volunteers													
Ambulance operatives	no.	100	603	115	4 217	1 282	557	-	-	6 874	2 853	58	2 911
Operational / corporate support	no.	26	-	-	364	192	-	-	-	582	-	-	-
Total volunteers	no.	126	603	115	4581	1474	557	-	-	7456	2853	58	2911
Community first responders													
Total Community first responders	no.	208	411	242	1 368	46	48	-	-	2 323	-	-	-



(a) VIC: Data on volunteers includes some remunerated 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 2012-13, Australia had 15,220 FTE salaried personnel employed by ambulance services; 82% of all staff employed primarily for operational purposes. New Zealand had 2045 full-time equivalent salaried personnel, of which 65% were operational.

For every 100,000  in Australia there are **68 Ambulance staff** 

For every 100,000  in New Zealand there are **46 Ambulance staff** 

Volunteers are counted in numbers and not FTE. Australian ambulance services in total had 7456 volunteers, of which 92% were involved in operations in 2012-13. New Zealand had 2911, who were all involved in operations.

For every 100,000  in Australia there are **33 Ambulance volunteers** 

For every 100,000  in New Zealand there are **65 Ambulance volunteers** 

In 2012-13, there were 2323 first responders in Australia. These are the type of volunteers that provide emergency responses (with no transport capacity) and first aid care before ambulance arrival.

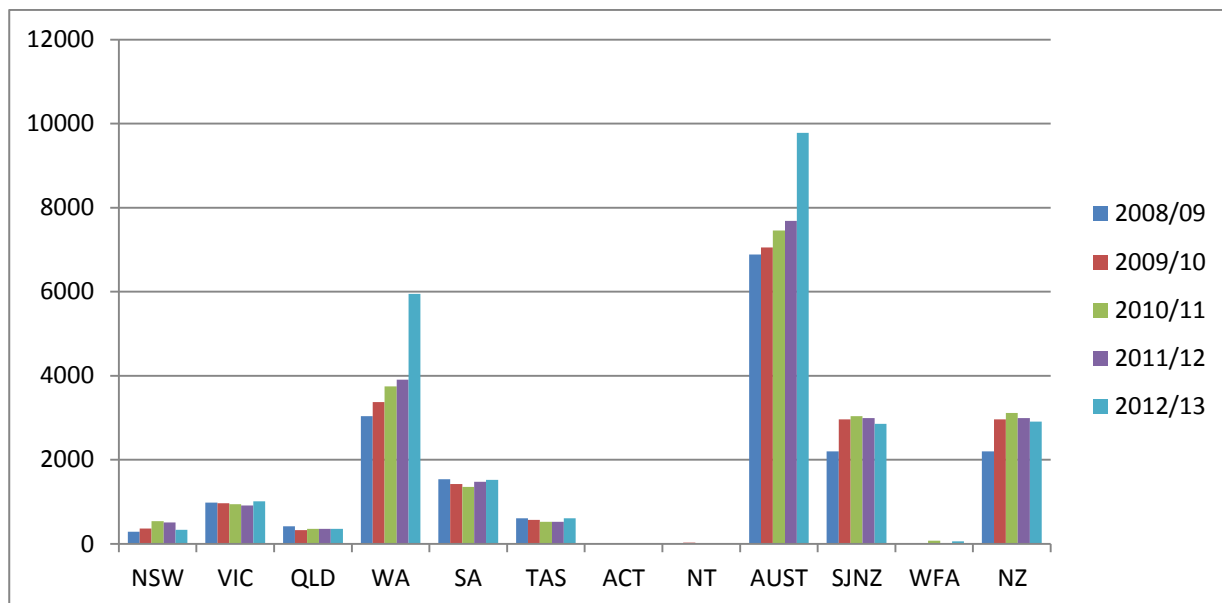


Figure 15 Ambulance service volunteers/first responders

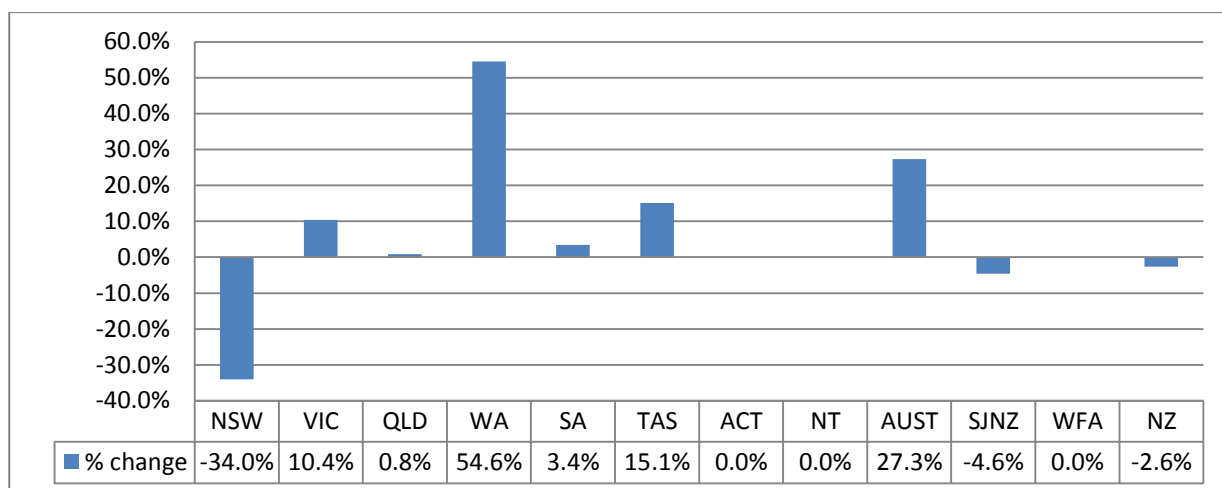


Figure 16 Ambulance service volunteers/first responders – annual growth

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 2012-13, ambulance services consisted of 9779 volunteers including community first responders. Volunteers and first responder numbers increased in Australia by 27%. NZ showed a slight decrease of minus 2.6%

Ambulance stations and locations, by staff type (a)

	Unit	NSW	Vic (b)	Qld	WA	SA	Tas	ACT	NT	Aust	St John	WFA	NZ
Ambulance stations and locations													
With paid staff only	no.	224	166	242	30	42	12	7	4	727	22	7	29
With mixed paid and volunteer staff	no.	6	62	–	12	3	16	–	3	102	109	5	114
With volunteer staff only	no.	38	29	27	147	68	21	–	2	332	60	–	60
Total	no.	268	257	269	189	113	49	7	9	1 161	191	12	203
Population (a)	million	7.3	5.7	4.6	2.5	1.7	0.5	0.4	0.2	22.9	3.9	0.5	4.4
Per 100 000 people													
With paid staff only	no.	3.0	2.9	5.2	1.2	2.5	2.3	1.8	1.7	3.2	0.6	1.4	0.7
With mixed paid and volunteer staff	no.	0.1	1.1	–	0.5	0.2	3.1	–	1.3	0.4	2.8	1.0	2.6
With volunteer staff only	no.	0.5	0.5	0.6	5.9	4.1	4.1	–	0.8	1.4	1.5	–	1.4
Total	no.	3.6	4.5	5.8	7.6	6.8	9.6	1.8	3.8	5.1	4.9	2.4	4.6

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

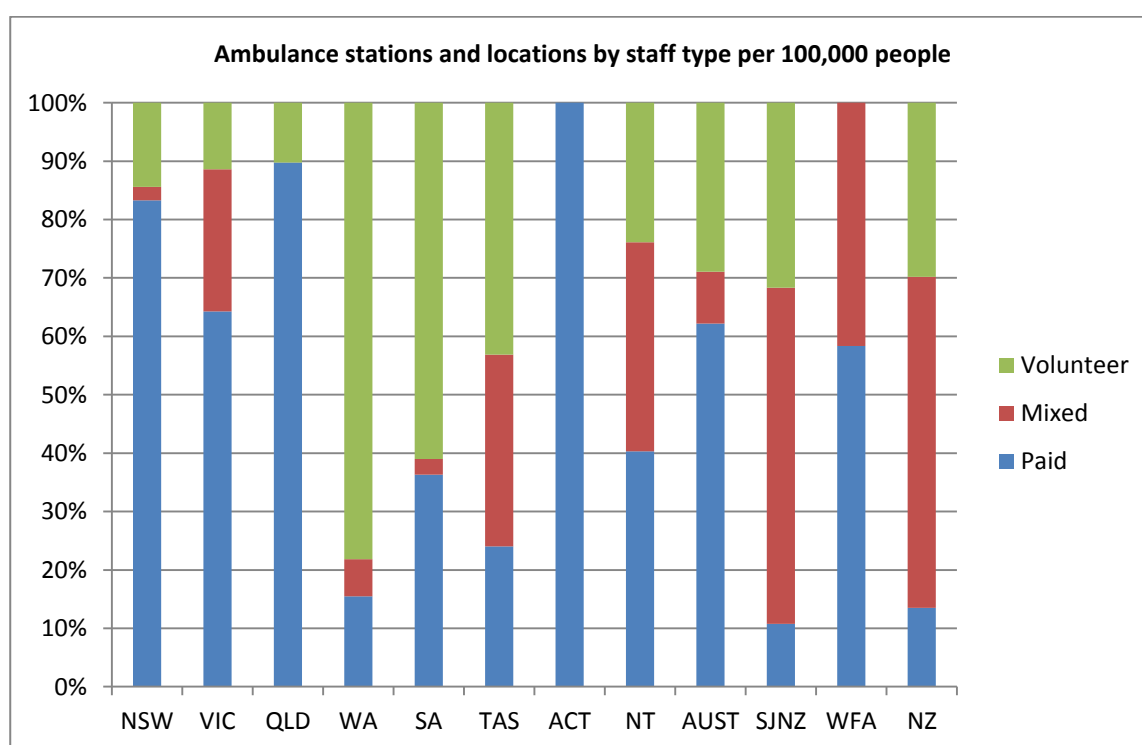


Figure 17 Ambulance stations and locations by staff type per 100,000 people

In 2012-13, there were 1161 ambulance response locations Australia wide, 62.5% with paid staff only, 9% combination of paid and volunteer staff, 28.5% fully volunteer supported. The distribution varies between states and territories, with WA, SA, and Tasmania heavily relying on volunteer based response locations in rural and remote areas.

New Zealand had 203 locations in 2012-13, 14% were paid staff supported, 56% were supported by paid and volunteer staff, and 30% 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.

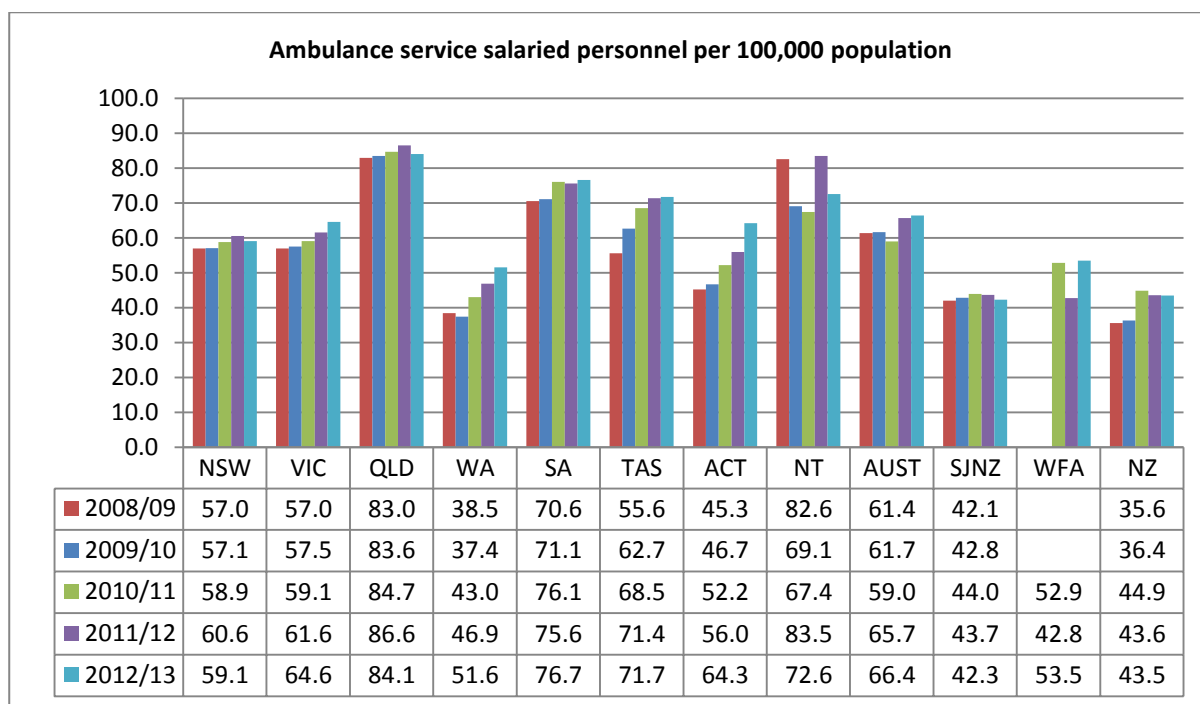


Figure 18 Ambulance service salaried personnel per 100,000 of population

In 2012-13, the number of ambulance service salaried personnel per 100,000 of population in Australia has increased, from 65.7 in 2011-12 to 66.4. In New Zealand, they experienced a slight decrease from 43.6 in 2011-12 to 43.5

In Australia, the number of ambulance service salaried personnel per 100,000 of population varies from 51.6 in WA to 84.1 in Queensland.

In New Zealand St John records 42.3 ambulance service salaried personnel per 100,000 of population and WFA have 53.5 in the 2012-13 financial year.

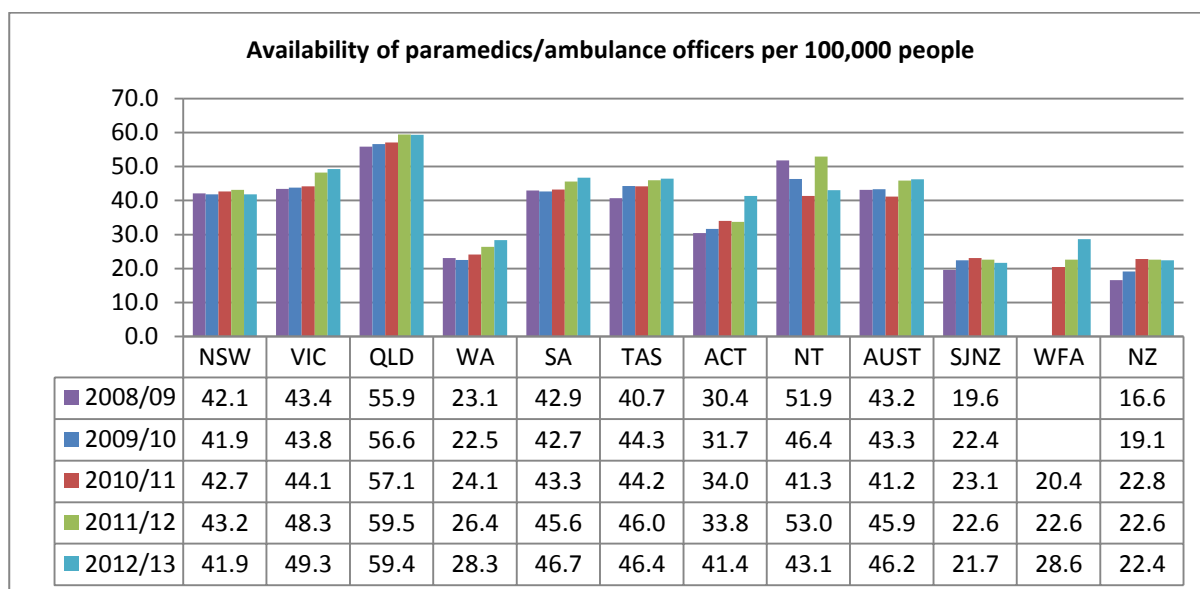


Figure 19 Availability of paramedics/ambulance officers per 100,000



Figure 20 Availability of paramedics/ambulance officers per 100,000 – annual growth

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 0.7%. Increases were highest in ACT 22.6% with NSW, QLD, and NT recording a decreased in numbers.

New Zealand saw a small decrease of -0.8% in ambulance officers/paramedics availability per 100,000 people. St John recorded a decrease of minus 4.1% and WFA saw a significant increase of 26.5%.

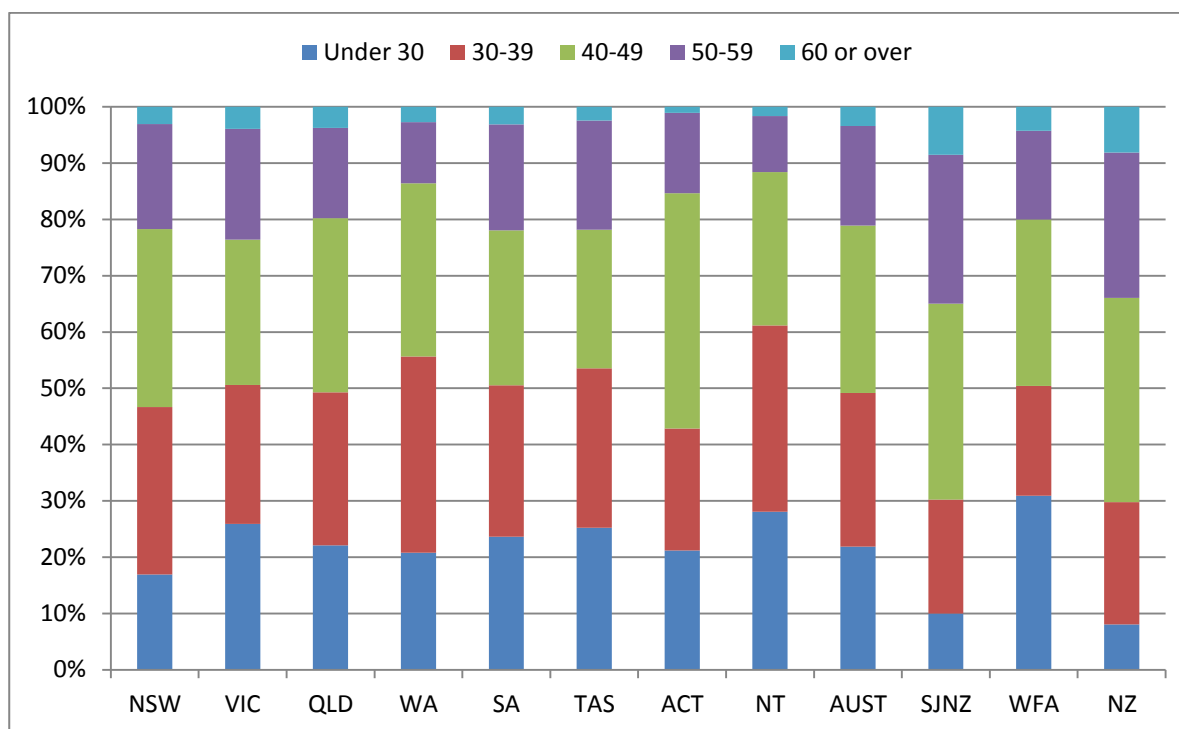


Figure 21 Operational ambulance workforce by age group

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 are consistent with the previous year's data.



Figure 22 Operational ambulance staff attrition

In 2012-13 staff attrition, which is calculated as the proportion of FTE employees who exit the organisation during the year, for Australia was 4.3% and varied between states and territories from 5.5 in NSW to 1.4 in SA.. New Zealand recorded a 2.3% staff attrition rate, with St John reporting 2.7% attrition rate and WFA 0%.

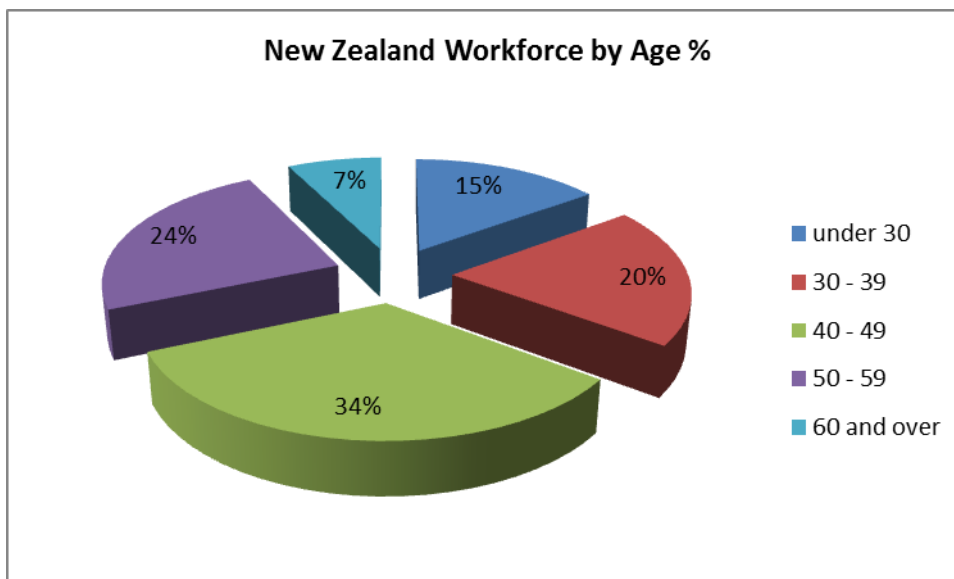
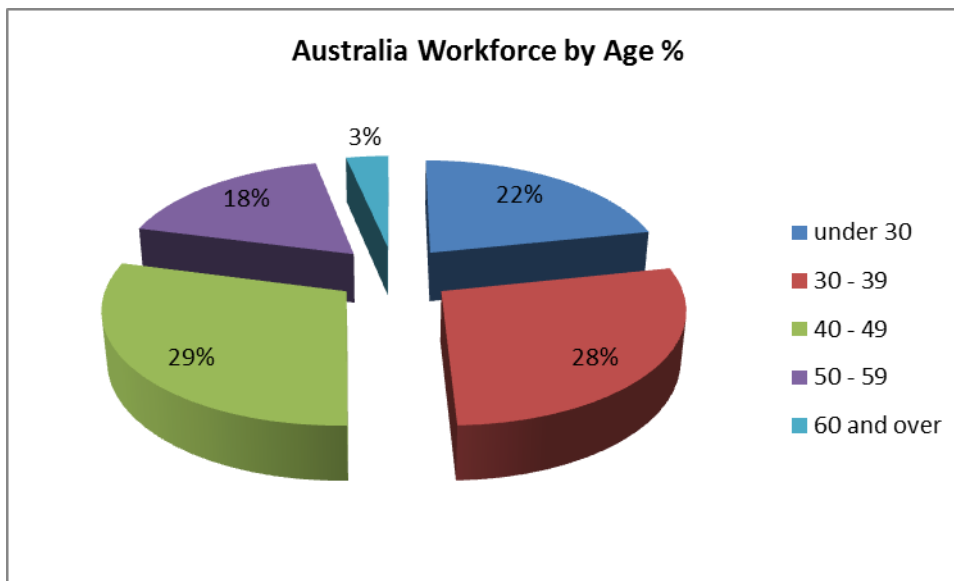


Figure 23 Total workforce by age Australia and New Zealand*

Assets

Ambulance assets (number) (a) (b)

	Unit	NSW	Vic (c)	Qld	WA (c)	SA	Tas	ACT	NT (c)	Aust (c)	St John	WFA	NZ
Ambulance stations and locations													
Response locations	no.	268	257	269	189	113	49	7	9	1 161	191	12	203
Communication centres	no.	5	–	7	1	1	1	1	1	17	2	-	2
Other locations	no.	60	28	51	175	21	6	4	2	347	29	6	35
Total	no.	333	285	327	365	135	56	12	12	1 525	222	18	240
First responder locations													
Ambulance	no.	16	58	29	456	8	5	–	–	572	34	-	34
Third party	no.	6	74	–	–	12	4	–	–	96	106	-	106
Ambulances and other vehicles													
Ambulance general purpose	no.	930	534	815	466	225	108	27	32	3 137	491	28	519
Patient transport vehicles	no.	116	57	106	31	20	13	4	3	350	122	20	142
Operational support vehicles	no.	306	316	210	32	87	31	11	12	1 005	45	10	55
Special operations vehicles	no.	94	18	18	1	44	3	–	1	179	68	7	75
Administrative vehicles	no.	70	146	40	66	22	5	1	6	356	120	3	123
Other vehicles	no.	66	32	48	17	14	6	4	5	192	39	2	41
Total	no.	1 582	1 103	1 237	613	412	166	47	59	5 219	885	70	955

(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) (2012-13 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	506 801	380 165	382 335	114 840	135 820	41 833	26 832	18 538	1 607 164	-	16824	16,824
Capital costs												
Depreciation	18 003	25 944	46 040	13 267	7 790	2 835	1 051	1 574	116 504	-	1353	1,353
User cost of capital - Other assets	12 723	17 323	26 185	7 787	4 264	1 914	787	331	71 313	-	642	642
Other costs	220 920	203 227	113 597	64 536	61 873	14 317	16 384	5 488	700 342	-	2400	2,400
Total expenditure (i)	758 447	626 659	568 157	200 430	209 747	60 898	45 054	25 931	2 495 323	-	19224	19224
Other costs												
Payroll tax	-	-	16 037	-	-	498	-	-	16 535	-	-	-
User cost of capital - Land	9 176	4 604	8 824	1 818	1 292	570	578	24	26 885	-	126	126
Interest on borrowings	-	-	-	-	118	-	-	-	118	-	-	-

(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.

What is the cost of Ambulance Services?

In **Australia** in 2012-13 ambulance services **responded 4,107,000 times**, the total core service **cost was \$2.5 billion**

EACH RESPONSE COST \$608



What is the cost of Ambulance Services?

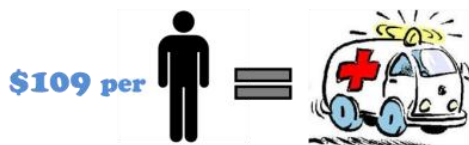
In **New Zealand** in 2012-13 **WFA** **responded 73883 times**, the total core service **cost was \$21 million**

EACH RESPONSE COST \$289



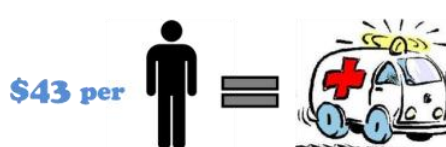
If we look at what is the cost of running Ambulance Services per person?

In **Australia** in 2012-13 the total core service **cost was \$2.5 billion** and there was 22.9 million people



If we look at what is the cost of running Ambulance Services per person?

New Zealand - WFA in 2012-13 the total core service **cost was \$21 million** and there was 500,000 people



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	1 300	1 300	1 300	1 300	1 300	1 300	1 300	10 400	–	8846	8846
Usable responses	no.	385	430	396	364	546	591	383	189	3 284	–	2 400	2400
Overall satisfaction (c)													
Very satisfied or satisfied	%	99	98	96	99	99	98	98	95	98	–	99	99
95% confidence interval	±	1.0	1.3	2.0	1.2	1.0	1.0	1.2	2.9	0.5	–	–	–
Neither satisfied / dissatisfied	%	1	1	2	1	1	1	1	3	1	–	–	–
Dissatisfied / very dissatisfied	%	–	1	2	–	–	1	1	2	1	–	1	1
Phone answer time													
Very satisfied or satisfied	%	98	98	97	97	98	98	98	96	98	–	98	98
Neither satisfied / dissatisfied	%	1	1	2	2	2	2	1	2	1	–	1	1
Dissatisfied / very dissatisfied	%	1	1	1	1	–	1	1	2	1	–	1	1
Ambulance arrival time													
Very satisfied or satisfied	%	95	93	95	96	98	98	95	89	95	–	95	95
Neither satisfied / dissatisfied	%	2	3	3	3	1	1	3	5	2	–	2	2
Dissatisfied / very dissatisfied	%	3	4	2	1	1	1	2	6	3	–	3	3
Satisfaction with treatment													
Very satisfied or satisfied	%	99	99	98	99	99	99	98	96	99	–	98	98
Neither satisfied / dissatisfied	%	1	–	1	1	–	1	1	3	–	–	1	1
Dissatisfied / very dissatisfied	%	–	1	1	–	1	1	1	1	1	–	1	1
Satisfaction with paramedic attitude													
Very satisfied or satisfied	%	99	99	98	99	99	97	99	95	99	–	98	98
Neither satisfied / dissatisfied	%	1	1	1	1	1	2	–	3	1	–	1	1
Dissatisfied / very dissatisfied	%	–	–	1	–	–	1	1	2	–	–	1	1
Total patients (est.) (b)	'000	958	739	824	243	234	71	37	47	3 152	–	74	74

(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.

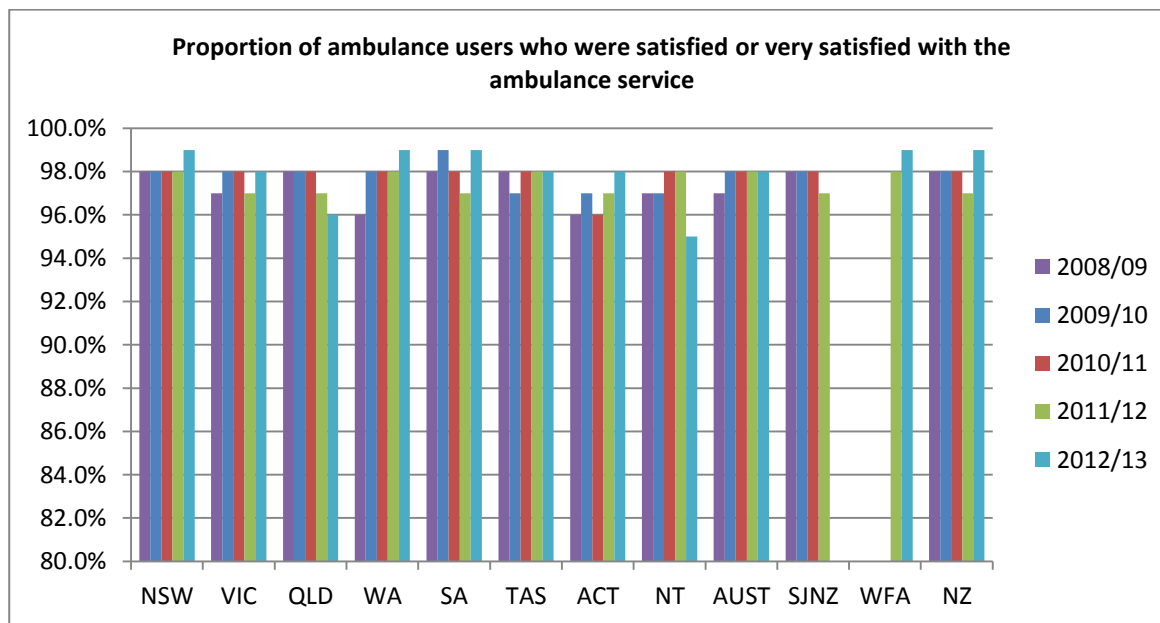


Figure 24 Proportion of ambulance users who were satisfied or very satisfied with the ambulance service

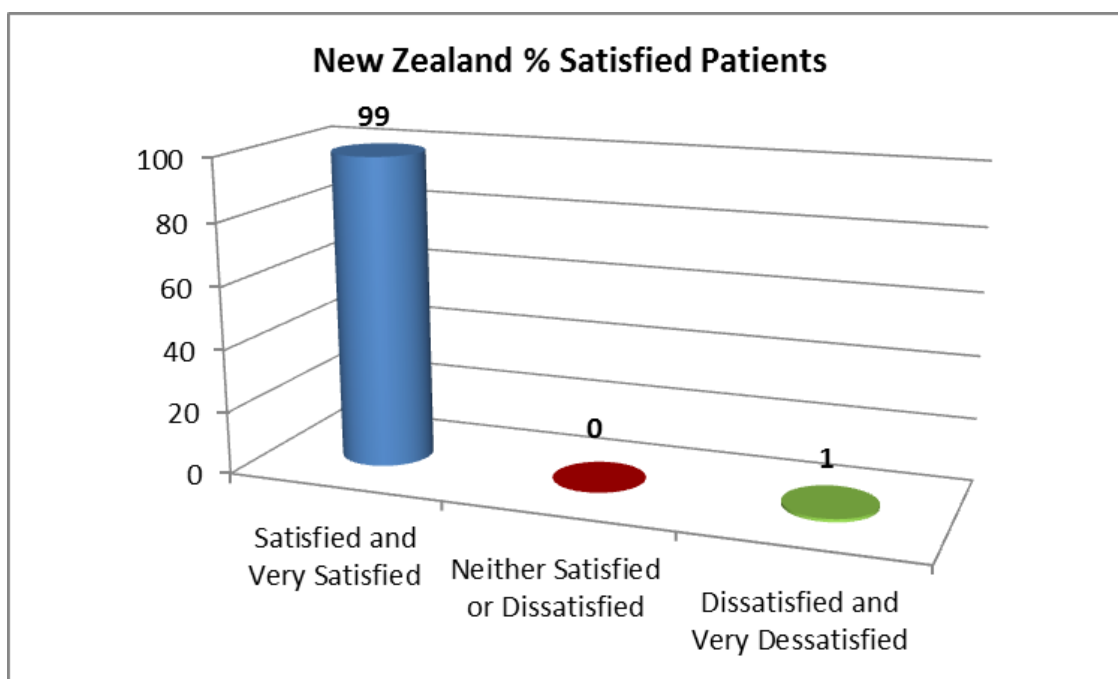
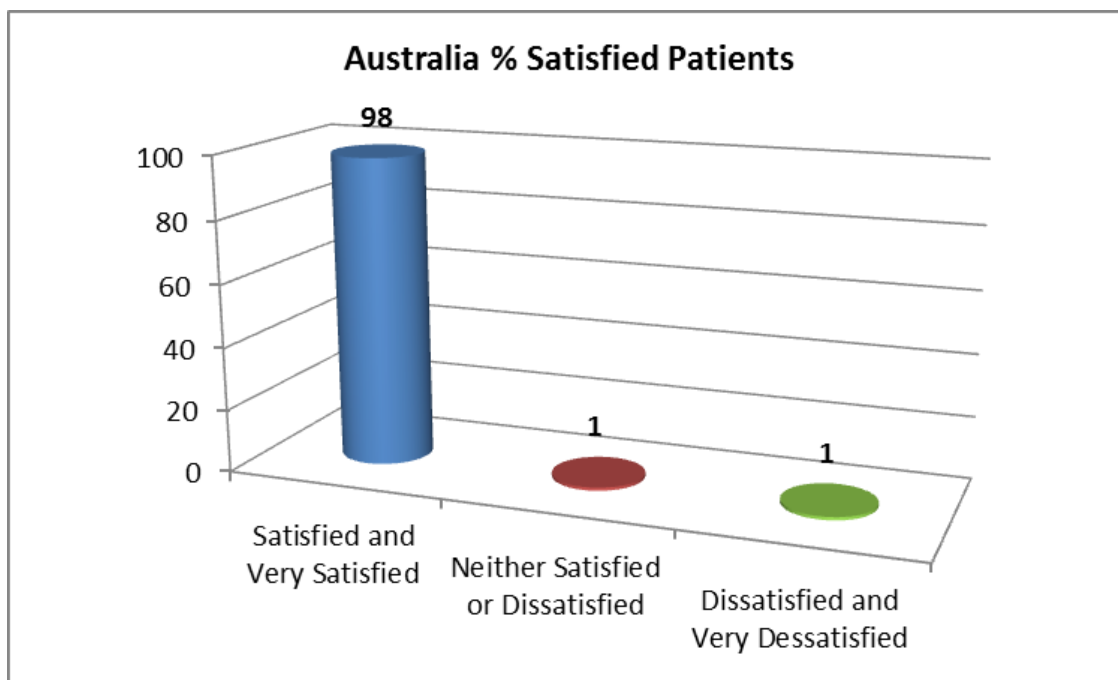


Figure 25 - Percentage Satisfied Patients- Australia & New Zealand

In 2012-13, the overall satisfaction with ambulance services in Australia and New Zealand was again high at 98% and 99% respectively.

The satisfaction levels have slightly increased from last year's results, seeing all states with exception of Qld and NT recording a small decrease.

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	11.1	11.2	8.2	9.1	9.4	11.0	8.7	9.5	10.3	9.1
Statewide 90th percentile	min	23.0	22.9	16.5	16.5	17.4	22.8	13.7	21.6	22.7	19.2
Capital city 50th percentile (f)	min	10.9	10.9	8.2	8.7	9.2	10.1	8.7	8.4	10.5	9.1
Capital city 90th percentile (f)	min	20.6	19.5	14.9	14.2	15.4	16.1	13.7	14.6	20.0	19.2
Urban centre (a)											
Population ('000)	000	4 608.9	4 169.4	2 147.4	1 833.6	1 264.1	216.3	368.0	129.1	4471	450
Area (sq km)	sq km	12368	9991	15826	6418	3258	1695	2358	3164	-	-
Population per sq km	no.	372.7	417.3	135.7	285.7	388.0	127.6	156.1	40.8	-	-

(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, whereas, 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	435	267	58	83	na	26	8	na	20
Survival incidents	no.	na	214	137	27	26	na	9	1	na	11
Survival rate	%	na	49.2	51.3	46.6	31.3	na	34.6	12.5	na	55.0
Adult cardiac arrests where resuscitation attempted (excluding paramedic witnessed)											
Incidents	no.	na	2 020	1 097	756	586	323	69	138	na	157
Survival incidents	no.	na	608	269	204	143	99	15	39	na	78
Survival rate	%	na	30.1	24.5	27.0	24.4	30.7	21.7	28.3	na	49.7
Adult VF/VT cardiac arrests (excluding paramedic witnessed)											
Incidents	no.	na	589	379	156	167	143	17	46	na	77
Survival incidents	no.	na	290	156	65	78	63	10	29	na	53
Survival rate	%	na	49.2	41.2	41.7	46.7	44.1	58.8	63.0	na	68.8

(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.