



“Trip Wired”

Tony Blaber, St John Director of Operations

(beating the rural transport challenge)



St John

first to care

What am I going to cover?

- Present situation
- Setting the scene, what are we dealing with
- Driving Hours Regulations
- Contracts
- Features of an ideal urgent transfer
- Key changes
- Visualising the rural challenge
- Additional resources
- Clinical Excellence Programme
- Summary

Present Situation

- **Many non-emergency IHT services delivered on the back of surplus emergency ambulance capacity**
- **Locations with critical IHT mass use dedicated IHT teams**
- **Immediate resource availability (vehicles and skills) is variable because of co-incidental demand**
- **Relay transfers mean escort return to base is logistically difficult**
- **Separate co-ordination of fixed wing services**
- **Insufficient formalised “user group” channels**
- **Inconsistent use of Roadside to Bedside ECCT structure**
- **Transport logistics change from changes in rural facilities**
- **“ambulance” often last link in the change management chain**
- **Driving hours regulations**
- **Safe working hours for other Health Professionals**

Setting the Scene – Key Dimensions

Data 1 March 2009 to 28 February 2010

	Northern	Midland	Central	Northern (SI)	Southern	Total
KEY DIMENSIONS						
Total Population Served	1,625,745	715,065	383,563	720,401	296,605	3,741,379
Total Land Area	22,678	45,292	28,113	86,136	65,994	248,213
Total Vehicles Dispatched	196,932	85,998	55,594	95,992	40,944	475,460
Total IH Transfers	26,776	9,776	6,444	8,134	4,363	55,493
<i>percentage IHT to total</i>	<i>14%</i>	<i>11%</i>	<i>12%</i>	<i>8%</i>	<i>11%</i>	<i>12%</i>
<i>square kms per transfer</i>	<i>0.8</i>	<i>4.6</i>	<i>4.4</i>	<i>10.6</i>	<i>15.1</i>	<i>4.5</i>
<i>IHTs per 100,000 population</i>	<i>1,647</i>	<i>1,367</i>	<i>1,680</i>	<i>1,129</i>	<i>1,471</i>	<i>1,483</i>

Setting the Scene – Patient Origin Hospitals

Data 1 March 2009 to 28 February 2010

	Northern	Midland	Central	Northern (SI)	Southern	Total
ORIGIN POINTS OF TRANSFER (that have recorded at least 1 job)						
Urban	18	19	14	13	13	77
Rural & Remote	14	10	3	24	6	57
<i>Area covered by origin locations (sqkms per origin)</i>	709	1562	1654	2328	3473	1852
"Rural Adjuster" Hospitals	3	8	5	14	6	36

Urban Service Area

(Main urban centres > 15,000 population – responses within city boundary as specified on service area map)

Rural Service Area

(Rural areas surrounding urban cities, or non-remote rural areas, or minor urban/provincial town centres <15,000 population as specified on service area map)

Remote Rural Service Area

(Very rural and remote locations as specified on service area map)

Setting the Scene – Clinical Priority

Data 1 March 2009 to 28 February 2010

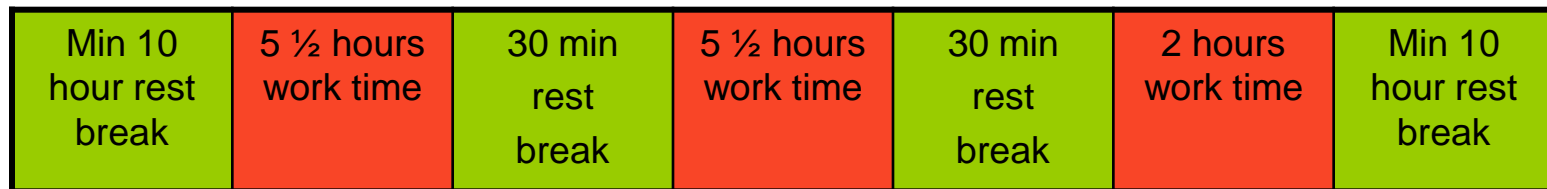
	Northern	Midland	Central	Northern (SI)	Southern	Total	
CLINICAL CARE / PRIORITY							
Life Threatened (ALS/P1)	789	147	30	66	19	1,051	1.9%
Urgent (ILS/P2)	1247	240	13	88	16	1,604	2.9%
Contracted Patient Transfer	24740	9389	6401	7980	4328	52,838	95.2%
<i>Total Transfers</i>	<i>26776</i>	<i>9776</i>	<i>6444</i>	<i>8134</i>	<i>4363</i>	<i>55,493</i>	
<i>P1 & P2 Emergencies %</i>	<i>8%</i>	<i>4%</i>	<i>1%</i>	<i>2%</i>	<i>1%</i>	<i>5%</i>	

Driving Hours Regulations

Maximum work time allowed

- > 13 hours in any 24 hour period (before a rest break of at least 10 hours is required)
- > The maximum work time permitted before a 30 minute break must be taken is 5 ½ hours

- > Below is an example of how this might work
> (using a standard 5½ hour period prior to a rest break)



Note: crews may be provided with their rest break earlier than 5½ hours to assist with all crews receiving their rest breaks in a timely manner.

Priority Medical Exceptions – medical emergencies in which the condition of the patient would or could deteriorate significantly if a member who was available but who was outside of their work time hours, was not asked to respond.

TWO PMEs permitted in any one shift with a limit of **FOUR PMEs** in any one block

Features of ideal Urgent Transfer

(applies also to non-urgent transfers)

- **Fast, error free booking and distance management planning**
- **Effective relationships between parties**
- **Good start-up communication between all parties**
- **Crew or escort available for duration to provide right care in transit**
- **Availability of other resource, right time, right place, safe etc**
- **Rapid and precise logistics planning for the job**
- **Communication with receiving hospital**
- **Patient (and escort) fully readied for transfer without delay**
- **Minimise relay transfers (minimum changeover time and handling)**
- **Good co-ordination between modes (road, helicopter, fixed wing)**
- **Set quality targets and aim for them**

Key changes in place/underway

- **85 additional ambulance officers into rural areas**
- **National Ambulance Sector Office**
- **Clinical Excellence Programme**
- **Logistics information from the field**
- **Better co-ordination of joint working**
- **Improving IHT booking and planning processes**
- **National IHT workstream project**
- **IHT desks in EACCs**
- **Advanced clinical oversight in EACCs**
- **Improved clinical audit of patient care**



85 Additional Ambulance Officers

In 26 rural locations to improve full crewing
and reduce reliance on “on-call” rosters

Cambridge

Dargaville

Foxton

Hastings

Huntly

Kaikohe

Kaitia

Kawakawa

Marton

Morrinsville

Napier

Ngaruawahia

Otaki

P North

Paeroa

Taihape

Taupo

Te Puke

Thames

Tokoroa

Waiheke Is

Waipukurau

Waiuku

Wanganui

Warkworth

Whakatane

Clinical Excellence programme

Continuing Clinical Education CCE

Four roles

- 3 with Authority to Practice**
- ALS – Post Graduate**
- ILS – Degree**
- BLS – Diploma**

Role specific education

- First Responder**
- IHT**
- EACC**

In Summary

SO

- Improving, with still some way to go
- Further progress to arrive at better solutions
- New / different relationship / collaboration needed
- Maybe more funding needed or just work smarter

BUT

- Can we think differently to work this rural service smarter?
- What transformational ideas are there at this conference
- What processes do we put in place to achieve change

AND

- Can we take the theme of this session “Trip Wired” and really get “wired” together to work on this



Thank you for your time



St John
first to care