

The New Zealand Ambulance Service Strategy

Summary Report Part 1

Summary of Findings and Analysis from Consultation

13 February 2009

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Introduction

The New Zealand ambulance services are justifiably proud of the service they deliver within existing constraints. The New Zealand Ambulance Service Strategy was developed to provide a mechanism to address and manage these key features:

- There is a high-risk nature to the ambulance service, which has meant that problems in the sector routinely end up as high profile media stories or, on occasion, Parliamentary inquiries.
- Stretched resources have led to a clinical management infrastructure that has struggled to proactively address those same risks.
- As a key gatekeeper and initial contact for the rest of the health system, the treatment decisions (getting it right) and transport decision (to the right place, if transporting at all) have significant consequences for patient outcomes, future cost, and overall system performance.
- While standards have been adopted, the funding levels from different Crown entities have not been sufficient to achieve those standards, resulting in lack of clarity in performance expectations and mixed signals from the Crown.

The New Zealand Ambulance Service Strategy represents an opportunity to make progress on an important public service, and in which perhaps, the most important first steps entail role clarification and leadership.

To progress these important goals, the former Ministers of Health and ACC released the draft New Zealand Ambulance Service Strategy for consultation on the 15th September 2008. Written comments were solicited from interested parties on the draft strategy, and the consultation process concluded on the 12th December 2008. Officials had determined that the draft strategy would be modified based on the submissions received, where there was a weight of support for change or where the views submitted otherwise made plain sense.

Overall there was widespread support for the draft strategy; this support included the need for a strategy and for the actual strategy itself. While there were several respondents who indicated that it seemed like just another version of what had been attempted previously with no success, there was quite wide support for the vision expressed in the strategy. This analysis summarises the submissions into consistent themes.

In parallel with the consultation process, a sector engagement process was undertaken to define the sequence of action steps to progress the strategy should be undertaken. The report on that process is more focused on steps that may be taken to address the issues identified in this report, and as a result should be viewed as a companion to this one.

Results

Sixty seven (67) submissions were received. These came from individuals such as clinicians, paramedics and members of the public to organisations. Organisations responding included but were not limited to: The Ministry of Civil Defence, Department of Internal Affairs, the Fire Service, St John, Ambulance New Zealand, local government, medical organisations, organised labour, several District Health Boards and departments of them such as Emergency Departments.

A small number of submissions expressed concerns that wider sector interest groups should have been involved in the draft strategy development.

Principal Themes

Three main areas from the draft strategy generated the most comment and interest; These are summarised below

- ***Strategic Leadership of the Sector.*** There were varying views on what this actually meant and what was required. Submitters were clear, though, that a single ambulance voice is required, *“The significant fragmentation of the sector remains a huge hurdle on the path to achieving the goals”*³² There were widespread calls for some form of ‘bringing together’ of the divergent delivery of ambulance services. These ranged from calls for underpinning legislation, an ambulance commission, a national ambulance service, a single provider or to be put under a body such as the fire service. *“New Zealand requires a service free of provider self interest”*⁵⁶

All seem to agree that this can only be achieved by ‘somebody’ exercising leadership. *“This [achieving the initiatives] will require targeted leadership, not excessive bureaucratic ‘out of sector’ resourcing within Crown agencies”*⁶² Many of the respondents urged the Crown to take responsibility for this leadership and provide the direction they claim is so desperately needed *“The importance of the Crown taking a key leadership role at last is essential as nationally the ambulance sector has been largely rudderless”*⁶⁷

Leadership was also widely seen as a foundation before any progress can be made on the other initiatives within the draft strategy which are required to improve the status quo. *“strategic management and leadership is necessary to inform all other decisions”*¹⁴

Whilst there was not unanimous agreement of what the future leadership and management function should actually look like, there was wide agreement that it was required. Both sector representatives and other submitters were clear

³² Joint Faculty of Intensive Care Medicine

⁵⁶ New Zealand Ambulance Association

⁶² Ambulance New Zealand

⁶⁷ Hawke’s Bay Helicopter Rescue Trust

¹⁴ Canterbury District Health Board West Coast Emergency Care Coordination Team

and consistent in saying that the lack of leadership needs to change and the sector needs it now.

- **Funding.** There has been widespread input about the problems with funding in terms of the amount and how it's divided amongst providers. There were many calls for urgent attention to increase funding for ambulance services. It was clear that there were considerable concerns from medical professionals about the availability of ambulance services for their patients.

“Our rural GPs have to deal with many challenging situations...when they have to sit for up to three hours with a patient (often in the middle of the night) while awaiting the availability of an ambulance for transport to Dunedin it is bad for the patient, an inefficient use of health provider resources and impacts on patient outcomes”³⁸

This point is not lost on the providers of these ambulance services either:

“The current funding arrangements do not provide certainty and consistency and do not allow strategic development...In order to progress meaningfully (in both the long and short term) the current low levels of funding needs to be acknowledged”³⁰

St John also drew attention to the finding of the Health Committee inquiry into the provision of ambulance services in New Zealand 2008 which discussed funding “*the majority of us consider that moving to a single stream of public funding, as proposed by some submitters, would address many of the concerns they raised*”³⁰

- **Clinical Standards.** It was clear from the responses that there are many people in the sector with a very real passion for patient-centred clinical improvement in the provision of the ambulance service.

There was overwhelming support for the initiatives that focussed on clinical aspects of the strategy. Most submitters identified this as necessary to achieve desired service reliability. Not only is this finding admirable, but also appears to be well supported from a risk management point of view:

“In my final report, I stated that the ambulance service did not have ‘adequate medical back up for services’ and that ‘the failure to have adequate medical support indicates lack of reasonable care and skill and is a breach of Right 4 (1) of the Code’⁶⁸

A very strong group of respondents submitted their views on the clinical aspects of the ambulance service and this has resulted in clear and consistent direction in this area.

²³ Auckland University of Technology Paramedicine and Emergency Management

³⁸ Aspiring Medical Centre

³⁰ St John

⁶⁸ Health and Disabilities Commissioner

“Consumers have the right to expect the same standard of care nationwide, irrespective of where they access ambulance services and who is providing the service. Consistency in clinical protocols also enables quality monitoring of performance, and standard delivery of education. A national clinical advisory group is necessary for seamless delivery”²³

The notion of the need for a national clinical advisory group was well supported; although such a group exists currently, it may well need some changes to better represent all stakeholder and Crown interests

“Practically these (clinical standards) should be defined by a multidisciplinary panel of experts in clinical care and trauma epidemiology, and supported by much higher levels of training of pre-hospital personnel... this group must also have influence in the hospital and post hospital-setting.”²⁰

A number of respondents highlighted the need for standards to be set and to be monitored. There was good support for mandating the standards and many suggested that the New Zealand Standard NZS8156 should be the benchmark. There was also substantial comment around the need to separate organisational performance measurements from patient outcome measures and caution on how these should be adopted. There was unanimous support for professional registration of paramedics with some calling for this to extend to all ambulance officers.

²⁰ Dr Grant Christey Trauma Surgeon Waikato Hospital

Analysis of Submissions by Initiative

Strategic Leadership: ensure that the ambulance sector has clearly defined roles in the emergency and health sectors

Initiative 1:

Form an accountable ‘strategic management’ function to provide strategic leadership to the sector

This initiative was widely commended and supported by respondents from many quarters. A widely supported form of how this ‘strategic management’ function should be composed in the future was similar to the current temporary structure under the National Ambulance Sector Office (NASO) to provide ongoing leadership to the sector, advice to government and to progress the ambulance strategy. *“Agree with the concept of a national group that is responsible for the strategic planning of ambulance services across New Zealand”*³²

Other options identified included a national ambulance service under an “Ambulance Commission”, a single provider led structure (St John) and that ambulance should be placed under an existing body such as the Fire Service Commission, or controlled through existing DHB-PHOs.

Initiative 1 therefore could be reworked with the objective of setting up a clearly defined unit within Government to progress to address the ambulance sector.

Initiative 2:

Develop transparent, sustainable funding model(s) that link external drivers to agreed service expectations

Respondents were consistent in their views on this initiative. The themes that were echoed by other respondents around funding could be grouped in the following categories

- Immediate under-funding needs addressing now
- Per patient funding model should go (move to bulk single funder)
- Part charges should be removed
- Charitable basis of some providers should be done away with
- Government to assume all costs

The first two of these are discussed in detail below.

With regard to overall funding levels, there was widespread agreement that current levels are inadequate.

“The NZFS strongly submits that the strategy will not achieve its stated objectives unless appropriate and realistic resources are allocated to its implementation. Any partial effort in this regard will certainly result in mediocre outcomes at best”²⁷

“Funding must be on a per capita basis reviewable every 3-5 years .. Must start at a minimum of \$60 to enable a world class standard”²²

The paradox of per-patient funding as an encouragement to transport vs. overloaded emergency departments was also an emerging theme. This wasn't just from an ACC perspective where the per-patient funding was seen as an issue, but also from a medical patient view, where overall funding is subject to a degree to how many patients are transported:

“Firstly the ambulance operators, who act as a gatekeeper in terms of who gets an ambulance, need as many calls as possible to earn as much money as possible. Secondly the hospitals who are becoming increasingly overloaded with patients want to see only those patients deserving of its services”⁵⁶

This again is an incentive to providers to transport the maximum number of patients but counter productive to reducing the load on emergency departments.

Initiative 2 has sound support from respondents and this would indicate that the majority of this initiative could remain but requires more coherent actions that lead to transparent model development.

Initiative 3:

Develop outcome performance indicators to monitor the contracted performance of providers

The support for performance monitoring was widespread, however there was caution urged, particularly from clinical specialists, around what should actually be measured. It was deduced from responses that it could be worthwhile clearly separating the organisational performance measures (provider) from the clinical patient outcome measures, albeit some links will always be required.

“Outcome based performance indicators will need to be carefully considered and clinically relevant, but are urgently required to monitor the performance of contractors. Mandating the standard NZS 8156 would seem to be a reasonable first step toward ensuring national uniformity of quality in the sector”³

A great deal of interest in the clinical aspects of the strategy was received and for this reason it is discussed in Initiatives 5 and 7 in this analysis that the clinical (patient focus) initiatives that exist in more than one area of the draft strategy be grouped together. There was wide support for mandating the New Zealand Ambulance Standard NZS 8156.

²⁷ New Zealand Fire Service

²² (Privacy Act no release of identity requested)

⁵⁶ New Zealand Ambulance Association

³ Royal Australasian College of Surgeons

It could be that no substantial changes are required to initiative three other than delineating organisational performance measures from patient outcome measures.

Community Resilience: deliver a long-term plan for meeting community emergency health needs

Initiative 4:

Develop a framework to facilitate effective consultation with the community on long-term planning.

There were considerable supporting responses that endorsed the importance of this initiative, particularly from the rural sector that raised concerns over resourcing and fears that the strategy will be treated as a one “size fits all” approach. Some respondents believed there needed to be more specifics on “how” the consultation will be achieved. *“There needs to be a clearer articulation of the strategy for community consultation”*³ St John believe that their structure already contains a community consultation process and this was supported by several other respondents.

Initiative 4 therefore could remain as it is in the strategy with strengthening of the specifics.

Initiative 5:

Improve the level and extent of clinical expertise and the sustainability of the paid and volunteer workforce

There was overall a very strong support for setting of clinical standards and also for performance setting and monitoring of providers and clinical standards based on patient outcomes, though caution was urged for use of response times as a measure or performance alone. It was also a widely held view that one national set of qualifications and protocols recognised by all be established. *“AUT fully supports consistency in clinical protocols across all New Zealand pre hospital care ambulance providers...back to a national protocol system in the immediate future,”*²³

There was mild dissent from the rural sector that some variation will always be needed to protocols based on local need.

Many responses discussed staff issues across both the paid and volunteer components. The very notion of the relevance of the use of volunteers in what is becoming an increasingly complex role was questioned, as was the sustainability of the volunteer workforce. Equally, however, there were submissions from a variety of quarters that showed strong support for the continuing role of volunteers. Some offered suggestions on how volunteers could be better trained, utilised more efficiently and appropriately, better supported and even remunerated for callout time.

“The capability of our current workforce is of significant importance to the overall delivery of Ambulance service to New Zealanders and we believe we currently have

³ Royal Australasian College of Surgeons

³² Joint Faculty of Intensive Care Medicine

²³ Auckland University of Technology Paramedicine and Emergency Management

significant gaps-both in terms of what is and what should be provided, and in terms of our work force's current competencies in relation to their expected level of capability”³⁰

Issues over attracting new paid staff emerged to a small degree, as did the need to consider structured remuneration and standard employment conditions. A moderate number of respondents from a variety of quarters cite the need for all ambulances to be double crewed, this ranged from two paid qualified ambulance officers, to other alternate methods, use of less skilled volunteers as drivers only to trainee or new doctors in rural areas, nurses and fire-fighters.

Union respondents and some individual staff responding cited that the Health Select Committee formation was originally in response to calls for full crewing and that this has been overlooked.

Because of the strong views held in this initiative it could be better divided into two separate areas, clinical standards (to be become initiative 7 and paid and volunteer workforce to become initiative 5). Clinical standards emerged as one of the top three priorities for sector improvement.

Initiative 6:

Improve the integration of the ambulance sector into the New Zealand emergency management planning system

Respondents did not raise many issues over any of these initiatives which would require significant change to these actions. There was some voice to support wider integration into emergency management through the civil defence emergency management agencies.

“Imperative that emergency services work together, fire and ambulance to provide this essential service to the community. In many cases the volunteers in rural towns are often the same people. Providing separate infrastructure is costly and distracts from the core work of volunteers.”⁶

“The New Zealand Fire Service is of the view it makes sound sense in smaller communities with limited resources to combine fire and ambulance resources (including volunteers) where rapid intervention will make a difference to clinical outcomes. Such initiatives would include co-location where possible and may require the use of incentives (including funding) to ensure it occurs”²⁷

It would appear appropriate that this initiative remain unchanged from the draft strategy.

Seamless Delivery: Integrate ambulance services within the wider health sector

³⁰ St John

⁶ Westland District Council (Mayor Maureen Pugh)

²⁷ New Zealand Fire Service

Initiative 7:

Develop protocols for integrating national care pathways, and extending the role of the paramedic

As noted above in initiative five, this topic (clinical standards) created a significant comment, almost all of it supportive and wanting to see standards achieved as a priority.

“A clinical oversight group will be essential to this process...this group must also have influence in the hospital and post-hospital settings. It should sit outside NASO but have a defined relationship”²⁰

The second part of the initiative (extending the role of the paramedic) although enlisting some support was not seen as a priority in the short term. A number of submissions outlined that it was more important for the ambulance sector to be focusing on pressure points and fixing issues before attempting wider responsibilities or roles.

“We do not see extending the role of the paramedic into primary health care and health promotion as a priority or even as being necessary. Please focus on providing a good service in your core business”³⁸

As noted in five (above) it could be best that all clinical focused initiatives and actions are assembled in one area, and further that the extended role of the paramedic action be given a lower priority so far as timeframes are concerned.

Initiative 8:

Introduce sector-wide information capability for evaluating health outcomes

There was general agreement by respondents that the ability to improve information systems would be a good step. This was linked to other initiatives within the strategy to better integrate the ambulance sector with primary health so that patient information could be available to ambulance staff and also that ambulance attendance information should be available to GPs, right through to hospital information.

“It is draconian that ambulance officers and paramedics are expected to establish a provisional working diagnosis to ensure appropriate treatment is instituted for patients that have been under DHB care and recently discharged without the access to current health information. This makes their job more difficult and potentially compromises their clinical decisions because of the inadequate information sharing”²³

And from the Health and Disabilities Commissioner:

²⁰ Dr Grant Christey Waikato Trauma Surgeon

³⁸ Aspiring Medical Centre

²³ Auckland University of Technology Paramedicine and Emergency Management

“In opinion 98HDC15374, I assessed the quality of communication between the ambulance service and the Emergency Department staff of a public hospital. My investigation revealed that ‘serious communication breakdowns’ between the two parties had detrimentally affected the service provided to the consumers. I noted that ‘liaison between agencies involved in complementary services is vital to ensure the quality and continuity of services’. By failing to liaise adequately with other health providers, the ambulance service breached Right 4(5) of the Code”⁶⁸

There were some issues raised around the Privacy Act requirements, and how the ambulance sector would manage that. Overall, though, there was no opposition to the initiative.

Initiative 8 therefore could concentrate on the issues around sharing of information between ambulance services, primary and secondary health such as the development of electronic patient reports and ready availability of information for those making clinical decisions.

Initiative 9:

Improve ambulance service configurations and deployment.

There was quite substantial comment on this initiative although some of it was more general than specific to the actual strategy. The rural sector was quite strong about the need for consultation with them about improvements they see as vital in the immediate short-term. Many respondents talked about better ways of using volunteers, and better use of qualified staff. A number of submissions raised the issue of double (full) crewing both from a staff and patient safety perspective.

Exposure to increasing violence, co-morbidity issues, multiple crashes etc. along with public expectations for high level intervention make double crewing essential for the safety of both patients and crews”⁴⁰

With regard to the rural sector resourcing initiatives, it seems respondents want to see them more strongly integrated in the strategy and are very concerned a “one size fits all” approach will be applied. These respondents want to be involved in future strategy development. They voiced concerns over the Primary Response in Medical Emergencies (PRIME) programme, support of volunteers and resourcing and have some very valid ideas for solutions. They strongly support volunteers but have concerns over their support and appropriate use.

This initiative could be enhanced around how the ambulance sector will achieve better use of resources in the future. Also, that the full crewing issue is addressed both in this initiative but also linked to the proposed new initiative 5, and be called “Improve the sustainability of the paid and volunteer workforce and investigate other staffing models”. It could also be necessary that some action of rural consultation is included.

⁴⁰ New Zealand Nurses Association

⁶⁸ Health and Disabilities Commissioner

**Initiative 10:
Strengthen triaging to ensure interventions accurately reflect the patient’s
condition**

As has been recommended above in initiative seven of this analysis, this initiative is well supported by respondents and a need for this group to overview Emergency Ambulance Communications Centres (EACCs) and other clinical governance has widespread support.

Those submissions received that related to the EACCs were almost all negative, citing widespread problems with systems. These comments came from ambulance staff and primary health.

“The three Emergency Ambulance Communications Centres are not co-located with Police and Fire Service Communications Centres, which leads to delays in medical and general assistance calls being placed to allied emergency services that may make a critical difference to patient outcomes. Co-location of EACC with the two other emergency service organisations is a priority. The CAD systems used by EACC are unable to interface directly with the different system utilised by the two statutory created emergency services”²²

There were suggestions to co-locate these resources with Police and Fire urgently, and to review the use of technology. Some responses indicated anecdotal evidence of their negative experiences with the EACCs which have caused them frustration.

As noted in 5 and 7 above the clinical advisory group as outlined in action one of this initiative could be included in new initiative 7 in which it is proposed that all clinical initiatives and actions could be grouped together for alignment.

It should be considered that this initiative is strengthened to improve mechanisms within EACCs.

²² (Privacy Act no release of identity requested)

Other Issues Emerging Outside of Draft Strategy

Some other themes emerged from the submissions that did not neatly fit into the draft strategy or the themes identified above. Those themes that were not specifically related to the strategy included:

1. Rural issues
2. Employee-employer issues
3. Anti-St John sentiment
4. Use of volunteers

Single voice and strongly divergent views were recorded and some are discussed by way of comparison within this paper.

1. Rural Issues

A number of submissions related to the provision of ambulance services in the rural sector. Several respondents were concerned that “*a one size*”¹ fits all approach would be used in allocating resources in this sector. Others cited problems with the current response levels with comments like

*“it is especially important for us that differences between urban and rural needs are recognised”*⁴⁴ and *“any nationwide strategy needs to make specific note of the needs of rural community which by virtue of remoteness and low population density can not be fairly resourced on a population based model”*⁵⁰

2. Employee-Employer Issues

Several respondents indicated they were current or past employees or volunteers and cited many perceived problems with the ambulance sector and in particular provider performance. These ranged from purely employer-employee relationship issues to claims of mismanagement of resources and incompetence. From a volunteer perspective there were issues surrounding the lack of support and mistreatment. To the extent these claims were able to be related to initiatives with the draft strategy or emerging themes, they have been noted in that context.

3. Anti-St John Sentiment

As in section 2 above, several respondents were current or past employees of St John. Their responses were negative towards St John. They voiced their displeasure at how they perceive St John operates.

Where these comments have been relative to the initiatives or emerging themes, which some were, they have been included.

5. Use of Volunteers

¹ Several Respondents

⁵ (Privacy Act no release of identity requested)

⁴⁴ Rural GP Network

⁵⁰ Wanaka Medical Centre

Distinct threads of submissions were received surrounding the issue of the volunteers within the ambulance service. From one end of the spectrum “*the whole question of appropriateness of sending volunteers to at times life threatening event[s], has to be debated in this country*”⁵. The other end of this spectrum was very widespread support for the role and contribution that volunteers deliver. A moderate number of respondents were concerned about the on-going viability due to retention challenges and the training commitment.

There was a reasonably consistent theme and support for better reimbursement of actual costs for volunteers training needs, and time spent on callout. This was particularly so in the rural sector where longer transport times were required. There were also suggestions on more appropriate use of volunteers such as a lesser requirement for medical qualification and restricted use in driver only roles to assist with full crewing achievement.

Methodology

The Consultation Process

Outreach

These efforts included:

- Inform stakeholders that consultation was underway
- Inform stakeholders of the purpose of this consultation
- Provide stakeholders with an overview of the key areas covered by the proposed strategy
- Inform stakeholders of the process, the timings, where to find the consultation document, how to make a submission and where to direct enquiries arising from the consultation.

Soliciting Input

Stakeholders. Many stakeholders were invited to make submissions on the draft ambulance strategy by way of letter which outlined the strategy process and invited participation. These stakeholders were selected from the known interest group constituency nationally which included:

- The Minister of Health and the Minister for ACC
- Treatment provider organisations within the ambulance sector who have a contract with ACC
- District Health Boards (clinicians, departments, management)
- Primary Health Organisations
- Other emergency services (Police, Fire, Civil Defence, Coast Guard)
- Ambulance Interest Groups (unions, associations)
- Ambulance Service Field Staff (middle management)
- Air Sector (governance, management)
- Medical Professional Groups Representative bodies (Surgeons, GPs)
- Local Government (Councils, Mayors)
- Sector sponsors and funders
- Private donors

The Public. In addition to the stakeholders engaged, the public were also invited to make submissions on the draft strategy. The notification of the consultation process was achieved in two ways: The first was by advertising in mainstream print media (newspapers), and the second was by way of a proactive media release. A media liaison person was nominated, and that person answered questions about the process made clarifications about the strategy. Media staff did not engage in discussion about what might come out of the consultation.

Internal Audiences. It was also identified during the communication planning process that internal staff audiences from ACC and MOH could add value to the process by being aware of the consultation process being underway.

For this reason internal communication was undertaken both in staff newsletters, emails and intranet pages. Staff were provided with the same information on the process and access to further information.

Staff from both organisations have regular contact with people in the sector, and may have previous or present interest in the sector so as to be able to contribute to the consultation.

Communication

The letters sent to stakeholders, press releases and other public announcements invited comments on the strategy by making a written submission directly to Government by post or by visiting the website of the National Ambulance Sector Office (www.naso.govt.nz). Written submissions were provided on a form with the draft strategy and asked eight questions to elicit views and feedback on the proposed ten initiatives. These questions are listed below.

In addition, the National Ambulance Sector Office invited sector participants to attend one of the 15 sector engagement meetings held nationwide to discuss the sequence of action steps to progress the strategy. The process used and results attained from those meetings are summarised in a separate document.

The Questions Asked in Consultation

1. Do you support the draft strategy's vision for the future of the ambulance sector in New Zealand?
2. Does the draft strategy identify the right goals for the ambulance?
3. What do you think about the initiatives for change under the Strategic Leadership goal?
4. What do you think about the initiatives for change under the goal of Community Resilience
5. What do you think about the initiatives for change under the goal of Seamless Delivery?
6. What do you think are the three most important initiatives to progress immediately and why?
7. Is there anything you feel is missing from the draft strategy?
8. Is there anything you feel should be added to the draft strategy?

Respondents were able to advise if they permitted release of their submissions pursuant to the Official Information Act or if they wished to retain anonymity.

The consultation process was open for submissions on the 15th September 2008 and officially closed on the 12th December 2008. To be as open as possible, extensions to this time frame were granted where requested by several respondents.

The Evaluation Process

All submissions were collated, numbered and an acknowledgement of receipt sent to the respondent either electronically or by mail, depending on contact information provided. All responses were analysed and the relevant clear views were categorised firstly by question number with other emerging thematic issues grouped into additional categories of information for further analysis.

This paper groups the responses to coincide with the ten initiatives contained within the draft strategy

The on-line responses were largely easy to categorise into the analysis spread sheet and followed a logical sequence. A number of other written submissions received did not follow the on-line format and were dialogue based. For these responses, they were analysed and where possible grouped into the eight question areas, or grouped into the other emerging issue areas. A number of responses could be described as single issue and were generally views of such things as minimum crewing levels, clinical considerations and employment-volunteer issues.

A number of respondents also included other papers such as their previous submissions to Select Committees or other papers with substantial detail and relative work. Much of this information should be referred to or called upon in future development of the initiatives rather than re-inventing the wheel where sound research has already been completed. A number of respondents also expressed wishes to be involved in future strategy development, such as clinician groups and some other interest groups.