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16 December 2020

L. Nichols

By email: fyi-request-13450-e9de384c@requests.fyi.org.nz
Ref: H202007785

Dear L. Nichols

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) which was transferred by the Central Region Technical Advisory Services Limited (TAS) to the Ministry of Health on 14 October 2020. On 12 November 2020, the due date for responding to this request was extended under section 15A of the Act, as further consultation was required.

You asked for information relating to the Ambulance Service Level Collaboration Charter (the Charter) and the Terms of Reference (the ToR). You also requested information relating to the 'New Zealand Ambulance Sector Design Working Group'. I wish to inform you that the latter group does not exist.

The Ambulance Service Level Collaboration was set up to strengthen the interface between key funders of ambulance services. The key funders are the Ministry of Health, Accident Compensation Corporation (ACC) and the 20 district health boards (DHBs).

Your request included named individuals who are not connected to the Collaboration, but who are members of a Clinical Governance Design Working Group (CGD Working Group). The CGD Working Group was established by the National Ambulance Sector Office (NASO) to consider and advise on how 'clinical governance' can better operate as part of the emergency ambulance sector and improve the quality of patient care. There is no direct relationship between the CGD Working Group and the Ambulance Service Level Collaboration.

A copy of your full request and information in response to each question is outlined in Appendix One of this letter.

I trust this information fulfils your request. Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry of Health website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Yours sincerely

Clare Perry
Acting Deputy Director-General
Health System Improvement and Innovation

Appendix One

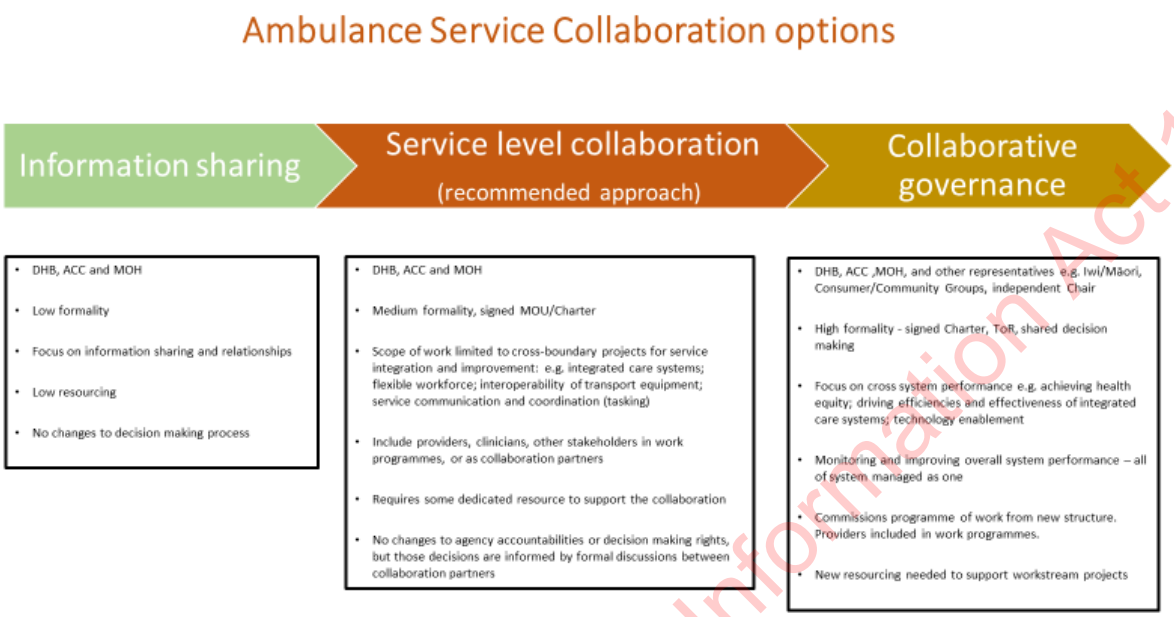
#	Requested information	Response
1	*"Please provide a copy of the Final Draft of the Ambulance Service Collaboration Charter ("The Charter") and the Terms of Reference for this Collaboration ("The ToR")."*	The Charter and ToR for the Ambulance Service Level Collaboration are available at: https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/national-ambulance-sector-office-naso/emergency-ambulance-services-eas/ambulance-service-level-collaboration. This part of your request is therefore refused under section 18(d) of the Act, as the information requested is publicly available.
2	*"Please provide any briefing papers, internal memos and discussion documents relating to the Charter and the TOR."*	One document titled *'Options Paper – Collaboration Charter and Terms of Reference – June 2020'* has been identified in scope of this part of your request. This is being released with some information withheld under section 9(2)(g)(i) of the Act, to maintain the effective conduct of public affairs through the free and frank expression of opinions by or between members of an organisation during the course of their duty. This was a working draft that provided options for consideration on the form and function of a collaborative arrangement between the three ambulance funders, that being ACC, the Ministry, and the 20 DHBs facilitated through TAS.
3	*"Please disclose authorship of The Charter and The TOR. If external input from other groups, agencies or organisations has occurred directly or indirectly, in making contributions to The Charter and/or The TOR, please make this clear, on a section by section basis where possible. Please outline on what basis such input has been used."*	The contributing authors of the Charter and the ToR were ACC, the Ministry of Health, and the 20 DHBs facilitated through TAS. TAS is an agency of the 20 DHBs.

4	*"If The Charter and The TOR have been shared, published, socialised or disclosed elsewhere, with any individuals, organisations or groups outside the NZ Ambulance Sector Design Working Group or TAS, please disclose this, AND which individuals, organisations or groups these documents have been shared with (eg professional associations, clinical networks, professional medical colleges, or committees/subcommittees of any of those bodies or groups). Please also disclose in each/any instance where this has happened, the date when The Charter and The TOR have been first made available to such individuals, organisations or groups."*	There is no 'New Zealand Ambulance Sector Design Working Group'. There is a CGD Working Group, which is a NASO-initiated group to consider and advise on how 'clinical governance' can better operate in the emergency ambulance sector and improve the quality of patient care. There is no direct relationship between the CGD Working Group and the Ambulance Service Level Collaboration. As noted in the response to part 1 of your request, the Charter and the ToR for the Ambulance Service Level Collaboration were made publicly available on the Ministry of Health website on 8 October 2020. Prior to being made publicly available, the Charter and the ToR were not shared with any other party outside of ACC, the Ministry of Health and the 20 DHBs facilitated through TAS.
5	*"If The Charter and The TOR have not been made available to other representative bodies for all the relevant and readily identifiable medical (PRIME GPs, General Practice, Urgent Care, Rural Hospitalist Doctors, ICU, Anaesthetics and Emergency Medicine Specialist representative groups or professional colleges), nursing (NZNO, COASTN) and paramedic (St John Ambulance, Wellington Free Ambulance, and the many aeromedical provider organisations) sectors in NZ, please clarify who made this decision, and on what basis."*	As noted in the response to part 1 of your request, the Charter and the ToR for the Ambulance Service Level Collaboration were made publicly available on the Ministry of Health website on 8 October 2020. Prior to being made publicly available, the Charter and the ToR were not shared with any other party outside of ACC, the Ministry of Health and the 20 DHBs facilitated through TAS. The Charter and the ToR guide group members that are party to the Ambulance Service Level Collaboration. These parties include the Ministry of Health, ACC and the 20 DHBs as they are the key ambulance services funders.
6	*"In addition, if The Charter and The TOR have not been made available to the member organisations of Ambulance NZ, please clarify who made this decision, and on what basis."*	

7	*"Please clarify the role TAS have had in developing The Charter and The TOR, and the role that TAS have had in any decisions to disclose, share, publish or socialise these documents outside TAS and the NZ Ambulance Sector Design Working Group."*	As an agency of the 20 DHBs, the role of TAS during the development of the Charter and the ToR was to coordinate their feedback. The CGD Working Group is a NASO-initiated group to consider and advise on how 'clinical governance' can better operate as part of the emergency ambulance sector and improve the quality of patient care. The CGD Working Group is not involved in the 'ambulance collaboration' that is the subject of this request for information and is not involved in wider 'Ambulance Sector' design. As noted in response to parts 4, 5 and 6 of your request, the Charter and the ToR for the Ambulance Service Level Collaboration were publicly released on the Ministry website on 8 October 2020.
8	*"Please clarify if TAS staff have reviewed a copy of the Conflict of Interest register for either the NZ Ambulance Sector Design Working Group, or any other groups or organisations that The Charter or The TOR may have been shared with, AND if these COI registers have been considered in making decisions to disclose/share The Charter and/or The TOR."*	The CGD Working Group is a NASO initiated group to consider and advise on how 'clinical governance' can better operate as part of the emergency ambulance sector and improve the quality of patient care. The CGD Working Group is not involved in the 'ambulance collaboration' that is the subject of this request for information and has not been involved in wider 'Ambulance Sector' design. The Charter and the ToR were not shared with the CGD Working Group.
9	*"Please provide all emails, either to or from staff in TAS, in relation to developing, and in relation to sharing, disclosing, publishing or socialising these documents outside TAS and the NZ Ambulance Sector Design Working Group, including all emails to or from the members of the NZ Ambulance Sector Design Working Group on these matters, from January 1 2020, until the date of this request. (The members of the NZ Ambulance Sector Design Working Group are Mr David Waters, Dr Alex Psirides, Dr Tony Smith, Dr Grant Christey, and Ms Norma Lane)."*	The 'New Zealand Ambulance Sector Design Working Group' does not exist. The Ministry has no record of any communication between the Ambulance Service Level Group and the CGD Working Group (Mr David Waters, Dr Alex Psirides, Dr Tony Smith, Dr Grant Christey, and Ms Norma Lane) nor any record of documents or emails concerning the Charter of the ToR being disclosed, shared, published or socialised with the CGD Working Group. As such, this part of your request is refused under section 18(g) of the Act, as the information requested is not held by the Ministry or another agency subject to the Act.
10	"Please provide all emails on this AND on all other matters, either to or from TAS Staff, to or from the members of the NZ Ambulance Sector Design Working Group, in relation to this or any other matters, from 1 January 2020 until the date of this request."	

At the last meeting of the executive leads, the following decisions were made:

1. To initially focus the collaboration on the middle of the options below, with the desire to move to a more inclusive collaborative governance model over time. Suggested timeframe was 12-18 months.



2. To appoint an independent Chair.
3. To provide a modest resource for secretariat support, location TBC.
4. Not to include broader participation immediately, but expect the individual organisations leading each project to apply the RASCI approach to identify what groups should be included and how.
5. That additional consultation with DHBs was not required before the collaboration was put in place.
6. That success of the collaboration would be measured by increased trust and resilience, having clear deliverables and outcomes, funding and service delivery being determined by need not driven by providers,

Ambulance Service Collaboration Charter

Charter Statement

This document outlines our shared commitment, objectives and the key principles and rules of engagement for the Ambulance Service Collaboration (the "Collaboration") and may be used by any other network/group within the Collaboration.

Question 1: Is there agreement that this ambulance governance charter may be used across all levels/structures of the ambulance system?

Question 2: Should the charter statement reflect the starting point (service level) or desired end point (broader cross sector model)?

Option one – reflects progression from initial service level	**Option two -reflects end point of inclusive model and service level as interim**
The Collaboration is a service level collaboration focused on projects that advance service integration and improvement. It is expected that the collaboration will evolve toward a more inclusive and collaborative governance structure with a wider scope once the current parties have been able to demonstrate its effectiveness.	The collaboration is an inclusive collaborative governance structure. As it will take some time to establish this model, the interim form of the collaboration will include only the Ministry of Health, ACC and DHBs.

The Collaboration is directed by members who have been appointed by their organisations to work collectively towards the Collaboration's goals. Members are not appointed as representatives of specific organisations or communities of interest, but because collectively they provide a range of competencies required for the Collaboration to achieve its mandate.

Question 3:

Is this description of non-representative membership desirable? What implications does it have for how parties nominate members? What implications does it have for the future state of the collaboration where members will be specifically carrying a position or view of the group they represent (for example iwi or consumer members)

Parties

The parties to this Collaboration are the Ministry of Health, the Accident Compensation Corporation and the 20 district health boards.

Purpose of this Charter

The purpose of this Charter is to guide the Collaboration's organised approach for transformation change that will ensure ambulance services are sustainable, safe and an effective part the wider health system, contributing to better health outcomes for all New Zealanders.[1]

[1] In pursuit of this purpose, the parties will have regard to the the goals of the NZ Ambulance Service Strategy (2010), and the broader objectives of the NZ primary care, health and disability strategies

To do this the Collaboration will focus on system improvement and performance of ambulance services, including:

Question 4: Should the purpose be limited to what is within the direct influence of the parties, or expanded to wider sector goals?

Option One: a more limited purpose • improving integration across systems and services • improving information transparency and ambulance service funding approach	**Option Two: a more expansive purpose** • improving equity of access for Maori, rural and vulnerable populations • improving patient health outcomes at a population level • improving integration across systems and services • improving information transparency and ambulance service funding approach • managing strategic relationships across ambulance services, the health sector, and professional's Colleges.

Strategic Goal and Priorities

The Collaboration's goal is to support increasingly integrated and coordinated ambulance services that cross boundaries between primary, community and hospital services, delivering a seamless patient journey that is implemented within a 'Best for Patient, Best for System' approach.

Question 5: Does the goal/priority statement above need to be expanded by the options below and is it fair/reasonable to measure the success of the collaboration against the achievement of these goals?

Option One: MOH, ACC and DHB health priorities	**Option two: some or all of the following statements** The Collaboration will achieve this goal through the initial phase of establishment to a full ambulance service collaboration by: • aligning our strategic areas of focus to government health priorities and • driving efficient, effective and safe services to support good clinical governance, innovation and plan collectively how to increase operational efficiencies • building capacity and capability of air ambulance services and transport systems at local, regional and national levels • enabling data and information sharing to improve equity of access to air ambulance and health services.

	• striving for equitable access to ambulance and healthcare services across all populations

Scope

The scope of the Collaboration is the interface between primary care and emergency ambulance and DHB funded health services, including where the following services interact:

- Emergency Air Ambulance Services (EAAS)
- Emergency Road Ambulance Services (ERAS)
- Patient Transfer Services (PTS)
- Inter-Hospital Transfers (IHT)
- Primary Response in Medical Emergencies Service (PRIME)
- Communications Centres
- Telephone health advice and triage
- Interface between ambulance services, extended care pathways, Community Health, Primary and Secondary Care, After Hours, Emergency Departments and Accident and Emergency Care

The following are out of scope of the Collaboration

- Emergency Response System e.g. NZ Police, Fire and Emergency NZ
- Core operational functions and Ministerial responsibilities of the Ministry of Health and ACC
- Contract management arrangements, issues and day-to-day management of ambulance services

Collaboration Principles

The foundation of the Charter is a commitment to act in good faith to reach consensus decisions based on 'Best for Patient, Best for System'. As members of the Collaboration we will conduct ourselves in a manner consistent with the following Collaboration principles, by:

- focusing on strategic decision making to support the purpose of the Collaboration
- making decisions by consensus, focusing on what is 'Best for Patient, Best for System' over the long term
- supporting decisions made within the Collaboration, regardless of individual views
- conducting ourselves with honesty and integrity, and build a high-trust environment
- adopting an open and transparent approach to sharing information
- respecting the rights, obligations and accountabilities of the members and their organisations
- holding each other to account for achievement of the objectives and demonstrating the principles of the Collaboration.

Functions

Question 6: How expansive should the functions be? Would you expect this collaboration to drive the work in response to a crisis (eg the issues that needed to be resolved in response to Covid-19) and if so, does anything need to be added to allow for that?

The functions of the Collaboration group are to:

Option One: More limited functions	**Option Two: functions in option one, plus**
• provide direction and monitoring of the agreed programme of work • commission and authorise resourcing for agreed joint projects from within representative's organisations • receive high-level reporting on strategic projects and clinical governance decisions • request and receive advice to / from the National Ambulance Clinical Network and other relevant groups. Note: this group has not yet been established	• provide system leadership, building sustainability, resilience and connections relevant to the agreed work programmes of the NASO and DHBs • provide strategic advice in support of the national ambulance strategic programme and provide advice to NASO within the mandate set by Ministers, the ACC Board and national DHB Chief Executives Group

Decision making

Question 7: Given the nature of the authorising environment, particularly Government Agency's responsibilities as advisors to Ministers, should the following statement on the limitations of the Collaboration's decision making be included?

Nothing in this Charter changes the existing accountabilities, funding arrangements, decision making rights, or legal obligations of any agency. Decisions are made by the Collaboration within the mandate each member holds on behalf of their agency and/or Minister. Decisions that fall outside of existing mandates will be referred to the appropriate decision maker, as required. Collaboration members will provide advice to the relevant decision maker that includes the views of the Collaboration.

Evaluation of the Collaboration

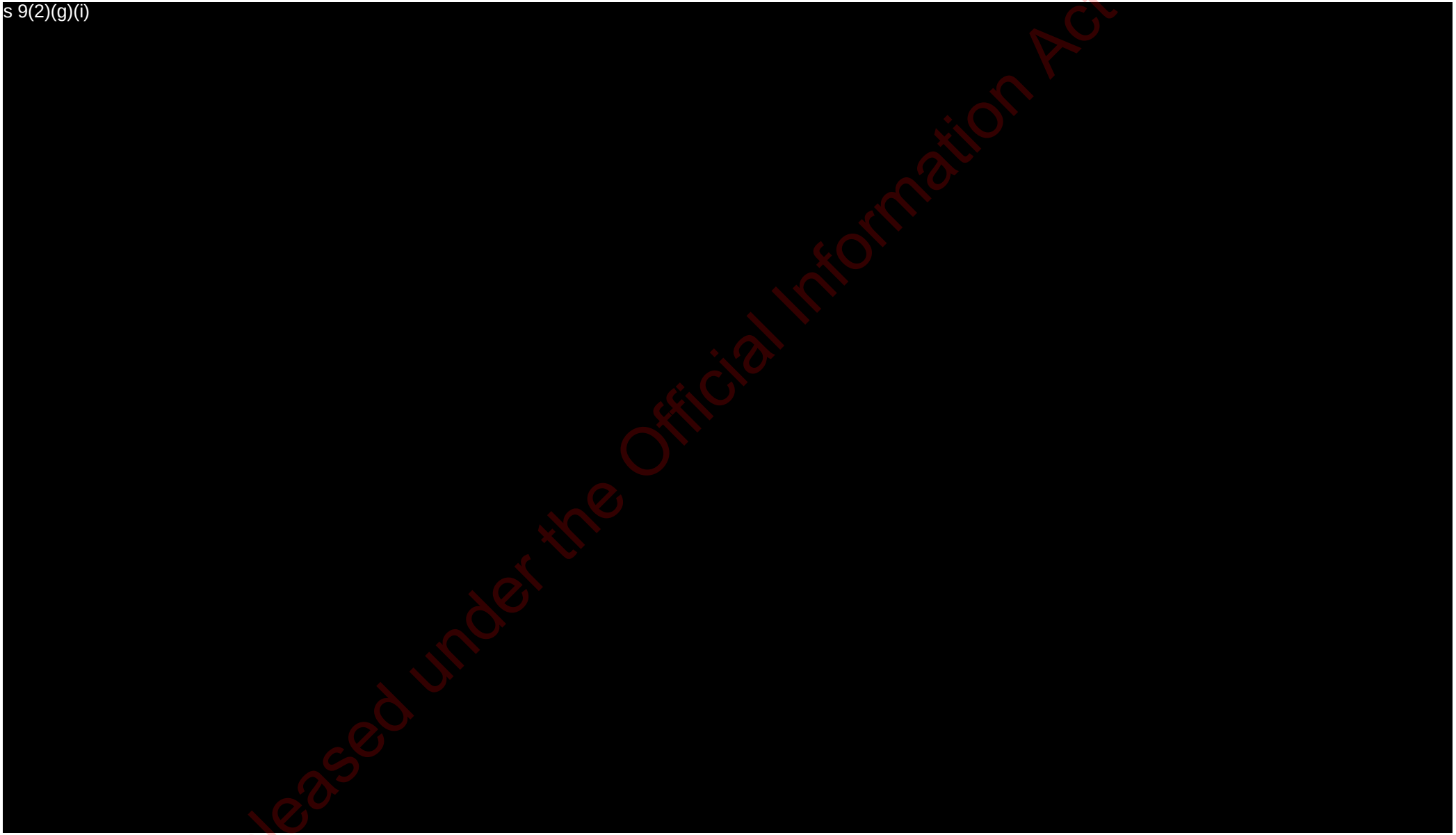
This Collaboration will be reviewed in 12 – 18 months, by members, to evaluate its performance against the Charter principles, functions and Terms of Reference objectives. Learnings from the service level collaboration phase will inform any changes to this Charter and the Collaboration Terms of Reference.

Members signed up to the Charter

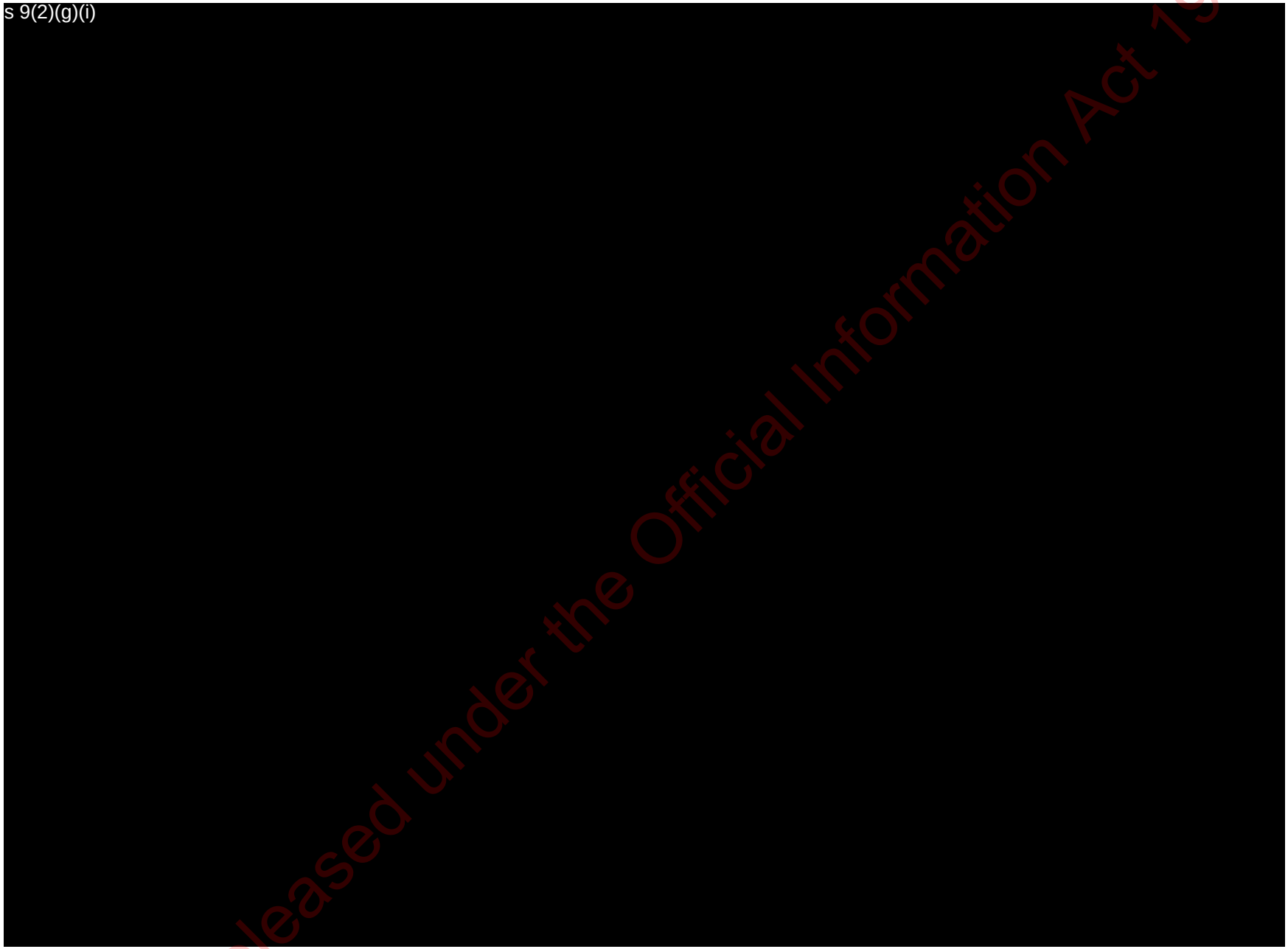
Name: Signature: Date:

Appendix

s 9(2)(g)(i)



s 9(2)(g)(i)



Ambulance Service Level Collaboration Terms of Reference

The Ambulance Service Collaboration Group (The Group).

Introduction

Question 9: is an introduction to the TOR necessary, if so, is the text below accurate and sufficiently concise?

s 9(2)(g)(i) [redacted]

Purpose

The Group will be responsible for the establishment and leadership of the service level collaboration, to lead and guide the strategic programme for system integration.

The Group will provide leadership and direction for integrated and coordinated ambulance services through clinically-led service development and implementation within a 'best for patient, best for system' approach.

In the first instance the Group's priority is to approve a strategic programme and where required this may include determining the feasibility of projects, implementation plans and agreed outcomes. The Group will work with the DHB/ACC strategic relationship governance group and the NASO

[2] Fixed wing refers to pre-hospital transportation by ambulance services

leadership group to agree the strategic programme. Implementation of the strategic programme remains the responsibility of the relevant organisations (DHB, ACC, MoH and NASO).

Question 10: Is the highlighted text above necessary, the function to agree a work programme is already listed in the Charter

The Ambulance Service Collaboration Charter outlines the scope, functions and the principles for working.

Membership

Independent Chair

DHB executive leader

ACC executive leader

MoH executive leader

Ex-offico (in attendance)

Secretariat support

NASO manager, when invited

DHB strategic advisor / DHB ambulance programme, when invited

Project leads, when invited

Question 11:

Chair – The executive group previously agreed to an independent chair, does this remain the wish of the group?

At this point in the establishment of the Collaboration, would membership be extended beyond ACC, MOH and DHB representatives? If so, who of the following and are there others?

Road and Air ambulance providers
Community
Iwi
Health Consumer
Clinical Network Chair (noting this is not yet established)

Member Roles and Responsibilities

Question 12: Is the level of detail of the roles and responsibilities of the Chair and members necessary? – the behaviours are outlined under the collaboration principles in the Charter document. The role of the secretariat would be retained.

The Chair of the Group will have responsibility for:

- chairing the meetings
- managing the process of conflict resolution and holding Group members to the Collaboration Charter principles
- facilitating Group discussion and summing up key themes to reach decisions
- summing up key messages/outputs of meetings to the Group
- ensuring the Group stay focused to the purpose and expected outcomes
- working with relevant programme leads and secretariat support to set Group agendas

Roles and responsibilities of Group members

- supporting clinical leadership, in particular promoting an environment for working together to reach decisions that ensure 'best for system, best for patient'
- fostering an open and transparent approach to sharing information including reporting of the Collaboration work programme and achievements
- communicating to agreed parties key messaging following meetings
- working with relevant teams/groups to support system improvements
- following through on assigned/delegated actions from Group meetings

Role and responsibilities of the Group's secretariat support

The DHBs, ACC and MOH will fund the secretariat support functions to the Group and will include the following responsibilities:

- ensuring that administrative support is provided to the Group
- taking minutes of the Group meetings and distributing draft copy to the chair and Group members within one week of the meeting date
- preparing agendas in partnership with the chair and collating meeting papers, ensuring the agenda and papers are circulated to Group members at least one week in advance
- maintaining a meeting action register and member conflict of interest register
- dealing with correspondence on behalf of the chair
- scheduling meetings on an annual basis

Decision Making

The Group will aim for consensus decision making informed by good data and clinical expertise.

Communication and engagement responsibilities for the strategic programme, projects and processes is defined through the Responsible, Accountable, Supported, Consulted, Informed (RASCI) model. The RASCI shown in Appendix 1 is a living document and will be updated periodically.

Meetings

It is anticipated that Group meetings will initially be held monthly via teleconference/videoconferencing as determined by key milestones. Meetings may be held less frequently once the programme settles.

Conflict of Interest

All members must agree to disclose any perceived or actual conflict of interest. This applies to any and all existing and potential conflicts of interest.

Question 13: Is there a need for a dispute resolution process, or is this the role of the Chair?

Members will be required to sign the Charter document

Question 14: Is this statement necessary?

This terms of reference will be reviewed at the same time as the Charter (after 12-18 months).