Table Office
Tuesday
6/09/2023

BOMET COUNTY EMERGENCY

REFERRALS AND AMBULANCE POLICY

Tabled on 6th September, 2023 at 9.30 a.m. committed Committee on Health

2023

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF BOMET

DEPARTMENT OF HEALTH SERVICES

BOMET COUNTY EMERGENCY REFERRAL AND AMBULANCE POLICY

2023

TABLE OF CONTENTS

Contents

ACRONYMS

ACLS	Advanced Cardiac Life Support
BLS	Basic Life Support
FBO:	Faith based organizations
CIDP:	County Integrated Development Plan
KEPH:	Kenya Essential Package for Health
ICT:	Information Communication Technology
CHP:	Community Health Promoter
CHA:	Community Health Assistant
SDGs:	Sustainable Development Goals
CHU:	Community Health Unit
VHF:	Very High Frequency
CHMT:	County Health Management Team
MCI	Mass Casualty Incident
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
TWG	Technical Working Group
UHC	Universal Health Coverage
EMS	Emergency Medical Services
EMT	Emergency Medical Technician

DEFINITION OF TERMS

Waiver: A mechanism put in place to boost equity in access by assessing the ability of a person to pay for services rendered and grant removal of part or whole of the bill to the individual's affordability.

Exemption: An automatic excuse from payment based on the patient meeting criteria set down in this policy.

Medical Expert: Trained Healthcare provider with expertise in a specific subject area

Emergency Referral: A referral process is transferring a person with emergency conditions that has the potential to worsen if no action is taken.

Initiating Facility

An organization, service, or community Health unit that initiates a referral process by preparing an outward referral to communicate the client's condition and status. An initiating facility is also known as a "referring facility."

Ambulance: An Appropriately equipped and authorized vehicles either land-based, waterborne or airborne designed or adapted to treat and convey a patient in an emergency care situation, marked in such a way as to indicate the category of medical care and transportation of the said vehicle and staffed with licensed ambulance personnel

Bystander: Any person who is near a medical emergency or disaster, who is not a trained EMC practitioner.

Dispatch: subsequent mobilization of response units to the scene of the incident

Emergency Department (ED): A dedicated area in a healthcare facility marked as such and treats patients 24 hours a day.

Emergency Medical Care (EMC) System: A system that coordinates essential emergency care functions at the scene of injury or illness, during transport, and through to emergency department and early inpatient care.

Emergency Medical Treatment: The necessary immediate health care that must be administered to prevent death or worsening of a medical condition as defined in the Health Act 2017

Mass Casualty Incident (MCI): An incident that overwhelms the capacity of local resources that would normally be able to respond, either due to the number of live casualties or complexity of the incident

Medical Emergency: Means an acute situation of injury or illness that poses an immediate risk to life or health of a person or has the potential for deterioration in the health of a person or if not managed timely would lead to adverse consequences in the well-being

Pre-hospital Care: Medical care provided to patients in settings other than a hospital and who are planned or intended to be transported to the nearest most appropriate healthcare facility for further care or evaluation

Tier of Care: The tiers of the healthcare system in Kenya are classified as primary care, county referral services and national referral service.

FOREWORD

Throughout the year emergencies requiring urgent attention occur. Management of medical emergencies requires efficiency referrals and ambulance services. The prevention of deaths and suffering among victims is heavily dependent on the quality of emergency services which in turn is a product of the efficiency of the referral systems and procedures for allocating resources earmarked for the emergency response. The Constitution of Kenya 2010 mandates this responsibility to county governments.

The ambulance service is a critical essential service which is in line with the Constitution of Kenya 2010, which stipulates that every citizen has a right to the highest attainable standard of Health and emergency care. This policy outlines the principles and processes for management of emergency ambulance services across Bomet County as provided for under Schedule four of the constitutions

The policy will guide the Department of Health services in building an effective referral system that responds to the health needs of the people of Bomet and thus contribute to the realization of the Vision 2030, Sustainable Development Goals (SDGs), and universal health coverage.

The department of Health Services endeavors to provide efficient and high quality health care services that are accessible, equitable and affordable for all residents of Bomet and beyond.

Hon Dr. Joseph Sitonik

County Executive Committee Member of Health Services (CECM)

ACKNOWLEDGEMENT

The development of the Emergency Referral and Ambulance policy was undertaken in a consultative and participatory process involving a series of meetings and workshops with stakeholders from relevant institutions and organizations.

The process was initiated by the County Executive Committee Member for Health services through the Technical team from the County Health Management Team (CHMT).

The process involved review of relevant documents, desk situation assessment of the referral system, and development of goals, objectives, priorities, and implementation strategy.

The draft policy was shared with health sector stakeholders including relevant county departments, private and faith based health care providers whose inputs were incorporated into the final policy.

We would like to acknowledge the commitment of the members of the CHMT, County Assembly Health Committee Members, and the Secretariat for their unwavering support in the development of this policy.

Milcah C. Ronoh

Ag. Chief Officer Health Services (COHS)

PREAMBLE

2.0: INTRODUCTION

2.1 County Profile

The Ministry of Health is committed to providing equitable access to quality health services for all Kenyans as one of the means of reversing declining health indicators in line with the international declarations, key policies, and strategic documents. A comprehensive service delivery approach, based on the availability of adequate guidance for service standards, service inputs (human resource, infrastructure, and equipment), and cross-linkages of services across different levels of care, has guided delivery of the existing services. This comprehensive strategic approach has guided development of national referral guidelines to ensure comprehensive, harmonized, and measurable health services for the people of Kenya.

In this regard, the County Government of Bomet saw the need to develop Emergency referral and Ambulance Policy to address the challenges faced in provision of emergency and referral services.

Bomet County has a wide catchment area, a total population of about 984555 *(projected from 2019 census)* spread across the five sub-counties namely: Chepalungu, Bomet Central, Bomet East, Konoin and Sotik.

Chepalungu Sub-County is located in an expansive semi-arid area. It has an estimated population of about 216,179 *(Projected from 2019 National Household Census)*. It has a distribution of health facilities spread across it. The main health facility in the sub county is a Level 4 hospital. The road network serving this area covers the entire health infrastructure.

Sotik Sub-County is located in the outermost part of the county with a total population of about 220,410 *(2019 National Household Survey Projection)*. Longisa county referral hospital is over 40km away from this sub-county. Ndanai Sub county hospital serves as the biggest hospital within Sotik. Kaplong Mission Hospital a faith based facility is domiciled in Sotik Sub County.

Konoin Sub-County is located over 30 km away from the nearest referral hospital-Tenwek Mission Hospital, with a total population of about 191,772 *(2019 National Household Census Survey)*. The topography in the sub county allows significant agricultural activity.

Bomet Central Sub-County is in the heart of Bomet County with a population of approximately 167,612 *(2019 National Household Census Survey)*. Other non-state actors in the healthcare space include Tenwek Mission Hospital, a level 6 that serves as a major health care provider and critical stakeholder.

Bomet East Sub-county is located to the East of Bomet town with a population of approximately 167,750 It hosts Longisa county referral hospital, the center of most referrals from all the five sub-counties and outside the county. It is a vast sub-county with mixed terrain and some areas with low socio-economic status.

2.2 Situational Analysis

The constitution of Kenya 2010 provides that every person has a right to the highest attainable standard of health and that a person shall not be denied emergency medical treatment. This is in line with the goal of the Constitution 2010.

Emergency Medical care has been defined in the Health Act 2017 as necessary immediate healthcare that must be administered to prevent death or worsening of a medical situation. It focuses on the immediate decision-making and action necessary to prevent death or disability.

Creating an emergency care and ambulance policy will increase efficiency and effectiveness with which emergencies are handled as early resuscitation and stabilization of acutely ill or injured patients greatly reducing morbidity and mortality.

A coordinated referral system and network has been shown to improve survival from acute illness or injury. This policy will aim to improve the healthcare system response to emergency care and referral/ambulance services.

Bomet county public health facilities comprises 133 dispensaries, 22 health centers, 5 sub-county hospitals and one County Referral hospital as per County gazette notice vol. 111-no.1 2015. The health facilities are distributed as per sub-county shown in the table below. Additionally, there are private and faith based health facilities.

TABLE 1: DISTRIBUTION OF PUBLIC HEALTH FACILITIES

S/NO	Sub-County	CATEGORY				
		No. of Dispensaries Level II	No. of Health Centres Level III	Sub-County Hospitals Level IV	County Hospital Level V	Total
1	Sotik	34	6	1		41
2	Konoin	22	5	1		28
3	Chepalungu	35	2	1		38
4	Bomet East	17	6	1	1	24
5	Bomet Central	25	3	1		29
TOTAL		**133**	**22**	**5**	**1**	**161**

The number of facilities will continue to change from time to time as per Bomet CIDP. The department of Health Services has to improve on service delivery and infrastructure thus the need to gazette more health facilities to accommodate those upgraded and newly established facilities. The county currently has 246 established community units linked to health facilities.

The growing aging population continues to exert pressure on health services. Non communicable diseases (NCD), HIV pandemic maturity, injuries from road traffic accidents, assault, burns, continue to pose a risk and burden on the healthcare system.

2.3 The Local Context

In the last two years total referrals went above 27,000 as shown in table 2 below:

Table 2: Summary referrals data for year 2021- 2022

SNo	Referral service	2021	2022	Total
1.	Referrals from Health Facilities	5748	4849	10597
2.	Referrals to other health facilities	5402	5910	11312
3.	Referrals from community units	322	255	577
4.	Referrals to community units	207	797	1004
5	Other referrals	2872	1448	4320

2.4 Gaps and Challenges

The Department of Health Services has a network of healthcare provision infrastructure. This includes community health units, and level 1 to 5 health facilities as illustrated above. Additionally, there are non-state actors which include faith based, community based organizations and private facilities.

There is no policy guiding emergency and ambulance services within the County of Bomet.

The county Government of Bomet currently has a fleet of 4 ambulances which are managed by the department of Health services. The mapping of other fleets in other non-state actors has not been documented. The human resource managing emergencies and referral system has not been adequately addressed

Financing of the ambulance service. This policy aims to address the budgetary allocation to the emergency and ambulance services. Equally, the adequate numbers of HRH with regard to EMC will be explored with the aim of ensuring sustainability of the ambulance service.

2.5 Policy Context

Constitution of Kenya 2010

In 2010, the Constitution of Kenya included economic, social, and cultural rights for the citizens. This includes the right to health care services including reproductive health care" is guaranteed for all Kenyans and the right to emergency medical treatment.

The Fourth Schedule of the Constitution distributes functions between the National Government and the County Governments and particularly shows the pertinent role played in the County providing Health services whereas the National Government develops various Health Sector Policies.

Kenya Vision 2030

Kenya Vision 2030 is the long-term development blueprint for the Country, aiming to transform Kenya into a "globally competitive and prosperous and newly industrialized middle-income Country providing a high quality of life to all its citizens in a clean and secure environment by 2030" Health is one of the components of delivering the Vision's Social Pillar, given the key role it plays in maintaining the healthy and skilled workforce necessary to drive the economy.

Health Act 2017

The Health Act 2017 establishes a unified health system to coordinate the interrelationship between the National government and County government health systems, to provide for regulation of health care service and health care service providers, health products and health technologies. It establishes a national health system which encompasses public and private institutions and providers of health services at the national and county levels.

Section 7 of the act defines emergency medical treatment including prehospital care stabilizing the health status of the individual; or arranging for referral in cases where the health provider of the first call does not have facilities or capabilities to stabilize the health status of the victim. It also penalizes any medical institution that fails to provide emergency medical treatment while having the ability to do so.

The Act recognizes the role of health regulatory bodies established under any written law and to distinguish their regulatory role from the policy making function of the National Government and Section 15 vests the National Government Ministry for Health with the mandate of developing health policies, laws and administrative procedures and programs in consultation with County Governments and health sector stakeholders and the public for the progressive realization of the highest attainable standards of health.

National Health Policy 2014-2030

The goal of the Kenya Health Policy 2014–2030 is attainment of the highest standard of health in a manner responsive to the needs of the Kenya population (Ministry of Health, 2014). Kenya's health policy framework future direction 2012 -2030 introduces new ways of managing the health sector as it seeks to provide health services to all. It also creates opportunities to upscale support to the health sector's requirements for the provision of adequate services and facilities for the attainment of the highest standard of health in a manner responsive to the needs of the Kenya population. The rights and freedoms granted to each citizen of Kenya shall be upheld in this context.

Other Legislation and Policy Documents

There are other pieces of enabling legislation that promotes various rights to health including. These include: the following Acts in the Laws of Kenya, the Public Health Act Cap 242 (revised 2012), the Environmental Management Coordination Act Cap 387 (revised 2012), Radiation Protection Act Cap 243, Pharmacy and Poison Act Cap 244, and the Standards Act Cap 496 and the following policy documents, National Actional Plan for Health Security, Health Sector Disaster Risk Management Strategic Plan, Public Health Emergency Operation Centre Framework, Kenya Public Health Emergency Supply Chain Framework, the National Disaster Response Plan (2014), and All Hazard Plan.

2.6 Scope

The Policy emphasizes enhancement of institutional response to emergency referral and ambulance services linkages to include both state and non-state actors in the provision of emergency medical care services in the county.

2.7 Policy Development Process

The Policy was developed under the stewardship of the County Government of Bomet, department of Health Services in consultation with stakeholders.

The policy goal and objectives were informed by a situational analysis. The comprehensive situational analysis included extensive consultations at different levels and stages.

3.0 POLICY OBJECTIVES

This policy seeks to address the following objectives:

(a) To establish a county infrastructure to support universal access to emergency referral and ambulance services

(b) To ensure the highest quality of service in emergency referral and ambulance services

(c) To provide mechanisms for operations of ambulance services and referral services

(d) To develop a framework for HRH development and management in the referral and ambulance services.

(e) To strengthen systems for monitoring, evaluation, surveillance and research on emergency referral and ambulance services

(f) To provide emergency referral and ambulance service leadership and governance.

3.1 Policy Measures and Strategies

The policy has 6 (six) main objectives which are to be implemented in the following strategic measures

Objective 1: To establish a county infrastructure to support universal access to emergency referral and ambulance services

This objective will anchor the key infrastructural components. In its implementation, the county puts forth the following strategies for its implementation:

A. Establish a County Single Short Code Toll-Free Emergency Medical Care Access Number
B. Map out and enhance ambulance standards at all levels of care including non-state actors
C. Establish and strengthen emergency operation and Ambulance dispatch centers at the County Headquarters control centre and the sub counties/referral hospitals

Objective 2: To ensure the highest quality of service in emergency referral and ambulance services

Prompt and effective management of emergency referrals is crucial towards achieving the goal of this policy. This objective will focus on updating and disseminating relevant referral protocols, enhancing the skills of EMTs, and ensuring access to appropriately equipped ambulances.

The following strategies will be employed:

A. Strengthen capacity for EMTs
B. Develop Standard Operating Procedures (SOPs) for Ambulances and Emergency referral services
C. Provide and enhance standards of Emergency Health Products and Technologies utilized in patient transfers.

Objective 3: To provide mechanisms for operations of ambulance services and referral services

Objective 4: To develop a framework for HRH development and management in the referral and ambulance services.

This objective focuses on promoting human resource development to address the shortage and

training/appropriately equipping EMTs and all the relevant staff.

To achieve this the following strategies will be implemented:

A. Create a scheme of service for EMC/EMTs/paramedical practitioners

Objective 5: To strengthen systems for monitoring, evaluation, surveillance and research on emergency referral and ambulance services

This objective focuses on strengthening the routine Health information system deployed, monitoring and evaluating the performance of the Emergency referral and ambulance System, and promoting the generation and use of evidence to inform the strengthening of the Emergency referral System.

Strategies:

A. Disseminate and enhance utilization of the guidelines/SOPCs in Emergency referral Surveillance
B. Increase Use of Emergency Medical Care Data for Decision Making
C. Conduct and Facilitate emergency referral and ambulance system Surveys
D. Facilitate Operational Research for Policy Making.

Objective 6: To provide emergency referral and ambulance service leadership and governance.

This objective addresses leadership and governance to provide a conducive policy implementation environment and the resources necessary for the achievement of the Policy goal and objectives.

3.2 Strategies:

A. Align emergency referral and ambulance service governance and legislation to mandates and core functions
B. Strengthen county and extra-county coordination of Emergency referrals.
C. Develop norms and standards for Emergency referral and ambulance services.

4.0 REFERRAL SERVICES

The referral services in this policy will have a service delivery approach and shall be based on KEPH levels of care.

4.1 Service Delivery Approach

The Kenya Essential Package for Health (KEPH) and the Health Service Norms and Standards were defined to guide service standard definitions and service norms for various inputs at each level of care. However, guidance on the linkage of services and continuity of care across the different levels has been inadequate.

Consequently, Bomet County department Health Services developed this Emergency referral and Ambulance policy to guide on provision of ambulance services.

4.2 Health Service Delivery Levels

The provision of health services is organized into KEPH levels:

Community services (Level 1) comprise all community-based demand-creation activities, organized around the Comprehensive Community Strategy defined by the health sector. Community-based referral mechanisms should exist to facilitate linkage with primary care services.

Primary care services (Levels 2 and 3) comprise all dispensaries, health centres, and maternity homes for public and non-public providers. Their capacity will be upgraded to ensure they can provide the appropriate demanded services. Primary care services should manage referrals from communities and facilitate referrals to the nearest county referral facility.

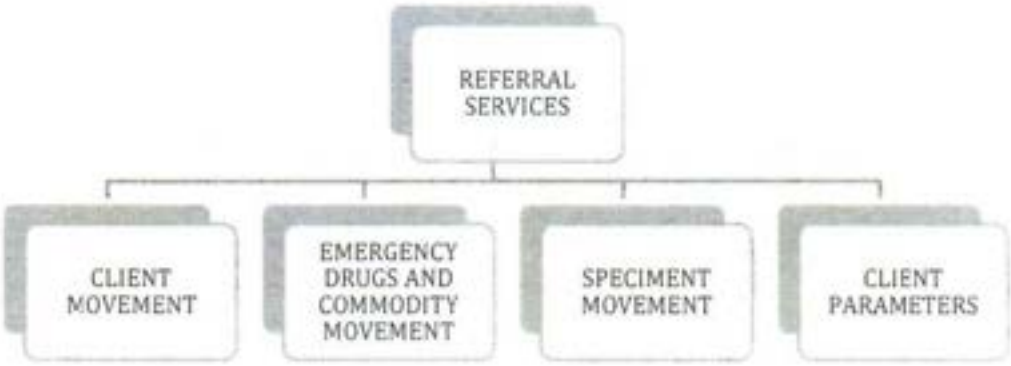
County referral services (Levels 4 and 5) include all levels 4 and 5 facilities that operate in a county and that are managed by the county and non-state actors. Together, all the facilities in a county form the county referral system, with specific services shared among the existing county referral facilities to form a virtual network of comprehensive referral services. Referrals are received from the following sources:

1. Primary care facilities within the county referral area of responsibility
2. Other county referral facilities in the county (horizontal referral)
3. Community units that are linked to the county referral facility and for which the county referral facility provides primary care services

National referral services (level 6) include facilities that provide national referral services with specialized health care services, including hospitals, laboratories, blood banks, and research institutions. These facilities operate with a defined level of autonomy.

4.3 Framework for Health Referral Services

The full scope of county referral services may include movement of clients, specimen movement, emergency health commodities and client parameters movement, as shown in Figure 1.



4.4 Framework for health referral services

Client and service movement: involves the actual response and movement of individuals within the health system that eventually leads to management of the clients' legitimate health needs.

Client movement: The actual client seeking an appropriate level of care at which their health needs are best addressed. This is the most recognized form of referral service expected of the health system, and is what most persons equate to a referral system. Adequate investments shall be made in the system to effectively manage movement of clients.

Specimen movement: Movement of just a specimen, usually for investigative purposes is one form of referral considered. Emergency biopsies and samples would best be managed through this referral approach. It avoids having to actually move the client within the health services.

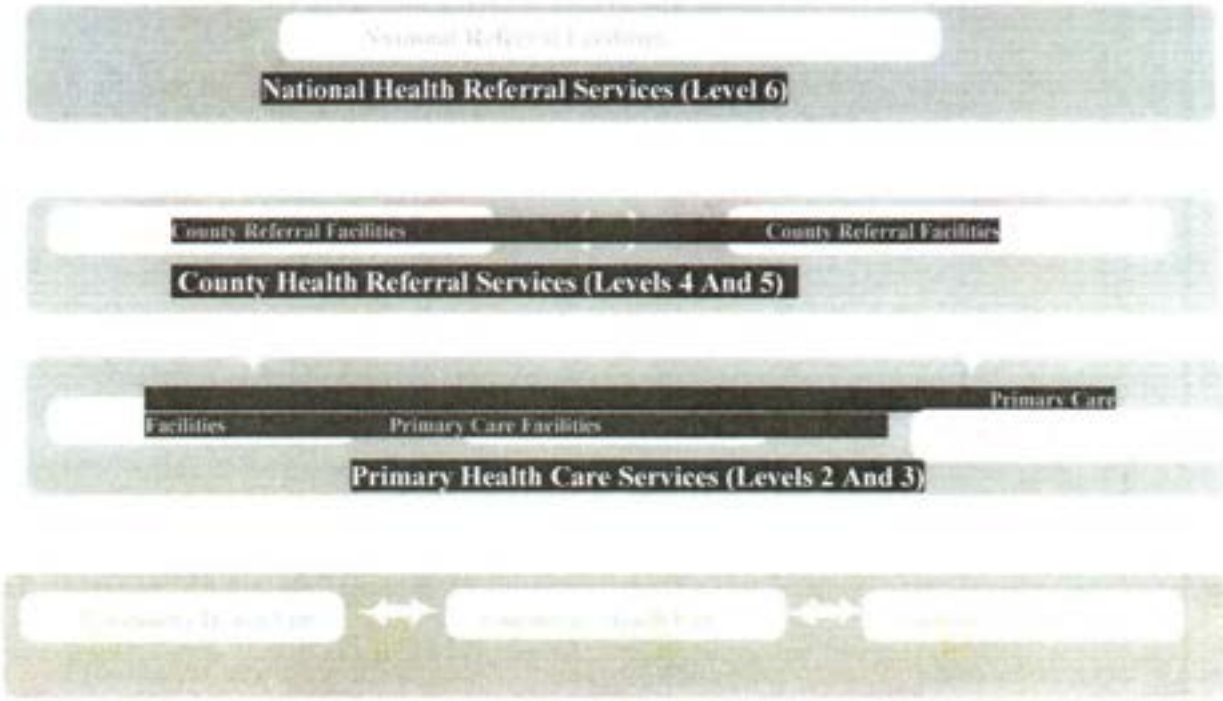
Emergency Drugs and commodities movement: movement of Emergency drugs and other emergency commodities such as Blood, blood components.

Client parameters movement: This type of referral is helpful in avoiding difficult or disruptive movement of clients, when a significant part of the management process can be provided at the level the client has presented. Client information can be sent for supportive diagnosis or management guidance to appropriate levels of the system. The scale up of innovative Information Communication Technology (ICT) in health services, particularly in the context of e-health scale up directly facilitates this form of referral. This type of referral does not require Ambulance services in this policy.

4.5 Referral Chain

The referral system links up the different levels of care based on the expected services being provided through the system.

Figure 2 shows the overall referral chain.



5.0 AMBULANCE SERVICES

Ambulance services shall be employed in the following:

- Transfer of patients requiring emergency care.
- Evacuation of casualties in a disaster
- Collection of emergency lifesaving commodities including but not limited to blood, and emergency medicines and non-pharmaceutical products.
- Transfer of cold cases under special considerations (Cold cases are life threatening conditions which do not necessarily need ambulance services but need specialized medical care.)

An ambulance will be defined as an appropriately equipped and authorized vehicle either land-based, waterborne or airborne designed or adapted to treat and convey a patient in an emergency care situation, marked in such a way as to indicate the category of medical care and transportation of the said vehicle and staffed with licensed ambulance personnel

5.1 Indications for ambulance service usage

The following is a list of reasons for referring clients who seek emergency services:

(i) To seek admission and further management
(ii) To request use of diagnostic and therapeutic tools for admitted patients
(iii) To evacuate victims of disasters and accidents

Every person has a right to Emergency Medical treatment and referral. Patients shall be referred from lower levels to higher levels and sometimes counter referrals from higher levels to lower levels, those clients suffering with terminal conditions can be referred higher levels to home-based care services or to the nearest health facility.

Standard Referral Procedure/Protocol

The referring facility/agent shall place a call/communicate with the receiving facility describing in detail, the relevant medical details of the patient/client/specimen to be referred, a concurrence of availability of bed space/service/expertise shall be accepted and granted. A call to the ambulance dispatch centre is then made and subsequently, dispatch of the relevant level of ambulance shall be made.

Referrals for ambulance services as per this policy shall be classified as follows

1. **Victims from Disasters e.g. Fires, accidents** etc –The emergency team shall evacuate the victims to the appropriate level of care for treatment and further referral as necessary. The Ambulance team shall fill in a referral form and patients notes/brief report for handing over to the receiving facility
2. **Patient from health Facility**-This is a patient or client examined by a healthcare worker or at an emergency care unit, in a public or private institution, who is deemed to be in need of specialized consultation or treatment or requires care and procedures that cannot be provided at the initial level of care, must be referred to the specialist or institution capable of continuing or providing the level of care required.

   The referring facility shall ensure that a client referral form is duly filled in a legible manner (printed where possible) with all the required patient information.
   If an e-referral system is in place, the form shall be completed and submitted electronically. The referral information is as contained in Annex 2.

   For emergency referrals, the referring facility shall communicate directly by phone or any other means of communication available to the receiving facility so as to confirm availability of bed space and services required by the client. The referral system has four levels namely community, primary care, county referral services, and national referral services. The Community Health Services (Level 1) which is an initiating facility for most referrals, can

refer directly to the ministry of health facility, Faith Based facility, or private facility based on proximity and or types of services facility offered.

Equally, a higher level of facility based on the tier of service can refer to a same level or lower level facility. Telemedicine and use of technology will be enhanced to facilitate e-referrals and consults.

Patients from Community/Households – These are clients from the community who fall ill at the household level and require to be referred to the health facility for treatment. At this level the community health promoter and community Health Assistant shall refer to the nearest facility for management.

3. **Patients in non state actors (Private/Faith Based Organization) Facilities within the county**- These are patients admitted in private/ **Faith Based Organizations** facilities within the county requiring referral. These institutions will use the standard referral protocol as indicated in the policy.
4. **Self-referrals** – This shall be discouraged and shall be dealt with as they arise through written approvals from the department of Health Services
5. **Referrals from outside the county**- This will require written approval from the department of Health Services The referring facility shall fill in a patient referral form to a Bomet county public health facility and prior communication made to the receiving facility.
6. **Patients/clients on palliative care at household** – These are client with terminal or chronic illness counter referred from hospital for care at home or primary facility near home. This kind of patient shall be treated as community referral as above.
   Cold cases or cases not requiring urgent transfers shall be booked prior to date of transfer and this will be done in writing to enable ambulance team plan well in advance. Special considerations shall be made for such cases so as to maintain the core function of emergency referrals.

5.2 Community based ambulance services

The Community Unit (CU) consists of:

a) Household Care Givers
b) Community Health promoters
c) Community Health Assistants

Each Community Unit shall have a leader who is responsible for all referrals through Community Health Assistant. All Community Units shall have a link facility. The Community Health Assistants are trained to recognize illness and gauge it's severity in order to refer to the next appropriate level of care.

In community referral, the Community Health Assistant shall call for ambulance services in case of emergencies disasters.

List of Community Health Assistant for each sub location should be available at Ambulance Coordinating Office for efficient communication.

5.3 Management of Ambulance human resource

Staffing

The system of the ambulance service-call/dispatch centre, ambulance, EMT and all human resource needed shall be adequately trained and posted to cover the service.

Facilitation

The department of Health Services shall establish funds for Ambulance services to facilitate Ambulance Vehicle maintenance and fuel, communication, and the staff allowances.

Training

To ensure compliance to set guidelines on patient transport, the Department of health services will ensure the staff receive updates on guidelines and keep a log of renewed licensure.

6.0 COORDINATION OF AMBULANCE SERVICES

Under this policy, the management and coordination of ambulance services shall be domiciled in the department of Health Services under the office of the ambulance/emergency coordinator.

The County Executive Committee Member in charge of Health Services shall appoint two senior officers from the serving technical staff to be the ambulance coordinator and the deputy.

The office shall be manned by a coordinator and deputy who will be in charge of ambulance services, under whom shall be other staff who includes drivers, paramedics and dispatch officers.

The Coordinator shall liaise with other players in disaster management and mass casualty incidents. This will involve other non-state actors in mobilization of ambulance and casualty evacuation plans

6.1 Location

There is provided central call/dispatch centre appropriately equipped with communication equipment.

6.2 Fleet management

The department of Health Services shall establish a fleet management system for ease of management and coordination of ambulance services. There shall be an online tracking system installed at the central call/dispatch centre

6.3 Communication.

The department shall provide communication equipment including but not limited to as Radio call (VHF) and phones for the call/dispatch centre and each ambulance.

6.4 Ambulance Services committee

There shall be a committee on ambulance services which shall be formed to oversee the management of ambulance services. The committee shall be answerable to the County Executive Committee Member in charge of Health Services

The composition of the Ambulance Services committee shall comprise of the following:

a. Chief Officer in charge of Health services or his/her designate who shall be the Chairperson
b. Medical superintendent of county referral hospital(s)
c. Director in charge of public health
d. Director in charge of Health Administration
e. Director Disaster Operations Department
f. One person from non-state actor's county referral facility
g. Two Members representing Community
h. Ambulance coordinator who shall be the secretary and an *ex officio*

6.5 Roles and responsibilities of ambulance committee

1. To provide leadership of Ambulance services
2. To spearhead planning and budgeting of ambulance services
3. To mobilize resources towards Emergency referral and Ambulance services
4. To ensure proper management and accountability of resources
5. To monitor and evaluate the performance of Emergency referral and Ambulance services

6.6 Conduct of meetings

a. The Committee shall meet on quarterly basis, however, the committee may sit to address emergency issues
b. The quorum shall be two-thirds of the total membership

6.7 Cost of referrals

The department will come up with cost estimates for each referral for planning and decision making.

7.0 MONITORING AND EVALUATION

The Policy implementation will be monitored and followed up using financial and non-financial targets and indicators. The targets will be in line with the county health goals and health sector priorities as set out in the County Annual Plans. These plans will be implemented and monitored through annual work plans and medium-term plans. The targets will be benchmarked against best practices.

7.1 Tracking progress

The M&E plan envisions the following:

a) Monitoring:

Quarterly performance monitoring meetings will be held to review the progress of implementation against targets in the annual work plans. Semi-annual stakeholder performance monitoring and review meetings will also review performance against targets, address any constraints in implementation, and refocus activities if needed.

b) Review and Planning Meetings:

As part of the commitment to performance monitoring, all stakeholders will meet biannually to review achievements against targets and milestones in the strategic plan and annual work plans. These meetings will also define and finalize priorities for the new financial year in line with quality, compliance with protocols and guidelines, documentation, client satisfaction, and responsiveness to clients and system needs.

The M & E framework will be implemented as indicated in the following matrix:

Monitoring and evaluation framework

Objectives	Activities	Indicator	Means of Verifications
Improve preparedness and response to emergencies and disasters	-Evacuation of victims during emergencies - Training of ambulance teams	-Number of emergencies handled -Number of staffs trained on ACLS, BCLS -Number of ACLS and BLS	-Emergency reports - Training reports

	-Maintenance of Vehicles and Equipment	Ambulance maintained and fully functional	- Health services Department reports
Emergency Transfer of clients from different levels	Movement of clients from one facility to the other	-Number of clients referred	transfer forms - journey logs - monthly reports
Provision of quality emergency services	Training of ambulance teams	-Number of staffs trained	-Number of skilled ambulance crew -Training reports
Improve coordination of ambulance and referral services	-Establishment of ambulance committee -Establishment of ambulance coordination office - Facilitation of Ambulance Services	- Presence of ambulance committee -Availability of operational ambulance office -Budget for ambulance services	- Approved list of committee members - Appointment letters for office bearers and TORs - Financial reports

Monitoring and evaluation shall be carried out to ensure the policy meets its objectives.

In this policy, the monitoring and evaluation section looks at the two levels of performance.

The first level is the performance in the implementation of the policy.

The second level routine performance monitoring must be undertaken to ensure quality, compliance with protocols and guidelines, documentation, client satisfaction, and responsiveness to clients and system needs.

7.2 Monitoring and Evaluation Indicators

To inform the implementation of Emergency Referral and Ambulance policy and the functioning of the health referral system, monitoring and evaluation systems will need to be established at the county level.

Referral system stakeholders will derive the following benefits from the results of continual referral system monitoring and evaluation:

- Availability of data and information for decision making to improve the referral system
- Availability of data for planning and investment in the referral system
- Availability of data to ensure accountability in the referral system

It is unlikely that all the relevant information needed to assess the functioning of a referral system will be captured through monitoring. Depending on the outcome to be studied, an evaluation or special study may be needed, but such studies should be based on need and resource availability. A relatively robust

monitoring system based on routinely collected information is, therefore, desirable. Information will be collected, collated, and reported through the health sector routine health information reporting system.

7.3 Referral system indicators for client referrals

The following is a list of some of the core indicators that will be used to monitor the referral system performance:

Indicator 1:

Referral rate from referring service (number of clients referred divided by the number of clients seen)

Indicator 2:

Referral uptake rate (number of referred clients seen at receiving service divided by the number of clients referred)

Indicator 3:

Counter-referral rate (number of clients received back at original referring service with counter referral information from receiving service divided by the number of clients referred)

Indicator 4:

Median delay in completion of referral (median time in days from referral to capture of the referral at the receiving service)

Indicator 5:

Emergency referral waiting time (median time in minutes taken after decision was made to refer to capture of the referral at the receiving service/facility)

Indicator 6:

Client satisfaction (number of referred clients satisfied with service divided by the number of referred clients interviewed)

Table 3: Summary of core indicators for monitoring client referrals

Referral rate from referring service	Number of clients referred out of referring services	Total number of clients seen for that service		Indicates if all necessary referrals are being made from the referring services Appropriate benchmarks depend on client and service characteristics	Register at service and the referral tracking slips
Referral uptake rate	Number of clients who complete referral	Number of clients referred		A barometer of referral success (if low, should trigger further investigation into barriers: cost, distance, stigma, locus of control, perception of low disease severity)	Register at referring and receiving facilities
Counter-referral rate	Number of clients who return to the referring facilities with counter-referral information	Number of clients referred		Indicates health provider compliance to the counter-referral protocols	Register at receiving facility
Median delay in completing referral	Median number of days from referral to completion	Not applicable		Essential when considering emergency referral Calls for dates to be recorded in referral registers and slips Use of median is desirable because a normal distribution is unlikely	Referral register at receiving facility
Emergency referral waiting time	Median time taken after decision was made to refer to referral completion	Not applicable		Essential in assessing the efficiency of the referral system	Referral register
Client satisfaction with referral	Number of clients reporting that they were satisfied with the referral service	Number of referred clients interviewed		Should be used as an indicator of referral and not be deferred to an evaluation Client satisfaction data can be collected in facilities routinely or through surveys	Customer satisfaction form Periodic surveys

The referral monitoring system should not monitor only the performance of the referral system; it also should have the following characteristics:

Data quality assurance: Mechanisms to ensure the quality of data collected is protected and secured.

Client confidentiality: Functioning mechanisms to protect the confidentiality of clients.

Low burden: The documentation and monitoring system should be of low burden for service providers

Data use: Mechanisms to facilitate the use of the collected information for improvement of the network and its referral system

All referring and receiving facilities in the referral zone or network must have in place the referral data collection tools to effectively track the flow of referrals through the referral system and ensure safety and quality of care. The health staff and managers should be trained on the core referral system indicators, the methods of documentation, data retrieval, analysis, and presentation for decision making.

8.0 ANNEXES

8.1 Annex 1 General supervision checklist for referral services

Sections	Area	Check as appropriate ●
A	PATIENT IDENTIFICATION	
	1. Is the patient identification complete and legible?	
	1.1 Patient's name is complete	
	1.2 Patient's Address is complete (house number, street, city, and district)	
	1.3 Date of birth, age, and gender are present	
	1.4 Name of next of kin (or responsible person in case of minors)	
	1.5 Telephone number and address of next of kin	
	1.6 All information is legible	
	2. Is the information on the referring health provider or unit complete?	
	2.1 Provider's name, title, and signature	
	2.2 Referring unit address and telephone number	
	2.3 Referral number	
	2.4 All information is legible	
B	REASON FOR REFERRAL	
	1. Is the reason for referral complete and clearly stated?	
	1.1 The reason for referral is stated	
	1.2 It includes a clinical diagnosis	
	1.3 The reason for referral is clinical	
	1.4 The reason for referral is administrative	
	1.5 The referral contains a brief summary of history and clinical findings	
	1.6 Vital signs are recorded	
	1.7 Treatment given is clearly stated	
	1.8 All information is legible	
C	TRANSFER INFORMATION	
	1. The transfer was executed in compliance with the established protocols?	
	1.1 The receiving physician or unit was previously contacted by phone	
	1.2 The patient referral form was faxed or mailed to the receiving unit prior to arrival	
	1.3 Instructions for transfer are attached to the patient referral form and were explained to the transfer team	

	1.4 All information is legible	
D	TRANSFER RECEPTION	
	1. Was the referral reception completed in compliance with established protocols?	
	1.1 Vital signs were recorded at reception	
	1.2 Patient was received by professional personnel (physician or nurse)	
	1.3 The transfer or reception form is signed and attached to the patient referral form	
	1.4 All information is legible	
E	COUNTER- REFERRAL	
	1. Was a counter-referral form completed and sent?	
	2. Was a counter-referral form received by the referring unit?	
	3. Was the general information complete?	
	3.1 Consultant's name and signature	
	3.2 Consultant's clinic address and phone number	
	4. Consultant's comments are relevant and clearly stated	
	4.1 A final diagnosis using ICD 10 classification is present	
	4.2 Treatment and follow-up instructions are present and clearly stated	
F	REFERRAL SYSTEM MANAGEMENT	
	1. Are referral guidelines and protocols available?	
	Are communication systems such as telephone and radios available?	
	Are standard referral forms available?	
	Are routine registers that allow for collection of referral data available?	
	Are referral data routinely analysed and discussed at the facility level?	
	Does the facility have access to a fully equipped, functional ambulance and personnel trained on emergency care?	
	Is a disaster management plan in place and is it known to all staff?	
	TOTAL POINTS	

8.2 Annex 2- Referral form

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF BOMET

DEPARTMENT OF MEDICAL SERVICES

Referral details

Management so far

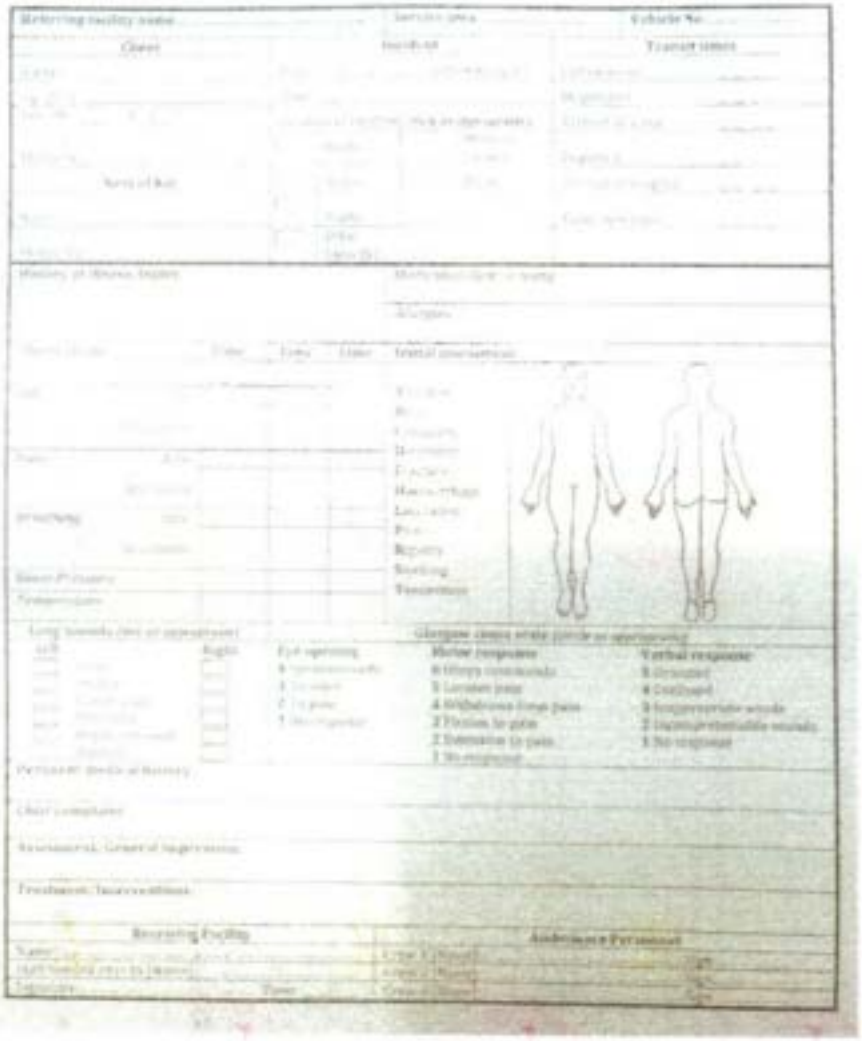
Reason for referral

Name of call

Signature

Referred

ANNEX 4: Client in Transit Monitoring Form



8.3 Annex 3- list of health facilities

MFL CODE	HEALTH FACILITY	SUB COUNTY	WARD
14728	Kapkoros Sub county hospital	Bomet Central	Chesoen Ward
	Kiptenden Dispensary	Bomet Central	Chesoen Ward
18522	Kitaima Dispensary	Bomet Central	Chesoen Ward
18520	Sibayan Dispensary	Bomet Central	Chesoen Ward
14384	Chesoen Dispensary	Bomet Central	Chesoen Ward
14903	Kiplelji Dispensary	Bomet Central	Chesoen Ward
15540	Segutiet Dispensary	Bomet Central	Chesoen Ward
14903	Kiplelji Dispensary	Bomet Central	Chesoen Ward
15540	Segutiet Dispensary	Bomet Central	Chesoen Ward

15710	Tarakwa Health centre	Bomet Central	Mutarakwa Ward
17294	Kapsangaru Dispensary	Bomet Central	Mutarakwa Ward
19848	Muiywek Dispensary	Bomet Central	Mutarakwa Ward
15608	Solyot Dispensary	Bomet Central	Mutarakwa Ward
14688	Kanusin Dispensary	Bomet Central	Mutarakwa Ward
14688	Kanusin Dispensary	Bomet Central	Mutarakwa Ward
18521	Kwenik-Ab -Ilet Dispensary	Bomet Central	Ndaraweta Ward
15323	Ndarawetta Health centre	Bomet Central	Ndaraweta Ward
18523	Nyongores Dispensary	Bomet Central	Ndaraweta Ward
22874	mogindo dispensary	Bomet Central	Ndaraweta Ward
21289	Good shepherd medical clinic	Bomet Central	Silibwet township
	Njerian dispensary	Bomet Central	Silibwet township Ward
19939	Bomet Youth centre	Bomet Central	Silibwet township Ward
14261	Bomet Health Centre	Bomet Central	Silibwet township Ward
22025	SILIBWET VCT	Bomet Central	Silibwet township Ward
14759	Kapsimotwa Dispensary	Bomet Central	Silibwet township Ward
	I Choose life Africa Bomet VCT	Bomet Central	Silibwet township Ward
15719	Tenwek Mission Hospital	Bomet Central	Silibwet township Ward
15570	Silibwet Dispensary (Bomet)	Bomet Central	Silibwet township Ward
21290	Bomet GK Prison dispensary	Bomet Central	Silibwet township Ward
15583	Singorwet Dispensary	Bomet Central	Singorwet Ward
18524	Kimuchul Dispensary	Bomet East	Chemaner Ward
14311	Chemaner Dispensary (Bomet)	Bomet East	Chemaner Ward
21298	Kakimirai Dispensary	Bomet East	Chemaner Ward
18526	Kipyosit Dispensary	Bomet East	Kembu Ward
15714	Tegat Health Centre	Bomet East	Kembu Ward
17083	Kembu Dispensary	Bomet East	Kembu Ward
21299	Chemengwa Dispensary	Bomet East	Kembu Ward
15171	Menet Dispensary	Bomet East	Kembu Ward
18525	Kiplabotwa Dispensary	Bomet East	Kipreres Ward
22168	Mulot stand alone VCT (Bomet)	Bomet East	Kipreres Ward
18519	Mulot Dispensary	Bomet East	Kipreres Ward
15421	Olokyin Health Centre	Bomet East	Kipreres Ward

21300	Cheboror Dispensay	Bomet East	Kipreres Ward
21171	Bomet county Beyond Zero mobile clinic	Bomet East	Longisa Ward
21297	Cheboin Dispensary (Bomet)	Bomet East	Longisa Ward
15077	Longisa District Hospital	Bomet East	Longisa Ward
14717	Kapkimolwa Dispensary	Bomet East	Longisa Ward
15178	Merigi Dispensary	Bomet East	Merigi Ward
14580	Irwaga Health Centre	Bomet East	Merigi Ward
	Kapsimbiri Dispensary	Bomet East	Merigi Ward
17085	Belgut Dispensary	Bomet East	Merigi Ward
14939	Kiromwok Dispensary	Bomet East	Merigi Ward
14628	Kaboson Health Centre	Chepalungu	Chebunyo Ward
20814	Chebunyo Stand Alone VCT	Chepalungu	Chebunyo Ward
14302	Cheboyo Dispensary	Chepalungu	Chebunyo Ward
14676	Kamongil Dispensary	Chepalungu	Chebunyo Ward
20438	Tilangok Dispensary	Chepalungu	Chebunyo Ward
14304	Chebunyo Dispensary	Chepalungu	Chebunyo Ward
20441	Roborwo Dispensary	Chepalungu	Chebunyo Ward
14815	Kataret Dispensary	Chepalungu	Chebunyo Ward
23337	Nogirwet Dispensary	Chepalungu	Chebunyo Ward
15388	Olbutyo Health Centre	Chepalungu	Kong'asis Ward
15116	Makimeny Dispensary	Chepalungu	Kong'asis Ward
20440	Kiboson Dispensary	Chepalungu	Kong'asis Ward
20439	Kimaya Dispensary	Chepalungu	Kong'asis Ward
20517	Kiriba dispensary	Chepalungu	Kong'asis Ward
15321	Ndamichonik Dispensary	Chepalungu	Kong'asis Ward
18664	Koimiret Dispensary	Chepalungu	Kong'asis Ward
14714	Kapkesosio Dispensary	Chepalungu	Nyangores Ward
20735	Cheptagum Dispensary	Chepalungu	Nyangores Ward
17092	Sachora Dispensary	Chepalungu	Nyangores Ward
14585	Itembe Dispensary	Chepalungu	Nyangores Ward
15751	Tumoi Dispensary	Chepalungu	Sigor Ward
20518	Chepkosa dispensary	Chepalungu	Sigor Ward
15565	Sigor Sub-District Hospital	Chepalungu	Sigor Ward
17093	Sugumerga Dispensary	Chepalungu	Sigor Ward
15100	Lugumek Dispensary	Chepalungu	Sigor Ward
18665	Lelaitich Dispensary	Chepalungu	Sigor Ward
18506	Kapisimba Dispensary	Chepalungu	Siongiroi Ward
14747	Kapoleseroi Dispensary	Chepalungu	Siongiroi Ward
15587	Siongiroi Health Centre	Chepalungu	Siongiroi Ward
18666	Bingwa Dispensary	Chepalungu	Siongiroi Ward
14921	Kipsuter Dispensary	Chepalungu	Siongiroi Ward
14376	Chepwostuiyet Dispensary	Chepalungu	Siongiroi Ward
20525	Kamundugi Dispensary	Chepalungu	Siongiroi Ward
14308	Chelelach Dispensary	Chepalungu	Siongiroi Ward
14828	Kenyagoro Dispensary	Konoin	Boito Ward
14584	Itare Dispensary	Konoin	Boito Ward
23026	Kabiangek Dispensary	Konoin	Boito Ward

18280	Boito Dispensary	Konoin	Boito Ward
14783	Kaptien Dispensary	Konoin	Boito Ward
18072	Michira Dispensary	Konoin	Boito Ward
23027	Chemelet Dispensary	Konoin	Boito Ward
14971	Koiwa Medical Clinic	Konoin	Boito Ward
14780	Kaptembwo Dispensary	Konoin	Boito Ward
19294	Kaproret Dispensary	Konoin	Chepchabas Ward
14331	Chepchabas Dispensary	Konoin	Chepchabas Ward
	Koruma Dispensary	Konoin	Chepchabas Ward
14310	Chemamul Dispensary	Konoin	Chepchabas Ward
14298	Chebitet Dispensary	Konoin	Chepchabas Ward
14365	Cheptabes Dispensary	Konoin	Chepchabas Ward
14287	Changoi Dispensary	Konoin	Chepchabas Ward
15717	Tenduet Dispensary	Konoin	Chepchabas Ward
15139	Marinyin Dispensary	Konoin	Chepchabas Ward
	Chemosit dispensary	Konoin	Chepchabas Ward
15576	Simotwet Dispensary	Konoin	Chepchabas Ward
15585	Siomo Health Centre	Konoin	Embomos Ward
18073	Embomos Dispensary	Konoin	Embomos Ward
14366	Cheptalal Sub County Hospital	Konoin	Embomos Ward
14927	Kiptenden Dispensary	Konoin	Embomos Ward
15620	Sotit Dispensary	Konoin	Embomos Ward
18074	Bosto Dispensary	Konoin	Embomos Ward
15533	Satiet Dispensary	Konoin	Embomos Ward
14760	Kapsinendet Dispensary	Konoin	Kimulot Ward
17999	Kimulot Dispensary	Konoin	Kimulot Ward
14289	Chebangang Health Centre	Konoin	Kimulot Ward
14285	Chemalal Dispensary	Konoin	Kimulot Ward
14757	Kapset Dispensary	Konoin	Kimulot Ward
23024	Salama Medical clinic	Konoin	Mogogosiek Ward
17583	Mogonjet Dispensary	Konoin	Mogogosiek Ward
14970	Koiwa Health Centre	Konoin	Mogogosiek Ward
15195	Mogogosiek Health Centre	Konoin	Mogogosiek Ward
21241	Kipajit Dispensary	Sotik	Chemagel Ward
14742	Kaplong Medical Clinic	Sotik	Chemagel Ward
21240	Kamirai Dispensary	Sotik	Chemagel Ward
15619	Sotik Health Centre	Sotik	Chemagel Ward
17880	Sotik Town VCT	Sotik	Chemagel Ward
14741	Kaplong Hospital	Sotik	Chemagel Ward
16317	Kapletundo Dispensary	Sotik	Kapletundo Ward
17808	Kapkesembe Dispensary	Sotik	Kapletundo Ward
16671	Kimawit-Uswet Dispensary	Sotik	Kapletundo Ward
17334	Cheptangulgei Dispensary	Sotik	Kapletundo Ward
14875	Kimolwet Dispensary	Sotik	Kapletundo Ward
15624	Soymet Dispensary	Sotik	Kapletundo Ward
23003	lelechwet dispensary	Sotik	Kapletundo Ward
15592	Siroin Adventist Dispensary	Sotik	Kapletundo Ward

14920	Kipsonoi Health Centre	Sotik	Kapletundo Ward
14297	Chebirbelek Dispensary	Sotik	Kapletundo Ward
18489	Grace Medical Centre	Sotik	Kipsonoi Ward
19849	Cheboet Dispensary	Sotik	Kipsonoi Ward
15233	Motiret Dispensary	Sotik	Kipsonoi Ward
17293	Kapkelei Dispensary	Sotik	Kipsonoi Ward
14938	Kiricha Dispensary	Sotik	Kipsonoi Ward
14932	Kiptulwa Dispensary	Sotik	Kipsonoi Ward
16318	Kapkures Dispensary (Sotik)	Sotik	Kipsonoi Ward
14290	Chebango Dispensary	Sotik	Kipsonoi Ward
15391	Oldepesi Dispensary	Sotik	Ndanai/abosi Ward
21242	Kapchemibei Dispensary	Sotik	Ndanai/abosi Ward
14531	Gorgor Dispensary	Sotik	Ndanai/abosi Ward
15322	Ndanai Dispensary	Sotik	Ndanai/abosi Ward
17722	Kapchumbe Dispensary	Sotik	Ndanai/abosi Ward
14740	Kaplomboi Dispensary	Sotik	Ndanai/abosi Ward
14505	Gelegele Dispensary	Sotik	Ndanai/abosi Ward
14918	Kipsingei Dispensary	Sotik	Ndanai/abosi Ward
15220	Monirre Dispensary	Sotik	Rongena/manaret Ward
14777	Kaptebengwo Dispensary	Sotik	Rongena/manaret Ward
14295	Chebilat Dispensary	Sotik	Rongena/manaret Ward
15532	Saruchat Dispensary	Sotik	Rongena manaret Ward
14215	Arroket Dispensary	Sotik	Rongena/manaret Ward
15497	Rongena Dispensary	Sotik	Rongena/manaret Ward
14273	Burgei Dispensary	Sotik	Rongena/manaret Ward
15575	Simbi Dispensary	Sotik	Rongena/manaret Ward

8.4 Annex 4- client transit monitoring form (Journey Logs)

ANNEX 4: Client in Transit Monitoring Form