Ministry of Health & Family Welfare
Government of India

OPERATIONAL GUIDELINES FOR NATIONAL AMBULANCE SERVICE (NAS)

2026

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Operational Guidelines for National Ambulance Service (NAS)

2026

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Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

MESSAGE

Access to timely and quality emergency medical transport is a critical component of a responsive and accountable public health system. Government of India remains committed to ensure that every individual receives timely and appropriate medical care, preventing avoidable loss of life and disability due to treatment delays.

2. The Operational Guidelines on National Ambulance Services have been developed to provide a comprehensive framework for States and Union Territories to standardise and strengthen emergency transport systems. The guidelines set out clear norms regarding ambulance categorisation, equipment and drugs, human resource requirements, training protocols, infection prevention measures, GPS-enabled fleet tracking, and integration with centralised command and control centres. They also emphasise performance monitoring, response time benchmarks, quality assurance, and accountability mechanisms.

3. Under the National Health Mission, the Ministry of Health and Family Welfare will continue to extend the requisite support to States and Union Territories to operationalise these standards effectively.

4. Efficient, accessible, and equitable ambulance services are indispensable for achieving Universal Health Coverage and advancing Sustainable Development Goals (SDG 3), particularly the reduction of mortality and morbidity from road traffic injuries and other emergencies. States and Union Territories are encouraged to align their emergency transport systems with these guidelines and take proactive steps toward systematic strengthening and standardisation.

5. I place on record my appreciation for the National Health Mission team, Ministry of Health and Family Welfare, and the domain experts whose technical guidance has shaped this framework. With collective resolve and sustained coordination, we can establish a dependable and future-ready emergency care network that protects lives and upholds the health security of our people.

(Punya Salila Srivastava)

#StopObesity
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MESSAGE

India's emergency care ecosystem is a vital pillar of the healthcare system, providing life-saving medical interventions during critical situations. Ambulances serve as the backbone of this system, acting as first responders that stabilise and transport patients during the critical "golden hour," significantly improving survival rates and health outcomes.

Under the National Health Mission (NHM), the Ministry of Health and Family Welfare has focused on strengthening emergency response services to ensure timely care for all. This includes a well-established ambulance network, encompassing Advanced Life Support (ALS), Basic Life Support (BLS), Patient Transport Vehicle (PTV) and innovative solutions such as bike and boat ambulances for geographically challenging regions. These services for emergency care reflect the Ministry's commitment to ensuring comprehensive access to emergency services across the country.

These National Ambulance Guidelines represent a major milestone in enhancing India's emergency response framework. These guidelines aim to standardise ambulance operations, ensure uniformity in equipment, medicines and establish a strong network of ambulances. By doing so, the aim is to provide equitable access to quality emergency care, even in the most underserved and remote areas.

I encourage all States and Union territories to adopt these guidelines to strengthen their emergency response systems. By leveraging these resources effectively, we can ensure timely and efficient emergency care delivery and reinforce our commitment to saving lives. I commend the Ministry of Health and Family Welfare, the National Health Systems Resource Centre, and all experts involved in the preparation of these guidelines. Let us work together to build a robust emergency care ecosystem that ensures health and well-being for all citizens.

(Aradhana Patnaik)

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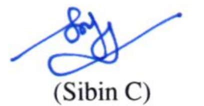
Message

Emergency medical services form the backbone of any healthcare system, acting as the first line of defence in saving lives during critical moments. Recognising this, the Ministry of Health and Family Welfare has developed the National Ambulance Services Guidelines (NAS) to set forth a standardised approach for delivering pre-hospital care, ensuring timely access to life-saving interventions, and strengthening emergency medical response across India.

India's emergency healthcare landscape has seen remarkable progress, from the introduction of centralised accident and trauma services to the adoption of toll-free numbers like 102 and 108. This guideline addresses the intricate and dynamic nature of emergency healthcare. These provide a robust framework covering essential aspects such as infrastructure planning, operational norms, human resource management, training, infection control, and the deployment of advanced technologies like GPS tracking and integrated command systems. While considering India's unique geographical and demographic challenges, the NAS guidelines are a milestone in elevating the quality of ambulance services nationwide.

The need for robust ambulance services was particularly evident during the COVID-19 pandemic, when ambulances played a critical role in managing patient transport, especially in high-demand and high-risk scenarios. I extend my gratitude to all stakeholders, including healthcare professionals, policymakers, and technical experts, who contributed to the development of these guidelines. Your hard work in preparing these comprehensive guidelines is a significant step in strengthening the emergency services of our country. I urge state governments, service providers, and allied agencies to embrace and implement these standards in letter and spirit. Together, let us reaffirm our commitment to a responsive, efficient, and inclusive emergency healthcare system that leaves no citizen behind.



(Sibin C)

Dated 22nd June, 2026

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राष्ट्रीय स्वास्थ्य प्रणाली संसाधन केंद्र
Ministry of Health and Family Welfare
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MESSAGE

The growing burden of trauma, road traffic accidents, and acute medical conditions like cardiovascular and respiratory emergencies highlights the urgent need for a robust emergency care framework. Over time, India's emergency care ecosystem has become a vital pillar for delivering timely medical interventions during crises. Early initiatives such as the establishment of emergency departments in hospitals and the launch of ambulance services marked the beginning of organised emergency medical services in the country.

Ambulances not only serve as the mode of referral, but also as the first point of contact in this ecosystem, serving as the first responders to the medical emergencies. These services bridge the gap between the scene of an emergency and definitive care facilities, significantly improving patient outcomes. Initiatives such as the National Ambulance Services have expanded pre-hospital care access in all parts of the country.

The release of these Guidelines marks a significant step towards further enhancing the emergency ecosystem in India. By standardising ambulance operations, ensuring uniformity in equipment & medicines, and promoting efficient patient referral protocols, these guidelines will strengthen the emergency response framework. This initiative aligns with the Ministry's vision of accessible, quality emergency care for all citizens and reinforces the government's commitment to saving lives through a responsive and resilient health system.

NHSRC is committed to work closely with the States and UTs in translating these guidelines into effective action on the ground by providing strategic guidance and continuous technical & implementation support. I am confident that implementation of these guidelines will strengthen emergency medical response system, improve service quality and support patient-centred care across diverse settings.

Prof. (Dr.) Pragya Sharma

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Message from Director, NHM

The Government of India is committed to achieving universal access to equitable, affordable, acceptable and quality care that is accountable and responsive to the needs of the people. All of these objectives are intended to be accomplished within the framework of the nation's vision for developing a comprehensive and resilient health system. Emergency medical services play a crucial role in healthcare delivery by providing prompt medical assistance in critical situations. Ambulances serve as the initial point of contact during emergencies, facilitating rapid stabilisation and care. Efficient emergency response systems are crucial for optimising the use of the critical period immediately following an injury or medical crisis. Proper management during this time can significantly impact outcomes in trauma care.

The National Health Mission (NHM) offers both technical and financial assistance to States and Union Territories to enhance their healthcare infrastructure, including support for ambulance services. A variety of ambulance types, such as Advanced Life Support (ALS) units, Basic Life Support (BLS) units, and innovative solutions like bike and boat ambulances for remote and difficult-to-access areas, ensure a comprehensive and inclusive approach to emergency care. The release of the Ambulance Guidelines marks a significant step forward in improving emergency medical care throughout India. These guidelines are designed to standardise ambulance operations, ensuring that emergency services are consistent and reliable for all citizens. This standardisation is crucial for enhancing the overall quality of care provided during emergencies.

I want to congratulate the entire team for their remarkable achievement in formulating and publishing the ambulance guidelines to be used by various state governments. This endeavour marks the first of its kind and serves as an invaluable resource for strengthening healthcare in India.

(Sh. Deepak Soni)

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Abbreviations

1. AA: Air Ambulance
2. ABC: Airway, Breathing, and Circulation
3. AED: Automated External Defibrillators
4. AIS: Automotive Industry Standards
5. ALS: Advanced Life Support
6. AMC: Annual Maintenance Contract
7. AMT: Aero-Medical Transportation
8. ANC: Antenatal Care
9. ASPA: Ancillary Service Procurement Agency
10. BA: Boat Ambulance
11. BLS: Basic Life Support
12. BMMP: Biomedical equipment management and maintenance program
13. BMW: Biomedical Waste
14. CAR: Civil Aviation Requirements
15. CATS: Centralised Accident and Trauma Services
16. CCC: Customer Contact Centres
17. CDC: Centres for Disease Control and Prevention
18. CMC: Comprehensive Maintenance Contract
19. CMO: Chief Medical Officer
20. CMVR: Central Motor Vehicle Rules
21. CPR: Cardiopulmonary Resuscitation
22. CRV: Comfortable Runabout Vehicle
23. DALYs: Disability Adjusted Life Years
24. DGHS: Directorate General of Health Services
25. DNR: Do Not Resuscitate
26. DMF: District Mineral Foundation Funds
27. EC: Emergency Care
28. ECG: Electrocardiogram
29. ED: Emergency Departments
30. EMT: Emergency Medical Technicians
31. EMS: Emergency Medical Services
32. ERO: Emergency Response Officers
33. GIS: Geographic Information System
34. GPS: Global Positioning System
35. HAIs: Healthcare-Associated Infections
36. HAZMAT: Hazardous Materials
37. HBV: Hepatitis B Virus
38. HCV: Hepatitis C Virus
39. HEMS: Helicopter Emergency Medical Services
40. HIV: Human Immunodeficiency Virus
41. HR: Human Resources
42. ICC: Integrated Command and Dispatch Centre
43. ICS: Incident Command System
44. ICU: Intensive Care Unit

45. IFT: Inter-Facility Transfers
46. IPC: Infection Prevention and Control
47. ISCO: International Standard Classification of Occupations
48. ISO: International Organization for Standardization
49. IV: Intravenous
50. JSSK: Janani Shishu Suraksha Karyakram
51. LMICs: Low- and Middle-Income Countries
52. LWE: Left Wing Extremism
53. MCI: Mass Casualty Incidents
54. MDGs: Millennium Development Goals
55. MDI: Multiple Dose Inhaler
56. MIS: Management Information Systems
57. MoHFW: Ministry of Health and Family Welfare
58. MoRTH: Ministry of Road Transport and Highways
59. MPLADS: Members of Parliament Local Area Development Scheme
60. MSG: Mission Steering Group
61. MVA: Motor Vehicle Accident
62. NAS: National Ambulance Service
63. NELS: National Emergency Life Support
64. NERS: Nationwide Emergency Response System
65. NHAI: National Highway Authority of India
66. NHM: National Health Mission
67. NSQF: National Skill Qualification Framework
68. OEM: Original Equipment Manufacturer
69. PCI: Percutaneous coronary intervention
70. PCR: Patient Case Record
71. PEEP: Positive End-Expiratory Pressure
72. PIP: Project Implementation Plan
73. POL: Petroleum Oil and Lubricants
74. PPE: Personal Protective Equipment
75. PPP: Public Private Partnership
76. PRI: Primary Rate Interface
77. PSAP: Public Safety Answering Point
78. PTV: Patient Transport Vehicles
79. RCH: Reproductive and Child Health
80. RFP: Request For Proposal
81. RTI: Road Traffic Injuries
82. RTA: Road Traffic Accident
83. RVSF: Registered Vehicles Scrapping Facilities
84. SDGs: Sustainable Development Goals
85. SDS: Safety Data Sheet
86. SLA: Service Level Agreement
87. SOP: Standard Operating Procedure
88. ToR: Terms of Reference
89. UT: Union Territory
90. WHA: World Health Assembly
91. WHO: World Health Organi sation

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1. Background

1.1 Introduction to Emergency Medical Services

During emergencies, people need reliable emergency medical services in every part of India. Emergency medical services provide life-saving care and transport patients to the nearest appropriate health facility.

Emergency services must be accessible and available to people rapidly, irrespective of their location. Emergency Medical Services (EMS) provide care at the scene, during transport and between facilities so that patients reach the right place at the right time.

EMS includes call receipt and dispatch, emergency response, field triage and stabilisation, and transport by ambulance (and, where available, other modes) to an appropriate health facility. It is a critical part of the health system because it:

- Reduces delay in reaching care,
- Provides life-saving support before reaching the hospital, and
- Offers safe medical transport between facilities.

1.2 Significance of Timely Emergency Care

Emergency care is an integrated platform to provide time-sensitive medical attention for acute illness and injuries across the life course. Many proven health interventions lose effectiveness due to a delay in care.

Global and regional evidence shows that:

- Effective pre-hospital and emergency care can prevent a large proportion of deaths and disability in low- and middle-income countries, and
- Trauma and emergency conditions account for a major share of deaths and disability in the South-East Asia Region.

In India, medical emergencies, including road traffic injuries (RTIs), are among the leading causes of death, with RTIs alone contributing to around two lakh deaths annually. Delays in recognising emergencies, arranging transport, and accessing appropriate facilities all contribute to avoidable deaths and complications.

Timely emergency care therefore, requires:

- Early recognition of danger signs,
- Rapid activation of ambulance service,
- Stabilisation during transport, and

- Prompt handover to a prepared facility.

A well-organised NAS is central to achieving this continuum of care.

1.3 Overview of Ambulance Service in India under NHM

1.3.1 Evolution of National Ambulance Service (NAS)

Ambulances were first used for emergency transport in 1487 by the Spanish forces. The civilian variants of the transport vehicles were put into operation in the 1830s. Advances in technology throughout the 19th and 20th centuries led to the invention of modern ambulances. In 1985, Mumbai took the lead in establishing a city-based ambulance service with a central dispatch system - the first for India. 1991 marked a milestone with the launch of the Centralised Accident and Trauma Services (CATS) in Delhi, a dedicated emergency response service with ambulances.

Ambulance service in India has grown from sporadic city-based models to a national network supported under the National Health Mission (NHM). The National Ambulance Service (NAS) were launched in 2012 under the National Health Mission (NHM). Dial 108 emerged as an emergency response service, whilew Dial 102 was used primarily for patient transport, especially for pregnant women, newborns and children. States are now expected to progressively integrate ambulance call handling with the unified emergency number 112, while ensuring continuity of existing 108/102 services during the transition.

As of December 2025, NHM supports **28,472 ambulances**[1] [ALS: 3287, BLS: 15472, PTV: 3912, Boat: 19, Bike: 81 and Others 5701 (Neonatal ambulances, Free Hearse Services/ Mortuary Vans & JSSK drop back services etc)] across the country. People in 34 States and Union Territories can access ambulance service by calling 108, 102, or 112. However, the focus is on establishing Integrated Command and Dispatch Centres with the common emergency helpline number 112.

To improve quality and standardisation, the National Ambulance Code was developed by MoRTH and MoHFW to define structural and functional criteria for road ambulances. However, implementation models, fleet size, service quality and governance arrangements still vary widely across States and UTs.

1.3.2 Need for National Operational Guidelines and Role of NAS Study

NHM has been supporting NAS for more than a decade, but no formally approved national operational guidelines existed to guide planning, deployment and monitoring. States and UTs required guidance on:

- Number and type of ambulances,
- HR and training norms,
- Call centre operations and integration with 112, and
- Performance indicators and governance.

NAS has now become the main organised referral and emergency transport

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[1]Available at URL https://nhm.gov.in/index4.php?lang=1&level=0&linkid=457&lid=686

system for pregnant women, newborns, trauma and acute medical conditions in many States. Call volumes for 112 (108/102 or state number) have also increased steadily, showing growing trust and utilisation. Some States have established robust EMT training systems, SOPs and integrated dashboards linking ambulances to emergency and critical care services.

However, gaps exist in terms of EMT skills, response times and expected outcomes. To address these gaps, the Ministry, through the NHSRC, undertook a rapid, mixed-methods National Ambulance Service (NAS) Study in nine States, covering both high-focus and non-high-focus States. The study assessed:

- Functionality and utilisation of ALS and BLS ambulances;
- Performance and capacity of call centres;
- Skills and working conditions of EMTs;
- Integration with 112 and referral networks; and
- Beneficiary perspectives on timeliness and quality.

Common findings included:

- Lack of competency-based structured training for EMTs and Pilots,
- Issues with deployment, delayed response times and fleet age;
- Significant off-road time in a few States due to breakdowns and delays in maintenance;
- Gaps in call-triage, documentation and use of GPS; and
- States with stronger triage protocols, GPS-based deployment and regular monitoring showed better response times and more efficient use of the fleet.

The multi-state NAS study directly informs the need for Operational Guidelines. The study provides an evidence base for these Guidelines and helps States and UTs standardise ambulance services while retaining flexibility for local needs. These Guidelines will guide States/UTs so that NAS can provide timely, equitable and high-quality emergency transport across the country.

2. Scope and Objectives of Guidelines

The guidelines provide a national framework to standardise the planning, operation, and monitoring of National Ambulance Service across States and UTs, covering ambulance types, operations, staffing, integration with emergency systems, quality assurance, and governance to ensure efficient, equitable, and timely emergency transport services.

2.1 Primary objective

To provide uniform national operational guidance for planning, deployment, and management of an integrated ambulance transport system that supports comprehensive emergency response and referral services across States and UTs.

2.2 Secondary objectives

- To provide technical guidance, protocols and specifications for the implementation and operation of National Ambulance Service in their States.
- To provide specifications regarding the type of ambulances (road ambulances) for Basic and Advanced life support.
- To define the norms and protocols for deployment, along with steps for maintaining the quality of the ambulances.
- To develop guidelines to run an integrated command and dispatch centre with a robust governance system for the smooth running of referral services.

3. Types of Ambulances

This chapter defines the different categories of ambulances used in India for emergency medical services, referral, and transport of patients. It provides specifications for road ambulances based on their function, equipment, staffing, and operational capabilities. Standardisation ensures safety, efficiency, and timely care for patients across diverse geographical and socio-economic contexts.

3.1 Road Ambulances

Road ambulances are the most common and widely used vehicles for pre-hospital care and patient transport. In India, the Ministry of Road Transport and Highways (MoRTH) classifies ambulances into four types based on medical equipment, level of care, and intended use.

As per Automotive Industry Standard -125 (AIS-125) provided by MoRTH, a "Road ambulance or Ambulance is a specially equipped and ergonomically designed vehicle for transportation / emergent treatment of sick or injured people and capable of providing out-of-hospital medical care during transit/when stationary, commensurate with its designated level of care when appropriately staffed."

Patient: Any sick or injured person whose condition requires appropriately trained personnel to provide medical care and/or suitable transport.

Emergency Patient: Patient who, through sickness, injury or other circumstances, is in immediate or imminent danger to life unless emergency treatment and/ or monitoring and suitable transport to appropriate medical facilities or medical treatment are provided.

Based on the care provided by the ambulance, the following types of ambulances are defined:

1. **Patient:** Any sick or injured person whose condition requires appropriately trained personnel to provide medical care and / or suitable transport.
2. **Emergency Patient:** Patient who through sickness, injury or other circumstances is in immediate or imminent danger to life unless emergency treatment and / or monitoring and suitable transport to appropriate medical facilities or medical treatment are provided.

Based on the care provided by the ambulance, the following types of ambulances are available:

Classification based on the Automotive Industry Standards-125

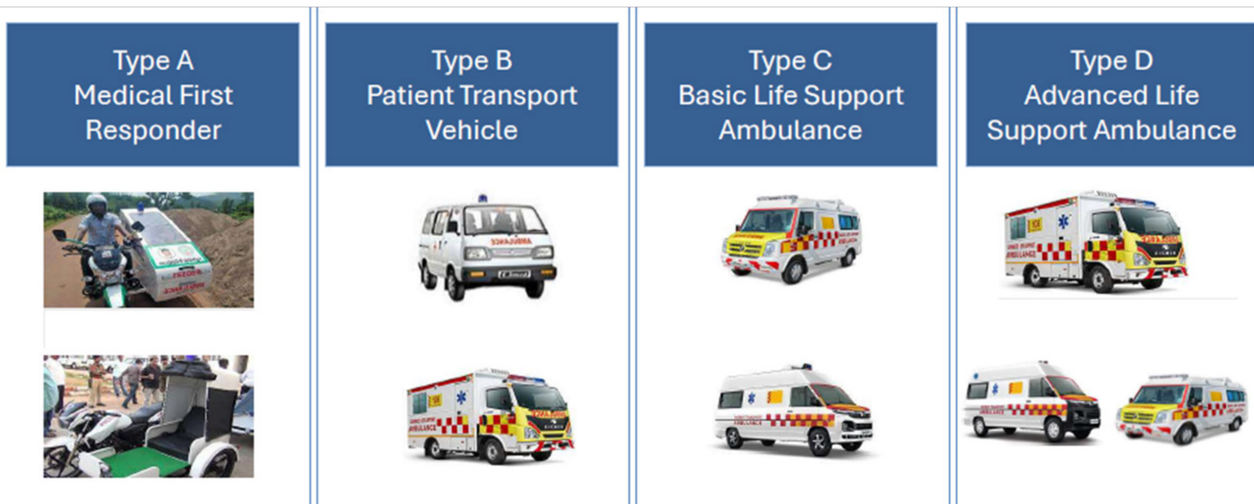
- **Medical First Responder (Type A Road Ambulance):** Road Ambulance designed to provide emergent out of hospital medical care to patients when stationary. This

vehicle maybe any Cental Motor Vehicle Rules 1989 (CMVR) approved Category M or L (refer CMVR for category details) vehicle suitable for the terrain to be used in but will not have the capability to transport patients in supine state or provide them medical care inside the vehicle. Bike ambulances are an example of a first responder ambulance.

- **Patient Transport Vehicle (Type B Road Ambulance):** These ambulances are used for the transport of patients who are not expected to become emergency patients.
- **Basic Life Support Ambulance (Type C Road Ambulance):** A vehicle ergonomically designed, suitably equipped and appropriately staffed for the transport and treatment of patients requiring non-invasive airway management/basic monitoring.
- **Advanced Life Support Ambulance (Type D Road Ambulance):** A vehicle ergonomically designed, suitably equipped and appropriately staffed for the transport and treatment of emergency patients requiring invasive airway management / intensive monitoring.

The constructional and functional requirements of Road Ambulances are also covered under AIS-125 (Part-1) as amended from time to time. The same has been notified under Rule 125F of CMVR, 1989, for all types of Ambulances specified therein. All ambulances manufactured on or after 1st April 2018 shall have to comply with the notified Central Motor Vehicle Rules 1989 (as amended from time to time) and AIS-125.

Examples of Type A, B, C, and D (indicative only)



3.2 Other Ambulances

Other ambulances, apart from road ambulances, such as Boat and Air ambulances, are also in use in the states. However, their norms are not specified in these guidelines.

Air Ambulance (AA):

An air ambulance is a specially equipped aircraft or helicopter that functions like a flying intensive care unit (ICU). It is staffed with a trained medical team and

equipped with life-saving medical equipment. The primary goal of air ambulances is to transfer patients swiftly and safely, especially in situations where ground transportation is not feasible due to distance, traffic, or patient condition.

Boat Ambulances (BA): A boat ambulance, or water ambulance, is a specialized vessel designed to provide emergency medical care and transport patients in areas inaccessible by road, like coastal regions, islands, or flooded zones, equipped with life support, stretchers, and trained staff to offer critical aid en route to hospitals.

A Few important features of Boat Ambulances are:

1. Water-Based Access: Serves communities located on islands or near extensive waterways where traditional ambulances can't reach efficiently.
2. Medical Equipment: Fitted with advanced life support (ALS) gear, including ventilators, defibrillators, operating tables, and medications, similar to land ambulances.
3. Trained Personnel: Staffed by paramedics and medical teams capable of providing immediate stabilization and treatment.
4. Stable Platform: Built for stability in water to allow for safe procedures, with features to resist rolling.

These ambulances bridge healthcare gaps by reducing response times and ensuring timely access to medical facilities for water-locked populations. Boat ambulances have high importance in situations like water accidents requiring urgent medical intervention, drowning incidents, etc. The fast response time and accessibility during flooding and monsoon season make water ambulances an excellent alternative in riverine areas. Two categories of boats include River Boats and Marine Boats.

Boat ambulances are not commonly supported under NHM, and if needed, are recommended only after thorough need assessment on a case-by-case basis.

3.3 Electric Ambulances

The e-Ambulance initiative under the PM Electric Drive Revolution in Innovative Vehicle Enhancement (PM E-DRIVE) Scheme is a key step by the Government of India toward sustainable and efficient emergency healthcare transportation. This scheme aims to accelerate electric mobility adoption nationwide. The Ministry of Heavy Industries (MHI) has notified a dedicated framework for electric ambulances under the PM E-DRIVE Scheme, earmarking Rs 500 crore in incentives to support the deployment of around 3,800 e-ambulances during FY 2027 and FY 2028. The incentive will be available to central and state government departments, public sector undertakings (PSUs), and other eligible public entities. The support can also be combined with assistance available under the National Health Mission (NHM) and other government schemes[2].

Under the scheme, three main categories of e-Ambulances: Type B (Patient Transport Vehicles), Type C (Basic Life Support), and Type D (Advanced Life Support) are eligible for incentives. The support aims to make e-ambulances more affordable and accessible, fostering a cleaner, technologically advanced

[2]Available at URL: https://pmedrive.heavyindustries.gov.in/docs/policy_document/273533.pdf

emergency response ecosystem. These vehicles must also comply with the Central Motor Vehicle Rules (CMVR), 1989 and Automotive Industry Standards (AIS-125) to ensure high performance, safety, and reliability in life-saving operations.

4. Principles of Planning

Planning for ambulance services should help a district team to answer four simple questions:

1. Where should we keep our ambulances?
2. How quickly can we reach the patient?
3. Which facility should the ambulance take the patient to?
4. Are the limited resources being used in the best possible way?

In the NAS study, districts that planned ambulance locations based on call patterns, accident spots, and referral linkages showed better response times and higher utilisation. These guidelines focus on practical principles that can be used by State, district and block teams while planning the number, type and location of ambulances, call centres, and staff.

States and districts should follow these principles while planning emergency referral transport services:

- **Adequate placement:**
    - Place ALS, BLS and PTV ambulances based on case load, geography and referral patterns such as maternity, trauma, cardiac and stroke emergencies.
    - Use call data from the Integrated Command & dispatch Centre (ICC) to identify high-risk zones- accident-prone stretches, high-risk pregnancy clusters, tribal and remote pockets.
- **Timely Response**
    - The aim is to reach the patient as early as possible and preferably within 20 minutes, with a long-term goal of 10 minutes in busy urban and peri-urban areas.
    - Base locations should minimise travel time, not only distance (traffic, road condition and terrain must be considered).
- **Adequate Linkage**
    - Ambulances should take patients to a functional facility where they can receive definitive care (e.g. FRU for deliveries, trauma centre, or higher facility for stroke and cardiac emergencies).
    - Referral linkages should be mapped and shared with call centres and EMTs.
- **Plan for difficult and vulnerable areas**
    - Special arrangements are needed for hilly, tribal, island, desert, flood-prone, hard-to-reach villages and Left Wing Extremism (LWE) areas.

- **Functional Fleet**
  - At least 95% of ambulances should be functional at any point in time.
  - District teams should monitor breakdowns, accident repairs and turnaround time with the service provider or transport unit.
- **Community awareness and easy access**
  - People must know the ambulance calling number (112).
  - Districts should conduct IEC activities periodically through VHNDs, VHSNCs, PRI meetings, schools, local media and other suitable platforms.

4.1 Deployment & Response Time

1. Evidence-based planning and deployment:

States should decide the number, type and location of ambulances based on population, geography, case load and response-time requirements. (For example: placing the ambulance in accident-prone areas/zones, high-density population clusters, public health facilities, and public institutions). It essentially entails providing access to a functional health facility where patients in emergent circumstances can be offered definitive care within the golden hour.

Golden hour in Trauma Cases

In trauma and many medical emergencies, the first hour after the incident is called the **"golden hour"**. If the patient reaches a facility where surgery or definitive treatment can be started within this hour, the chances of survival and recovery are much higher.

For District and Block teams, this means:

- Placement of ambulances in accident-prone locations, highway junctions, industrial areas and busy market stretches.
- Patrol vehicles, Crash Rescue Vehicles (CRVs) and ambulances should work in coordination in accident/trauma cases (e.g. at highway stretches).
- Ambulances should give only essential pre-hospital care (e.g. airway, breathing, circulation, control of external bleeding, immobilisation) and move quickly to the appropriate facility.

Response Time

Response time is the time between receiving the call and the ambulance reaching the patient. It is a key indicator of ambulance performance. Based on global experience and more than a decade of NAS support in India, the following benchmarks are recommended:

- **Response Time up to 20 minutes** should be used as the standard measure of performance for NAS.
- States and districts should gradually aim to bring it **closer to 10 minutes.**
- District teams should regularly review response time data with the call centre and service provider, identify "slow" areas, and adjust base locations or routes accordingly.

Global Scenario

According to the US EMS Act, 95% of the emergency requests should be served within 10 min in urban areas and within 30 min in rural areas.

In the United States, the average ambulance response time for an EMS unit to arrive on the scene from the time of 911 call was 7 minutes. This emergency response time increased to more than 14 minutes in the rural settings, as per a report whereas that in UK was 8 minutes for the ambulance to arrive if the call is life-threatening or an emergency.

The "Scoop and Run" treatment is generally to transport the patient within ten minutes of arrival, hence the birth of the phrase, "the platinum ten minutes" (in addition to the "golden hour"), for trauma cases.

For Cardiac cases, the gold standard is the door to balloon time, which should not be more than 90 minutes. This can be achieved when appropriate patients are identified by EMTs in the field and directly transported to Primary Percutaneous coronary intervention (PCI) labs

Response Time Parameters:

The response time of the ambulances may be measured or assessed on six different parameters:

1. **Dispatch time:** This is the time taken by the Emergency Response Officers (ERO)/Dispatchers in dispatching the ambulance from the time of receiving an emergency call.
2. **Chute time:** The time taken by the ambulance to start moving towards the scene of emergency from the time the case is being allotted to them by the ERO operating from the call centre.
3. **Response time:** The time taken by the ambulance to reach the scene from its point of dispatch.
4. **Time on Scene:** It is the time spent by the ambulance on the scene after reaching there, till the time it departs.
5. **Transport time:** It is measured from the moment the ambulance leaves the scene until the patient arrives at the destination health facility.
6. **Return time:** It is the time taken by the ambulance to reach its base location after leaving the health facility where they have handed over the patient.

Collectively, the entire period from dispatch to placing an ambulance back in service is referred to as total call time.

Some other critical points:

- When organizing emergency response ambulance services, it is important to gather all available ambulances from the state, NHM, MPLADS, donations, NHAI, MoRTH, or any other source to offer comprehensive coverage.
- Based on the requirements/calls received and the nature of the emergency, the utilization of various ambulances may vary. Hence, different States/UTs would require different implementation strategies, based on their existing status of ambulance services utilization and vehicle mix.
- It is advisable to have good motorable road/air/water connectivity for various habitations for effective emergency response services.

2. GIS-based mapping of various health facilities and real-time GPS tracking of ambulances

For appropriate and timely response & referrals, all public health facilities and ambulances should be incorporated into a GIS and GPS mapping system. Along with this, mapping of the vacant number of beds, blood availability and Operation theatre/ ICU/ Emergency/ maternal delivery room readiness in the health facilities should also be undertaken. Public Emergency Management agencies like the Police and Fire Service should also be integrated into the real-time information system for guidance, monitoring, and other necessary actions. GIS-based mapping will enable the real-time positioning of the ambulances.

At the district level, a simple map showing ambulance base locations, major facilities and high-risk areas, updated every 6-12 months, is sufficient to start using GIS and GPS data for better planning. The mapping process should be integrated into routine review meetings so that ambulance deployment decisions are based on evidence instead of assumptions. District authorities can compare response times across blocks, identify underserved areas, and revise ambulance stationing accordingly. In rapidly growing urban or peri-urban areas, mapping of the traffic congestion patterns and changing settlement locations should also be undertaken.

4.2 Centralised Call Centre: Technology and integration with 112

Ideally, all the ambulances in any State/UT should be accessible through a single Emergency Number 112. It is envisaged that for efficient utilisation of available resources, all ambulances in a State/UT are mandated to be GPS-enabled, networked and interconnected through a Centralised Call Centre.

All NAS call centres/ICCs should be equipped with:

- Computer and software systems for call logging, triage and dispatch.
- GPS-based system to track the ambulances, identify the nearest available vehicle and referral points (Healthcare facility).
- Dashboards to monitor key indicators such as response time, trips per vehicle, and ambulances off-road.

4.3 Quality Improvement

Quality improvement is a continuous process, and to ensure the same, adherence to standards, SOPs, training of EMTs, competency-based certification and ensuring the availability of the equipment and medicines is of paramount importance. Quality checkpoints have to be part of service level agreements, with mechanisms for regular audits along with corrective actions to be facilitated through designated nodal officers.

5. Norms for Ambulances

Ambulance norms guide the strategic deployment of vehicles and define human resource requirements, including the roles and skills of EMTs, drivers, and support staff. States and UTs are expected to adopt these guidelines to ensure timely, safe, and effective pre-hospital care through a responsive and sustainable ambulance network.

5.1 Population Norms:

The population norms for ambulances are based on geographic and demographic considerations. The table below gives indicative norms for planning the number of ALS, BLS and PTV ambulances at the State and district levels. While planning ambulance services, the following aspects must be taken into consideration:

- Case load (for example, deliveries, trauma, NCD emergencies),
- Geography and distances,
- Existing public and private transport options, and
- Current/existing NAS performance

The population norms are as detailed below:

Type of Ambulance	Population Norms	Region
ALS*	1 ALS per 5 lakh population	All Regions
BLS	1 BLS per 1 lakh population	All Regions
PTV	1 PTV per 50,000 population	All Regions

*Ambulances for neonates & children are counted in the fleet of ALS ambulances only.

However, if the time to care or the average utilisation per ambulance per day is higher than four trips (or 120 Kms travelled) for densely populated areas and 3 Trips (or 80 Kms travelled) for hilly areas, then the State can be supported for additional ambulances.

Additional support is provided based on:

1. Norms approved by Mission Steering Group.
2. Performance indicators.
3. Additional ambulance for projected requirements.

4. Special considerations for difficult and vulnerable areas.

5.2 Human Resource requirements for various ambulance types

Human resources are the backbone of NAS. Even with good vehicles and equipment, services will not function well without trained and motivated staff.

Type of Ambulance	Indicative HR Deployment	
	HR	Number/Shift
Advanced Life Support (ALS) Ambulance	Driver	One
	EMT(Advanced)*	One
Basic Life Support (BLS) Ambulance	Driver	One
	EMT(Basic)	One
Patient Transport Vehicle (PTV)	Driver	One

*In case EMT (Advanced) is not available, the services of OT Assistants/ ICU Nurses, etc. can be utilised. Note: If a pt. Requires a higher level of invasive ventilation/ monitoring during transport or interfacility transport; a doctor may accompany the patient.

The detailed roles & responsibilities of ambulance staff are provided as Annexure 3.

Recruitment standards for EMTs and Drivers

States and service providers should follow clear recruitment standards:

EMTs

Minimum qualifications for EMTs deployed under NAS:

- Should possess a recognised qualification in Emergency Medical Technician/Pre-Hospital Trauma Technician Course, aligned with the national or State-notified EMT curriculum[3] and approved by the National/State Allied and Healthcare Professionals Council or a recognised university / AICTE-affiliated institution.
- Maintain valid Basic Life Support (BLS) certification, and, for EMTs posted on ALS ambulances, valid Advanced Life Support (ALS/ACLS) certification from accredited training providers[4] with periodic re-certification.
- Be able to communicate clearly in the local language, with functional proficiency in basic Hindi and English, and meet the minimum age, fitness and regulatory requirements prescribed for EMTs in the State.

Detailed eligibility criteria, including regulatory, age and fitness requirements, are provided in Annexure 6.

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[3](for example, National Skill Qualification Framework (NSQF)-aligned HSSC EMT-B / EMT-A or equivalent),

[4]for example, Indian Red Cross Society / American Heart Association

Drivers

Ambulance drivers deployed under NAS should:

- Hold a valid transport / commercial driving licence for the relevant vehicle category, with at least three years of accident-free driving experience, or as per extant State norms.
- Have completed a formal training in safe and defensive driving, basic vehicle maintenance, and Basic Life Support (BLS) / first aid from a recognised training provider, so that they can support the EMT during emergencies.
- Be familiar with local geography and road conditions, and able to communicate basic information clearly in the local language (and basic Hindi/English where needed) for coordination with patients, families and facilities.

Basic welfare and safety provisions should include:

- Defined duty hours and rest periods, including for night shifts.
- Accident insurance and medico-legal support for staff injured while on duty.
- Safe accommodation or rest facilities for staff posted in remote or high-risk areas.
- Mechanisms for grievance redressal, including for harassment, especially for women EMTs and call-centre staff.

6. Logistics

This section describes the logistics and their maintenance for optimal functioning of the National Ambulance Service. The equipment, drugs and consumables are described in accordance with the classification of ambulances under the CMVR.

6.1 Medical Equipment, Drugs and Consumables

a. Specifications, Procurement and Maintenance of Medical Equipment

The medical equipment and medical devices required in ambulances shall comply with AIS-125 and specifications notified by MoRTH[5], as amended from time to time. The equipment list for BLS and ALS ambulances is provided in Annexure 4.

Medicines and consumables for ambulances shall be maintained as per the minimum list provided in Annexure 5. This medicine list is intended as a practical minimum list for NAS operations and should be used only by trained and authorised personnel as per State-approved clinical protocols.

The implementing agency or service provider should ensure calibration, maintenance, servicing and availability of spares/consumables for all equipment through AMC/CMC with the OEM or other competent agencies.

Where the State operates ambulance services directly, it may maintain medical equipment through the Biomedical Equipment Management and Maintenance Program (BMMP) or any other approved State mechanism.

Each ambulance should maintain an equipment checklist. The EMT on duty should check all equipment before every shift, record its functional status and immediately report any malfunction or failure to the fleet supervisor. Any equipment found to be malfunctioning will be taken out of service and replaced with spare equipment. Non-availability of the major life-saving equipment (medical oxygen, bag and mask ventilation device, ventilator, monitor, defibrillator, suction pump, infusion pump) will warrant de-rostering the ambulance and imposition of penalty till the time the equipment is replaced/repaired.

b. Inventory Management for Drugs and Consumables

The Ambulance Service provider will be responsible for providing the consumables and drugs as listed in the appendix. Records will be kept by the fleet supervisor regarding the expiry dates of the drugs and consumables. The service provider should replace near-expiry drugs and consumables before their expiry date.

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[5]Available at URL: https://hmr.araiindia.com/Control/AIS/227201553254PMAIS-125_Part_2_F.pdf

States may adapt or expand the medicine list based on local epidemiology, availability of trained EMTs, legal provisions, storage conditions and medical direction through the Integrated Command and Dispatch Centre (ICC). High-risk medicines, controlled drugs, thrombolytics, vasoactive infusions and specialist critical-care medicines should not be made mandatory for routine ambulance deployment unless clear protocols, training, storage, documentation and medical oversight are ensured.

Each ambulance will have a checklist/log book of the inventory. The ambulance EMT, before commencement of his duty, will check the inventory items and report to the fleet supervisor regarding near-expiry items/ used items. The used items will be replenished based on a timely ordering system. Similarly, if any disposable items are used in the previous shift, they will be replaced. They will sign the checklist at the beginning of their duty and hand it over to the next ambulance personnel after the conclusion of their duty

The ambulance EMT shall be responsible to maintain at-least 90% of the total storage capacity of Oxygen. If the Oxygen storage goes less than 50%, the ambulance EMT must replace the cylinder with a 100% full oxygen cylinder.

6.2 Vehicle Maintenance

Preventive maintenance schedule

The service provider shall implement a preventive maintenance schedule for the regular and detailed inspection of all vehicle components, including the engine, oils and lubricants, underbody parts, tyres, and electrical systems. The schedule shall prescribe recommended service intervals, which may be modified based on local operating conditions. In doing so, due consideration shall also be given to the manufacturer's recommendations and instruction manual.

An illustrative example would be:

S. No.	Service Schedule	Service Points
I	Daily	Check lights, signals, warning systems, engine oil level, Brake oil, Gear oil level, Engine coolant level, fuel levels, 2tyre pressure (Pneumatic), air conditioning, heating system, wipers, brakes, and overall engine condition.
II	5000 KM	Change oil, oil filters, air filters, check suspension, belts, alternator check, brake wear, battery load test, plus daily checklist.
III	25000 KM	All of II plus, check suspension and differential, fuel filter, brake pads and rotors.
IV	50000 KM	All of III plus, replace belts, fuel filters, and transmission fluid.

S. No.	Service Schedule	Service Points
V	100,000 KM	All of IV, plus replace A/C compressor and dryers, hoses, oil bypass lines, repack bearings, and replace shock absorbers.

Before taking over the ambulance, the driver should check that all vehicle systems are functional, including siren, communication device, headlights, emergency lights, brake lights, patient-compartment lights, wipers, air-conditioning and other required systems. The ambulance driver shall keep up and maintain all the vehicle documentation. The shortcomings should also be documented on the driver check sheet and reported to the Supervisor. Vehicles will be washed daily, and both the interior and exterior should be cleaned. The patient cabin should be cleaned and disinfected with a 1% sodium hypochlorite solution after every patient transport, especially following the transportation of a patient with a suspected infectious disease. Further details are provided in the infection control section.

6.3 Scrappage of ambulance vehicles

Ministry of Road Transport and Highways (MoRTH) has introduced the Voluntary Vehicle-Fleet Modernisation Program (V-VMP)[6] also known as the Vehicle Scrapping Policy, aimed at promoting an environmentally friendly ecosystem to phase out unfit and polluting vehicles. As part of this initiative, a network of Registered Vehicle Scrapping Facilities (RVSFs) has been established across the country to ensure safe and Eco-friendly disposal of these vehicles. Under this Policy, the MoRTH issued a notification (G.S.R. 29 (E) dated 16th January 2023), which mandates the non-renewal of the Certificate of Registration for Government vehicles older than 15 years. Such vehicles must be scrapped exclusively at Registered Vehicle Scrapping Facilities (RVSFs). Scrappage of ambulances shall be dealt with in accordance with the provisions therein for various categories of vehicles.

The following criteria are provided for the scrapping of vehicles at the Registered Vehicles Scrapping Facilities (RVSFs):

- Those vehicles that have not renewed their Certificate of Registration as per Rule 52 of the CMVR, 1989.
- Vehicles that have not been granted a fitness certificate in accordance with Section 62 of the Motor Vehicles Act, 1988.
- Vehicles which might have been damaged due to unforeseen circumstances like fire, riot, natural disaster, accident or any calamity, etc., when the owner may self-certify the same as scrap.
- Vehicles that have been declared obsolete, surplus, or beyond the scope of economic repair by the Central/State Organisations of the government and have been offered for scrapping.

[6] Available at URL: https://www.pib.gov.in/PressReleasePage.aspx?PRID=1985809®=3&lang=2

- Vehicles that have outlived their utility or application.
- Vehicles voluntarily offered to an RVSF for scrapping, at the discretion of the owner

The State and District Nodal Officers should ensure the implementation of the Scrapping Policy.

6.4 Fleet functionality and reserve capacity

All ambulances approved under NAS shall be treated as the mandated fleet and are expected to always remain deployed and available for service, except for short periods of approved downtime for maintenance, breakdown or accident repairs.

For performance monitoring and payment:

- The overall fleet availability should not fall below 95% of the fleet at any given day.
- Each ambulance should remain available for service for at least 28.5 days in a calendar month, unless prior written approval for longer downtime for an absolute essential is obtained from the District Nodal Officer (DNO).

Days on which a vehicle is off-road without written approval from the district authority, shall not be counted for payment and may attract penalties as per the Service Level Agreement (SLA). The service provider shall inform the district authority before taking any vehicle off-road (except in a sudden breakdown/accident) and specify the expected date for restoring the vehicle to operational status.

District Nodal Officer should maintain a record of off-road vehicles and reasons for downtime, review this every month and take action where repeated or long downtime is seen.

How a district can practically use these norms

- Start with the population norm table to estimate the number of ALS, BLS and PTVs needed for the district.
- Review NAS call data (108/102/112) for the last 6-12 months: number of calls, type of emergencies, major locations.
- Identify high-need areas: tribal blocks, accident black spots, high-delivery load facilities, urban slums.
- Decide base locations and link each ambulance to a set of facilities (CHC, FRU, DH, Medical College).
- Ensure at least 95% fleet functionality at any given day and monitor down-time.
- Review the plan once every year or earlier if there are major changes in population, facility availability or road conditions.

State teams can request technical support from NHSRC, for planning ambulance deployment/services.

7. Costing Norms for Ambulances

Every year, the Government of India supports States and UTs to run and expand ambulance services through the NHM Program Implementation Plan (PIP). States propose the number and type of ambulances required, along with the recurring cost of operating them, based on the local gaps, utilization, geography and service requirements. States/UTs may use the NHM-approved norms for ambulances.

8. Training and Skill Upgradation /Capacity Building

8.1 Principles of training

Training for EMTs, ambulance drivers, and call centre staff should not be a one-time activity. It is the responsibility of the service provider to ensure that only trained and eligible EMTs and drivers, as per the minimum criteria given in these Guidelines and related annexures, are deployed under NAS. All such staff should undergo structured induction and regular refresher training, including nationally developed courses such as NELS.

8.2 Induction training for EMTs

After recruitment, no EMT should be posted in an ambulance without completing induction training.

States should ensure that:

- Every EMT completes a formal induction programme and is given a certificate upon successful completion. The training programme covers patient assessment, triage, management of common emergencies, equipment use, documentation, communication, infection prevention, and personal safety.
- Induction training includes the Pre-Hospital Emergency Life Support (NELS) course or an equivalent nationally/State-approved pre-hospital emergency care course; and
- A post-training assessment (knowledge and skills) must be conducted before the EMT is allowed to function independently.

8.3 Induction training for drivers and call centre staff

Ambulance drivers and call centre / ICCC staff also require structured induction training appropriate to their roles.

States should ensure that:

- Ambulance drivers receive induction in safe and defensive driving, basic vehicle upkeep, route planning, communication and basic life support / first aid so they can support EMTs during emergencies.
- Call centre staff (call-takers and dispatchers) are trained in call handling, use of software and GPS, simple medical triage protocols, communication with distressed callers, and coordination with field teams and facilities.

States may integrate this induction into their existing NHM training plans, with clear responsibility assigned to the ambulance service provider and oversight by the State Health Department / State Health Society.

8.4 Refresher training and drills

To maintain skills and update staff on new protocols, States should organise regular refresher training for EMTs, drivers, and call centre staff.

As a general approach:

- EMTs and call centre staff (Emergency Response Officers, Reporting Officers & Support staff) should receive periodic refresher trainings (at least once a year), with a focus on high-volume emergencies such as trauma, maternity, cardiac and stroke cases.
- Practical skill stations and scenario-based exercises should be used wherever possible.
- Simulation and drills for mass casualty incidents, disasters and outbreaks should be conducted at least once a year, involving EMTs, drivers and call centre staff.
- All induction and refresher trainings should be properly documented, so that State and district nodal officers can track coverage, plan future batches and ensure that no EMT or driver remains without the updated knowledge and skills for long periods.
- Display of Protocols and SOPs necessary for immediate reference should be kept available inside ambulances and with the EMTs.

8.5 Accreditation and flexibility for States

States should base their EMT and NAS-related training programmes on nationally or State-approved curricula and modules. While these Guidelines provide minimum criteria for EMT and driver qualifications, States have the flexibility to:

- Select appropriate training institutions and partners; and
- Design training calendars and delivery models suited to their context, in alignment with NAS Guidelines, provided that all deployed EMTs and ambulance drivers meet the minimum eligibility criteria notified by the State and outlined in these Guidelines/annexures.

8.6 Gender and safety considerations

States are encouraged to promote greater participation of women as EMTs, drivers (where feasible), call centre staff and supervisors to ensure gender equality.

States and districts should ensure safe and supportive working conditions to protect staff rights, improve well-being, and build a motivated NAS workforce.

States/Districts should:

- Avoid posting women staff alone on night duty in high-risk locations.

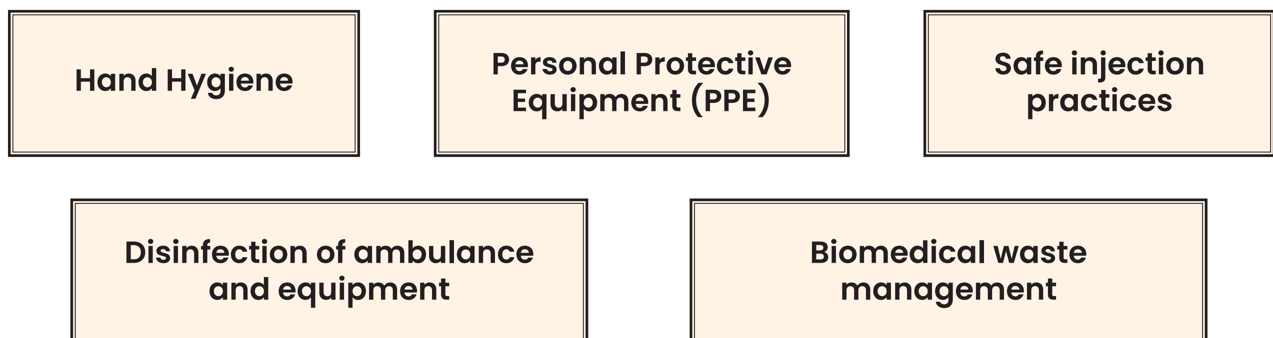
- Ensure safe transport as a standard safety measure.
- Provide access to functional grievance redressal mechanisms and a zero-tolerance approach to harassment.

9. Infection Prevention and Control

Ambulance or emergency health care workers are exposed to many infectious agents during their work. Transmission of infectious disease can occur while providing emergency care, rescue, and body recovery/removal. The risk of nosocomial and cross-infections during patient transport underscores the need for an effective infection prevention and control are central to providing high-quality health care for patients and a safe working environment for those who work in healthcare settings. Implementation of good infection control practices helps to minimise the risk of spread of infection to patients and staff.

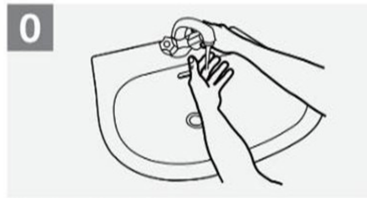
Standard Precautions

All the Ambulance staff need to be trained in the following "Standard Precautions" while handling patients in the ambulance.



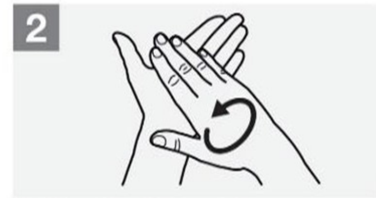
9.1 Hand Hygiene

Hand hygiene is the single most important practice to reduce the transmission of infectious agents in healthcare settings. The term "hand hygiene" includes both hand washing with either soap and water, and the use of alcohol-based products (gels, rinses, foams) that do not require the use of water. It is important to ensure the availability of hand rub products at all times in the ambulance to ensure hand hygiene compliance.

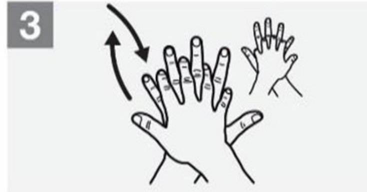


Wet hands with water;

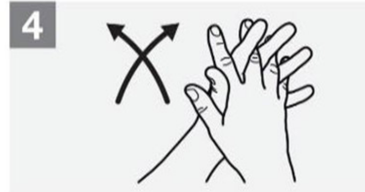
Apply enough soap to cover all hand surfaces;



Rub hands palm to palm;

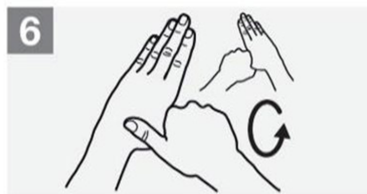


Right palm over left dorsum with interlaced fingers and vice versa;



Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

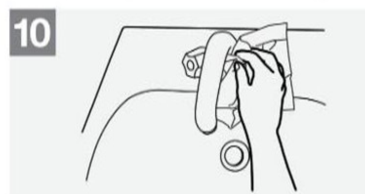


Rotational rubbing of left thumb clasped in right palm and vice versa;

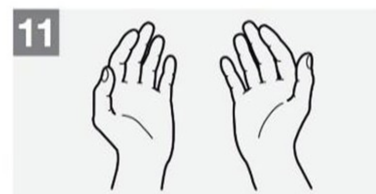
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

Rinse hands with water;

Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.

Figure 1: Procedure for Hand Washing with soap and water (WHO)

9.2 Personal Protective Equipment (PPE)/ Use of barrier precautions

Personal protective equipment (PPE) refers to physical barriers used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The Healthcare worker must possess knowledge and skill regarding the use and removal of the PPE after its use.

9.3 Disinfection of Ambulance and Equipment

Disinfection of Ambulance:

- All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls and work surfaces) should be thoroughly cleaned and disinfected using 1% Sodium Hypochlorite solution.
- Clean and disinfect reusable patient-care equipment before use on another

patient with alcohol-based rub.

- Cleaning of all surfaces and equipment should be done every morning, evening and after every use (patient transfer), with soap/detergent and water.

The following procedure must be followed while decontaminating the ambulance:

- Gloves and N95 masks are recommended for sanitation staff cleaning the ambulance.
- Disinfect (damp wipe) all horizontal, vertical and contact surfaces with a cotton cloth saturated (or microfiber) with a 1% sodium hypochlorite solution. These surfaces include, but are not limited to, stretcher, Bed rails, Infusion pumps, IV poles/Hanging IV poles, Monitor cables, telephone, Countertops, and sharps containers. Spot clean walls (when visually soiled) with disinfectant-detergent and windows with glass cleaner. Allow contact time of 30 minutes and allow air dry.
- Damp mop floor with 1% sodium hypochlorite disinfectant.
- Discard disposable items and Infectious waste in a Bio/Hazard bag, which should be given to the hospitals to dispose of, according to their policy.
- Change cotton mop water containing disinfectant after each cleaning cycle.
- Do not place the cleaning cloth back into the disinfectant solution after using it to wipe a surface.
- Remove gloves, dispose them in accordance with Biomedical Waste (BMW) Management Guidelines, and perform hand hygiene immediately thereafter.

Disinfection of Equipment:

Equipment and surfaces are contaminated if they have come in contact with the patient's skin, blood or body fluids, which can spread infection. Therefore, it is mandatory that these are cleaned and disinfected using 1% sodium hypochlorite or alcohol-based disinfectants (for example: Ethanol and Iso-propyl alcohol solutions with concentration 60% - 80%) at least once daily and after every patient contact.

Blood/Body fluid Spill Management:

Wear gloves, a gown, and eye protection. Use absorbent pads or spill kits specifically designed for biohazardous materials. Place contaminated materials in a leakproof bag marked as biohazardous waste. Clean and disinfect the affected area with an appropriate disinfectant solution. Maintain a well-stocked spill kit: The kit should include PPE, absorbent materials, neutralising agents, disposal bags and specific chemical spill kits.

9.4 Safe injection practices

It includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and a healthcare provider, and also to prevent harms such as needle stick injuries.

Needle-stick injury: Needle-stick injury is **a cutaneous cut, scratch, or puncture** from a needle contaminated with the **patient's blood, whether or not the injury**

drew blood. There is a high risk of transmission for blood-borne infections after needle-stick injury contaminated with infected blood. Worldwide, the most common causes for needle-stick injury in healthcare settings are two-handed capping of the needle after use and unsafe collection and disposal of sharps waste.

Management: The area should be washed with soap and running water, and the bleeding should be encouraged. The wound should not be sucked or squeezed. A waterproof dressing should be applied.

1. Splashes to intact skin:

The affected area should be washed immediately with warm soapy water.

2. Splashes to the mouth:

The mouth should be rinsed with large quantities of water.

3. Splashes to the eyes:

Eyes should be rinsed immediately with water or, if available, with sterile saline.

Prevention of needle stick injury

1. Sharps like needles, scalpels should be used only once.
2. While handling sharps, the sharp end of instruments shall be positioned away from oneself and others.
3. Used sharps should be disposed of immediately in designated puncture-proof containers (labelled with a biohazard symbol)
4. Do not recap used needles; if necessary, use the single hand "scoop" method.
5. Do not bend or break a used needle.
6. Do not pick up a handful of sharps simultaneously.

Note: Reporting the inoculation injuries, splashes to the mouth, eyes/ and mucous membranes should be controlled in the environment, reported to the department manager and to the occupational health department or the emergency department for further advice.

9.5 Biomedical Waste Management

Segregation, storage and discard of Bio-medical waste should be done as per the latest BMW rules. Regular training and monitoring of ambulance staff is required for effective implementation of BMW management.

The biomedical waste segregation process is depicted in the figure:

10. Integrated Command & Dispatch Centre for Ambulances

10.1 Call Centre/ Integrated Command and Dispatch Centre (ICC)

The call centre / Integrated Command and Dispatch Centre (ICC) is the nerve centre of NAS. This section explains, in simple terms, what a call centre/ICC should do, what minimum staffing and technology are needed, and how district and State teams can monitor its performance. The guidance is based on existing NHM practice and the multi-State NAS study, which found variation in call handling, triage, response time monitoring and integration with the 112 single emergency number across the nine States.

Every State must operate an 'Integrated Command & Dispatch Centre' (ICC). The centre should be accessible through a uniform Toll-Free Number as may be notified by the Government from time to time (presently used numbers include 108/102/112, etc.). The call centre (ICC) should remain operational 24×7 throughout the year, ensuring uninterrupted service with no downtime. **The Government of India has now notified "112" as the national single emergency number, and further integration of existing numbers is in process.**

Two state-wide models are utilised for ambulance service operations:

1. Operations through Public-Private Partnership (PPP) mode, including outsourcing of Call Centre and HR. For example, Tamil Nadu, Uttar Pradesh, Odisha, Bihar, etc.
2. State-owned and operated (including Call Centre and HR managed by State/ UT). For example, Haryana, Puducherry, Nagaland, etc.

10.2 Core functions of the call centre/ ICC

The call centre/ICC should perform the following core functions:

1. Receive calls

- Answer all incoming calls quickly (for example, within 3-5 rings).
- Record the caller's name, phone number, location, type of emergency and any special risks (for example, unconscious patient, active bleeding, pregnancy, child).

2. Triage calls

- Use a simple triage protocol or software to decide whether the case is:
- Life-threatening/ time-critical (for example, severe trauma, unconscious, seizure, chest pain, labour with bleeding or convulsions);

- Urgent but not immediately life-threatening;
- Non-emergency/transport request only.
- Mark high-priority calls clearly and process them first.

3. Dispatch ambulances

- Identify the nearest appropriate ambulance (ALS, BLS or PTV) using GPS/location information.
- Inform the EMT and driver about the location and suggested destination facility.
- Record dispatch time, time of arrival at the scene, start time of transport and time of arrival at the facility.

4. Support the field staff

- Provide basic guidance to EMTs, if required, based on protocols and available medical supervision.
- Coordinate with facilities to ensure readiness to receive the patient (for example, labour room, emergency room, ICU).

5. Document and report

- Ensure that every call and trip is recorded in the system or register.
- Generate basic daily, weekly and monthly reports on the number of calls, the number of trips, the type of cases and response times.

10.3 Requirements for customer contact centres

Establishment of a Command and Dispatch Centre integrates and coordinates the functions of Client, Customer and Customer Contact Centre. ISO 18295 (ISO 18295-1 and ISO 18295-2) specifies the service requirements for customer contact centres (CCC) and specifies a framework for any CCC that aims to assist in providing clients and customers with services that continuously and proactively meet or exceed their needs. These standards are applicable to both in-house and outsourced CCCs of all sizes, across all sectors and all interaction channels, including inbound and outbound. The relationship matrix is given in the Annexure 9.

10.4 Establishing a Command & Dispatch Centre

The centre should be established as per the GoI Guidelines and RFP developed for establishing a Command centre. States/UTs may also refer to the Nationwide Emergency Response System (NERS) Guidelines[7]. ((Pan-India Single Emergency Number '112') issued by the Ministry of Home Affairs, Government of India, while planning/developing the emergency response system in their jurisdictions.

Trained staff should operate the centre, receive calls, conduct basic triage, dispatch ambulances, monitor their movement and report key data to the authorities.

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[7]Available at URL https://www.mha.gov.in/sites/default/files/202208/NERSGuideline_2100815%5B1%5D.pdf

The call centre should have access to trained doctors for online medical direction whenever required, and to ensure proper field triage so that patients are taken to the nearest appropriate hospitals.

The major components shall be as follows:

- The centre should be connected with the main telecommunications exchange/ base through dedicated PRI lines.
- The number of PRI Lines & simultaneous channels required should be calculated based on the expected peak incoming call load requirement of the call centre, and adequate reserve capacity should be built into the system to cater to mass casualty & disaster situations.
- Ideally, the call centre should be capable of identifying the distress-caller's location automatically without requiring the caller to inform the same.
- It is feasible as the Department of Telecommunication, Ministry of Communications, has already notified the Dial-102, Dial-108 and "112" (the Pan India single Emergency Number) as "Public Safety Answering Point" (i.e., PSAP) for which all telecom operators are obligated to share the caller's location, if called upon by an authorised agency.[8]

10.5 Ambulance Dispatch and Coordination

When notified of the need for an emergency medical response, as stated in previous section, the call centre should automatically identify the location of the caller. Further, in parallel, the communications system should be used by trained emergency medical dispatchers:

- To talk to emergency callers to determine the nature and severity of the medical emergency.
- To provide on-site callers with pre-arrival instructions.
- To dispatch the most appropriate Ambulances to the site of the emergency promptly.
- To guide them directly to the site with minimum delays.
- To direct them to an appropriate emergency medical facility.
- To ensure that they become available for further assignment as soon as possible.
- While EMS vehicles are enroute to a patient, the communications system is used to keep them informed regarding access to the patient and patient condition.
- ICC doctors to guide the EMTs for necessary care and support during transit.
- For Coordination with the nearby available Health facility regarding the transport of patient and his/her condition for making sufficient early arrangements.
- For feedback regarding services provided by the ambulance during transport.

[8]Vide DO Letter no 16-04/2015-AS-III/NP/67/120 dated 04.05.2016

The EMT, after the initial assessment of the patient, should coordinate with the medical team (Doctor) and take guidance for first aid and critical care for the stabilisation of the patient during transit. The EMT also discusses the nearest appropriate health facility with the medical team for transfer of the patient for further care. The use of telemedicine facilities can be explored for enabling transit care and providing real-time clinical guidance from doctors to EMTs during patient transport.

10.6 Human resources in an ICC

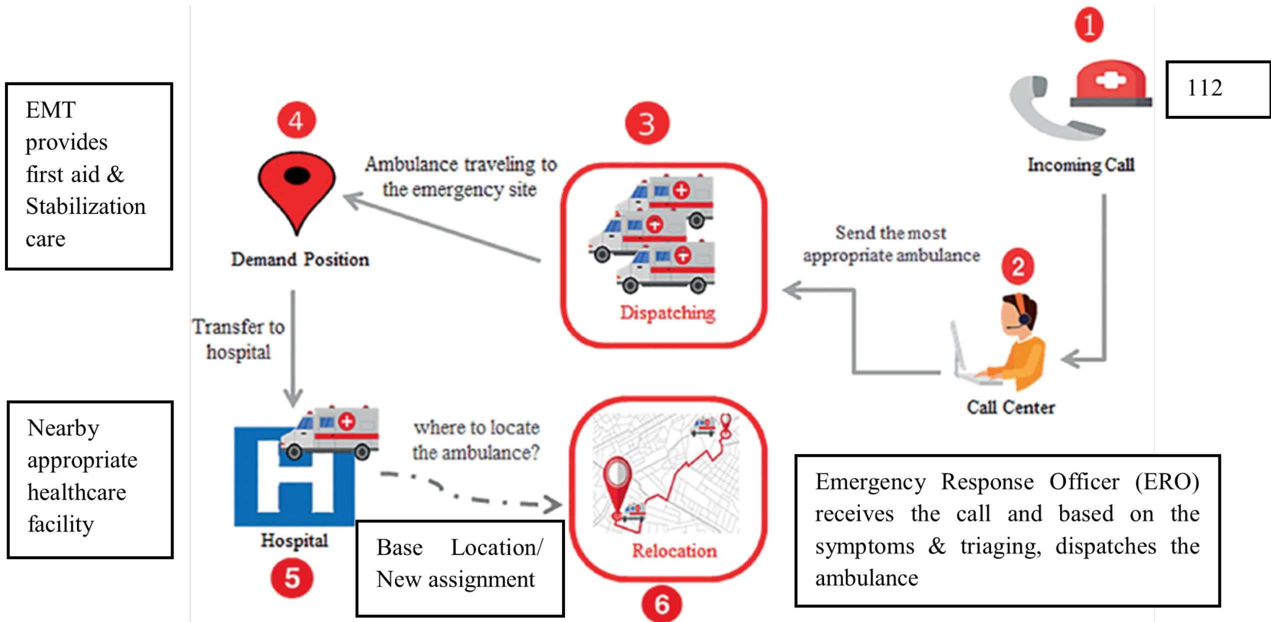
Basic staffing principles:

- Ensure round-the-clock (24x7) coverage with adequate staff for each shift based on call volume.
- Maintain a minimum ratio of call-takers to lines, so that most calls are answered without delay.
- Provide structured induction training to all call centre staff in:
- Use of software and equipment;
- Triage protocols;
- Communication skills, including talking calmly to distressed callers.

HR is engaged in the centralised ambulance dispatch call centre:

1. **Call takers/Emergency Response Officers(EROs)/Dispatchers:** These are the first point of contact for people who need an ambulance. They answer calls, assess the caller's needs, and dispatch the appropriate ambulance. They will also help steer the vehicle to an appropriate pick-up site and can also direct the vehicle to a facility where care for that type of emergency is available.
2. **Reporting Officer:** The call takers must report to the concerned officer regarding any issues.
3. **Medical directors:** Medical directors are responsible for the overall medical care provided by the ambulance service. They develop protocols for call takers/dispatchers, and they provide medical oversight to EMTs.
4. **Support staff:** Support staff provides administrative and technical support to the call centre. This may include tasks such as answering non-emergency calls, maintaining computer systems and IT support, and providing data entry (Recording of data).

10.7 Call Response Mechanism and Post-trip Deployment



11. Monitoring and Evaluation

States and districts should integrate NAS monitoring into routine review systems. It should use data that are already collected by the call centre, service provider and facilities. This section gives a set of key indicators that States and districts can track regularly. These indicators are aligned with the findings of the multi-State NAS study. They are meant to be simple enough for use at District Health Society and facility-level review meetings. Teams should consider the following key areas while evaluating NAS. The evaluation of NAS should focus on the following key areas:

1. **Response times:** To assess the timeliness and efficiency of emergency response services.
2. **Call volume:** To monitor service demand and the system's ability to manage variations in call load.
3. **Patient outcomes**: To evaluate the effectiveness of NAS in improving outcomes for emergency and time-sensitive conditions.
4. **Patient satisfaction:** To assess patient and caregiver experience with ambulance services, communication, and quality of care.

11.1 State and District Level Monitoring

For overall in-person administrative and technical monitoring of the ambulance services on a regular basis, a Nodal officer needs to be identified at both the State and District levels.

State Level: At the state level, the State NAS Nodal Officer, preferably a medical officer, should collect district monitoring reports regularly, analyse key gaps and ensure timely corrective action. The State Nodal Officer should review NAS performance with districts every month and place a consolidated quarterly review before the State Health Society.

District Level: Each district should constitute a District NAS Committee to oversee ambulance approval, registration, verification and monitoring. The Committee should include the District Magistrate or representative, CMO, ACMO, DQAC representative, Anaesthetist as NAS Nodal Officer, District Biomedical Engineer, District Finance Officer/Accounts Officer and a representative of the RTO/Motor Vehicles Department. The roles and responsibilities of the District-level committee officer are attached at Annexure 3.

At the district level, the nodal officer should be identified from the existing health workforce, preferably an Anaesthetist. The district nodal officer will be responsible for overall planning, operationalisation, monitoring and evaluation of ambulance services. The nodal officer themself, or an appointed consultant, should conduct

a quarterly audit of all ambulances in the district to ensure compliance with the terms of the agreement and the NAS guidelines. The district nodal officer should also conduct a monthly review meeting with all blocks to review performance, resolve operational issues and plan corrective actions. The roles and responsibilities of the District nodal officer are attached at Annexure 3.

The district team should resolve identified discrepancies at the district level wherever possible. The matters that are to be dealt with at the State level should be escalated to the respective nodal officers of the State. The penalties must be enforced against the outsourcing agencies as per the agreement document.

The **administrative** aspect of managing ambulance service includes monitoring condition of vehicle and equipment's, utilization of vehicle, quality assurance, optimal use of call centre infrastructure, human resources such as Emergency Medical Technician (EMT), Drivers, EROs, Medical teams etc, patient feedback & grievance redressal, assessing additional requirements, preparing prospective plans along with physical progress, timely release of funds, monitoring vehicle maintenance, monitoring average handling time of calls, etc.

The **technical** aspect includes timely procurement and availability of good quality drugs, equipment maintenance, regular certification of operational conditions of technical equipment, compliance with infection prevention protocols and quality assurance, unannounced and periodic inspection, training additional workforce for replacement when required, assessment of knowledge and skills of EMTs and orientation and refresher trainings of the ambulance staff.

In addition, the District-level Committee shall verify and certify all ambulances proposed by the selected service provider at the time of contract award, and whenever a replacement vehicle is inducted, to ensure compliance with tender conditions, AIS-125 norms and these Operational Guidelines. The verification shall be done jointly with a representative of the RTO / Motor Vehicles Department, and only those vehicles certified by the Committee shall be deployed and considered for payment under NAS.

11.2 Performance Indicators

The performance of ambulances is to be measured using the following parameters:

Overall Ambulance Services (for all types of ambulances):

1. Fleet availability and uptime: At least 95% of the sanctioned fleet should be available for service on any given day, and each ambulance should be available for service for at least 28.5 days in a calendar month, unless prior written approval for longer downtime is obtained from the District Nodal Officer.
2. Average response time- call to scene (target: less than 20 minutes)
3. Average number of trips per day (target: 3-4 trips per ambulance per day)
4. Average kilometres travelled (target: 80-120 km per ambulance per day)
5. Complaints received and resolved (target: 100% complaints resolved within defined timelines)
6. Ambulances with functional GPS (target: 100% of operational fleet)

7. Beneficiary satisfaction score (target: above 90%)

Key indicators for monitoring call centre/ICC performance:

District and State nodal officers can use the following simple indicators to monitor call centre/ICC performance:

1. Call pick-up time: Percentage of calls answered within 20 seconds of 1st ring. (target: ≥ 95% of valid incoming calls)
2. Calls handled: Percentage of calls successfully handled out of total calls received. (target: 100%)
3. Dropped/abandoned calls: Percentage of calls dropped/abandoned before being answered. (target: < 1% of total incoming calls)
4. Call-back of dropped/missed calls: Percentage of dropped/missed calls that the call centre calls back. (target: 100%)
5. Dispatch time: Average time from call registration to dispatch / movement of vehicle. (target: < 3 minutes)

These indicators should be reviewed at least once a month at the district level and once a quarter at the State level. The monthly payment for the services to the vendor should be based on a monthly review and attainment of these KPIs, and exercising a penalty (Annexure 8) as per the Agreement if KPIs are not achieved.

Additional data elements to be monitored

Fleet and operations Data

1. Ambulance-to-population ratio by type (ALS and BLS) at State / district level
2. Percentage of ambulances with required human resources in place (EMT and driver as per norms)
3. Average number of patients transferred per ambulance per month
4. Total number of emergency patients transported (all categories)
5. Number of Janani drop-back trips (as per JSY/JSSK or State schemes)
6. Number of other patient drop-back trips
7. Percentage of ambulances with required equipment available, functional and calibrated as per specifications
8. Percentage of ambulances with essential drugs available as per agreement

Call centre Data

9. Number of call-centre seats (call-takers) available in each shift
10. Average number of calls handled per call-centre seat per day (or per shift, as defined by State)
11. Response time during night hours (8 pm to 8 am)

Emergency Case Data

12. Number of obstetric emergencies transported
13. Number of newborn emergencies transported
14. Number of child emergencies transported (1 month to <18 years, excluding newborns)
15. Number of road traffic injury (RTI) cases transported
16. Number of other trauma cases transported (excluding RTI and burns)
17. Number of burn emergencies transported
18. Number of cardiovascular emergencies transported
19. Number of poisoning cases transported
20. Number of hanging and drowning cases transported
21. Number of snake bite cases transported
22. Number of Heat Stroke patients transferred (during heat season)
23. Number of other medical emergencies transported (State may specify sub-categories)

A checklist for monitoring the ambulances is available at Annexure 10.

The State/UT may periodically monitor the performance of ambulance services through an independent third party/agency.

12. Grievance Redressal System & Feedback Mechanism

An effective grievance redressal mechanism for ambulance services should be integrated with the State/District grievance redressal system with a clearly defined escalation matrix (Annexure 11) with accountability mechanism and aligned with the emerging 112 single emergency number.

Districts may:

- Use the existing State/District Grievance Redressal System (GRS) for registering, tracking and resolving complaints related to ambulance operations and patient care.
- Route ambulance-related complaints through the 112 platform, where such integration is enabled.

Every ambulance should prominently display:

- 112-emergency number for all emergency calls and ambulance-related grievances; and
- The contact details (phone/email) of the District NAS Nodal Officer or designated grievance officer, so that beneficiaries and facilities know where to escalate unresolved issues.

12.1 Beneficiary feedback and patient satisfaction

In addition to the formal grievance redressal mechanism (through 112/ State GRS), there should be a simple system to capture patient feedback and satisfaction with NAS regularly. This helps assess the quality of services, identify gaps and plan corrective action.

The quality unit of the call centre/service provider, under the supervision of the District NAS Nodal Officer, should:

- Make telephonic follow-up calls to a sample of beneficiaries; and
- Record their feedback in a simple, standard format.

Feedback may be sought on aspects such as:

1. Behaviour and courtesy of the call taker at the call centre
2. Time taken by the ambulance to reach the scene
3. Quality of first aid / pre-hospital care provided
4. Quality of care during transport

5. Cleanliness and hygiene of the ambulance
6. Handover of the patient to the hospital staff
7. Whether any ambulance staff asked for or took money for the services

The feedback and grievances highlighted by beneficiaries should be compiled at least once a month and shared with the District NAS Nodal Officer, along with action taken / resolutions. Key findings and actions should also be presented in the District Health Society review meetings. The unresolved, repeated, or serious grievances may be escalated to the State level for further review and necessary action.

13. Legal Framework

Article 21 of the Indian Constitution guarantees the fundamental "Right to Life," which has been judicially interpreted to include the right to timely and adequate medical care. Accordingly, the failure of any institution to provide prompt medical assistance may amount to a violation of this constitutional right. To ensure timely access to emergency healthcare, ambulance services play a critical role within the healthcare delivery system. In India, ambulance services operate under a decentralised framework managed by both the Central Government and individual State Governments, along with public and private service providers.

The legal and policy framework governing ambulance services varies depending on the region and service provider, as mentioned below:

1. Central Government:

1.1 National Health Mission (NHM): Responsible for supporting and guiding state-level emergency medical services (EMS) initiatives. Their website offers various guidelines and documents, including:

a. Motor Vehicles Act, 1988 and the Central Motor Vehicles Rules, 1989 & its amendments.

b. ERS/Patient Transport Service[9]

c. National Ambulance Code, 2013[10]

1.2 Ministry of Health and Family Welfare- May have additional policies and regulations related to ambulance services on their website.

2. State Governments:

a. Each state has its own ambulance service policies and regulations.

b. Many states operate their own dial 108 or 102 ambulance services, however this has to be integrated with 112 emergency helpline number. The official websites of these services often have information about their legal framework and operational guidelines.

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[9]Available at URL https://nhm.gov.in/

[10]https://morth.nic.in/gsr-868e-regarding-ambulance-code

14. Records and Register

- The EMT will keep a record of patient movement that will include demographic data, location, start time, end time, medical interventions provided and the status of the patient while handing over at the Emergency Department.
- All relevant records and information should be handed over in writing to the next on-duty EMT/driver during shift change through a documented written handover process.
- The service provider (supervisor) will keep records about the comprehensive warranty and annual/preventive maintenance of medical equipment in ambulances under his/her jurisdiction. They will also keep records of the repairs/ replacements/ modifications made to the medical equipment.
- Patient Care Record (PCR) shall be maintained by the EMT, which shall include patient systems, vital medical parameters and details of drugs and disposables consumed. The time or receipt of call, time of arrival at the incident location, time started towards the hospital and time when reached the hospital would be logged in by the driver, which will automatically get logged in the ICC system on a real-time basis. A backup paper-based log book shall also be maintained in the Ambulance.
- If death is pronounced on scene by a medical authority, all actions of the crew before the declaration of death shall be recorded on the PCR and the same shall be informed to ICC and follow instructions from ICC.
- The Patient Care Record shall be acknowledged by the Duty Doctors /Nurses at the medical facility/ hospital for any patient taken to the medical facility/ hospital.
- In case of any victim, if a bystander refuses transportation, the same may be recorded by EMT in the patient care record and obtain the signature of the victim or attendant. In case he refuses to sign, the same shall be recorded in the patient care record.

Annexures

Annexure 1

<u>Aero-Medical Transportation</u>

Needs of different types of patients transported through Air ambulances:

1. **Stable patients:** They require minimal treatment in flight but often require careful observation because the flight environment may impose physiological stresses that may cause their condition to deteriorate.
2. **Stabilised patients:** They might have received initial treatment but are intended to be moved for urgent treatment elsewhere. They require careful observation and treatment, but would usually have a stabilised airway, or haemorrhage, if any, will be controlled, fluid replacement may be in progress, and any fractures would be stabilised.
3. **Unstable patients:** They are moved by air only when they cannot be treated before flight. They require a full medical team with resuscitation and airway management skills. They usually have a life-threatening condition, and the purpose is to bring them as quickly as possible to a well-equipped treatment facility. The mechanism has to be there to adjudge the criticality of the patient before deciding to transport through air so as to ensure the judicious utilisation of air ambulances.

Classification of Aero-Medical Transportation (AMT) transfers:

AMT transfers are commonly classified according to the response activity depending upon the degree of stabilisation of the patient. The three types of AMT transfers explain how different AMT responses work and are as follows:

1. **Primary Response:** It involves the recovery of the patient from the location of their injury or illness. The air ambulance is primarily dispatched to the scene of an accident/incident and may be the only unit responding to the emergency, or at least, it may be the first to arrive. The treatment of the patient commences immediately and continues while the patient is rapidly transported to the nearest appropriate hospital.
2. **Secondary Response:** It is an indirect action that requires action from ground EMS ambulance to facilitate rapid on-carriage of a critical patient to a higher or more appropriate level of medical care. In this case of response, some degree of stabilisation is performed initially. Then, an air ambulance is employed to reduce the overall transfer time to definitive care in cases of time-sensitive patients.

Primary and secondary responses are categorised as pre-hospital care and require the aircraft to be suitably equipped with life-support equipment to treat a vulnerably stabilised patient.

3. **Tertiary Response:** It is a planned urgent transfer of patients, or medical supplies including blood and tissue requiring specialised care, or of medical personnel between hospitals. In such cases, transfer journeys deemed clinically excessive by road are performed by aircraft. The transport is planned, and the medical crew and equipment are tailored to the specific needs of the patient to be transported. The aircraft is used in an AA role, and the transfer is usually initiated by the dispatching hospital in consultation with the specialist receiving hospital in accordance with appropriate clinical protocols. This type of transfer is called an inter-facility transfer.

Note: The air ambulances must not be utilised in the transport of healthy post-operative patients to their overseas homes. The service provision will be limited to the transport from one place to another within the country.

Applicability of Rules:

2.1 Rule 134A of the Aircraft Rules, 1937 specifies that no person shall operate any non-scheduled air transport service from, to, in, or across India except with the permission of the Central Government. This Civil Aviation Requirement contains minimum requirements for the operation of Aeromedical Transportation (AMT). This CAR is issued under the provisions contained in Rule 133A of the Aircraft Rules, 1937.

2.2 The provisions of this CAR shall apply to all Aeromedical Transportation (AMT) operations that include Air Ambulance (AA) flights operated by aeroplanes and helicopters, and Helicopter EMS (HEMS) operations.

General considerations for AMT (Aero-medical transportation):

AMT should offer a clear advantage to the patient, and the judgment should be made only after a thorough assessment of the medical benefits for the patient. This will be certain when sophisticated medical care is required urgently. Still, sometimes the advantage of speed has to be weighed against the benefits of maintaining medical care on the ground and the potential complications during transportation.

The type of aircraft and the composition of the medical team should be determined by the clinical condition of the patient and the distance to be moved. Careful medical direction shall be exercised during AMT, and contraindications should be anticipated.

Patients should be reassessed regularly throughout the transfer since there are specific risks inherent in aeromedical flight that interact with medical status. These are related to physical properties of flight and associated factors, which include reduced atmospheric pressure, decreased oxygen tension, dehydration, motion sickness, vibration, noise, inactivity, etc.

Requirements for Air Ambulance:

1. The aircraft shall -

a. have spacious, secure, and comfortable space for at least one stretcher and seating for para-medical staff and a family member who would want to

accompany the patient.

b. have sufficient space for storage of medical equipment and medical supplies, which may be locked against unauthorised entry.

c. have demonstrable unobstructed vertical space at the head and thorax areas of the upper surface of the stretcher to allow for administration of life care support.

d. have the crew consisting of specially trained EMTs and doctors capable of providing critical care on the flight

e. have climate control in the cabin of the aircraft to prevent extremes of temperature and humidity that would adversely affect the patient.

f. have an electrical system capable of servicing the power needs of all equipment for patient care carried on board the aircraft.

g. have adequate interior lighting so that the patient care can be administered and status monitored without interfering with the pilot's vision.

h. have a communication system between the pilot and medical personnel to enable the exchange of information.

i. have an adequate supply of oxygen on board for the complete duration of the flight.

2. All the air ambulances shall be accompanied by qualified medical personnel as per the concerned medical authority. The medical personnel shall include a doctor, nurse or emergency medical technician. Such a person shall have completed the initial and recurrent training programme for medical personnel.

Before undertaking any flight, a Medical Manifest, which is a record of such a flight, shall be prepared to be signed both by an authorised representative and the captain of the aircraft. The record of the Medical Manifest shall be maintained for a period of at least 12 months.

3. Any stretcher, when used in the Air Ambulance, should:

a. be positioned in the aircraft to allow the medical personnel a clear view and access to any part of the patient's body that may require attention.

b. have a rigid surface suitable for performing cardiac compressions.

c. be constructed of material that may be cleaned and disinfected after each use with a mattress or pad that is impervious to liquids.

d. be capable of elevating the head of the patient up to a 45°degree angle from the base.

e. have harness/belts for child and adult patient to provide adequate restraint.

4. Onboard medical equipment, when fitted in the aircraft, shall be positioned in a manner such that it: -

a. Allows medical personnel a clear view of and access to the patient to perform monitoring and therapeutic intervention as needed.

b. Permits access to normal and emergency exits.

c. Permits access to emergency equipment.

d. Does not interfere or is likely to interfere with the operation of aircraft controls.

e. Is appropriately secured/fixed to avoid potential injury to occupants.

Guidelines on Categorisation of patients:

Priority: This category gives an indication of the need and urgency for AMT.	
Priority	**Explanation**
1: Urgent	Patient for whom AMT is necessary to save life or limb, or to avoid serious permanent disability.
2: Priority	Patient who requires specialised treatment not available locally and who will suffer pain and disability unless evacuated with the least possible delay.
3: Routine	Patient whose immediate treatment can be undertaken locally, but who would benefit from further treatment in advanced care.

Dependency: This category gives an indication of the level of medical care required during AMT.	
Dependency	**Explanation**
1: High	Patient who requires intensive medical and nursing care in flight; may be ventilated and require intracranial pressure monitoring, central venous pressure or cardiac monitoring.
2: Medium	Patient who, although not requiring intensive support, requires frequent monitoring and whose condition may deteriorate in flight; may require oxygen and multiple IV infusions and have drains and catheters in situ.
3: Low	Patient whose condition is stable and is not expected to deteriorate in flight; requires nursing care and may need regular medical therapy while in flight.
4: Minimal	A patient who does not require nursing or medical care in flight, but who may need help with mobility or with bodily functions.

Classification: This category defines the patient's need for space on the aircraft and gives an indication of the patient's mobility in the event of an aircraft emergency. It also describes the degree of supervision required for psychiatric patients.	
Class	**Explanation**
1A: severely disturbed	A disturbed patient who will require very close supervision in flight may also require sedation and even physical restraint.
1B: intermediate severity	Patient who is not disturbed before flight but who may react badly to flight and require sedation; needs close supervision.

Classification: This category defines the patient's need for space on the aircraft and gives an indication of the patient's mobility in the event of an aircraft emergency. It also describes the degree of supervision required for psychiatric patients.	
Class	**Explanation**
1C: mildly disturbed psychiatric patients	A patient who is stable, cooperative and has proved reliable under pre-flight observation is at low risk of requiring sedation during flight.
2A: immobile stretcher patients	A patient who is unable to move without aid and who, in an aircraft emergency, would require assistance to leave the aircraft.
2B: mobile stretcher patients	A patient who requires a stretcher while in flight but who, in an emergency, could leave the aircraft without help.
3A: sitting patients	A patient who, in an emergency, would require help to leave the aircraft.
3B: sitting patients	A patient who, in an emergency, could leave the aircraft unassisted.
4: walking patients	Patient who requires no nursing care and is able to travel unattended; may require assistance with their baggage.

Guidelines for the Attendants:

1. Communication should be provided between pilot and attendant, and it is desirable to have communications between the attendant and ground. Every communication should allow the attendant to remain in the immediate vicinity of the patient.
2. Attendants should be on every air ambulance, and they should be informed medically on the interhospital transfers. Further, it should be required that the attendant and the pilot-in-command have knowledge of basic resuscitative techniques and basic aviation physiology.

Annexure 2

Need for Boat Ambulances in India:

India is a country with a very diverse terrain. In some regions, waterways are more viable mode of transport when compared to roadways. When considering medical emergencies, people often loose valuable time in reaching the health facility and getting the required treatment. Giving due consideration to the Indian landscape in mind, introduction of emergency ambulance services like bike, boat and air ambulance becomes extremely important.

Difficult Terrain: As per 2011 Census, 8% of the Indian population consists of tribals who live in isolated areas, located close to water bodies. Boat ambulances services can actively help these residents reach medical services in time.

Onshore Accidents: During monsoons, tourist boating adventures and fishing expeditions may sometimes go wrong and result in fatalities. In addition, navy merchants, fishing communities and island dwellers are out on the sea route for months, where they might face unprecedented accidents that require urgent medical care. In such scenarios, boat ambulances can serve as precautionary measures and be the protectors on the waterfront.

Natural Disasters: In areas where flooding may lead to many casualties, boat ambulances can be used to provide relief and rescue the ones in need and help save more lives.

Capacity needs for Boat Ambulances:

a. Composition and training of rescue teams:

The boat pilot and the Emergency Medical Technician (EMT), would be occupied in different ways in different circumstances:

1. **Navigation**: As pilot drives the boat ambulance, the EMT communicates with the dispatch and the base, apart from monitoring the obstacles.
2. **Docking:** The EMT is expected to assist docking by handling cables and in positioning the ambulance.
3. **Embark and disembark of patients**: Both pilot and EMT are required to embark patient on the stretcher. It is usually important to look for help from the residents.
4. **Stabilization and Care:** EMT should ensure that the patient is stabilized.

b. Personal Protective Equipment (PPE):

The availability of suits to the workforce should be in sufficient quantity and should be suitable to the water activities. The suits should not get very heavy when wet.

Factors affecting the applicability of Boat Ambulances:

1. **Geography of territories:** The boat ambulance should be properly equipped for healthcare delivery, depending on the geography of the area. It should be ensured that the ambulances should dock. Moreover, during extremely rough weather and sea conditions, the boat ambulance will not be able to navigate in open sea areas, and thus the alternate ways of emergency transfers must be thought of by arranging air ambulance and thereafter the land ambulances as

per the requirements.

2. **Environmental issues:** Very heavy rains prevent water ambulances from leaving. Even when the boat is dispatched, the patient's discomfort, in severe cases, can be increased by waves and excessive bumping. The docking stations should be properly lit, so that it is easy for the staff to move around during night. The protective equipment, such as hats, ultraviolet protection clothes, special shoes, etc. should be made available in sufficient quantity as their absence in turn increases the chance of accidents, illnesses and puts the lives of the deputed teams at risk.

3. **Communication:** The ambulance staff should understand and speak the language that the indigenous communities speak, so that proper channel of communication is established, and the service is delivered as per the expectations of the community. The EMT should also communicate adequately with the inland physicians. Having proper channel of communication is also important to assist the team in their transit to scene or when moving towards health facility.

4. **Awareness among the community:** The communities should be aware of the availability of boat ambulances and that they can avail the services free of cost as and when required.

Annexure 3

<u>Roles and Responsibilities:</u>

District Level Committee

Approvals, Registration & Compliance Monitoring:

Oversee approval processes for new ambulances entering service, ensure timely registration of all ambulances, and verify compliance with AIS-125 specifications. During pre-induction verification, the Committee should confirm, at a minimum, that:

- The vehicle is registered as a commercial/transport vehicle and has valid registration, fitness certificate, road tax, insurance and permits as per the Motor Vehicles Act and rules;
- The ambulance type and build comply with AIS-125 and tender specifications for the designated category (ALS, BLS, PTV, etc.);
- Mandatory medical equipment, furniture, oxygen system, electrical fittings and safety items are installed, functional and fixed as per norms. ensure the timely implementation of Annual Maintenance Contracts (AMC) and Comprehensive Maintenance Contracts (CMC) to maintain optimal performance;
- GPS device and communication equipment are installed and functional as per NAS requirements; and
- External and internal branding, logo and colour scheme follow the State / NAS guidelines.

Any replacement or additional vehicle introduced during the contract period shall also undergo the same Committee verification and formal acceptance before deployment and billing. States may prescribe a simple standard checklist and certificate format for this purpose to be used across all districts.

District Nodal Officer:

1. Approvals, Registration & Compliance Monitoring: Facilitate the approval of new ambulances entering district service, ensure timely registration through Regional/District Transport Office, renewal of all vehicles, and verify compliance with AIS-125 technical standards.
2. Equipment Assessment & Maintenance: Review the condition and technical suitability of ambulance equipment during procurement and fleet replacement, ensuring adherence to required specifications. Ensure availability, functionality, and proper maintenance of equipment as per agreement, and monitor timely execution of AMC/CMC for all ambulance equipment.
3. Monitoring of Ambulance Operations: Plan and track ambulance deployment, response times, utilisation, daily trips, and overall operational performance to ensure timely and efficient emergency services across the district.
4. Quality of Care & Human Resource Oversight: Verify certification and training status, and monitor the quality of pre-hospital care and clinical protocols followed in ambulances.

5. Drug Compliance: Verify the availability of essential drugs and consumables in all ambulances as per the approved agreement.
6. Grievances, Incident Review & Safety: Review complaints, operational challenges, safety incidents, and service gaps, and recommend corrective and preventive actions to improve service quality and safety.
7. Coordination & Reporting: Facilitate coordination between ambulance operators, health facilities, and the emergency call centre for smooth service delivery.
8. Monthly Field Monitoring of Ambulances: The nodal officer themself, or an appointed consultant, should conduct a quarterly audit of all ambulances in the district to ensure compliance with the terms of the agreement and the NAS guidelines.
9. Monthly Review Meetings: Conduct monthly review meetings with block-level teams, and as required by the State Nodal Officer, to assess performance, resolve issues, and strengthen ambulance service delivery.
10. Verify and certify all vehicles proposed under NAS, in coordination with the RTO / Motor Vehicles Department, before deployment and whenever replacement vehicles are introduced, and maintain a record of all such approvals

Ambulance Staff

1.Pilot (Driver):

The pilot in an ambulance is entrusted with the responsibility to recognize and respond to situations where quick response and skills will save the lives of citizens. The person should possess great physical and mental agility so that he has the presence of mind to help with emergency situations as they occur. The driver needs to have a valid driver's license and certification in both CPR and First Aid.

Terms of reference:

1. Inspect the ambulance before each shift, checking the air, fuel, oil, transmission fluid, wiper fluid and coolant and report any needed repairs.
2. Complete a mechanical checklist before the start of their shift to ensure the ambulance is in working order, and must report any mechanical issues to the Administrator.
3. Maintain a logbook of driving assignments for each trip to record officially each transport, noting patient name, address, travel time, mileage and service performed.
4. Keep the Ambulance clean from the outside, clean and sanitise the interior of the ambulance and change the linen daily and/ whenever soiled.
5. Segregation and handing over biomedical waste as per BMW management rules.
6. Accept assignments (emergency and/or events) daily as received by the call centre and drive the ambulance with necessary medical personnel/EMT to the patient or event location. Map out appropriate routes on either conventional maps or the GPS.

7. Ensure proper lifting and handling techniques are applied as per training when moving patients to and from ambulance stretcher during emergency and non-emergency situations and Aid EMT as per their instruction in medical procedures such as First Aid and CPR.
8. Transport patient to assigned medical facility, help unload and take patient inside facility and to the location directed by medical personnel.
9. Accompany EMTs on emergency calls/events to transport patients to hospitals when assigned to do so.
10. Maintain a professional, pleasant, and polite demeanour to all contacts while on duty.
11. Assist EMTs in setting up emergency equipment such as oxygen tanks and defibrillators.
12. Attend educational/training sessions.
13. Any other duties as assigned by the nodal officer.
14. Report facts concerning accidents or emergencies to hospital personnel or law enforcement officials.

2. Emergency Medical Technician (EMT):

An Emergency Medical Technician (EMT) is a paramedic trained to respond quickly to emergency situations regarding medical issues, traumatic injuries, and accident scenes.

Terms of reference:

1. Respond to emergency calls from the call and command centre for medical assistance. Reach the scene on time and provide pre-hospital care to the victim as per medical need/direction. If necessary, the EMT shall interact with the ICC and patch in a Doctor for medical advice and guidance.
2. The EMT shall be seated at the rear of the ambulance during patient transport to provide continuous monitoring and empathetic care to the patient.
3. Perform a quick initial assessment of the patient, evaluate & undertake initial management.
4. Use spine boards and restraints to immobilise patients and secure them in the ambulance for transport. (Wherever required)
5. Perform CPR (Cardiopulmonary Resuscitation), provide medical aid such as AED, prevent spinal damage, ventilation, control severe bleeding, prevent shock, bandage wounds, etc., to stabilise their condition.
6. Be able to use medical equipment such as ECGs, external defibrillators, and bag and mask resuscitators in advanced life-support environments.
7. Perform emergency diagnostic and treatment procedures, such as stomach suction, airway management, and cardiac monitoring during an ambulance ride.
8. Ability to administer drugs, orally or by injection, IV fluids, and blood, etc. and perform intravenous procedures under a physician's direction.

9. Shifts patients to the ambulance with the help of the pilot (driver).
10. Seeking guidance from the command and teleconsultation centre or other linked experts for managing and stabilising the patient during transportation.
11. Inform the contacting facility and provide the details of the patient's status/ condition.
12. Create a patient care report, vitals, and document the medical care given to the patient at the scene and en route to the hospital.
13. Help transfer patients to the emergency department of a healthcare facility and report their observations and first aid treatment to the taking-over hospital staff.
14. Maintain functionality of every critical piece of equipment and availability of Emergency medicines while taking charge of the ambulance at the beginning of the shift.
15. Similarly handing over functional equipment & refilled drug trays to the EMT taking charge of Ambulance at the end of the shift.
16. Disinfect the ambulance's interior, and equipment after every trip.
17. Inventory management- Restock all medicines and consumable supplies in the ambulance after use and replace used blankets, linens, and other supplies.
18. Attend refresher programs and continuing education as required by medical control, employers, certifying or licensing agencies.
19. EMT is responsible for maintaining the ambulances and ensuring the functionality of available equipment. S/he is also responsible for triaging, initial assessment, resuscitation, and provision of required necessary patient care.

National Emergency Life Support courses for Doctors/Nurses and Paramedics[11]

The course aims to impart hands-on skill-based training to paramedical personnel and emergency medical technicians deployed in emergency departments of hospitals and ambulances of the country, to enable them to function effectively in resuscitating any kind of emergency patients, stabilize the patient during pre-hospital phase of transfer to hospital/ health facility.

[11] Available at URL: https://main.mohfw.gov.in/sites/default/files/Provider%20Course%20Manual%20for%20Paramedics.pdf

Annexure 4

List of equipment for Ambulances

Note: The equipment listed in this Annexure is aligned with AIS-125 requirements[12] for road ambulances. States/UTs should ensure that ambulance design, fixation systems, medical equipment, electrical systems, oxygen systems and safety-related fittings comply with AIS-125 and related MoRTH notifications, as amended from time to time.

S. No.	Equipment as per AIS 125	BLS (17)	ALS (28)
1	**Main Stretcher / Undercarriage**	✓	✓
2	Pick up a stretcher	✓	✓
3	Immobilisation, a set of fractures	✓	✓
4	Cervical upper spinal immobilisation devices Cervical Collar Set	✓	✓
5	Extended Upper Spinal Immobilisation Extrication Devices or Short Spinal Board (one of these)	✓	✓
6	B. P. Monitor (Cuff Size: 10 cm - 66 cm)	✓	✓
7	Stethoscope	✓	✓
8	Pulse Oximeter	✓	✓
9	Digital Thermometer	✓	✓
10	Glucometer	✓	✓
11	Diagnostic Light	✓	✓
12	Nebulization Apparatus	✓	✓
13	Electric portable suction aspirator	✓	✓
14	Portable suction aspirator, manual	✓	✓
15	Oxygen supply system (Stationary)	✓	✓
16	Portable oxygen cylinder with valve	✓	✓
17	Resuscitator with oxygen inlet & masks for all ages & oxygen reservoir	✓	✓
18	Infusion Pump	X	✓
19	Infusion mounting	X	✓
20	Laryngoscope with paediatric & adult blades	X	✓
21	Pressure infusion device	X	✓

[12] Available at URL: https://www.araiindia.com/downloads/ais-downloads

S. No.	Equipment as per AIS 125	BLS (17)	ALS (28)
22	Defibrillator with rhythm	X	✓
23	Cardiac Monitor	X	✓
24	External Cardiac Pacing	X	✓
25	Thorax Drainage Kit	X	✓
26	Syringe Infusion Device	X	✓
27	Transport Ventilator with accessories	X	✓
28	Capnometer	X	✓

Annexure 5

<u>**List of Medicines for Ambulances**</u>

Note: AIS-125 provides standards for ambulance design, equipment and medical devices. The medicine list below provides the minimum emergency medicines and consumables to be maintained in ambulances under NAS. States may adapt or expand this list through approved clinical protocols, especially for cardiac, obstetric, trauma, poisoning, snakebite and disaster-related emergencies.

Medicines should be used only by personnel trained and authorised under State-approved protocols.

A. Medicines for BLS Ambulances:

S.N	Medicine/item	BLS	ALS	Remarks
1	Oral glucose/glucose gel	✓	✓	For suspected hypoglycaemia, as per protocol
2	ORS packets	✓	✓	For dehydration, where clinically appropriate
3	Tablet Aspirin	✓	✓	For suspected acute coronary syndrome, as per protocol
4	Salbutamol inhaler/ nebulisation solution	✓	✓	For wheeze/bronchospasm, as per protocol
5	Paracetamol tablet/ syrup	✓	✓	For fever/pain, as per protocol
6	Ondansetron oral	✓	✓	For nausea/vomiting, as per protocol
7	Diclofenac oral/Inj.	✓	✓	For relieving pain
8	Povidone iodine / Chlorhexidine solution	✓	✓	External use for wound care
9	Normal Saline for wound irrigation	✓	✓	For wound cleaning/irrigation
10	Burn dressing/burn gel	✓	✓	For initial burn care

B. Additional Medicines for ALS Ambulances:

S.N	Medicine/item	BLS	ALS	Remarks
1	Inj. Adrenaline	X	✓	Cardiac arrest/anaphylaxis, as per protocol
2	Inj. Atropine	X	✓	Bradycardia/poisoning protocols
3	Inj. Amiodarone	X	✓	Arrhythmia protocol
4	Inj. Dextrose 25%/50%	X	✓	Severe hypoglycaemia

S.N	Medicine/item	BLS	ALS	Remarks
5	Inj. Normal Saline (0.9%)	X	✓	IV fluid resuscitation
6	Inj. Ringer Lactate	X	✓	IV fluid resuscitation
7	Inj. Hydrocortisone	X	✓	Anaphylaxis/severe asthma, as per protocol
8	Inj. Chlorpheniramine/ Diphenhydramine	X	✓	Allergy/anaphylaxis support
9	Inj. Naloxone	X	✓	Suspected opioid overdose
10	Inj. Diazepam/ Midazolam	X	✓	Seizures, as per State protocol
11	Inj. Magnesium Sulphate	X	✓	Eclampsia / specific arrhythmias, as per protocol
12	Inj. Oxytocin	X	✓	Obstetric emergency / PPH protocol
13	Misoprostol tablet	X	✓	Obstetric emergency / PPH protocol
14	Inj. Tranexamic Acid	X	✓	Trauma / PPH, as per protocol
15	Inj. Sodium Bicarbonate	X	✓	Selected emergency indications
16	Inj. Calcium Gluconate	X	✓	Selected emergency indications
17	Nitroglycerine sublingual tablet/ spray*	X	✓	Chest pain/ACS protocol, with BP monitoring
18	Ipratropium nebulisation solution	X	✓	Severe bronchospasm, where approved
19	Inj. Ondansetron	X	✓	Vomiting during emergency transport
20	Inj. Pralidoxime	X	✓	For organophosphate poisoning-prone areas

*To be used with extreme caution in patients having Hypotension, Bradycardia & Tachycardia

C. State-specific/Specialist-use Medicines

These medicines should not be mandatory for all NAS ambulances. States may include them only where trained staff, storage systems, legal authorisation, medical direction and approved protocols are available.

S. N.	Medicine/item	Suggested classification
1	Anti-snake venom	State-specific; only with cold chain, protocol and medical oversight

S. N.	Medicine/item	Suggested classification
2	Inj. Tenecteplase/ Streptokinase*	Specialist / doctor-directed cardiac care transport only
3	Inj. Morphine/ Fentanyl*	Controlled drug; only where legally permitted and protocolised
4	Inj. Hydroxycobalamin (S/C)	Special chemical/smoke inhalation emergency protocol
5	Sodium thiosulfate*	Special chemical emergency protocol
6	Procainamide*	Specialist-use; not routine ambulance stock
7	Verapamil*	Specialist-use; not routine ambulance stock

*To be used in presence of a doctor

Protocol-based cardiac/ACS loading-dose kit: States may include a **cardiac loading-dose kit** for suspected ACS/ STEMI cases, where a State-approved protocol, EMT training, ECG / teleconsultation linkage and medical oversight are available. The kit may include:

- Aspirin 300/325 mg, chewable or crushed;
- Clopidogrel 300 mg; and
- Atorvastatin 80 mg
- Inj Dobutamine

This kit should be administered only as per State-approved ACS / STEMI protocol and preferably after medical direction through the ICC / hub facility, especially where ECG interpretation or teleconsultation is required.

S. N.	List of Consumables for Ambulances	BLS	ALS
1	Ice packs/ Instant cold packs (4-6 packs of 500-1000gm each)	√	√
2	Spray Bottles (at least 2 of 500-1000ml each) for evaporative cooling	√	√
3	Cold Boxes (for storing cold water, ice cubes, IV fluids & ice packs)	√	√
4	Waterproof zipper body bags/cadaver body bags for immersion cooling with ice and cold water	√	√
5	Cooling towels/sheets (Minimum 2-4)	√	√
6	Tarpaulin Sheet for TACO (Tarpaulin Assisted Cooling Oscillation) method	√	√
7	Rectal thermometers and rectal probes	√	√

S. N.	List of Consumables for Ambulances	BLS	ALS
8	Bedding equipment	√	√
9	Micropore	√	√
10	Elastic adhesive bandage	√	√
11	Material for treatment of wounds (Sterile gauze pieces, cotton, pads, bandages)	√	√
12	Materials for treatment of burns and corrosives (Chlorhexidine dressings)	√	√
13	Kidney Bowl	√	√
14	Vomiting Bag	√	√
15	Non-Glass Urine Bottle	√	√
16	Sharps Container	√	√
17	Sterile Surgical Gloves, Pairs	√	√
18	Non-Sterile Gloves for Single Use	√	√
19	PPE kits	√	√
20	Emergency Delivery Kit	√	√
21	Waste Bag	√	√
22	Non-Woven Stretcher Sheet	√	√
23	Folley's Catheter: all sizes	√	√
24	Ryle's Tube/Nasogastric tube: all sizes	√	√
25	IV cannula: Adult & Paediatric & IV set	√	√
26	Oxygen	√	√
27	Sterile Water Ampoules for injections	√	√
28	Drinking Water	√	√
29	Disposable Glasses, Spoon	√	√
30	Sodium Hypochlorite 1% Solution	√	√
31	Alcohol based Hand rub	√	√
32	Endotracheal tubes: Adult & Paediatric	X	√
33	PMO line	X	√
34	Mouth Gags: all sizes	X	√
35	Airways	X	√

The above list provides a minimum framework for ambulance medicines and consumables under NAS. States may add or remove medicines based on local

needs, epidemiology, legal provisions and availability of trained staff. However, no medicine should be stocked in an ambulance unless the State has defined who can administer it, under what clinical conditions, under whose medical direction, and how its use will be documented. All medicines should be stored as per manufacturer instructions, checked for expiry at the beginning of each shift, replenished after use, and reviewed during monthly/quarterly ambulance audits.

Annexure 6

Minimum Qualification Criteria for Emergency Medical Technician for National Ambulance Service

1. Educational and professional qualification

1.1 The Emergency Medical Technician shall hold a recognised qualification in Emergency Medical Technology or Emergency Medical Technician that:

- Is aligned with the nationally or State-notified Emergency Medical Technician curriculum, including qualifications mapped to the National Skills Qualifications Framework for the job role "Emergency Medical Technician Basic" (Qualification Pack code HSS/Q2301) at National Skills Qualifications Framework Level 4 or higher, and
- Is approved by the National or concerned State Allied and Healthcare Professionals Council under the National Commission for Allied and Healthcare Professions Act, or is awarded by a recognised university or an institution affiliated to the All India Council for Technical Education, as applicable.

1.2 The minimum entry educational qualification for training as an Emergency Medical Technician Basic shall be successful completion of Senior Secondary (Class 12) or an equivalent qualification, as specified in the approved qualification file for Emergency Medical Technician Basic at National Skills Qualifications Framework Level 4.

1.3 An Emergency Medical Technician aligned to the National Skills Qualifications Framework Level 4 is expected to:

- Possess factual and practical knowledge in emergency care in familiar and predictable situations.
- Demonstrate the ability to carry out routine and non routine emergency care tasks independently using established protocols and tools.
- Take responsibility for the quality of one's own work and for continuous learning, as described in the National Skills Qualifications Framework level descriptors.

2. Life support certification and clinical competence

2.1 The Emergency Medical Technician shall maintain a valid provider level certification in Basic Life Support issued by accredited training providers such as the Indian Red Cross Society, St John Ambulance, or other accredited organisations, with periodic renewal as per the certifying body's norms.[13]

2.2 For ambulances designated to provide advanced life support or critical care, at least one onboard clinical professional (which may be an Emergency Medical Technician or another clinical cadre as per State norms) shall additionally hold valid certification in Advanced Life Support or equivalent advanced resuscitation training from nationally or internationally recognised organisations, including those

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[13] Available at URL: https://www.indianredcross.org/ircs/program/firstaid/

affiliated with the American Heart Association or similar bodies.[14]

3. Registration and regulatory compliance

3.1 Where registration of Emergency Medical Technologists or Emergency Medical Technicians under the National or State Allied and Healthcare Professionals Council is notified, the Emergency Medical Technician shall obtain and maintain such registration and shall adhere to the code of ethics and professional conduct prescribed by the relevant council.[15]

3.2 The Emergency Medical Technician shall meet, at minimum, the National Skills Qualifications Framework Level 4 standard for Emergency Medical Technician Basic as notified by the Healthcare Sector Skill Council and the National Skill Development Corporation and shall comply with any higher level or additional criteria notified by the Government of India or the State Government for specific categories of ambulance services.[16]

4. Communication skills and personal attributes

4.1 The Emergency Medical Technician shall be able to communicate clearly and empathetically in the predominant local language of the area of deployment and shall have functional proficiency in basic Hindi and English sufficient for patient interaction, documentation, and clinical handover at receiving health facilities, as reflected in the communication outcomes of the Emergency Medical Technician Basic curriculum.[17]

4.2 The Emergency Medical Technician shall possess the physical and mental fitness, professionalism, and behavioral competencies required for pre hospital emergency care, including the ability to work in shifts, respond to emergencies at any time, assist in lifting and transporting patients, and function effectively as part of a multidisciplinary emergency response team, consistent with the role expectations described in the Emergency Medical Technician Basic qualification file and model curriculum.[18]

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[14] Available at URL: https://cpr.heart.org/en/cpr-courses-and-kits/healthcare-professional/basic-life-support-bls-training

[15] Available at URL: https://www.indiacode.nic.in/bitstream/123456789/16824/1/aA2021-14.pdf

[16] Available at URL: https://nsdcindia.org/emergency-medical-technician-basic

[17] Available at URL: https://healthcare-ssc.in/images/qp/model-curriulumn/Emergency-Medical-Technician-Basic.pdf

[18] Available at URL: https://hsdm.org.in/doc/qualification_packs/Emergency_HSS_Q2301_v1.pdf

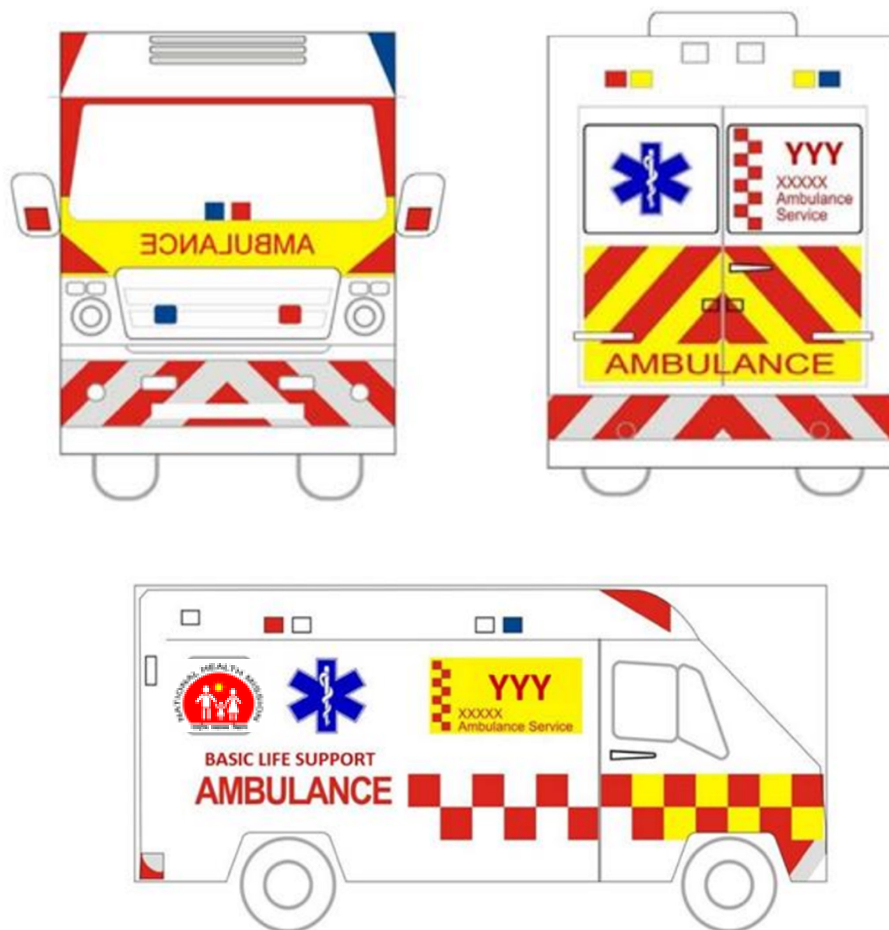
Annexure 7

Design Considerations: Standards for ambulance design, branding and logo

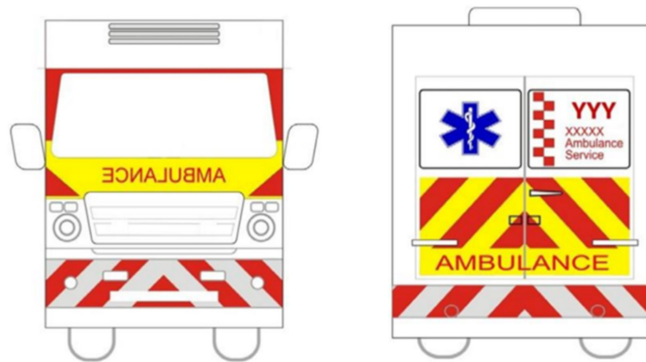
XXXXX: National Ambulance Service (NAS)

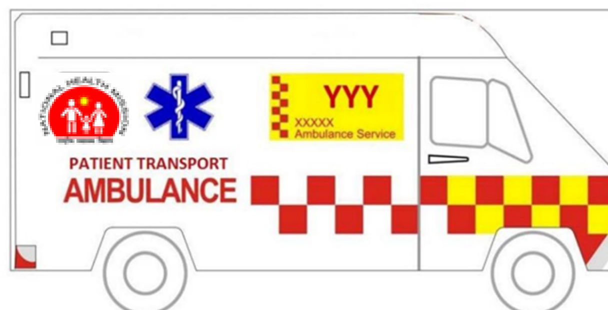
YYY: Ambulance Calling Number (112)

ALS/BLS:



PTV:





The Central Motor Vehicles Rules (Ninth Amendment), 2016 is an amendment of the Central Motor Vehicles Rules; 1989, and were published as required under sub-section (1) of section 212 of the Motor Vehicles Act, 1988 (59 of 1988) vide notifications of GoI in the MoRTH G.S.R. 316 (E), dated the 23rd April, 2015 and number G.S.R. 335€, dated the 23rd March, 2016, in the Gazette of India, Extraordinary, Part II, section 3, sub-section (i), inviting objections and suggestions from all persons likely to be affected thereby, before the expiry of thirty days from the date on which copies of the Gazette containing the said notifications were made available to public.

The constructional and functional requirements of Road Ambulances should be referred from the National Ambulance Code and includes the design, considerations, standards for ambulance design, branding, and logo.

Annexure 8

<u>Sample Service Level Agreement:</u>

Template for contractual agreements with service providers

1. BACKGROUND

1.1 <NAME OF THE ASPA> desirous of outsourcing the services relating to operation of Ambulances in <name of the identified region> had invited tenders from eligible bidders vide TE No _________________ dated ______________. <Name of the Service Provider> having submitted his bid in response to the tender enquiry and having been found technically qualified as per the conditions in the same TE, has been awarded the agreement by the competent authority in the <ASPA>. <Name of the Service Provider> has also performed required obligations after the award of agreement was communicated to him.

1.2 Both <Name of the ASPA> and <Name of the Service Provider> hereby willingly enter into this agreement and agree to abide by all obligations enjoined on them by this agreement.

2. SERVICE AIMS

2.1 Since the ASPA will provide all of medical equipment and vehicles, the primary obligation of the service provider will be to operate the Ambulance to provide primary and selected secondary health care ensuring that Ambulance

a. Is manned by adequate manpower resources as per the requirement enumerated in "Annexure III" of the Service agreement list.

b. The Ambulances are provided with necessary fuel for carrying on operations on regular basis.

2.2 It is the responsibility of <Name of the ASPA> to arrange supply of good quality generic drugs and consumables as per the requisition received from the service provider. <Name of the ASPA> would make all efforts to keep the Ambulances well stocked with drugs and consumables at all times. Supplies shall be made within 3 days of requisitions.

3. SERVICE OBJECTIVES

3.1 It is explicitly stated that both the parties are committed to enhance the health and wellbeing of residents of the area covered by the Service Level Agreement by providing high quality service to meet identified needs within the resources available to both the parties.

3.2 The service provider will also provide the operational set such as power generator, fuel for the vehicles, human resources and all other requirements to keep the vehicle in operational condition at all times.

4. SERVICE DESCRIPTION AND RESPONSIBILITIES

Ambulance Operation

A. Field Operation

1. The ICC (Integrated Command & Dispatch Centre) informs the ambulance in the respective locations to attend to the emergency victim. Agency shall strategically locate the ambulances in order to maintain the response time as specified in the RFP and hereunder.
2. Ambulances would have all equipment for life support as defined under RFP. Agency shall staff these ambulances with trained personnel as defined in RFP.
3. On receipt of instructions from the ICC, the ambulance crew shall reconfirm the location of the incident and start immediately. After reaching the location, the ambulance crew shall ensure scene safety before reaching the patient /victim. After attending to the patient / victim, the Emergency Medical Technician would assess the need for ambulance transport.
4. In case no emergency exists, the crew shall inform the ICC for further instructions and proceed according to instructions of ICC
5. In case of mass casualties and if there is need of additional ambulances, the same shall be communicated by the ambulance crew. If any other resource is needed to attend to the emergency including help from police and fire agencies, the same shall also be communicated by the ambulance crew.
6. The call shall be primarily screened at ICC level to ensure that ambulance is dispatched as per protocol only. The screening procedure- will be done at the ICC level as per the ICC protocol shared by the Agency. The emergency operation shall be limited to any response to a scene that there is perceived to be a high probability of life-threatening injury or illness, and a reduced response time may mitigate the illness or injury. In case of the emergency requiring transport, Emergency Medical Technician (EMT) shall assess the type of emergency and seriousness and transport the patient to the nearest appropriate medical facility and pre-hospital care shall be provided en-route. If necessary, the EMT shall interact with the ICC and patch in a Doctor for medical advice and guidance.
7. Patient Care Record (PCR) shall be maintained by EMT which shall include patient systems, vital medical parameters and details of drugs and disposables consumed. The time or receipt of call, time of arrival at the incident location, time started towards hospital and time when reached the hospital would be logged in by the driver using GPS system which will automatically get logged in the ICC system on real-time basis. Back-up paper-based log book shall also be maintained in the Ambulance.
8. Near Expiry / Expiry medicines/consumables should be taken out from the ambulances before it expires.
9. Concerned Driver and EMTs will be held responsible and liable to be taken strict action if they violate the protocol of shifting of patient.(Transferring of patient to private healthcare facilities must be avoided unless guided by the ICC/District Health Society).

B. Defining a Case/ Trip/ Emergency

1. An emergency is defined as an occurrence of any sudden event that threatens life and demands immediate attention. Emergencies could vary vastly in scope, magnitude and management. Effective emergency response significantly reduces deaths, disabilities, suffering from the length of hospital stay, and losses from fire incidents.
2. Emergency Response is medical services and medical care that reduce the levels of risk to life and health.
3. For 112, A trip results in the pick-up and drop-off of a patient from the site to a hospital. Multiple patients in a single trip will be considered a single trip/case. So, one trip is equivalent to one case.
4. For Janani, A trip could be either (a) pick-up from Home to Hospital or (b) drop back from Hospital to Home.
5. In case of multiple beneficiaries (applicable for only drop back cases), 2nd beneficiary shall be considered a 0.6 trip and the third as a 0.4 trip. More than three beneficiaries in a vehicle is not allowed. Multiple beneficiaries in case of pick up is not allowed.
6. If Ambulances are deployed for Specific events/ Festivals /Mela, etc., in such cases, the ambulance would be considered as having completed the minimum number of trips.
7. If on reaching the hospital, the patient is referred to a higher hospital on an immediate basis as an inter-facility transfer, then the said transfer would be a new case and trip.

C. Returning from the Hospital

1. When returning to the base location after handing over the patient to the health facility, the EMT should inform the ICC that the Ambulance is back in service unless a cleaning/reconditioning is required.
2. Should another ambulance call be dispatched while returning, it is the responsibility of the dispatch officer at the ICC to ensure that the closest ambulance responds to the call.
3. When the Ambulance is able to take another emergency call, it should be placed back in service.
4. While returning back to the location and if in between another emergency call is assigned to ambulance, the crew will immediately respond to such calls and close the old case and start the new case from that location only.
5. For the earlier trip the distance (KM run exclusively to attend the call) would be considered till the closure of the call and for the new call the KM reading will have begun from the time the new call is started. Both of these two calls would be considered as a separate trip.

5. RECORD KEEPING AND DOCUMENTATION

1. All the forms viz., the Patient Consent Form and Patient Care Record will be in the custody of the EMT present in the ambulance. All documents shall be handed

over to the authorized person of the provider with due acknowledgement.

2. The Patient Care Record shall be acknowledged by the Duty Doctors /Nurses at the medical facility/ hospital for any patient taken to the medical facility/ hospital.
3. It is the responsibility of the Government hospital staff to ensure proper receiving of the acknowledgement of the patient by on duty doctor from the ambulance crew and free the ambulance within 15 Minutes maximum.

6. BASE TO BASE AND CLEANING OF AMBULANCE FOR NEXT TRIP

1. The EMT and the Driver at the beginning of a shift must do a complete regular check. Any missing items must be restocked immediately, and responsibility pinned down to the previous crew and Cluster Leader informed about the missing items. This check has to be carried out according to the check list provided through the Ambulance Supervisor.
2. It is the responsibility of the EMT to ensure that the Ambulance is disinfected and restocked after each trip. If any items are unavailable, the Cluster Leader and Operations Head should be notified as soon as possible, and a replacement should be made.
3. The crew shall clean the ambulance regularly. When cleaning the Ambulance or equipment, the crew shall assume that all fluids are uncontaminated and appropriately use gloves and clean all surfaces with appropriate disinfectant.
4. All the medicines/consumable drawers must be properly labelled.
5. Ambulance crew need to follow the preventive maintenance check.

7. SANITATION

1. An ambulance well-maintained and in proper, sanitised condition for the safety of patients and the ambulance crew themselves.
2. Each ambulance must be maintained in full operating condition, and the repair and documentation of maintenance must be kept in the file.
3. The interior and exterior of the ambulance, including all storage areas, must be kept clean to be free from dirt, grease, and other offensive matter. It is the responsibility of the service provider to ensure that ambulances are washed daily and as per the requirement.
4. If an ambulance has been used to transport a patient who is known or should be known by the attendant or driver to have a transmissible infection or contagious disease, other than a common cold, liable to be transmitted from person to person through exposure or contact, surfaces in the interior of the ambulance and surfaces of equipment and materials that come in contact with such patient must, immediately after each use, be cleaned so as to be free from dirt, grease, and other offensive matter and be disinfected or disposed in a secure container so as to prevent the presence of a level of microbiologic agents injurious to health.
5. Smoking inside any portion of the ambulance is prohibited.
6. Bio medical waste to be segregated as per Government norms. Bio medical waste to be deposited with designated government facility.

8. EQUIPMENT MAINTENANCE

1. The EMT and the Driver on duty shall maintain an inventory of all equipment. At the end of every shift, the EMT and Driver shall hand over the ambulance to the next crew along with a checklist to this effect signed by both of them.
2. The Cluster Leader / Ambulance Supervisor shall issue all Ambulance equipment to the ambulance crew only as indicated with the approval of the Operations Head.
3. All personnel who receive Ambulance equipment must sign for that equipment and must agree to take financial responsibility for such equipment from damage, loss, and/or theft. However, the overall responsibility for such damage/ loss will fall on the operator.
4. It is the responsibility of the operator to keep the ambulances and all their equipment (vehicle, tracking system and medical equipment) in safe working condition before putting them on service, except the equipment pending for procurement from the Government side.

9. EXCEPTION

A. Do Not Resuscitate (DNR) Policy

1. Operator shall follow the policy regarding "Do Not Resuscitate (DNR)" in accordance with the existing laws in the country as approved by the Department.
2. When ICC of an unresponsive patient receives a call with attendants suspecting him/ her as dead, on arrival at the scene, EMT shall collect the following information from the bystanders:
   a. When was the patient last found breathing/ responsive?
   b. How long the patient has been unresponsive
   c. Interventions, if any, attempted by bystanders
3. The EMT confirms the absence of vital signs. EMT or any staff of the provider, including the Doctor who the ICC patches in, shall not declare or pronounce the death.
4. The bystanders may be clearly informed about the absence of vital signs as the situation warrants. The same shall be recorded in the Patient Care Record, which shall be filled with all the observations, with a record of the time when the assessment was completed.
5. In case of a mob situation, the EMT would act as per the need of the hour and transport the patient/victim to the nearest government hospital.
6. No death certificate/ death intimation shall be given by Operator and/or its crew

B. Emotionally/ Mentally Disturbed Patients

1. On arrival, if an emotionally disturbed patient needs transport to a psychiatric facility, the ambulance may transport without a patient attendant, or the police in case of patient restraint, as the EMT deems it to be safe.
2. An emotionally disturbed patient boarded by the EMT may then be handed over to any nearby government. The hospital will take further action and treatment;

the hospital will not refuse the case anyway.

3. If an emotionally disturbed patient refuses treatment or transport, the EMT shall request a patient attendant or police to accompany the patient.
4. If a patient displays violent tendencies or violence towards ambulance personnel, bystanders or other personnel on scene, the crew shall retreat and return to the scene after police and relations secure the scene.

C. Unattended Death

1. If the patient is not declared Dead on Arrival or death has not been pronounced at the scene of the call, resuscitative measures shall be taken in accordance with prevailing medical protocol.
2. If death is pronounced on scene by a medical authority, all actions of the crew before the declaration of death shall be recorded on the PCR and the same shall be informed to ICC and follow instructions from ICC.
3. The Ambulance personnel shall not disturb the body of a deceased person under any circumstances.
4. Pass information to ICC.

10. PATIENT OR LOCATION NOT FOUND/ UNABLE TO GAIN ENTRY

1. Upon arrival at the scene, it is the responsibility of the EMT to attempt to locate the patient. If the patient/ location is not immediately found, the EMT must contact the EMS Dispatcher to attempt to determine the location. A search of the immediate area should be performed.
2. If no further information can be discerned, a Patient Care Report must be filled out, and any significant findings must be documented as to the effort undertaken to find the patient/ location.

11. CRIME SCENE OPERATIONS

1. A scene shall be considered a crime scene if evidence of a crime or suspected crime is found, including but not limited to:
   a. Homicide
   b. Suicide
   c. Rape
   d. Road Traffic Accident involving serious injury or death
   e. Assault
   f. Intake of Drugs and Narcotics
2. Upon the discovery of a crime scene, the police shall be informed if not already present, and only personnel necessary to the treatment of the patient shall enter the scene.
3. On a crime scene, the EMS personnel shall work in close communication with law enforcement personnel while performing care. Care should also be taken to preserve evidence on the scene if possible while providing patient care. The scene and all actions taken by EMS shall be thoroughly documented in the PCR.

Preservation of evidence shall not take priority over patient care.

4. If the scene is deemed unsafe, police shall be informed, and EMT shall intervene as required only after the police ensure safety.
5. Ambulance personnel shall not reveal details about a crime scene to any other ambulance personnel except the authorities permitted under the law.

12. MASS CASUALTY INCIDENTS (MCI)

1. For the operational purposes of the Ambulance, a Mass Casualty incident shall be any large number of casualties produced in a relatively short period of time, usually as a result of a single incident such as a military aircraft accident, hurricane, flood, earthquake, fire, bomb blast, armed attack, vehicle collision, etc. that exceeds local logistic support capabilities.
2. A mass casualty incident (often referred to as MCI and sometimes called a multiple-casualty incident or multiple-casualty situation) is any incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties. For example, an incident where a two-person crew is responding to a motor vehicle collision with three severely injured people could be considered a mass casualty incident. The general public more commonly recognises events such as building collapses, train and bus collisions, earthquakes and other large-scale emergencies as mass casualty incidents.
3. The first arriving EMT is responsible for initial triage and the request for additional resources.
4. In a situation where an Ambulance reaches a site that has multiple individuals who are injured and require first aid/transportation, the following process shall be followed:
   a. If medical triage establishes that more than one person needs to be transported, then the ambulance crew shall immediately inform the control room, which shall send additional ambulances.
   b. Each ambulance shall only transport one patient. In the event of a Mass Casualty Incident (MCI), the crew may transport more than one patient/victim in each ambulance; credit shall be given as explained in the trip definition (4B.5) in the SLA.
   c. Each ambulance shall only allow one person to accompany the patient/victim in the ambulance.
5. In case of big events and natural calamities, when the ambulances are required to be mobilised for preventive measures, the Department of Health & Family Welfare can make a written request for deploying ambulances at various locations.
6. Any other Operational protocols for special circumstances (natural calamities, mass casualty events (both manmade and natural), unattended deaths, transportation of minors, transportation of obstetric cases, pediatric patients, neonates, crime scene operations, fire & accidents relating to hazardous material). State Health Society will assist in the development of the operational protocols for such special circumstances.

13. FIRE / HAZARDOUS MATERIALS (HAZMAT) CALLS

1. The duty crew of an ambulance for a Fire or HAZMAT stand by shall remain on the scene, out of service, until released by the Fire personnel.
2. Upon arrival at any major incident where Command has previously been established, the EMT must report to the command post and advise the Senior Officers (Fire and/or police agencies) of the location of the ambulance in case EMS assistance is needed.
3. The Driver is responsible for the staging of the ambulance, keeping lanes clear for additional Fire Apparatus and allowing exit for all emergency vehicles.
4. The EMT shall request First Responders to be on alert or to respond to the scene, as necessary, and must make sure that the Ambulance Supervisor has been notified of the incident.
5. The Fire Department will automatically be dispatched to all calls for Motor Vehicle Accidents with a confirmation that people are trapped.
6. Additional fire department response may be used at the discretion of the EMT/ Nurse/ Doctor (stability of a vehicle involved in RTA, possible Hazmat, CPR assistance, forced entry, etc.)

14. INTER-FACILITY TRANSFER/REFERRAL TRANSPORT

PROTOCOL FOR INTER-FACILITY TRANSFER OF PATIENTS

1. Inter Facility Transfers would be considered only on the request of the Medical Officer (on duty) of the facility in special cases, where the Patient is in critical condition, and the existing facility doesn't have appropriate treatment facilities. These transfers should be accompanied by the doctor, if possible.
2. The condition of the patient may be critical if proper treatment is not extended in time, and the treatment facility is not available in the existing facility
3. The existing facility is only a primary care provider and doesn't have round-the-clock operations.
4. Inter-facility transfer has to be through ICC. The physician at the transferring facility should provide detailed instructions to be followed for safe transport. The physician at the transferring facility should enter on the PCR form the reason for transferring and the sign & seal.
5. Where the patient is transferred before being admitted to the facility due to the absence of the doctor or health staff, then this shall not be considered as an inter-facility transfer/referral transport, and the patient shall be moved to the next nearest appropriate health facility. However, the service provider is required to maintain a record of such instances.
6. Critical or unstable patients must be transported to the closest designated Government/ empanelled facility based on the levels of care provided.
7. The following are criteria that require transport to the closest Emergency hospital unless otherwise ascertained by the EMT on the ambulance in consultation with the advising doctor:
   a. Cardiac or respiratory arrest

b. Unmanageable or obstructed airway
c. Continuous or recurring seizures
d. Major trauma
e. Amputations
f. Burn patients
g. Imminent birth
h. Suspected myocardial infarction in any patient over age 40 with severe chest
i. Patients in the ICU, irrespective of the disease, suffering from
j. Patients in SNCU

Freedom for EMTs to decide:

- The EMT shall have the freedom to decide the transfer of a critical patient/victim if they think that the patient/victim is in a life-threatening condition and requires urgent medical care in the nearest medical facility.
- EMT of ambulance is under no obligation to transport any patient to a facility that does not have appropriate medical facilities or is not listed (mapped) under the scheme.

In case of any victim, if a bystander refuses transportation, the same may be recorded by EMT in the patient care record and obtain the signature of the victim or attendant. In case he refuses to sign, the same shall be recorded in the patient care record.

Criteria for transferring facilities:

- The Emergency MO of the Community Health Centre is authorised to transfer an emergency case directly to the next higher (Tertiary) health care facility side stepping the District Hospital (Secondary health care facility) during odd hours, with a proper Emergency Form giving complete details as regards to the clinical condition and management of the patient.
- A patient can only be transferred from a tertiary-level health care facility, on the recommendation of the Medical Superintendent of the concerned hospital or any officer authorised on his behalf. Without a signature on the referral form, the service provider shall not transfer the patient.
- Inter-facility transfer of a patient is generally permissible from a lower to a higher health care facility.
- Since the Govt. Medical Officers are not authorised to refer patients to any private hospitals; no patient from a Govt health facility can be referred to any private hospital by the government. Medical Officer. Such referral is only permissible on the recommendation of the Medical Superintendents of the Government. Hospitals.

Referral in case of a suspected death:

- While carrying a patient on board, if the EMT of the ambulance suspects that the patient is not likely to be alive, he will take the patient to the nearest government

health care facility instead of the health care facility to which the patient has been referred, for a check-up.

- If the patient is declared dead by the Medical Officer there, the EMT shall leave the dead body at the hospital and inform the attendant/ relation of the patient to make their alternative arrangement for carrying the dead body and return to the base location of ambulance.
- If the patient's relations insist to take the suspected dead body home instead of a government health facility to confirm death, the EMT must not comply and instead take the dead body to the nearest government health facility to confirm death.
- The protocol on inter-facility transfer should be prominently displayed in every Govt. Health Care Facility and inside the ambulances.

Advance Life Support Ambulance:

The patients with following conditions can be transported by ALS ambulance after initial assessment for management.

1. Chest Pain- when the patient requires application of Nitro-glycerine patch/ requires monitoring with Cardiac Monitor/ having dysrhythmias.
2. In Anaphylaxis
3. Acute Myocardial infarction (Heart attack)
4. Cerebro-vascular Accident (Stroke)
5. Abnormal Delivery (breech/limb presentation/prolapsed cord/multiple birth)
6. Post-partum Haemorrhage
7. Miscarriage
8. Diabetic Emergencies; Hypo/Hyperglycaemic conditions
9. Severe Dyspnoea
10. Poisonings: severe cases of ingested/ inhaled/ poison on skin/ in eye/ insect bite/snake bite
11. Seizures (in Diabetic emergency cases only)
12. Severe cases of Chest injuries/ Abdominal injuries/ severe Extremity injuries/ Spinal injuries/ Crush injuries
13. Severe Hemorrhage
14. Severe Burn cases (including thermal, chemical and electrical burns)
15. Shock (Hypoperfusion)
16. Head/ Neck/ Spinal Injuries
17. Unconscious/drowsy patients

Basic Life Support Ambulance:

All other emergencies which are non-critical and non-invasive in nature can be transported through Basic Life Support ambulances.

Patient Transport vehicle (PTV):

All patients who do not require supervision/intervention during the transit can be transferred through PTVs. It includes patient going for dialysis, chemotherapy, Janani drop back etc.

15. REFERRAL PROCESS & ELIGIBILITY

15.1 It will be the responsibility of <Name of the ASPA> to provide the Service provider an "information matrix" for nearest facilities including their capacity in terms of existing emergency care, Laboratory services, diagnostic services, and human resources available.

15.2 It will be the responsibility of the Service Provider to keep the Medical Officer(s) in charge of the Ambulance informed of the information matrix. For services not available at the Ambulance, patients can be referred to nearest facility in accordance with the "information matrix ".

15.3 Both the parties hereby agree that no patient will be referred to any private medical establishment either formally or informally without specific prior approval of the <Name of the ASPA>.

16. INFORMATION AND REPORTING REQUIREMENTS

16.1 The Service provider shall ensure that information, records and documentation necessary to monitor the agreement are maintained and are available at all times to the <Name of the ASPA> or its authorised representative. The Service Provider hereby agrees that he and all his staff shall at all times co-operate with the reasonable processes of the Service procuring agency for the monitoring, evaluation and carrying out quality audit and financial audit by any third party authorised by <Name of the ASPA>.

16.2 The Service provider hereby agrees to maintain all relevant data and records of all patients served by the ambulance.

16.3 The Service provider further agrees to maintain confidentiality of these data and records and commits that such data and records will not be shared with any third party for any purpose.

16.4 The Service provider agrees to provide data to <Name of the ASPA>. Failure to do so may entail cancellation of the agreement.

16.5 The Service provider hereby agrees to maintain log book showing all movements of the vehicle and keep record of consumption of POL. The log book should be maintained as per the format in vogue in any government office. Logbook shall be made available for verification by the any authority nominated by Service procuring agency.

16.6 The Service provider agrees that the vehicles will not be used to advertise any product or organisation including the Service provider's own.

16.7 The Service provider agrees to display copies of this agreement, list of medical equipment available with the ambulance, stocks of drugs and consumables at prominent place in the ambulance. The names of the Medical Officer and other personnel on duty must also be displayed during duty hours.

17. PERFORMANCE

17.1 A monthly review meeting will be held and attended by appropriate levels of officials of Service procuring agency and Service providers to review the performance, the anticipated outcome of the agreement and future service developments and changes. Further meetings may be arranged at any time to consider significant variation in the terms or conduct of the agreement and where corrective action on either part is indicated.

17.2 Both the Service procuring agency and Service Provider agree to consider introduction of any further service in line with any new initiative of the government or in response to local demand which could not be anticipated earlier.

17.3 Both the Service procuring agency and Service Provider agree that such services should be provided without extra cost. However, if it is felt by both the parties that the additional services would require additional resources/manpower, the Service procuring agency agrees to consider reasonable increases in amount disbursed to the Service provider based on the cost of additional resources. It is agreed that the Service provider will be under no obligation to introduce the additional service unless a commitment to reimburse additional cost has been provided to him.

18. HEALTH AND SAFETY

18.1 The Service Provider agrees to adequately train, instruct and supervise staff to ensure as is reasonably practicable, the health and safety of all persons who may be affected by the services provided under the agreement.

18.2 The Service provider agrees that he would collect periodic feedback from the patients through structured questionnaire at his cost. The periodicity will not be less than once in six months. Responses to the questionnaire will be submitted in original to the Service procuring Agency. Telephone numbers where patients can lodge their complaints will also be displayed on the ambulance.

19. DATA PROTECTION, CONFIDENTIALITY AND RECORD KEEPING

19.1 All Service Users have a right to privacy and therefore all information and knowledge relating to them and their circumstances must be treated as confidential. The Service Provider must advise all staff on the importance of maintaining confidentiality and implement procedures which ensure that Service User's affairs are only discussed with relevant people and agencies.

19.2 The Service Provider shall comply with all legislations, which otherwise would have been applicable had the services been run directly by the Government agencies.

20. STAFFING

20.1 The Service provider agrees that he would ensure that a minimum compliment of staff mentioned in the agreement would be in position in each ambulance.

20.2 The Service provider will ensure that, at all times, it has sufficient suitably trained staff to ensure that services comply with all the statutory requirements and meet patient needs.

20.3 The Service provider agrees that a record of qualifications shall be maintained by the provider and available for inspection.

20.4 The Service provider hereby expresses his commitment to training and staff

development and the maintenance of professional knowledge and competence.

21. FINANCE ARRANGEMENTS

21.1 Both parties agree that the payment arrangements as quoted by the Service provider in his bid against the above-mentioned tender enquiry and/or subsequent bid submitted by him as a result of negotiations shall be adhered to.

21.2 It is agreed that payments would be made monthly basis. To facilitate this, the Service provider will submit invoices with all documents in support of his claims on every last working daly of the month.

21.3 The Service procuring agency has the right to impose -if any/all of the key performance indicators/services are not complied by the service provider as per the norms agreed upon by the two parties. Given below are the suggestive penalty clauses:

KPI	Description	Penalty
Picking up the call within 20 seconds of first ring	At least 95% of valid incoming calls in a month should be answered within 20 seconds of the first ring/ beep.	If the monthly performance falls below the target, a penalty of INR 1,000 per ambulance per month shall be deducted for that month.
Dispatch of ambulances within 3 minutes of end of call	Ambulances should be dispatched within 3 minutes of call closure/ completion.	If the monthly performance falls below the target, a penalty of INR 2,000 per ambulance per month shall be deducted for that month
Delay in Response Time	For each instance where the actual response time exceeds the maximum permissible response time as defined by the State (for example, 20 minutes), for the relevant urban / rural / difficult area category	INR 20 per minute shall be deducted for each minute (or part thereof ≥ 30 seconds) of delay beyond the maximum permissible response time for that call.
Average less than 120 km and 4 trips per ambulance per district (for densely populated areas)	From the commencement date, the service provider should meet an average of at least 4 trips per ambulance per day and 120 km per ambulance per day in plains / densely populated districts (subject to demand).	For shortfall in distance travelled below 120 km per ambulance per day, the reduction in payment shall be INR 20 per kilometre for every kilometre of shortfall. (States may exempt districts where low utilisation is due to documented low demand, not provider performance.).

KPI	Description	Penalty
Average less than 80 km and three trips per ambulance per district (for hilly areas)	From the commencement date, the service provider should meet an average of at least 3 trips per ambulance per day and 80 km per ambulance per day in hilly, tribal and difficult districts (subject to demand and road conditions).	For shortfall in distance travelled below 80 km per ambulance per day, the reduction in payment shall be INR 25 per kilometre for every kilometre of shortfall. (States may exempt periods / areas where low utilisation is clearly due to external factors such as disasters, road blocks, law-and-order situations.)
Fleet availability and vehicle uptime	The service provider must keep at least 95% of contracted ambulances operational on any day. Each ambulance must remain available for service for at least 28.5 days in a calendar month, unless the District Nodal Officer gives prior written approval for longer downtime.	At least 95% of the contracted ambulances shall be operational and available for service on any day, and each ambulance shall be available for service on at least 28.5 days in a calendar month (prior written approval for downtime should be obtained from the District Nodal Officer) The authority shall not pay operational costs for off-road days beyond the permitted downtime. Repeated or prolonged downtime may attract additional penalties as specified in the Agreement.
GPS tampering	The GPS device in ambulance is non-functional or has been tampered or removed. It is further clarified that, in case a faulty GPS device is identified, then the Service Provider shall immediately inform the Authority about the fault and the intention to replace/rectify the device. The Service Provider shall be provided 72 hours to replace/rectify the identified GPS device and under such circumstances levy of damages shall not be considered.	INR 25,000 per ambulance

KPI	Description	Penalty
Beneficiary Grievance Redressal	Gross misconduct of staff/ gross omission of services/ denial of services. There should be zero tolerance to the above mentioned.	Gross misconduct of staff / gross omission of services/denial of services (including demand or acceptance of money from beneficiaries, refusal to transport eligible cases, or abusive behaviour). Penalty: To be decided by the District / State Health Society based on the nature of the complaint; may include financial penalty, suspension or termination of staff, and in serious cases, termination of the contract for repeated violations.
Beneficiary Satisfaction Score	90% of feedback calls should have a satisfactory level rating, then there will be no damages levied.	If the monthly satisfaction score falls below 90%, a penalty of INR 1,000 per ambulance for that month shall be deducted.
Availability of Human resource	For any ambulance shown as “operational / on duty”, both driver and EMT must be present as per duty roster	If, during supervision and monitoring, any operational ambulance is found without the required HR on duty, a penalty of INR 10,000 per ambulance per instance shall be deducted, in addition to non-payment for that period if the vehicle is off-road.
Shortcomings during supervisory and monitoring visits	If, during ongoing supervision and monitoring, any of the defaults/shortcomings are identified: 1. Even a single item of medicines/medical consumables/ supplies is found to be unavailable/found beyond expiry date in the Ambulance or is so reported by any user/ Patient 2. Poor general cleanliness of Ambulance	INR 5,000 per ambulance per day

KPI	Description	Penalty
	3. Logbook, stock register and vehicle maintenance record are not updated as prescribed by Authority 4. Non-functioning of air-conditioning of Ambulance 5. Non-functioning/ Absence of any vehicle equipment and medical equipment mentioned in the agreement	

Suggestive Indicators for calculating Beneficiary Satisfaction Score:

1. Response Time

- Up to 20 minutes (10)
- 20-30 minutes (5)
- More than 30 minutes (2.5)
- No arrival (0)

2. Ease of calling/ access

- Call connected immediately and instructions were clear (10)
- Call connected with minor delay OR instructions partly clear (5)
- Significant difficulty in connecting OR unclear instructions (2.5)
- Not connected/ call dropped/ no guidance received (0)

3. Staff Behaviour, Communication and courtesy

- Politeness, empathy, and respect shown by ambulance staff (10)
- Rude behaviour/aggressive attitude (0)

4. Patient Handling & Safety

- Handled patient safely, assisted in lifting/positioning, and provided appropriate care/treatment during transit (10)
- Provided either safe lifting/positioning OR treatment during transit (5)
- Did not assist in lifting/positioning and provided no care during transit (0)

5. Cleanliness & Hygiene of ambulance

- Good (10)
- Satisfactory (5)
- Poor (0)

6. Infection Prevention Practices of EMT

- Good (10)- EMT consistently followed hand hygiene, used alcohol-based hand rub/handwashing at appropriate times, and wore PPE during patient care.
- Poor (0)- EMT did not adhere to hand hygiene protocols and/or failed to use PPE during patient care.

21.4 The Service procuring agency or any other agency as per existing rules of the government will have the right to examine the invoices as required under relevant rules. If such examination reveals any extra payment already provisionally made, the extra amount will be adjusted from the next payment due to the Service provider under intimation to him.

21.5 The Service provider hereby agrees to maintain all required books of accounts and agrees to provide them to such audit as may be required to be carried out.

21.6 The Service provider hereby agrees that the Service procuring agency will deduct from all payments such amount of statutory taxes and duties as he is required to deduct under provisions of law. The amount would be deducted if the vehicle becomes non-operative.

22. VARIATION

22.1 This Service Level Agreement may not be varied unless a variation is agreed in writing and signed by all parties.

23. DISPUTES

23.1 The agreement shall be governed by and interpreted in accordance with the laws of India for the time being in force. The Court located at the place of issue of agreement shall have jurisdiction to decide any dispute arising out of in respect of the agreement. It is specifically agreed that no other Court shall have jurisdiction in the matter.

23.2 Both parties agree to make their best efforts to resolve any dispute between them by mutual consultations.

24. ARBITRATION

24.1 If the parties fail to resolve their dispute or difference by such mutual consultations within thirty days of commencement of consultations, then either the Service procuring agency or the Service provider may give notice to the other party of its intention to commence arbitration, as hereinafter provided. The applicable arbitration procedure will be as per the Arbitration and Conciliation Act 1996 of India. In that event, the dispute or difference shall be referred to the sole arbitration of an officer as the arbitrator to be appointed by the <Name of the ASPA>. If the arbitrator to whom the matter is initially referred is transferred or vacates his or her office or is unable to act for any reason, he/she shall be replaced by another person appointed by <Name of the ASPA> to act as Arbitrator.

24.2 Work under the agreement shall, notwithstanding the existence of any such dispute or difference, continue during arbitration proceedings and no payment due or payable by the ASPA or the firm/contractor shall be withheld on account of such proceedings unless such payments are the direct subject of the arbitration.

24.3 Reference to arbitration shall be a condition precedent to any other action at

law.

24.4 Venue of Arbitration: The venue of arbitration shall be the place from where the agreement has been issued.

25. TERMINATION

25.1 Either party may terminate this agreement by giving not less than 3 months' notice in writing to the other. This notice shall include reasons as to why the agreement is proposed to be terminated.

25.2 The Service Procuring agency may terminate the agreement, or terminate the provision of any part of the Services, by written notice to the Service provider with immediate effect if the Service Provider is in default of any obligation under the agreement, where:

a. the default is capable of remedy the Service Provider has not remedied the default to the satisfaction of the Service procuring agency within 30 days of at least two written advice or such other period as may be specified by the Service procuring agency, after service of written notice specifying the default and requiring it to be remedied.

Or b. the default is not capable of remedy; or

c. the default is a fundamental breach of the agreement

25.3 If the Service procuring agency terminates the agreement and then makes other arrangements for the provision of the Services, it shall be entitled to recover from the Service provider any loss that had to be incurred due to such sudden termination of agreement.

25.4 Both the parties agree that no further payment would be made to the Service provider, even if due till settlement of anticipated loss as a result of premature termination of the agreement.

25.5 The ASPA reserves the right to terminate the agreement without assigning any reason if services of the ambulance create serious adverse publicity in media and prima facie evidence emerges showing negligence of the Service provider.

26. INDEMNITY

26.1 By this agreement, the Service provider indemnifies the Service procuring agency against damages of any kind or for any mishap/injury/accident caused to any personnel/property of the Service provider while performing duty.

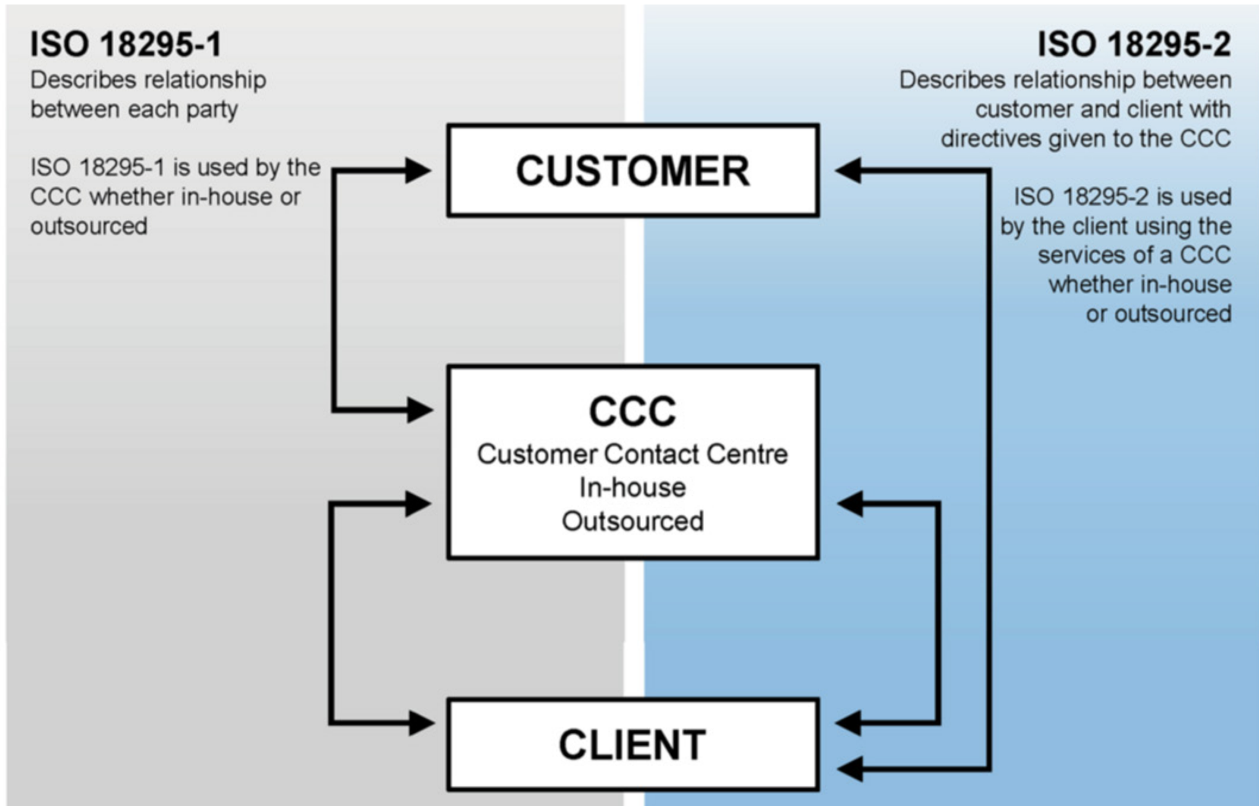
26.2 The Service provider agrees that all liabilities, legal or monetary, arising in any eventuality shall be borne by the Service provider.

27. PERIOD OF AGREEMENT

27.1 This Service Level Agreement shall take effect on .... until .... The period may be extended for another period of three years with the agreement of both parties after mutual negotiations.

Annexure 9

Requirements for Customer Contact Centres (CCC) : [19]



[19] Available at URL: https://www.iso.org/obp/ui/en/#iso:std:iso:18295:-1:ed-1:v1:en

Annexure 10

Referral Transport (ALS/BLS) Assessment Checklist

<table>
<tr><td colspan="2">Name of State____________________</td><td colspan="2">Name of Monitor________________</td></tr>
<tr><td colspan="2">Name of District__________________</td><td colspan="2">Name of EMT___________________</td></tr>
<tr><td colspan="2">Name of Block____________________</td><td colspan="2">Name of Pilot__________________</td></tr>
<tr><td colspan="2">Date of Assessment________________</td><td colspan="2">Type of Ambulance: ALS/BLS_________</td></tr>
<tr><td colspan="2">Vehicle Number________________</td><td colspan="2">Year of Manufacturing________________</td></tr>
<tr><td rowspan="2">1. General condition</td><td>Visuals:
1) Ambulance branding & logo is as per the Guidelines
2) Lights:
-Headlight (LHS & RHS)
-Emergency Light
-Brake Light
-Patient compartment Light
3) Wipers
4) Air Conditioning
5) Sanitation & cleanliness of an Ambulance</td><td>Yes/No

Functional/Non-functional
Functional/Non-functional
Functional/Non-functional
Functional/Non-functional

Functional/Non-functional
Functional/Non-functional
Good/Bad/Satisfactory</td><td rowspan="2">Remarks</td></tr>
<tr><td>Audio:
1. Presence of functional Hooter/siren</td><td></td></tr>
</table>

	2. Charged Mobile Phone/ Communication set	Yes/No Yes/No	
	Tracking system: 1. GPS installed 2. GPS operationality	Yes/No Functional/Non-functional	
2. Human Resources	Driver:	Yes/No	
	EMT:	Yes/No	
	Doctor: (only for ALS)	Yes/No	
	Back up Staff	Yes/No	
3. Training (*Monitor needs to specify the means of verification*)	EMT Qualification		
	EMT Training	Basic/Advanced Induction Training________(duration) Refresher Training________(duration)	
	EMT trained in Life support units (Cardiac monitor, Defibrillator, Ventilator)	Yes/No	
	EMT trained in Vital Signs	Yes/No	
	EMT trained in Trauma skills (Bleeding control, Shock/Burn management, etc.)	Yes/No	
	EMT trained in Immobilization	Yes/No	
	EMT trained in managing Seizures	Yes/No	
	EMT trained in managing Obstetric emergencies	Yes/No	

	EMT trained in Mental/ psychiatric emergencies	Yes/No		
	EMT trained in various Medical equipment found in an ambulance	Yes/No		
4. Equipment	**List of Equipment**	**BLS**	**ALS**	
	Main Stretcher / Undercarriage			
	Pick up stretcher			
	Immobilisation, a set of fractures			
	Cervical upper spinal immobilisation devices Cervical Collar Set			
	Extended Upper Spinal Immobilization Extrication Devices or Short Spinal Board (one of these)			
	B. P. Monitor (Cuff Size: 10 cm. - 66 cm)			
	Stethoscope			
	Pulse Oximeter			
	Digital Thermometer			
	Glucometer			
	Diagnostic Light			
	Nebulization Apparatus			
	Electric portable suction aspirator			
	Portable suction aspirator, manual			
	Oxygen supply system (Stationary)			
	Portable oxygen cylinder with valve			

	Resuscitator with oxygen inlet & masks for all ages & oxygen reservoir			
	Infusion Pump	X		
	Infusion mounting	X		
	Laryngoscope with pediatric & adult blades	X		
	Pressure infusion device	X		
	Defibrillator with rhythm	X		
	Cardiac Monitor	X		
	External Cardiac Pacing	X		
	Thorax Drainage Kit	X		
	Syringe Infusion Device	X		
	Transport Ventilator with accessories	X		
	Capnometer	X		
	Availability of calibration, servicing and spares for all equipment	Yes/No		
	Fitness report of equipment with mechanical or electrical parts	Yes/No		
5. Medicines	**List of Essential Medicines**	**BLS**	**ALS**	
	Oral glucose/glucose gel			
	ORS packets			
	Tablet Aspirin			
	Salbutamol inhaler/nebulisation solution			
	Paracetamol tablet/syrup			

	Ondansetron oral			
	Diclofenac oral/Inj.			
	Povidone iodine / Chlorhexidine solution			
	Normal Saline for wound irrigation			
	Burn dressing/burn gel			
	Inj. Adrenaline	X		
	Inj. Atropine	X		
	Inj. Amiodarone	X		
	Inj. Dextrose 25%/50%	X		
	Inj. Normal Saline 0.9%	X		
	Inj. Ringer Lactate	X		
	Inj. Hydrocortisone	X		
	Inj. Chlorpheniramine/ Diphenhydramine	X		
	Inj. Naloxone	X		
	Inj. Diazepam/Midazolam	X		
	Inj. Magnesium Sulphate	X		
	Inj. Oxytocin	X		
	Misoprostol tablet	X		
	Inj. Tranexamic Acid	X		
	Inj. Sodium Bicarbonate	X		
	Inj. Calcium Gluconate	X		
	Nitroglycerin sublingual tablet/spray	X		

	Ipratropium nebulisation solution	X		
	Inj. Ondansetron	X		
	Inj. Pralidoxime	X		
	State specific/Specialist use Medicines			
	Anti-snake venom			
	Inj. Tenecteplase / Streptokinase			
	Inj. Morphine / Fentanyl			
	Inj. Hydroxocobalamin (S/C)			
	Sodium thiosulfate			
	Procainamide			
	Verapamil			
	Aspirin			
	Clopidogrel			
	Atorvastatin			
	Dobutamine			
	Medicines/consumables drawers are properly labelled	Yes/No		
6. Consumables	Ice packs/ Instant cold packs			
	Spray Bottles for evaporative cooling			
	Cold Boxes (for storing cold water, ice cubes, IV fluids & ice packs)			
	Waterproof zipper body bags/cadaver body bags for immersion cooling with ice and cold water			

	Cooling towels/sheets (Minimum 2-4)			
	Tarpaulin Sheet for TACO (Tarpaulin Assisted Cooling Oscillation) method			
	Rectal thermometers and rectal probes			
	Bedding equipment			
	Micropore			
	Elastic adhesive bandage			
	Material for treatment of wounds (Sterile gauze pieces, cotton, pads, bandages)			
	Materials for treatment of burns and corrosives (Chlorhexidine dressings)			
	Kidney Bowl			
	Vomiting Bag			
	Non-Glass Urine Bottle			
	Sharps Container			
	Sterile Surgical Gloves, Pairs			
	Non-Sterile Gloves for Single Use			
	PPE kits			
	Emergency Delivery Kit			
	Waste Bag			
	Non-Woven Stretcher Sheet			
	Folley's Catheter: all sizes			
	Ryle's Tube/Nasogastric tube: all sizes			

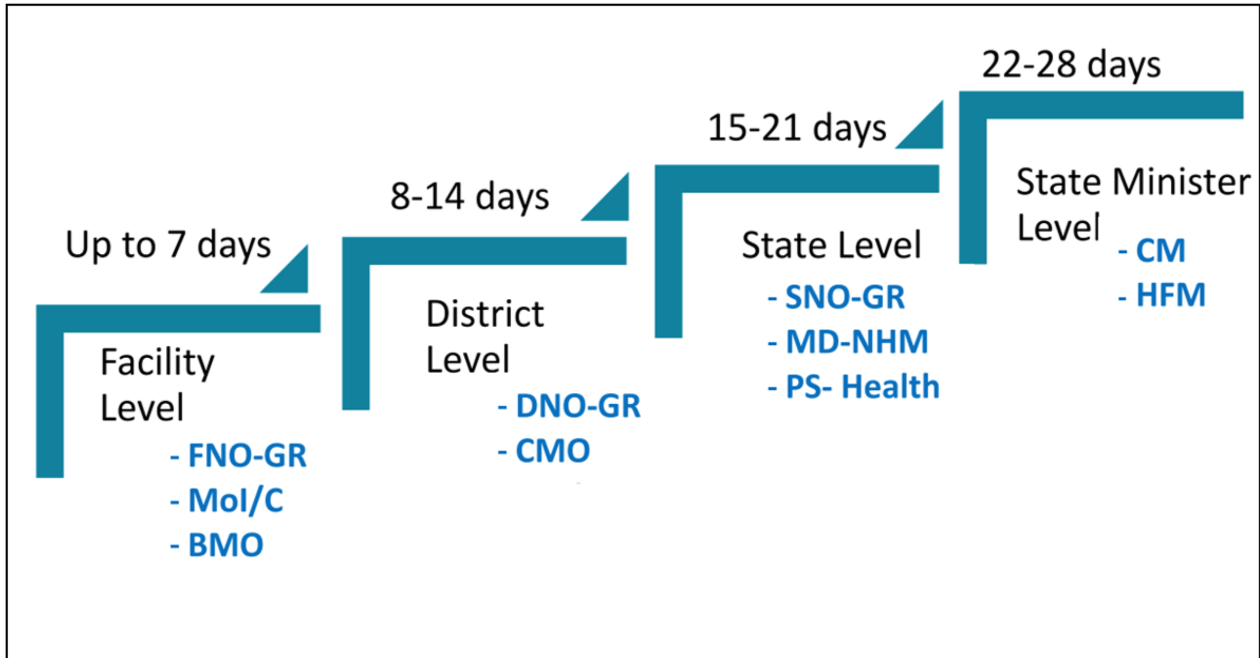
	IV cannula: Adult & Paediatric & IV set			
	Oxygen			
	Sterile Water Ampoules for injections			
	Drinking Water			
	Disposable Glasses, Spoon			
	Sodium Hypochlorite 1% Solution			
	Alcohol based Hand rub			
	Endotracheal tubes: Adult & Paediatric	X		
	PMO line	X		
	Mouth Gags: all sizes	X		
	Airways	X		
7. Infection Prevention Services	Presence of alcohol based Handrub products	Yes/No		
	Presence of PPE (Gloves, N-95 Masks etc)	Yes/No		
	Presence of 1% Sodium Hypochlorite Solution	Yes/No		
	Presence of Damp vipe; Mop	Yes/No		
	Presence of spill management kit	Yes/No		
	Presence of BMW Bins	Yes/No		
	How is the vehicle cleaned?			
	Frequency of Vehicle Cleaning			
8. Records & Registers	Patient movement record (demographic data, location, start time, end time, medical interventions provided and	Yes/No		

	status of the patient while handing over at Emergency Department)		
	Records pertaining to comprehensive warranty and annual/preventive maintenance	Yes/No	
	Patient Care Record (PCR) [patient systems, vital medical parameters and details of drugs and disposables consumed]	Yes/No	
	Inventory management for Drugs & Consumables	Yes/No	
9. Overall ambulance services	Average number of trips per day and average kilometers travelled. (in last one month)	____________________	
	Average Response Time (in last one month)	____________________	
	The number of times the ambulance was in downtime in a month. (in last one month)	____________________	

Annexure 11

Grievance Escalation Plan

As per the Government of India (GoI) Guidelines on Establishment of Grievance Redressal and Health Helpline[20].



[20] Available at URL: https://nhm.gov.in/images/pdf/programmes/Grievance_Redressal_System/Guidelines_for_Establishing_Grievance_Redressal_and%20_Health_Helpline.pdf

Annexure 12

Sample Request For Proposal (RFP) for the selection of service provider for Establishment, Operation & Maintenance of Emergency Response Services (Ambulances) in States/UTs

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Tender Schedule

Authority would endeavour to adhere to the following schedule:

S.No.	Bid Stage	Date
1.	Pre-Proposal/Pre bid meeting	_____ at____hours Venue: _________
2.	Last date for receiving pre-Proposal / pre bid queries	______on or before___ (through e-portal only)
3.	Tender submission date	_____on or before_____
4.	Due Date for submission of original Bank Guarantee towards Bid Security	_____ on or before Submitted to _____ Director (HFW) DIRECTORATE OF HEALTH & FAMILY WELFARE SERVICES _______________ _______________ Ph. No:
5.	Opening of Qualification Submissions	_____ on or before____(time)
6.	Opening of the Technical Proposal	Tentative date _____ at
7.	Opening of Price Proposal	Tentative date _____ at
8.	Letter of Award (LoA)	Tentatively Within 15 days of opening of Price Proposal
9.	Validity of Proposals	180 Days from the Proposal Due Date
10.	Signing of the Agreement	Within 15 (Fifteen) days from acknowledgement of LoA

Definitions

1. "RFP" shall mean this Request for Proposal along with all formats and draft Agreement attached hereto and shall include any modifications, amendments alterations or clarifications thereto;
2. "Agreement" shall mean the contract between the Authority and the Successful Bidder in accordance with the provisions of the RFP.
3. "Authority" means the Procuring Authority that has the financial power under Delegation of Financial Power Rules to carry out this procurement.
4. "Proposal" it shall mean the Technical Proposal and Financial Proposal submitted by the Participant, in response to this RFP, in accordance with the terms and conditions hereof. This is also called as "Bid".
5. "Bidder" shall mean a single business entity that has submitted a Bid in accordance with the provisions of this RFP. It shall mean a bidding company, bidding registered society or proprietorship firm submitting the bid as the context may require.
6. "Successful Bidder" means the Bidder selected by the Authority, pursuant to this RFP to perform the Scope of the Project as per the terms of the Agreement, and to whom the Letter of Award (LOA) has been issued;
7. "Chartered Accountant" shall mean a person practicing in India or a firm whereof all the partners practicing in India as a Chartered Accountant(s) within the meaning of the Chartered Accountants Act, 1949.
8. "Company" shall mean a body incorporated in India under the Company's Act 2013 or earlier Act.
9. "Conflict of Interest" A participant may be in a Conflict of Interest with one or more participants in the same procurement process under this RFP if they have a relationship with each other, directly or indirectly through a common company / entity, that puts them in a position to have access to information about or influence the proposal/offer of another participant.
10. "Department" means Department of Health & Family Welfare, Government of_______ (State Name); the Procuring Department.
11. "Effective Date" shall mean the date of signing of agreement by both the parties.
12. "Ambulance Service" is a 24x7 Emergency Medical Response Service of the Government under National Ambulance Service (NAS) to ensure timely and appropriate medical attention in case of medical emergency. This service is available free of cost to any one in a situation of medical emergency by dialing a toll free telephone number "102/108/112".
13. "Integrated Command & Dispatch Centre" is a centralized call-centre, which receives the call from public (who requires ambulance/emergency services). The command centre shall screen all the calls received and shall decide whether the call is for emergency medical services- ALS/BLS Ambulance and after preliminary triaging accordingly dispatch the ambulance/vehicle to attend the user call. The centre would ensure medical guidance to EMT while enrouting the patient to the medical facility.

14. “Force Majeure conditions” means any event or circumstance which is beyond the reasonable direct or indirect control and without the fault or negligence of the Agency (i.e., Service Provider) and which results in Agency’s inability, notwithstanding its reasonable best efforts, to perform its obligations in whole or in part and may include rebellion, mutiny, civil unrest, riot, strike, fire, explosion, flood, cyclone, lightening, earthquake, epidemic, act of foreign enemy, war or other forces, ionizing radiation or contamination, Government action, inaction or restrictions or an act of God or other similar causes.
15. “Foreign Company” any entity that has incorporated outside India and happens to have a place of business in India either physically through any other agent or via electronic or digital means. Or business activities are conducted by the entity in any other manner.
16. “Government” means State/UT Government/ Department of Health & Family Welfare.
17. “GPS” means Global Positioning System device for tracking and tracing of all vehicles. Every GPS device used should be satellite connected with at least one month data back up with biometric attendance, fixed to vehicles, web application with customized reports and additional feature, if any. Wherever word GPS is mentioned, it shall have specifications as defined above.
18. “Project Facilities” means any facility created for dedicated operation and management of the project such as ICC shall be one of such Project Facility.
19. “Registered Society” shall mean a Society registered under the Society Act 1860 or any other state act as well as registered under the section 12A of Income Tax Act, 1961.
20. “Statutory Auditor” shall mean the auditor appointed under the provisions of the Companies Act, 2013 or under the provisions of any other applicable governing law.
21. In “partnership firm”, the beneficial owner is the natural person(s) who, whether acting alone or together, or through one or more juridical person, has ownership of entitlement to more than fifteen percent of capital or profits of the partnership;
22. “PIA” means Proposal Inviting Authority who is Mission Director, National Health Mission, __________ (State Name)

Introduction

1. Background:

1. The Directorate of Health and Family Welfare, Government of ___________ (the "Authority") is providing medical emergency response services through '108' ambulances with private participation and it currently operates with a scale of _______ (number of ambulances) ambulances operating across the state. Now the Authority intends to up-gradation of existing technologies with inclusion of a well-defined governance framework for an efficient service delivery in ___________ (the "Project") through private participation basis. Pursuant thereto, the Authority has decided to carry out the bidding process for selection of a suitable entity to whom the Project may be awarded.
2. The Authority intends to select service provider for providing medical emergency response ser- vices for the State of ___________.
3. The selected Bidder (the "Service Provider") shall be responsible for setting up of a modernized Control Room, operate, maintain and transfer of the Project Facilities, under and in accordance with the provisions of the draft agreement (the "Agreement") to be entered into between the Selected Bidder and the Authority enclosed as Volume II of the Bidding Documents pursuant hereto.
4. The scope of work will broadly include installation and operations of the Control Room and carrying out operations of the fleet of ambulances across the State during the tenure of the Agreement.
5. Proposals submitted by the Bidders, would be evaluated on the basis of the evaluation criteria set out in the RFP in order to identify the successful Bidder for the Project.
6. The Successful Bidder would then have to enter into an Agreement with Authority, and perform its obligations as stipulated therein in respect of the Project.
7. The statements and explanations contained in this RFP are intended to provide a proper under- standing to the Bidders about the subject matter of this RFP and should not be construed or interpreted as limiting in any way or manner the scope of work and obligations of the Service Provider set forth in the Project Agreement or the Authority's rights to amend, alter, change, supplement or clarify the scope of work, the Right to be awarded pursuant to this RFP or the terms thereof or herein contained. Consequently, any omissions, conflicts or contradictions in the Bid- ding Documents including this RFP are to be noted, interpreted and applied appropriately to give effect to this intent, and no claims on that account shall be entertained by Authority.
8. The Authority shall receive Bids pursuant to this RFP in accordance with the terms set forth in this RFP and other documents to be provided by the Authority pursuant to this RFP (collectively the "Bidding Documents"), as modified, altered, amended and clarified from time to time by the Authority, and all Bids shall be prepared and submitted in accordance with such terms
9. The Successful Bidder would be required to:
   a. Setting up of a modernized Control Room as per the provisions of the draft Agreement

b. Operate, maintain and manage the Project Facilities as per the draft Agreement,

c. Provide regular and preventive maintenance of the Project Facilities as specified in the draft Agreement;

d. Perform services as per the Performance Standards prescribed in the draft Agreement.

10. The Bidder shall quote the payment ("Contract Price") as per Appendix-G sought from Authority to undertake the Project. Such Contract Price shall include all costs, duties and taxes applicable from time to time except Goods and Services Tax (GST)

2. Scope of Proposal:

1. Detailed description of the objectives, scope of services, deliverables and other requirements relating to integration, operation, and maintenance of Emergency Response Service (including ALS/BLS/Others), are specified in this RFP along with the manner in which the proposals are to be prepared and submitted by participating Firms. Eligibility criteria, evaluation and selection method and other terms and conditions are also given for the understanding of all intended participants.
2. The Service Provider shall be selected based on the evaluation of the proposals submitted (by the participants) by the evaluation committee duly appointed by the Authority, in the manner as specified in this RFP. Participants shall be deemed to have understood and agreed that no explanation or justification for any aspect of the selection process will be given, and the decisions of the Department shall be final and binding.
3. The participating firms (i.e., applicants) shall submit its Proposal in the form and manner specified in this RFP.

3. Brief Description of Bidding Process:

1. The Authority has adopted a single stage bidding process (the "Bidding Process") for selection of the Bidder for award of the Project and invites bids ("Bid") from eligible parties ("Bidders"), whose expression shall be in accordance with the terms of this RFP. The Authority shall not be held responsible for failure on part of the Bidder to furnish all or any of the documents as part of its Bid through E-Procurement Website or for rejection of Bids by E-Procurement for whatsoever reasons. No correspondence shall be entertained by Authority in this regard.
2. A one-time registration in the e-Procurement platform is a pre-requisite for submission of Bids. If an interested Bidder is not already registered, it shall procure a digital signature certificate and get registered in e-Procurement platform. The Authority will not be held responsible for technical glitches in the desktop and internet connectivity services used by Bidders or in case of failure on part of the Bidder to submit the Bid Security or any documents as required to be submitted through E-Procurement Website or for rejection of Bids by E-Procurement for whatsoever rea- sons. No correspondence shall be entertained by the Authority in this regard.

Contact information

For further clarifications, please contact on helpline number provided on e-Procurement Portal of Government of __________.

3. The Bidders would need to submit the following documents:
    a. Documents relating to establishing the qualification of the Bidder in terms of the qualification criteria set out in the RFP ("Qualification Submissions")
    b. 2. Documents relating to technical requirements of the Project ("Technical Proposal") and
    c. 3. Financial proposal ("Price Proposal") for the Project should be furnished in electronic mode only, which shall be filled up by the Bidder in the format made available on the E- Procurement Website. The specimen of the Price Proposal is provided at Appendix G: Format for Price Proposal of the RFP
4. The evaluation of the Proposals would be carried out in four steps. The stages of evaluation are briefly provided below:
    a. The first step would involve a test of responsiveness of the Proposals submitted by the Bidders. Those Proposals found to be substantially responsive would be evaluated in the next step.
    b. In the second step, the Qualification Submissions of the Bidders relating to their experience and financial capability would be evaluated. Bidders meeting the experience and financial capability criteria as set out in the RFP shall be short-listed (the "Qualified Bidders") for further evaluation.
    c. In the third step, the Technical Proposals from Qualified Bidders would be verified for conformance with the minimum technical specifications of the Project Facilities. The Qualified Bidders may be invited to make a presentation of Technical Proposals to the Technical Evaluation Committee. Technical presentation should include approach, methodology and demo for execution of the project by the Bidder.
    d. In the fourth step, the Price Proposals of the Technically Qualified Bidders would be opened in the E-Procurement Website by Authority. The Composite Score of each Bidder shall be calculated on the basis of the Technical Score and the Financial Score as set out in Section 3 of the RFP, in order to identify the Preferred Bidder.
5. The RFP shall be made available to the Bidders on the E- Procurement Website/ Offline mode.
6. It may be noted that all subsequent notifications, changes and amendments on the Project/the RFP would be posted on the E-Procurement Website/ Offline mode.

Instructions to Bidders

A. General

1.1 Eligible Bidders

1.1.1 The entities eligible for participating in the qualification process shall be any one of the following categories:

a. a company incorporated under the Companies Act, 1956/2013 or
b. a partnership firm registered under the Indian Partnership Act, 1932 or
c. a society registered under the Societies Registration Act, 1860 or
d. Co-operative Societies registered under relevant co-operative Societies Registration Act of any state government in India

The term Bidder would hereinafter apply to both the above-mentioned categories.

1.1.2 The following documents shall be submitted by the Bidders along with the Qualification Submissions as proof of being a Company, or partnership firm, or society, or co-operative society:

a. A copy of Certificate of Incorporation/partnership deed, certificate from registrar of society/certificate from registrar of co-operative society, Document authorised by any competent entity of government of India;
b. Charter documents such as Memorandum of Association and Articles of Association/byelaws etc. as may be applicable;
c. An undertaking issued by the Chief Financial Officer/ Company Secretary of the Bidder confirming its status in terms of this clause 1.1.2.

1.1.3 Any entity which has been barred or blacklisted by the Central/ State Government, or any entity controlled by it, from participating in any project, and the bar subsists as on the date of Bid, would not be eligible to submit a Bid, either individually or in partnership, undertaking of the same in 200/- e-Stamp paper from individual participants.

1.1.4 A Bidder should, in the last 3 (three) years, have neither failed to perform on any contract, as evidenced by imposition of a penalty by an arbitral or judicial authority or a judicial pronouncement or arbitration award against the Bidder, as the case may be, nor has been expelled from any project or contract by any public entity nor have had any contract terminated by any public entity for breach by such Bidder/ Associate

1.2 Eligibility conditions for bidders from a country which shares a land border with India

1.1.1 The entities eligible for participating in the qualification process shall be any one of the following categories:

a. a company incorporated under the Companies Act, 1956/2013 or

b. a partnership firm registered under the Indian Partnership Act, 1932 or

c. a society registered under the Societies Registration Act, 1860 or

d. Co-operative Societies registered under relevant co-operative Societies Registration Act of any state government in India

The term Bidder would hereinafter apply to both the above-mentioned categories.

1.1.2 The following documents shall be submitted by the Bidders along with the Qualification Submissions as proof of being a Company, or partnership firm, or society, or co-operative society:

a. A copy of Certificate of Incorporation/partnership deed, certificate from registrar of society/certificate from registrar of co-operative society, Document authorised by any competent entity of government of India;

b. Charter documents such as Memorandum of Association and Articles of Association/byelaws etc. as may be applicable;

c. An undertaking issued by the Chief Financial Officer/ Company Secretary of the Bidder confirming its status in terms of this clause 1.1.2.

1.1.3 Any entity which has been barred or blacklisted by the Central/ State Government, or any entity controlled by it, from participating in any project, and the bar subsists as on the date of Bid, would not be eligible to submit a Bid, either individually or in partnership, undertaking of the same in 200/- e-Stamp paper from individual participants.

1.1.4 A Bidder should, in the last 3 (three) years, have neither failed to perform on any contract, as evidenced by imposition of a penalty by an arbitral or judicial authority or a judicial pronouncement or arbitration award against the Bidder, as the case may be, nor has been expelled from any project or contract by any public entity nor have had any contract terminated by any public entity for breach by such Bidder/ Associate

S.No.	Conditions
1.	Any bidder from a country which shares a land with India will be eligible to bid in this tender only if the bidder is registered with the Competent Authority.
1.1	"Bidder from a country which shares a land border with India" for the purpose of this Order means:
	a. An entity incorporated, established or registered in such a country; or
	b. A subsidiary of an entity incorporated, established or registered in such a country; or
	c. An entity substantially controlled through entities incorporated, established or registered in such a country; or
	d. An entity whose beneficial owner is situated in such a country; or
	e. An Indian (or other) agent of such an entity; or
	f. A natural person who is a citizen of such a country; or
1.2	The beneficial owner for the purpose of above clause will be as under: (i) In case of a company or Limited Liability Partnership, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has a controlling ownership interest or who exercises control through other means. Explanation- a. “Controlling ownership interest” means ownership of or entitlement to more than twenty-five percent of shares or capital or profits of the company; b. “Control” shall include the right to appoint majority of the directors or to control the management or policy decisions including by virtue of their shareholding or management rights or shareholders agreements or voting agreements;
10.	(ii) In case of a partnership firm, the beneficial owner is the natural person(s) who, whether acting alone or together, or through one or more juridical person, has ownership of entitlement to more than fifteen percent of capital or profits of the partnership;
	(iii) In case of an unincorporated association or body of individuals, the beneficial owner is the natural person(s), who, whether acting alone or together, or through one or more juridical person, has ownership of or entitlement to more than fifteen percent of the property
	or capital or profits of such association or body of individuals;
	(iv) Where no natural person is identified under (i) or (ii) or (iii) above, the beneficial owner is the relevant natural person who holds the position of senior managing official;

S.No.	Conditions
	(v) Where no natural person is identified under (i) or (ii) or (iii) above, the beneficial owner is the relevant natural person who holds the position of senior managing official;
1.3	An Agent is a person employed to do any act for another, or to represent another in dealings with third person.
1.4	A certificate for having read the above clauses is required to be submitted / uploaded by the tenderer separately in the following format: "I have read the clause regarding restrictions on procurement from a bidder of a country which shares a land border with India; I certify that this bidder is not from such a country or, if from such a country, has been registered with the Competent Authority. I hereby certify that this bidder fulfils all requirements in this regard and is eligible to be considered. (Where applicable, evidence of valid registration by the Competent Authority shall be attached.)"
1.5	**IN CASES WHERE SUBCONTRACTING IS PROVIDED:** A certificate is required to be submitted/ uploaded by the Tenderer in respect of sub-contracting separately in the following format. "I have read the clause regarding restrictions on procurement from a bidder of a country which shares a land border with India and on sub-contracting to contractors from such countries; I certify that this bidder is not from such a country or, if from such a country, has been registered with the Competent Authority and will not sub-contract any work to a contractor from such countries unless such contractor is registered with the Competent Authority. I hereby certify that this bidder fulfils all requirements in this regard and is eligible to be considered. [Where applicable, evidence of valid registration by the Competent Authority shall be attached.]"

1.3 Number of Proposals

1.3.1 Each Bidder shall submit only 1 (one) Proposal, in response to the RFP. Any Bidder who submits or participates in more than 1(one) Proposal shall be disqualified and shall also cause disqualification of all the Proposals in which such Bidder has participated.

1.4 Proposal Preparation Cost

1.4.1 The Bidder shall be responsible and shall pay for all of the costs associated with the preparation of its Proposal and its participation in the bidding process. Authority will not be responsible or in any way be liable for such costs, regardless of the conduct or outcome of the bidding process.

1.5 Project Inspections and Visit to Sites

1.5.1 Bidders are encouraged to submit their Proposals after ascertaining for themselves the location, surroundings, utilities and existing systems or any other matter considered relevant by them.

1.5.2 It is deemed that by submitting the Proposal in response to the RFP, the Bidder has:

a. made a complete and careful examination of the RFP;

b. received all relevant information requested from Authority;

c. made a complete and careful examination of the various aspects of the Project including but not limited to:

   i. the Project sites;

   ii. the Project Facilities including but are not limited to the existing facilities, infrastructure, structures, interiors, vehicles if any;

   iii. the conditions of utilities in the vicinity of the Project sites;

   iv. conditions affecting transportation, access, disposal, handling and storage of materials, travel and access by personnel;

   v. clearances obtained by Authority for the Project if any; and

   vi. all other matters that might affect the Bidder's performance under the terms of the RFP.

1.5.3 Authority shall not be liable for any mistake or error on the part of the Bidder in respect of the above.

1.6 Right to Accept or Reject any of the Proposals

1.6.1 Notwithstanding anything contained in the RFP, Authority reserves the right to accept or reject any Proposal or to annul the bidding process or reject all Proposals, at any time without any liability or any obligation for such rejection or annulment, without assigning any reasons.

1.6.2 Authority reserves the right to reject any Proposal if: at any time, a material misrepresentation is made or discovered, or the Bidder does not respond promptly and diligently to requests for supplemental information required for the evaluation of the Proposal.

1.6.3 Rejection of the Proposal by Authority as aforesaid would lead to the disqualification of the Bidder. If such disqualification / rejection occurs after the Proposals have been opened and the preferred Bidder gets disqualified / rejected, then Authority reserves the right to take any such measure as may be deemed fit in the sole discretion of Authority, including annulment of the bidding process.

B. Documents

1.7 Contents of RFP

RFP comprises of the contents listed below and would additionally include any Addendum issued in accordance with clause 1.7.

S. No.	Contents
1.	Notice Inviting Tenders
2.	Volume I - Instructions to Bidders
3.	Volume II - Draft Agreement

1.8 Amendment of RFP

1.8.1 At any time prior to the Proposal Due Date, Authority may, for any reason, whether at its own initiative or in response to clarifications requested by a Bidder, modify RFP by the issuance of Addenda.

1.8.2 Any Addendum thus issued will be uploaded in the E-Procurement Website and the same shall be binding on the Bidders.

1.8.3 In order to provide the Bidders with a reasonable time to examine the Addendum, or for any other reason, Authority may, at its own discretion, extend the Proposal Due Date. Extension, if any, of the Proposal Due Date will only be uploaded on the E-Procurement Website.

1.9 Pre-Proposal Meeting

1.9.1 To clarify and discuss issues with respect to the Project and RFP, Authority may hold pre-Proposal meeting(s).

1.9.2 Prior to the pre-Proposal meeting(s), the Bidders may submit to Authority in writing or by fax and e-mail in accordance a list of queries and propose deviations, if any, on the Project requirements and/or the Agreement. Bidders must formulate their queries and forward the same to Authority as per the time schedule set out in Section 4 of this Volume of RFP ("Bidding Schedule"). Authority shall endeavour to respond to the queries within the period specified therein, but no later than 15 (fifteen) days prior to the Proposal Due Date. The responses to queries raised by the Bidders during the pre-Proposal meeting will be uploaded on the E-Procurement Website without identifying the sources. Authority may, in its sole discretion or based on inputs provided by Bidders that it considers acceptable, amend the RFP.

1.9.3 Authority shall endeavour to respond to the questions raised or clarifications sought by the Bidders. However, Authority reserves the right not to respond to any question or provide any clarification, in its sole discretion, and nothing in this Clause shall be taken or read as compelling or requiring Authority to respond to any

question or to provide any clarification.

1.9.4 Authority may Suo moto, if deemed necessary, issue interpretations and clarifications to the Bidders and the same will be uploaded on E-Procurement Website. All clarifications and interpretations issued by Authority shall be deemed to be part of the RFP. Verbal clarifications and information given by Authority or its employees or representatives shall not in any way or manner be binding on Authority.

1.9.5 Bidders may note that Authority will not entertain any deviations to the RFP at the time of sub- mission of the Proposal or thereafter. The Proposal to be submitted by the Bidders would have to be unconditional and unqualified and the Bidders would be deemed to have accepted the terms and conditions of the RFP with all its contents including the draft Agreement. Any conditional Proposal shall be regarded as non-responsive and would be liable for rejection.

1.9.6 Authority will endeavour to hold the pre-Proposal meeting as per Bidding Schedule.

1.9.7 Attendance of the Bidders at the Pre-Proposal meeting is not mandatory. All correspondence / enquiries should be submitted to the following in writing by fax/ registered post / courier.

1.9.8 No interpretation, revision, or other communication from Authority regarding this solicitation is valid unless it is in writing and is signed by a person not less than the rank of the Commissioner for Authority.

C. Preparation and Submission of Proposal

1.10 Language and Currency

1.10.1 The Proposal and all related correspondence and documents should be written in the English language. Supporting documents and printed literature furnished by the Bidder with the Proposal may be in any other language provided that they are accompanied by appropriate translations of the pertinent passages in the English language. Supporting materials, which are not translated into English, may not be considered. For the purpose of interpretation and evaluation of the Proposal, the English language translation shall prevail.

1.10.2 The currency for the purpose of this proposal shall be Indian Rupee (INR).

1.11 Bid Security

1.11.1 The Proposals would need to be accompanied by a Bid Security for an amount of Rs. 0,00,000/- (Rupees_________Crores only).

1.11.2 The Bidder shall pay a part of Bid Security equal to an amount of Rs. (Rupees__________ only) through_____________ (E-procurement website/ Offline mode):

Online payments through E- Procurement website up to __________ :

a. Credit Card
b. Direct Debit
c. Internet Banking

Please note that payment submitted through cheque or demand draft shall not be accepted. For further details regarding e-payment, please refer to E-Procurement Website.

Offline payments for remaining amount:

d. Bank Guarantee

Remaining Bid Security amount shall be provided in the form of Bank Guarantee acceptable to the Authority at the time of submission of Bid. The validity period of Bank Guarantee shall be not less than 9 (nine) months from the Proposal Due Date, inclusive of a claim period of 60 (sixty) days, and may be extended as may be mutually agreed between the Authority and Bidder from time to time. The Bidder shall provide part of the Bid Security in the form of a Bank Guarantee acceptable to the Authority, as per format at Appendix H.

The Bid Security payable for the Project through E-Procurement Website and through bank guarantee is set out in the table below:

Bid Security (in Rs.)	Through ________(E-procurement website/Offline mode) (in Rs.)
_______________/-	_____________/-

Note: The Authority shall not be held responsible in case of failure on part of the Bidder to furnish part of the Bid Security through E-Procurement Website or for rejection of Bids by E-Procurement Website for whatsoever reasons. No correspondence shall be entertained by the Authority in this regard.

1.11.3 The Bid Security shall be returned to the unsuccessful Bidders within a period of 8 (eight) weeks from the date of announcement of the Successful Bidder. The Bid Security submitted by the Successful Bidder shall be released upon furnishing of the Performance Security in the form and manner as stipulated in the Agreement.

1.11.4 The Bid Security shall be forfeited in the following cases:

a. If the Bidder modifies or withdraws its Proposal except as provided in clause 1.16;

b. If the Bidder withdraws its Proposal during the interval between the Proposal Due Date and expiration of the Proposal Validity Period;

c. If the Successful Bidder fails to provide the Performance Security and execute the Agreement with Authority within the stipulated time or any extension thereof provided by Authority;

d. If any information or document furnished by the Bidder turns out to be misleading or untrue in any material respect.

1.12 Validity of Proposal

1.12.1 The Proposal shall remain valid for a period not less than 180 Days from the Proposal Due Date (“Proposal Validity Period”). Authority reserves the right to reject any Proposal, which does not meet this requirement.

1.13 Extension of Validity of Proposal

1.13.1 In exceptional circumstances, prior to expiry of the original Proposal Validity Period, Authority may request Bidders to extend the Proposal Validity Period for a specified additional period.

1.14 Format and Signing of Proposal

1.14.1 The Bidder shall provide all the information sought under the RFP in electronic mode as per the RFP. Authority reserves the right to evaluate only those Proposals that are received in the required format and is complete in all respects.

1.14.2 All the documents of the Proposal sought under this RFP shall be typed or written in indelible ink and signed by the authorized signatory of the Bidder who shall also initial each page, in blue ink. All the alterations, omissions, additions or any other amendments made to the Proposal shall be initial led by the person(s) signing the Proposal.

1.14.3 The Bidder shall submit the following documents in the correct slots as provided in the E-Procurement Website, on or before the Proposal Due Date.

Qualification Submission, consisting of the following:

a. Letter of Proposal as per Appendix A: Format for Letter of Proposal
b. Power of Attorney as per Appendix B-1: Format for Power of Attorney for Signing of Proposal, authorising the signatory of the Proposal to commit the Bidder
c. Letter of Commitment as per Appendix B-3: Letter of Commitment
d. Details of Bidder as per Appendix C: Details of Bidder
e. Anti-Collusion Certificate as per Appendix D-1: Format for Anti Collusion Certificate
f. Letter of Undertaking from Bidder as per Appendix D-2: Format for Undertaking
g. Bid Security and part of Bid Security as Bank Guarantee in the prescribed format Appendix H.
h. Certificate of Incorporation, Memorandum of Association and Articles of Association for Companies; Certificate of Registration for Partnerships, Societies, Trust Deed, as the case may be
i. Format for statement of experience for Fleet as per Appendix E-1:
j. Format for statement of experience for System Integration as per Appendix E-2
k. Statement of Financial Capability as per
l. Annual reports of the three completed financial years preceding the Proposal Due Date
m. Signed copy of the RFP, draft Agreement and any amendments thereof
n. Technical Proposal
o. Power point presentation on parameters set out in Annexure to this RFP
p. Supporting documents

1.14.4 All the documents of the Proposal submitted in electronic mode under the RFP shall be uploaded on E-Procurement Website ________________(link) using digital signature.

1.15 Submission of Proposals

1.15.1 The documents accompanying the Proposal submission shall include "Qualification Submission" and "Technical Proposal".

1.15.2 The Price Proposal, consisting of the Bidders financial offer for the Project shall be submitted in electronic mode only on the E-Procurement Website. Proposals submitted by fax, telex, telegram or e-mail shall not be entertained and shall be rejected.

1.15.3 Authority reserves the right to seek original documents for verification of any of the documents submitted in electronic mode or documents in light of clarification with respect to the Bid submit- ted during evaluation.

1.16 Proposal Due Date

1.16.1 The Proposals, in electronic mode in the E-Procurement Website shall be submitted on or before 16:00 hrs. IST on the Proposal Due Date as specified in the RFP. The original Bank Guarantee to- wards part Bid Security should be submitted upto Due Date and not earlier than the Proposal Due Date, as per the Schedule of Bidding Process provided in the manner and form as detailed in this RFP and an acknowledgment /proof of delivery shall be obtained.

1.16.2 Authority may, in its sole discretion, extend the Proposal Due Date and / or Due Date for hard copy submission of the original Bank Guarantee towards part Bid Security by issuing an Addendum in accordance with clause 1.7 uniformly for all the Bidders.

1.16.3 Proposals received by the Authority after the specified time on the Proposal Due Date and / or Due Date for submission of Original Bank Guarantee towards part Bid Security shall not be eligible for consideration and shall be summarily rejected.

1.17 Withdrawal of Proposals

1.17.1 The Bidder may withdraw its Proposal after submission via electronic mode but prior to the Proposal Due Date. No Proposal may be withdrawn by the Bidder on or after the Proposal Due Date.

1.17.2 Any alteration/ modification in the Proposal or additional information supplied subsequent to the Proposal Due Date, unless the same has been expressly sought for by Authority, shall be disregarded.

1.17.3 No Proposal may be withdrawn during the period after the Proposal Due Date and during the Proposal Validity Period. Withdrawal of Proposal during this period would result in forfeiture of the Bid Security.

D. Evaluation of Proposal

1.18 Proposal Opening

1.18.1 Authority would open the Qualification Submissions at the time and date indicated in the Bidding Schedule for the purpose of evaluation.

1.18.2 Authority would subsequently examine and evaluate Proposals in accordance with the criteria set out in Section 3 of the RFP.

1.19 Confidentiality

1.19.1 Information relating to the examination, clarification, evaluation, and recommendation for the Bidders shall not be disclosed to any person not officially concerned with the process. Authority will treat all information submitted as part of Proposal in confidence and would require all those who have access to such material to treat the same in confidence. Authority will not divulge any such information unless it is ordered to do so by any authority pursuant to applicable law or order of a competent court or tribunal, which requires its disclosure.

1.20 Clarifications

1.20.1 To facilitate evaluation of Proposals, Authority may, at its sole discretion, seek clarifications in writing from any Bidder regarding its Proposal and may request any Bidder to provide hard copy of the documents provided as part of the Proposal through E-Procurement Website.

1.21 Proposal Evaluation: Qualification Submissions

1.21.1 The Qualification Submissions of the Bidders would first be checked for responsiveness as set out in clause 3.1. All Proposals found to be substantially responsive shall be evaluated as per the Qualification Criteria set out in Section 3.

1.21.2 Bidders who meet the qualification criteria shall be shortlisted for further evaluation.

1.21.3 The Technical Proposal of the Bidders who do not meet the Qualification Criteria would not be opened.

1.22 Proposal Evaluation: Technical Proposal

1.22.1 The Technical Proposals of the Qualified Bidders would be evaluated by Technical Evaluation Committee as per the technical evaluation criteria set out in Section - IV.

1.22.2 The Price Proposal of the Bidders who do not qualify in the evaluation of Technical Proposal would not be opened.

1.23 Proposal Evaluation: Price Proposal

1.23.1 Price Proposal of only the Technically Qualified Bidders would be opened on the E-Procurement Website by Authority and evaluated as per process set out in Section 3 to identify a preferred Bidder.

1.24 Declaration of Successful Bidder

1.24.1 Authority at its discretion may either choose to accept the Price Proposal of the Preferred Bidder or invite him for negotiations.

1.24.2 Upon acceptance of the Price Proposal of the preferred Bidder with or without negotiations, Authority shall declare the preferred Bidder as the “Successful Bidder”.

1.25 Letter of Award by Authority

1.25.1 After selection, a Letter of Award (the "LoA") shall be issued, in duplicate, by Authority to the Successful Bidder.

1.26 Acceptance of Letter of Award and Execution of Agreement

1.26.1 The Successful Bidder shall, within 7 (seven) days of the receipt of LoA, sign and return the duplicate copy of LoA in acknowledgement thereof. In the event the duplicate copy of LoA duly signed by the Successful Bidder is not received by the stipulated date, Authority may, unless it consents to extension of time for submission thereof, appropriate the Bid Security of such Bidder as mutually agreed genuine pre-estimated loss and damage suffered by Authority on account of failure of the Successful Bidder to acknowledge LoA, and the next eligible Bidder may be considered.

1.26.2 After acknowledgement of LoA as aforesaid, by the Successful Bidder, it shall execute the Agreement within the period of 15 days. The Successful Bidder shall not be entitled to seek any deviation in the draft Agreement (Vol-II). Except for insertions to the agreement conditions pertaining to details of the Successful Bidder and Price Proposal, no other modifications would be made by Authority at this stage. All changes that may be necessary due to Authority responses sent to pre- Proposal queries would be made by Authority. No other changes to the draft Agreement would be made therein.

1.27 Performance Security

1.27.1 The Successful Bidder shall furnish Performance Security by way of an irrevocable Bank Guarantee for an amount of 5% of project cost issued by any Nationalized Bank or Scheduled Commercial Bank notified by Reserve Bank of India in favour of the Authority, as required under the Agreement.

1.27.2 Failure of the Successful Bidder to comply with the requirements of clause 1.26 or 1.26.1 shall constitute sufficient grounds for the annulment of the LoA, and forfeiture of the Bid Security. In such an event, the Authority reserves the right to take any such measure as may be deemed fit in the sole discretion of the Authority, including annulment of the Bidding Process.

Scope of Work

1. To procure, deploy, operate, maintain, manage and monitor Ambulances (ALS/ BLS/PTV/Others) under Emergency Response Services across _______ (State/ UT Name).
2. To set up, operate, maintain and manage a call centre in accordance with the requirements of the Project.
3. To equip the call centre with all necessary hardware and software for computer telephony integration, computer aided dispatch of Ambulance along with GIS, GPS, Automatic Vehicle Tracking, Artificial intelligence enabled systems wherever applicable.
4. To develop a web-based application for use by stakeholders as per the requirement of the Contract.
5. To provide transit healthcare and treatment on a 24*7*365 basis to patients/ emergency patients, with the goal of successfully treating the trauma/ injury or arranging for timely transfer of the patient to the next point of definitive care at the nearest and appropriate identified Public and Private health facility.
6. To ensure coordination with all stakeholders viz. administration, other State agencies such as Police, Road Transport, Fire, beneficiaries and any Third parties etc assisting the Project.
7. To provide and support the NHM-Govt of ______ (State name) during existence of the Contract, towards the introduction, operationalization, maintenance and management of any other services that may be required in future.
8. Recruit and train qualified manpower required for operation and maintenance of all services including call centre operation, fleet management, onboard patient care, transportation and other operations or activities as per recognized norm duly approved by the Government. The Agency (incoming) shall ensure that the past performance, conduct and track record of personnel recruited for this project are clean and satisfactory. The new incoming service provider is allowed to select the staff out of the existing pool based on their good service record.
9. All movable and immovable assets created in the project will be the property of State Government. The assets will have to be handed over to the Government at the time of termination/expiry of the contract or as and when sought by the Government, whichever is earlier.
10. The vehicles shall be registered in the name of State Health Society/ Authority.
11. Selected bidder shall be responsible for registration of all vehicles. All the vehicle registration numbers preferably should be in a sequence form.
12. The bidder shall comply with various requirements during the contract period as provided in this RFP.
13. The information of ambulances to be filled periodically on the State Government/ Government of India (GOI) portals whenever asked.

Responsibilities of selected Bidder:

1. Provide new/ good, conditioned vehicle directly through the company or their authorized showroom/dealer.
2. Undertake fabrication works in the vehicles. Take approval of the prototype before undertaking fabrication works.
3. Provide equipment with comprehensive warranty, insurance and maintenance support.
4. Install and commission equipment.
5. Ensure compliance of the vehicle to various standards and performance requirements throughout the scope of the contract period as per standard norms provided by the government.
6. Provide all relevant invoices and vehicle papers in agreed formats within specified timeline.
7. Comply with procedures of RTA of the State of ___________ in registration of the vehicles, including payment of taxes and fee as required.
8. Provide maintenance support such as repairing, regular servicing etc.
9. Provide comprehensive warranty support towards vehicle repair/replacement of the vehicle.
10. Provide and maintain all types of required insurance for the vehicles.
11. Submit "monthly reports" on vehicles including vehicle logbooks, vehicle condition etc.
12. Provide equipment required at the "Training Centre" of the Integrated Command and Dispatch Centre for training of staff.
13. Provide "towing support" in case of breakdown of vehicle at no extra cost to Government. Provide monthly status report on breakdowns, action taken and other details.
14. The service provider will provide information to the authority once the vehicle is taken off road in the case of breakdown/planned maintenance of vehicle/s within 48 hours from the time call is logged. Upon repair of such vehicle, while it is re-operationalized, the information of such on-roading of the vehicle must be provided to the concerned authority within 48 hours. Provide replacement vehicle for this time period to ensure the continuity of the services.
15. The bidder shall take comprehensive insurance and extended warranty for whole of contract period covering 100% costs incurred towards accident, theft, damage, repair, maintenance and replacement of any/all vehicle parts including parts and equipment supplied/fabricated.
16. The comprehensive insurance and extended warranty mentioned above shall be transferred to the authority for maintenance of vehicles. The bidder shall maintain the ambulances on behalf of authority.
17. The bidder at all times shall respond to the concerns raised by authority with regard to vehicle maintenance.

18. Servicing of ambulance, fabrication and equipment shall be done by the bidder free of cost during the contract period.
19. Supply equipment as mentioned in Operational guidelines on National Ambulance Service.
20. Deliver equipped ambulances to the parking locations identified by the Authority.
21. Buy back of all vehicles supplied, at the end of contract, at a minimum 10% of vehicle price (vehicle, equipment and fabrication) discovered through this RFP process.

Responsibilities of Authority:

1. Inspect, check and accept vehicles in accordance with the requirements mentioned in this RFP.
2. Provide parking place for vehicles.
3. Make payments on a regular basis to the selected bidder.
4. Facilitate approvals from other state government departments, if required, for registration and running of vehicles.
5. Appoint a Service Provider (selected Bidder) for operation of vehicles on 24x7 basis who shall also be responsible for system integration, establishment and operation of Integrated Command and Dispatch Center to interface and coordinate with vehicles for providing emergency response services.
6. Conduct technical examination, tests and audits of vehicles on a periodic basis or as and when desired.

Evaluation of Proposals

3.1. Tests of Responsiveness

3.1.1 Prior to evaluation of Proposals, the Authority will determine whether each Proposal is responsive to the requirements of RFP. A Proposal shall be considered responsive if the Proposal:

a. is received/deemed to be received by the Proposal Due Date including any extension;

b. is accompanied by the Bid Security as stipulated in clause 1.11;

c. is accompanied by the Power of Attorney, the format for which is specified in Appendix B1 and Appendix B2;

d. contains all the information as requested in the RFP;

e. contains information in formats same as those specified in the RFP; and

f. mentions the validity period as set out in clause 1.12

3.1.2 Authority reserves the right to reject any Proposal which is non-responsive and no request for alteration, modification, substitution or withdrawal shall be entertained by Authority in respect of such Proposals.

A. Evaluation of Qualification Submissions

3.2 Evaluation Parameters

3.2.1 The competence and capability of the Bidder is proposed to be established by the following parameters:

a. Experience in terms of:

   i. Experience in delivering emergency response services and system integration set- ups to Government Department/ Agencies

   ii. Experience in Emergency Response Services and system integration in India;

   iii. Operation of ambulance or healthcare related fleet;

b. Financial capability in terms of:

   i. Net worth; and

   ii. Annual turnover.

c. Quality certification in terms of:

   i. Should have Quality Certification (Essential- Qualifying ISO 27001 and Desirable- CMMi level 3)

3.2.2 On the above parameters, the Bidder would be required to meet the evaluation criteria as detailed in this **Section 3.**

3.2.3 Notwithstanding anything to the contrary contained herein, in the event that the Proposal Due Date falls within three months of the closing of the latest financial year of the Bidder, it shall ignore such financial year for the purposes of its Proposal and furnish all its information and certification with reference to three years or two years or one year as the case may be, preceding its latest financial year. For the

avoidance of doubt financial year shall, for purposes of the Proposal hereunder, mean the accounting year followed by the Bidder in the course of its normal business.

3.3 Qualification Criteria for Experience

3.3.1 For the purpose of qualification, Bidders shall demonstrate experience as on the Proposal Due Date for all the criteria ("Experience Criteria") set out in table below:

S No.	Criteria	Description
1.	Experience in System Integration of emergency response system	Should have implemented at least one Project comprising of system integration and Operation & Maintenance of Emergency response services including Integrated Command and Dispatch Centre with at least- **Essential:** Demonstrated experience in running EMS in at least 1 **project state applications** of minimum call Centre seats______ **(N= at least 5% of required ambulances.)** (functioning 24 hours a day), during **last 8 years** for any government entity in India with the Operation & Maintenance phase for at least 3 years with the following minimum services: a) Computer Aided Dispatch for Emergency Medical Service. b) GIS and GPS Based Ambulance Assignment and Tracking System **Desirable:** Demonstrated experience in running EMS software in at least 1 project state applications of minimum call Centre seats______ **(N= at least 5% of required ambulances.)** (functioning 24 hours a day), during **last 5 years** for any government entity in India with the Operation & Maintenance phase for at least 3 years with the following minimum services
2.	Operation of Ambulances	Should have experience of operating a minimum- – **Essential: 40% of required ambulances** on behalf of state/district health authorities/ Public Sector undertakings of which a minimum **10% of ambulances** should be Advanced Life support (ALS) 4-wheeled ambulances and Remaining basic Life support 4-wheeled ambulances (BLS).

S No.	Criteria	Description
		Desirable: 75% of required ambulances on behalf of state/district health authorities/ Public Sector undertakings of which a minimum **10% of ambulances** should be Advanced Life support (ALS) 4-wheeled ambulances and Remaining basic Life support 4-wheeled ambulances (BLS). *Please note that: *All Emergency Medical Service Ambulances experience claimed should be GPS fitted Ambulances & Experience of Drop-back Service Ambulances (like Janani- Express, 102-Drop back Service, etc.), Hearse Ambulance Service, Geriatric Care Ambulance Service, and Mobile Medical Units, shall not be considered as Emergency Medical Ambulance Service.*
3.	Training of para-medics	Essential: Should have trained and deployed a minimum of _______ (N= 80% of the required number of ambulances) Emergency Medical Technicians for any State Government in India, during the last five years (Annexure – 8 A Certificate to be uploaded). Desirable: 50% of the EMTs trained in NELS curriculum
4.	Quality certification	Essential: Should have Quality Certification qualifying ISO 27001 • Should follow AIS-125 standards for Constructional and Functional Requirements for Road Ambulances. Desirable: Quality certification for CMMi level 3 (or above). Note: all bidders are required to possess ISO Certification issued exclusively by accreditation bodies recognized by the National Accreditation Board for Certification Bodies (NABCB)
5.	Blacklisting	Not blacklisted to provide any such similar services to any State/Central Government agencies

3.4 Details of Experience

3.4.1 The Bidder shall furnish evidence to support its claim as per Appendix E1 and Appendix E2

3.5 Financial Capability

3.5.1 The financial capability (the “Financial Capability”) of the Bidders would be evaluated on the basis of the following:

a. Net worth as at the end of the latest completed financial year (Ref. Appendix E3); and

b. Annual turnover for the last two completed financial years (Ref. Appendix E3).

3.5.2 The Bidder shall submit the evidence to support its Financial Capability as per format set out in.

3.5.3 The Proposal must be accompanied by the audited annual financial statements of the Bidder for the latest 3 (three) completed financial years preceding the Proposal Due Date.

3.6 Qualification Criteria for Financial Capability

3.6.1 For the purpose of qualification, a Bidder shall be required to demonstrate the Financial Capability as set out below.

S No.	Financial Capability Criteria
1.	Positive Net worth in the latest completed financial year.
2.	**Essential:** Average Annual turnover of _______ (N= at least 50% of total cost of required number of ambulances) during the **last 3 (three) Financial Years.** **Desirable:** Average Annual turnover of _______ (N= at least 75% of total cost of required number of ambulances) during the **last 3 (three) Financial Years.**

3.6.2 For the purposes of evaluation only figures from the latest three audited annual financial statements would be considered.

3.7 Qualified Bidders

3.7.1 Bidders meeting the Experience Criteria and Financial Capability shall be declared as qualified bidders ("Qualified Bidders"). The Technical Proposals of only the Qualified Bidders shall be considered for further evaluation.

B. Evaluation of Technical Proposal

3.8 Technical Proposal Evaluation Parameters

3.8.1 The Technical Proposals of the Bidders would be evaluated on the basis of the evaluation parameters set out in Appendix F: Format for Technical Proposal of this RFP.

3.9 Components of Technical Proposal

3.9.1 The Bidders shall submit the following as part of Technical Proposal:

a. Supporting documents as per the parameters set out in Appendix F: Format for Technical Proposal of this RFP.

3.10 Evaluation of Technical Proposal

3.10.1 Preliminary examination

a. The Technical Proposal shall first be scrutinized to determine whether the Bidder has submitted the Technical Proposal complete in all respect with all supporting documents as per Appendix F: Format for Technical Proposal of

this RFP.

b. The Technical Evaluation Committee shall evaluate the Technical Proposals. The Technical Evaluation Committee may in its discretion, based on the preliminary examination, determine the substantial responsiveness of the Technical Proposals. Technical Proposals without any material omissions, errors or incompleteness may be considered responsive.

c. Authority reserves the right to reject any Proposal which is non-responsive.

3.10.2 The Technical Evaluation Committee shall award marks to each Bidder considering the evaluation parameters set out in the Appendix F: Format for Technical Proposal of this RFP.

3.11 Short listing of Technically Qualified Bidders

3.11.1 The Technical Proposals of the Qualified Bidders:

a. Which are found to be in conformance with the minimum technical specifications provided in Appendix F: Format for Technical Proposal;

b. Which has been awarded at least minimum cut off marks provided for each of the parameters set out in Appendix F: Format for Technical Proposal of this RFP;

c. Which has been awarded a total of at least _______marks (75% of total marks) allocated for overall experience, key professional staff and certifications

d. Which has been awarded a total of at least 75% marks shall be shortlisted for opening of the Price Proposal ("Technically Qualified Bidders").

3.11.2 The total marks awarded to the Technical Proposal of the Technically Qualified Bidder as per clause 3.10.2 of the RFP shall be the Technical Score (ST) of the Bidder.

C. Evaluation of Price Proposal

3.12 Evaluation Parameters

3.12.1 The Bidders shall quote the Contract Price (calculated on monthly basis) as per Appendix G as part of the Price Proposal.

3.12.2 The Contract Price (calculated on monthly basis) in the Price Proposal shall include all the costs and expenses that the Service Provider would incur in performance of its obligations. The Contract Price shall be submitted in the Price Proposal format set out as Appendix G. An indicative list of costs to be included to arrive at the Contract Price including but not limited to the following:

a. Cost associated with setting up of Control Room

b. Cost associated with integration of Project Facilities with the IT Infrastructure

c. Cost of procurement, operations, management, maintenance and monitoring of the Project Facilities throughout the Agreement period

d. Cost of consumable pertaining to the Project

e. Cost of manpower deployment

f. Cost of manpower training

g. Communication expenses (broadband internet/ toll free line)

h. Submission of progress reports and other MIS reports

i. Other direct and indirect expenses relating to the Project.

3.12.3 Bids determined to be substantially responsive will be checked for any arithmetic errors. Errors will be corrected by Authority as follows;

3.12.4 The amount stated in the Price Proposal will be adjusted by Authority in accordance with the above procedure for the correction of errors, with the concurrence of the Bidder and shall be considered as binding upon the Bidder. If the Bidder does not accept the corrected amount the Proposal will be rejected, and the Bid Security may be forfeited.

3.12.5 Authority may in its sole discretion reject any Price Proposal if any of the following conditions outlined below are true:

a. Incomplete Price Proposal is submitted by the Bidder.

b. Total price quoted by the Bidder does not include all statutory taxes and levies applicable.

3.13 Evaluation of Price Proposal

3.13.1 For evaluation of the Price Proposal, the Contract Price indicated in the Price Proposal shall be considered. Each Price Proposal shall be assigned a Financial Score (SF).

3.13.2 The lowest Contract Price (FM) will be given a Financial Score (SF) of 100 points. The financial scores of other Proposals will be computed as follows:

SF = 100 x FM/F (F = amount of Price Proposal)

3.14 Computation of Composite Score

3.14.1 Proposals will finally be ranked according to the combined Technical Score (ST) and Financial Score (SF) as follows:

S = (ST x TW) + (SF x FW)

Where,

S is the Composite Score and TW and FW are weights assigned to Technical Proposal and Price Proposal that shall be 0.75 and 0.25 respectively.

3.14.2 The Bidders shall be ranked in descending order and the Bidder scoring the highest combined score ("Composite Score") shall be ranked first. The Bidder scoring the highest Composite Score shall be declared as the Preferred Bidder.

3.14.3 In the event that the first ranked Bidder withdraws its Proposal or is not selected for any reason in the first instance, the Authority may invite the second ranked Bidder for negotiations.

3.14.4 In the event that two or more Bidders obtain the same Composite Score, (the "Tie Bidders"), the Authority shall select the Bidder who scores higher in the Technical Proposal as the Successful Bidder.

Bidding Schedule

Authority would endeavour to adhere to the following schedule:

S.No.	Bid Stage	Date
1.	Pre-Proposal meeting	_____ at 12.00 Noon. **Venue**: HEALTH & FAMILY WELFARE SERVICES, ____________ ROAD, _______ Ph. No.
2.	Last date for receiving pre-Proposal queries	___________ (Tentative date) on or before ______ (Time) through e Portal only
3.	Proposal Due Date	______ on or before (time)
4.	Due Date for submission of original Bank Guarantee towards Bid Security.	_____ on or before(time) Submitted to _____ HEALTH & FAMILY WELFARE SERVICES ________________ ________________ Ph. No:
5.	Opening of Qualification Submissions	_____________ on or before (time)
6.	Opening of the Technical Proposal	___________ (Tentative date) at______ (Time)
7.	Opening of Price Proposal	__________ (Tentative date) at ______ (Time)
8.	Letter of Award (LoA)	Tentatively Within 30 days of opening of Price Proposal
9.	Validity of Proposals	9 (nine) months from the Proposal Due Date
10.	Signing of the Agreement	Within 30 (thirty) days from acknowledgement of LoA

Appendix A: Format for Letter of Proposal

(On the Letter head of the Bidder)

Date

To,

Director,

Health and Family Welfare Department

_______________road,

____

Sub: RFP for the selection of service provider for the establishment, operation & maintenance of 108- emergency medical service (Ambulance service) in ___________ for a period of two years

Dear Sir,

1. With reference to your RFP document dated *****, I/We have examined the Bid Documents and understood their contents, hereby submit my/our Bid for the aforesaid Project.
2. I/We intend to participate in the bidding process as Single Business Entity.
3. I/ We submit that Bid submitted for the subject Project is unconditional and unqualified.
4. All information provided in the Bid and in the Appendices is true and correct.
5. I/ We shall make available to the Authority any additional information it may find necessary or require to supplement or authenticate the Bid.
6. I/ We acknowledge the right of the Authority to reject our Bid without assigning any reason or otherwise and hereby waive, to the fullest extent permitted by applicable law, our right to challenge the same on any account whatsoever.
7. Any entity which has been barred or blacklisted by the Central Government, any State Government, a statutory authority or a public sector undertaking, as the case may be, from participating in any project during the past 3 (three) years, and the bar subsists as on the date of the Proposal Due Date, would not be eligible to submit a Bid either by itself or through its associate.
8. I/ We certify that in the last three years, we have neither failed to perform on any contract, as evidenced by imposition of a penalty or a judicial pronouncement or arbitration award, nor been expelled from any project or contract nor have had any contract terminated for breach on our part.
9. I/ We declare that:
    a. I/ We have examined and have no reservations to the Bidding Documents, including any Addendum issued by the Authority.
    b. I/We have not directly or indirectly or through an agent engaged or indulged

in any cor- rupt practice, fraudulent practice, coercive practice, undesirable practice or restrictive practice, in respect of any tender or request for proposal issued by or any agreement entered into with the Authority or any other public sector enterprise or any government, Central or State; and

c. I/ We hereby certify that we have taken steps to ensure that no person acting for us or on our behalf has engaged or will engage in any corrupt practice, fraudulent practice, coercive practice, undesirable practice or restrictive practice.

10. I/ We understand that you may cancel the Bidding Process at any time and that you are neither bound to accept any Proposal that you may receive nor to invite the Bidders to bid for the Project, without incurring any liability to the Bidders.
11. I/ We believe that we satisfy(ies) the Qualification, Technical and Financial Capacity criteria and meet(s) the requirements as specified in the RFP document and are/ is qualified to submit a Proposal in accordance with the RFP document.
12. I/ We declare that I/we is/ are not a Member of any other Consortium submitting a Proposal for the Project.
13. I/ We certify that in regard to matters other than security and integrity of the country, we have not been convicted by a Court of Law or indicted or adverse orders passed by a regulatory authority which could cast a doubt on our ability to undertake the Project or which relates to a grave offence that outrages the moral sense of the community.
14. I/ We further certify that in regard to matters relating to security and integrity of the country, we have not been charge-sheeted by any agency of the Government or convicted by a Court of Law for any offence committed by us.
15. I/ We certify that I/ we have not been issued any pre-termination notice, solely due to non-per- formance, in and any medical emergency response services Government project in the last 3 years
16. I/ We further certify that we are not barred by the Central/ State Government, or any entity con- trolled by them, from participating in any project, and the bar subsists as on the date of RFP, would not be eligible to submit a Proposal.
17. I/ We further certify that no investigation by a regulatory authority is pending either against us or against our CEO or any of our Directors/ Managers/ employees.
18. I/ We undertake that in case due to any change in facts or circumstances during the bidding pro- cess, we are attracted by the provisions of disqualification in terms of the guidelines referred to above, we shall intimate Authority of the same immediately.
19. In the event of my/ our being declared as the Selected Bidder, I/We agree to enter into an Agreement in accordance with the draft that has been provided to me/us prior to the Proposal Due Date. We agree not to seek any changes in the aforesaid draft and agree to abide by the same.
20. I/We have studied all the bidding documents carefully. We understand that except to the extent as expressly set forth in the draft Agreement, we shall have no claim, right or title arising out of any documents or information provided to us by Authority or in respect of any matter arising out of or concerning or relating to the bidding process including the award of Rights.

21. The Contract Fee has been quoted by me/us after taking into consideration all the terms and conditions stated in the RFP; draft Agreement, our own estimates of costs and revenues and all the conditions that may affect the Proposal.
22. I/We offer a Bid Security of Rs. ___00,000,000/- (Indian Rupees___Crores only) to the Authority in accordance with the RFP Document.
23. I/We agree and understand that the Proposal is subject to the provisions of the Bidding Documents. In no case, I/We shall have any claim or right of whatsoever nature if the Project is not awarded to me/us or our Proposal is not opened.
24. I/We agree to keep this offer valid for 270 (Two Hundred and Seventy) days from the Proposal Due Date specified in the RFP.
25. I/We agree and undertake to abide by all the terms and conditions of the RFP document.

In witness thereof, I/we submit this Bid under and in accordance with the terms of the RFP document.

Yours faithfully,

Date:	(Signature of the Authorized signatory)
Place:	(Name and designation of the of the Authorized signatory)
	Name and seal of Bidder/Lead Firm

Appendix B-1: Format for Power of Attorney for Signing of Proposal

(On stamp paper of appropriate value)

Power of Attorney

Know all men by these presents, We.. (name of the firm and address of the registered office) do hereby irrevocably constitute, nominate, appoint and authorize Mr./ Ms. (name),........................ son/daughter/wife of.................................... and presently residing at ...., who is presently employed with us and holding the position of ...., as our true and lawful attorney (hereinafter referred to as the "Attorney") to do in our name and on our behalf, all such acts, deeds and things as are necessary or required in connection with or incidental to submission of our Bid with respect to Provision of Medical Emergency Response Services in _________(State Name) under _________ Framework to the Health and Family Welfare Department, Government of _________(State Name) (hereinafter referred to as the "Authority") including but not limited to signing and submission of all Bids, bids and other documents and writings, participate in the Bidding Process and other conferences and providing information/ responses to the Authority, representing us in all matters before the Authority, signing and execution of all contracts including the Agreement and undertakings consequent to acceptance of our bid, and generally dealing with the Authority in all matters in connection with or relating to or arising out of our bid for the said Project and/or upon award thereof to us and/or till the entering into the agreement of the Authority.

AND we hereby agree to ratify and confirm and do hereby ratify and confirm all acts, deeds and things lawfully done or caused to be done by our said Attorney pursuant to and in exercise of the powers conferred by this Power of Attorney and that all acts, deeds and things done by our said Attorney in exercise of the powers hereby conferred shall and shall always be deemed to have been done by us.

IN WITNESS WHEREOF WE, ..., THE ABOVE NAMED PRINCIPAL HAVE EXECUTED THIS POWER OF ATTORNEY ON THIS .... DAY OF ...., 2.....

For ....

(Signature, name, designation and address)

Witnesses:

1.

2.

(Notarized)

Accepted

.... (Signature)

(Name, Title and Address of the Attorney)

Notes: The mode of execution of the Power of Attorney should be in accordance with

the procedure, if any, laid down by the applicable law and the charter documents of the executant(s) and when it is so required, the same should be under common seal affixed in accordance with the required procedure.

Wherever required, the Bidders should submit for verification the extract of the charter documents and documents such as a resolution/ power of attorney in favor of the person executing this Power of Attorney for the delegation of power hereunder on behalf of the Bidder. For a Power of Attorney executed and issued overseas, the document will also have to be legalized by the Indian Embassy and notarized in the jurisdiction where the Power of Attorney is being issued. However, the Power of Attorney provided by Bidders from countries that have signed The Hague Legislation Convention 1961 are not required to be legalized by the Indian Embassy if it carries a conforming Apostille certificate.

Appendix B-2: Letter of Commitment

(The Letter of Commitment is to be submitted by the Bidder)

Date:

To, Director

Health and Family Welfare Department

____

____

Sir,

Re: RFP for the selection of service provider for the establishment, operation & maintenance of 108-emergency medical service (Ambulance service) in _______ (State Name) for a period of two years

This has reference to the Proposal being submitted by (name of the Bidder), in respect of the abovementioned Project.

We hereby confirm the following:

We have examined in detail and have understood and satisfied ourselves regarding the contents mainly in respect of the following:

1. The Request for Proposal issued by the Authority;
2. All subsequent communications between Authority and the Bidder, represented by(name of Bidder)
3. The Proposal being submitted by (name of Bidder)

Dated this the ___________

Day of__________20

For ___________

(Name and designation of the person(s) signing on behalf of the Bidder)

Appendix C: Details of Bidder

1. Name
2. Address of the office(s)
3. Date of incorporation and/or commencement of business.
4. Brief description of the Company including details of its main lines of business.
5. Name, Designation, Address and Phone Numbers of Authorised Signatory of the Bidder:

   Name:

   Designation:

   Company:

   Address:

   Telephone Number:

   Fax Number:

   Mobile Number:

   E-Mail Address:
6. Details of individual (s) who will serve as the point of contact / communication for Authority within the Company:

   Name:

   Designation:

   Company:

   Address:

   Telephone Number:

   Fax Number:

   Mobile Number:

   E-Mail Address:

Appendix D-1: Format for Anti Collusion Certificate

(On the Letterhead of the Bidder)

We hereby certify and confirm that in the preparation and submission of our Proposal for the Selection of Service Provider for providing medical emergency response services (Project), we have not acted in con- cert or in collusion with any other Bidder or other person(s) and also not done any act, deed or thing which is or could be regarded as anti-competitive.

We further confirm that we have not offered nor will offer any illegal gratification in cash or kind to any person or agency in connection with this Proposal.

Dated this ___________ Day of__________, 20___________

____

(Name of the Bidder)

____

(Signature of the Authorized Person)

____

(Name and designation of the Authorized Person)

Appendix D-2: Format for Undertaking

(On the Letterhead of the Bidder)

Date:

Director,

Health and Family Welfare Department

_______________road,

____

Sir,

Re:RFP for the selection of service provider for the establishment, operation & maintenance of 108-emergency medical service (Ambulance service) in ________ (State Name) for a period of two years.

We confirm that we are not barred by Department of Health and Family Welfare, Government of_____________ (State Name), any other State Government in India (SG) or Government of India (GoI), or any of the agencies of SG/GoI from participating in infrastructure/computerization projects (BOT or otherwise) as on_______ (Proposal Due Date).

Yours faithfully,

____

(Signature of Authorised Signatory)

____

(Name and designation of the Authorised Person)

Appendix E-1: Emergency Medical Service Experience Certificate

This is to certify that M/s___________whose Head Office is situated at ____________(provide Complete address) who has provided / is providing Emergency Medical Service from DD- MM-YYYY to DD-MM-YYYY / till date without any discontinuity_________________in_______________State/ Province / County / Region of___________Country. The Said Emergency Medical Service consisted of/ consists of the following Services:

1. Emergency Medical Service (EMS) / Emergency Medical Ambulance Service from DD-MM-YYYY to DD-MM-YYYY without any discontinuity.
2. Emergency Medical Ambulance Service consists of Operation & Maintenance of an Emergency Medical Service Ambulance Fleet of Four-Wheeled Emergency Medical Service Ambulances (in words) from DD-MM-YYYY to DD-MM-YYYY / till date without any discontinuity.
3. The Emergency Medical Service (EMS) consists of Operation & Maintenance of an Emergency Medical Service Contact Centre without any discontinuity of functional capacity of ___________Seats (in words) from DD-MM-YYYY to DD-MM-YYYY / till date. The System Integration of the said EMS Contact Centre was performed by M/s (Name & Address of the System Integrator) in consultation with the Service Provider,

The EMS Contact Centre consists of the following services** :

a. Computer Aided Dispatch for Emergency Medical Service.

b. GIS, GUI, and GPS Based Ambulance Assignment and Tracking System.

c. Integration of all Public and Private or Public / Private (in countries where there are no Private or Public Hospitals) Hospitals' Emergency Departments or Casualty / Trauma Care Centres or Hospitals' contact Databases with the Emergency Medical Service Contact Cen- tre and EMS Ambulance MDTs / Mobile Digital Computers of the Service Provider, in its area of operation.

d. Data Analytics I T Solution which comprises Descriptive, Advanced and Big Data Analytics.

e. Emergency Medical Technician App available in the Contact Centre, Smart Phones of the Pre-Hospital Care Staff, and MDTs of Ambulances.

f. Electronic Medical Records / e-Patient Care Records Management IT Solution integration with the Contact Centre and MDTs / Mobile Digital Computers of the Ambulance Fleet.

g. Grievance Redress App for patients / attenders to register their grievances.

h. Contact Centre IT Solution for managing patients / their attenders / callers for Emergency Medical Services across multiple channels like voice calls, video calls, SMS, Chat, IVRS, and other social media.

i. Location Based Service*** for Caller Location Identification.

4. The said EMS / Emergency Medical Ambulance Service Provider has established and Operated & Maintained / is Operating & Maintaining an Emergency Medical Service Training Centre at___________(provide complete address) from DD-MM-YYYY to DD-MM-YYYY / till date. In the said EMS Training Centre, the following number of Emergency Medical Technician / Emergency Medical Service Providing Staff were trained in Pre-Hospital Care of Patients / Emergencies:

S.No.	Financial Year	No of EMTs Trained
1.		
2.		
3.		

* The certificate format is provided for reference, and additions and subtractions can be made as per the evaluation and marking criteria mentioned in this RFP and bidders' own experience.

**(Strike out whichever is not applicable)

*** LBS (Location Based Service for Caller Location Identification)

4. Original Equipment Manufacturer / LBS Service Provider shall produce proof of evidence as an Experience Certificate issued from the Telecom Service Provider / the Telecom Authorities that describes / confirms the successful integration and implementation of LBS in the Emergency Med- ical Service (for the number of years' experience is claimed).

Date: XX-XX-2024

Signature:________
Place:________

Name:________

Designation:________

Complete Address:________

(Seal)

Appendix F: Format for Technical Proposal

The Bidders shall prepare the Technical Proposal on the basis of the evaluation parameters set out in the table below

EVALUATION CRITERIA & MARKS FOR TECHNICAL PROPOSAL (MAX 100 MARKS)			
Sl. No	**Evaluation Criteria**	**Experience**	**Marks**
	Bidders experience, professional staff & Certification		
1.	Essential: Demonstrated experience in running EMS software in at least 1 project state applications of minimum call Centre seats______ (N= at least 5% of required ambulances.) (functioning 24 hours a day), during **last 8 years** for any government entity in India with the Operation & Maintenance phase for **at least 3 years** with the following minimum services: a) Computer Aided Dispatch for Emergency Medical Service. b) GIS and GPS Based Ambulance Assignment and Tracking System **Desirable:** Operation & Maintenance of Emergency service contact center with at least ______ seats (N= at least 5% of required ambulances.) (functioning 24 hours a day), **during last 5 years** for any government entity in India with the Operation & Maintenance phase for **at least 3 years**.	a) 1 project= 5 marks >1 project= 7.5 marks b) Call centre seats (5% of required number) = 7.5 marks > 5% = 10 marks c) Experience of Operation & Maintenance phase of at least 3 years in last 8 years= 5 Experience of Operation & Maintenance phase of at least 3 years in last 5 years= 7.5	
2.	Should have experience of operating a minimum- – **Essential:** 40% of required ambulances on behalf of state/district health authorities/ Public Sector undertakings of which a minimum 10% of ambulances should be Advanced Life support (ALS) 4-wheeled ambulances and Remaining basic Life support 4-wheeled ambulances (BLS).	a) 40% - 60%= 15 marks b) 60% - 75% = 20 marks c) > 75%= 25 marks	

EVALUATION CRITERIA & MARKS FOR TECHNICAL PROPOSAL (MAX 100 MARKS)			
Sl. No	**Evaluation Criteria**	**Experience**	**Marks**
	Desirable: 75% of required ambulances on behalf of state/district health authorities/ Public Sector undertakings of which a minimum 10% of ambulances should be Advanced Life support (ALS) 4-wheeled ambulances and Remaining basic Life support 4-wheeled ambulances (BLS).		
3.	**Essential:** Average Annual turnover of _______ (N= at least 50% of total cost of required number of ambulances) **during the last 3 (three) Financial Years.**	50%-75%	10 marks
	Desirable: Average Annual turnover of _______ (N= at least 75% of total cost of required number of ambulances) **during the last 3 (three) Financial Years.**	>75%	15 marks
4.	Quality Management System / Service Management System / Processes Improvement Appraisal*, valid on the day of Bid Submission	Certificates**	
	a) Quality Certification qualifying ISO 27001	QMS	10
	b) Quality certification for CMMi level 3 (or above).	SMS	5
5.	**Key Professional Staff**		**20**
	Essential: Should have trained and deployed a minimum of _______ (N= 80% of the required number of ambulances) Emergency Medical Technicians for any State Government in India, during the **last five years.**		15
	Desirable: 50% of the above EMTs trained in NELS curriculum		5

Note: Along with the soft copy of the technical proposal, the Bidder shall be required to submit relevant certificates from Statutory Auditor/ Client/ Details of EMTs along with their training completion certificate as proof of submissions.

Appendix G: Format for Price Proposal

The Bidder shall submit Price Proposal in the ___________ e-procurement portal as per below:

Component	Quoted Amount
Total quoted value (calculated on monthly basis for the total duration of the contract)	INR _____ per month for total duration of the contract period

Note:

1. The financial evaluation (L1) will be carried out on the total quoted value.
2. No escalation on payment of Component

Appendix H: Bank Guarantee for Bid Security

(To be executed on Stamp Paper of appropriate value)

1. In consideration of you _______, having its office at_______, (hereinafter referred to as "Authority", which expression shall unless it be repugnant to the subject or context thereof include its, successors and assigns) having agreed to receive the Bid of _______[a Company registered under provision of the Companies Act, 1956 or equivalent law abroad] and having its registered office at (hereinafter referred to as the "Bidder" which expression shall unless it be repugnant to the subject or context thereof include its/their executors administrators, pursuant to the RFP Document dated ***** issued in respect of "Provision of Medical Emergency Response Services in __________ under_______" (hereinafter referred to as "the Project") Project and other related documents (hereinafter collectively referred to as "Bidding Documents"), we [Name of the Bank] having our registered office at _______and one of its branches at _______(hereinafter referred to as the "Bank"), at the request of the Bidder, irrevocably, unconditionally and without reservation guarantee the due and faithful fulfilment and compliance of the terms and conditions of the Bidding Documents (including the RFP Document) by the said Bidder and unconditionally and irrevocably undertake to pay forthwith to Authority an amount of Rs._______(Rupees_______) as bid security (hereinafter referred to as the "Bid Security") as our primary obligation without any demur, reservation, recourse, contest or protest and without reference to the Bidder if the Bidder shall fail to fulfill or comply with all or any of the terms and conditions contained in the said Bidding Documents.
2. Any such written demand made by Authority stating that the Bidder is in default of the due and faithful fulfilment and compliance with the terms and conditions contained in the Bidding Documents shall be final, conclusive and binding on the Bank.
3. We, the Bank, do hereby unconditionally undertake to pay the amounts due and payable under this Guarantee without any demur, reservation, recourse, contest or protest and without any reference to the Bidder or any other person and irrespective of whether the claim of Authority is disputed by the Bidder or not merely on the first demand from Authority stating that the amount claimed is due to Authority by reason of failure of the Bidder to fulfill and comply with the terms and conditions contained in the Bidding Documents including failure of the said Bidder to keep its Bid open during the Bid Validity Period as set forth in the said Bidding Documents for any reason whatsoever.
4. Bank under this Guarantee. However, our liability under this Guarantee shall be restricted to an amount not exceeding Rs._______(Rupees).
5. This Guarantee shall be irrevocable and remain in full force for a period of 180 (One Hundred and Eighty) days from the Proposal Due Date inclusive of a claim period of 60 (sixty) days or for such extended period as may be mutually agreed between Authority and the Bidder, and agreed to by the Bank, and shall continue to be enforceable till all amounts under this Guarantee have been paid.
6. We, the Bank, further agree that Authority shall be the sole judge to decide as to whether the Bidder is in default of due and faithful fulfilment and compliance with

the terms and conditions contained in the Bidding Documents including, inter alia, the failure of the Bidder to keep its Bid open during the Bid Validity Period set forth in the said Bidding Documents, and the decision of Authority that the Bidder is in default as aforesaid shall be final and binding on us, notwithstanding any differences between Authority and the Bidder or any dispute pending before any Court, Tribunal, Arbitrator or any other Authority.

7. The Guarantee shall not be affected by any change in the constitution or winding up of the Bidder or the Bank or any absorption, merger or amalgamation of the Bidder or the Bank with any other person.
8. In order to give full effect to this Guarantee, Authority shall be entitled to treat the Bank as the principal debtor. Authority shall have the fullest liberty without affecting in any way the liability of the Bank under this Guarantee from time to time to vary any of the terms and conditions contained in the said Bidding Documents or to extend time for submission of the Bids or the Bid validity period or the period for conveying acceptance of Letter of Award by the Bidder or the period for fulfilment and compliance with all or any of the terms and conditions contained in the said Bidding Documents by the said Bidder or to postpone for any time and from time to time any of the powers exercisable by it against the said Bidder and either to enforce or forbear from enforcing any of the terms and conditions contained in the said Bidding Documents or the securities available to Authority, and the Bank shall not be released from its liability under these presents by any exercise by Authority of the liberty with reference to the matters aforesaid or by reason of time being given to the said Bidder or any other forbearance, act or omission on the part of Authority or any indulgence by Authority to the said Bidder or by any change in the constitution of Authority or its absorption, merger or amalgamation with any other person or any other matter or thing whatsoever which under the law relating to sureties would but for this provision have the effect of releasing the Bank from its such liability.
9. Any notice by way of request, demand or otherwise hereunder shall be sufficiently given or made if addressed to the Bank and sent by courier or by registered mail to the Bank at the address set forth herein.
10. We undertake to make the payment on receipt of your notice of claim on us addressed to [name of Bank along with branch address] and delivered at our above branch that shall be deemed to have been duly authorized to receive the said notice of claim.
11. It shall not be necessary for Authority to proceed against the said Bidder before proceeding against the Bank and the guarantee herein contained shall be enforceable against the Bank, notwithstanding any other security which Authority may have obtained from the said Bidder or any other person and which shall, at the time when proceedings are taken against the Bank hereunder, be outstanding or unrealised.
12. We, the Bank, further undertake not to revoke this Guarantee during its currency except with the previous express consent of Authority in writing.
13. The Bank declares that it has power to issue this Guarantee and discharge the obligations contemplated herein, the undersigned is duly authorized and has full power to execute this Guarantee for and on behalf of the Bank.

Signed and Delivered by _______ Bank

By the hand of Mr./Ms. _______, its _______

and Authorised official. (Signature of the Authorised Signatory) (Official Seal)

LIST OF CONTRIBUTORS

S No.	NAME AND DESIGNATION
Ministry of Health & Family Welfare	
1	Ms. Punya Salila Srivastava, Secretary (H&FW)
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