The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Dear Ms Parker

PRIME Service Review 2016: Steering Group Draft Report to the National Ambulance Sector Office

Thank you for opportunity to comment on the *PRIME Service Review 2016: Steering Group Draft Report to the National Ambulance Sector Office (NASO)* (the Report). We commend the Steering Group's work on the review of this important health service for rural areas. However, we are concerned that the recommendations in the Report have been constrained by undertaking the review within the existing funding envelope.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

The consultation

We understand that in June 2016, NASO proceeded with a formal review of (Primary Response to Medical Emergencies) PRIME and the Steering Group was established to oversee the review. The key objectives of the review are to ensure:

- PRIME is dynamic.
- PRIME is balanced centrally and locally.
- PRIME is aligned to the themes in the New Zealand Health Strategy 2016.

The project expects to realise the following:

- PRIME continues to be relevant and add value to rural ambulance services.
- PRIME practitioners feel well supported in their role.
- PRIME continues to meet its objectives in a sustainable manner.
- PRIME funding arrangements are well understood, with improved utilisation of available resources.

The Steering Group is now seeking feedback on a range of recommendations proposed by five working groups that form the platform for the findings in the Report.

The College's feedback

The College commends the Steering Group on the thoroughness of the review on the PRIME Service. Our submission focuses on areas of the Report directly relevant to the College and matters of concern as expressed by College members.

PRIME funding

The Report states that the review will provide recommendations on PRIME funding arrangements "to ensure funding is equitable and effective" (page 7). Additionally, a key objective of the review is to develop PRIME "to ensure it is safe, effective and sustainable" (page 6), and a key benefit is that "PRIME continues to meet its objectives in a sustainable manner".

The College considers that these statements are inconsistent with the scope of the review, which except in limited circumstances (ie robustness of the review and strong case for good investment by government), provide no additional funding. We are of the view that sufficient funding is critical to the sustainability and effectiveness of PRIME. We are disappointed that the collective recommendations "must not increase the existing funding envelope".

Thus, it also seems the statement that "PRIME continues to meet its objectives in a sustainable manner" is an aspirational goal rather than an actual outcome of the review. College members acknowledge that while PRIME may be sustainable for St John, NASO and the Ministry of Health, it is not currently sustainable for the businesses and individuals providing the service.

College members state:

> "The real costs of PRIME involve having a practitioner who is trained, equipped and available to respond 24 hrs a day, 365 days a year. The *total* amount provided by PRIME medical funding does not even cover our fixed costs, yet alone reasonable wages to be available and respond. Even if we did have fixed costs covered, the existing hourly rate for PRIME medical and PRIME ACC sees medical providers take a significant pay cut in order to respond to PRIME during consulting hours. …
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> There are also administrative and good-will costs of cancelling or rearranging appointments and the personal costs of working later to catch up and losing sleep etc. PRIME pay should cover our real fixed and response costs. As the report stated: 'Funding for PRIME responses is expected to cover costs'. We also expect funding to cover costs but the reality is that is it doesn't.
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> Using 'sustainable' to describe the current situation could be misleading and risks being interpreted as: 'PRIME is sustainable and provides the services as it stands. Why would we change the funding?' There are practices who are pleading: 'PRIME is <u>not</u> sustainable' and the country is at [a] very real risk of losing their service and failing to achieve the intention of PRIME and 'Roadside to Bedside'. Perhaps the intention of the statement is to say: 'PRIME is a cost-effective means of delivering emergency care to rural communities' which we agree with. You could even say that many providers find the contribution to their communities and the variety of work rewarding (but not the pay)."

Another member also raised concerns that the actual costs of providing PRIME services are not recognised. She says the 'call out fee' mentioned in the review and original agreement does not recognise the cost of providing 'on call' for 24 hours of the day, seven days of the week. She believes most PRIME practitioners provide the service out of a sense of obligation to their patients. Those on a minimum annual payment from PRIME would receive about $1.60 per hour to be 'on call'.

The College has concerns about the risks to the sustainability of PRIME. A general practitioner (GP) who has provided PRIME services for almost 18 years explained that St John is not always able to provide crew because there are no volunteers. Consequently, the GP has been used as an ambulance officer rather than as a PRIME doctor. Another member commented that the mostly volunteer ambulance services are a wonderful testament to their goodness, but human limits exist. If PRIME continues as is, it is unlikely to be sustainable.

A College member who first undertook PRIME training 15 years ago considers it was life changing. She says the training provided to rural GPs and nurses was a large improvement to any other training in dealing with emergency situations in the rural setting. She believes that:

> "It will be an enormous loss to New Zealanders if financial support for it doesn't continue".

The College strongly recommends that fairer compensation be provided to PRIME providers for service delivery. In particular, we support the recommendation of a schedule that aims to more evenly distribute funding to PRIME providers. Moving to a 14-band funding is a positive step. However, we note potential problems may arise with this approach without additional government funding.

In relation to greater integration of PRIME at the local level, the Report notes that "PRIME, while working alongside after-hours services in local areas, is a stand-alone service providing timely access to clinical skills that have the potential to improve outcomes for medical emergencies in rural areas" (page 2).

College members endorse this statement and state:

> "Clearly PRIME is a service over and above after hours with its own additional training, equipment and wages costs. As such, it also needs its own *adequate* funding over and above after hours."

The College notes that the Workstream 1: Funding Arrangements Group felt strongly that a formal PRIME funding review is needed. The College considers this is a matter of urgency in order to sustain the PRIME Service.

Transparency of PRIME funding

The College fully supports the recommendation on improving the transparency of how PRIME funding has been determined. College members stated:

> "One explicit point that ought to be made transparent is that ACC does not contribute to the fixed costs. At present providers can easily assume ACC are helping meet their fixed costs *and* paying an hourly rate, which may help explain why there were less concerns raised about ACC's funding compared to PRIME medical funding. Certainly we were under the impression that the ACC hourly pay was only for covering the cost of responding.
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> The related second point that should therefore be made transparent is how ACC calculated its hourly rate for call outs, given that they presumably consider the rate to include fixed costs as well as a fair hourly pay."

We acknowledge the Steering Group has agreed that ACC and the Ministry of Health should consider aligning their approaches to PRIME funding in a similar way to the funding for ambulance services (page 18).

Fixed-cost component

The Report states: "A fixed-cost component is considered important and must to [sic] be retained in the PRIME provider funding" (page 22). The College questions whether the Steering Group has given due consideration to all fixed costs. College members gave further examples of costs not discussed in the Report:

- Vehicle expenses – having a vehicle serviced, kept well-filled with fuel, equipped and available has a fixed cost as well as a cost for travel when responding.

- Protective and warm clothing, eg fireproof overalls cost $400 and are not supplied as part of PRIME equipment. Health and safety, and practical requirements (such as keeping warm and keeping clothes clean) oblige them to obtain such clothing. Clothing such as rainproof clothing, warm hats, and fleece have been purchased as part of PRIME equipment (and would not be required for routine on call work).

- Essential medical equipment not supplied as part of PRIME equipment including capital, maintenance and replacement. For example:

    - EZ-IO drill (capital cost and cost of replacing expired or used needles). The review suggests holding off supplying these for now, but some practitioners may deem it negligent not to purchase such equipment when it is available, potentially life-saving and used by other emergency providers (including St John).

    - Automated external defibrillator (AED): Some practitioners consider an AED as a necessary piece of equipment and already have one in their vehicle. Electricity and high quality cardiopulmonary resuscitation saves lives in cardiac arrest, and for solo responders, an AED can free them to do other jobs more effectively.

    - A suggested practical approach to AEDs is to survey PRIME practitioners, and to provide those without this equipment, starting with the practitioners with the highest response rates.

- Time spent on regular meetings and communication with St John.

- Overheads such as rent, rates and insurance for the building from which to provide PRIME, restock bags, and undertake administrative activities.

A College member further suggested that PRIME equipment needs to be included in the suggested funding review. He notes that paramedics at a distance of half an hour from a hospital have EZ-IO whereas PRIME practitioners do not, despite being hours from a hospital and more likely to be called to hypothermic patients.

Governance of PRIME

The College supports the establishment of an integrated national-level group, the national PRIME committee that has corporate and clinical functions, including overseeing the PRIME programme and providing guidance and decisions on operational and clinical service improvements.

The College strongly supports the recommendation to strengthen the oversight of PRIME at the national level including to ensure linkages exist between regional PRIME committees and rural service level alliance teams (SLATs). The College considers good communication is key. It is crucial that all groups know what is going on with the PRIME Service in their regions. We acknowledge that local issues are likely to be similar elsewhere.

The College strongly recommends disseminating further information about the respective roles of the regional PRIME committees and the national PRIME committee, and providing guidance to the regional PRIME committees on matters that need elevation to a national level. This will ensure the regional PRIME committees are not working in silos, and issues are addressed at the appropriate level.

Clinical audits

The review recommends a requirement for PRIME committees to review at least 20 cases (clinical audits) each year as part of continuous quality improvement through case review. We also note the Workstream 3: Clinical Governance group identified concerns about the audit process including its ad hoc structure, methodology and representation from treating clinicians. The Report makes a suggestion about clinical audits that will enable College members to improve their clinical practice in PRIME service delivery while concurrently complying with the College's recertification programme. The College is interested in exploring options for the development of such audit activities as we review the continuous professional development programme in line with the Medical Council of New Zealand's recertification requirements (the subject of a current consultation).

PRIME training / syllabus

The Report recommends improving the course delivery and, if needed, ensuring high quality tutors (page 27). The College advocates for the provision of high quality training to PRIME practitioners by dedicated people who have the time and appropriate expertise in pre-hospital care. A College member considered that given the limited funding available, funding quality training is a priority; a great kit is only as useful as the person carrying it.

Another member noted that while aligning the curriculum with that of St John seems sensible, it does not "really address the problems with the syllabus and curriculum. It is very unwieldy and desperately needs updating."

The Report acknowledges the College's interest in being responsible for and delivering PRIME training in partnership with the College of Primary Health Care Nurses. We support this option of the College delivering PRIME training as an accredited provider of vocational training and continuing professional development. However, we note this recommendation does not immediately change the findings of the review, and will be considered by NASO in due course.

We further acknowledge the Workstream 4: Training and Syllabus group commented on the difficulty of accessing a PRIME course especially for those who need to attend a refresher course to remain in practice. It is further argued that the generic training is not appropriate for the varied competencies of the practitioners who attend the course. Allowing the College to provide PRIME training would help to address these concerns.

The Report states (at page 26):

> "A recommendation to establish a PRIME course pre-requisite of having ACLS Level VII is not supported. There is no indication that adding this requirement, which creates a barrier to PRIME training (time and cost), would improve the quality and safety of the PRIME service."

The College questions the reasoning of this recommendation and whether this poses a real barrier to PRIME training. There is also a potential risk that the recommendation creates further health inequity for rural populations if a lower standard of care (ie ACLS Level VII is not a prerequisite) is accepted. In contrast to rural populations, those in urban settings have better access to hospital level emergency care.

We acknowledge that core Level V and Level VII are the same in duration and cost because both levels are held and assessed on the same two day course. College members noted that candidates sit different examinations and are expected to perform to a higher level during scenarios. Trainees' standard of knowledge is significantly improved, particularly in relation to electrocardiogram interpretation and rhythm management. This makes a huge difference to the confidence of a PRIME practitioner, and would make a big difference to progressing the field of pre-hospital care.

It was also noted that some PRIME trainees cannot read an electrocardiogram, and need Advanced Cardiac Life Support (ACLS) skills to make the most of the PRIME course. Core Level VII is only really Basic Life Support and use of an AED, and does not equip the practitioner to run a resuscitation; Level VII does.

Currently the College facilitates access to PRIME training by registrars in the general practice vocational training programme. The College typically seeks the funding from ACC for a number of registrars each year and liaises with St John for training. It would be helpful if this process is better streamlined.

PRIME responses and stand-downs

The review recommends amending one of the PRIME response criteria from "seen the patient" to "been located at the scene" (page 3).

The College strongly suggests retaining "seen the patient" as a PRIME response criterion. College members explain that many PRIME practitioners live out of town and the ambulance crew may well arrive at the scene before them. Sometimes the crew will ask the PRIME practitioner to meet them at the medical centre where there is more space, equipment and (sometimes) staff. The amended criteria risks disincentivising this pragmatic approach that benefits patient care.

College members further explain that the need to retain "seen the patient" becomes all the more important if health care providers are expected *not* to charge a co-payment even for patients seen in the medical centre (page 21). Some patients may be taken to a medical centre for prolonged treatment (eg intravenous fluid rehydration) or observation, and consequently St John is not required to transport the patient to hospital. This saves hospital resources and is more convenient for the patient and their family. The proposed text could mean a PRIME practitioner is unable to claim reimbursement for a PRIME response or via a patient fee despite having urgently left home to meet the ambulance at the clinic, seen the patient and provided extended care.

In addition, in relation to "seen the patient", a stand-down may have resulted in the health practitioner cancelling an hour or more of work, and driving some time only to have no patient to see and thus no claim. Some College members have asked that their reports include the number of stand-downs they receive so that they (and funders) have a better idea of their cost.

The College suggests that if the proposed wording "been located at the scene" is adopted, then the Steering Group or Ministry of Health would need to ensure adequate funding is available either through PRIME (ie by considering the situations as a response) or by requiring district health boards to provide funding to the practitioners for "secondary care/emergency care".

College members raised a further concern of a risk that people who ring 111 and say the appropriate words (eg "chest pain"), will be triaged as a purple or red incident, and then get their medical condition (eg annoying cough) attended to for free.

The Report points out that one of the reasons for the fixed-cost component paid to PRIME practitioners being considered as a contribution to stand-downs (rather than counting 'stand-downs' as PRIME responses), is the higher administrative cost of accurate monitoring (page 17). College members considered it may become cheaper if, for example, smart phones are used to track practitioners. St John could then 'see' in real time if a practitioner had left their home or practice, but had not located at the scene. Such technology might make it relatively simple and cheap to track 'responded' call outs in addition to the currently recorded 'non-responded' and 'located'.

College members also suggested that 'attendance' could be used instead of 'response' to overcome the inherent confusion. 'Response' can include ringing in, cancelling patients, dressing appropriately, and driving out of town, which is not then counted as a 'PRIME response'.

Rate of PRIME responses

The Report discusses the rate of PRIME responses (notification versus attendance) (page 17). College members felt that the PRIME response rates stated in the Report of around one in three to one in six as "astonishingly low" (if practitioners are paged for red and purple calls). It is agreed that the variation of attendance rates should be monitored and this may require further investigation particularly for each provider.

Aligning to ambulance clinical procedures and guidelines (CPG)

The Report states: "PRIME will align with ambulance CPGs. Furthermore, PRIME will align with the Paramedic practice level. This is considered to be the most suitable alignment as medicines and interventions utilised at Paramedic level are sufficient for the vast majority of PRIME responses" (page 4).

College members noted this recommendation may cause confusion when PRIME practitioners are also expected to follow guidelines such as HealthPathways or guidelines from district health boards. The College suggests including clearer guidance for health practitioners on this point.

The review agreed that CPGs describe both the procedures and guidelines for ambulance service personnel, and scopes of practice, which define the medicine and interventions that personnel can administer at each practice level. The College considers that the use of the term "scopes of practice" in this context may lead to confusion. Section 11(2) of the Health Practitioners Competence Assurance Act 2003 (HPCAA) defines the term "scope of practice" in the context of regulated health practitioners. However, we understand that paramedics are not yet regulated under the HPCAA and Ambulance New Zealand's application for regulation of paramedics is progressing.

PRIME equipment, kit and medicine

One College member suggested using vacuum mattresses to transfer injured or sick people as the long distances can chill them further. This equipment is used in Queensland.

Health and safety obligations

The Report makes reference to difficult radio or mobile phone communication in some areas (page 19). We note the Health and Safety at Work Act 2015 requires general practices, their officers, and their workers to do everything that is reasonably practicable to ensure safety in the workplace. The "workplace" includes any place where a worker goes while at work. This may include offsite locations.

To reduce the risk when attending offsite location, the College encourages its members to set up security arrangements where possible. This includes 'check in' procedures, personal alarms, and arrangements with local services such as police or support staff. The expectation under the PRIME agreement for PRIME practitioners to maintain contact with the Emergency Ambulance Communication Centre while at the scene of an accident or illness provides them with some security.

The College advocates for greater support to PRIME practitioners to reduce their health and safety risk when on call. Specifically, we recommend including a device with good personal alarm capability in the practitioners' kit. For example, a device where a timer is set for the 'expected duration' of activity and shares an alert to a nominee regardless of the coverage, battery state or otherwise of the phone; or an alarm with inbuilt GPS satellite navigation positioning capabilities.

The College is currently finalising a resource for GPs on providing health care when on-call and offsite, and after-hours safety.

A College member commented that support from the receiving hospital and the PRIME administrator to practitioners at the rural roadside or incident against 'back seat' drivers (bystanders) would help to ensure PRIME is safe.

Other comments

The following points were also raised by College members:

- The lead at the scene should be taken by the most senior or highly trained person present. In some cases, they will be an intensive care paramedic, not the PRIME practitioner.
- Setting up a simple on-line network via the St John PRIME portal would help to facilitate representation of PRIME doctors and nurses at the grass roots level.
- A body should be responsible for holding and maintaining the currency of a list or register of PRIME practitioners. The holders of a PRIME agreement should be responsible for ensuring their staff have a valid certificate.
- The Report states that PRIME should be structured to allow for local autonomy and appropriate central control as required (page 6). It would be helpful to clarify the meaning of "appropriate central control as required".

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely,

Michael Thorn
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