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Dr Tony Smith
Clinical Director, St John New Zealand

By email: Tony.Smith@stjohn.org.nz

Tēnā koe Dr Smith,

Re: The review of the role and deployment model of Intensive Care Paramedics

Thank you for the opportunity for the Australasian College for Emergency Medicine (ACEM; the College) to respond to this review. The thinking and drivers behind the review are patient focussed and have the potential to improve patient care if implemented appropriately.

ACEM sought feedback from its Aotearoa New Zealand Faculty, in particular Directors of Emergency Medicine (DEMs) as well as the members of its Ambulance Liaison (ALPs) Network.

With regards to the specific questions, please find our collective feedback on each question below.

Do you think the proposed future role and deployment model of Intensive Care Paramedics (ICPs) is appropriate?

Yes, with the following comments:

1. While the model attempts to define clear parameters for a complex adaptive system, there is risk that significant unintended consequences may emerge in some areas. This is particularly so given the heterogeneity of several variables: the geographical distribution of patient population/age/health varies widely, as do the practices and capabilities of the public hospital emergency medical systems throughout NZ. It will be important that the proposed changes consider all other network stakeholders, inputs and users, and other agencies and groups that may be impacted (Paramedic training organisations, FENZ, Aeromedical providers, PRIME Practitioners, GPs, Urgent Care Medical Clinics, EDs etc). Information about such proposed changes should be provided to other groups to allow early planning, where such services may be significantly impacted.

2. It is unclear if an analysis of likely changes of access to care for Māori has been undertaken as part of this project. What role has Iwi consultation played in formulating this plan? ACC and the Ministry of Health (MoH), through the National Ambulance Sector Office (NASO) is "…focused on commissioning emergency ambulance services to enable safe, effective, sustainable and more equitable health outcomes for all New Zealanders" This needs to be considered through the lens of the NZ Government's Te Tiriti obligations, and we suggest that a specific equity-based impact analysis is performed. It is critical that any proposed changes enhance access to high level prehospital care for Māori. Systems to measure changes in access need to be thoughtfully defined and in place before any significant changes are made.

3. The system of sole advanced practitioners being deployed by car is advantageous by not tying such advanced resources to transport ambulances. Having more experienced clinical support locally should also add value and ultimately lead to better patient care.

4. The proposed changes are a significant shift from the current skill distribution model. Enhancing the skills of a very large group of practitioners and changing the geographic distribution of those skilled practitioners will be a complex project with large Clinical Governance and Human Resource implications. The training burden will be very high, and the ongoing costs of skill maintenance will require institutional commitment and financial outlay. Robust avenues for providing such high-quality advanced training and particularly for

ongoing maintenance of skills will need to be thoroughly explored and put in place early on. Alternatively, if the burden of skills maintenance is shifted to the individual practitioners, then it is likely that they will require increased specific financial support to maintain their own Continuing Professional Development (CPD), under the independent HPCAA registered practitioner model, as many other health care professionals do in large institutions like DHBs. There will need to be pathways to manage this situation, to ensure that the entire ICP workforce reaches an acceptable standard.

5. Clear Standards of Care, reporting and documentation should be developed, particularly relating to new high-skill practices. Clear standards for skill maintenance, competence, currency and procedural exposure and pathways to support this should be defined prior to introduction of such new high-skill practices (including for example wider training for rapid sequence intubation, management of medicine infusions, mechanical ventilation and mechanical CPR). Where currencies are not achieved over credentialling and currency cycles, a strong support/maintenance system will need to be provided (See: 4 above).

6. Some concerns have been expressed within the Emergency Medicine workforce that the ICP scope is becoming too wide. These concerns are exacerbated by perceptions of poor or inconsistent quality of training that has been in place to date, particularly for some of the skills that have been introduced in recent years. Given the proposed expanded scope and the increase in overlapping skills, informal comparisons with Emergency Medicine (EM), Prehospital and Retrieval Medicine (PRHM) and Critical Care Medicine (CCM)/Anaesthetics advanced training systems will be inevitable. St John should consider actively and formally benchmarking to other professional groups and agencies in developing and setting their training, competency, credentialling and currency standards to provide reassurance to such groups and professional bodies and the NZ public.

7. Providing an opportunity for an expanding scope of practice can confer an implicit bias to practitioners that more intervention in any patient generally equates to better care. This can sometimes introduce risk without conferring benefit – the 'Stay and Play' vs 'Load and Go' tension is a good example where this is seen. This will always need to be balanced by a strong emphasis on clinical inertia. Additionally, ICPs will be operating as sole practitioners with little or no opportunity for advanced observed-practice or peer feedback and this may provide conditions where significant practice creep could occur. This will need to be managed carefully and consideration should be given for a system of "observed practice" shifts, with mentors or fellow ICPs as a moderating measure. This would have further cost implications that need to be factored in before committing to any such model.

8. Introduction of rarely performed skills also brings risk that needs to be systematically managed. The aphorism that "To a man with a hammer, everything starts to look like a nail" describes such a situation, where additional practitioners may wish to perform skills, where a clinical indication may be unclear or absent. This can lead to drift, and again can introduce increased risk for no benefit. A system of structured audit of rare/critical procedures will be required to manage this.

9. Clear mechanisms will need to be developed to manage situations where practitioners are identified as deficient in specific skills or procedures. Given the recent establishment of paramedic registration, it may be unclear where the balance for managing such situations will lie. As a provider, St John will have a duty to provide care of an appropriate standard under the HDC Code of Rights and also Health and Safety at Work Legislation. While formal complaints will trigger appropriate systems to respond to these concerns, there are circumstances where the onus will fall back on St John as the employer to initiate remedial actions. The requirement of health practitioners to make a notification to the Kaunihera Manapou (Paramedic Council) under HPCAA will also need to be maintained, alongside any other systems that St John puts in place to manage such deficits, even in the absence of a customer complaint.

10. A structured transition plan will be required to facilitate the proposed changes. Such a plan should have input from partner agencies and involve regular communication and consultation as it is brought into effect, particularly where resource or practice implications for other such agencies/stakeholders exists, to facilitate planning across the whole sector. Internally for St John, such a plan will obviously have some complex Human Resource/Industrial issues to deal with. There are likely to be current ICPs who choose to not train to perform such challenging new skills. There may also be individuals who fail to meet standards.

What are your views on the approach to determining the future base locations of ICPs?

ACEM supports the approach to determine the future base of locations for ICPs, with general agreement that locations should be needs-based. There is some concern that areas where ICPs may be withdrawn may suffer

markedly worse access for critically unwell patients, particularly those areas that do not have the support of a local helicopter service. Factors that exacerbate this include areas with very long road access times, as there will always be times where helicopters are not available or cannot fly due to bad weather. Trying to maintain or enhance equity of access to expert level pre-hospital care and transport to all rural areas in NZ is essential.

The location of PRIME Doctor/Nurse practitioners may ameliorate some of this risk but this needs to be considered carefully, and ongoing commitment made to supporting and resourcing such PRIME practitioners as part of a long-term model if this forms part of a fail-safe system.

Do you have any other comments about our proposed changes to improve the role and deployment of ICPs

Such a significant planned change to the system of advanced prehospital care will need ongoing robust mechanisms of feedback from stakeholders. As identified through prior work between St John and ACEM in 2019-2020, NZ Emergency Departments are best positioned to provide this feedback. To make this effective requires investment in the systems to support engagement and ensure that feedback is useful. The St John Clinical Governance system needs to be robust, transparent and ideally interrogable.

We also suggest that there be formal agreements/policies between district health boards/EDs/rural hospitals and ambulance staff so that during complex/critical patient care episodes, particularly where responsibility may shift from one lead clinician to another over time (e.g. staging at rural hospitals while awaiting helicopter transport), systems are in place to support the best clinical and logistical decision making through an entire patient journey. This will be made more complex when the ICPs are no longer part of local teams and may not know the local hospital teams as well.

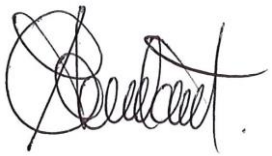
We also recognise that the proposed changes to the current system, and indeed some of our own suggestions, will carry significant financial costs. It may be worthwhile advocating for more public funding to cover these changes and the required system changes to support them, to improve the quality of advanced prehospital care.

For more information

For more information, or if you need further clarification, please feel free to contact us, or Ali Watt at the ACEM Aotearoa New Zealand Office at acemnz@acem.org.au.

Nā mātou noa, nā

Dr John Bonning
ACEM President



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