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

21 April 2017 Our Ref: MT17-232

Liz Parker
PRIME Review Project Manager
Ministry of Health
P O Box 5013
WELLINGTON 6145

Email: liz_parker@moh.govt.nz

Dear Ms Parker

PRIME Service Review 2016: Steering Group Draft Report to the National Ambulance Sector Office (Draft version 02)

Thank you for opportunity to comment on the updated report, *PRIME Service Review 2016: Steering Group Draft Report to the National Ambulance Sector Office (Draft version 02)* (the updated report). We commend the Steering Group's on its further work on the report.

I also refer to the College's submission dated 2 March 2017.

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.

There are 106 College members who are also PRIME practitioners.

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.

Your consultation

We understand the report has been updated based on the feedback received and considered by the Steering Group as part of the January – March 2017 stakeholder consultation. The Steering Group is now undertaking a second and final round of consultation before finalising the report to the National Ambulance Sector Office.

The College's feedback

Set out below are the College's comments further to our submission of 2 March 2017.

1. Funding

In our submission of 2 March 2017, the College expressed concern that the draft recommendations had been constrained by a review within the existing funding envelope. We particularly noted that the actual costs of delivering PRIME services are not recognised, and that fairer compensation should be provided to PRIME providers for service delivery. We acknowledge the updated report, at the outset, acknowledges strong disagreement with the earlier decision to conduct a review within a fixed funding envelope. However, the College is disappointed that the original requirement to carry out the review within the existing funding envelope remains unchanged.

The College fully supports the strong recommendation to review the funding from the Ministry of Health and ACC. It is our view that it is unreasonable for the state to continue to depend on the goodness of dedicated health practitioners for the delivery of the PRIME service. The real cost to PRIME practitioners should be determined, and adequate funding provided to ensure the sustainability of PRIME. The College also considers that if the recommendation to review funding proceeds, then the PRIME service would need to be reviewed in light of the new funding available.

The College strongly advocates for increasing national awareness of the PRIME service and considers this would play an important role in its sustainability. We note the lack of investment to date in a public awareness campaign on the PRIME service. In particular, for public safety reasons it appears important to highlight the implications of a green flashing light on a vehicle.

2. PRIME training and syllabus

The College advocates for the provision of high quality training to PRIME practitioners. As you will be aware, the College is the accredited provider of vocational training and continuing professional development in New Zealand for general practice and rural hospital medicine. As such we insist that the College, in partnership with the College of Primary Care Nurses, holds the responsibility for setting the standard for PRIME training, with the College having significant input into curriculum development and approval of the general practitioner training content. We note the updated report recommends that the national PRIME committee will consider whether standards should be developed and, if so, how they will be approved, assessed and maintained. The College eagerly awaits the national PRIME committee's consideration on this matter.

On 2 March 2017, the College questioned the statement that "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 … would improve the quality and safety of the PRIME service". We now note the updated report recommends that the national PRIME committee will consider the recommendation to introduce this course pre-requisite (page 35). We are pleased this matter will be given further attention.

The updated report states that the national and regional PRIME committees should get regular reports and monitor access to and location of PRIME courses. The College encourages the delivery of PRIME courses locally to allow practitioners to have timely access to courses without needing to travel significant distances to attend. We suggest making this point more explicit in the report.

3. Governance of PRIME

In our previous submission, the College expressed support for the recommendation to strengthen the oversight of PRIME at the national level through the establishment of a national PRIME committee. It is the College's view that it is important for the governance of PRIME to sit with the PRIME practitioners who deliver PRIME services. This would be in keeping with the recommendation on improving clinical governance at all levels of PRIME, and the strong view that clinical and corporate governance cannot be separated. We note the Steering Group's finding that clinical governance should be included as a function of the national PRIME committee. Moreover, it is expected that the clinical function of the governance body will include setting guidelines, developing audit and clinical review processes, and having oversight of the clinical governance functions of the regional PRIME committees. Thus, strong clinical input is crucial to the governance of PRIME.

4. PRIME responses

We previously suggested retaining the PRIME response criteria of "seen the patient" rather than replacing it with "been located at the scene". We note the updated report has retained "seen the patient", but an additional point clarifies that while incidents in a medical centre are generally not considered to be a PRIME response, the national PRIME committee will consider formalising exceptions to this rule where there are good reasons.

One of our members expressed concerns again about what constituted a 'PRIME response' as defined in the updated report. He stated:

> "a patient could ring 111, our ambulance may be in town and [be] able to respond more quickly than the PRIME [practitioner and] bring the patient to the medical centre where we meet them. [It] will not qualify for PRIME despite us dropping tools at home and responding ASAP to the ambulance communications centre call out. If calls *originate* in a medical centre, I can understand it not being PRIME – the patient has attended expecting to pay the medical centre fees. If the public ring 111, they may not expect a doctor or nurse so not expect a charge and we may neither be able to charge them nor claim PRIME. When I ring and ask for an ambulance to come to the medical centre, I do not consider myself 'dispatched' so I still think [the wording in points (a) 'been dispatched by an ambulance communications centre' and (b) 'responded to the incident' can be left as stated with point (c) 'seen the patient' retained], without PRIME providers 'double dipping'.
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> Another example in Te Anau is when the ambulance has picked up a patient from up the Milford Road and is transporting to Southland Hospital coming right past our [medical centre]. The call may not have come through as a high priority, but the patient deteriorates and the crew ask us to attend. Again, we have not responded 'at the scene' so where would the funding come from?"

The updated report also clarifies that counting stand-downs as PRIME responses is not supported, and instead, the fixed-cost component paid to PRIME providers is considered a contribution to stand-downs.

5. Safety

In the College's previous submission, we noted the applicability of the Health and Safety at Work Act 2015 in relation to ensuring safety of PRIME practitioners. We are pleased the updated report states that PRIME contracts will be updated to reflect this.

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
Manager – Strategic Policy