New Zealand Ambulance Service Strategy

Summary Report Part 2

Results of Sector Engagement Process

13 February 2009

NASO
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Introduction

The ambulance sector has been the subject of numerous reviews in recent years, including:

- A National Air Ambulance Network for New Zealand (the 'Cull Report'), 1996
- Roadside to Bedside - A 24-Hour Clinically Integrated Acute Management System for New Zealand, 1999
- Ambulance Service Sector Standards, NZS 8156, 2002
- National Air Ambulance Strategy, 2004
- Ambulance Services Sustainable Funding Review, 2005
- Advanced Air Ambulance Strategy, 2005
- Air Ambulance Reference Group, 2008
- DHB Inter-Hospital Transfer Initiative for Air Ambulances, 2008
- Select Committee Inquiry into the Provision of Ambulance Services in New Zealand, 2008

Following on these previous analyses, the Ministers for Health and ACC released the Draft New Zealand Ambulance Service Strategy for consultation on 15 September 2008. Written comments were solicited from any interested parties on the draft strategy, and the consultation process on the strategy concluded on 12 December 2008. The results of that consultation process have been summarised in the companion document entitled "The New Zealand Ambulance Service Strategy: Summary of Consultation and Recommendations for Approval."

Officials were aware that many in the sector held the view that little change on the ground had resulted from the various studies identified above and were sceptical that this effort would result in any change either. Identifying sensible short term actions to be implemented quickly would assist in restoring confidence.

Concurrently, officials identified that implementing the draft strategy – however it would be modified based on the consultation - would require initiation of a number of interdependent work streams, and the sequence of those work streams would require more and different information from the sector. Accordingly, a process to establish the sequence of work priorities was developed. This process is referred to as the 'Sector Engagement Process.'

The goal of the Sector Engagement Process was to allow a cross-section of those with direct experience with the ambulance sector to provide input into a dialogue to identify the sequence of priorities that would advance the sector as a whole.

A summary of the process used is attached as Appendix 1.

Results

The engagement process had 419 participants across the 15 meetings, with an average attendance of 28. The meetings all had a cross-section of attendees, though some stakeholders had a more consistent presence. A summary of attendance is shown below:

Constituency	Attendance
Provider Board Members	Low
Provider Senior Management	High
Provider Middle Management	High
Provider Field Staff	Low
Field Staff Labour Representatives	Medium
DHB	High though uneven (with some senior executives and some with no representation)
PHO	Medium
Police	High
Fire Service	High
Other Emergency Service (Coast Guard, Civil Defense, etc.)	Low
Local Government	Low though uneven (with some senior executives and some with no representation)

The top opportunities identified at each meeting is shown below. As this process does not reflect a statistically representative sample, the results should be treated with caution.

Figure 1
Summary of Sector Engagement Findings
Identified Top Opportunities

Meeting	Attendance	Sector 'Leadership'	Health Sector Integration	Crewing/Volunteers	Funding Methodologies	Clinical Standards	Education	Inter-hospital Transfers	Data Collection and Metrics	Extended Role and Education	Total
	Draft Strategy Initiative	1	7	5	2	7	5	Nil	3/8	7	
Whangarei	29			√		√				√	3
Auckland	23	√	√		√						3
Hamilton	30	√			√				√		3
Tauranga	32	√	√				√				3
New Plymouth	25	√	√	√			√				4
Wanganui	20	√					√		√		3
Palmerston North	26	√	√	√	√	√					5
Masterton	16	√			√			√			3
Wellington	35	√	√	√		√					4
Nelson	29	√			√	√		√			4
Greymouth	25		√	√							2
Christchurch	46	√	√	√							3
Dunedin	41	√		√	√						3
Invercargill	24		√		√		√				3
Hastings	18	√				√		√			3
	419	12	8	7	7	5	4	3	2	1	49

The mapping of the identified opportunities to the draft strategy initiatives is also shown. There is strong consensus among those that participated in the process that initiatives 1, 2, 5 and 7 are the most important to progress first.

It should also be noted that the meetings were uniformly positive and productive. Despite wildly divergent settings and in some cases groups that were heterogeneous, the groups were solutions focused and constructive. Of the 419 attendees, only one person left visibly frustrated with issues unrelated to the strategy or engagement pocess, and that person returned shortly to resume positive participation.

Principal Themes

The themes that emerged in the sector engagement are described in detail below.

Leadership (Draft Strategy Initiative #1)

It was very frequently mentioned that there is a need for mandatory standards of clinical and operating performance, and the recognition that the current structural relationships between government, providers and within the sector inhibit the adoption of a more consistent approach to service provision. There was little opposition to this theme, though not all participants agreed on which solution was most appropriate.

Importantly, while a number of operating issues were identified – and related perceived funding shortfalls – the vast majority of participants believed that these structural issues needed to be addressed *before* focusing on operating issues.

"Leadership" meant different things to different people, though the same word was often used and many participants would agree that all of the definitions of 'leadership' are necessary. The different components include:

- Joined up funding from all Crown entities with an integrated contracting approach
- Development of common standards for clinical and operating purposes, mandatory adoption of those standards, and monitoring to reflect performance against those standards
- Taking responsibility for progressing the strategy, which in itself was seen as a step forward
- Setting a vision for the group of provider organisations that deliver ambulance services, with many participants suggesting different funder/provider relationships such as devolution to DHBs, a single national provider or nationalisation

Some of the nuances that emerged from this process included:

- The most common words used to describe the requirement was for greater 'Crown Leadership.'

- A common theme was the identified need for standards to be established by some recognised experts. Police and Fire Service participants routinely mentioned the value of an Ambulance Commission on a par with the Police and Fire Commissions to provide that kind of expert input. Physicians tended to refer to bodies such as Clinical Advisory Groups.

- NASO – the joint venture of ACC and MoH – was very commonly recognised as an important step forward, as the divergence of interests between the Crown funders had led to a dilution of whatever 'Crown Leadership' may otherwise have been in place.

- There was little commonality among the desired relationship between NASO and oversight bodies – including sector bodies.

- It was recognised that clinical standards differ from operating standards. Many participants noted that divergent clinical standards had been a particular issue in the past, both in terms of training, clinical protocol/standing orders, and call audit and review processes. A few participants noted that while these issues had been

problematic in the past, there had been successful recent sector-wide efforts to address some of these issues through the auspices of Ambulance NZ.

- Operating standards were widely identified as insufficient, and many participants were aware that the Crown contracts (both ACC and MoH) had a 'best endeavours' qualification that rendered the standards less firm than desired. Most participants felt that the 'best endeavours' clauses reflected the reality that current funding levels do not permit providers to attain the specified performance. A minority had the view that the standards should be lowered to current performance levels to reflect a better match between reasonable performance and available funding.

- The recommendations to address sector structure followed a wide continuum, with no consensus on the best option. The continuum included:

  - Devolve to DHBs, either to contract with existing providers or establish their own services
  - The most commonly mentioned options was a central government function like NASO, Ambulance NZ with a government mandate, or both
  - A sector oversight body such as a commission
  - A single provider nationally
  - Nationalise the ambulance service completely

<u>Health Sector Integration (Draft Strategy Initiative #7)</u>

The second most common theme was the need for greater integration of ambulance services with the health sector. This finding is more nuanced than it seems; in some parts of the world, ambulance services are more closely aligned with public safety (police and fire, for example) than the health sector. In New Zealand, however, the strong consensus view is that the ambulance service is a part of the health system; hence the vision statement developed in the draft strategy and widely agreed "The First Line of Emergency Intervention in the Health System."

In the sector engagement meeting, this theme emerged in three different ways:

- *Emergency Department Decompression*, with paramedics having more authority and resources to divert some patients that do not require emergency treatment elsewhere or treated at home.

- *Primary Care Connections*, with GPs gaining access to information about incidents related to their patients and treatment provided, paramedics gaining access to primary care information about patients (chronic conditions, medications, allergies, etc.), co-location with primary care practices in rural areas to extend the primary care workforce, etc.

- *Extended Scope of Practice for Paramedics*, with paramedics having greater training in primary care conditions to provide for more comprehensive treatment in the home, alternative disposition other than transport, and more effective utilisation of resources (e.g. avoided night call-outs for district nurses).

These themes, it should be noted, all reflect an underlying core commonality: the greater integration with the health sector, in particular primary care. Some of the nuances that emerged from this process included:

- The term ‘discretionary disposal’ was mentioned in New Plymouth as a way of capturing the widely discussed notion nationally that not all ambulance patients need to be transported to hospital. However, many of these were transported anyway because:
  - ACC only pays for those accident patients that are transported
  - Field staff may not have options other than ED
  - Greater training is required, particularly in primary care issues, in order to be able to safely treat and leave non-urgent patients at home
  - There are no identified follow up mechanisms to assure that patients are not ‘lost in the system.’
  - EACC has limited options for non-urgent calls other than sending an ambulance

  The Wellington group, for example, mentioned necessary referral pathways to:
  - Plunket
  - ED
  - GPs
  - Mental Health Services

- Registration for paramedics under the Health Care Provider Competency Assurance Act was often mentioned as a mechanism for enhancing credibility of ambulance staff with the broader health community. The registration process was thought to provide a recognisable standard of training – particularly given the different labels that are currently in use around the country for similar training levels – and a quality assurance process in which other professionals could have confidence. A minority of participants believed that registration would add cost for field staff without recognisable benefit.

- Clinical pathways was a commonly identified methodology for assuring that patients receive the same treatment by ambulance staff as by other heath professionals in other settings. The administration of thrombolytics by Wellington Free Ambulance staff on the Kapiti Coast was mentioned, for example, as a standard clinical pathway that was patient-centred (i.e. based on patient condition) rather than type of treatment professional.

- Data capture and transfer was a common theme in these discussions, including the need for access to reliable patient histories, to transfer information gained in the field to other relevant health professionals (especially in ED and the GP/PHO community), and to track care delivered. The lack of an electronic patient record for patients treated in the ambulance setting was noted.

- The rural service delivery model – and the need for change – was a common theme, particularly in the South Island. Some key comments included:

  - There were multiple comments in several meetings about co-location of ambulance staff in GP offices in rural areas to extend the available staff in primary care, assure skill maintenance for ambulance officers that respond infrequently, and assure that strong relationships are maintained with local health professionals.
  - There were also several mentions of ‘hub’ concepts in which paid Advanced Life Support staff would be located in rural centres and co-respond with outlying volunteer staff, particularly to life-threatening calls. This was seen not only to enhance the clinical care to patients but also to provide necessary

    support to lower trained volunteer staff that receive relatively few call-outs. This concept was mentioned in Invercargill in the context of 'Community First Resonse' teams in very small communities.
  - The PRIME programme to support GPs and Practice Nurses to respond to emergency incidents was widely appreciated.
  - The right staff are often in the right communities, but the connections have not been made. This is particularly true with PRIME practitioners.
  - Some evolving technology – such as remote video equipment – may enhance the ability of receiving a consult in the home, and therefore reduce the need for some patients to be transported, particularly long distances.

- The high level of clinical risk inherent in the lack of clinical standards and monitoring was frequently mentioned, and an obstacle to gaining the necessary credibility for the ambulance sector to interact effectively with the broader health sector. This issue was also mentioned as a risk item on its own merits as it relates to patient safety.

- One group suggested the formation (and funding) of a university-based centre for research and education, as new ideas and state-of-the-art practices are often generated and supported by such centres.

Funding Methodologies (Draft Strategy Initiative #2)

This theme was often mentioned in the context of the both the *amount* of funding available as well as the *way* those funds were paid to providers. The workshop participants were encouraged to defer discussions about the amount of funding in favour of discussions about the results that could be gained from specific initiatives and the funding that such initiatives would require.

The specific issues raised with regard to funding methodologies represent a list that has been raised in previous reviews. The most commonly mentioned items include:

- Joined up funding from ACC and the Ministry of Health. For those that were aware of the NASO joint venture between ACC and MoH, this was viewed as an important and welcome step. For those that were unaware of NASO, an initiative like NASO was often mentioned as necessary. There was much discussion – often contradictory – about how expansive the role that NASO should be.

- There was a consistent theme across all workshops about the linkage between standards and funding – which also emerged as a basis for the dialogue summarised above regarding sector structure.

- The fee-for-service incentive in the ACC payments only for transports was almost universally described as counter-productive for those engaged with this topic. Many participants felt that it was more sensible for ACC to pay for capacity and capability rather than individual instances of service. The challenges identified included:

  - The requirement that patients be transported in order to receive payment result in a bias towards transporting some patients to hospital that might otherwise be treated at the scene and released. Providers can easily justify such transports as appropriate caution even for injuries that may appear to not be serious.
  - Air responses almost always involve the response of a road and air unit or units, and if there is only one patient, only one provider would be paid.

  - Costs for the sector are more or less fixed, but payments will vary depending on actual ACC volume. This means that, from the providers perspective, they have extra cash if there happen to be more ACC transports than predicted and too little if there are fewer ACC transports.

- The funding sector-wide creates confused incentives for patients. At present, ACC services for accidents are free to the patient, medical services result in user charges in some parts of the country, and all of these are different from going to see a GP in their offices.

- Air providers in particular noted that short term contracts are inappropriate for providers who must make large, long-term commitments to provide the service and secure the aircraft, train the staff and secure expensive specialised equipment. Some participants suggested evergreen contracts with cancellation provisions is a potentially sensible approach.

- Other observations included:

  - Funding methodologies should evolve away from input-based funding and towards expected outcomes
  - Successful pilots need to have an identified funding source in order to mainstream
  - Demand management and continually increasing call volume is a challenge for fixed budgets
  - Fund clinical progression for staff and enhanced clinical skill levels across the board
  - Community funding represents an additional funding source – with both challenges and opportunities
  - Cost of volunteers is not explicitly accounted for in current funding methodologies
  - Capital is not funded by the Crown, and the Crown therefore owns no assets in the ambulance sector
  - There is no funding for an Research and Development function to identify necessary and appropriate changes required to the system.
  - DHBs that operate services should not be in the Population-based Funding methodology, as that formula does not necessarily apply in the same way as other health services, and other ambulance services are not paid in that way.

Crewing and Volunteers (Draft Strategy Initiative #5)

As noted, while there was very strong consensus that the resourcing for the sector was inadequate – which in turn resulted in fewer staff available at lower training levels than is desirable or specified in the National Ambulance and Paramedical Standards, the prevailing view was that the overall sector structure was the first priority to address this standards variance. Nevertheless, crewing levels were noted as an additional issue. Some nuances in this area included:

- Use of volunteers in rural areas is a major reason for single crewing.

- Compensation for volunteers was commonly mentioned. While all participants recognised that the role of volunteering is to provide a community benefit, the substantial training requirements and, in the case of remote rural areas, very long travel times can be a substantial burden. Ideas mentioned to address this included:

- Reimburse volunteers for lost wages while in training
- Reimburse volunteers for lost wages while on long call-outs, particularly inter-hospital transfers
- Introduce some form of time away from employers that is expected – and reimbursed – as in the case of Territorials, for example.

- There were many comments about how volunteers in the rural areas may be necessary, but are not appropriate in urban and semi-urban settings. This point was not, however, agreed among volunteer participants in the engagement process.

- The large quantity of staff, particularly volunteers, that are not trained to the Basic Life Support level (that is, are at less than that level) was mentioned as a major concern for achieving a consistent quality standard.

- A key dynamic for volunteers, particularly new volunteers in low volume areas that have not had sufficient training, is fear of doing something wrong. This can often lead to turnover among newer volunteers, and represents a missed opportunity. Support for training, particularly volunteer training, can address this concern. These volunteers also require support from the provider, as in the Rural Support Officer programme.

- The linkage between retention on the one hand and clinical standards and training on the other was made in these groups, with the recognition that a high performance orientation to clinical skills and education was an important way to retain high calibre field staff.

- The large volume of Inter-hospital transfers in the rural areas – in areas that are heavily reliant on volunteers in the first instance – was frequently mentioned in those areas (e.g. Palmerston North, Masterton, Nelson and Greymouth). Reducing the size and scope of local hospitals in favour of regional referral centres has stretched the available transportation resources, particularly as many areas prefer to reserve the few available paid staff for emergency use and volunteers for long road transfers.

Additional Comments

The sector engagement process identified 5 additional themes, many of which contained a view on points otherwise made in other sections and summarised above. There were several secondary themes worthy of note:

- Data collection and analysis was widely viewed as inadequate, and does not provide a basis for a feedback loop on standards. A key theme, as noted above, has been that standards are not clear; in addition, participants noted that the clinical and operating performance data is also not available to determine if those standards are being met even if those standards were clear.

- Several groups identified the lack of explicit inclusion of DHB-funded inter-hospital transfers in the strategy as a particular concern. To these groups, the strategy appears to be emergency-focused. As inter-hospital transfers are a substantial user of ambulance resource and impact on resource availability, particularly air ambulance availability, inclusion of these transfers in the strategy and integrated funding from ACC, Ministry of Health and DHBs is necessary.

Appendix 1
Process Overview

The sector engagement process had several phases as noted below.

- *Identification of Sites and Meeting Planning.* Officials identified potential locations in concert with Ambulance NZ. Road and Air providers in each selected location were approached to organise the meetings. In each location a lead provider was selected, and a contract was executed with that provider to organise a location, facilitator, catering and other logistics. Lead providers were also asked to generate invitation lists to represent agencies identified by NASO. These invitation lists were provided to NASO to assure that no obvious agencies had been missed. NASO generated invitations and maintained lists of those that indicated they would attend.

- *Development of the Meeting Protocol and Orientation of Facilitators.* A meeting was held with facilitators from around the country in Wellington on 13 October. At that meeting the goals of the process were identified, a sample agenda was presented, and the structure of each meeting discussed. The agenda was revised based on facilitator feedback.

- *Distribution of Background Materials.* To assure that all participants had access to the same relevant information, a background booklet entitled "The New Zealand Ambulance Strategy: Getting it Done!" was prepared and distributed to any individual that indicated that they would attend. Booklets were also provided to providers in bulk to distribute to their staff in advance of the meetings and were available at the meetings for anyone who did not receive it.

- *Conducting the Meetings.* The meetings all followed the same format. The orientation included:
    - Introduction by the facilitator
    - Orientation and purpose for the meeting, presented by the NASO Group Manager
    - Presentations from local road and air providers and the Emergency Ambulance Communications Centre (EACC)
    - Overview of the draft strategy, presented by the CE of Ambulance NZ (in all cases except Christchurch, in which case the NASO Group Manager presented that segment.

  The attendees then broke up into small groups for discussion and addressed the first question, which was "What are the 3 most important opportunities facing the ambulance sector in NZ? Are these national and/or regional opportunities?"

  After the groups reported back, the facilitators organised a process to identify the top 3 opportunities across all groups; in fact, the top opportunities ranged from 2 to 5. The attendees then broke up into groups again to work on only one of the 3 identified opportunities, and addressed the second question, which was "For the opportunity that you are working on, what are the critical actions that would bring results? Which action would have the most impact? In what order would you do these actions and why?"

  The facilitators then brought the meeting back together for a group summary and an introduction to the web-based continuing dialogue.

- *Website Dialogue and Follow-up.* The attendees were all issued passwords for the secure portion of the website, in which blogging technology was used to post pictures of the written output of each group. Each attendee was invited to comment on any aspect of the process or ideas to progress the sector. This dialogue continued until late January 2009 and generated 59 posts or comments.