St John
Here for Life

Proposal to regulate paramedics under the HPCA Act

St John response to the Ministry of Health

30 June 2017

Contents

1. Introduction

1.1. Overview

In May 2017 the Ministry of Health (MoH) released a document entitled *'Regulating the paramedic workforce under the Health Practitioners Competence Assurance Act 2003: Consultation document'*. The consultation document articulates a proposal to register the paramedic workforce, as proposed by Ambulance New Zealand (NZ) and invites feedback from key stakeholders.

This document is St John's formal response to the MoH consultation document and the proposal to regulate the paramedic workforce.

1.2. Executive summary

- St John supports the proposal to regulate Paramedics and Intensive Care Paramedics (ICPs) under the Health Practitioners Competency Assurance (HPCA) Act 2003.
- St John views regulation of the paramedic workforce under the HPCA Act as an extension of its internal frameworks which will further enhance protection for the public by adding an additional layer of protection.
- St John and the ambulance sector are unique within health owing to its reliance on volunteers to provide acute and emergency healthcare services. St John does not support regulation of Emergency Medical Technicians (EMTs) at this time, owing to the potential negative impact on volunteer recruitment and retention. We acknowledge this is an area of contention among stakeholders.
- St John is not funded to meet the costs associated with registration. We estimate the cost for St John personnel to be >$640k per annum for our current Paramedics and ICPs alone.
- St John believes that there is an opportunity to further safeguard the public by ensuring all providers are able to demonstrate they have sufficient infrastructure to enable their clinical personnel to operate safely.
- St John recommends that title protection extends to cover 'paramedic' not just 'registered paramedic'; otherwise title protection may be of little consequence.

2. Correspondence & enquiries

This document has been authored by Daniel Ohs (Assistant Director of Operations – Clinical Practice), on behalf of Peter Bradley (Chief Executive Officer), Norma Lane (Director of Clinical Operations) and Tony Smith (Medical Director).

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3. St John response to Ministry survey questions

3.1. Section overview

This section reflects the views of St John after considering the content of the MoH consultation document, submissions from St John personnel, the current ambulance operating environment and the responsibility of St John to maintain emergency ambulance services throughout New Zealand (NZ). It is structured in the same order as the questions posed by the MoH to St John.

3.2. MoH question one

Do you agree that the paramedic workforce provides a health service as defined under the HPCA Act, and poses a risk of harm to the health and safety of the public?

St John response

St John submits that the paramedic workforce does provide a health service as defined by the HPCA Act and that it poses a risk of harm to the health and safety of the public.

We believe the risk of harm to the public is well mitigated through our robust clinical governance, education, consolidation and maintenance frameworks, which will be further strengthened through implementation of the new St John Continuing Clinical Education (CCE) programme. St John views regulation of the paramedic workforce under the HPCA Act as an extension of its internal frameworks which will further enhance protection for the public by adding an additional layer of protection.

3.3. MoH question two

Do you agree with the consultation document's description of the nature and severity of the risk of harm posed by the paramedic workforce? If not, please provide comment.

St John response

St John submits that it only agrees in part with the MoH consultation document description of the nature and severity of the risk of harm posed by the paramedic workforce. This is because the Ministry appears to have emphasised interventions that can be performed by paramedics as a risk of harm.

All interventions are a balance of risk, however in number of instances the Ministry document fails to account for the benefits of those interventions and the consequences of not performing them.

For example:

- Cricothyroidotomy – this is a rescue airway. In the absence of performing this intervention the patient will die.

- Jugular IVs – these are only indicated where the patient has a life threatening problem that requires immediate parenteral medication, such as cardiac arrest.
- Parenteral medicines – bleeding may occur from administration of thrombolytics; however research clearly demonstrates that it reduces both mortality and morbidity in patients with ST elevation myocardial infarction.

In these examples the likely benefit to the patient outweighs the low risk of harm. This is the case in multiple interventions which can be provided by paramedics.

The greatest risk of harm posed by our workforce is not the interventions they can provide it is the decisions they make, particularly those relevant to transport and non-transport recommendations.

3.4. MoH question three

Do you consider there is a high frequency of harm being caused by the practice of the paramedic workforce? Please provide comment about your answer.

St John response

St John submits that this question is ambiguous as it asks the respondent to make a judgement as to what defines a 'high' frequency of harm. We do not believe there is a high frequency of harm caused by our paramedic workforce; however St John considers that no level of harm to its patients (or personnel) is acceptable.

3.5. MoH question four

Are you aware of any instances of harm to patients being caused by the paramedic workforce? If so, please provide further information.

St John response

St John submits that it is aware of instances of harm to patients being caused by the paramedic workforce. These are regularly reported to the Ministry and we share cases with our personnel for their learning. Cases are also internally reported and reviewed by our Clinical Safety and Quality Committee. We have noted an increase in incidents over the past years owing to a stronger reporting culture within St John.

3.6. MoH question six

Do you consider that, under the Ministry's guidelines, it is in the public's interest to regulate the paramedic workforce under the HPCA Act?

St John response

St John submits that under the Ministry's guidelines, it is in the public's interest to regulate the paramedic workforce under the HPCA Act.

3.7. MoH question seven

Do you consider that the existing mechanisms regulating the paramedic workforce are effectively addressing the risks of harm <u>from</u> paramedic practice? Please provide comment about your answer.

St John response

St John submits that within St John, the existing mechanisms regulating the paramedic workforce are effective at reducing the risk of harm associated with paramedic practice. These mechanisms include the following:

- A robust clinical governance framework supported by focused clinical governance and clinical management committees.
- A solid audit framework supported by the electronic patient report form platform and Medical Director oversight.
- Robust clinical practice frameworks grounded in comprehensive vocational foundation and maintenance education via our CCE programme.
- Internal regulation through a standalone Patient Safety and Quality Team which stands separate to the internal Clinical and Operational delivery frameworks.
- World class Clinical Procedures and Guidelines with 'red flags' checklists, a focus on appropriate patient triage, resource utilisation and patient treatment. These are deployed both in writing and via our award winning CPG application.
- A requirement for clinical excellence within the Clinical Internship Programme which all personnel must pass to be issued with Paramedic or ICP ATP.
- Significant self-investment in a Clinical Development Team consisting of Medical Directorate, audit and research, clinical support, clinical education (including CCE), moderation and patient focused pathways teams delivered via 110 FTE.
- Real time clinical support via the St John Clinical Hub, consisting of paramedic support via our Clinical Desk and Air Desk. This is further supported by Registered Nurse Triage and an on call specialist physician.
- External validation of internal processes through adherence to the ambulance and paramedical standard NZS:8156:2008 conducted by TELARC.

However, St John recognises that a number of non-emergency providers lack the robust harm reducing frameworks employed by St John. We also recognise that a number of our personnel do not view the St John processes as being independent.

Furthermore St John notes that there is a wide variation in the baseline qualifications, experience and competency of personnel who refer to themselves as paramedics outside the emergency ambulance sector. St John recommends that as part of regulation, title protection should extend to cover 'paramedic' not just 'registered paramedic'; otherwise title protection may be of little consequence in the protection of public safety.

3.8. MoH question eight

Can the existing regulatory mechanisms regulating the paramedic workforce be strengthened without regulating the paramedic workforce under the HPCA Act? Please provide comment about your answer.

St John response

Despite the robust processes summarised in 4.7, St John submits that we support regulation of the paramedic workforce under the HPCA Act as it provides an additional layer of external scrutiny and protection for the public which cannot be achieved in the absence of regulating the paramedic workforce under the Act. It also ensures personal and practitioner accountability to the public, rather than just personal accountability to the employer.

Additionally we share the concerns of a number of our personnel about some non-emergency ambulance providers, who in our view and experience can pose a significant risk to the public both in terms of standards of care, but also in ensuring that 'fit and proper' persons are involved in the delivery of patient care.

For example we are aware of a number of ex-personnel who have been 'exited' from St John for reasons that a registering authority would find sufficient to remove their registration - and they are now working for non-emergency providers.

3.9. MoH question nine

Should the ambulance sector consider implementing a register of paramedics suitable/unsuitable to practise instead of regulation under the HPCA Act?

St John response

St John submits that this process already exists (in part) within emergency ambulance providers through the maintenance of a list in each agency which defines the ATP of all ambulance personnel. St John is not confident that the creation of such a list will reduce the incidence of harm to the public as each provider currently maintains its own processes and standards.

3.10. MoH question ten

Are there other regulatory mechanisms that could be established to minimise the risks of harm of the paramedic workforce? Please provide comment about your answer.

St John response

St John submits that there are multiple regulatory mechanisms that could be introduced to reduce the risk of harm from the paramedic workforce. These include

- Requiring all ambulance providers to adhere to the ambulance and paramedical standard NZS:8156:2008.

- Requiring all ambulance providers to have a process to ensure all personnel complete regular police checks to ensure its personnel are 'fit and proper' persons. This links back to safeguarding our most vulnerable (e.g. children).

  We are aware of a number of personnel who have been 'exited' from St John following a conviction who are now working for non-emergency ambulance providers.

  Recent high profile media coverage of non-emergency ambulance providers also demonstrate that there is a need for this area to be strengthened.

- Requiring that all ambulance providers have a specialist physician appointed as their Medical Director, with the name of this physician and their contact details publicly available.
- Mechanisms to ensure full and open disclosure following incidents where the workforce has caused harm to a patient are in place, in the same way that emergency ambulance providers do currently.
- Creation of a new vehicle and equipment standard that all vehicles registered as 'ambulances' are required to adhere to at the time they are issued with a certificate of fitness. This new vehicle standard would also include an assessment of stretcher and medical fittings. This minimises harm from the paramedic workforce by ensuring that ambulances are of an appropriate standard to enable safe and effective patient treatment and transport across the entire ambulance sector.
- A requirement to submit regular reports to the MoH in the same way emergency ambulance providers do currently.

3.11. MoH question eleven

Do you agree that regulation under the HPCA Act is possible for the paramedic workforce? Please provide comment about your answer.

St John response

St John submits that regulation of the paramedic workforce under the HPCA Act is possible. The key considerations that must be worked through include:

- How professional registration can be implemented in a way which enables the ambulance sector to maintain its precious input from volunteers.
- Who will pay the cost of professional registration and indemnity insurance.
- What clinical practice levels will be subject to regulation under the HPCA Act.
- How the public can be further safeguarded from harm against non-emergency ambulance providers.

3.12. MoH question twelve

If you are an ambulance organisation or ambulance provider, do you consider that the paramedic workforce:

a) understands the individual responsibilities required under the HPCA Act?

b) is prepared to pay the estimated annual practising certificate fee (and other regulatory fees) set by the proposed Paramedic Council?

c) understands the purpose of obtaining professional indemnity insurance?

St John response

- It is clear there are parts of the paramedic workforce who do not understand their individual responsibilities under the HPCA Act.
- While it is recognised that costs associated with the annual practicing certificate and indemnity insurance are the responsibility of the individual practitioner, it is inevitable (as in other areas of health) that contract negotiations will focus on these being reimbursed by the employer. St John is not funded to meet this cost which we estimate at >$640k for our current Paramedics and ICPs alone.
- It is clear there are parts of the paramedic workforce who do not understand the purpose of obtaining professional indemnity insurance.

3.13. MoH question thirteen

Do you have anything to add to the consultation document's list of benefits and negative impacts of regulating the paramedic workforce under the HPCA Act?

St John response

St John submits that regulation of the paramedic workforce under the Act will serve as a platform to enable paramedics to extend their practice further into areas not afforded to paramedics currently. This includes the ability to prescribe (practitioner model), refer directly for certain tests (such as x-ray) and refer directly to in-hospital and out-of-hospital health pathways.

Additionally, with the tertiary sector supplying more graduates than can be employed by the emergency ambulance sector, paramedic registration will enable graduate skills to be more transferable both internationally and across health.

Finally with the increasing 'right care' agenda, paramedics will increasingly be called upon to apply robust clinical decision making to enable 'hear and advise' and 'see and advise'. Professional registration will further enable these pathways whilst concurrently adding an additional layer of protection for the public.

3.14. MoH question fourteen:

Do you consider that the benefits to the public in regulating the paramedic workforce outweigh the negative impact of regulation? Please provide comment about your answer.

St John response

Overall St John submits that provided St John is not expected to pay the costs of registration, either directly (for their workforce) or indirectly (by reimbursing the workforce) then the overall benefits to the public in regulating the paramedic workforce outweigh the negative impacts of registration

St John wishes to signal strongly that costs associated with professional registration are not a 'current cost' and therefore in the first instance we would look to recoup such costs incurred by St John from the Ministry. If St John is unable to recoup costs from the Ministry then it will need to cut services to the public to fund the cost of registration.

In this setting it is the St John view that the benefits to the public would be outweighed by the negative impact of St John withdrawing some services (noting that the risk of harm to the public from the paramedic workforce appears low).

4. Additional feedback and considerations

4.1. St John clinical practice levels

4.1.1. Number of St John personnel at each level

St John has four clinical practice levels which have been defined by the National Ambulance Sector Clinical Working Group. Understanding how many personnel are at each level is important because it will define (in part) the number of St John personnel who will be registered. We note that within the MoH consultation document the numbers of personnel at each practice level need to be updated.

The current numbers (correct as at 25th June 2017) are:

- ICPs: 349 (8.46%)
- Paramedics: 708 (17.16%)
- EMTs: 1553 (37.65%)
- First Responders: 1515 (36.73%)
- TOTAL: 4,125

Note that the above numbers reflect the number of individuals that hold a clinical practice level; they bear no relevance to the number of FTEs at each level.

4.1.2. Future numbers of personnel by practice level

We have a number of personnel (approximately 100) who will be promoted to the Paramedic clinical practice level, from the EMT clinical practice level (all paramedic degree holders) over the next 12 months as part of an agreed 'buffer' system we have implemented internally (note that exact figures are currently being worked through). In addition the new injection of funding into St John to enable the double crewing of each emergency ambulance will see approximately 40 new Paramedics employed by St John.

4.1.3. Link between tertiary study and paramedic regulation

It is the desire of St John that only those who are registered will be eligible to apply for and complete the internal St John process (Internship Programme) to be issued a clinical practice level of Paramedic or above. To enable this (as with other health professions) we anticipate that persons who hold a Bachelor of Health Science (BhSc) in Paramedicine will be able to apply to be regulated under the HPCA Act.

St John currently has 143 personnel who hold a BHSc Paramedicine and we are aware of 235 others actively completing the degree (AUT University students only).

4.1.4. Potential number of St John personnel to be regulated

We believe that there are currently 1,210 St John personnel currently eligible for professional registration (1,067 Intensive Care Paramedics and Paramedics, 143 degree holders).

In addition we believe around 275 additional St John personnel may be eligible for professional registration within three years (235 completing the AUT University degree and 40 additional personnel associated with the funding for double crewing).

Note that we do not have accurate data pertaining to the number of personnel currently studying toward a BHSc Paramedicine at Whitireia NZ.

Therefore conservatively, we believe over 1,500 personnel from St John will be eligible for Professional Registration over the next three years (presuming that only ICPs, Paramedics and those who hold a BHSc Paramedicine will be registered).

4.2. Proportionate representation

The majority of Paramedics and ICPs within NZ are employed by St John. For this reason St John would like to emphasise its desire to be well represented in discussions moving forward.

This is especially important as changes are likely to have a significant impact on emergency ambulance providers relative to non-emergency providers.

4.3. St John calculation of costs

In calculating an approximation of costs, St John has used the following assumptions:

- The MoH consultation document has estimated the cost of an annual practice certificate to be $425.
- The *'Governance model and estimated costs to regulate paramedics under the Health Practitioners Competence Assurance (HPCA) Act 2003'* document supplied to St John by the MoH has indicated that the cost of professional indemnity insurance to range between $180 and $350 per annum.
- There are currently 1,210 St John personnel eligible for professional registration (1,067 Intensive Care Paramedics and Paramedics, 143 degree holders).
- Including 275 additional St John personnel who may be eligible for professional registration within three years and 40 Paramedics associated with double crewing, we believe 1,500 St John personnel will be eligible for Professional Registration over the next three years.

Table 2: Cost scenarios

Scenario	APC cost	Insurance cost	Total cost p.a.
1,067 existing ATP best case	$425	$180	$645,535
1,067 existing ATP worst case	$425	$350	$826,925
1,210 existing ATP + degree best case	$425	$180	$732,050
1,210 existing ATP + degree worst case	$425	$350	$937,750
1,500 three year best case	$425	$180	$907,500
1,500 three year worst case	$425	$350	$1,162,500

Based on the above the cost to St John and or its personnel could range from $645k to $1.16m per annum.

St John submits that this cost will likely as a result of employment negotiations be recovered from the employer. St John cannot pay these costs without reducing services. Therefore in this scenario the Ministry should pay the cost of professional registration including indemnity insurance.

4.4. Volunteering in St John

Each year St John volunteers respond to tens of thousands of incidents as part of an emergency ambulance crew, first response units and through the provision of event ambulance services. No other part of the NZ health sector has such a reliance on volunteers in the routine provision of health services in an acute and emergency healthcare context. Without volunteers the ability for St John to deliver these services (including following the implementation of double crewing) will be crippled.

For this reason St John has grave concerns about the potential impact on volunteering in St John and the flow on impacts to the community should EMTs be regulated under the HPCA Act.

St John has over 3,000 volunteers who actively participate in the above activities and approximately 700 volunteers are active at EMT level. We believe that inclusion of EMTs would have a direct negative correlation on retention of EMT volunteers and therefore our ability to deliver ambulance services throughout New Zealand.

We believe this to be the case owing to both the costs associated with registration and the potential that the requirements of the APC would be above the requirements to maintain ATP with St John.

Additionally we believe that the existing clinical governance frameworks employed by St John, combined with the future CCE model will be enough to both internally regulate and maintain the baseline clinical competency of our EMTs

There is a much smaller number of volunteers operating at Paramedic and ICP level (29 nationally) and in these instances, should registration proceed, St John would work with these personnel to aide them in the maintenance of their APC where appropriate.

For the above reasons should registration proceed then St John would submit that:

- St John and the ambulance sector are unique within health owing to its reliance on volunteers to provide acute and emergency healthcare services.
- Regulation under the HPCA Act 2003 may be a barrier to volunteer retention, which would then have a direct impact on St John's ability to provide emergency ambulance services. For this reason St John does not support regulation of EMTs (noting this does not remove the ability for this to be reviewed in the future).
- The existing and future frameworks employed by St John are enough to maintain the baseline clinical competency of our EMTs, but we do think it's appropriate to discuss registration of EMTs in the future.
- For the small number of Paramedics and ICPs operating as volunteers, St John will work with them to maintain the requirements of an APC, where appropriate.

5. St John – internal regulation and support

5.1. Clinical governance and support

St John has a well-established clinical governance and support framework, supported by 110 full time equivalent (FTE) clinical personnel. This includes

- ***Clinical Governance Committee***. Responsible for overseeing the overall clinical direction of St John, its membership includes the Chancellor, the Chief Executive Officer, the Medical Director, Director of Clinical Operations and other senior members of the Order of St John.
- ***Strategic Operations and Clinical Committee***. This committee is responsible for overseeing the strategic delivery of ambulance, event medical services, patient transfer services and clinical development within St John.
- ***Clinical Safety and Quality Committee***. This committee is responsible for monitoring trends, reportable events, complaints, investigation and clinical risk.
- ***National Ambulance Sector Clinical Working Group***. This group is chaired by the St John Medical Director and compromises the clinical leads from both St John and Wellington Free Ambulance (WFA). The working group is responsible for reviewing and writing the St John Clinical Procedures and Guidelines (CPGs).

5.2. St John authority to practise framework

We believe it will be very unlikely that the paramedic registering authority will grant prescribing rights for Paramedics and ICPs. This means that Paramedics will still need to work to a standing order and for this reason they will still require ATP. Therefore all existing ATP frameworks within St John will need to remain in place and professional registration will become an additional new layer of protection for patients, relevant to those at or aspiring to Paramedic or ICP level.

For the above reasons St John submits that should registration proceed then:

- There will be no reduction in administrative workload or administrative cost for St John associated with regulation of paramedics under the HPCA Act.
- It is likely that the additional administrative burden of providing additional information to the registering authority will generate additional cost for St John.
- Following introduction of professional registration, St John will continue to select the best persons to be promoted to Paramedic and ICP level.
- The requirement for personnel moving to Paramedic or ICP level to apply for and pass the St John Internship programme will remain.
- If the paramedic workforce were granted prescribing rights. St John will continue to restrict access to certain clinical equipment, medicines and consumables in line with operational skill-mix requirements and financial restraints.

5.3. Continuing professional development in St John

5.3.1. Current St John CCE programme overview

St John has been running an internal continuing professional development programme since 2009. Internally this programme is referred to as Continuing Clinical Education (CCE). Topics are set by the St John Strategic Operations and Clinical Committee and content is endorsed by the St John Medical Director.

The current CCE model consists of:

- 16 hours (on average) face to face education is delivered per year to First Responders.
- 32 hours (on average) face to face education is delivered to all personnel with ATP (EMTs, Paramedics and ICPs).
- Emergency Medical Assistants complete the equivalent volume of education in line with their clinical practice level.
- Online learning activities are created to support the face to face learning as required.
- Clinical Focus (the St John internal clinical periodical) is produced and circulated as an adjunct to CCE.
- A Clinical Wiki has been created and maintained as an adjunct to CCE.
- A CPG application has been developed and is maintained to both aide clinical learning and on-scene clinical decision making.

Compliance with all St John CCE requirements is currently above 80% for personnel at EMT level and above 90% for personnel at Paramedic and ICP level.

5.3.2. Future St John CCE programme overview

St John is developing a new CCE programme which will include:

- A mix of mandatory and optional clinical maintenance opportunities, both provided by Clinical Development and self-directed.
- Small ‘bite sized’ responsive learning modules which are easy to create, update and complete in line with trends, incidents, pathways and organisation wide objectives.
- **Minimum CCE requirements** tailored to each clinical practice level, ranging from 16 hours at First Responder through to 40 hours at ICP (see 5.5.3).
- An ***electronic portfolio of evidence (ePOE)*** which will be maintained by personnel at EMT, Paramedic and ICP level (see 5.5.4).
- A ***body of knowledge*** will be populated over three years as an adjunct to the ePOE (see 5.5.5).

5.3.3. Future CCE programme – minimum CCE requirements

The following are the intended minimum CCE hours:

- First Responder - 16 hours face to face, no self-directed, totalling 16 hours.
- EMT - 16 hours face to face, 8 hours self-directed, totalling 24 hours.
- Paramedic - 16 hours face to face, 16 hours self-directed, totalling 32 hours.
- ICP - 16 hours face to face, 24 hours self-directed, totalling 40 hours.

EMAs complete the appropriate volume of CCE for their clinical practice level.

Table 1: Minimum CCE requirements matrix

	4 hours	8 hours	12 hours	16 hours	20 hours	24 hours	28 hours	32 hours	36 hours	40 hours
First Responder	16 hours face to face									
EMT	16 hours face to face				8 hours self-directed					
Paramedic	16 hours face to face				16 hours self-directed					
ICP	16 hours face to face				24 hours self-directed					

5.3.4. Future CCE programme – electronic portfolio of evidence (ePOE)

The ePOE has been designed to enable personnel to track clinical maintenance, exposure and to set them up for success in the context of registration, this includes:

- Personnel baseline ambulance related experience and professional qualifications able to be entered and displayed.
- Reflective logs which enable the learner to input or draw data direct from an incident they have attended using electronic patient report form (ePRF) data, they can then describe the incident, discuss the clinical condition, positively challenge their own decision making and enable reflection.
- CCE dashboard(s) which enable the learner, their manager and St John Clinical Support Officers to see the learner's progress against learning requirements.
- Clinical exposure dashboard(s) which draw mobile data terminal (MDT) and ePRF data to enhance transparency over the number of patient contacts and number of frontline ambulance hour's personnel are completing. Additionally the most and least performed interventions in the past 12 months will be displayed.

Key operating features of the ePOE include:

- Able to be used on all platforms (smart phones, tablets, desktops etc.).
- Future proof to enable ePOE to draw other information from the MDT and ePRF.
- Able to be printed as evidence of competency, exposure and development.
- Able to store (via a cloud server) an ePOE for all St John ambulance personnel.

5.3.5. Future CCE programme – body of knowledge

The body of knowledge will form the 'whole brain' for knowledge within St John Clinical Operations. Initially the body of knowledge will focus on clinical topics but it is being developed to enable it to extend to operational, health safety and wellness and management education topics as needed.

Essentially it is an electronic platform which enables the learner to easily overview all knowledge required to be competent in a particular topic within defined categories. The learner can then choose to review knowledge or complete the 'verification task' section within that topic. This enables learners who have a high degree of knowledge and competence to complete quickly, enabling the new CCE model to reward learners who are already remaining contemporary with clinical content.

Clinical topics (the focus of the initial build) are being structured in line with the CPGs. The dashboard will look similar to reading the contents of the CPGs. When a topic is selected this will reveal categories including:

5.3.6. Future CCE programme – timelines

The electronic portfolio of evidence will be piloted in St John from July 2017 and we plan on it being fully operational by February 2018. The model will be formally launched in the North Island in July 2018 and in the South Island from July 2019.

5.3.7. Future CCE programme – implications for registration

Based on the above information relevant to CCE St John submits that should registration proceed then:

- The St John CCE programme should contribute toward the hours required for registered practitioners to maintain their APC (this is supported by 93% of respondents to the St John survey).
- The St John ePOE is evaluated and accepted to enable it to be accepted by the registering authority as evidence for maintenance of the APC (this is supported by 89% of respondents to the St John survey).

St John believes these are important principles as these will keep the overall costs of registration lower for its personnel, by utilising an existing framework.

6. Appendix A - Submissions to St John

6.1. Section overview

On the 6th June 2017 St John released all consultation information provided by the MoH to all St John personnel and invited feedback via both an electronic survey and an internal email address linked directly to the author. In the three weeks provided for St John personnel to provide input, we received 116 submissions.

This appendix contains the results of those submissions, along with a cross-section of submitted comments. While there is a large cross section of views provided here, all were taken into consideration in the preparation of this submission and have been included here for completeness

6.2. MoH question one

Do you agree that the paramedic workforce provides a health service as defined under the HPCA Act, and poses a risk of harm to the health and safety of the public?

92% of submissions to St John agreed with the MoH survey question as written above in 4.2. There was no opportunity for personnel to comment on this question.

6.3. MoH question two

Do you agree with the consultation document's description of the nature and severity of the risk of harm posed by the paramedic workforce? If not, please provide comment.

91% of submissions to St John agreed with the MoH survey question as written above in 4.3. Submitted comments included:

- *"I don't believe there is any evidence to suggest the paramedic workforce poses a significant risk to the public".*
- *"Yes but this represents such a small sample of the workforce, I believe EMTs also potential for harm and the public need to be protected from this cohort of the workforce - should include EMTs now."*
- *"I feel they [the Ministry] tend to lump all the problems associated with a procedure into one group and there is no differentiation between the very rare and common issues with a procedure (tables 3,4,5)."*
- *"The distinction between paramedic and EMTs misses the point that there are substantial risks from mismanagement by EMT's. Examples include drug administration errors (e.g. neb salbutamol for ACPO, GTN for tachydysrhythmia, and clinical decision making. e.g. poor non-transport choices). The key risk areas are where EMT's are the lead clinicians in rural areas where the pressure to avoid transport is high."*

- *"I think the key word is POSSIBLE, how frequently have these incidents actually happened and in comparison with other registered health professionals causing harm in the same manner."*
- *"This seems very focussed on the risks and potential harm when specific care or skills are provided. However I feel there is a risk is when care or specific skills are not provided (under treatment) because the need for that care or those skills is not recognised".*
- *"As can be seen from previous years there have been TWO incidents where paramedics were investigated on these grounds it would seem a reasonable assumption that existing monitoring/ safeguarding structure is adequate!"*

6.4. MoH question three

Do you consider there is a high frequency of harm being caused by the practice of the paramedic workforce? Please provide comment about your answer.

82% of submissions to St John disagreed with the MoH survey question as written above in 4.4 (i.e. 82% did not believe there was a high frequency of harm caused by the paramedic workforce). Submitted comments included:

- *"From what I have seen, we do a really good job given what we are faced with on a daily basis. Clearly we do cause harm but the frequency is not high."*
- *"As indicated the actual frequency is of harm is relatively low (may be under captured and we expect an increase with ePRF). However, the potential for harm is very real."*
- *"Referring to Table 6 HDC complaints - ambulance officers have very low numbers."*
- *"If there was a high incidence of harm being caused there would be significantly more reporting of incidents."*
- *"St John has a very robust training, CCE, and mentorship program that ensures a very low frequency of harm. St John staff often openly discuss clinical issues that they have experienced from which others can learn and gain experience from."*
- *"if existing records are accurate (no reason to doubt them) then two reportable incidents in countless thousands of patients contacts across both islands in a period of four years enables us to state we practice safely now.'*
- *"There is potential for harm if [the] paramedic workforce do not work within [their] scope of practise or consult. However clinical audit processes look at this. Also if we are transparent about adverse events and the implication to staff, and the process being open and non-judgemental then any issues of harm will be highlighted."*

- *"I really don't know. What is the threshold for the public to complain about an ambulance officer? We are the most trusted profession and St John has an excellent name and brand. Being a charity may also raise the threshold for the public to complain ... do not know what the frequency of harm is."*
- *"The key areas for potential harm being caused are through leaving a patient at home who requires medical attention and performing interventions and administering medications. Of this I am not personally aware of malpractice occurring."*
- *"It would be the exception rather than the rule that there is any harm."*
- *"No I do not believe there is a high frequency, however I do believe there are several aspects of current regulation models that is insufficient for the growth and change in the paramedic profession."*
- *"Statistically the risk is low compared with other HC professions, but due to the nature of practice the potential is high, also the concern with poorly managed private providers."*
- *"No, I myself have been investigated by HDC, but not aware of any other cases in my career of 30 years. Most complaints are of a behavioural and attitudinal nature, rather than reportable events, such as dangerous medicine doses."*
- *"While self-regulation has worked till now, there is a good potential and the risk is as high as equivalent health disciplines such as nurses."*
- *"Concerning and high risk to NZ public that anyone can call themselves a paramedic."*
- *"Harm is very subjective in this description. Often there are staff that do not operate consistently at the expectation of their ATP due to skill degradation or personal lack of commitment. Therefore if harm included the omission of skills that are clinically indicated then yes. Like all health professionals 100% accuracy is simply unrealistic."*
- *"Not a high frequency - most are well trained and working in pairs provides a second check. HOWEVER if things go wrong, they have the potential to go very wrong - serious harm or death to patients."*
- *"Not Currently due to working conditions within St John (including safe practice policy and guidelines) which have a high focus on Do no harm for patients and the majority of NZ paramedic workforce are working within those conditions."*
- *"I agree the low rate of harm is reflected by the low number of HDC complaints. I also believe that the CPGs and ongoing CCE provided by St John is very effective at ensuring that appropriate care is given by Paramedics to patients and that the risk of harm is minimised. I also believe that the option of contacting the Clinical Desk is another very useful adjunct that helps to ensure safe and appropriate care."*

6.5. MoH question four

Are you aware of any instances of harm to patients being caused by the paramedic workforce? If so, please provide further information.

47% of submissions to St John agreed that they were aware of incidents. Submitted comments included:

- *"We see these in the 'Lessons Learned' cases which come through Clinical Focus. You can also see some cases listed on the HDC website. We have also discussed these in CCE."*
- *"My role with St John involves remediation when actual harm occurs so yes. Other than that, the professional practice in St John is of a high standard most likely due to the traditional discipline (rank, uniform, formal practice) within the ambulance service as opposed to other health professions."*
- *"Psychological harm caused through inappropriate examination of a patient."*
- *"Not specifically any St John staff, other than what has been made general knowledge through the St John CCE platform. i.e. the Incident of non-defy of a patient in unconscious VT that due to lack of knowledge with the Marx by the attending crew, support crew & Doctor on scene. It was a national CCE topic some time ago."*
- *"General inappropriate drug doses given, mistakes that happen due to human error."*
- *"I'm aware of incidents highly publicised and HDC cases."*
- *"Beyond reported events I do believe there is inadequacy in self-reporting adverse events/clinical error due to an impression of punitive disciplinary process."*
- *"Have seen poor practice by both public and private providers"*
- *"Lack of paramedic physical fitness for duty and ongoing manual handling incidences. Although often minor still pose a risk of harm and are often overlooked."*
- *"I don't have specific details but am aware of instances that I have heard have happened."*
- *Current on-going unstable ex members of St John claiming to be paramedics and treating members of the NZ public."*
- *"Unmanaged airways. Variance on drug administration outside of CPG's Inaccuracy around R35 [ambulance not required]."*
- *"Inappropriate RSI. Poor airway management resulting in worsening hypoxic brain injury. Opiate poisoning from excessive morphine administration."*

- *"The most common forms of harm I see are where our workforce (at all ATP's and including TM's and SM's) avoid transport due to laziness - they are tired and don't want a 3 or 4 hour return trip to ED, or they are avoiding end of shift late finishes - so they delay and muck around and basically act as an obstacle to patients getting to ED in a timely fashion. In some cases they (our staff) are just contrary and obstinate, and sometimes simply ignorant of what they are dealing with clinically."*
- *"Out of date clinical knowledge and ICPs in management roles who have barely practiced for years occasionally treating patients and attempting to perform advanced skills."*
- *In over 20 years of service with much of that as a clinical auditor I have seen less than a handful of cases where any actual harm has befallen a patient. I have however seen the self-imposed regulatory audit processes identify areas of potential harm with the result of preventative and educational steps being implemented."*
- *"I am currently a TM so privy to complaints. I am also a RSI skilled ICP and frequently called to critical patients where I believe the care is sub optimal and basics have not been done well."*
- *"Very few clinical problems. A lot of problems with attitude, behaviour and people that have forgotten we are here for the patient. The recent use of black T shirts by staff - scaring patients and risking their own health and safety is an example."*

6.6. MoH question six

Do you consider that, under the Ministry's guidelines, it is in the public's interest to regulate the paramedic workforce under the HPCA Act?

79% of submissions to St John agreed that it is in the public's best interest to regulate the paramedic workforce. Submitted comments included:

- *"The Ambulance Service has now become a very highly trained & qualified provider of pre-hospital accident & medical care. Time has come to assure the public that those practitioners within the ambulance services are operating & qualified to perform the duty's they do and are monitored to a nationally acceptable standard. That should any practitioner not preform to their required standard that disciplinary measures are in place to deal with those individuals."*
- *"As an ex UK paramedic (currently registered in the UK), I have been this entire process before. In the UK all that has been achieved is the creation of yet another regulatory body that exists under the guise of "developing' the profession, in reality it is a body that both polices and disciplines the profession to the detriment of the very people it is supposed to serve!"*

- *"The main purpose of regulation must be to reduce potiential harm to the public. As harm events are so few regulation will not achieve this goal. It may in fact increase harm events by shifting responsibility away from employers to individuals creating a wide range of competency maintenance standards amongst individual Paramedics. Employers can at least control and monitor standards on a daily basis. It would be regulation for regulations sake and introduce a cost structure that would be better used putting more staff in the field."*
- *"But the EMT workforce also needs regulation, or, the ability to independently initiate a non-transport must be removed from the EMT ATP, options could include a mandatory clinical review of all EMT non-transports, or requiring clinical desk approval for EMT non-transport. A risk matrix which identifies known factors (early hours of morning, end of shift, etc.) would help identify high risk non-transport scenarios."*
- *"If it ain't broke, don't fix it." I believe St John is doing a fantastic job of ensuring that its Paramedics are appropriately skilled and monitored to deliver safe care to the public. I would worry that a move to registration could "look nice on paper" but in fact create a situation where there are potentially less controls or appropriately focussed monitoring, and this could actually cause and increase in the risk of harm to patients."*

6.7. MoH question seven

Do you consider that the existing mechanisms regulating the paramedic workforce are effectively addressing the risks of harm from paramedic practice? Please provide comment about your answer.

44% of submissions agreed that the existing mechanisms regulating the paramedic workforce are effectively reducing the risk of harm from paramedic practice.

Submitted comments included:

- *"Non-government funded providers do not have to comply with Ambulance standard Currently ambulance providers not the individual have the responsibility to maintain clinical competencies Currently no independent body to refer to for issues around competency and professional conduct."*
- *"St John has a good clinical framework including CCE. This will only get better once the new CCE model is finally launched with the portfolio."*
- *"To a large degree yes. However the separation of ambulance employment with control of clinical ATP is important to even up the power imbalance. I am in no way saying that St John is abusing the situation but the potential is there and I believe there have been historical issues. The maintenance of ATP through an independent RA separate to the employer removes the potential for that abuse. Registration also provides the public improved accountability and transparency."*

- *"Existing mechanisms effectively address risk in the full time government funded agencies. There are no effective mechanisms to reduce risk to the non-government aligned services."*
- *"No. While I believe that the internal processes of the two main providers (St John and Wellington Free Ambulance) do address the risks of harm associated with specific skill delivery I strongly believe that neither has adequate processes to control all of the risks associated with pre-hospital care at any qualification level."*
- *"To safeguard the public and paramedics it is in the best interest to be regulated by an independent body which will offer more transparency and reporting of malpractice."*
- *"Generally yes as both St John & Wellington Free have individual processes for their respective Services that are effectively addressing risk, but unsure of what other non-Government providers have in place, if any."*
- *"Currently there is no robust system of ensuring on-going clinical competence in the ambulance service, especially amongst low-volume rural clinicians. This creates undue risk to the public and it appears (given there are no systems in place to address this definitively) that St John is unable to financially support on-going skills maintenance within this particular group of clinicians. A simple solution is regular metropolitan road-time for rural and lower volume area clinicians however this is not consistently applied, if at all nationwide."*
- *"I think that St John has done an excellent job of attempting to mitigate risk, have a very good complaints mechanism but there is a culture within the workforce of still keeping things quiet in fear of punitive consequence.*
- *"St John and perhaps Wellington Free have done a great job and are able to provide the high standard of safety. However, the scope of practice is now comparable or even wider than RNs and non-government funded organisations also need to have same standards and be monitored by independent body."*
- *"St John and WFA have well established policies and procedures, other providers who are offering a similar service is a concern. There must be a consistent [sector] wide policy."*
- *"This is rather an obvious answer if there have been two incidents of alleged malpractice in past four years is not blatantly obvious existing mechanisms are robust? If paramedics had the same level of complaints as, for example doctors this would indeed, be a point worth debating."*
- *"I believe the current system the St John ambulance service has in place is appropriate however strict penalties have to be established for inappropriate practice. Also a no blame policy for staff that report inappropriate clinical practice by another staff member. In the current workforce if you report inappropriate clinical practice work life can become for uncomfortable and difficult."*

- *"Existing mechanisms seem unlikely to manage the ever increasing scope of invasive skills and interventions. Someone may have been a good Paramedic/ICP 5 years ago when gaining their patches, but there is minimal personal onus on ensuring skills and knowledge remains up to date."*
- *"I say no with a great deal of respect for our internal systems for regulating our practice. At the end of the day they are internal. Audit systems is good with enough variance in it to reduce biases. When there are somewhat more serious incidents it is often left to the local manager to follow up and organise process. That will significant vary dependant on the individual managers personal thinking experience and ATP."*
- *"We currently receive very little feedback regarding our practice - in this sense we are "flying blind", we have no mandatory formal way to follow up on patient outcomes, especially non transports, and so we miss most opportunities to improve our practice. Our current mechanisms rely on patient complaints (too subjective) and usually relate to non-clinical concerns. Clinically we are currently flying in white-out conditions"*
- *"Inconsistent and under resourced patient safety team managing adverse incidents and then conversely over the top ATP processes preventing clinicians from returning to practice from work off-shore who have previously practiced safely at a specific level. No protection of title of "paramedic" which harms patients by unqualified providers posing as paramedics".*

6.8. MoH question eight

Can the existing regulatory mechanisms regulating the paramedic workforce be strengthened without regulating the paramedic workforce under the HPCA Act? Please provide comment about your answer.

49% of submissions to St John agreed that regulatory mechanisms could be strengthened absent the need to register the paramedic workforce under the HPCA Act. Submitted comments included:

- *"No - As we currently only have two 111 providers and a myriad of other providers who cover events and do not generally get exposure to high acuity patients and when they do generally do an appalling job."*
- *"I believe it can be strengthened but unsure of how due to culture and lack of individual responsibility taken from a clinical perspective."*
- *"More tutor lead classroom time for existing Paramedics/ICP's along with more clinical coaches providing support and mentoring on the frontline. More ambulances on the road results in less time pressures influencing decisions thus decreasing the opportunity for mistakes."*

- *"While I believe the current system provides good oversight of staff practicing, this system is not independent from the employer. In my view oversight of practice should be provided by an independent organisation."*
- *"It would require A LOT more training of Managers at local levels and recourses. Our access to resources is often the barrier to system improvement."*
- *"I believe they could but this would require more funding for enough staff with high standard of appropriate skills to be available to audit all incidents and this is not feasible."*
- *"Yes - but only with a formal process on how harm and poor performance will be managed, this would involve consistent outcomes and more importantly absolute but in from unions, which I don't think you will get."*
- *"As above heavier penalties for inappropriate clinical practice. An independent and impartial complaint and misconduct investigation team as the New Zealand Police have. A nationwide team, staff that work in this team may be ex Paramedic workforce however not long standing ICP's that have mates in operations teams, staff no longer work in the operations team and must have a complaints and regulatory qualification or back ground. This team is not lead by clinical or operations teams, it is led by an impartial operations support management structure so they are not coerced to act inappropriately to keep people in the workforce or at a clinical practice level because they have worked in a company for years."*
- *"We can always improve but the low incidence of harm is a reflection of the current systems effectiveness."*
- *"There is absolutely no reason to suggest otherwise, given the almost non-existent problem - do they actually require strengthening?"*
- *"Not in my opinion. The whole point is to have a transparent system that is independent of employers so that the public can have confidence. How do ambulance officer's behaviours in say WFA become transparent to St John when they seek to transfer employment? The public have no choice as to what ambulance officer turns up."*
- *"Increase and support regular skills-maintenance via Clinical Suite simulation and access to metropolitan road time for staff not working in metro areas. Reinstate regular ATP competency assessment via Clinical Coaches and CSO's."*
- *"Without a National body that encompasses all paramedic practitioners that is governed by statute, no one singular body would have the power to enforce standards & practice."*
- *"I believe that an independent third party with binding authority would address concerns regarding providing transparency and fairness."*

- *"It requires proper resourcing. Paid/Protected Auditor time. Increasing the Clinical Audit Team resources (FTEs). To enable audit processes are monitored and cases examined."*
- *"Roll out the new CCE model (not sure why this is taking so long) and maybe have a regular revalidation requirement as part of CCE."*

6.9. MoH question nine

Should the ambulance sector consider implementing a register of paramedics suitable/unsuitable to practise instead of regulation under the HPCA Act?

72% of submissions to St John disagree that the ambulance sector should implement a register as described in the MoH question above. Submitted comments included:

- *"The problem with enabling this is that there is more than just St John and Wellington Free in the ambulance sector. Some of those other ambulance providers call themselves paramedics but they are just cowboys."*
- *"In a sense this is done unofficially by the two providers. However this again does not address the monopoly situation by the employers."*
- *"While a register would provide some protections to the public it does not control those who may or may not call themselves paramedics and could practice outside the group who are so identified. This also does not provide the assurance required under the regulatory process."*
- *"This should [have] been done already, but with the HPCA, it is overdue with already other health professionals listed on this. A lot of these health professionals are people we work with every day and either way Paramedics are soon going to become under the same act."*
- *"A simple register will lack the legislative teeth and how would this transparently protect the public and ensure equal treatment of the ambulance workforce for similar breaches both within the profession and between or compared to other professions (e.g. nurses, dentists, doctors etc.)."*
- *"Does any other healthcare profession do this? The opportunities for paramedics to practice outside traditional ambulance roles should be viewed as a positive, not a negative."*
- *"It is costly, may reduce public confidence and what measures would be used to ensure people receive fair assessment prior to be placed on a register? What processes of appeal /grounds would be used to assess fitness to practice (there have been multiple services overseas where medics have been considered unsuitable to practice due to seeking assistance for PTSD etc.)? Doesn't address issues of ensuring recognisable and uniform standards of practice."*

6.10. MoH question ten

Are there other regulatory mechanisms that could be established to minimise the risks of harm of the paramedic workforce? Please provide comment about your answer.

Unfortunately there was a design error in this survey question which means we are unable to report on the overall preference from submissions to St John. There was however a number of comments provided:

- "*Specific ambulance legislation could be introduced similar to Drs, nurses, Fire Service etc."*
- *"Register of paramedic names and qualifications could be formed, difficult to keep validated and up to date with in the context of paramedic practice. Would not record paramedic competencies. Would require input from ALL ambulance providers including non-government funded operators."*
- *"No - New Zealand has a legislative framework why would you reinvent the wheel. This also ensures consistency of handling of breaches between professions."*
- *"The current model is working well, but to do better we need legislation and independent moderator to standardise and monitor its standard of paramedic practice."*
- *"Formal registration is required. Particularly due to the expanding amount of tasks those paramedics can perform."*
- *"Existing measures are satisfactory and do not require alteration."*
- *"Law changes to ensure only registered individuals can operate and call themselves paramedic. I would go further and extend this to EMT and EMA level."*
- *"Staying employed and meeting employer expectation with the genuine desire to help people and be as professional as possible has so far created a minimal harm environment, why change something that isn't broken."*
- *"Regardless of registration the paramedic workforce is still subject to the Health and Disability Commission and is still accountable under appropriate Government legislation. An independent ambulance complaint and misconduct investigation team and tribunal would be more than appropriate to manage issues that arose from inappropriate clinical practice."*
- *"Maybe this should be tabled to the "whole" workforce-proposal has paramedic and ICP only being regulated-the bulk of the workforce is EMT and First Responder."*
- *"Registration is the least confusing, if we want to move our practice to other parts of the health sector."*

- *"At a minimum we need to be very clear about what harms we cause, and to measure the frequency of these harms. At the risk of repeating myself, I would be very surprised if paramedic mediated IV catheter shear is a bigger problem than EMT initiated unsafe non transport. We shouldn't have to wait for registration to own this part of our clinical practice. We should know this."*
- *"More effective self-management. All paramedics and ICP should keep skills ledger and record of practice (as ePRF can be used for) and other continuing education, as a portfolio to support their practice. If medics are shown to have not completed a requisite number of uses of a particular skill then they need to do clinical refreshers, around the skill and the theory."*

6.11. MoH question eleven

Do you agree that regulation under the HPCA Act is possible for the paramedic workforce? Please provide comment about your answer.

93% of submissions to St John agreed that it is possible to register the paramedic workforce. Submitted comments included:

- *"Absolutely - it is a matter of a small mind-set change the about responsibility for one's own practice, but you need to register the entire workforce not just paramedics and ICPs. This will reduce the cost per individual. EMTs do pose a risk of harm ... certainly more than oral hygienists, occupational therapists or dieticians."*
- *"Whilst it is possible, its cost will be [significant], setting up a regulatory council will be time consuming and its cost appears to be borne by the paramedics it will regulate in the form of expensive annual practising certificates."*
- *[Yes], but the risk is that we will not be registered by a body which understands what we do and how we do it. The low quality registration paper indicates the low level of understanding of our current practice by NASO so I can't imagine being registered under the umbrella of the Nursing Council improving this situation.*
- *"To me this all seems to be an unnecessary expense and level of bureaucracy that will achieve no greater gains other than what we have now (except for that of a "Registered" Paramedic title). I certainly do not think any of this will improve public safety. For me, I do not have a Bachelor of Health Science degree. Does this mean I will lose my Paramedic ATP?"*
- *"Yes, it is has worked for other health professionals such as nurses, doctors, physiotherapists, etc. A similar system is operating in the UK where paramedics are registered by the HCPC."*
- *"Yes it is possible but potentially it will reduce the level of autonomy we currently have under standing orders and make all treatment much more prescriptive, which in turn is likely to lead to more transporting of [patients]."*

- *"It has been spoken of for years. However for me it would be cost prohibitive, unless St John was to pay for registration."*

6.12. MoH question twelve

If you are an ambulance organisation or ambulance provider, do you consider that the paramedic workforce:

d) Understands the individual responsibilities required under the HPCA Act?

e) Is prepared to pay the estimated annual practising certificate fee (and other regulatory fees) set by the proposed Paramedic Council?

f) Understands the purpose of obtaining professional indemnity insurance?

According to the submissions received by St John:

- 51% of respondents stated that they understand their responsibilities under the HPCA Act, 7% state they do not and 42% would like further information.
- 47% of respondents stated that they are prepared to pay the costs associated with registration, 53% stated they are not.
- 60% of respondents stated they understand the purpose of obtaining professional indemnity insurance, 7% state they do not and 33% would like further information.

6.13. MoH question thirteen

Do you have anything to add to the consultation document's list of benefits and negative impacts of regulating the paramedic workforce under the HPCA Act?

- *"Most of the work force will assume that St John and Wellington Free will pay the cost of registration for all staff. It needs to be made clear whether this would be the case so that staff are fully informed. There is no clarity in the proposal with respect to those Paramedics and Intensive Care Paramedics who qualified under the pre-degree regime. There needs to be clarity for that reasonably significantly sized group as to whether they would be registered at the relevant practice level under a grandfathering arrangement."*
- *"No, as I believe the document has adequately covered all the reverent issues and points that demonstrate confidence and protection to the public, and protection of qualification for the paramedic."*
- *"Potential pay increase as to recognise our professional qualifications? Also this will prevent workforce mobility to other employment overseas."*
- *"It may make self-reporting of error more palatable in that the workforce may have more confidence is a system that is supportive of veracity."*

- *"I believe this has been initiated by St John to reduce competition in their workplace. It has no benefit to either paramedics or the general public."*
- *"Risk of inaction, deciding not to perform an intervention (e.g. not starting CPR, not [cardioverting], not reducing fracture with distal vascular compromise). Inappropriate referral decisions."*
- *"The cost to staff will drive many to get out of the industry and others to wonder if the experience will be worth the effort to reinvent the wheel."*
- *"People who hold a BHSc (Paramedicine) should also be eligible to apply for registration as a Paramedic (such as in the UK) and St John should accept this ATP."*
- *"I could not be expected to understand the legal intricacies of such a detailed document but my understanding as a layperson is such that I understand the responsibilities the all healthcare workers are in extremely privileged positions and that the lives we are entrusted with deserve the very best care that is available to them. In saying this we are all human and at times make mistakes, surely the focus should be on limiting the factors that create mistakes such as fatigue, time pressure and lack of resources and or support. It seems the focus of regulation is dealing with the mistakes after they happen not preventing them in the first place. The role of paramedic/ICP has evolved due to public need and demand from the employer. Clearly these roles are not what most staff originally signed up for but have risen to the challenge and statistics support this statement with very few incidents of harm to the patient."*
- *"It should also be possible to regulate what skills and drugs a person could perform and administer without the need for an ATP from a Medical Director."*
- *"As someone who is currently a registered paramedic I am in a good position to comment on this situation, please do not disregard my comments I have been through this entire process and have first-hand experience of its consequences to the workforce. Although NZ differs from the UK in many ways, the Paramedic workforce is very similar; many of the reasons given for implementing registration are exactly the same as I was listening to in the UK.*

  Several years ago everyone was talking about registration and the benefits it would bring us, parity with other health care professionals such as doctors, midwifes, physiotherapists in reality when we began paying a large amount of money to create a body that polices our practice. Few, if any of us realised what the future would bring. As for preventing anyone using the title Paramedic this actually was of little, or no consequence as unregistered or disbarred Paramedics simply found employment in private Ambulance services and medical event cover companies that proliferate the UK.

  Please don't think by implementing registration you will "cleanse' the profession, all you will achieve is a bigger carpet to sweep them under!. After registration life

at the sharp end changed and not for the better. In the UK the Ambulance service is free also many people have difficult access to a GP. Many jobs are those that a GP would, could or indeed should be dealing with. This in turn exposes the clinician to a far greater degree of risk; many people in the UK, on phoning 999 are bitter and angry with previous treatment or a lack of it, so let's push a clinician into this scenario that may not have had a break in 6 hours+.

Whilst many people in the UK will not make a complaint against a GP or surgery the majority will readily complain about the Ambulance service Paramedic - result, the service passes the complaint onto the HCPC who suspends the clinician and investigates this usually ends in a formal disciplinary hearing at which the paramedic can look forward to conditions of practice imposed, suspension of license or disbarment.

The net result of all this has not been good and has resulted in a culture of fear and defensive practice that neither forwards professional standards nor develops staff. I wonder if you can appreciate how this is to staff, particularly new staff with little clinical confidence, even existing staff become cowed, defensive and cynical in their practice "we just took her in, who cares if its right, if you don't it's your license". That is the type of magic you will impose on the practice, why do you think the UK Ambulance service is so short of paramedics?"

- *"The issue for me is limiting risk to the public whilst improving patient outcomes. Time to definitive care saves lives and that is why we have an ambulance service. Those who love the job have tended to get carried away with field paramedicine options with little stats supporting new medicines and interventions. If we keep our overall skill set to what we do the most and resist the temptation to ever expand our patient intervention options we will limit harm events and probably improve time to definitive care. Too many options produce too much on scene time to little or no improvement in overall patient outcomes whilst increasing the potential for harm events. There simply [isn't] enough [exposure to] patient interventions to justify or maintain skill sets and medication options that we now offer at ICP and to a lesser extent paramedic [level]."*
- *"The definition of a Paramedic is someone who holds a Bachelor of Health Science in Paramedicine degree, I do not agree with this definition. In 2009 I completed an intensive Paramedic program run by the Order of St John Ambulance training department to become a Paramedic. In 2011 I went through an intensive Intermediate Life Support Paramedic program run by the Order of St John Ambulance training department to become what is now known as a Paramedic. I have been working alongside degree qualified Paramedics for over 6 years and have not had a single clinical misadventure over this time. However in this proposal document I am no longer defined as a Paramedic because writers have now changed the goal post which has significant potential to affect my future employment and remuneration if I remain a front line operational ambulance officer."*

- *"It may make innovation and new procedures and guidelines more difficult to bring out. It may make the complaints process very difficult and demoralising process for paramedics to go through."*

6.14. MoH question fourteen:

Do you consider that the benefits to the public in regulating the paramedic workforce outweigh the negative impact of regulation? Please provide comment about your answer.

Overall 72% of survey respondents believe that the benefits to the public in regulating the paramedic workforce outweigh the negative impact of regulation. Submitted comments included:

- *"The question the public could rightfully ask is why do I have a registered plumber/electrician/teacher/Dr/nurse/podiatrist etc. and not a registered paramedic?"*
- *"Protects the Paramedic name. Applies to all paramedics regardless of the employer status."*
- *"As BLS make up around 75% of the workforce then a large percentage of the population would not receive care from registered paramedics and external providers with BLS only crews will still not be covered. The proposal leaves large holes of area uncovered and does not meet many of the issues required to be addressed by registration."*
- *"Yes for sure: as the qualifications & practice level of paramedics rise, the need for protection from pseudo-paramedics, and confidence for the public increases. As more opportunities for NZ paramedics to gain work & practice overseas also increase to be part of the on-going registered body of legislative paramedics is extremely important. We must look forward and act in what is not only nationally in the best interests of all New Zealanders, but be regarded as a leader in paramedic practice and governance."*
- *"Unsure, would like to be informed more regarding this. A forum would be suitable to help educate the multiple people whom are ILS and ALS and Degree qualified. Also how does this apply to EMTs whom hold a Paramedic degree?"*
- *"Yes - indeed registration should of occurred years ago. Paramedicine has come a long way over the last decade - Paramedics Australasia is a professional body that represents the Australasian ambulance workforce, albeit that NZ numbers are low."*
- *"I don't believe there are any benefits to the public at all."*
- *"if we were registered now my treatment would be exactly the same, indeed, if you want to implement a culture of defensive practice that will overload your EDs and ultimately create a paramedic shortage in NZ then implement registration."*

- *"I don't believe they do and I remain relatively neutral on this statement. I don't believe the public will be too concerned over a 'registered' vs 'non-registered' practitioner when they dial 111 in an emergency."*
- *"I fail to see how registration of the paramedic workforce will have significant impact on making paramedic clinical interventions safer. ICP"s, Paramedics and EMT's will still provide inappropriate treatments and have inappropriately long scene times, Paramedics, EMT's and First Responders will still wait on scene for backup or those and ICP's will continue to make inappropriate recommendations to leave patients at home I firmly believe that all staff that provide treatment to patients without a Doctor on scene should be regulated in some way."*
- *"Significantly outweigh. Especially with the movement towards integrated care across providers - future potentials for expanded scope, reduced admission, integration with medical centres and community care. Funding more redistributed - i.e. acc funding of point of care wound suturing by paramedics/ placement of medics in medical centres to avoid care bottle necks."*
- *"Only in as much as it captures those providing "paramedic services" that aren't in 1 of the 2 main ambulance services. St John and WFA have put robust effort in to CPGs and CCE and endeavour to monitor staff through audit process - which could be more robust. The public do have the right to know the people treating them are able to do so safely and to a set standard, but the potential for a more prescriptive provision of paramedic care, especially in more remote areas could lead to a lesser actual service for the community."*
- *"Not only to the public, there are benefits to holding the paramedic workforce to a higher standard too with defined consequences for not maintaining standards."*
- *"I feel this just adds an unnecessary level of bureaucracy and cost burden to Paramedics with no likely improvement in increasing public safety, just to gain a registered title and some ease moving to/from overseas. Individual ambulance service providers need to continue to self-regulate and manage their clinical risk (along with their brand)."*

END