Submission on regulating the paramedic workforce under the Health Practitioners Competence Assurance Act 2003

Submission To:	**Ambulance New Zealand** Via email info@healthworkforce.govt.nz
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1. Introduction

1.1 First Union welcomes the opportunity to make a submission on regulating the Health Practitioners Competence Assurance Act 2003.

1.2 DEFINITIONS AND ABBREVIATIONS

ICP (Intensive Care Paramedic)
EMT / BLS (Emergency Medical Technician/Basic Life Support)
EMA (Emergency Medical Assistant)
The Union (Ambulance Professionals First, First Union)

1.3 The submission is structured to first present to Ambulance New Zealand the relation between the union and the sector. General submission points are subsequently presented to emphasize the union's position relating to matters covered in the proposed regulation. Answers to the discussion questions follow.

1.4 For clarification on this submission please contact:

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2. Union Background

2.1 First Union represents approximately 27,000 members employed by hundreds of companies including around 850 members employed as Ambulance Professionals including; ICP Paramedics, Paramedics, EMTs/BLS, EMAs and Contact Centre Employees.

2.2 First Union is the largest union with the highest ambulance membership in New Zealand.

2.3 First Union has collective agreements with both in St John Ambulance, where we have two, one for operational employees and the other for management and a collective agreement with Wellington Free Ambulance.

3. General Submission Points

Ambulance Professionals First does not support the introduction of registration under the Health Practitioners Competence Assurance Act 2003, as outlined in the Consultation Document provided to us for comment.
If regulation were to go ahead then the substantial EMT/BLS workforce must be included as their roles fall under the guidelines for considering public interest in regulation applies equally to this category of ambulance professional.

4. Discussion Questions

4.1 QUESTION 1:

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?

Yes.

Furthermore the qualified ambulance workforce poses a risk of harm to the health and safety of the public, to the same level as the paramedic workforce.

4.2 QUESTION 2:

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.

No.

- Additional factors include single crewing which exposes the public to a reduced level of clinical care,
- Crew fatigue is a notable Health and Safety omission from Table 3. In light of inadequate resourcing this is an unavoidable significant risk,
- Pressure from external stakeholders (i.e. Aged Residential Care) is not included in the risk matrix in Table 3 of the submission document,
- There has been a progressive expansion of the clinical scope of practice at all levels and EMT/BLS have seen a progressive increase in significant and invasive skills over the last 10 years. We strongly believe the nature and severity of the risk of harm equally applies to the EMT/BLS qualified staff and thus, importantly, is not limited to the paramedic workforce.
- We note that St John is moving to a new Continuing Clinical Education (CCE) program – as presented to First Union by Dan Ohs June 2017 – which First Union strongly believes will provide adequate skill revalidation and oversight as it incorporates bodies of evidence and reflective practice logs consistent with those records otherwise required to be maintained by other registered medical persons.

4.3 QUESTION 3:

Do you consider there is a high frequency of harm being caused by the practice of the paramedic workforce? If so, please provide further information.

No.

The number of reported adverse incidents appears low however due to single crewing and other factors listed within the consultation document we believe less than ideal standards of care are being delivered at times which is not captured within current reporting mechanisms. The new CCE model that St John is moving to (as outlined in Question 2), significantly reduces the likely frequency of harm being caused by clinicians going forward – regardless of the presence of a regulatory or registration body.

4.4 QUESTION 4:

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

Yes.

Many of these incidents – including those featuring significant harm/death – are historic and St Johns internal reporting and incident management (i.e.: ATP credentialing committee) has significantly improved in the intervening time. A number of anecdotal reports reviewed by our union were in the setting of EMT/BLS crews which are not targeted by the defined Paramedic Workforce.

Additionally we note that harm is a spectrum – from minor to significant. We do not believe that the very minor harm on that spectrum adds to the case for registration when considering the cost to benefit ratio.

4.5 QUESTION 5:

If you are a non-government funded ambulance provider, does your workforce practice high-risk interventions? Please provide comment about your answer.

Not applicable.

Our members are exclusively employees of The Order of St John or Wellington Free Ambulance. Our membership anecdotally report a number of incidents of high risk procedures being carried out by third party providers. Our members have expressed concern regarding the clinical appropriateness of these procedures however we are not in a position to offer advice on these concerns.

4.6 QUESTION 6:

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

No, not as provided for in the consultation document:

- 77% of the overall clinical workforce is EMT/BLS (St John statistics) and we do not see equivalency with allied health professions. 77% of practicing Doctors are not unregistered in New Zealand, or 77% of practicing Nurses.
- That 77% of the clinical workforce (EMT/BLS) have a heavy weighting towards rural/remote placement, with a higher likelihood of being single crewed, in no less of a clinical risk than that presented by the paramedic workforce
- The 77% of the clinical workforce (EMT/BLS) are not entirely restricted in their scope of clinical interventions. It must be borne in mind that those staff may deploy high risk paramedic and intensive care paramedic interventions under delegated instruction, usually via remote telephone advice. When placed in context of the risk matrix provided in Table 3 of the submission document we consider these risks to be considerable, and thus EMT/BLS staff must be included in registration coverage, if it proceeds.
- EMT/BLS providers have the highest non-transportation rate of any of the qualification levels. Not transporting patients to a medical provider (i.e. Hospital) clearly represents a source of major clinical risk for the pre-hospital workforce.
- We believe that St John and Wellington Free Ambulance's internal procedures are robust and offer adequate protection for the public. Thus, we strongly believe, that registration does not pass the cost to benefit threshold when considering this question.

First Union notes that they strongly support internal regulation of the entire clinical workforce.

4.7 QUESTION 7:

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

No.

While the internal processes of the two main providers (St John and Wellington Free Ambulance) do address the risks of harm associated with specific skill neither has adequate processes to control all of the risks associated with pre-hospital care at any qualification level. We refer you back to our answer to question 2 in this regard as fatigue and single crewing are significant contributing Health and Safety factors which we do not believe have been adequately addressed at any time.

While both primary provider's internal processes do appear to adequately address the specific clinical risks as they are written, we do see benefit in a third party being involved to improve transparency and fairness.

4.8 QUESTION 8:

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.

Yes.

An independent third party with binding authority would address our concerns regarding providing transparency and fairness. If enacted would obviate the need for registration under the HPCA Act.

4.9 QUESTION 9:

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

Yes.

This would represent a more cost effective solution within the New Zealand context.

4.10 QUESTION 10:

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

Yes.

- We would propose a common adverse incident reporting system facilitated by NASO (National Ambulance Sector Office) as a regulatory body,
- We would propose clinical role definitions be protected by regulation (i.e. Paramedic, Intensive Care Paramedic) to provide clarity to the public as to whether a suitable person is who they claim to be.

4.11 QUESTION 11:

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

Yes.

However, all clinical levels should be covered either by regulation or registration if it proceeds. In the setting of registration costs to the individual volunteer officer, of which there are many, will probably be prohibitive and could result in a significant loss of the volunteer workforce.

4.12 QUESTION 12:

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? Refer to Appendix Four of the consultation document for the list of individual responsibilities.
No.
The workforce does not fully understand what their responsibilities would be under registration (HPCA Act).

(b) Is prepared to pay the estimated annual practising certificate fee (and other regulatory fees) set by the proposed Paramedic Council?
No.
The workforce is currently undervalued financially and having either the staff directly paying to maintain their registration, or having the cost incorporated as part of the remuneration package offset against an overall pay rise, equates to a financial penalty.

(c) Understands the purpose of obtaining professional indemnity insurance?
No.
This needs further clarification given the existence of the ACC Act within the New Zealand context.

4.13 QUESTION 13:

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?

- If registration proceeds for the Paramedic Workforce the situation of a registered clinician working with a non-registered person will be commonplace and this creates an additional stress factor for the registered person who will have clinical responsibility for 100% of their patients in a day instead of approximately 50% as they currently do if they are double crewed with another clinician.
- Public perception is that the majority of ambulances are crewed with Paramedics, and thus the perception going forward would be of having registered Paramedics attending them. The practical reality in New Zealand is quite different. 77% of the overall clinical workforce are qualified below Paramedic in New Zealand, and in a number of locations around the country, even in the setting of registration, both treating crew members will be unregistered under the proposed model.

4.14 QUESTION 14:

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.

No.

On balance we do not see registration as meeting the cost to benefit ratio required for us to support registration of the Paramedic Workforce, thus excluding 77% of the clinical workforce. Registration will as a natural consequence of training and crew disposition more heavily favour metropolitan areas. As a result rural areas, where lower qualification levels are more likely, might be seen to be being disproportionately negatively impacted by having significantly lower numbers of registered Paramedics providing care in their communities.

We do not agree with the list of benefits as outlined in the consultation document. The concept of registration has been debated for some time within the industry and one of the key drivers of that conversation among new and developing staff have been the academic bodies who have been training those staff. Those academic bodies are likely to derive financial benefit from registration and so there should be a disclosed bias/conflict of interest in this debate.

A regulatory body is needed, and that regulation within the industry is feasible – however that regulation needs to extend to all clinical levels; partly defined as anyone who can perform any form of invasive intervention and/or patient assessment where non-transportation can be recommended.

We submit that the new CCE model (as defined in our answer to Question 2) further moves forward the professional reflective practice of the major pre-hospital care provider in New Zealand and in doing so downshifts the benefit over cost of registration and regulation.