# PRIME Service Review 2016

**Steering Group Report to the National Ambulance Sector Office**

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<tr>
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<tr>
<td>Draft version 01</td>
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<td>PRIME Review 2016 Steering Group</td>
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<td>PRIME Review 2016 Steering Group</td>
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<td>PRIME Review 2016 Steering Group</td>
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**Final report**

May 2017
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**Introduction**

In early 2016, the National Ambulance Sector Office (NASO), on behalf of the Accident Compensation Corporation (ACC) and the Ministry of Health (the Ministry), asked for formal feedback on the PRIME (Primary Response in Medical Emergencies) service. The purpose of this feedback was to better understand the issues being raised on PRIME from the sector and to enlighten NASO on whether a formal review was required.

NASO received a considerable amount of feedback from a range of sources, including St John, PRIME providers, PRIME practitioners, primary health organisations (PHOs), rural service level alliance teams (rural SLATs), PRIME committees, emergency care coordination teams (ECCTs), National Rural Health Advisory Group (NRHAG) members, and members of the New Zealand Rural General Practice Network (NZRGPN).

Based on feedback received, in June 2016, NASO decided to proceed with a formal review of PRIME. A Steering Group was established to oversee the review and is made up of representatives from NASO, ACC, the Ministry, NZRGPN, St John, the Royal New Zealand College of General Practitioners (RNZCGP), and the College of Primary Health Care Nurses (CPHCN). The review was planned to be completed in the first half of 2017 and the scope of the review required recommendations to be considered within the existing funding envelope.

Five working groups were established in August 2016 to work through separate issues identified by the Steering Group, with recommendations submitted to the Steering Group on 31 October 2016. Across the five workstreams, the Steering Group received over 190 recommendations for consideration. The working group recommendations form the basis for the findings in this report.

This report provides the Steering Group’s recommendations after considering those from the working groups and feedback from two rounds of consultation.

The Steering Group acknowledges and appreciates the considerable contribution of members from the five working groups who, in addition to their normal commitments, provided a range of recommendations on specific issues. Without this contribution the review would not have been able to reach the conclusions described in this report.
Executive summary

The key findings of the Steering Group are described below.

Scope of the review

1) It is acknowledged that many strongly disagreed with the decision to conduct a review within a fixed funding envelope stating that the current arrangement is financially unsustainable. While the original position is unchanged (that an increase in funding is outside the scope of this review), a review of Ministry and ACC funding is strongly recommended.

Governance of PRIME

2) A strong need was identified to strengthen the oversight of PRIME at a national level by establishing a national PRIME committee, chaired by the NZRGPN. Its purpose is to:
   a) oversee the PRIME programme
   b) monitor and implement changes that result from this review
   c) be the conduit between regional PRIME committees and the PRIME administrator (St John)
   d) provide guidance and decisions on operational and clinical service improvements.

   The committee would serve as a national forum of PRIME providers (contract holders), PRIME practitioners, funders, the PRIME administrator, and special interest groups to discuss issues across aspects of the PRIME service. This would serve to inform ACC, the Ministry and the PRIME administrator of decisions around the PRIME service.

3) Clinical governance needs to be improved at all levels of PRIME, with the updated structure supporting this.

4) The structure should continue to have four regional PRIME committees, with improvements made to consistency and administrative and clinical functions to ensure they are effective and fit-for-purpose.

PRIME administrator

5) There continues to be a need for a PRIME administrator to undertake a range of functions for ensuring the success of PRIME.

6) There needs to be greater clarity and transparency of the broad roles and functions St John has as the PRIME administrator and how funding is used.

7) The PRIME administrator should:
   a) improve communication with PRIME providers and PRIME practitioners
   b) continue with six-monthly contract relationship meetings with PRIME providers and develop a guideline to ensure a nationally consistent approach
   c) ensure the view of PRIME practitioners is included in relationship meetings to address contract and practitioner service level issues at these meetings.

8) The Ministry should update the PRIME administrator contract with St John including the PRIME service specification in relation to the PRIME administrator function.

9) All contract documents should be updated to ensure:
   a) contracts are current
   b) contracts reflect changes from this review
   c) contract holders meet their health and safety obligations from recent legislation changes.

Greater integration of PRIME at the local level

10) Almost always the PRIME practitioner on call is also providing after-hours primary care services with a significant workload. Therefore an integrated service at the local level is important and there are areas where better integration would improve the relationship between St John and PRIME providers and practitioners, such as:
   a) improving the sharing of information from St John (eg. when there is no ambulance coverage in an area, which would impact on the local PRIME provider)
b) supporting closer working relationships between local primary care and ambulance services to enhance alignment and improve services for the community – for doing whatever is applicable locally for an effective and efficient service to meet individual community needs.

11) PRIME, while working alongside after-hours services in local areas, is a stand-alone service providing timely access to clinical skills that have the potential to improve outcomes for medical emergencies in rural areas. PRIME provider contracts set the criteria for initiating a PRIME response. However, there are opportunities for PRIME and after-hours services to work more effectively together and local communities need to work out what is the best arrangement locally.

*Monitoring the effectiveness of PRIME*

12) There should be a set of regular reporting measures for PRIME that expands on existing reporting and goes to a wider audience. However, more work is required to understand what is available, useful, and appropriate to share.

*Configuration of PRIME sites*

13) The number and location of PRIME sites is not reviewed in a timely and systematic way and there needs to be a more effective way of reviewing this on a regular basis.

14) The criteria for determining PRIME locations should be amended to as follows.

*Sites will usually be considered as a potential PRIME site if the site is more than 30 minutes by road from an ambulance station that has 24/7 staffing with a Paramedic.*

However, this is only a guideline and, when considering the allocation of PRIME sites, the national PRIME committee will also consider other factors, including: the area covered by the PRIME site, the other ambulance resources usually available in the area, the travel time from the nearest PRIME site, the travel time from the nearest hospital and the population within the area covered by the PRIME site.

15) An objective, timely and systematic process is required to determine appropriate PRIME site configuration (ie. for setting up or exiting sites), which will be refined by the national PRIME committee. To ensure a consistent approach is applied, rationale for these decisions will be recorded in the national PRIME committee meeting minutes and publicly available.

*PRIME response criteria*

16) Amend the PRIME response criteria to the following.

*To qualify as a PRIME response, the PRIME practitioner must have::*

a) been dispatched by an ambulance communications centre

b) responded to the incident, and

c) been located at the scene (amended from ‘seen the patient’).

17) Incidents in a medical centre are generally not considered a PRIME response, but the national PRIME committee will consider formalising exceptions to this rule if there is a good case to do so.

18) In instances where PRIME practitioners are on call to respond to PRIME while providing primary care services (including after-hours services), the main responsibility of PRIME practitioners is to their primary care service. PRIME practitioners are in the best position to decide if they can respond to a PRIME call given their primary care obligations.

*Responding to less urgent (ie. incidents coded not purple or red)*

19) Introduce the following criteria for using PRIME for incidents not coded as purple or red.

*In instances where the incident has been coded as less urgent than a red or purple incident, but the ambulance communications centre is of the view that a PRIME response may make a significant difference (eg, for severe pain), then they may contact the PRIME practitioner and ask if they are prepared to respond, but the PRIME practitioner is under no obligation to do so. The ambulance communications centre should consider how using PRIME for less urgent incidents affects overall coverage.*

20) The regional and national PRIME committees are to monitor PRIME responses to less urgent incidents in order to identify and manage (if required) any outliers or trends.
PRIME funding

21) Medical-related response funding currently has three funding bands, and this funding includes a fixed-cost payment of $8,000. A fairer system needs to be implemented to make the funding more equitable across PRIME sites (while remaining within the current funding envelope). The Steering Group agrees with the recommended approach of:
   a) moving to a 14 band funding system, with each band incrementally increasing by 10 responses
   b) increasing the fixed-cost component for providers with 24/7 coverage to $12,000 (a 50 percent increase), which allows for average funding of $219 per PRIME medical-related response (in addition to the fixed-cost component).

22) The current pro-rata system for sites with less than 24/7 coverage should continue. Funding is based on the hours covered and does not take into account when in the week responses occur. The national PRIME committee should review whether or not it is acceptable to have sites that do not have 24/7 coverage.

23) ACC will consider a simpler funding approach for injury-related responses to address the current confusion due to providers using a mixture of PRIME and ACC Rural General Practice (RGP) contracts or ACC Cost of Treatment Regulations (CoTR) to invoice for PRIME callouts. The simpler approach to consider is introducing a fair and reasonable hourly rate that would cover all injury-related costs, including: total attendance time (including time travelled), consultation, procedures used, and administration (e.g. restocking, clinical notes and debrief).

24) Funding for PRIME responses is expected to cover costs without the need for a co-payment from the patient. There should be no general medical subsidy (GMS) or maternity claims submitted for PRIME responses, given the PRIME payment is provided to cover the cost of the response.

25) In response to concerns that too much of PRIME funding goes towards administration, management and governance, it is accepted that transparency of funding needs to be improved, such as making it more explicit in contracts, how much funding goes towards the administrator function and how much goes to service provision, and ensuring this information is publicly available.

Responsibility for the scene and treatment

26) There are instances of confusion and difference of opinion about whether an ambulance staff member or PRIME practitioner has responsibility for scene management or providing care. To support effective communication in these instances, PRIME training is to cover crew resource management.

Standing orders

27) The national PRIME committee should develop a framework to support registered nurses obtaining standing orders. This does not mean that a national group will provide standing orders, but will implement systems to reduce some existing barriers.

28) Where registered nurses have difficulty obtaining standing orders to practise as PRIME practitioners, they should have the option of applying for authority to practise as a paramedic and having standing orders issued by the respective ambulance medical director for the paramedic delegated scope of practice. Longer term, the need for standing orders may be superseded by the registered nurse prescribing model.

Formal PRIME practitioner network

29) A formal representative group for PRIME practitioners (or specifically for PRIME nurses) is not supported as NZRGPN fulfils this role already for both doctors and nurses. However, there should be an informal network on St John’s secure PRIME website to support networking.

Critical incident support

30) To improve critical incident support, St John should make its support available for PRIME practitioners, which includes access to professional services such as an Employee Assistance Programme (EAP). St John may explore other ways to provide support, such as an operations manager making contact after incidents that may be considered traumatic.
31) In addition to the responsibilities of the PRIME administrator, there is:
   a) personal responsibility for PRIME practitioners to seek help when needed
   b) responsibility for PRIME practitioner colleagues to provide support or facilitate access to appropriate help
   c) responsibility on PRIME providers to support their practitioners.

Aligning to Paramedic practice level

32) PRIME will align with the ambulance sector’s Paramedic practice level. This alignment means that the minimum level for PRIME training will be to Paramedic level and the PRIME kits (including their equipment and medicines) will be the same as those issued at Paramedic level. As PRIME practitioners practice independently or under standing orders, this alignment does not and cannot limit a PRIME practitioner’s scope of practice.

33) Paramedics do not intubate and intubation should be limited to those who perform it regularly in their substantive (non-PRIME) role.

PRIME training and syllabus

34) There are mixed opinions on PRIME training. Some view it as very enjoyable and of a high quality and others disagree. Regardless, the PRIME training syllabus need to be updated, but the initial five-day course, the two-day refresher, the two year update requirement and the course pass/fail requirement will be retained.

35) PRIME courses should be updated so that it aligns with the Paramedic scope of practice, at a minimum (and may include training for medicines or procedures outside the Paramedic scope).

36) The Working Group agrees with the feedback that there should be timely access to PRIME courses and that they should be delivered in locations that consider where PRIME practitioners are. The national and regional PRIME committees should get regular reports from the PRIME administrator and monitor adequate access and location to PRIME courses.

37) The RNZCGP expressed interest in being responsible for setting standards and approving the general practitioner training content, in partnership with CPHCN for standards applying to nursing and nursing training content. The Steering Group recommends that the national PRIME committee considers whether there should be the development of standards and how those standards would be approved, assessed and maintained.

PRIME equipment, kit and medicines

38) PRIME kits and their contents, including medicines, should be the same as those used by ambulance services. In particular, the same as those carried at Paramedic practice level. Further work is required before this would be able to be implemented.

39) If it can afford to do so within available funding, the national PRIME committee may add a medicine or equipment above that at Paramedic level to the standard PRIME kit manifest.

40) As PRIME practitioners are practising independently or under standing orders, the PRIME provider or PRIME practitioner may add medicines or equipment to their kit, at their own discretion, that are not supplied as part of PRIME.

41) Automated external defibrillators (AEDs) are a critical piece of equipment for PRIME practitioners given they are responding to immediately life threatening incidents. Ideally, the AED would be the same as those used by ambulance and fire services to allow for interoperability and interchangeable consumables. However, at a cost of $3,000 each and with more than 70 PRIME providers, further work is needed to determine requirements, costs, timing and funding.

42) The recommendation that an EZ-IO (an intraosseous vascular access device) should be issued to PRIME practitioners is not currently supported as it is outside the Paramedic scope of practice, but should be considered in the future.

43) The recommendation that those performing intubation must have electronic capnometry has not been considered because this intervention is not considered part of PRIME (as it is outside the Paramedic practice level).
Safety equipment

44) The national PRIME committee is to review the standard safety items issued to PRIME practitioners.

45) It is agreed that any standard issue safety equipment should be the same as that used by ambulance services and clearly state ‘PRIME Responder’ so they can be clearly identified as emergency responders by the public and as PRIME practitioners by ambulance and allied services.

PRIME conference

46) There was a recommendation that an annual PRIME conference be held to provide an opportunity for PRIME to have a national forum where knowledge could be shared and networks developed. While an independent conference is not achievable, PRIME should be part of the annual national rural health conference hosted and organised by NZRGPN. NZRGPN will need to work through the specifics of this with the national PRIME committee.
Review overview

Purpose of PRIME

The purpose of PRIME is to provide timely access to clinical skills that have the potential to improve outcomes for emergencies in rural areas. PRIME aims to ensure high quality access to pre-hospital emergency care in areas where there is a shortage of suitably trained paramedics, or where ambulance service rural response times may be longer than usual.

PRIME is provided by specially trained medical practitioners, nurse practitioners and registered nurses (PRIME practitioners) who assist ambulance services. It is a 24-hour, seven-day a week service where PRIME providers are on an on-call roster.

PRIME was first established in 1998 in the South Island following a rural general practitioner’s advocacy to design a new integrated pre-hospital system. Roadside to Bedside (1999) provided a framework for a 24-hour clinically integrated acute management system, and its implementation plan required PRIME to be rolled out nationally.

PRIME is funded by the Ministry and ACC, and administered by St John.

PRIME Review 2016

PRIME has not been formally reviewed since it was implemented in 1999. In response to receiving a range of ad-hoc feedback on PRIME for an extended period of time, the National Ambulance Sector Office (NASO) asked for formal feedback in March 2016. The purpose of asking for feedback was to understand the issues more clearly and to inform whether a formal review was required.

Considerable feedback was condensed into a summary document in May 2016, which was then distributed to key stakeholders and presented to the National Rural Health Advisory Group (NRHAG). Following discussion on the issues raised, it was agreed that a review was required.

A Steering Group was formed with the following representation.

- Rachael Bayliss, Senior Advisor Primary Care, Ministry of Health.
- Jon Gaupset, Category Manager Primary Care, ACC.
- Dr Kristin Good, Senior Medical Advisor, ACC.
- Dalton Kelly, CEO, New Zealand Rural General Practice Network (NZRGPN).
- Dr Tim Malloy, President, Royal New Zealand College of General Practitioners (RNZCGP).
- Linda Reynolds, Deputy CEO, NZRGPN.
- Dr Tony Smith, Medical Director, St John.
- Kate Stark, Nurse Practitioner, PRIME Practitioner, Executive Member, College of Primary Health Care Nurses (CPhCN).
- Jared Stevenson, Portfolio Manager, NASO [Chair].
- Angelika Weinheimer, Category Advisor Primary Care, ACC.
- Fraser Wilkins, Category Manager Primary Care, ACC.

Review objectives

The key objectives of this review are as follows:

- Dynamic: PRIME will be developed so that it can evolve to ensure it is safe, effective and sustainable.
• Balanced centrally and locally: PRIME is structured so that it allows local autonomy, but has appropriate central control as required.
• Aligned to the themes in the New Zealand Health Strategy 2016: people-powered, closer to home, value and high performance, one team, and smart system.

Review key benefits

The review expects to realise the following key outcomes and benefits. PRIME:
• continues to be relevant and adds value to rural ambulance services
• practitioners feel well supported in their role
• continues to meet its objectives in a sustainable manner
• funding arrangements are well understood, with improved utilisation of available resources.
Project deliverables and approach

Project scope

**Within scope**

The review will provide recommendations on the following:

- PRIME funding arrangements: to ensure it is equitable and effective.
- An effective structure to administer PRIME: the role of the PRIME administrator; communication; PRIME committees; PRIME sites; the role of rural service level alliance teams (rural SLATs); and improved data collection and analysis.
- Clinical governance: roles and responsibilities; nurse standing orders; clinical audit; quality assurance; dispatch of PRIME; and scene management.
- Training and syllabus: ensuring content and delivery are fit-for-purpose and content is regularly reviewed and updated.
- Supplied kit and equipment: standard-issue equipment; principles for any changes and updates; clear understanding of how items can be changed and at whose expense; medicine requirements; and safety.

**Out of scope**

The review will not provide recommendations on the following:

- Increase in funding for the PRIME service: additional funding is outside the scope of this review and – in general – the collective recommendations must not increase the existing funding envelope. The exception to this is that the Steering Group Chair may agree to include additional recommendations for increased funding, provided that (a) exclusion would limit the robustness of the review, and (b) there is a strong case that it presents a good investment for government given its priorities at the time. However, there is no expectation that any recommendation for increased funding would be realised.
- Technology (electronic patient report forms, PRIME application for mobile devices).
- Workforce issues (outside of those specifically identified as being in scope).

High-level milestones and deliverables

Five workstreams were established to work through the identified issues:

1. Funding arrangements
2. Administration
3. Clinical governance
4. Training and syllabus
5. Equipment, kit, and medicines.

Each workstream had an appointed lead and a working group made up of representatives from: PRIME practitioners, PRIME committees, St John, emergency care coordination teams (ECCTs), and rural service level alliance teams (rural SLATs).

*Appendix 1: Membership of the five workstream working groups* identifies the working group members. Each of the five working groups developed recommendations based on key issues defined by the Steering Group, which are outlined in *Appendix 2: Review workstreams: key issues identified by the PRIME review Steering Group*. These recommendations were considered by the Steering Group in mid-November 2016, and form the basis for this PRIME Review Report.

Final approval for any recommended changes were to be provided by the Ministry and ACC. The review was expected to be completed in the first half of 2017.
Acronyms and terms

The following are some key acronyms and terms used in this report as a quick reference.

Table 1: Acronyms or abbreviations used in this report

<table>
<thead>
<tr>
<th>Acronym or abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>The Accident Compensation Corporation</td>
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<td>CAD</td>
<td>Computer aided dispatch system used by ambulance services</td>
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<td>CoTR</td>
<td>Cost of Treatment Regulations (ACC)</td>
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<td>CPGs</td>
<td>Clinical procedures and guidelines</td>
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<td>CPHCN</td>
<td>College of Primary Health Care Nurses</td>
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<td>ECCTs</td>
<td>Emergency care coordination teams</td>
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<td>NASO</td>
<td>National Ambulance Sector Office</td>
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<td>NRHAG</td>
<td>National Rural Health Advisory Group</td>
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<td>NZRC</td>
<td>New Zealand Resuscitation Council</td>
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<td>NZRGPN</td>
<td>New Zealand Rural General Practice Network</td>
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<td>RNZCGP</td>
<td>Royal New Zealand College of General Practitioners</td>
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<td>PRIME</td>
<td>Primary Response in Medical Emergencies service</td>
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<td>RGP</td>
<td>Rural general practice (ACC contract)</td>
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<td>SLATs</td>
<td>Service level alliance teams</td>
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<tr>
<td>The Ministry</td>
<td>The Ministry of Health</td>
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<td>ToR</td>
<td>Terms of reference</td>
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Table 2: Terms used in this report

<table>
<thead>
<tr>
<th>Term</th>
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<tr>
<td>PRIME administrator</td>
<td>The administrator of PRIME who holds the contract with the Ministry and performs a range of tasks, including holding agreements with PRIME providers.</td>
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<td>PRIME practitioners</td>
<td>Doctors, nurse practitioners and registered nurses that deliver PRIME services on behalf of a PRIME provider.</td>
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<tr>
<td>PRIME providers</td>
<td>Service providers with contract agreements with St John and ACC to provide PRIME. Typically medical centres, but includes agreements with other providers, such as district health boards.</td>
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<tr>
<td>PRIME sites</td>
<td>Sites are where PRIME is delivered from. In most regions a site is located with the provider’s site, but in some instances a single provider may have multiple sites.</td>
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Key findings

This section outlines the review findings determined by the PRIME Review 2016 Steering Group, which have been based on the recommendations from the five workstreams and subsequent stakeholder consultation.

General

Fixed funding envelope

The Steering Group acknowledges that: many strongly disagreed with the decision to conduct a review within a fixed funding envelope; many PRIME providers are finding the current arrangement financially unsustainable; and many are of the view the 50 percent increase in Ministry contribution to fixed costs still does not adequately cover real costs.

While the original position that an increase in funding is outside the scope of this review is unchanged, version two of this documents has much firmer and clearer recommendation to the funders on conducting a review of PRIME funding (see section: Key findings: 7. PRIME service funding: Review of PRIME funding).

The NZ Fire Service and NZ Police

Following feedback during the consultation phase, more explicit consultation with the NZ Fire Service and NZ Police has been made. Both organisations were invited to provide feedback on the second round (March 2017) of consultation.

Paramedics as PRIME practitioners

The Steering Group supports the principal of paramedics being employed by PRIME providers to work as PRIME practitioners. In the absence of paramedic registration, the employer (who, in this case, is the PRIME provider) would need to ensure the paramedic has a standing order to supply or administer prescription medicines to meet the requirements of the Medicines (Standing Order) Regulations 2002. Further work on this should be conducted by the national PRIME committee.

1. Governance of PRIME

There is a need to strengthen the oversight of PRIME at the national level. There is also a need to ensure the national PRIME structure can effectively address key issues as they arise, and is aimed at strengthening:

- national oversight of operational issues, including the delivery of a nationally consistent service
- the information received by regional PRIME committees to make decisions required of them – especially on how sites are performing
- the role of regional PRIME committees regarding making recommendations to the PRIME administrator, St John, for action
- clinical representation on regional PRIME committees to ensure strong clinical input into decisions
- the representation on regional PRIME committees
- the linkage between regional PRIME committees and rural SLATs – currently rural SLATs may not have the linkages required into these groups to know what is going on with PRIME in their regions.

There are concerns that issues raised about aspects of the PRIME service over a number of years are only now being addressed as part of the review. An outcome of the review needs to be to ensure the PRIME service is governed in an effective way going forward, addressing any key issues as they arise.

The following describes an improved governance framework for PRIME.
National PRIME committee

To provide effective oversight of PRIME, a new integrated national-level group, the national PRIME committee, should be established to have administrative (corporate) and clinical functions. In effect, this is re-launching the former National PRIME Coordinating Committee that has not operated in recent years, but provided national oversight.

The national PRIME committee would have broad representation and be chaired by a representative from NZRGPN. Terms of reference (ToR) for this committee will be developed in collaboration with NASO, the Ministry, ACC and St John. Any costs associated with the national PRIME committee should be met within current administration funding.

The purpose of the national PRIME committee is to:

a) oversee the PRIME programme
b) monitor and implement changes that result from this review
c) be the conduit between regional PRIME committees and the PRIME administrator
d) provide guidance and decisions on operational and clinical service improvements.

It would serve as a national forum of PRIME providers, PRIME practitioners, funders, the PRIME administrator, and special interest groups to discuss issues across aspects of the PRIME service. This would serve to inform ACC, the Ministry and the PRIME administrator of decisions around the PRIME service.

The national PRIME committee membership would include:

- NZRGPN representative who will also be the national PRIME committee Chair
- NASO representatives (on behalf of PRIME funders, the Ministry and ACC)
- PRIME administrator (St John) representative
- Royal New Zealand College of General Practitioners representative
- New Zealand College of Primary Health Care Nurses representative
- emergency road ambulance service medical director representative
- emergency road ambulance service provider (St John, Wellington Free Ambulance) representative
- all regional PRIME committee chairs
- PRIME provider (practices that are PRIME contract holders) representative
- PRIME practitioner (medical practitioners) representative
- PRIME practitioner (nurse practitioners and registered nurses) representative
- rural SLAT representatives
- Fire and Emergency New Zealand (FENZ) representative.

To ensure ongoing external visibility of PRIME in rural health, the national PRIME committee would provide regular reports to the National Rural Health Advisory Group (NRHAG). Appendix 3: PRIME national structure outlines the proposed PRIME national structure. The national PRIME committee would be supported by NASO and the PRIME administrator.

Clinical governance

Best Practice Advocacy Centre’s (BPAC’s) definition of clinical governance will be used for PRIME:

“Clinical Governance is a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

There is a strong view that clinical and administrative (corporate) governance cannot be separated. They are interdependent and must come together in an overall integrated governance structure despite needing to perform separate functions at times. Clinical governance needs to be implemented throughout all levels in the PRIME system, and the governance structure needs to support and strengthen this.
It is recognised that some elements of clinical governance are provided to PRIME practitioners by other existing bodies (eg. professional bodies and regulatory authorities) but they are not specific for PRIME activities. It would be a key role of the national PRIME committee to draw all these elements together and develop a congruent governance framework that is safe for PRIME practitioners and fit-for-purpose for PRIME. The Steering Group agrees with the feedback that this activity must not duplicate the activity of other bodies.

In terms of the clinical function of the national PRIME committee, it would be expected to set guidelines, develop audit and clinical review processes, and have oversight of the clinical governance functions of the regional PRIME committees, which need to be improved and strengthened. The clinical governance component of the national PRIME committee would:

- align PRIME curriculum, as far as reasonable, with the ambulance sector's clinical procedures and guidelines (CPGs)
- ensure guidelines and curriculum are evidence-based, up-to-date and are circulated to key stakeholders whenever changes/updates occur
- put in place mechanisms to manage any concerns over clinical performance or decision-making which can be rapidly registered and reviewed by the relevant regional PRIME committee
- address systemic or recurring issues of national relevance
- bring together the St John incident review system/clinical audit and the PRIME case review process, where appropriate.

While the establishment of a permanent national PRIME clinical committee (a sub-group of the national PRIME committee) was considered, the Steering Group finds that clinical governance should be included as a function of the national PRIME committee. The Chair will have the option of forming temporary working groups, if required, to address specific issues or projects identified. The Chair would also determine appropriate working group membership depending on the specific issue being addressed.

**Continuity of care from the scene**

It was raised that there are instances where the responding ambulance cannot continue to administer medicines started by the PRIME practitioner. However, ambulance CPGs provide clear guidance and direction for continuity of care in these situations.

**Regional PRIME committees**

There is support for the continuation of regional PRIME committees, although there was recognition that not all of them are working as well as they should be. There are four regional PRIME committees (Northern, Central, South Island – North, South Island – South) and there is no proposal to change the number or their boundaries.

Regional PRIME committees need to have a clearer understanding of both their administrative and clinical governance functions, and clear guidelines and processes around how they provide an appropriate forum and methodology for case reviews (a substantial part of their improvement activity).

A key remit of the national PRIME committee should be to ensure regional PRIME committees have: inclusiveness; a culture of safety and support and appropriate case selection; and mechanisms for addressing concerns around performance and that communication to PRIME practitioners is strengthened.

The regional PRIME committees’ current ToR states its purpose is to: review and evaluate the functioning of the regional PRIME system; recommend possible improvements to systems or processes; provide peer support to practitioners; and communicate relevant information and/or recommendations to stakeholders. This should continue.

Regional PRIME committees are a key component of the PRIME governance structure. However, they require improvement to ensure meetings: have a formal structure; are well run with continuity of issues; maintain retention of historical knowledge; maintain traction with solving issues and progressing initiatives; and abide by the agreed ToR.
The regional PRIME committees’ ToR should be updated to reflect changes that result from this review (see Appendix 4: PRIME committee terms of reference for current ToR).

Key issues identified as part of this review for improved regional PRIME committees include:

- addressing isolation of the front-line from PRIME committees, including: improved communication between PRIME committees and PRIME practitioners – communicating directly with PRIME practitioners (rather than through PRIME providers)
- ensuring the PRIME administrator, St John, improves the PRIME provider and practitioner email distribution lists for each region and that the database for PRIME practitioners is current and accessible
- improving the St John secure PRIME website for PRIME committee information to enable PRIME providers and practitioners to access information on their regional PRIME committee
- ensuring PRIME practitioners are kept well informed about the role of PRIME committees, the St John secure PRIME website is easily accessible to all PRIME practitioners and that committee members are accessible
- holding meetings at times that suit PRIME practitioners (generally meeting times during standard working hours do not work for general practice clinicians)
- strengthening links with rural service level alliance teams (rural SLATs).

The recommendation for regional PRIME committees to offer mentoring to sites that may require assistance is supported (eg. for new PRIME sites and newly-trained PRIME practitioners). This mentoring service should link with rural SLATs given the support they provide to PRIME providers in their regions. There will also be a requirement for each PRIME provider to mentor/provide peer support for their PRIME practitioners as a clause in PRIME provider contracts.

It is recognised that there will be a need to ‘relaunch’ regional PRIME committees once these changes are made to improve engagement, understanding, and support from the sector.

The Steering Group supports the proposal to provide remuneration for members to attend national and regional PRIME committee meetings, where an individual is not being paid by their employer or organisation they represent. This total cost is estimated at $20,000 per annum and would be covered by the PRIME administrator, St John. Note: this funding is only provided for duties over and above standard requirements of all PRIME practitioners, such as attendance at clinical reviews (which are a component of service provision).

Requirements for PRIME committees to review 20 cases (clinical audits) each year

There is a requirement for PRIME committees to review at least 20 cases (clinical audits) each year as part of continuous quality improvement through case review.

The term ‘clinical audit’ is used to describe a process of assessing clinical practice against standards. Currently, clinical audits are conducted by regional PRIME committees, as a requirement in the ToR – each regional PRIME committee will review at least 20 cases per annum considering a range of factors.

The review identified significant concerns about the audit process. There were concerns about the ad-hoc structure, methodology, and representation from treating clinicians. Many doctors do not participate in an audit as they do not want to be criticised by nurses or paramedics. Concerns were also raised that the activity was not a protected quality assurance activity under the Health Practitioners Competency Assurance Act 2003.

Discussion within the clinical governance working group highlighted concerns about the safety of the activity, that there were no clear guidelines around how the process was being implemented, how the audit was conducted, what standards were being used to determine audit outcome, who had access to the information and where it was going, and that the practitioner whose work was being audited was not part of the process.
It was felt that audit activity does have the potential to improve quality but that it needed to be within a culture that is supportive and safe. Doctors have a requirement for an annual audit activity as part of their continuing professional development requirements and it is also a requirement for nurses working at an advanced level, such as a PRIME practitioner. An opportunity exists for development of audit activities that serve the dual process of improving clinical practice in PRIME service delivery and complying with RNZCGP mandatory ongoing professional standards (MOPS) and Nursing Council of New Zealand requirements.

A handy resource on clinical audits can be found at:

Making case review effective requires:

- a better mechanism for collecting cases for review that anyone involved can action easily (one easy point of contact in each region – as occurs for user groups for the communications centres)
- a requirement for all practitioners to attend (usually by teleconference) at least two case review sessions per year as part of an “audience of peers”
- a participant-friendly format, technology and set of ground rules with strong and supportive chairmanship
- support and mentoring if those involved in cases feel vulnerable
- protection and confidentiality
- emphasis on learning and support
- opportunities for cross-sector collaboration.

The Steering Group proposes that the requirements in the PRIME contract for regional PRIME committees to undertake 20 case reviews per year be replaced with a requirement that:

“Regional PRIME committees conduct regular case reviews in an appropriately constituted peer review setting with an adequate quorum, clear guidelines and ground rules, minimum attendance criteria for all PRIME practitioners, protection as a Protected Quality Assurance Activity and clear quality improvement goals and support for participants. The criteria for the measures described will be determined and reviewed from time to time by the national PRIME committee.”

Further work by the national PRIME committee is needed to refine, trial and assess the outcome of new guidelines and their implementation by regional PRIME committees.

2. PRIME administration

Current contracting arrangement for PRIME

St John administers PRIME on behalf of NASO, via an agreement with the Ministry that is being extended to end 1 July 2017. During this contracted period the Ministry has not sought to test the market for other potential providers for the following reasons.

- The goods or services require specialised skills or are very complex and there is a limited number of qualified providers.
- Standardisation or compatibility with existing equipment or services is necessary, and can be achieved through only one provider.

The Ministry’s internal assessment indicated that a change of provider would cause significant inconvenience or be impractical in the circumstances, and the cost of seeking quotes or tenders would be out of proportion to the value of the benefits likely to be obtained.

NASO has indicated it will adhere to the Ministry’s Procurement Policy for assessing and choosing an appropriate procurement process in the lead up to the end of the current contract term. This is not considered to be included in the scope of the PRIME service review.
St John administrator function

There is a need for an administrator role to undertake all the functions for ensuring the success of PRIME. What is apparent as part of this review is that currently there is not a clear understanding in the sector of the broad-range role and functions St John has as the PRIME administrator.

There is a need to make the administrator functions clearer to PRIME providers and practitioners. There needs to be a better mechanism for communicating with PRIME stakeholders, as currently there are identified issues with communication between St John and PRIME providers and practitioners to keep them informed of PRIME. Information is especially lacking for PRIME practitioners. St John needs to communicate with both PRIME providers and practitioners, and it is felt that currently the interface between St John and PRIME practitioners is not effective, especially at the regional level.

The St John website has a secure access site for PRIME information through a common user name and password provided to each PRIME site. This website should be used for sharing information, and should be promoted to the sector as a go-to resource for PRIME information.

St John holds a database of all PRIME providers and practitioners. It also logs any training undertaken by PRIME practitioners. While the database contains information known to St John via contracts with PRIME providers and attendance at PRIME training, there needs to be a mechanism for PRIME providers to update information for their sites (ie. current PRIME practitioner details).

St John’s administrator functions are outlined below.

- Administration and management of PRIME, including:
  - contracting with PRIME providers and contract monitoring (around 75 individual PRIME contracts)
  - managing payments to PRIME providers
  - undertaking reviews based on work volumes to check if PRIME providers are on the right contract (correct funding level)
  - administering St John’s secure PRIME website where information on kits, PRIME committee minutes etc are available for PRIME providers and practitioners
  - maintaining a database for all PRIME practitioners.

- PRIME training – training is undertaken by the same clinical team that trains St John staff. Changes were made two years ago to address issues from the sector to improve training. As well as funding provided by the Ministry, training is also funded by ACC.

- Providing kits, equipment, and supplies.

- Secretariat function for the regional PRIME committees.

The key areas where transparency should be improved are:

- enhanced communication with PRIME providers, PRIME practitioners and the wider sector

- greater use of the St John website – there is a PRIME secure access site for PRIME providers, with one user name and password for each PRIME provider (PRIME site) – all PRIME practitioners at the site share a common login

- reporting on PRIME – St John currently report quarterly to NASO, and these reports (or a variation of them) should be accessible on the St John PRIME secure access website

- regular updates on PRIME to share with the sector (suggest quarterly) – these would be put on the St John PRIME secure website and distributed via a St John email sent out to PRIME providers and practitioners, and through NZRGPN channels, with links to the information included on the Ministry (NASO) and ACC websites

- St John to set up a dedicated PRIME email address to enable providers and practitioners to contact the PRIME administrator with any queries/concerns (eg. prime@stjohn.org.nz).

The contract between the Ministry and the PRIME administrator will be improved, including the service specification in relation to the PRIME administrator function through:

- updating the service specification to ensure St John’s role in communicating with the sector is enhanced, aimed at improving transparency of the administrator function
• including contract clauses to ensure transparency of PRIME funding; eg. clearly outlining the split in funding between administration and what goes to PRIME providers for service delivery – the current split is around 33 percent for the administration function and 67 percent for service delivery
• including a contract clause that ensures PRIME funding within these two distinct areas be ‘ring-fenced’ to ensure that funding provided for PRIME service delivery goes to service delivery
• including a contract clause that ensures unspent PRIME funding at year-end does not go into St John year-end baseline, rather it can be carried forward for investment in the PRIME service in the next financial year.

The Steering Group finds that the current requirement for St John, as the PRIME administrator, to have six monthly relationship meetings with PRIME providers should continue. However, a national standard is required for contract/relationship meetings between the PRIME administrator and PRIME providers to ensure nationally consistent contract management across all providers.

PRIME practitioners (who are not contract holders) have requested that an additional requirement is included to ensure PRIME providers (practices that are contract holders) gather information from their PRIME practitioners to inform discussion, and enable contract and practitioner service level issues to be addressed at these meetings. The Steering Group supports this proposal.

Updating the current PRIME contract documents

A general update of all contract documents is required to ensure: (a) contracts are current, (b) contracts reflect changes from this review; and (c) contract holders meet their health and safety obligations from recent changes to legislation.

Current contract documents include: the contract between the Ministry and the PRIME administrator (St John); ACC’s PRIME Contract Operation Guideline; ACC’s PRIME vendor service schedule; and St John’s contracts with PRIME providers.

3. Greater integration with PRIME at the local level

Integration between emergency services and PRIME providers

An integrated service at the local level is important and there are other areas where better integration would improve the relationship between St John and PRIME providers and practitioners. One aspect is to improve the sharing of information from St John when it is aware that there is no ambulance coverage in an area, which would impact on the local PRIME provider(s). In some areas information is shared (ie. proactively providing the St John roster to the PRIME provider so they can be aware of times when there is no coverage). However, this information is not being shared consistently around the regions. This information needs to be shared:

• proactively ahead of time as information becomes available (noting that rosters can change)
• when a call comes through and the local ambulance is not available (eg. ambulance on another call or stood down).

The Steering Group notes there are other requirements that impact on ambulance coverage at the local level, such as New Zealand Transport Authority requirements for ‘passenger service vehicles’. Work-time for volunteers not only includes work-time covering the volunteer shift, but also work-time in other employment. These requirements create workforce limitations. ‘First response vehicles’ are not ‘passenger service vehicles’, however St John still has protocols around fatigue management.

There are opportunities to develop closer working relationships between primary care and ambulance services to enhance alignment and improve services for the local community, such as in areas with poor ambulance coverage using the ambulance as a local resource for PRIME initiated responses, rather than first responses. There should be opportunities for the provision of specialised local arrangements with the ability to develop local arrangements – for doing whatever is applicable locally for an effective and efficient service. Rural SLATs would play a key role in facilitating this integration. There is also a role for regional PRIME committees to promote this integrated approach at the regional and local level.
Greater alignment with after-hours models of care

Several rural and remote locations have a combined after-hours and PRIME service – both services rely on each other, including the pooling of funding, to provide an efficient and effective service. The Steering Group acknowledges that flexibility is required to ensure that this can work as required to suit local needs, but note PRIME funding is allocated in the same way for all PRIME providers (ie, based on hours of coverage and number of responses for medical emergencies, and fee-for-service related to injury-related responses).

PRIME, while working alongside after-hours services in local areas, is a stand-alone service providing timely access to clinical skills that have the potential to improve outcomes for medical emergencies in rural areas. The current PRIME contracts between the PRIME administrator or ACC and PRIME providers set the criteria for initiating a PRIME response. However, there are opportunities for PRIME and after-hours to work more effectively and it is up to local communities to work out what is the best arrangement locally to ensure alignment between the two services. Rural SLATS will have a role in this.

4. Developing measures for monitoring the effectiveness of the PRIME service

There should be a set of regular reporting measures for PRIME that expands on existing reporting and goes to a wider audience. For example, regional PRIME committees may want to know the activity of their PRIME sites, government may want to evidence outcomes and therefore value to the health system, and the national PRIME committee may want to monitor reportable events.

To develop this, more work is required to understand what is available, useful, and appropriate to share. NASO will work with St John and the national PRIME committee to agree on what data will be reported and to what stakeholders.

The national PRIME committee would ensure that reporting measures continue to be fit-for-purpose as available data or an audience’s needs change.

The Steering Group agrees with the comments that there should be measures of outcomes, and this will be considered by the national PRIME committee as it begins to understand what data can practicably be reported. As part of this, the national PRIME committee would engage with others in health that are that are measuring rural health outcomes, to see what opportunities there are to work collaboratively.

5. Ensuring the configuration of PRIME sites is fit-for-purpose

Composition of PRIME sites

Currently there are around 75 PRIME sites. The number and locations of PRIME sites is not reviewed in a timely and systematic way, and there needs to be a more effective way of undertaking this on a regular basis.

Criteria for determining PRIME locations

The criteria used to determine locations for PRIME sites needs to be kept simple. Access to emergency air (helicopter) ambulance services should not be considered as criteria given there are other dependencies with this service, such as adverse weather conditions, especially in remote locations.

The current criteria for a PRIME site location is:

- at least 30 minutes standard driving time from a secondary hospital providing level 3 or higher emergency department services as described in the Ministry of Health service specifications for emergency departments
- within an area where an advanced life support paramedic (now referred to as ‘Intensive Care Paramedic’) ambulance coverage is not available within 30 minutes.
Some flexibility is accorded in the above criteria and other factors may be considered, such as geography, population, seasonal climate, population changes, on-call practitioner rosters, and availability of ambulance resources.

The limitations of the current criteria are that: (a) today’s Paramedic is comparable to that of advanced life support when PRIME was initiated 17 years ago; (b) it does not consider whether the closest ambulance is crewed 24/7; and (c) the flexibility afforded when deciding the location of a PRIME site is not obvious enough.

The Steering Group proposes amendments to the current criteria so that it reads as follows:

Sites will usually be considered as a potential PRIME site if the site is more than 30 minutes by road from an ambulance station that has 24/7 staffing with a Paramedic.

However, this is only a guideline and, when considering the allocation of PRIME sites, the national PRIME committee will also consider other factors, including: the area covered by the PRIME site, the other ambulance resources usually available in the area, the travel time from the nearest PRIME site, the travel time from the nearest hospital and the population within the area covered by the PRIME site.

Process for reviewing sites

An objective, timely, and systematic process is required to determine appropriate PRIME site configuration (i.e. to determine the need for establishing or disestablishing sites). This process will be refined by the national PRIME committee, but will consider the following:

- regional PRIME committees are expected to make recommendations to the national PRIME committee about changes to PRIME sites, but the final decision is that of the national PRIME committee
- the national PRIME committee must give thought to the impact on the PRIME administrator (St John) when considering changes, such as available funding
- St John will undertake analysis (modelling based on the above criteria) each year to inform the national PRIME committee and regional PRIME committees about possible changes to PRIME site configuration
- St John, as PRIME administrator with contracts with PRIME providers, will work with locations to establish new sites, disestablish existing sites, or make changes to existing sites (as agreed by the national PRIME committee)
- reviews of PRIME site configuration to be undertaken at least annually by regional PRIME committees and the national PRIME committee
- there should be opportunities to make changes to PRIME site configuration throughout the year, as required – this will include PRIME sites requesting less than 24/7 coverage (noting that a PRIME site’s reduced coverage may be unplanned and the national PRIME committee needs a process to manage those situations)
- guidelines to be developed around what triggers a concern with a PRIME site, including when less than 24/7 PRIME site coverage is acceptable
- in order to apply a consistent approach, any decision by the national PRIME committee to make changes will be recorded in the meeting’s minutes (that will be publicly available) with the rationale for that change.

The New Zealand Fire Service

While the location of fire services is not a criterion in determining the location of a PRIME site, it is important to be aware that the New Zealand Fire Service (NZFS) also responds to medical emergencies in support of emergency ambulance services.

The NZFS has all of its frontline staff trained in first aid so all fire appliances can co-respond to ‘purple’ (immediately life threatening) incidents (i.e. to all cardiac or respiratory arrests). And there are 56 stations where the NZFS provides First Responder capability; these are predominately volunteer and more rural stations that, if closer than an ambulance, respond to a broader range of incidents than other NZFS stations. In total, the NZFS responds to nearly 10,000 incidents each year.
Work is underway to establish Fire and Emergency New Zealand (FENZ) on 1 July 2017, which amalgamates urban, rural and volunteer fire services, including the NZFS and the National Rural Fire Authority. This will see greater alignment of the role that fire services have in responding to medical and other emergencies in rural communities.

6. PRIME responses

Clarification on a PRIME response

A PRIME call is one that has: (a) been received by an ambulance communications centre, either by ‘111’ or ‘non-urgent’ telephone line; (b) been coded as a ‘purple’ (immediately life threatening) or ‘red’ (potentially life threatening or time critical) incident; and (b) a PRIME practitioner dispatched to the incident.

A PRIME practitioner can make the phone call that initiates a PRIME call. However, a call not activated from an ambulance communications centre is not considered to be PRIME.

Currently, to qualify as a PRIME response, the PRIME practitioner must have:

- been dispatched
- responded to the incident, and
- seen the patient.

There is no intent to move away from dispatching PRIME to incidents prioritised as immediately or potentially life threatening (see colour coded dispatch system below).

The Steering Group proposed replacing the criterion ‘seen the patient’ with ‘been located at the scene’. The first draft of this review did not explain the rationale for this change, which was to cater for instances where the PRIME practitioner located to a scene in good faith, but, for whatever reason, a patient could not be seen. To make it clear this would still count as a PRIME response, the Steering Group recommended this change.

There was a lot of concern about this change, viewing it as an attempt to narrow the number of instances that count as a PRIME response (as opposed to the actual intention of broadening it).

The feedback highlighted the following points.

- There is a view that a PRIME response should count those that are in a medical centre (eg, when an ambulance crew bring in the patient): in general, the Steering Group does not consider incidents in a medical centre a PRIME response, but will consider formalising exceptions to this rule if there is a good case to do so.
- There is a view that being told to ‘stand-down’ once responding from the ambulance communications centre should count as a PRIME response: the Steering Group’s position described in in the Key findings: 6. PRIME responses: Counting stand-downs as PRIME responses section that stand downs are covered by the contribution to fixed cost is unchanged.
- There is concern that meeting the ambulance crew in the community (as opposed to going to the original scene) does not count as a ‘been located at the scene’: in these instances, with the exception of a medical centre (see above), the Steering Group considers the ‘scene’ to be wherever the patient is (not the origin of the incident) and therefore are still considered PRIME responses.

See Key findings: 10. Practices charging in addition to receiving a PRIME fee for discussion on co-payments in medical centres.

Responding to less urgent incidents

Practitioners believe there are a significant proportion of callouts to be outside of red and purple incidents – especially in areas where there is no ambulance coverage (eg. the West Coast region). If this is acceptable current practice, then the wording describing what constitutes a PRIME callout will need to be amended. It is not anticipated that this will have implications for counting PRIME volumes in sites given these calls are already included in medical-related PRIME counts.
Accepting this may constitute ‘scope creep’ for the PRIME service, with concerns that if PRIME was to be used for ambulance responses at a lower level, then it might be that this masks problems in other areas of the rural after-hours service (ie, creating work-arounds for other possible services).

The PRIME practitioners on the funding arrangements working group felt that this ‘scope creep’ is acceptable in this instance given they are ‘there for the patient’ and it is a duty of care issue. PRIME is there to make a difference to the population and provide better outcomes for patients – putting patients at the centre. However, this needs to be carefully monitored to ensure that it is the exception rather than the rule.

In response to feedback received during consultation, the Steering Group proposes more explicit criteria for using PRIME for incidents not coded as purple or red.

*In instances where the incident has been coded as less urgent than a red or purple incident, but the ambulance communications centre is of the view that a PRIME response may make a significant difference (eg, for severe pain), then they may contact the PRIME practitioner and ask if they are prepared to respond, but the PRIME practitioner is under no obligation to do so. The ambulance communications centre should consider how using PRIME for less urgent incidents affects overall coverage.*

The regional and national PRIME committees are to monitor PRIME responses to less urgent incidents in order to identify and manage (if required) any outliers or trends.

**Colour coded dispatch system**

Concern was raised about the quality and accuracy of the colour coded dispatch system used by emergency ambulance services. Ambulance services base an incident’s priority on the internationally-used Medical Priority Dispatch System (MPDS) that uses a software system called ProQA. It is designed to reduce the risk that those with most urgent needs will not be missed but, as a result, sometimes will allocate a higher priority than is necessary. The Steering Group does not support a move away from this robust system.

**Counting stand-downs as PRIME responses**

A 'stand-down' occurs when a PRIME practitioner is dispatched and then told they are not required before reaching the incident. Counting stand-downs as PRIME responses so providers can be more accurately remunerated is not supported. Instead, for the following reasons, the fixed-cost component paid to PRIME providers is considered a contribution to stand-downs: (a) St John is unable to distinguish between not arriving at the destination and not responding; (b) stand-downs make up a small proportion of PRIME responses; and (c) the administrative cost of accurately monitoring this would be higher.

**Emergency air ambulance service responses**

Emergency air ambulance service (EAAS) responses are not part of the PRIME service, however they do become part of a response when a PRIME practitioner requires and receives assistance. They are distinct services with separate funding streams even if the same personnel are involved across both services (ie. you can be both a PRIME practitioner and EAAS clinical crew). EAAS callouts are not counted as a PRIME response.

**Real time notification of PRIME attendance**

There are many instances where the ambulance communications centre is notified of a PRIME practitioner attendance after the event (as opposed to notification at the time). However, real time notification (or as close as possible) of PRIME practitioner attendance is mandatory for: the safety of PRIME practitioners; the safety of patients; the accuracy of PRIME responses (and therefore PRIME provider remuneration); and accuracy of ambulance records and data collection (eg, coroners often request ambulance records during an investigation). It is acknowledged that there are some barriers to accuracy and timeliness of records, which are discussed immediately below.
Improving the accuracy and timeliness of PRIME response information

St John volumes come from the road ambulance service computer aided dispatch (CAD) system – each PRIME provider has a call sign in CAD, and this is flagged in CAD when they are called and when they attend at the location.

There are a number of factors that negatively affect the accuracy and timeliness of ambulance communications centre records of PRIME notifications and attendances. For example: difficult radio or mobile phone communication in some areas; lack of processes to support real time notification; and lack of awareness about individual responsibilities.

The national PRIME committee and St John must improve accuracy and timeliness of PRIME information, and need to consider:

- investigating the merits of a smartphone app to allow PRIME practitioners to record, in real time, when they respond and locate at the scene
- other technology solutions, such as giving PRIME providers a satellite phone where communication is problematic
- developing a process for ambulance staff to advise over the radio when a PRIME practitioner is in attendance
- including in PRIME training a reminder of the need for real time notification
- developing a national template for PRIME providers to log responses, which can be reconciled with St John’s records, as required.

PRIME notification and the paging network

It is noted that the pager network, which is currently used for notifying PRIME practitioners of an incident, may be discontinued in the near future. Ambulance services and other users of the paging network (eg. fire services) are working through solutions to maintain this communication (this is outside the scope of this review).

Rate of PRIME responses (notifications versus attendances)

Not all notifications from an ambulance communications centre to a PRIME practitioner result in an attendance, which is generally considered acceptable. However, there are variations of attendance rates that should be monitored and may require further investigation (eg. PRIME attendance rates across St John’s three regions show 33 percent in the northern region, 16 percent in the central region, and 37 percent in the South Island region).

It is expected that:

- regional PRIME committees and the national PRIME committee will monitor these rates to identify and manage any anomalies (ie. higher response rates for injury-related incidents than medical-related incidents)
- St John will ensure quarterly reports on national, regional, and local (PRIME site) notifications and attendances (and their respective attendance rates) are consistently provided to the national and regional PRIME committees
- the national PRIME committee consider whether systems are to be implemented that would support a PRIME practitioner’s decision to respond to a notification (eg. developing criteria for PRIME practitioners or providing a more direct link between the PRIME practitioner and the communications centre (possibly to the clinical desk)).

2 Examples of reasons for not attending notifications are: knowing the patient and their history and arranging a house-call instead; tied up on another urgent case; sickness; the locum is not PRIME trained.

3 The PRIME attendance rate (shown as a percentage) is calculated by dividing the number of PRIME incidents attended by the number of PRIME notifications.
Obligations to primary care and after-hours services

In many instances PRIME practitioners are on call to respond to PRIME while providing primary care services, including after-hours services. The Steering Group wants to make it clear that, in these instances, the main responsibility of PRIME practitioners is to their primary care service. PRIME practitioners are in the best position to decide if they can respond to a PRIME call given their primary care obligations. See Key findings: 6. PRIME responses: Rate of PRIME responses (notifications versus attendances) section for more discussion on improving information flow to PRIME practitioners.

7. **PRIME service funding**

Key high-level principles for the PRIME service going forward

These key high-level principles should be adopted for the PRIME service going forward when considering PRIME funding.

1. Equity of access for patients (get the necessary care to patients as per Roadside to Bedside).
2. Equity of remuneration for providers.
3. Accuracy of data (for monitoring PRIME responses).
4. Appropriate level of administration.
5. Transparency of the PRIME service.

Review of PRIME funding

The scope of this review is to consider how existing funding can be used in the most effective way, within the existing funding envelope. It is noted, however, that the funding arrangements working group felt strongly that there is a need for a formal PRIME funding review to: (a) ensure funding reflects real and reasonable costs of delivering the PRIME service, including the cost of readiness to respond; (b) ensure funding addresses the increasing workload and costs; (c) consider PRIME funding linkages with rural after-hours services; and (d) develop a mechanism to ensure that medical-related and injury-related funding is equitable.

There was similar strong feedback received from stakeholder consultation, highlighting that many felt that PRIME funding does not adequately cover real costs and is financially unsustainable for PRIME providers.

While an increase in funding review is still considered outside the scope of this review, the Steering Group strongly recommends that ACC and the Ministry review the funding of PRIME that:

- considers how the Ministry and ACC could align how they fund PRIME
- determines the real cost (fixed and variable) to PRIME providers
- considers the relationship between after-hours and PRIME
- provides recommendations to ensure PRIME funding is sustainable to providers and the funders.

While the Steering Group acknowledges that recommendations from this original review may change if a funding review occurs (as decisions were often made within the scope of a fixed funding envelope), any subsequent increase of funding would not trigger another review as that funding would have a specific purpose.

Transparency of PRIME funding

There is a need for the Ministry and ACC to improve the transparency of how the total PRIME funding has been determined, including how annual funding increases align with cost pressures. For example, annual reporting of that year’s funding, how much went to providers and any increase in funding.

In accordance with Part 1 of the Public Finance Act 1989, Ministry funding is contingent upon the appropriation of adequate levels of funding for services of the type covered, and this requirement needs to inform any funding allocated to the PRIME service.
8. Funding for medical-related incidents

The funding arrangements working group provided recommendations to address funding issues for medical-related incidents, which is considered to currently be inequitable. The aim was to ensure medical-related funding considered accident-related funding (ie. they work together to form a fair and effective funding arrangement), and consider practitioner concerns of additional costs for PRIME providers and practitioners that are not remunerated (eg. attendance at training).

Overview of current state

There are circa 75 PRIME sites, with approximately 23 sites providing less than 24 hour coverage. St John has provided data on PRIME responses for the calendar years 2010 to 2015.

Table 3: PRIME responses at scene 2010 to 2015 (St John, 2016)

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Medical-related</th>
<th>Injury-related</th>
<th>Other⁴</th>
<th>Total</th>
<th>Growth in Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,500</td>
<td>680</td>
<td>430</td>
<td>2,610</td>
<td>--</td>
</tr>
<tr>
<td>2011</td>
<td>1,356</td>
<td>584</td>
<td>517</td>
<td>2,457</td>
<td>-5.9%</td>
</tr>
<tr>
<td>2012</td>
<td>1,294</td>
<td>562</td>
<td>465</td>
<td>2,321</td>
<td>-5.5%</td>
</tr>
<tr>
<td>2013</td>
<td>1,596</td>
<td>586</td>
<td>438</td>
<td>2,620</td>
<td>12.9%</td>
</tr>
<tr>
<td>2014</td>
<td>2,152</td>
<td>822</td>
<td>207</td>
<td>3,181</td>
<td>21.4%</td>
</tr>
<tr>
<td>2015</td>
<td>2,230</td>
<td>851</td>
<td>217</td>
<td>3,298</td>
<td>3.7%</td>
</tr>
<tr>
<td>Average annual year-on-year growth</td>
<td>4.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ministry of Health funding from 2011/12 to 2016/17 for medical-related incidents has increased from $1.73 million to $1.82 million. Within this, funding paid to PRIME providers has increased by $100,000 (9 percent) from $1.12 million (actual amount) to $1.22 million (budgeted amount). The overall increase in PRIME responses from 2010 to 2015 is 26 percent.

Medical-related response funding

The Ministry contracts with St John to administer the PRIME service. St John, as the administrator of PRIME, holds contracts with PRIME providers for medical-related incidents. Currently, the medical-related funding has three funding bands:

- Band 1: 1-20 responses: $13,314
- Band 2: 21-40 responses: $18,435

This funding includes a fixed-cost payment of $8,000⁵, with the remaining funding being the variable amount based on the number of PRIME responses. For the year to February 2016, PRIME provider medical-related responses ranged from 0 to 136 (with those doing 136 responses being remunerated at the same level as those doing 41 responses). Average funding per response is:

- Band 1: $956.00
- Band 2: $355.00
- Band 3: $197.00.

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⁴ Other includes hoax calls, stand-downs, etc. (Note: the increase in proportion of medical-related calls is correlated with the decrease in the proportion of other calls, which indicates possible change in how it is counted rather than increasing demand).

⁵ This fixed-cost payment is not specified in current contracts.
Equitable distribution of PRIME medical-related funding

14 band funding schedule

A fairer system needs to be implemented to ensure funding is more equitable across PRIME sites (while remaining within the current funding envelope). The Steering Group agrees with the recommended approach of:

- increasing the fixed-cost component for providers with 24/7 coverage to $12,000, which allows for average funding of $219 per PRIME response (in addition to the fixed-cost component)
- moving to a 14 band funding schedule, with each band incrementally increasing by 10 responses to more evenly distribute funding to PRIME providers.

A fee-for-service model was considered, however, this would significantly increase administration costs and poses a risk funding would exceed government’s appropriation. Moving to 14 bands each with 10 responses will make significant progress towards achieving equitable distribution.

Appendix 5: 14 band funding schedule contrasts the current three funding bands and the proposed 14 band funding schedule. It is important to note that the funding set for each of the 14 bands is provided as an example only. It may need to be amended slightly to ensure that the total medical-related funding allocated to PRIME providers fits within the current funding envelope.

It is expected that, with a change to the 14 band funding schedule, funding will decrease for around one-third of current PRIME providers and funding will increase for the remaining two-thirds, compensating those PRIME providers with higher volumes of responses.

To ensure PRIME providers are remunerated based on the number of responses, each PRIME provider’s responses in the previous year must be formally reviewed (as happens now). Additionally, there must be an opportunity for review throughout the year if a review is warranted (eg. changes in local circumstances that significantly impact on volumes).

Under the 14 band funding schedule there is approximately $230,000 to $250,000 of funding for PRIME providers that sit in the first two bands (with each doing under 20 annual medical-related responses). These PRIME sites will be looked at as part of the review of the configuration of existing PRIME sites to ensure they are fit-for-purpose and provide value-for-money. The review will take into account special locational requirements for remote sites.

Ensuring financial stability of PRIME

There is a risk that, if the 14 band funding schedule is agreed, an overall increase in PRIME sites or their responses may require total funding that exceeds the amount funded by government (currently $1.2 million). Once implemented, the funding allocated to each band will not decrease and, therefore, the PRIME administrator will have the following levers at its disposal to mitigate this risk:

- Providing additional funding that exceeds that allocated for providers, at its own expense, if it considers this good value to do so (eg. St John decides it is better to contribute some additional funding to establish a new site rather than to introduce additional ambulance resources).
- Reducing the overall number of sites to ensure funding is within that allocated for PRIME providers (value-for-money justification).

As described in the Key findings: 2. PRIME administration section, any unspent PRIME provider funding would be carried forward for investment in the PRIME service in the next financial year (and will not go into the PRIME administrator funding baseline).

Fixed-cost component

A fixed-cost component is considered important and must to be retained in the PRIME provider funding, and is to be the same for all PRIME providers with 24/7 coverage. However, the fixed-cost component is to be increased to $12,000 (a 50 percent increase) to reflect the significance of fixed-costs for readiness, regardless of the number of responses.
The fixed-cost funding provides a contribution to the fixed-costs of PRIME providers (costs in addition to those incurred during PRIME responses), which includes, but is not limited to:

- disbursement to attend PRIME training courses\(^6\)
- on-call costs
- locum cover
- administration costs (including: conducting internal audits of policies and procedures as part of a continuous quality improvement plan; stocking and rechecking kits; and participation in developing and maintaining a locality PRIME plan, as necessary)
- equipment used (in addition to that provided by the PRIME administrator)
- stand-down responses (a small proportion of PRIME responses)
- participation in clinical audits/case reviews
- assisting with local ambulance officer training sessions and incident debriefs, where appropriate.

The funding arrangements working group’s recommendation to keep the fixed funding contribution the same nationally is supported. While taking into account local geography and population size (including over holiday periods) was considered, a single approach is fairer and less complicated to administer. As the funding envelope is fixed, any increase in administration costs reduces funding available for providers. Regarding PRIME sites in holiday destinations, the fixed-cost over these periods would not change significantly, and increased response volumes will be accounted for in the variable funding, which is based on annual response volumes.

**Fixed-cost funding provided to PRIME sites with less than 24/7 coverage**

The current pro-rata system for sites with less than 24/7 coverage should continue. Funding is simply based on the hours covered and does not take into account when in the week they occur. Fixed-costs do not significantly reduce with reducing on-call so there is an argument for paying higher than a pro-rata rate, but there is greater personal cost to getting out of bed in the middle of the night that the pro-rata rate rewards. On balance, the current pro-rata system is considered fairest.

**Allowing less than 24/7 coverage**

There is limited information on why sites are providing less than 24/7 coverage so it is difficult to determine whether the current approach of allowing reduced hours is fair. The following actions are proposed.

- Develop a guide to support decisions about whether a site can provide less than 24/7 coverage.
- Any requests for reduced coverage will go to the relevant regional PRIME committee for consideration and, if supported, the national PRIME committee for final approval.
- Develop a process for the national PRIME committee to manage reduced coverage that is unplanned (eg. a site provides notification that, effective immediately, it cannot provide 24/7 coverage).

**9. Funding for injury-related incidents**

ACC contracts with PRIME practices for the provision of accident-related responses. PRIME practices are paid on a fee-for-service basis utilising ACC’s PRIME contract, Rural General Practice (RGP) contract, and Cost of Treatment Regulations (CoTR).

Under the PRIME contract, practitioners invoice for the service items listed in Table 4: ACC service items.

\(^6\) Excludes non-PRIME practitioners attending a PRIME course as a requirement of ACC’s RGP contract.
In addition PRIME practices are able to invoice under the RGP contract for the actual treatment provided at the accident scene. If the client requires further treatment at the general practice clinic, a second consultation may be invoiced to ACC.

ACC does not contribute to the fixed-cost component of the funding provided to PRIME providers; however an overhead cost component is built into the hourly rate and ACC contributes 50 percent towards the cost of PRIME training and PRIME kits.

The average ACC claim under its PRIME contract (for attendance and time travelled) was $253 in 2015/16, with ACC’s total contribution being between $215,000–$280,000 for PRIME injury-related responses. In addition to claims made under the PRIME contract (for attendance and kilometres travelled), providers invoice ACC for consultations and procedures under the RGP contract or CoTR. ACC cannot distinguish between RGP and CoTR payments for PRIME and payments for services provided by a medical centre on the same day.

ACC should consider a simpler funding approach for injury-related responses. This will address confusion: (a) due to providers using a mixture of PRIME and RGP or CoTR to invoice for PRIME call-outs; and (b) around PRIME and RGP contracts and CoTR. The simpler approach to consider is introducing a fair and reasonable hourly rate that would cover all injury-related costs, including: total attendance time (including time travelling), consultation, procedures used, and administration (eg. restocking, clinical notes, and debrief). This approach addresses feedback from PRIME practitioners that procedures are not frequently used and it is their clinical skills that are used most often.

**10. Practices charging in addition to receiving a PRIME fee**

**Charging patients co-payments**

Funding for PRIME responses is expected to cover PRIME provider costs without the need for a co-payment from the patient. There is acknowledgement that there can be frustration with some callouts. For example, the PRIME provider believes the patient should have visited primary care (and would have been charged a co-payment) instead of calling for an ambulance (where the PRIME provider cannot charge a co-payment). However, patients do not know that a PRIME practitioner will attend and do not necessarily know when they can be safely seen in primary care, and they would have had to have been prioritised by a communications centre as a red or purple response in order to be a PRIME callout.

The current contract will be amended to clearly state that patient co-payments cannot be charged for a PRIME response. This also applies to a medical-related PRIME responses where the patient is brought to a medical centre during the same episode of care.

**Emergency incidents at a medical centre**

PRIME does not fund emergency care in medical centres. While recognising these incidents use greater resources, this is not the intention of PRIME. Therefore, these incidents would not be counted as a PRIME response and should be managed by the practice as they would for any other patient that requires unplanned care. This includes being able to charge for those services, even if that patient was brought to the practice by ambulance. For more discussion see [Key findings: 6. PRIME responses: Clarification on a PRIME response](#).

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7 Rural General Practice (RGP) and Cost of Treatment Regulations (CoTR).

8 Episode of care, in this context, refers the care provided as part of a PRIME response. A follow-up appointment (eg, the next day) is not considered part of the episode of care.
General Medical Subsidy (GMS) and maternity claims for PRIME responses

There should be no GMS or maternity claims submitted for PRIME responses, given the PRIME payment is provided to cover the cost of the response. Relevant sections clarifying this are outlined in the Primary Health Organisation (PHO) Services Agreement and Primary Maternity Services Notice 2007.

PHO Services Agreement

No double payment: Subject to subclause (5), the PHO may not claim or receive a payment under this Agreement for services if the PHO is entitled to receive payment for those, either directly or indirectly, under any other agreement or arrangement with the DHB or any other organisation, Government body, or agency, including the Accident Compensation Corporation.

Primary Maternity Services Notice 2007

CC2 No claim if claim is covered by another arrangement

(1) A maternity provider may not claim under this notice if—

(a) the maternity provider, or a practitioner who works for the maternity provider, is entitled to have the claim satisfied (whether directly or indirectly) under any other arrangement with the Ministry of Health or a DHB; or

(b) the primary maternity services that relate to the claim have been provided by a practitioner in their capacity as an employee of a DHB.

(2) For the purposes of audit, a practitioner employed by a DHB must keep a record of the hours of employment (including on-call hours) with the DHB.

11. Lack of transparency of funding

Overview of administrator funding

In response to concerns that too much of the PRIME funding goes towards administration, management, and governance (rather than funding PRIME providers), an overview of PRIME administrator funding and activity is outlined below. While the share of funding that goes to the administrator is considered acceptable by the Steering Group, it is accepted that transparency of funding needs to be improved, such as contracts explicitly stating how much funding goes to the administrator and how much goes to providers, and ensuring this information is publicly available.

St John is the administrator of PRIME through an agreement with the Ministry. The contracted amount for 2016/17 is $1,817,645 (GST exclusive). Of this, St John receives approximately $600,000 for the administrator function, which is used to manage PRIME, maintain kits and supplies; and deliver PRIME training. Table 5: St John allocation of Ministry PRIME funding for financial year 2015/16 outlines the funding allocation for the 2015/16 financial year.

Table 5: St John allocation of Ministry PRIME funding for financial year 2015/16

<table>
<thead>
<tr>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$460,153</td>
<td>1. PRIME management, including: providing a dedicated PRIME resource; management functions; contract and relationship management; and secretariat function for PRIME committees</td>
</tr>
<tr>
<td>$139,000</td>
<td>2. PRIME kits and supplies, including issuing and restocking PRIME kits</td>
</tr>
<tr>
<td>$1,211,251</td>
<td>4. Funding for PRIME medical-related services (for PRIME providers)</td>
</tr>
<tr>
<td>$1,810,404</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

9 Reference: PHO Services Agreement, Part F, clause F6(4) [pages 80 and 81]
Management of PRIME: to manage PRIME St John provides a dedicated PRIME resource; national office management support; manages circa 75 individual contracts; provides regional contract/relationship management with PRIME providers; maintains the PRIME page on its website; provides secretariat function for regional PRIME committees; and runs a clinical hub with medical advisors available for PRIME practitioners.

PRIME training: in 2015/16, approximately 23 percent of administrator funding was allocated to PRIME training and, in addition, ACC contributed $150,068 (total funding for training in 2015/16 was $289,068).\footnote{11 This funding from ACC excludes the amount ACC spends on the full cost of a PRIME course for RGP practitioners.}

PRIME kits and equipment: it is estimated that at least 10 percent of funding is used for issuing and restocking PRIME kits (it is difficult to get an accurate figure as kits are typically restocked at the scene using ambulance supplies). At a cost of $3,393 each, St John provides kits for PRIME practitioner use. In addition to the Ministry funding, ACC pays 50 percent of the cost (there are very few new kits distributed). ACC also pays for half of the oxygen supply for PRIME at a cost of approximately $5,200 per annum.

ACC contributions to PRIME administrator costs

While ACC contributes to the cost of PRIME training and new kits, it does not contribute to other functions of the PRIME administrator, such as the PRIME committee secretariat function and kit replenishment.

Some believe ACC should contribute a representative share of PRIME administrator funding, however, this would require additional funding, which is outside the scope of the review. If ACC was to review its share of PRIME administrator funding, there might be more Ministry of Health funding available: (a) for PRIME providers doing medical-related responses making it more equitable with funding for injury-related responses; or (b) to be invested in equipment, kit and medicines.

12. Responsibility for the scene and care

In most cases ambulance staff and PRIME practitioners function well as a team to ensure the best outcome for patients, however there are instances of confusion and difference of opinion about who has responsibility for scene management and providing care.

The Steering Group agrees that it is important that there is always a lead at a scene and good communication is incredibly important to this, but it recognises that it is not practicable to develop default guidelines for what are very dynamic situations.

To provide a tool to discuss conflicts in a safe way, the Steering Group recommends that PRIME training includes content on crew resource management.

Performance issues

The national PRIME committee should put in place mechanisms to address any concerns over the performance or decision-making by one party or another at a scene.

Systemic or recurring issues of national relevance need to be forwarded to the national PRIME committee for consideration and resolution. Finding a way of bringing together the St John incident review system/clinical audit and the PRIME case review process where appropriate will be one challenge.
13. **Standing orders**

PRIME practitioners who are registered nurses are responsible for obtaining appropriate clinical oversight and standing orders\(^\text{12}\) in order to maintain their PRIME scope of practice.\(^\text{13}\) It is acknowledged that sometimes registered nurses cannot get or maintain their standing orders for PRIME (eg. when there is no permanent general practitioner or nurse practitioner at a medical practice).

**Expectation of PRIME providers**

It is expected that PRIME providers (eg. medical centre or DHB) will issue standing orders for the registered nurses who are delivering PRIME on their behalf. Agreements between St John and PRIME providers may need to be updated to make this expectation more explicit.

**Standing orders framework**

The Steering Group recommends the national PRIME committee develop a framework to support registered nurses obtaining standing orders. This does not mean that a national group will provide them, but will implement systems to reduce some existing barriers. It is noted that the Canterbury Clinical Network and the Standing Orders Development Group, in association with Canterbury Healthpathways and South Island HealthLearn LMS, have already developed an electronic framework on this and have offered support. The national PRIME committee should engage with this group to explore this option further.

**Authority to practice at Paramedic level**

Registered nurses having difficulty obtaining standing orders should have the option of applying for a Paramedic authority to practice. The ambulance medical director would issue standing orders for the Paramedic delegated scope of practice. A nurse-to-paramedic pathway exists that recognises current qualifications and experience, which does require additional study and assessments, but is not considered onerous.

A lot of concern was raised about this option, but the Steering Group emphasises that gaining an authority to practice at Paramedic level does not take away from, and only adds, to the individual’s existing scope of practice. And, this is completely optional and provides an alternative when normal channels for obtaining standing orders have been unsuccessful.

**Registered nurse prescribing model**

In 2016, regulations for registered nurse prescribers came into force enabling registered nurses practising in primary health and specialty teams who meet educations requirements of the Nursing Council of New Zealand to prescribe under the designated authority criteria. This model enables appropriately trained and experienced nurses to make prescribing decisions within their scope of practice.

There is a real possibility that, longer term, this model could be used to supersede standing orders by enabling PRIME practitioner registered nurses to prescribe PRIME medicines. While this is unlikely to resolve issues in the near future, the Steering Group encourages the Ministry of Health to work with the Nursing Council to explore this further and provide updates to the national PRIME committee.

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\(^{12}\) **Standing orders** are a written document containing rules, policies, procedures, regulations, and orders for the conduct of patient care in various stipulated clinical situations.

\(^{13}\) Standing orders need to be appropriate to the needs of the practice and must also incorporate the treatments and medicines used for PRIME. These must be signed off by an authorised prescriber (GP or nurse practitioner) and reviewed on an annual basis.
14. A formal PRIME practitioner network

Register of active PRIME providers

To minimise the isolation that PRIME practitioners feel, there needs to be an accurate register of active PRIME practitioners available to be shared. St John has a register on its secure PRIME site, but there is an ongoing need for PRIME providers to send through updated information on their practitioners.

Formal representative group

A formal representative group for PRIME practitioners (or specifically for PRIME nurses) is not supported as the NZRGPN fulfils this role already for both doctors and nurses. It is acknowledged that this role requires some development in the future.

While a formal network is not supported, there is a place for an informal network for PRIME practitioners. The review previously discussed that there should be greater use of St John’s secure PRIME website, which should support this (eg. discussion forums) (see Key findings: 2. PRIME administration: St John administrator function).

In terms of providing a safe environment to improve PRIME, the review previously makes it clear that regional PRIME committees have inclusiveness and a culture of safety and support (see Key findings: 1. Governance of PRIME: Regional PRIME committees).

15. Critical incident support

It is recognised that PRIME practitioners may not receive adequate support after critical incidents. To improve critical incident support, St John will make its support available for PRIME practitioners, which includes access to professional services. St John may explore other ways to provide support, such as an operations manager making contact after incidents that may be considered traumatic.

It is noted that, in addition to the responsibilities of the PRIME administrator, there is: personal responsibility for PRIME practitioners to seek help when needed; responsibility for PRIME practitioner colleagues to provide support or facilitate access to appropriate help; and responsibilities on PRIME providers to support their practitioners.

The impact of events affects everyone differently and this should be factored in to any support processes. Culture should support PRIME practitioners actively involving themselves in effective critical incident debriefing as a matter of routine. A clear definition of 'critical incident' needs to be established, with the national PRIME committee having responsibility for ensuring this is undertaken.

16. Aligning to Paramedic scope of practice

As described in the Key findings: 1. Governance of PRIME: Clinical governance section of this report, it is agreed that PRIME should align with the Paramedic practice level and its delegated scope of practice (see Appendix 6: Ambulance scopes of practice and practice levels for ambulance scopes of practice).

Alignment to Paramedic level defines the minimum interventions and medicines that are taught and routinely issued in PRIME kits. More information is provided in the Key findings: 17. PRIME training and syllabus and Key findings: 18. PRIME equipment, kit and medicines sections.

As PRIME practitioners are practising independently or under standing orders, responding as a PRIME practitioner does not and cannot take away or minimise their current scope of practice. PRIME practitioners are in no way limited to the Paramedic scope of practice and may choose to administer additional procedures or medicines, working to the top of their scope.

The benefits of aligning PRIME with the Paramedic practice level include:

a) ensuring practice is aligned with important conditions faced in the out-of-hospital environment
b) ensuring practice is regularly updated (through the ambulance sector’s updates every two years)
c) providing an efficient way to maintain currency, by using already-established systems
d) providing a clear scope of practice that training content/syllabus will be aligned with

e) providing a clear scope of practice that equipment will be aligned with

f) improving access to guidelines, including: electronic copies of ‘pocket’ and ‘comprehensive’ of ambulance CPGs; and an app for mobile devices.

Some will view a limitation of this approach as not all medicines and interventions in the Intensive Care Paramedic practice level will not be taught on PRIME training and nor will equipment be supplied (with endotracheal intubation being the intervention that is expected to get the most attention).

The Paramedic practice level is considered the most suitable to align with PRIME because:

- medicines and interventions for the Paramedic practice level are sufficient for the vast majority of PRIME responses, with PRIME practitioners acknowledging that it is their knowledge (not medicines and interventions) that is used most often
- the Paramedic practice level is a good alignment for most PRIME practitioners (eg. intubation should be limited to those who perform it regularly in their substantive (non-PRIME) roles and only a few PRIME practitioners would meet this requirement)
- the costs (training, equipment, and administration) would need to increase significantly to: (a) align all PRIME practitioners to Intensive Care Paramedic practice level; or (b) have a second tier for a small number of higher level PRIME practitioners.

17. PRIME training and syllabus

There are mixed opinions on PRIME training. Some view it as very enjoyable and high quality while others disagree.

Regardless, the PRIME training course and syllabus need to be updated, but the following elements should be retained.

- The initial five-day course.
- The two-day refresher course, to be completed every two years.
- The requirement for the course to be pass/fail.14

Aligning PRIME with the Paramedic practice level (see Key findings: 16. Aligning to Paramedic scope of practice) will address the issues of the curriculum becoming outdated (as it will be updated every two years in accordance with ambulance CPG updates) and improving access to guidelines (as electronic copies of ambulance CPGs and an app for mobile devices will be readily available).

Subject to Ministry and ACC funding, the PRIME course should be updated to ensure it:

- is based on current best practice
- is aligned with ambulance CPGs
- is aligned to the Paramedic level scope of practice at a minimum (and may include training for medicines or procedures outside the Paramedic scope)
- considers greater focus in areas identified by working groups (eg. mental health, health and safety, and patient handovers)
- considers the need for more simulation workshops and problem-based learning
- considers the need for blended learning (eg. having online and in-class activities)
- considers course feedback from PRIME course attendees.

14 The current pass/fail component is not considered onerous and there is no intent to increase this requirement.
Course pre-requisite

The Steering Group received a recommendation to establish a PRIME course pre-requisite of having ACLS Level VII, which has been replaced by CORE Advanced courses on the New Zealand Resuscitation Council (NZRC) ‘Rescuer Framework’ (NZRC no longer has ‘Rescuer Levels’).

The Steering Group recommends that, when the PRIME course is updated following this review, the national PRIME committee consider this recommendation to introduce a pre-requisite. The national PRIME committee would need to balance any improvements this would make to the quality of PRIME against any additional barriers and costs this would create for PRIME providers and practitioners.

Advanced PRIME practitioner level

The recommendation of having an advanced PRIME practitioner level is not supported. As described previously in the Key findings: 16. Aligning to Paramedic scope of practice section, the benefit is not considered to outweigh the cost.

Improve consistency

The recommendation to improve the course delivery through improved consistency and, if needed, ensuring high quality tutors is supported. St John will use quality assurance processes to ensure consistent delivery of training.

Using PRIME practitioners for teaching

While there was general support that including a PRIME practitioner doctor to teach on PRIME courses would add value, it was agreed that it would be unaffordable.

St John indicated it will actively explore using PRIME practitioners (doctors, nurse practitioners and registered nurses) for parts of the course and absorbing this cost. More work is required.

Prioritisation for attendees

The priority for attending PRIME courses is given to PRIME practitioners and those attending as part of their requirements under their RGP contract with ACC ahead of others that wish to undertake the course.

Ongoing training

During the consultation phase it was recognised that some PRIME practitioners would appreciate additional development in between the PRIME refresher training. It was agreed that the national PRIME committee would consider this further and it may look to use St John e-learning and online learning resources.

The recommendation to have formal development opportunities for PRIME practitioners (further exposure at emergency departments and accompanying an Intensive Care Paramedic on duty) is not supported via a national mechanism. PRIME practitioners are welcome, through local arrangements, to observe on ambulances as they see fit.

The Steering Group discussed that regional PRIME committees should play a role of supporting their PRIME practitioners and offering voluntary development opportunities.

Access to and location of courses

The Steering Group agrees with feedback received that there should be timely access to PRIME courses and that they should be delivered in locations that consider where PRIME practitioners are.

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While the Steering Group is of the view significant improvements have been made in these areas in recent years, it will be important for the national and regional PRIME committees to receive regular reports from the PRIME administrator so that this can be monitored.

Standards

The RNZCGP expressed interest in being responsible for setting standards and approving the general practitioner training content, in partnership with CPHCN for standards applying to nursing and nursing training content.

The Steering Group recommends that the national PRIME committee considers whether there should be the development of standards and how those standards would be approved, assessed and maintained.

18. PRIME equipment, kit and medicines

While all recommendations from the Equipment, Kit and Medicines working group were made in the spirit of the review, many recommendations would require additional funding. As an increase in overall government funding is outside the scope of the review, options to fund these recommendations include: shifting funding used elsewhere in PRIME; having the costs absorbed by an organisation; or having a recommendation in this report to seek additional government funding (but recognising there would be no assurance of approval). The working group also recommended a programme that addresses the recommendations over a two year period, not extending past financial year 2018/19.

After considering the working group’s recommendations and feedback during consultation, the Steering Group’s recommendations are described below.

Align PRIME kits with Paramedic level

The minimum requirement for PRIME kits and their contents, including medicines, is that they should be the same as that used by ambulance services. In particular, the same as that carried at Paramedic practice level (see Key findings: 16. Aligning to Paramedic scope of practice).

Benefits of this alignment

As PRIME providers currently source their own medicines, this approach would see a standard list of medicines routinely issued to PRIME. It is important to note that, while Paramedics may only administer some medicines in very limited circumstances (eg. Paramedics may only administer midazolam intravenously for seizures), PRIME practitioners practise independently or under standing orders and will be issued those Paramedic medicines and may administer it for other reasons, as their scope allows.

This approach would see the average PRIME kit issued with a lot more equipment than it currently is. However, equipment for the following procedures would no longer be issued as they are not within the Paramedic scope of practice: chest decompression (needle), cricothyroidotomy, endotracheal intubation, and finger thoracostomy.

Every two years the ambulance sector updates its CPGs. This would ensure that there is a timely and regular review of the medicines and equipment issued to Paramedics, and typically results in the overall increase in scope. This means that more medicines and equipment would be automatically added to PRIME.

Ambulance services use a nationally-consistent ‘modular’ approach whereby equipment is separately packaged (eg. airway management and medicine modules). This allows PRIME practitioners and ambulance personnel to work seamlessly together by ensuring both parties can instantly locate and use equipment at an incident, regardless of whose kit is being used. It also allows quick and easy restocking of a kit by simply replacing the used module.
Implementation and operating costs

There will be a cost to replace existing kits with those used by ambulance services and to begin issuing medicines routinely, as per the recommendation just described. Further work is required by the national PRIME committee and St John to understand if these costs can be absorbed or whether they are dependent on finding additional funding. Furthermore, St John is about to review its kit manifests in 2017 and it is prudent to wait until this is completed.

Carrying or issuing items above Paramedic level

If it can afford to do so within available funding, the national PRIME committee may add a medicine or equipment above that at Paramedic level to the standard PRIME kit manifest.

As PRIME practitioners are practising independently or under standing orders, the PRIME provider or PRIME practitioner may add medicines or equipment to their kit, at their own discretion, that are not supplied as part of PRIME.

Intraosseous (IO) vascular access device

The recommendation that an EZ-IO (an intraosseous vascular access device) should be issued to PRIME practitioners is not supported. It comes at considerable cost and is not in the Paramedic scope of practice. As described previously, this does not stop PRIME practitioners from sourcing their own EZ-IO for PRIME responses, as happens now (as they are not issued by PRIME).

If in the future the ambulance sector includes this in the Paramedic scope of practice, or the national PRIME committee decides it could afford to issue them as standard within given funding, then it would be included in PRIME kits.

Electronic capnometry

The recommendation that those performing intubation must have electronic capnometry has not been considered as this intervention is not considered part of PRIME (see section: Key findings: 16. Aligning to Paramedic scope of practice).

Automated external defibrillators

It is agreed that automated external defibrillators (AEDs) are a critical piece of equipment for PRIME practitioners given they are responding to immediately life threatening incidents; and, ideally, the AED would be the same as that used by ambulance and fire services\(^\text{16}\) to allow for interoperability and interchangeable consumables. However, at a cost of $3,000 each and with circa 75 PRIME providers, further work is required to determine requirements, costs, timing and how they would be funded.

Safety items

In general, the current safety equipment issued for PRIME may not be sufficient to meet obligations under the health and safety legislation (noting access to safety equipment appears inconsistent).

The recommendation that PRIME practitioners are issued safety glasses, a torch, leather gloves, reflective gear (a jerkin and reflective jacket), and a helmet as a minimum ($419 per bundle\(^\text{17}\) is to be considered by the national PRIME committee to confirm these items are the minimum required and consider how this would be funded.

It is agreed that any standard issue safety equipment should be the same as that used by ambulance services and clearly state “PRIME Responder” so they can be clearly identified as emergency responders by the public and as PRIME practitioners by ambulance and allied services.

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\(^\text{16}\) The AED routinely used by ambulance and fire services is a Physio-Control LIFEPAK 1000.

\(^\text{17}\) Estimated cost of minimum safety equipment is $419 (safety glasses, $9; torch, $33; leather gloves, $21; hi-viz jerkin, $35; hi-viz jacket, $160; safety helmet, $161).
Having a ‘menu’ of optional safety equipment (safety boots, overalls, kevlar suits, green flashing light for vehicles, and magnetic signage on vehicles) that PRIME providers and practitioners can purchase is not supported. It is not considered necessary for PRIME and would be costly to administer. PRIME providers and practitioners may source these items by other means as they see fit.

The decision to issue a radio is best determined locally between the relevant ambulance service and the PRIME provider.

The Steering Group noted feedback that employers too have obligations under the Health and Safety at Work Act 2015 to do all that is reasonably practical to ensure the safety of its employers. As described in the Key documents: 2. Prime administration: Updating the current PRIME contract documents section of this review, contracts will be updated to reflect this.

**Maintenance and responsibility of PRIME kits**

PRIME kits are to continue to be issued to PRIME providers (as opposed to PRIME practitioners). While the default position will be for PRIME providers to be issued one kit, the national PRIME committee can request St John increase the number for a PRIME provider if needed for their local context.

PRIME providers are responsible for restocking and regularly maintaining their kits. Regularly checking kits ensures they are maintained and that PRIME practitioners are familiar with their content. The current practice of PRIME providers restocking kits from local ambulances and ambulance stations should continue. A process to support this should be developed by St John and it needs to consider situations where restocking or replacing of equipment is not undertaken at the scene.

**Standard medicines list**

A recommendation for a standard list of PRIME medicines was received and appreciated. However, PRIME medicines should be the same as those carried at Paramedic practice level (as discussed earlier in this section).

**19. ECCTs and rural service level alliance teams**

The PRIME service specification describes the role of Emergency Care Coordination Teams (ECCTs) in PRIME. However, not all district health board (DHB) regions have an ECCT with much of their activity being undertaken by acute demand or rural service level alliance teams (rural SLATs). The PRIME service specification needs to be updated to reflect these variations (including that there will be varying levels of interest in PRIME). The recommendation that the Ministry and ACC reinforce to regional hospitals the importance of ECCTs is outside the scope of this review.

**20. PRIME conference**

A recommendation was made to hold an annual PRIME conference to provide an opportunity for PRIME to have a national forum where knowledge could be shared and networks developed. While an independent conference is not achievable, PRIME is to be part of the annual national rural health conference organised and hosted by NZRGPN. NZRGPN will need to work through the specifics of this with the national PRIME committee.

18 There are two ECCTs working out of Dunedin and Christchurch hospitals and a key role is to oversee the integration of emergency services between primary and secondary care.
Appendix 1: Membership of the five workstream working groups

The working groups met from August to October 2016 via teleconference. There was good engagement from working group members, and their voluntary time and commitment was appreciated.

Workstream 1: Funding Arrangements

The working group held 12 weekly teleconferences to work through the identified issues from 18 August to 26 October 2016. There was excellent attendance at these teleconferences.

The working group members were:

- Liz Parker, Senior Project Manager, Ministry of Health (Workstream Lead)
- Jon Gaupset, Category Manager Primary Care, ACC
- Murray Holt, Head of Clinical Operations Support, St John
- Dr Mike Hunter, Southern Regional Emergency Care Coordination Team (ECCT)
- Dr Rex Yule, General Practitioner and PRIME Practitioner Amberley, PRIME Committees
- Dr Stephen Hoskin, General Practitioner and PRIME Practitioner, Te Anau
- Dr Kate Armstrong, General Practitioner and PRIME practitioner Colville, Hauraki (rural SLAT)
- Kirsty Murrell-McMillan, Registered Nurse and PRIME Practitioner
- Justin Butcher, Midland Health Network, Waikato DHB Rural Health Advisory Group
- Bianca Prentice, St John.

Workstream 2: Administration

The working group held 11 weekly teleconferences to work through the identified issues from 18 August to 27 October 2016. There was excellent attendance at these teleconferences.

The working group members were:

- Liz Parker, Senior Project Manager, Ministry of Health (Workstream Lead)
- Angelika Weinheimer, Category Advisor Primary Care, ACC
- Murray Holt, Head of Clinical Operations Support, St John
- Pam Adams, Coordinator Southern Regional Emergency Care Coordination Team (ECCT)
- Dr Bryan MacLeod, General Practitioner and PRIME Practitioner, Coromandel Health
- Dr Robin Barracough, General Practitioner and PRIME Practitioner, Tasman District
- Jo Talarico, Nurse Practitioner and PRIME Practitioner, Twizel
- Paul Rowe, Well South PHO and Rural Service Level Alliance Team (rural SLAT)
- Nigel Ogilvie, PRIME Provider, Westland Medical Centre
- Justin Butcher, Midland Health Network, Waikato DHB Rural Health Advisory Group.

Workstream 3: Clinical Governance

The working group held weekly teleconferences to work through the identified issues from 1 September to 31 October 2016. There was varied attendance at these teleconferences, with some members of the group attending less than half of the scheduled meetings due to competing priorities.

The working group members were:

- Dr Kristin Good, ACC Senior Medical Advisor (Workstream Lead)
- Dr Mike Hunter, Southern Regional Emergency Care Coordination Team (ECCT)
- Kirsty Murrell-McMillan, Registered Nurse and PRIME Practitioner
- Dr Craig Ellis, St John
- Dr Sarah Creegan, General Practitioner and PRIME provider/ practitioner, Waimate
• Kate Stark, PRIME Practitioner, Roxburgh Medical Services Trust; Nurse Practitioner, Gore Health Limited
• Leonie Howie, Registered Nurse and PRIME Practitioner, Great Barrier Island
• Dr John Elliot, General Practitioner and PRIME practitioner, Kumeu; Rural SLAT.

Workstream 4: Training and Syllabus

The working group held teleconferences between mid-August and 31 October to work through the identified issues.

The working group members were:

• Adrian Skinner, PRIME (Clinical) – National, St John (Workstream Lead)
• Dr John Chambers, ECCTs
• Dr David Richards, PRIME Committees (South Island – South), ED Consultant
• Dr Rachel Thomson, General Practitioner and PRIME practitioner, Te Kaha
• Dr Robin Barraclough, General Practitioner and PRIME practitioner, Tasman district
• Gina Mills, Registered Nurse and PRIME practitioner, Tapanui
• Dr Buzz Burrell, General Practitioner, Renwick and Rural SLAT Chair
• Peter Davis, Intensive Care Paramedic and PRIME trainer, St John.

The group also sent out a survey to the sector on 16 September 2016 and again on 19 September to additional addressees. There were 60 responses, which informed the group’s recommendations.

Workstream 5: Equipment, Kit and Medicines

The working group held teleconferences between mid-August and 31 October to work through the identified issues.

The working group members were as follows:

• Dan Ohs, Head of Clinical Practice, St John (Workstream Lead)
• Dr Mike Hunter, Southern Regional Emergency Care Coordination Team (ECCT)
• Dr Chris Henry, General Practitioner and PRIME practitioner, Kalkopura
• Dr Robin Barraclough, General Practitioner and PRIME practitioner, Tasman District
• Dr Kate Armstrong, General Practitioner and PRIME practitioner, Colville, Hauraki SLAT
• Gina Mills, Registered Nurse and PRIME practitioner, Tapanui
• Dr Cheryl Tallon – General Practitioner and PRIME practitioner, Methven.

The group also developed a survey which was sent out to the sector on 10 October 2016. There were 90 responses, which informed the group’s recommendations.
Appendix 2: Review workstreams: key issues identified by the PRIME review Steering Group

Workstream 1: Funding arrangements
A. Funding for medical-related attendances
i. review the $1.2m funding mechanism and distribution for PRIME medical-related responses, which is considered inequitable
ii. ensure medical-related funding considers accident-related funding (ie, they work together to form a fair and effective funding arrangement)
iii. address the perceived inequity between accident-related and medical-related funding

- Accident-related funding: ACC PRIME practitioners are paid for a) time on travel, b) kilometres travelled, c) consultation fee d) any associated usage
- Medical-related funding: PRIME practices are funded based on three tailed system (ie, number of medical-related attendances within a set range)

iv. consider practitioner concerns of additional costs for PRIME practices and practitioners that are not remunerated (eg. attendance at training)

B. Not receiving correct level of funding due to inaccurate records
i. address disparity concerns between St John’s records and the number of actual responses resulting in PRIME practices on wrong level of medical related funding

C. Practices charging in addition to receiving a PRIME fee
i. review whether practices are charging a co-payment for medical-related incident or new arrangements explicitly prohibit co-payments, but this is not the case in older contracts

D. Lack of transparency of funding
i. address concerns that too much of PRIME funding goes towards administration, management, and governance – rather than funding front-line services

Workstream 2: Administration
A. Governance – general
i. consider whether all parts of the governance structure are adequate and/or (effective, but should link with, clinical governance)

ii. consider the option of a new governance board that could address many of the issues raised about PRIME

iii. address concerns raised about transparency of St John as PRIME administrator

iv. address concerns raised about inconsistency in how PRIME is administered:

- greater integration with St John
- greater alignment with after-hours model

- need for results-based accountability

- address contrast between St John’s centralised model and local needs

v. consider the structure and function of PRIME committees, including whether other parts in the health system could fulfil this role (ie, rural service level alliance teams)

B. Information and support from St John
i. consider communication issues

- the flow of information from St John to providers

- the information that St John receives and how it responds

- communication directed to contract-holding practices rather than the individual providers: assess whether communication should be with practices and practitioners in parallel

ii. review adequacy of current database for recording PRIME practices and providers

C. Review if the configuration and function of existing PRIME sites is fit-for-purpose
i. provide a) objective guidelines for where PRIME should be located, and b) guidelines for modifying any PRIME site (eg, establishing a new site, disestablishing an existing site, or making changes to an existing site)

ii. look at the role of the PRIME committees (including whether this could be fulfilled by other organisations, such as the rural SLATs) in providing advice to the administration on modifications to current PRIME areas or additional PRIME areas

iii. address concerns that new PRIME sites are not being established when there is a need, including concerns raised regarding contract-holding practices refusing to allow others in

iv. consider whether, or under what circumstances, less-than-24-hour coverage is acceptable

v. consider whether it is practicable (ie, affordable, manageable, and sustainable) that a PRIME area could respond to a wider range of incidents than the minimum criteria (see clinical governance)

D. Improve the collection and analysis of data
i. look at options for improving the collection and analysis of data

Workstream 3: Clinical Governance
A. Responsibility for the scene and treatment
i. review the requirement for clear parameters about what is expected at the scene and providing care accordingly

B. Governance – clinical
i. address concerns about clinical governance, specifically the need for a clear understanding of the clinical oversight each stakeholder has; eg concern that St John, as an ambulance provider, attempts to maintain clinical supervision over the actions of doctors and nurses, but many PRIME practitioners ignore any attempt to direct or correct them

ii. develop guidelines to clearly separate roles and responsibilities of key stakeholders, including quality assurance versus clinical governance

C. Contracted requirements
i. review PRIME agreement requirements as follows:

- Prime committees to review at least 20 cases each year as part of continuous quality improvement through case review

- PRIME service providers must be registered medical practitioners or registered nurses under the Medical or Nursing council, respectively

PRIME service providers must maintain clinical competency, which includes demonstrating clinical competency to the medical or nursing council through a practical assessment at a refresher course (PRIME service provider who are nurses and are responsible for ensuring they have obtained appropriate clinical oversight in order to ensure their scope of practice is maintained, including addressing current protocols for obtaining and maintaining a standing order

D. Changes to clinical audit process
i. review clinical audit requirements conducted by PRIME committees (as required in their terms of reference) to address concerns they are ad hoc with regard structure, methodology, and representation from treating clinicians

ii. consider protocols for how audits will be conducted, if relevant that this is an appropriate way to monitor safe practice

E. Assess the need for a formal network and forum for PRIME nurses
i. consider whether the following should be established for PRIME nurses, given they are generally staff employed in PRIME practices rather than owners:

- an independent voice

- support network

F. Dispatch and coordination – threshold requiring a PRIME response
i. consider if the PRIME response threshold is at the right level

G. Critical incident support
i. consider if the support offered following critical incidents is sufficient (especially for very traumatic events)

Workstream 4: Training and Syllabus
A. Access to training
i. address issues raised regarding the difficulty of accessing a PRIME course, especially for those who need to attend a refresher to remain in practice

ii. confirm that access to St John PRIME training has significantly improved over the past 24 months and that previous concerns have been addressed

iii. look at alignment of training locations with PRIME sites

B. PRIME training syllabus
i. assess protocol (and associated costs) for regular reviews of the training syllabus to ensure continued fit-for-purpose, including evaluation of courses for effectiveness, noting MOH and ACC own the intellectual property rights of PRIME

ii. address concerns raised that PRIME’s generic training approach is not appropriate for the varied competencies of those attending

iii. address the best mechanism to ensure all stakeholder are involved in the development of the content of PRIME syllabus; including the potential for training with other key organisations (fire, police, health – including Health’s mobile surgical units)

C. Delivery of PRIME training
i. address concerns that PRIME teaching staff should reflect the varied backgrounds of the learners and draw on the strengths of different occupational groups, including specialists in relevant disciplines; senior and accomplished rural practitioners (both nursing and medical) and ambulance trainers

ii. address concerns that there is variability of training across the country

D. Not enough PRIME manuals distributed
i. assess whether the current PRIME manual distribution process is adequate currently each PRIME practice gets one PRIME manual regardless of the number of PRIME practitioners

E. Timing of revalidation for PRIME practitioners
i. review the requirement for PRIME practitioners to undertake a refresher every two years of their last refresher, given concerns that the current revalidation requirements (not more than 2 months before expiry and six months after) could be improved

Workstream 5: Equipment, Kit and Medicines
A. Changes to equipment issued
i. review the current protocols around the standard equipment kit to ensure it remains fit-for-purpose, the review is to include:

- equipment provided (including whether specific additional equipment is required – automated external defibrillators (AEDs); and

- interoosseous vascular access devices (ie, EZ-IO)

- whether the PRIME kits should be the same as those used by St John’s practices

- paramedics (ICPs)

- the role of PRIME committees and the administrator in seeking changes to equipment

ii. can any recommended changes be met within budget

B. Safety items
i. consider the need for safety items such as:

- uniforms; high visibility items; (fireproof) overalls; boots; vehicles suitable for emergency responders; signage for vehicles; and emergency lighting for vehicles (ie, flashing lights)

- describe the risks that PRIME practitioners face (including their likelihood and consequence), and map these against indicative costs that PRIME should be responsible for (eg. the costs to address some risks could be the responsibility of their primary employer)

- given the expected cost to address each issue relative to its risk (likelihood and consequence), provide a list (on a priority list

- using the priority list, work with the administration standard to understand what risks (if any) could be funded

C. Maintenance and responsibility of PRIME kits
i. review protocols around maintenance of, and responsibility for, kits and requirements around the use of kits by PRIME providers – the review will include:

- whether kits are issued to PRIME practitioners rather than practices

- whether standard protocols to ensure kits are regularly checked and maintained to a set standard

- mechanism for replacing contents

D. Temporary shortage of kits during replishment
i. address concerns regarding the limited number of kits, including PRIME sites that are temporarily without a kit while replenishment takes place

E. Medicines – no standard medicines list
i. address concerns that there is no standard medicines list

- whether kits need to have a standard minimum drug list for consistency of practice and simplicity of re-supply

- whether kits should consitute with St John’s clinical procedures and guidelines (CPGs)

- whether PRIME practices should be responsible for providing medications – some practices are purchasing medications at their own cost (eg, $100 for crash injury medicines)
Appendix 3: PRIME national structure

National Ambulance Sector Office (NASO)
- ACC contracted funding (accident-related responses)
- MOH contracted funding (medical-related responses)

PRIME Administrator (St John)

PRIME Providers (sites)

PRIME Practitioners

National Rural Health Advisory Group (NRHAG)
- Member
- Agreement

National PRIME Committee
- Chair: NZRGPN
- Functions include corporate and clinical governance
  (mandated to set up temporary working groups, as required, to address specific issues)

Regional PRIME Committees
- Quarterly meetings

South Island - South
South Island - North
Central
Northern

Terms of Reference

Health sector regulatory bodies

Professional colleges / societies / networks

Ambulance services

ECCTs

ACC contracted funding
MOH contracted funding

Member

Contract

Terms of Reference

Agreement

Engagement
Appendix 4: PRIME committee terms of reference

(Current PRIME Committee Terms of Reference from appendix 3 of the current service specification)

Background

The Primary Response in Medical Emergencies (PRIME) scheme involves the co-response of medical and/or nursing practitioners with ambulance services to serious emergencies in rural areas. The purpose of the PRIME scheme is to:

- improve access to effective, coordinated emergency services in rural areas;
- promote a team approach to rural emergency response; and
- contribute to improved patient outcomes for medical, surgical, accident, psychiatric and maternity emergencies in rural areas.

PRIME fits with the Roadside to Bedside vision of clinically integrated regional emergency care networks. It involves response, on-site care, and transport to definitive treatment. System components include planning, training, equipment, communication, triage, teamwork and evaluation.

Stakeholders

The PRIME service is provided for the benefit of rural communities. Professional and government stakeholders in PRIME include:

- ambulance providers, ambulance officers, and their professional and representative bodies;
- rural GPs, other rural medical practitioners and their respective professional and representative bodies;
- rural nurses and their professional and representative bodies;
- rural midwives and their professional and representative bodies;
- hospital emergency department and other acute medical, trauma, psychiatric and maternity services;
- District Health Boards;
- NZ Police and Police Search and Rescue;
- NZ Fire Service;
- the Accident Compensation Corporation;
- the Ministry of Health.

Purpose of the PRIME Committee

The purpose of the regional PRIME committee is to review and evaluate the functioning of the regional PRIME system; recommend possible improvements to systems or processes; provide peer support to practitioners; and communicate relevant information and/or recommendations to stakeholders.

Objectives of the PRIME committee:

The objectives of the PRIME committee are to:

- develop and review plans for the delivery and coordination of PRIME services;
- identify service coverage issues and propose solutions to address these issues;
- review and make recommendations regarding access to appropriate equipment for rural emergency response;
- review and make recommendations regarding the content of, and access to, training for rural emergency response;
- make recommendations and support education around clinical practice;
- plan for emergency response (including Pandemic Planning) during infectious disease epidemics;
- review and make recommendations with respect to communication centre triage protocols for rural emergencies;
- identify, review and disseminate evidence-based guidelines for PRIME patient care;
• identify need for, and facilitate access to, critical incident and operational debriefing for PRIME Service Providers;
• act as a contact point for PRIME Service Providers to raise issues and concerns;
• ensure that PRIME Service Providers and their representative bodies are kept informed of key issues discussed and recommendations made by PRIME committees.

Membership
The PRIME Committee members will elect a chairperson for a period of two years.
The PRIME committees are open to all PRIME Service Providers to attend and will include at least the following representatives:

• ambulance regional operations manager;
• PRIME Service Providers including at least one GP and one nurse representative;
• paramedic / ambulance officer representative, if possible;
• EACC representative;
• Maori Health representative; and
• other representatives to be invited as appropriate, e.g. hospital clinician, PHO or DHB funding & planning representative.

Meetings may be attended via teleconference (which the PRIME Administration Provider will make available to members). The time of the meetings will be consulted with members to ensure as large an attendance as possible.

Communications
The PRIME committee is the conduit for communications regarding planning and evaluation of the PRIME system. The PRIME Administration Provider is responsible for ensuring that PRIME committees develop and maintain communication with stakeholders in their region.
The agenda of each PRIME committee meeting and a report including discussion items and action points will be available to all practitioners and will be forwarded by email to:

• all PRIME Service Providers in the region;
• the Rural Faculty of the Royal College of GPs;
• the regional ECCT;
• a nominated person at ACC;
• a nominated person at the Ministry of Health;
• the Rural GP Network;
• the College of Nursing;
• the New Zealand Nurses Organisation; and
• other stakeholders as requested.

In addition, the PRIME committee will be responsible for ensuring all stakeholders (as listed above) are aware of the PRIME system and its operation, and have the opportunity to raise issues with, or receive information from, the committee.

PRIME Service Providers Representative
Each PRIME committee will appoint one official PRIME Service Provider representative for medical practitioners and one for nurses, for a minimum period of one year. The role of the PRIME Service Provider representative is to:

• attend all PRIME committee meetings during the period as PRIME Service Provider representative;
• co-ordinate input in the PRIME committee by acting as a contact point for other PRIME Service Providers.
PRIME Service Providers are encouraged to complete a system development form (attached) for review by the PRIME committee.

**Continuous Quality Improvement through Case Review**

Each regional PRIME committee will review at least twenty cases per annum, considering the following factors:

- triage of incident by the EACC, quality and timeliness of information made available to ambulance and PRIME Service Providers;
- appropriateness of resources dispatched to incident;
- care provided at the scene, including use of equipment, drugs, or other clinical interventions;
- destination decisions; and
- delivery of patient to hospital-based care and care provided during transport.

A standard Ambulance / PRIME record sheet will be used for patient records for the use of ambulance officers, doctors and nurses involved in the PRIME scheme. Copies will be used for audit of the system. In addition to normal details, the sheet will record:

- a unique identifier;
- physiological measurements suitable for future outcome analysis;
- nature of incident (e.g. accident, medical, maternity);
- category codes – assigned by the most senior person present at initial assessments and handovers.

Any member of the PRIME Committee or any PRIME Service Providers may nominate cases for review by the Committee.

For the identified incidents, the PRIME committee provider (i.e. ambulance provider) will obtain a copy of the hospital records of the relevant patient(s) for review by the committee.

**Relationship to Emergency Ambulance Communication Centre User Group**

The PRIME Committee is to link closely with the appropriate Emergency Ambulance Communication Centre (EACC) User Group. The Terms of Reference for this group are attached as Appendix 4 in the service specification.

Issues raised in the PRIME Committee that related to the triage, dispatch and coordination of the incident will be passed on to the EACC User Group for consideration. Any member of the PRIME Committee may attend the EACC User Group when an issue forwarded by that PRIME Committee is on the agenda.

**Relationship to Emergency Care Coordination Teams**

The PRIME Committee is to link closely with the appropriate regional Emergency Care Coordination team (ECCT). The purpose, composition and objectives of the ECCT are defined in the joint Ministry of Health/ACC service specifications ED8001.

Issues raised in the PRIME committee that reflect on the wider emergency care system will be passed on to the regional ECCT for consideration. At least one member of the PRIME committee must attend each ECCT meeting and represent the committee.

The PRIME committee will supply a detailed report on the PRIME service for the ECCT annual report.

**Frequency**

PRIME committees should ideally meet a minimum of four times per year, and the committee members will determine if more meetings are required on an as needed basis. The committee members will also determine their preferred media of communication.
## Appendix 5: 14 band funding schedule

**NOTE:** Proposed funding for each band in 14 band schedule is provided as an example only. Funding per band will need to be confirmed to ensure allocation remains within the current funding envelope.

### CURRENT PRIME FUNDING (3 BANDS)

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### PRIME FUNDING - 14 BAND SCHEDULE

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<td>300,000</td>
<td>100,000</td>
<td>30,000</td>
</tr>
<tr>
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</tr>
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<tr>
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<td>900,000</td>
<td>300,000</td>
<td>90,000</td>
</tr>
</tbody>
</table>

**NB:** All funding is per year.

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Appendix 6: Ambulance scopes of practice and practice levels

Ambulance personnel practice at one of the specified ‘practice levels’ listed below. Each practice level has a ‘scope of practice’ that defines the medicines and interventions that ambulance personnel may administer when treating patients (ordinary interventions that are not listed at any level may be performed by all personnel, such as automated defibrillation).

As described in the Key findings: 16. Aligning to Paramedic scope of practice section, at a minimum, training and equipment will be aligned with the Paramedic practice level.

Table 6: Ambulance practice levels (source: St John 2016-2018 CPGs)

<table>
<thead>
<tr>
<th>Practice levels</th>
<th>Scope of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medical Technician (EMT)</td>
<td>Adrenaline IM, IN, nebulised and topical, entonox inhaled, glucagon IM, GTN SL, ibuprofen PO, ipratropium nebulised, laryngeal mask airway, laryngoscopy (airway obstruction), loratadine PO, methoxylurane inhaled, ondansetron PO, paracetamol PO, PEEP, prednisone PO, salbutamol nebulised, tramadol PO, urinary catheter troubleshooting.</td>
</tr>
<tr>
<td>Paramedic</td>
<td>All of the above plus the following. Adrenaline IV (cardiac arrest only), amiodarone IV (cardiac arrest only), amoxicillin / clavulanic acid IM or IV, clopidogrel PO, enoxaparin SC, fentanyl IN and IV, gentamicin IV, glucose IV, heparin IV, IV cannulation, lignocaine (1%) SC, manual defibrillation, metoprolol IV, midazolam IM (seizures or agitated delirium only), midazolam IV (seizures only), morphine IM and IV, naloxone IM and IV, olanzapine PO, ondansetron IM and IV, oxytocin IM, sodium bicarbonate (0.9%) IV, synchronised cardioversion, tenecteplase IV, valproate IV.</td>
</tr>
<tr>
<td>Intensive Care Paramedic (ICP)</td>
<td>All of the above plus the following. Adenosine IV, adrenaline (all routes), amiodarone IV (cardiac arrest only), atropine IV, calcium chloride IV, chest decompression (needle), cricothyroidotomy, endotracheal intubation, finger thoracostomy, IO access, ketamine (all routes), lignocaine (1%) (all routes), magnesium IV, midazolam IV, pacing, rocuronium IV, sodium bicarbonate (8.4%) IV, suxamethonium IV (RSI endorsed personnel only).</td>
</tr>
</tbody>
</table>