REPORT ON THE COLLABORATIVE, INTERAGENCY WORKSHOPS ABOUT PRIME, AFTERHOURS & RELATED SERVICES

March 2021

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Contents

Notes:

- The content and recommendations of this report have been endorsed by workshop participants
- A report summarising the discussions held in the first workshop were endorsed by workshop participants. This report is available upon request to any of the workshop participants.
- RGPN acknowledges the support of the Ministry of Health and ACC throughout the course of this project. Their representatives participated in the workshop as observers and therefore have not contributed to the writing of this report.

Executive Summary

The purpose of this report

The purpose of this report is to provide PRIME Stakeholders with a summary of the discussions that were held across two interagency workshops that were held in November 2020 and March 2021. The workshops were convened to define and address issues associated with the sustainability of the delivery of PRIME and rural after-hours services.

Workshop participants[1] endorsed the content of this report and the recommendations included in it.

The background to the discussion

The PRIME service, which delivers high quality, timely access to pre-hospital emergency treatment in remote and rural areas, has been in place and relatively unchanged for 21 years. During that time the environment in which it operates and the mix of population it serves, have changed substantially. Many PRIME Providers[2] are finding that maintaining the service is a significant challenge.

On November 10, 2020 the first of two collaborative, interagency workshops was held to more clearly articulate the problem being faced, to identify how best to approach solving it and to plan the actions required to move the problem-solving exercise forward.

To inform a second workshop that was held in March 2021, information about PRIME, Ambulance, FENZ, ED, rural hospital and after-hours services was collected and collated by St John in an interactive map of NZ.

Workshop participants agreed:

"Those involved in the delivery of after-hours and emergency services to rural communities agree that the current system is not sustainable at either a personal or an operational level"

The information collected during this process, contributed to setting the following objectives for the second workshop:

- How can the themes of locality planning described in the Health and Disability System Review be applied to better allocating resources in rural areas, to ensure that rural communities have access to access sustainable and equitable services
- Identify opportunities to consistently deliver sustainable after-hours and emergency services to rural communities
- Identify any addressable service gaps against minimum service specifications
- Develop options that could address these gaps.

Workshop participants agreed that paramount to the sustainability of PRIME service provision is the untenable health and safety risks PRIME providers face on many of their call outs. The long-standing underfunding of all rural primary care services, not just PRIME, is increasingly putting the service in crisis and negatively impacts not only on the health outcomes of rural NZ but also, significantly on the service providers.

Key issues discussed in the workshops

Both funders and providers of services across organisations connected to PRIME and rural primary care services including DHBs, PHOs, ACC, St John, and rural general practice service providers participated in the workshops.

The critical components of rural primary care services including day to day rural primary care service priorities, PRIME, after-hours and urgent care services were discussed.

[1] Appendix 2: List of participants in this Workshop 2

[2] PRIME Providers: Rural General Practices and /or their staff who respond to PRIME call outs

Issues related to the PRIME administrator, St John, and the National PRIME Committee (NPC) were also discussed. The issues discussed in this report are:

1. Health and safety risks faced by PRIME service providers
2. Improving the integration and sustainability of PRIME, after-hours and urgent care services
3. The Health and Disability System Review - sub-localities within localities
4. Identifying and resolving PRIME service gaps for rural communities
5. Broader interlinked issues included are
    i. Workforce challenges
    ii. Improved access to telemedicine
    iii. Rural after-hours funding
    iv. Funding of the PRIME Administrator to progress the recommendations in this report.

Summary of the recommendations made by workshop participants

Workshop participants agreed on the following recommendations that result from discussions in this report.

i. St John should:
    - Review and accept the health and safety risk analysis that is included as Appendix 1 to this report
    - Work with the National Prime Committee and PRIME Providers to develop a programme of work that implements operational and systemic risk mitigation.

ii. Major health providers (including all rural general practices), current PRIME Providers, DHBs, PHOs, and St John, should co-operate in sub-locality planning to ensure the best use of all available resources and the long term sustainability of all services through an assessment of rural communities' access to after-hours and emergency response services. This will include:
    - A review of the availability (including hours covered) of PRIME sites
    - An assessment of the locations where PRIME may no longer be required (due to increased emergency ambulance coverage) and,
    - Identifying locations where new PRIME sites may be required.

iii. Apply the analysis outlined in recommendation 2 above to a reconfiguration of PRIME sites, which may lead to associated changes to the contractual arrangements between St John and the PRIME Providers. The current funding bands may also need to be reviewed within available funding, to ensure they are appropriate for each PRIME site.

iv. St John, NZRGPN and National PRIME Committee participating organisations engage with the Transition Unit and the Ministry of Health about how PRIME and rural after hours services will be commissioned and funded as part of the health system reforms.

v. That the NPC undertake two related pieces of work:

    - An assessment of progress against the PRIME Service Review 2016 recommendations Review and update its Terms of Reference to ensure they enable the effective functioning of the NPC within its current operational mandate.

vi. That the PRIME Administrator should work with the National PRIME Committee to agree a programme of work that actions the operational improvements recommended in this report. This may include the PRIME administrator seeking NPC endorsement for a request for additional funding for improvements that fall outside the parameters of current funding arrangements.

Intended actions for the year ahead

Over the next year, the National PRIME Committee will:

- Review and update its Terms of Reference to ensure they enable the NPC to fulfil its ongoing operational requirements
- Assess its progress against the recommendations in the PRIME Service Review 2016
- Develop a workplan to action recommendations from the above assessment.

St John will:

- Set up a project plan to progress the recommendations from the report – this may include seeking funding to enable operational improvements that fall outside current funding arrangements e.g. GPS tracking
- Complete the interactive service mapping tool and associated contract review processes
- Systematically review PRIME service configuration in line with sub locality planning principles.

NZRGPN will:

- Appoint a Chair to the NPC according to the reviewed and updated TOR
- Work closely with St John, and the NZRGPN working group to progress recommendations in this report
- Work with St John and National PRIME Committee participating organisations to engage with the Transition Unit and the Ministry of Health about how PRIME and rural after hours services will be commissioned and funded as part of the health system reforms.

The Five Key Issues Discussed in the Workshops

1. Health and safety risks faced by PRIME service providers

The PRIME service operates in a fashion that is largely unchanged from its inception in 1999. Since then, rural populations and workloads have changed significantly, as have health and safety at work regulatory requirements.

Three inter-related PRIME service health and safety risks[3] that were identified by workshop participants and require urgent mitigation are:

1. Emotional and physical fatigue experienced by PRIME Providers that is caused by onerous PRIME and after-hours primary care rosters
2. Risks to the health and safety of PRIME Providers who respond to calls on their own
3. Injury from moving or managing patients on-site.

Taking actions to mitigate these risks is a priority for all PRIME stakeholders. A number of the mitigating actions will also improve the sustainability and attractiveness of the service, which is important from a workforce wellbeing perspective, and will contribute to overall service efficiency.

Key mitigations of the three risks noted above include:

- Operational guidelines and health and safety responsibilities of St John and Providers are integrated into the PRIME Service contractual arrangements
- St John offer guidelines for Providers about:
    - how they should manage fatigue and ensure that requirements for rest periods are met - including clarification of a Provider's ability to decide to not respond to a call out
    - hazard management at remote sites
    - lone working protocols
    - how to ergonomically and safely move patients
- Establish a coordinated, locality based PRIME Provider triage process
- Health and emergency Providers within sub-localities (including FENZ and St John) work together to configure resources and develop sustainable rosters that optimise the response to patients and reduce the number of lone responses
- PRIME contracts realistically reflect the sub-localities available workforce and capacity
- Encourage uptake of St John's Member Assistance Programme (MAP) services among PRIME Providers
- St John provide GPS tracking on call outs and ensure Providers have appropriate PPE
- Provide training in dealing with aggressive, violent and agitated patients.

Relentless expectations on rural general practices

A 4 FTE doctor Practice in a beachside community has 4500 registered patients, relevant levels of staff for this. They are sometimes able to get locum help for holiday periods. There is a low level of St John capacity in the town that is 30 minutes away.

Over Easter, the population swelled to around 45,000. The onus to respond to after-hours, and PRIME call-outs and a constant stream of urgent care presentations, falls heavily at the feet of the Practice team.

Demand for these services is relentless. The only on-call doctor is the lone responder to many of the PRIME calls until St John or Police can get there.

The community and health system's expectation, that the rural general practice will be able to cope with massive seasonal fluctuations in population and outdated funding models, exposes practice staff to dire health and safety risks.

[3] Appendix 1: Register of PRIME service Health and Safety Risks and potential mitigations

Recommendations:

i. St John should:
   - Review and accept the health and safety risk analysis that is included as Appendix 1 to this report
   - Work with the National Prime Committee and PRIME Providers to develop a programme of work that implements operational and systemic risk mitigation.

2. Improving the integration and sustainability of PRIME, after-hours and urgent care services

The 2020 Health and Disability System Review[4] made a number of comments and recommendations specifically about rural health, including reiterating that rural New Zealanders need sustainable and equitable services (page 14). It recognised that services may need to be delivered differently in rural areas compared to urban (page 137), that rural communities should be specifically planned for (page 147), that these plans should prioritise telehealth (page 164) and should encourage new ways of working, particularly with ambulance services (page 166).

The Review went on to articulate how locality plans, developed by DHBs should show how primary health care services would be configured and delivered to each population group to improve health outcomes and to address inequities between groups (page 64).

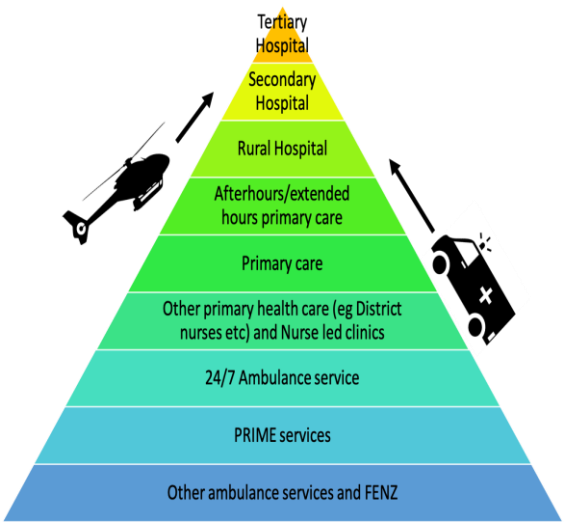
The workshop participants agreed that the implementation of this locality approach was critical for rural communities. They also agreed that the approach must be different from urban locality planning as there is are many contributing factors that must be taken into account, not the least of which is the widely variable mix of health, community, and emergency services available in each rural community.

3. The Health and Disability System Review – Sub-Localities Within locality planning

Rather than a national approach to planning for rural communities, workshop participants suggest that the concept of sub-localities be used for planning rural health services particularly, after-hours, PRIME and urgent care.

This concept embraces the idea that within a larger population 'locality' there are nested groups of sub-localities. Each sub-locality has a unique set of resources available to it eg: GPs, nurses, community health and social services, ambulance. All of these can be considered when planning service responses that meet the needs of each rural community.

Figure 1 Emergency and after-hours services hierarchy



Sub-localities recognise that not all services are available in all rural areas. Distance to core services, including secondary or tertiary hospitals, and after-hours services vary greatly from community to community (Figure 1). Consequently, the emergency and after-hours solutions for each community should reflect the relative configuration of services locally available, while incorporating those services that are available at a locality or regional level. Provision of comprehensive rural after-hours and emergency services should no longer be the domain of those Providers who are professionally and ethically committed to ensuring their communities have access to these, but arise from a well-planned and co-ordinated network of all resources available in a sub-locality.

[4] https://systemreview.health.govt.nz/final-report/

The service hierarchy (Fig 1) shows the interconnected but escalating network of after-hours and emergency services that should be in place for all rural communities. Not every rural community (or sub-locality) should expect to have immediate access to all the services in the hierarchy, but their relative access to each set of services must inform decision making on the configuration of services in that rural community. For example, a community without afterhours primary care services may be prioritised for deployment of increased ambulance services, or the negotiation of a new afterhours and PRIME contract.

From the workshop discussions a set of service planning and design principles emerged:

1. Planning should encompass a **sensible geographic area**, that varies according to the community's population, impact of holiday and tourist activity, and distance to secondary and specialist services.
2. The sub-locality planning should **utilise all of the available health workforces** including rural hospitals, primary care, district nursing services and paramedics.
3. **Planned use of telehealth** after-hours services, particularly to manage patients presenting with lower acuity medical problems.
4. **Improve on-call coordination** across PRIME sites so not all are on-call all of the time e.g. an on-call roster across a sub-locality such as Waikari, Culverden, Amberley and Cheviot or Otautau, Tuatapere and Te Anau.
5. **Improved use of data** informs on-call and coverage requirements of PRIME and ambulance service locations.

The financial duress of PRIME and after-hours service delivery

A 5 doctor remote Practice in the heart of adventure tourism NZ provides after-hours and PRIME services for, not only their community, but the constant stream of tourists and holiday makers into the area.

A doctor is on-call for PRIME and after-hours 365 days a year. Through the peak summer season, a nurse is also on-call 24/7.

Their financial information shows that the **net loss** to the practice owners of providing these services is in the vicinity of $100,000 per year.

Recommendation:

ii. Major health providers (including all rural general practices), current PRIME Providers, DHBs, PHOs, and St John, should co-operate in sub-locality planning to ensure the best use of all available resources and the long term sustainability of all services through an assessment of rural communities' access to after-hours and emergency response services. This will include:
    - A review of the availability (including hours covered) of PRIME sites
    - An assessment of the locations where PRIME may no longer be required (due to increased emergency ambulance coverage) and,
    - Identifying locations where new PRIME sites may be required.

4. Identifying and resolving PRIME service gaps for rural communities

St John have established an interactive, national map of PRIME, after-hours, urgent care and emergency services across all rural communities. This is likely to develop into a crucial resource for sub-locality planning for services as it includes the following geolocated services:

- Hospital emergency departments
- Rural Hospitals
- Primary care after-hours
- PRIME Provider locations
- St John ambulance locations and staffing
- Rescue Helicopter bases, and
- FENZ (Fire and Emergency New Zealand) stations and response times.

It is currently difficult to understand the actual levels of PRIME service cover for rural communities. This has come about over time as St John and the PRIME providers have agreed variations to the number of days per week, and hours per day, that the Provider is contracted to provide PRIME services. This contributes to an urgent need for analysis of the PRIME response capacity in sub-localities to transparently identify the actual levels of PRIME and ambulance service availability. This will ensure that PRIME service contracts are based on each rural community's need for PRIME and ambulance services and the actual capacity in that sub-locality to meet that need.

Based on the information currently available, and on the minimum service expectations, there are several areas that appear to have significant service gaps. The extent of these service gaps is dependent on clarifying the level of cover contracted from PRIME providers; for example rural areas from East Cape down to Wellington have no apparent PRIME cover.

***Workshop participants agreed**:*

"all rural communities should have access to:

- *Effective and informed triage*
- *Appropriately qualified first response and emergency transport, and*
- *After-hours access to primary care services*."

Recommendation:

iii. Apply the analysis from the previous recommendation to a reconfiguration of PRIME sites which may lead to associated changes to the contractual arrangements. The current funding bands may also need to be reviewed to ensure they are appropriate for each PRIME site.

5. Broader but related issues

Workforce challenges

The government's vision for the health system reform is to create a system that delivers Pae Ora / healthy futures for all New Zealanders, where people live longer in good health and have an improved quality of life[5].

This vision needs to apply to our health workforce as well. The whole health system is under increasing pressure from an aging population, increasing prevalence of co-morbidities and greater clinical complexity. If the government wishes to deliver on its vision and close equity gaps known to exist in rural areas, the rural health workforce must have a healthy future as well. This will necessitate:

- Similar protections for excessive work hours and safety-at-work guidelines that exist for urban health workers
- Increased rural training opportunities for general practitioner and nurses, including career development support that recognises challenges faced by rural health workers
- Improved opportunities for placement of health workers in training in rural locations, where they can also experience working in different settings e.g. general practice, rural hospitals, after-hours and emergency settings.

Improved access to telemedicine

Both rural health providers and rural communities will benefit from greater planned support through telemedicine. The health system has significantly more resources available in urban settings and, with the experience of Covid-19 behind us, increased confidence in the effectiveness and clinical safety of virtual health services.

The health system overall, and rural communities in particular, have a vested interest in providing attractive working conditions and career development opportunities for rural health practitioners. Planned telemedicine services incorporated into a sub-locality plan has the potential to:

- Support the rural health workforce by delivering:

[5] https://www.beehive.govt.nz/speech/case-change-health-system-building-stronger-health-and-disability-system-delivers-all-new

- Specialist advice into rural general practice settings to improve treatment effectiveness for complex patients
- A mentoring service for rural health professionals
- After-hours services that lessen the burden of after-hours cover and on-call PRIME rosters
- Triage of after-hours issues

- Support rural communities by:
  - Providing after-hours telemedicine access for urgent issues
  - Being the first point of call between 10pm and 6am for rural health needs (reducing reliance on PRIME Providers)
  - Improving access, without travel, to secondary specialist services (this could be hosted by rural general practice or hospitals to promote continuity of care).

At a regional level existing urban after-hours services are likely to have capacity to accommodate a significant portion of rural sub-acute after-hours demand via telemedicine channels, if enabled.

Rural after-hours funding

Workshop participants clearly articulated the correlation between significantly undervalued, underfunded, rural health services and the untenable health and safety risks they face as PRIME Providers. They maintain this has a direct and negative impact on the health outcomes of the rural communities they care for, and themselves.

This is a view that is widely held across the rural health sector and key stakeholders.

Furthermore, there is consistent feedback from rural health providers about the lack of transparency and flexibility of the rural adjuster funding, that is included in DHBs annual funding envelope, to address the unavoidable increased cost of delivering health services in rural NZ. Some of the rural adjuster funding makes its way through to rural general practice through their PHO Services Agreements which state that once the level of funding allocated to the rural general practice providers in a DHB has been agreed, any changes to the funding allocation requires the agreement of:

1. 75% of Rural Contracted Providers, and
2. Rural Contracted Providers who control at least 75% of the enrolled population of all such contracted providers.

These rules make it very difficult for DHBs to respond to the changing needs of their rural communities and equally, for rural Providers to have their request to a DHB for a change in their rural funding considered.

This is because the "voting power" resides with existing rural providers who may be financially conflicted in this decision, and less focussed on areas of emerging community need. This is particularly true if, over time, some of a DHB's Rural General Practices have lowered their response levels to after-hours and PRIME callouts, but continue to receive the funding intended for it.

Rural Service Level Alliance Team 'Stalemate'

It's not mandatory for a provider to respond to a PRIME call. One of the smaller DHBs has 6 Rural General Practices that hold PRIME contracts and also receive their share of the DHBs allocated rural premium fund each year. Only three of the Practices respond in person to after-hours or PRIME call-outs.

Those three Practices struggle to fund the level of doctor and nurse staff needed maintain the necessary rosters to do this. One of the Practices is in the center of a major tourist attraction where the volume of call-outs is disproportionately high.

In order to get the DHBs rural premium allocation altered to reflect where the work is actually done, the 3 active Practices will have get 75% of the 6 RSLAT members to agree to the change. This means the 3 practices that get the funding, but don't respond to call-outs, are able to essentially hold the process to request a funding change to ransom.

Funding of the PRIME Administrator to progress the recommendations in this report

The National PRIME Committee (NPC) discussed the early findings of this report at its quarterly meeting held on the 6 April 2021. The NPC noted that much of the recommendations in this report align to the system level recommendations in the PRIME Service Review 2016 which have yet to be actioned. The NPC agreed to undertake a review of its progress against the recommendations within PRIME Service Review, 2016 and also undertake a review of its Terms of Reference.

These actions will ensure that the NPC is well positioned to continue in its governance over the implementation of recommendations included in this report.

At an operational level, the responsibility for actioning most of the recommendations in this report, particularly those targeted at mitigating the health and safety risk to PRIME responders, will fall to the PRIME administrator (St John). This includes systems and process development, training of PRIME providers, and significant improvements in current communications systems.

A programme of work of this size and impact will require additional funding to enable the PRIME administrator to undertake it.

Recommendations:

iv. St John, NZRGPN and National PRIME Committee participating organisations engage with the Transition Unit and the Ministry of Health about how PRIME and rural after hours services will be commissioned and funded as part of the health system reforms.

v. That the NPC Undertaken two related pieces of work:

- An assessment of progress against the PRIME Service Review 2016 recommendations
- Review and update its Terms of Reference to ensure they enable the effective functioning of the NPC within its current operational mandate.

vi. That the PRIME Administrator should work with the National PRIME Committee to agree a programme of work that actions the operational improvements recommended in this report. This may include the PRIME administrator seeking NPC endorsement for a request for additional funding for improvements that fall outside the parameters of current funding arrangements.

"Supporting a sustainable rural general practice model that is attractive and rewarding for the workforce is a critical enabler for maintaining effective after hours and emergency services in our rural communities" PRIME providers

Appendix 1: PRIME Service Health and Safety risks and potential mitigations

	Risk / Harm Description	Hazards	Current Risk Likelihood	Current Risk Impact	Overall Risk	Mitigation
1	Emotional and physical fatigue caused by onerous PRIME and after-hours primary care rosters • Stress/overload/mental health • Impairment of clinical judgement leading to poor patient care • Loss of family time /social opportunities • Withdrawal of services to community • Driving and other accidents / harm	• Not enough staff to share rostering load • Over scheduling individuals • Emergency calls not triaged effectively • Not enough scheduled breaks or rest periods • Inability to turn down calls whether perceived or contracted • No support services to clinical staff • No guidelines for clinical staff on rest periods	Very High	Major	Very High	• Guidelines from St John on managing fatigue and required rest periods • Robust clinical triage processes established to ensure PRIME response are clinically beneficial • Sub-locality to configure rosters across workforce • PRIME contracts suitably matched to local service levels and community needs • Clear ability for PRIME providers to elect not to respond to calls • Uptake of MAP encouraged among PRIME providers
2	Risks to the health and safety of PRIME providers who frequently respond to calls on their own: • Unknown terrain, environment, people. • Provider has a driving accident while travelling to the call-out • Is injured due to site conditions, rescue operations • People / patient at the scene are aggressive, impaired, under the influence of drugs and/or alcohol • Getting lost on the way to a scene • Hypothermia	• Driving alone, particularly in bad weather or late at night • Responding alone • No GPS tracking • Hazardous accidents sites • No support and/or training in dealing with impaired people • Inappropriate PPE	Very High	Major	Very High	• Guidelines provided on lone working protocols • Provide GPS tracking on call outs • Provide appropriate PPE • Guidelines on hazard management at remote sites developed between St John and general practices • Sub locality rosters reduce the sole reliance on individual clinicians/providers and lone responses – include Police, FENZ or others in response* • Provide training in dealing with violent, aggressive and agitated patients
3	Injury from moving or managing patient on-site	Having to move patients in difficult, constricted, cramped situations Increase level of obesity Lack of bystander support to assist Aging responders	Possible	Major	High	• Training and guidelines on how to ergonomically move patients • Get assistance from public or other responders • Wait for St John response to arrive to assist

Appendix 2: Participants in the discussion and workshops

RGPN PRIME sub committee	Dr Tim Malloy, Dr Bryan MacLeod, Adele Robertson, Kate Stark, Gemma Hutton, Dr James MacMillan, Dr Sarah Creegan
St John	Kris Gagliardi
MOH	Nikki Canter-Burgoyne, Carleine Receveur, Alison Randall, Rachel Bayliss
PHOs	Bill Eschenbach (Waitaha), Jo Scott Jones (Midlands Pinnacle) , Paul Rowe (WellSouth)
DHBs	Andrew Goodger (NMDHB), Lisa Gestro (SDHB), Rose Laloli (TAS)
ACC	Karen Robertson, Jeremy Ly
Homecare Medical	Mary Anne Thompson, Dr Kristin Good
RGPN	Grant Davidson, Marie Daly, Andy Inder (Consultant and workshop facilitator)