ANZCA
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS

New Zealand
National Committee
PO Box 25506
Featherston Street
Wellington 6146
New Zealand
Level 7, EMC House
5 Willeston Street
Wellington 6011
T: +64 4 499 1213
F: +64 4 499 6013
E: anzca@anzca.org.nz
www.anzca.org.nz
www.anzca.edu.au

February 5, 2019

Sam Mason
Senior Advisor Standards Development
Standards New Zealand
PO Box 1473
Wellington 6140

By email: Sam.Mason@mbie.govt.nz; SNZPublicComments@mbie.govt.nz

Dear Mr Mason

Draft Revision of NZ Standard DZ 8156 Ambulance, paramedicine, and patient transfer services

As you are aware, the Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine, is responsible for the training, examination and specialist accreditation of anaesthetists and pain medicine specialists and for the standards of clinical practice in Australia and New Zealand. ANZCA's mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine, and pain medicine.

Anaesthesia is a pioneering stakeholder in pre-hospital and retrieval medicine both in New Zealand and internationally. This continues, with many anaesthetists and anaesthetic departments being responsible for the coordination and clinical treatment of patients in a pre-hospital and retrieval medicine context.

Although anaesthetists have been integral to the development of New Zealand standards and other pre-hospital and retrieval medicine guidelines, it is surprising and indeed disappointing that ANZCA has had no formal representation on the P8156 Committee. To remove any confusion or ambiguity about ANZCA's expertise in this area, the gazetted scope of practice of anaesthetists, as defined by the Medical Council of New Zealand, specifically includes retrieval medicine. Retrieval medicine is also included in ANZCA's Statement on Duties of Specialist Anaesthetists PS57.

ANZCA wishes to make the following general comments:

Our understanding is that health standards set minimum requirements for safe and appropriate care. This approach should be taken with this standard. As a minimum standard, we consider that the inclusion of a doctor does not need to be mandated for all aspects of pre-hospital and retrieval medicine. Instead, a doctor should be considered as an addition to usual care, where appropriate and feasible.

The lack of strong evidence of healthcare improvements and better patient outcomes in physician-led pre-hospital and retrieval services makes it difficult to support mandating physician-led pre-hospital and retrieval care in all situations, particularly as a minimum standard. The New Zealand health system faces considerable financial pressure. In the past, physician-led pre-hospital and retrieval systems have been established only to later be discontinued for funding reasons.

ANZCA is aware that developments in pre-hospital and retrieval medicine are likely and believes that the standard should anticipate these changes. New Zealand is considering registration of paramedics under the Health Practitioners Competency Assurance Act (HPCCA), and initial discussions highlight the likelihood of increased scopes of practice for some paramedics. Papers that describe these potential changes specifically refer to the existing intensive care paramedics and new roles of paramedic clinician and paramedic consultant having increased skills in intensive care, resuscitation and aero-medical activities.

ANZCA has the following specific comments to make on the draft document:

Section 5.2: Medical director practice expectations
With the likely changes to paramedic registration, it is questionable whether each organisation should be required to have a registered medical director. Some pre-hospital and retrieval medicine organisations may have paramedic and nursing staff that are responsible to their relevant registration boards. In other jurisdictions where this has occurred, the role of medical director has been disbanded and has not been replaced in some cases. In other contexts, the medical director has been replaced by a medical advisor (with decreased responsibilities) or replaced by a clinical advisory group. The key is good governance, which may not necessarily be provided solely by a medical director.

Section 7.9: Coordination of patient transfers and retrievals
If a national coordination centre is established, it is unclear how the standard would be interpreted in relation to:

- The movement of patients who have an unexpected emergency at a low-acuity, private surgical facility and subsequently require ICU/HDU level care at a different (and likely public) facility.
- DHBs who use a service (e.g. anaesthesia at CMDHB) to coordinate and transfer patients between different service locations within the same DHB.

Section 9.1: Clinical care requirements
For intensive care or critically unwell patients, the level of care during transfer should be no less than that received in the intensive care unit. For example, a patient on multiple pharmacological infusions, with a complex and challenging ventilatory strategy at a regional ICU would benefit from being escalated to care in a major metropolitan tertiary level ICU. This patient is likely to be best transported by an intensive care team (e.g. ICU registered nurse +/- intensive care specialist). Similar examples of this can be found in other areas of healthcare including, but not limited to, anaesthesia, paediatrics, obstetrics, neuro and management of long-term complex patients.

For patients in Category 1 described in subsection 9.1.2(a) of the standard, our view is that the team should not include a ‘generalist’ doctor. Rather, it should include a doctor with specialist training in the appropriate medical discipline, for example, intensive care medicine.

There is increasing evidence that handovers compromise clinical care. Minimising the number of handovers in transporting a patient from one facility to another should be a key principle of the standard.

The use of the term ‘appropriately skilled’ in subsection 9.1.4 is vague. We consider that doctors working in pre-hospital and retrieval medicine will not be able to competently manage **all** potential cases, such as complex obstetric or complex paediatric patients. Some of these cases would clearly benefit from a doctor with specialist expertise for the relevant clinical issue.

The challenge we see, is producing a standard that fulfils competing requirements. For example, defining a minimum standard that facilitates flexibility in the provision of high-quality, systematic care, yet at the same time ensuring that similar care is provided for complex patients or those with

uncommon conditions. In parallel to this, tension exists between finding the right skill set for the patient and at the same time, the environment. For example, a doctor with recognised training in inter-hospital transfers (IHT) and pre-hospital and retrieval care versus a doctor who can provide the highest level of care by virtue of sub-specialisation in a specific clinical area, but who requires support working in the IHT environment. It is impossible for any one group of doctors to provide optimal care to all patients in the combined IHT and pre-hospital and retrieval fields and achieve good clinical outcomes.

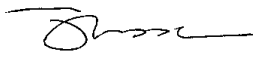
Appendix B – Registered Healthcare Providers Training and Experience Requirements
ANZCA continues to strongly object to the criteria in B1.6.1 and B1.6.2. These are historical, out of date criteria, which are no longer appropriate and are not supported by the medical education literature.

To conclude, the main points on the draft standards that ANZCA wishes to convey to the P8156 Committee are:

- The standard is confusing as it attempts to cover both pre-hospital and retrieval medicine, which are entirely different activities.
- The standard should include paramedics given the likelihood of them being registered in New Zealand in the future.
- The standard should reflect that, for patient transfers and retrievals, the team needs to have the appropriate expert skill sets to manage a patient's condition.
- The standard should not include time-based criteria, which is completely at odds with the current competency-based training requirements for medical colleges.

Thank you for the opportunity to provide feedback on the draft standard. If you have any questions on this submission, please contact Mary Harvey (Senior Policy Adviser) in the first instance at policy@anzca.org.nz or on 04 495 9780.

Yours sincerely



Dr Jennifer Woods
Chair, New Zealand National Committee