PC 25

Ymchwiliad i ofal sylfaenol

Inquiry into primary care

Ymateb gan: Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Response from: Welsh Ambulance Services NHS Trust

Health, Social Care and Sport Committee

Inquiry into Primary Care

RESPONSE FROM THE WELSH AMBULANCE SERVICES NHS TRUST

The Welsh Ambulance Services NHS Trust (WAST) welcomes the opportunity to provide a response to the Health, Social Care and Sport Committee, which will assist their consultation on primary care.

WAST has provided answers to the questions below that are applicable to the significant work it undertakes in conjunction with primary care: nationally, through the Directors of Primary Care and Mental Health (DPCMH); and, locally, via direct working with certain primary care clusters.

1. How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).

The Welsh Ambulance Services NHS Trust (WAST) continues to fully recognise the importance of developing a working relationship with primary care. In 2015 - 2016, an extensive analysis was undertaken to identify opportunities to develop future services in line with the needs of primary care. This involved engagement with key stakeholders such as the Directors of Primary Care & Mental Health Services, Primary Care Cluster Lead General Practitioners (GPs), and Public Health Wales (Cluster Regional Network events – Pacesetter Projects).

This engagement led to mutual recognition that integrated working between WAST and clusters will support the emerging model for a sustainable primary care service in Wales and improve patient flow within the unscheduled care system.

Through this collaboration, the following key points have been identified to illustrate how WAST can work with clusters, and health boards, to support primary care in driving transformational change and ensuring patient needs are met through a prudent approach to healthcare:

- Creating a scheduled service for the admission of patients to hospital, who require transport within an agreed timeframe, but not necessarily a ‘blue light’ ambulance. Our service improvement team has illustrated that this call volume is very predictable and has previously developed a model with Cwm

Taf Health Board, which has proved to be successful in terms of increasing patient satisfaction and increasing the efficiency in patient handover at hospital. In terms of benefits, this approach can be summarised as improving patient flow for the high, and predictable call volume for GP (and other Health Care Professional – HCP) requests for low acuity transport and hospital admission (within a stipulated time period of 1 to 4 hours).

- Education and training for 'Community Paramedics' to develop their skills in primary care, and attach them to clusters to respond to appropriate calls for both the 999 and primary care service. Such an approach potentially increases GP capacity to see patients at primary care centres.

- Providing Advanced Paramedic Practitioners (APPs), educated to master's degree level, to work as part of a multi-disciplinary team (MDT - pharmacist, district nurse etc.) to staff primary care hubs / support teams as part of enhanced services provided by clusters. Such an approach potentially increases GP capacity to assess the patients with more complex needs, and increases the capacity of clusters to provide more holistic care within communities.

- Introduce chronic disease plans that can be accessed / interpreted by paramedics for patients who are being treated and managed within the community. This will potentially avoid unnecessary conveyance of these patient groups to hospital, & enable paramedics to 'link in' with community teams.

- Future estate developments, where ambulances can be co-located with primary care centres. This would support enhanced services, create a working relationship for clinical leadership by GPs, and provide rapid responses to any critically ill / injured patients who require advanced life support (ALS) either within the community, or as a result of attending the centres.

2. The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).

WAST has the capability to respond to the needs of a wide range of patients, and provides a similarly broad portfolio of services to achieve this including: critical care; clinical telephone triage and advice; scheduled patient transport; an, website-based health advice. As identified in point 1 above, there is also a significant opportunity to develop models of care that support the emerging multi-disciplinary team (MDT).

For this reason, the key priority agreed between WAST and the primary care community for 2017/2018 is the development of the MDT approach. Within WAST's Integrated Medium Term Plan (IMTP), the main objective is to focus on developing and evaluating the MDT models that have been agreed and will be initiated with clusters during the last quarter of 2016. Specific examples are outlined below:

- Primary Care Support Team Model (Hywel Dda – in operation): Role development for five Advanced Paramedic Practitioners (APPs), who are part of a GP- led MDT, which works with identified practices to provide additional support and increase the capacity / efficiency of that particular primary care service.
- GP Out of Hours Service (OOHs) model (Aneurin Bevan – planned for end of January 2017): Role development for two APPs undertaking home visits on behalf of the GP OOHs in AB Health Board area. The posts will be rotational, with APPs continuing to also undertake shifts for WAST.

- Primary Care Practice model (Cwm Taf – planned for end of January 2017): Role development for four APPs (trainees) undertaking home visits during the day, on behalf of the Aberdare practice as a result of calls being triaged by a GP, and allocated accordingly to the scope of the APPs' practice. In addition, the APPs will support Cwm Taf GP OOHs (as per the GP OOHs MDT model in Aneurin Bevan above) and WAST with any operational resilience plans, and will be required to undertake shifts for these services as and when required.

The above MDT models will ultimately inform the best option for the development of future joint team working between WAST and primary care. There will also be an indication of associated costs, and governance requirements to ensure sustainability of such changes.

In addition to the MDT models, there has also been agreement to test new ways of community working between Clusters and WAST's existing operational model:

- Community-based partnership model (Cardiff & Vale planned for end of January 2017)

Develop and test a new model and pathway linking the local rapid response vehicle (RRV) directly to the three local primary care practices within the Western Vale Primary Care Cluster Group. This will create collaborative working between the two unscheduled care services in that geographical area. The aim is to improve communications to avoid untimely responses and unnecessary patient admissions to hospital, create care packages for frequent service users, develop alternative care pathways and create chronic disease plans/anticipatory care plans for paramedics to utilise. This model is heavily dependent upon being clinically led by GPs, who will retain the duty of care for the patients, unless it is identified that the paramedics need to convey the patients to hospital.

- Community-based partnership model (Powys planned for April 2017)

A similar scheme to Western Vale Cluster, but enabling four paramedics to be part of an integrated team in the Llandrindod Wells Minor Injury Unit.

3. The current and future workforce challenges.

As identified in point two above, WAST and primary care colleagues have identified opportunities to develop / test new MDT models, based upon the findings of the Pacesetter Projects. This work has revealed both current and future challenges.

- The current challenge is to avoid the potential creation of an 'internal market'. There is a risk that paramedics or nurses are developed to a high level of clinical practice through educational programmes, but are then employed by individual practices, as opposed to undertaking rotational roles that would benefit the whole unscheduled care and primary care systems (e.g. WAST retain contracts of employment and colleagues work across both primary & emergency care).

- As well as developing APPs to directly support the emerging model for primary care (home visits, primary care hubs, support teams), a future challenge will involve identify training needs for paramedics to work in an integrated way with primary care, as part of a community - based service. This training needs analysis will inform WAST's Strategic Education and Development Group (SEDG) to develop paramedics beyond current critical care skills and meet the changing clinical demand.

In WAST's 2016-19 IMTP these challenges have been recognised, and the Year 2 options include:

- Development of business cases to inform service planning/ commissioning of joint services for agreed MDT models with Clusters to meet the healthcare needs of the population (Health Care Needs Assessment).

- Cost effective sourcing of estate opportunities, where WAST and primary care could undertake feasibility work to identify options to bring together joint centres / 'hubs' of community care leading to better access, advanced life support co-located with primary care for critically ill/injured patients, clinical support and supervision for paramedics and encouraging MDT working with GPs and community teams.

4. The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.

WAST has observed occasions where funding is being dealt with at a local level as a response to a problem in recruiting General Practitioners (GPs), practice nurses, and community nurses, rather than as a strategic choice. For example, in Hywel Dda (see initiative described in paragraph two), APP costs have been re-charged to the HB, with funds being released as a result of GP vacancies.

A more strategic approach might involve devolving further unscheduled care monies either to EASC or directly to WAST to ensure an integrated model of service delivery, which provides clinical support and expertise to GP clusters, while retaining the skills of APPs within WAST and provides an interesting professional development opportunity for staff. This could help reduce levels of

attrition in terms of turnover and attract more APPs, either by encouraging existing paramedics to develop their skills and/or encourage colleagues from elsewhere to relocate to Wales. This could prevent the potential 'internal market' risk as described in paragraph 3.

5. Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.

Not applicable (N/A) to WAST

6. The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.

During the engagement and analysis exercise undertaken with all cluster lead groups, WAST had a very positive response. All cluster lead GPs were receptive to suggestions of joint working.

From WAST's perspective, there is variation in the manner and speed with which we have been able to develop pieces of work with the clusters. Examples of good work are described above in answer to question 2 – specifically relating to the formation of multi – disciplinary team working, and the community based model that will directly link GPs with a response paramedic in the Western Vale geographical area.

7. **Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, *Setting The Direction.***

N/A to WAST

8. Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.

The evaluation criteria for measurement of the various models of community care being developed in conjunction with primary care (see question two above) include:

- Reduction in the number of patients being conveyed / admitted to emergency departments by ambulance.
- Increase in the number of alternative pathways accessed on behalf of patients by ambulance crews.
- Compliance with WAST's operational plans (priority postings – vehicle availability for 999 calls) – i.e. an increase in capacity, and increased availability / presence in geographical areas, because of fewer journeys to hospital and a concomitant increase in the volume of patients remaining safely at home with community care packages in place.