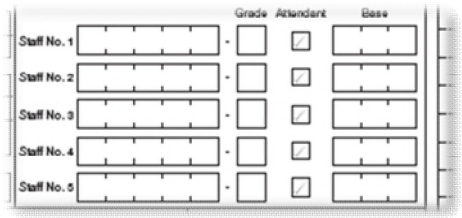
PACESETTER SCHEMES 2018-19

Health Board	Betsi Cadwaladr University Health Board
Pacesetter Title	Advanced Practice Paramedics – Urgent Home Visiting Service.
Context: what is the current evidence and how does this project add value?	The proposal is for a 24/7, 365 days a year model of utilising Advanced Practice Paramedics to provide a rapid response service to patients requiring home visits, which would previously have been provided by their GP. The service aims to address the immediate health needs of patients that if not seen promptly will end up being admitted into Hospital. The aim of the scheme is to support GP practices in North Wales to improve the quality of care, transform the way that care is delivered in the community and help sustain Primary Care services; reduce emergency admissions; improve patient access; release capacity for GPs to focus on planned care appointments in their Practices; achieve better patient satisfaction. The Welsh Ambulance Services NHS Trust (WAST) and BCUHB Primary Care will work together to establish a strategic and operational collaborative to ensure consistent practice and clinical governance. This will support local populations and ensure the development of Paramedic competences in support of GP home visits, by delivering home assessments, post triage with view to investigation, diagnosis, treatment and signposting to the most appropriate pathway in line with prudent health care. The strategic aim is to support the 5 step Ambulance Care pathway, the new clinical model and GP Practices to strengthen care of patients in the community with the aim of avoiding admission into hospital Unscheduled Care services. The collaborative working will allow Paramedics to work within General Practice to build on their skills and portfolios. The Paramedic working in collaboration with GP Practices will undertake the following duties; • Respond to patients assessed as appropriate by the GP to initiate initial assessment of the patient's condition. • Maintain close contact with the regional Clinical Contact Centre (CCC). • Generate incidents via CCC on to the Computer Aided Dispatch (CAD) prior to responding to any incidents. • Identify and treat any acute conditions within their scope of practice and approved clinical guidelines. • Administer medication in line with JRCALC Clinical Practice Guidelines. • Carry out a comprehensive patient assessment and complete a WAST Patient Clinical Record (PCR). • Utilise the Manchester Triage System for further enhance clinical decision making. • Arrange appropriate conveyance to hospital where required utilising WAST Backup Matrix. • Provide comprehensive clinical assessment verbal reports to GP. • Work with GP to establish the best pathway of care for the patient, based on clinical assessment and GP consultation. • Complete all relevant documentation. • Complete GP Cluster documentation and populate I Pad record

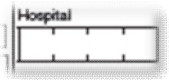
	It is envisaged that the scheme will support Primary Care sustainability, improve patient access, and deliver more services in the community. It is also envisaged that the scheme will support WAST in developing a workforce for the future, and an alternate model to the current way that the service is provided. The scheme is an opportunity to develop staff that are already on / considering an MSc advanced practice journey through supporting them at a Practice/Cluster level by mentoring GPs who are able to provide clinical support and supervision. It is also an opportunity to truly be innovative with North Wales at the forefront being the first to adopt prescribing Paramedics to deliver care closer to home. It is an opportunity for WAST to fully deploy the model that has been developed for Advanced Practice Paramedics with opportunities to rotate through rostering, gaining experience and expertise in the 3 levels of the proposed model.(appendix 1)
Aims of project	• Reduce Patient Conveyance Rate • Reduce number of Hospital Admissions • Reduce Patient Waiting Times • Improve quality of Patient Experience • Provide prudent health care • Right Resource, Right Skills, Right Patient, Right Time • Improve education with self management • Explore the benefits of Masters Level Community Paramedics compared to other CP models across WAST • Release Capacity in GP Surgeries to enable Doctors to concentrate on planned care. GPs no longer have to leave unexpectedly for urgent home visits with lengthy travel times. There will be a better and more productive use of existing clinical resources. • Care Closer To Home – will increase the number of patients seen in their place of residence, especially in rural areas such as Dwyfor and Meirionnydd.
Allocation	£760,000
Start date of project	1st April, 2018.
Alignment with Emerging Model	The objectives are to release capacity within GP Practices for planned care appointments, support the sustainability of the Primary Care service in North Wales, particularly in enabling the creation and utilisation of a more suitable service to serve the needs of the population to avoid unnecessary emergency hospital admissions; improve the outcome for patients who might otherwise be admitted to hospital and achieve better patient satisfaction. The service is aligned to the Care Closer to Home strategy and forms part of the 2018-2019 Primary Care IMTP. The scheme adds to the strategy for transforming the way services and healthcare is delivered in Primary Care and adds to the model of developing the multidisciplinary team that surrounds the GP. The scheme is an innovative change in the delivery of care; distributed evenly across all the Clusters and populations; introduces a new role with

	new skills; will have an immediate impact; and is a model that will improve the satisfaction of both the users and the clinicians that are the providers. The clinical governance of the scheme will rest with the GPs when the Paramedics work on their behalf, but rest with WAST for Emergency Red Category patients.
Potential to demonstrate financial redesign / resource shift	This scheme is designed to use the appropriate Health Care Professional and skills for urgent home visiting in Clusters. Paramedics will do the work previously done by GPs. • Cost avoidance - right person, right skills, right location and right time. • Cost avoidance – GP time is focussed on planned care appointments in the GP Practice. • Cost avoidance – unnecessary Unscheduled Care hospital admissions; WAST activity; GP home visits. • Cost avoidance – adds to the MDT within a Practice and as a result supports the sustainability of that Practice.
Dates for submission of Business Plan and Delivery agreements	28th February, 2018.
Status within: **HB strategy** **IMTP process** **Cluster Action Plans**	• The Scheme has a common theme to the existing Pacesetter and Delivery agreements within the Health Board and meets the 3 aims of Primary Care funding; Service sustainability; improved access; more services now available in the community. • The Scheme is an action for the IMTP being developed by Primary Care with implementation in Quarter 1 for 2018-2019, • The Scheme is currently not included in Cluster Action Plans, but will be included in all the 2018-2019 plans. This provides an opportunity to deliver the services is a different way. There is opportunity for creativity; innovation and to lead the change in the NHS. This strategy aims to help combat the present and future recruitment and retention issues facing the General Practitioner workforce and to contribute to a sustainable Primary Care workforce of the future.
Timescales for each stage of project, with rationale	**Quarter one**: Recruit staff to post. Memorandum of Understanding between WAST and BCUHB. Operational plan with objectives, outcomes and timescales. Agree evaluation criteria, key performance and quality indicators and exit strategy for the end of the Pacesetter period. Conclude analysis and planning phases. **Quarter two:** Implementation phase. Evaluation of progress. **Quarter three**: Implementation phase. Evaluation of progress. **Quarter four**: Implementation phase. Evaluation of progress.
Evaluation methodology and measures to be used	There will initially be four data sets that will be audited by WAST. I. Number of patients seen II. Non conveyance to ED III. Alternative Patient Dispositions

Data set 1: (N^0 of patients seen) will be collated by isolating the PIN Number of the Paramedics involved in the service from the PCRs.



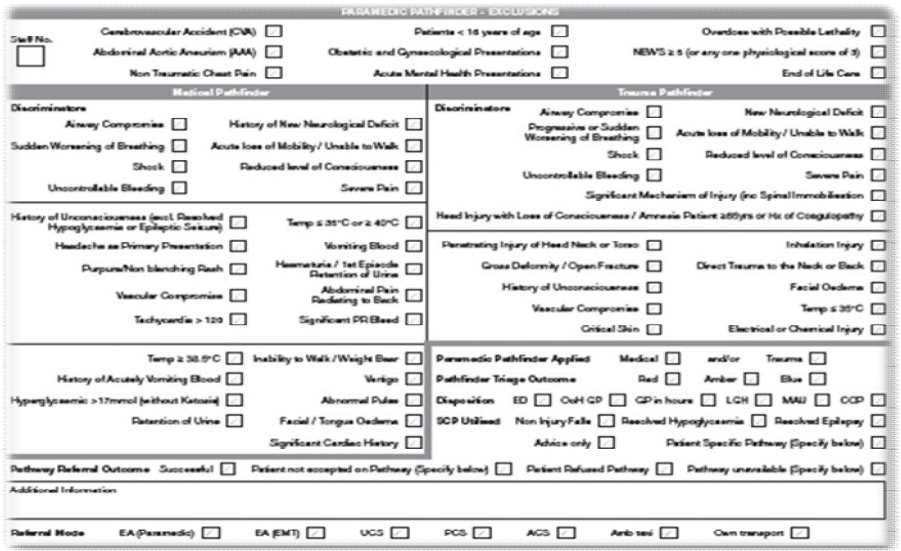
*Data set 2***:** (Non-conveyance to ED) will be collated from the PCRs relating to the trial. It is imperative that non-conveyance to hospital is highlighted by placing four Xs in the Hospital field of the PCR.

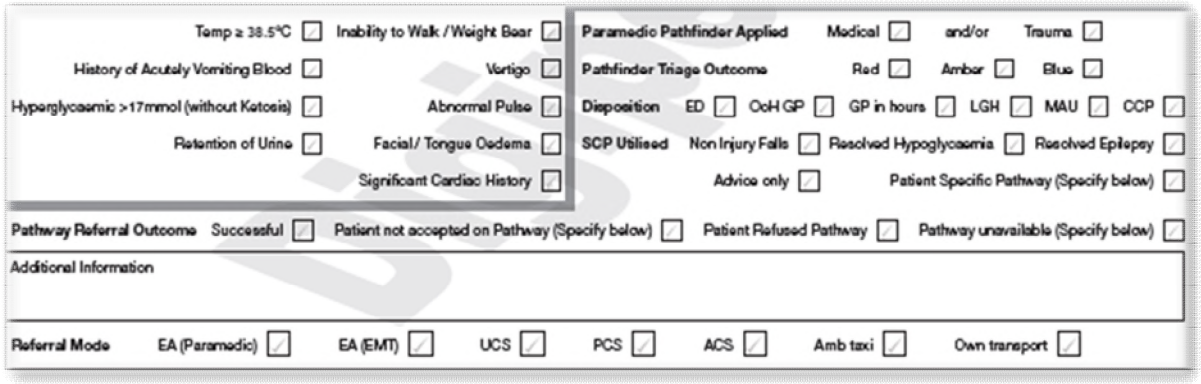


To compliment this, Data set 3 will illustrate where a patient has been transferred to if an alternative to ED was identified and used.

Data set 3: (Alternative Dispositions) will be collated from information populated in the Paramedic Pathfinder section of the PCR.

Patients conveyed to alternative points of care must be highlighted utilising the Paramedic Pathfinder fields of the PCR. In these fields, Paramedic Pathfinder can be applied in the normal way, or where applicable, Manchester Triage outcomes can be written.



	In particular, the triage outcomes and alternative dispositions can be recorded in this field. These fields are completed for all WAST patients, but the R&I code will identify and separate patients from the trial.  Temp ≥ 38.5°C ☐ Inability to Walk / Weight Bear ☐ History of Acutely Vomiting Blood ☐ Vertigo ☐ Hyperglycaemic >17mmol (without Ketosis) ☐ Abnormal Pulse ☐ Retention of Urine ☐ Facial/ Tongue Oedema ☐ Significant Cardiac History ☐ Paramedic Pathfinder Applied Medical ☐ and/or Trauma ☐ Pathfinder Triage Outcome Red ☐ Amber ☐ Blue ☐ Disposition ED ☐ OoH GP ☐ GP in hours ☐ LGH ☐ MAU ☐ CCP ☐ SCP Utilised Non Injury Falls ☐ Resolved Hypoglycaemia ☐ Resolved Epilepsy ☐ Advice only ☐ Patient Specific Pathway (Specify below) ☐ Pathway Referral Outcome Successful ☐ Patient not accepted on Pathway (Specify below) ☐ Patient Refused Pathway ☐ Pathway unavailable (Specify below) ☐ Additional Information Referral Mode EA (Paramedic) ☐ EA (EMT) ☐ UCS ☐ PCS ☐ ACS ☐ Amb taxi ☐ Own transport ☐ The data sets audited by the BCUHB Primary Care/GP Practice will include the following; 1. Quality measures– patient satisfaction, staff satisfaction, clinical effectiveness measurement, near misses, concerns. Effectiveness of working remotely, especially in more rural areas (50 miles plus from host Practice/60 mins plus from host Practice, etc.) 2. Delivery measures– key performance indicators relating to activity, hospital admissions and avoidance, re admissions, planned care activity within Practices, escalations to GP care, de escalations from GP care. Analysis of trends such as presenting conditions, age range, locations, distance from Practice/ED, etc. 3. Finance measures– efficiencies in terms of costs and cost avoidance. 4. Workforce measures – recruitment and retention information linking into the workforce sub group and project management team.
Project support available	1. Access to Programme Management office and Service Improvement Team for support. 2. Access to Primary Care Workforce Project Manager for support. 3. Dedicated named Project Manager to oversee the development and implementation of the scheme.
	1. Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.

Describe anticipated impact on health inequalities	Primary Care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing ongoing mental and physical health conditions and helping recovery from episodes of ill health and injury. General Practice plays a significant part in Primary Care and the model must remain committed to these principles and how they are applied locally to best meet the needs of the populations that they serve Primary Care has a vision of working with its populations to sustain and improve health services, improve health, and reduce health inequalities. Primary Care is defined as 'services providing the first point of care, day or night, for more than 90% of people's contact with the NHS in Wales (Welsh Government). They are considered as the 'heart of the NHS' and play a central role in achieving this aim by ensuring a coordinated service for patients, centred on the needs of the people they serve, and not as silo organisations (NHS England). The proposed new chosen model is an opportunity to improve services to patients. It is an opportunity to sustain and improve care, during these challenging times. There are considerable challenges to overcome as Primary Care moves towards the delivery of the strategy for the future. A high percentage of the population live with health related problems, and more of them will live longer with more chronic conditions. Medical treatments are also getting more complex and expensive. Health care as a result, will need to be delivered in different ways, in more effective and efficient ways, and the current challenges faced by Clusters, provides an opportunity to test out this model. **2. Care for those with the greatest health need first, making the most effective use of all skills and resources.** The Primary Care workforce in the area is changing with the utilisation of non medical roles and models delivering services that were traditionally delivered by the GP. A patient is now as likely to be seen by an Advanced Physiotherapist, Pharmacist or Nurse than being seen by a GP for a certain condition. There is an opportunity to develop a new clinical role for the area to deliver home based emergency visiting service, further releasing the capacity for planned care appointments within the GP Practice. **3. Do only what is needed, no more, no less; and do no harm.** The new urgent home visiting fulfils the key principles of a General Practice Strategy and provides; • Quality driven services – Providing high quality, cost effective, responsive and safe services. • Services as local as possible – Teams working in the community in conjunction with GPs and in-reaching into Secondary Care where possible. • Increasing appropriate capacity and capability – recruiting prudently to the existing workforce, developing new roles to support the GP and Nursing workforce. This will ensure that patients are well managed, and service delivery is effectively transformed with new and innovative models to manage their conditions. • Primary Care access arrangements – ensuring access to meet the needs of the populations. • Maximised appropriate use of integrated/aligned care pathways – new models of care that take a lead from existing models and good practice already implemented across the Cluster, Health Board and the NHS, to support our population effectively.

	• Engaging patients to ensure the services and pathways are optimised. This will form part of improved care in the community. **4. Reduce inappropriate variation using evidence based practices consistently and transparently** A high quality service can only be delivered if there is a focus on the three key quality dimensions of clinical effectiveness, safety and patient experience. It is important to ensure that the challenges of delivering the new model does not detract from being clinically effective, being safe and ensuring patient satisfaction. Primary Care will continue to support innovation in clinical practice, and pathways that improve effectiveness, enhance the experience and provide value for money. There is an opportunity for the Clusters/Practices to collaborate with each other to provide planned care services that are more effective, safer and patient centred. GPs have a greater holistic understanding of their patients, and management can be supported by the use of health technology and Advanced Practitioners. There is also a commitment to the provision of social prescribing to support patients requiring healthcare. There is an opportunity for the Clusters/Practices to collaborate with each other to provide services that are fit for purpose, shared and are effective and efficient for the needs of their populations. The Practices are committed to working collectively to improve patient outcomes but due to the previously mentioned shortage of GPs such working is patchwork at best. There is an opportunity to develop 'baskets of care' that support themselves, and shift care away from hospital based services, with the support of the Home Visiting Service. By creating this service, it will enable the practices in the area to provide a tailored alternative that is mindful of the area's recruitment issues. Pooling expertise and utilising appropriate support in Clusters through this proposal will offer a sustainable option to alleviate the pressures on our General Practitioners, while ensuring patients are supported in the community as long as possible
Potential for rollout at scale, with indication of costs and workforce implications	The vision for the future of the model will be developed during Quarter 1, with a clear evaluation framework and an indication of the options for mainstreaming into core services at the end of the Pacesetter period.

NATIONALLY AGREED CRITERIA FOR PACESETTER PROGRAMME – 2018/19

1. The schemes should be aligned to the work of the Implementing the Emerging Model Group in terms of building on:

    - Outcomes of previous Pacesetter projects
    - The whole system emerging model for primary care
    - Outcomes of the Pacesetter Critical Appraisal
    - Outcomes of the Parliamentary Review into Health and Social Care

2. Projects should actively explore the potential for whole system financial redesign and resource shift between sectors

3. Each project to be underpinned by a clear business plan and delivery agreement that has been agreed by the Health Board executive team, PC Directorate, cluster leads, the relevant cluster and the professionals responsible for delivering project outcomes.

4. A clear and realistic approach to timescales for project outcomes that takes account of bedding in, transforming care and reporting arrangements.

5. Robust measures for evaluation to be defined at the outset and using an appropriate range of methodologies to give a clear understanding of outcomes and benefits, including costing

6. The programme of work to be an integral part of the relevant cluster action plan, the health board strategy and the IMTP process

7. Evidence that the project team will be supported through appropriate backfill arrangements; dedicated project management; access to expertise in research analysis, IT systems usage and data analysis.

8. Consideration should be made of the specific challenges faced by professionals working with deprived communities in relation to innovation and redesign. Primary care teams in these areas often need more support and/or resource to initiate new ways of working and a proactive approach is required to promote innovation.