APP Focus Group – Masters Education Experiences

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Background

The focus group was convened with a group of Cohort I and Cohort II Advanced Paramedic Practitioners (APPs) to discuss three final items from the Pacesetter Evaluation framework;

- their experiences of the part-time and full-time Masters course respectively,
- skills and knowledge the APPs take back to WAST as a result of the Primary Care rotation and;
- working autonomously.

The Pacesetter APPs completed their Masters in Advanced Clinical Practice at either Bangor or Glyndwr University. The part-time Masters in Advanced Clinical Practice had been the only option, until WAST commissioned Glyndwr to run a full-time course for one year only in 2019/20.

The majority of Pacesetter APPs completed a part-time Masters, which took them between three and five years to complete, two years taught education and further one to two years to write their dissertation, and some APPs deferred or extended the write up period.

Four APPs followed the one-off full-time route comprising two days in University, two days in practice and a study day per week. The first year of their taught course was equivalent to the first two years of the part-time Masters programme, the dissertation was written up during their second year whilst back working for WAST.

Methods

A focus group interview took place on Microsoft Teams with four APPs who completed their Masters at either Bangor or Glyndwr University. Two APPs undertook the part-time route and two completed the Masters full-time. A limited number of individuals were approached to take part to ensure there was representation from both course routes.

An interview schedule was developed to complement the items discussed during the interview with the University programme lead delivering the Masters course to WAST APPs. It also included discussion topics on skills back to WAST and autonomous practice. The content and processes were agreed by the project team and a representative from BCUHB Information Governance department. Data was collected and reported within the remit of a service evaluation. This item of data collection fulfilled the education aspect of the evaluation framework (comparing Masters routes), as well as the APP component (working autonomously), and WAST (skills APPs take from Primary Care and transfer back to WAST).

Each aspect of the focus group is discussed below, with some of the key findings outlined.

Results

Part-time versus full-time Masters course

Course structure

The APPs who enrolled on the part-time course all followed a slightly different pathway, which was often dependent on individual line management. Of the APPs in the focus group, one completed the first two years followed by a year's break, and two years to complete the dissertation. The other completed it in three years and was released for two days per week for University attendance plus

some clinical hours. They were provided with mileage and travel time but completed their dissertation outside work hours.

"there has been quite a lot of disparity amongst other students with that because I think that it wasn't sort of a clear definition, it was just depending on who your locality manager was at the time. Some were more supportive than others." APP 1

For the early groups of Masters qualified APPs, there was no defined career pathway at the end of the course and it was some time before they were appointed to these roles in North Wales.

"we were the first cohort if you like …we finished the Masters there wasn't an advanced post to go straight into. Advanced practice didn't, it existed but there was only like 5 advanced practitioners in WAST at the time. There was no clear definitive job at the end of the Masters process… then it was about another 2 years before I went into practice, to start practising advanced practice." APP 1

Completing coursework around work and home commitments was thought to impact on aspects of their personal life, particularly because of the length of time it took to complete.

"*it is quite hard to keep the motivation up for so long…I had to sort of work it out around work and things like that. And I remember when I finished it, I realised that my youngest kid, hadn't really known me without this weight of a Masters round my neck for I don't know, 5 years. And, suddenly I could put it to bed*." APP 2

In contrast, those studying full-time for the Masters were taken off the road for the duration of the taught course. The APPs recognised they had been privileged to have the opportunity focus exclusively on their Masters course for a year.

"we were really lucky, it was an amazing opportunity …we felt like we had the time to, to consolidate the learning and then use what we have learnt in practice. We got to choose where our placements were, the only issue was we struggled to get placements which then became harder because Covid then hit." APP 4

"*I wasn't distracted by shifts... rotas and things …for me we could focus my attention solely to the Masters."* APP 3

The drawback to this Masters route was that juggling work and dissertation was a challenge, and after a year out of day-to-day ambulance work, APPs described some difficulties settling back in to WAST aspects of the rotation but felt more comfortable with the Primary Care work on the Pacesetter rotation.

"I was back in the job having to juggle shifts and things, alongside doing the dissertation so actually for me that was the probably the most difficult part of the MSc journey." APP 3

"when we went back, personally I struggled being in a brand new job role, after not doing anything paramedic based for a year … the only thing that was actually back to normal was the Primary Care. Because we had actually been doing that for the last year. So I felt that was easier." APP4

The Cohort I APPs reflected on this experience and agreed they would have found it difficult to settle after an extended period away from the ambulance service. They suggested that ride-outs, occasional Primary Care or WAST shifts could be built in to the full-time Masters journey to provide balance and make the transition easier on return.

Opinions were divided on an ideal model of education, and share of time between Primary Care and WAST. One APP made the case for a majority Primary Care focus to ensure they were exposed to a broad range of presentations and picked up some of the Primary Care skills, such a management of risk, but with some time assigned for WAST shifts.

"I think … the 75:25 split or thereabouts. Primary Care you see a lot more people, you have got supervision mentorship, close at hand haven't you? But it is just that application within WAST where you are working more as a lone clinician I think… the bulk probably still needs to be Primary Care just to get the volume through really and see the, the sort of types of presentations and learn about managing risks and learn the you know, they maybe unwell but we can watch and wait and things like that." APP2

The two APPs who followed the full-time pathway were more in favour of keeping the course time exclusively for Primary Care having already worked as experienced paramedics. A phased return back into the ambulance service may have been beneficial, particularly as they were also undertaking their dissertation at the time.

"I would probably argue against that [75:25]…my two days that I had in Primary Care I felt were really beneficial and quite precious time and actually to dilute that further, or reduce the time I had in Primary Care I don't think would have helped me. I knew how to work as a paramedic… I would not want to change that first year …to shoehorn another aspect of the role in, i.e. if we were to also get a fourth dimension there, ambulance." APP3

"I think keeping the course the same for the year one, and maybe I don't know, three to four weeks of a return, …then you will have more mental space to focus back on just starting the new role on the road as an APP…. CCC and then, the dissertation on top I think it was, I think it was too much, too much going on over a short period of time." APP4

Amongst the group there was agreement that personal circumstances and preferences, mean not all APPs would want to follow the same Masters route and WAST need to keep both options open to potential students.

"You are going to have people who would prefer to do it in three years, you are going to have people who prefer and might have a better academic background and say let's just blast this now for a year, get it boxed off, job done. …how do you marry that into a model that sort of fits all? … I think there has to be flexibility in that approach and it might be better for WAST to keep those open on both options." APP 1

Clinical Supervision and Placements

Clinical supervision and placements were a source of some contention during the focus group. There was frustration around the difficulties securing placements and clinical supervision in Primary Care, particularly as Masters students receive no support from the University with this process. It resulted in some APPs experiencing delays starting their placement and additional pressure once started.

"they just said you have …two days placement time do what you want with them, go wherever you want. Which there was benefits to that, however there was also negatives that it was really hard to get into places. …actually having placements lined up for people would be of benefit I like personally I really struggled… I went three months where I didn't have a placement and I was, I was literally knocking on GP surgeries doors, I was ringing GP surgeries up, I was e-mailing I was hassling…then I

ended up really down on hours and actually, which meant that I then had to work extra hours when I did get placements." APP4

As a compulsory component of the course, it was suggested that either WAST or the University could assist APPs to identify potential supervisors and find placements, for example holding a register of suitable staff or incentivise funding for GP supervisors.

"if WAST are saying ok we are happy to allow 10 people this year to go and study a MSc and we want you to be proficient in urgent care, Primary Care or have Primary Care type skills, then maybe the emphasis should be on them to try and obtain those or arrange those placements." APP 3

"if you apply for a course like a paramedic science or nursing course, they don't expect you to come into that course with a mentor…if they know they are getting 60 on, why haven't they got 60 placements that they can place people in?" APP1

"the University has got some responsibility to make sure that their students meet the bare minimum of the course, … maybe if there was some funding behind it, to support placement time." APP2

The APPs who took part in the focus group had a mixed experiences of supervision once in their Primary Care placement. For full-time students, APPs were able to apply course learning directly on their placement and one of the APPs had a positive experience with a particular GP mentor.

"*it was just fantastic. It was just, it felt pretty seamless to be honest, in that we were learning information that we could just apply directly to our place of work at that point in time, Primary Care … I had a GP mentor who understood the MSc process, and was used to mentoring people through it, mentoring ACPs through it so she had a good understanding of what it was I needed to do, what kind of OSCEs I was doing, and where I was at the start of my journey as a clinician but not one used to Primary Care. APP 3*." APP 3

However, elsewhere some APPs outlined how they were made to feel a "nuisance", and their role in Primary Care was poorly understood, potentially compromising the quality of supervision provided to APPs. This point also emphasises the value of careful selection of GP mentors to provide good quality supervision and a positive experience on placement.

"The biggest bugbear with me was the placements. And it was purely because people didn't want us or understand what we were there for, and we are not funded like the junior doctors are, so we are basically taking up people's time, slowing down their day job, for good will really… [APPs] might just get some pieces of paper signed saying they have done 300 hours and get no sort of quality out of it." APP 2

"going back right to the beginning of all this, and a lot, at the time the route was very, very new and people didn't even know what the route actually meant. And I think I was in the same position where I approached about 5 or 6 GPs … before I had someone actually say oh yes, we will run with this. I was very fortunate in that respect." APP1

In the longer term, the early Cohorts of Masters qualified APPs and prescribers may be able to support trainee APPs, which would reduce pressure on GPs.

"there might be some APPs within the team who might be in a position to mentor you know new APPs in Primary Care and maybe that is sort of the future route." APP 3

"Because we are sort of quite nomadic in our work style… we don't belong to a GP practice do we really.…As time goes on and we get more an established APP team hopefully that will help future courses and generations coming along because we have got the options already in-house." APP 2

There was a perception that evidencing the required number of hours was important, but further learning came afterwards when the APPs were practicing autonomously.

"You almost get to the 90 hours and then signed off and then you relax a bit to sort of learn a bit more or you can learn once you are in the job, like passing your driving test isn't it, you sort of once you are out there on your own that's when the responsibility kicks in and you learn for yourself." APP2

APPs who followed the full-time route, and were away from WAST for a year appreciated communication from senior colleagues in WAST who would regularly "check in" which helped maintain communication and a sense of belonging to WAST. There was also some expectation to pick up WAST shifts during University holidays such as Christmas and Easter and optionally at weekends for "pocket money".

Skills back to WAST

The second topic of the focus group was around the skills and knowledge that the APPs are able to share with WAST or use on shift, as a result of the Primary Care rotation. Some of them were non-quantifiable improvements, but help demonstrate that this Pacesetter has met its aims of each aspect of the rotation improving clinical practice in the other two.

First, the APPs outlined how the allotted consultation times in Primary Care had encouraged them to work more efficiently during a consultation (in WAST and Primary Care) without compromising patient safety.

"my consultation or assessment time per patient I would argue has halved in some instances. … I have got 20 minute consultations which some might say is quite generous … in that time I am expected to carry out history, physical examination, and inform the patient and relative and document the findings… I think it is being able to recognise well and unwell people quicker and have an idea of what to do and how to safety net them in a far shorter period of time." APP3

"I think, becoming more slick and speedy … not always reflected within WAST because of the paperwork we have to do sometimes, it is just that is the bit that slows you down." APP 2

Time in Primary Care improved perception and management of risk, and safety netting appropriately to give the APPs a better understanding of who is best placed to look after patients in the community. This was particularly true for patients with specific presentations or conditions where ED would have been considered the only option on WAST shifts. Offering more care at home, and in the community can potentially improve the patient experience and patient outcomes.

"you learn quite quickly when you go into Primary Care … they are more willing to be risk adverse in the sense that they will just provide stringent safety netting and then will review it again tomorrow or in 48 hours and it is that giving that patient a chance to actually be managed in the community." APP 1

"there is a lot more yes balancing that risk and then recognising what can be treated in Primary Care … traditionally you would be…maybe a bit twitchy and we will send you in just in case …but it is that

balance of risk to remain at home whilst unwell and getting better, with the safety netting … Whereas if you are happy to take that risk on board, and try and treat at home … that gives them the best chance of recovery without getting lost within the hospital system and maybe never coming out again." APP 2

The APPs are thinking differently and recognise the importance of preventative care. One APP illustrated this with an example of managing patients with incidental findings and making every contact count.

"every contact counts …patients that I used to see that … were hypertensive but they weren't enough that I was thinking 'it matters to your clinical presentation right now', I actually I say … 'well make an appointment' or go and do a 10 day log of blood pressures and take those down to the GP surgery and you know it is trying to catch these patients before they have the CVA." APP 4

Linked with risk management and better safety netting, was the navigation of Primary Care, better knowledge of local services, and signposting to alternative services which were beneficial for both WAST and Primary Care shifts.

"it is definitely that signposting,…that, recognising you know what peripheral services you have in your area that can support that community management plan." APP 1

"for me it is that knowledge of how Primary Care works, and knowing actually … you don't need to take them into A&E right now, actually you know they can have a referral and see someone as an outpatient, rather than going straight through ED it is knowing those pathways." APP 4

Having had exposure to a broader range of presentations in Primary Care, the APPs could identify areas they felt their practice had improved. Having gained experience, APPs had increased confidence managing these cases and were better able to distinguish between unwell and sick patients.

"would probably say paediatrics, mental health, surgical, oh dermatology as well…those patients that you see more of in Primary Care, I feel a lot more confident and the transferability of those skills that you gained in Primary Care obviously they come directly back into WAST…it is having the confidence as well to refer into those, into those specialities … I feel a lot more confident in having a chat with the surgical team to accept that referral now." APP 1

"a general improvement in confidence and knowledge about most [physiological] systems." APP 2

"unwell or sort of virally, virally children I think the sort of exposure to virally kids in Primary Care is just massive. So, I like to think I can fairly quickly distinguish between a virally sort of unwell child and an unwell child now." APP 3

From a non-clinical perspective, the APPs recounted how their learning from Primary Care has been used to support colleagues in WAST and change the way they manage cases or provide advice.

"The role in control we are there for sort of support of other crews, and I have definitely given different advice having gone through Pacesetter than I would have done prior to that. …advice to colleagues wise, definitely a bit more pragmatic… There was one the other day that you had an urgent referral already in place, he was unwell when the paramedic was with him, but then nothing changed since the referral was put in so you think, well actually, A&E is not going to add anything to that." APP 2

One example was described where an APP taught a crew about an online tool (CRB65) used in Primary Care to aid decision making for patients with community acquired pneumonia and advise whether

they can stay at home with oral treatment or are likely need IV antibiotics in hospital. It's hoped that this type of knowledge will spread further through non-APP colleagues to provide the most appropriate care and keep patients at home where possible.

"a crew called me out for a patient who was unwell, and I wasn't entirely sure whether to manage them in the community or in hospital, so I used a, a tool which we used regularly in Primary Care … it just gives a little bit more backbone … more structure to my decision making and they were like 'oh, that is interesting, I will consider that'." APP 3

This point was noted to be particularly important as the number of standard paramedics far outweighs the number of APPs so sharing knowledge from Primary Care with the wider workforce has potential for a far reaching impact.

"there are far more paramedics than there are advanced paramedics and I think that if we can sort of just help pass on some of the nuggets of information that we have learnt that helps us, onto our colleagues … that ripple could be far wider reaching." APP 3

There was also an element of what was described as indirect learning, when APPs can impart some of their Primary Care knowledge during informal discussions, particularly to new staff.

"you have got that indirect forms which I think you are picking up on there so that is you know when a, when a crew is on station or you are having a brew or whatever and then they said 'oh I went to this the other day, what would you have done with that patient'. Or 'is it appropriate to do this with that type of patient' and you know particularly now in our area at the moment there is an influx of really new staff." APP 1

Following up on a previous data collection item with APPs, there was a discussion about appropriate referrals into secondary care, both in their Primary Care and WAST capacity. Such referrals from APPs were sometimes challenged or refused by hospital colleagues, thought to be due to lack of understanding around the scope of the APP role. The APPs had more success introducing themselves as Advanced Clinical Practitioners but were keen to raise the profile of paramedics working in advanced practice roles.

"I think the trick is don't say paramedic…. I used to sign my referral letters Primary Care advanced clinical practitioner but I am now making sure I get the word paramedic in there, just because I think we need to break through this barrier…people need to know that paramedics also work in advance practice roles I think." APP3

"I had someone recently say 'oh are you back in your surgery now', I was like 'no I am just outside the patient's house', not telling them that I was working an ambulance shift …it is just being loose with your terms and it works,…and they were happy to accept … you say paramedic and instantly you do get a, like a wall yes it just makes life harder. So advanced clinical practitioner works." APP4

"Just called yourselves an advanced practitioner or any kind of version of that, if they hear paramedic then they get a bit twitchy." APP 3

"I have never had that pushback personally. … I know a few of the bleep holders now, so I know them on a sort of first name basis, and they are quite, you know accepting of referrals …they haven't stopped taking my referrals so I am guessing I am sending the right people in." APP 1

Autonomous practice

The final topic explored during the focus group was around APPs as autonomous practitioners.

Throughout the data collection for Pacesetter, APPs have described themselves as beginner or novice in terms of their Primary Care practice. This was also true for autonomy, and the shift from practicing confidently and autonomously for WAST, to having little autonomy in Primary Care and having to develop the knowledge in Primary Care.

"I felt like as a paramedic we are autonomous workers most of the time … I felt like I went from an autonomous role to no autonomy at all, initially in Primary Care, and then slowly that's creeped in as time has gone on, and rightly so because it is a completely different ball game you know, you are seeing different completely different types of patients." APP 4

Over time, the APPs perceived that they were seeking advice or second opinion for fewer consultations in Primary Care as a result of increased confidence in their own patient management plans and autonomous decision making. But they were still asking for advice where appropriate, or for issues beyond their Primary Care scope of practice.

"I think there are patients that I see now I would have asked for advice on before that I don't do. And I have not heard they were bad decisions yet, so I will stick with it. … I was sort of formulating different management plans before speaking to the doctors … I think and it is knowing when you need that advice as well I think that is recognising that when you know that you are beyond your scope." APP 2

This has also been demonstrated as a shift in the relationship between APP and GP, and working as clinician-to-clinician rather than paramedic-to-clinician. APPs are needing to seek reassurance less often and are instead contacting GPs or surgeries for requests.

"But one big change in my practice is I used to, as a paramedic I used to ring GPs just to check you know, … getting a seniors name to my paperwork whereas now I ring a GP if I want an action to be carried out, or I want the GP to really be aware of this situation and to carry out monitoring. You know, sometimes I just ring up the receptionist and say right can you just put these notes on, or can you can you action these tests etc… I have never had any of the practices say no… And I think actually that is going to take off some of the Primary Care work load as well. … occasionally I will call and ask for their advice, …'what should I do in this situation, I am stuck'." APP 4

This also has potential to reduce some of the Primary Care workload where APPs have been able to 'box off' a consultation without GP intervention. This was illustrated with examples of how GPs value professional relationships with APPs.

"I would go the other way and say that people, they are actually really grateful for the phone calls now because a lot of the time I call up and …say … 'I don't feel you need to come out and do a home visit, these are my clinical findings, and this is what I would like' and it is often 'oh, you have done it thank you very much', that is that boxed off you know. So yes I think people are pretty, pretty happy when we call up about a patient." APP 3

"I had seen a patient … I went there [surgery], …the doctor came out of his clinic and he was like this is a fantastic service, so you prescribed for this patient?' 'Yes'. 'And you have done this for this patient?' 'Yes'. 'And you brought a urine sample in'. 'Yes'. 'Are you working all day, can I phone you throughout the day if I need you?'. You know they are really receptive of it in the community they love what we can do, they love what we can provide, and you know everything that everyone said

about autonomy really is the more exposure you get, the more confident you get, the more autonomous you get, and it is just the, just about personal development and you just seem to develop every year that is passing." APP 1

APPs noted a change in their perception of seeking advice in relation to working autonomously. Autonomous practice comes with the responsibility of recognising when something is beyond the scope of their role or needs a second opinion. They recalled that cultural norms in the ambulance service historically linked asking for help, with being a poor practitioner. But working in Primary Care, APPs have observed GPs asking their medic colleagues for opinion or advice which has influenced their own practice.

"maybe it is just learning the GPs, knowing which ones tend to treat which condition and how. Because they are all coming with their own point of view and own management plan for every, every given situation. … Whereas in WAST, when I first joined, it was almost like if you need to ask for advice it means you don't know what you are doing. So don't ask for advice. … you need to have the confidence to admit that you don't know, and the confidence to ask people and go, 'what do you think?' get that second opinion." APP 2

The work the APPs have done in Primary Care on the Pacesetter rotation has helped to raise the profile of their role in North Wales, and in future may go some way to overcoming some of the barriers around secondary care referrals.

"I work in [Cluster] so you know no one in [different Cluster] knows me…and actually if I say I am an APP they all go 'oh brilliant'. I think we have changed the name of paramedics on the road, I think we have got we have got a good name in GP surgeries." APP 4

Conclusion

This focus group was the first opportunity to convene a small group of APPs who had followed both the part-time and full-time Masters pathways and discuss their experiences. The journey and experiences varied widely, in terms of duration, managerial support, and study time, even for those who followed the same Masters route. Like the course lead, the APPs were in agreement that a universal model for the Masters wouldn't fit all APPs, and was very much dependent on learning needs and personal life commitments.

There were drawbacks and advantages to both routes. For the part-time students, it affected their personal life, and they had difficulties maintaining motivation to complete a demanding course over several years, however, it enabled them to continue working. Whereas APPs who followed the full-time Masters perceived it to be a better route educationally, but experienced some challenges returning to WAST having been out of day-to-day APP practice for so long. Informal communications from senior WAST colleagues 'checking in' was appreciated and helped maintain connection and contact with the ambulance service for the duration of the first year Masters course.

The main criticism of the course from both Cohorts was around difficulties securing clinical placements and supervision in Primary Care, which became more problematic after the COVID-19 outbreak due to staff shortages and workload pressures. There was agreement that either the University, or WAST need to take some responsibility to support students with this process. The findings from the interview with programme lead indicated this was the responsibility of the student, but there was a willingness to engage with students and make changes to improve the experience and could be a focus for support in future.

Once in practice, some APPs described a poor quality of supervision, and potential lack of understanding of the role and APP skills. As a relatively new course for paramedics this may have been true of early Masters cohorts. One of the APPs who completed the course more recently reported a highly positive experience, so potentially some GPs are now more understanding of their expectations. However, it highlights the importance of good quality mentorship and supervision in Primary Care, rather than an exercise to simply achieve the specified number of hours.

The discussion identified a range of skills and knowledge that APPs were able to deploy in WAST as a result of their time in Primary Care. Examples included working more efficiently in the development of management plans, improved risk management and safety netting, signposting, and navigation. They have been able to share this learning through informal discussions, and during call-outs with non APP paramedics. Some of the examples outlined were 'soft-skills' or non-quantifiable but they could still recognise these as improvements as a result of the Primary Care rotation. It also demonstrates the aim of the Pacesetter is being met whereby each arm of the rotation improves clinical practice in the other areas.

More broadly, the APPs perceived that the Pacesetter had raised the profile and status of the role of the APP in the community and garnered the respect of local GPs who now trust them and work clinician-to- clinician with APPs, to receive instructions for patient care rather than providing advice.

Although the APPs are still relatively small in number, sharing their learning with the wider WAST workforce has huge potential and small changes could add up to make a big difference as outlined in the example of the CRB65 tool. The APPs acknowledged there was still some way to go in raising the paramedic profile as an advanced practice role, particularly in secondary care where there was sometimes some hesitation accepting referrals from APPs.

The final part of the focus group discussed the concept of autonomy. The APPs recognised the shift from working as proficient autonomous practitioners in WAST to having little autonomy in Primary Care and having to build this up again. An important part of this was balancing the need to seek advice from GP colleagues, against developing confidence in their own practice, and again this linked to skills such as learning to manage risk and safety netting appropriately.

Having spent some time in Primary Care, the APPs are now seeking less advice and reassurance from senior colleagues. They described 'boxing off' consultations on WAST shifts without the need to seek advice (as a result of their Primary Care knowledge) which was appreciated and valued by GP colleagues. In the long term this has potential to reduce Primary Care pressures, particularly where APPs are able to deploy their advanced practice skills such as prescribing.

Throughout all discussion, there was an emphasis on reducing ambulances conveyances but APPs recognised that this is only done when it is safe and appropriate to do so, and that they can provide an extra layer of support to crews and patients when a patient does need treatment in secondary care.

In addition, the APPs were able to link changes and improvements to providing care holistically, thinking differently which ultimately improves their practice, the patient experience and patient outcomes.