Benefits & Barriers to implementation

April 2022

Benefits of the Model

- Project aims - The data collected as part of the evaluation has evidenced the broad project aims
    - to increase capacity in primary care, and provide an additional member of the primary care multidisciplinary team
    - for each arm of the three-part rotation enhanced clinical practice in the other two parts
    - Improved care provided by a team of effectively supported and educated clinicians who are better integrated within the right system and can make better decisions.

- Partnership approach – The collaboration between BCUHB and WAST ensured joint ownership of the project, and integrated working beyond the scope of the project.
- Education Framework – Access to structured education delivered by GP educators has well received and there is an extension piece of work on the gaps in the current education / development provision for new to Primary Care Practitioners.
- Clinical Supervision - Access to clinical supervision and peer support is essential in the development of the practitioner. Practitioner expectations need to be managed.
- Thinking differently - Improved decision-making when on the WAST rotation and improved critical thinking and perception and management of risk.
- Train Where you Work- Accessing local pathways in Primary Care, allowed navigating patients through these same routes easier when rotating through WAST.
- Prescribing - Support for prescribing competencies means five Pacesetter APPs are now annotated prescribers, and a further three are currently training. The Pacesetter project has prompted discussions within WAST regarding the future of prescribing.
- Improved patient experience – confidence to manage patients in the community, reduction in transfers to secondary care, therefore delivering safer care closer to home for more patients.
- Retention – 100% retention in the pilot project cohorts.

Barriers to Implementation
• Primary care pressures – workforce pressures due to recruitment challenges and the Pandemic have meant that the APPs have had fewer face to face appointments which has impacted on their learning however, telephone and video consultation skills have been developed and improved. • Managing expectations – articulating the level of experience that the APPs had in a primary care setting and in managing a planned workload. • Flexible rotational model – one-size fits all approach would not work, consideration for APP, population and practice. • Funding – The Pacesetter APPs were funded from Pacesetter project, but encountered challenges in the move to a business as usual model – if proven successful there must be provision to apply for new monies to implement. • Number of Paramedics – sufficient numbers of paramedics aspiring to be APPs, APPs that want to work in Primary Care. • Prescribing – route to prescribing is different to other practitioners and APPs have to do this after they have completed the full MSc. • APP or Not APP – is a prescribing paramedic practitioner sufficient to work in a PC setting –rather than an Advanced Paramedic Prescriber. • COVID 19 Pandemic – The pandemic had not been considered as an initial risk. The outbreak was declared 9 months into the Pacesetter project, although the APPs were able to continue working on rotation. • Roles within the Partnership – defining roles and responsibilities of the Partners at the outset is key. • Being Accountable / Trust – Holding partners to account is important. • Securing clinical placements- the availability of GP mentorship for both MSc and Prescribing programs. • Financial and Organisational Investment – when the bottom line is how much does it cost, then the full range of benefits cannot be achieved. Consideration must be given to the hidden costs of management, professional development, improved partnership working. These costs must either be budgeted for – recognising that a delivery or at the point of transaction the costs should not be borne by the service but by the system.