Final Interviews
Primary Care

April 2022

Contents

Background

One of the final items from the Pacesetter evaluation framework was to undertake semi-structured interviews with a range of stakeholders from BCUHB and WAST, to examine a range of topics spanning the course of the project.

Methods

The topic guide was developed and agreed with the project team to ensure it would incorporate the final objectives from the evaluation framework, and was undertaken within the remit of a service evaluation. The questions and prompts also aligned with the topic guide for WAST stakeholder interviews and the process and content were agreed by BCUHB Information Governance department.

As the interview findings were contributing to a Masters by Research, a participant information sheet and consent form were prepared, and approved by Bangor University School of Health Sciences ethics committee.

Informed consent was obtained prior to starting the interview. Interviews took place between August and October 2021 over Microsoft Teams and were recorded and transcribed verbatim.

Eleven staff (representing five Clusters) from a range of professions and seniority were interviewed including GPs, Nurses, Physician Associate, and Non-clinical staff.

The transcripts were manually coded using NVivo software to manage to the data. Initially 55 codes were identified but thematic analysis (Braun & Clarke, 2006) was used to further refined to produce the themes listed in this document.

The findings are presented here around some of the project landmarks, and topics which have been relevant to the Pacesetter, and a business as usual model beyond the project.

Results

Recognising the APP skillset

The interviews provided an opportunity to reflect on the experience of working alongside the Advanced Paramedic Practitioners (APPs) as part of the Pacesetter rotation.

From a nursing perspective, one individual admitted she did not have an appreciation for the APP clinical expertise until studying and working with APPs, and that more education was needed to increase understanding of the role.

"I think that I gained a lot of respect for paramedics when I was doing my advanced clinical practitioner masters. … with quite a group of paramedics. And until that point, I think, as a nurse, I thought they were a bit of a nuisance, to be honest. That they'd rock up to the practice to pick a patient up and that they're, 'Oh, I know it all,' kind of thing. … I kind of used to think that I had done all this training,… what had they done? But I think I realised at that point, my goodness, the knowledge of these guys is phenomenal. So, I do think people still see them in that green jumpsuit and it's just someone to come and scoop and run."

Stakeholder 2

Other Primary Care colleagues acknowledged their enhanced skillset beyond the traditional emergency response role. There were differences in their role compared to nursing, but were still seen to be well placed to work in the Primary Care setting.

"I think we have a very different set of skills. So, they're acute and, I suppose, initial, and their thinking will be different. We're trained differently but…we've all completed ANP pathways or APP pathway. It's fundamentally based around the same thing." Stakeholder 11

"they've got other skills, haven't they, that we don't have. And they've got a lot of experience that we haven't got…because of the nature of what they do they respond to so many different things, don't they? It's not just-. They're not just responding to somebody who's got a life-threatening injury." Stakeholder 6

"I think whilst they are proving to be highly skilled and quite dynamic in what they're prepared to do, there is definitely a role for them in Primary Care and in practices." Stakeholder 5

The APPs brought transferrable skills to Primary Care and were valued as resilient, autonomous members of staff.

"I think what they bring is, initially, just this element of actually being able to cope. … They don't get flustered with things. They're used to that autonomous working. They have to go out, and they have to deal with it, and they're used to being on their own and having that kind of support work, network if they need it. …But they've known their limitations." Stakeholder 2

"as paramedics, they're used to thinking on their feet: what do we do with this situation? Whereas, in general practice, you kind of are aware of what the patient's coming in with." Stakeholder 5

The APPs were viewed as 'starting from scratch' in Primary Care. Despite being highly qualified and experienced paramedical professionals.

"…it's a very different knowledge base, isn't it? …almost starting from scratch, isn't she? Even though she's got this wealth of other knowledge. …It would be like putting a GP in an ambulance and saying, 'Go and do [APP] job for a day,' and I'm sure they would be horrified, wouldn't they?" Stakeholder 8

The model for each Primary Care varied between Cluster areas. During Phase I, there was a mixture of home visiting and surgery clinics, however during Phase II this changed to include increasing numbers of telephone and virtual consultations.

In some areas, APPs were deployed to deliver a home visiting service to capitalise on existing skills managing patients at home. However, the need to spend time in surgery was recognised to gain wider exposure and develop skills for their Primary Care role in future.

"we've tried really hard not to just get them to do the home visits. … what we want is for them to see patients in the surgery to expand their skills. …we want them to be able to … deal with everything. … the thing that I would like to see them looking at in the future is thinking more about long-term condition management…Because if you only ever deal with people in acute exacerbations, you don't really have an understanding of what good should look like." Stakeholder 2

"as paramedics, they're used to being out and about on the road. But we don't want them to almost be a one-trick pony.. … they need that wider experience of dealing with more of the common conditions, rather than the emergency situations that they're usually called to. …My opinion would be that they would probably enhance their range of skills…I think that their paramedic training is inherent. I don't think they'd lose that." Stakeholder 5

There are longer term plans to utilise APPs alongside other ACPs to develop clinical specialities which can potentially improve patient care.

"we need to start developing some advanced practitioners who deal with long-term conditions, who become that kind of specialist. I think everyone should have their own area that they specialise in. You need to have a broad understanding there's no reason why the paramedics couldn't take that role on—it leads to much better care." Stakeholder 2

It was viewed as an opportunity for APPs, to take responsibility for aspects of care they may have previously passed to primary or secondary care colleagues.

"I think, probably, they just didn't get that opportunity to do that before. There was no call for it …That would either be passed to a GP or they'd be taking them to hospital for those sorts of examinations. But yeah, yeah, I really think it has probably broadened their skillset." Stakeholder 6

Initial expectations

Reflecting on the early stages of Pacesetter, there was a general lack of understanding about what to expect of an APP joining Primary Care in terms of skills, role and day-to-day practice in Primary Care.

"I think it's just that initial, 'Oh, it's a new service. Who is this person?' But that, obviously, they've been there for two years now. Yeah, everybody is well aware of their role. Yeah, staff and patients." Stakeholder 1

"I think that when these guys came to us nobody really knew what they could do or what they would do. I think what we've learnt is the skills that they bring. So, over time, they've extended in their role as we, now, see what they can do." Stakeholder 2

"we just were thrown into the role. And it's like, 'Oh, by the way, I've got some paramedics coming to join us.' … I was sent a lot of the documentation ahead of that, … really, it was important for me to understand why they were going into Primary Care and what the whole concept was." Stakeholder 8

"I'm not even sure that when the Pacesetter started with the paramedics that we had …That the Pacesetter programme had a clear vision of what they were going to expect out of it…." Stakeholder 5

"it wasn't a total surprise and we kind of did get a bit of an idea. …how they'd work things a little bit. So, that helped. So, that made sense. It wasn't a complete shot in the dark. …The impression we got was that this is a training role, and we didn't have a very clearly defined picture of exactly what they should be doing." Stakeholder 7

For colleagues in Primary Care there was some confusion over why an APP would be working in practice what their role would entail and the level of crossover between the roles.

"initially, yeah, I didn't know clearly what they were going to be doing. But working alongside them, it just became evident, then, of how beneficial it was… We were told, 'Oh, you're going to have paramedics coming to work with you,' and we were all like, 'Oh, okay. How are they going to work with us?'" Stakeholder 6

"I was really confused….My initial thoughts were, oh, great. So, if there's anyone in this practice that needs an ambulance, he'll go….then I was a little bit confused: 'oh, I wonder what he'll be doing. I wonder if he'll be seeing my patients'. …I heard about him after he'd arrived … they let me know that there would be someone else doing home visits now, not just me… told me a little bit about the role. And then, I went to find out more." Stakeholder 3

Once in surgery, the APPs clinical skills soon became clear, and colleagues could recognise some of the benefits such as admissions avoidance and prescribing. Initial misunderstanding was attributed to communication at the practice level.

"But then, when you realise, actually, they're doing the prescribing, they're going to be doing working in another role, they're going to be looking at trying to prevent those hospital admissions for the minor ailments, and things like that, then, yeah, it became clearer. … I think that's not the fault of the service. I think it might be the fault of maybe the practice didn't disseminate that information to us, didn't communicate that with us." Stakeholder 6

Cultural influences

Individuals from five Cluster areas in North Wales were interviewed. Discussing cultural influences on the rotation and Pacesetter, the importance of the Welsh language and unique geography were the most commonly discussed items. The Welsh language was thought to be particularly valued by elderly patients or those with dementia.

"Speaking Welsh definitely helps. …especially with the elderly, with dementia. Not all people with dementia remember their English…. Knowing the area quite well-…you have some places that are just out in the sticks, and it's local knowledge that makes things flow a bit easier. There are a lot of people that don't have phone service or Internet… A little bit of local knowledge would go a long way, I think. But I think you'd pick up on that pretty quickly if you didn't come from here, as well." Stakeholder 4

"He's a Welsh speaker, isn't he, like me? He does go down well with the older generation, that he can speak in their own language." Stakeholder 3

"When you say to people you need to speak Welsh, …people think you need to be fluent to help deliver care in Welsh. I think sometimes, for patients, just being able to understand most of what they Is far better than having someone that knows nothing. So, it's just having that level of confidence." Stakeholder 9

"they know the roads and then, obviously, they're Welsh-speaking, … Especially with the elderly in that area, their first language is Welsh. I think that's a definite advantage." Stakeholder 1

The local geography caused some challenges in parts of rural North-West Wales. Long distances between surgeries and patient homes caused some difficulty fulfilling their clinical workload.

"It's difficult because they're spread out on such a large area. [APP] was with us yesterday, so we had quite a bit of [practice] work to do because we only had one GP. But he also had jobs to do in [town], which is really far away… because the area that they have to cross between the practices is quite far. They have to balance their workload, and they can't always reach what needs to be done throughout the day." Stakeholder 4

Another challenge was of recruitment of GPs and healthcare professionals. Difficulties attracting staff from outside the area has led to local innovations to develop the current workforce.

"Recruitment is a big issue for us, especially with our geography… we're not actually bringing any new, young blood into the system because they're moving to where all the jobs are. So, yeah, we've just got to do something about encouraging …so that we can start growing our own and have world-class service type of setup." Stakeholder 5

"I think some of it is to do with our rural geographic location in some places. But because we have, therefore, problems with recruitment, we are having to look wider and develop that multi-disciplinary team model quicker. And that's where; actually, it opens us up really nicely to actually look at schemes like this." Stakeholder 2

What presented as a challenge to Primary Care, became an opportunity to diversify the workforce by employing a wider range of professions, and potentially putting areas in the North-West at the forefront of developing a multi-professional workforce.

*"…the fact that we are having to **diversify** our workforce within Primary Care has meant that we've had to look further afield. So, I think we're probably slightly further ahead than, maybe-. Certainly, the east. Possible the centre, as well, in what our allied health professionals are doing within Primary Care."* Stakeholder 2

Multidisciplinary workforce

A priority in some areas now is to build and develop the multi-professional workforce comprising a range of allied health professionals, and to best utilise their skills in the delivery of evidence based care.

"we are working far more on a multi-disciplinary team, and I definitely think that's the way to go…. and it has got to be more than GPs, which just don't exist anymore…we have to look at the fact that we've got these really, really experienced staff, and lots of people coming through with lots of different skills, and actually just making sure that people are using those skills in the most effective manner." Stakeholder 2

"Rather than looking at it because we can't get the GPs, what it has done is made us think about doing things differently. …we've got to do now is strengthen our workforce with allied health professionals, … by using this consulting GP model, …the GP orchestrates and does the second opinion or the more complex cases and signs the prescriptions." Stakeholder 5

"we can't get GPs or ANPs. We've tried …and we had no applicants. …*I think we are trying other professions, as well, like OTs. …mental health practitioners in our practices. …It just proves that we should be moving away from the traditional models of GPs, because we don't need GPs to see all, every patient. … and we've got the community resource teams, as well, who are helping the social aspects."* Stakeholder 1

"I was glad that more roles are advancing, that we're integrating different disciplines into the mix, really. Because Primary Care needs that. … it's the way forward, really. And maybe we could go together, that the advanced practitioner roles could find ways to develop… And the more the merrier, really. We need this." Stakeholder 3

Recruitment challenges and the success of the Pacesetter project mean that teams are thinking differently about their workforce model. In some areas, they are looking to employ WAST staff for projects that would be able to utilise their skills.

"Before the Pacesetter project, we probably wouldn't have looked at advanced paramedics because it's not something that has been trialled before—in our areas, anyway. And I think it has been proven that it does work." Stakeholder 1

"are ***looking at paramedics to take on some of their frailty work because they've tried to recruit nurses to that role and haven't been successful.*** *And so, they're looking at developing because paramedics have done home visits and things. They're looking at developing that frailty model with the paramedics."* Stakeholder 2

Alongside the move towards a multidisciplinary Primary Care workforce, will be a change to some of the terminology. Instead of focusing on profession or role, advanced healthcare professionals in Primary Care staff will be known as advanced clinical practitioners (ACPs) or Primary Care practitioners, and would develop their Primary Care skillset over time to become more equal practitioners.

"we're almost branding all of the advanced clinical practitioners as Primary Care practitioners. So, you could be a nurse, you could be a paramedic, you could be an occupational therapist. If you've done that advanced clinical practice module in your masters, we'll just brand you as a Primary Care practitioner." Stakeholder 5

"we want to use the term 'advanced clinical practitioner' between an ANP and an APP, or an advanced physio. Because, really, they should all be able to do a lot of the same, and it's about merging of roles, isn't it? So I see, really, that our advanced paramedics would be working exactly the same as an advanced nurse practitioner in the future, because they should, over time, be able to develop the same skillset." Stakeholder 2

Each area has made its own adaptations, and one stakeholder highlighted how differences between Clusters means what works in one area, such as a multidisciplinary community resource team, might not work elsewhere.

"we've got a very good and vibrant community resource team…Community nurses, social workers, elderly, mental health, third sector. They're all happily working together, sometimes sharing in the building. … We set that up intentionally. … But that might not work in another Cluster where they don't have that developed quite as well." Stakeholder 10

Mutual learning

The rotation into Primary Care provided an opportunity for mutual learning, both in terms of APPs acquiring new skills and knowledge, and also sharing their own best practice, information and procedures from WAST which can benefit Primary Care. Some of these conversations have formed the foundations for the bigger changes, such as thinking differently in Primary Care, and improved perception and management of risk.

"you've got trainees, they're almost upskilling your other staff in the most current guidance….someone, then is abreast of the current guidance and what's changing and they can disseminate that information across to the rest of the practice, because you can't possibly stay up to date with everything in Primary Care. It's just not possible." Stakeholder 2

"I always feel that individuals who are undertaking training are great to work with because you really learn so much from them and you get the up-to-date information where-. Although you keep yourself up to date, I don't know, they're a little bit more ahead of the ball, …they're actually looking at the data, and the research, and the evidence that's new…. They approach things from a slightly different angle … it can help you to improve your practice, because you might not think about doing it that way because you've always done it this way." Stakeholder 6

Much of the time, the learning was through informal discussions or case based learning with each profession learning from the other.

"If I see him, I use the opportunity to discuss a recent case, and he's done the same. Or if he's seen someone that he knows that I used to see in the chronic conditions capacity, he would say." Stakeholder 3

"Because we have many case-based discussions about things, interesting things, that he has seen and things that I've seen." Stakeholder 4

"we'd have lots of discussions about patients and their treatment. So, we'd learn from each other. …because they work slightly differently to us, it did help with just sort of making you think a little bit more about other aspects and not just about the problem that you're dealing with." Stakeholder 6

The key practical skills that APPs were said to bring to Primary Care was their knowledge around acute care, and interpretation of ECGs.

"they've worked with the ACPs, some of that acute examination kind of stuff, they've been able to help to upskill some of our staff. And things like ECGs. They're really hot on the ECG side of it, which our advanced nurses aren't. So, that has been brilliant. And in fact, the GPs, even, have said, 'Oh, they're really good at reading the ECGs.'" Stakeholder 2

"If I needed to do an ECG on someone, if I knew he was around, I'd have a chat with him about that. So, that's useful, as well… it's great. It complements the whole team. But I don't see him or work alongside him often enough, really, if you see what I mean, to comment much on that" Stakeholder 3

"You'll take on board anything. I mean, every day you're learning in this job, I think. But I think, yeah, I'd say I've learned from them, having worked alongside them in certain aspects…, you do learn more about

the acute stuff and their knowledge on ECGs is completely different. …I think they're going to be a source of knowledge and skills in their own right. And therefore, I think they'll be an asset to any team." Stakeholder 11

From a clinical practice perspective, observing another somebody from another professional background has proved beneficial in terms what can be learned even for simple examinations.

"even though we might do an examination on a patient, we might do exactly the same examination but we might approach it from a different perspective or a different angle. And, do you know what? Just even something so basic as listening to somebody's chest. I know that might sound really simple but just listening to somebody's chest and then watching somebody who does it in a different manner is really-. As nurses, we tend to get fixed into doing things in-. I think you do, don't you, when you're in a role? You tend to do what your role does. And I just found it really, really helpful, and I just learned so much from both of them." Stakeholder 6

Primary Care professionals have benefitted from understanding more about WAST protocols, procedures and the paramedic profession.

"a talk by [APP] in WAST …gave us an insight into loads of things we didn't know before, so that was still useful. …it was really interesting for us to know what they carry, what policies they go by, …It could only be a positive thing, I thought… bringing his experience and skills from his setting into ours-." Stakeholder 3

"they've got a greater knowledge of what a paramedic does or is capable of." Stakeholder 8

"spending time with paramedics on the ground is useful, anyway, I think, because you get an idea of their perspective, and that has got value, hasn't it?" Stakeholder 7

It was thought that on WAST shifts, APPs would benefit from improved navigation of Primary Care and potentially offer other alternative services and pathways which could reduce the number of conveyances to ED, and benefit patients.

"definitely good sound knowledge of the local area, and the hope that, if [APP] was in the area on a call-out, she's got much more awareness of the services that are out there … also, the abilities of the services. …, I'm sure, can then prevent people just being sort of taken to A&E. You know, that there are other avenues that they can explore, hopefully, before they just rock up at the door there, isn't it?" Stakeholder 8

Education sessions

The Pacesetter APPs were provided with an education session delivered by GP trainers for half a day each week. Primary Care colleagues recognised the importance of tailored education for experienced professionals, new to Primary Care and there was overwhelming support for the education and supervision opportunities. It was seen as bridging the gap between Masters and practice, and delivering learning which equips the APPs with skills to work in Primary Care.

"They can go off and they can do advanced clinical practice and Uni. They can do their masters. ***But that doesn't equip them for Primary Care****, and that's where this course has been so good, … what they're getting on the academic side is brilliant….Primary Care is so different to any other area of healthcare, and it does have its own challenges. And therefore, it does need its own specific Primary Care training packages…. it's like taking a brand new member of staff on again, like taking someone that has just come out of qualification, because they're like a fish out of water."* Stakeholder 2

The importance of supporting education was recognised for the Cohorts of Pacesetter APPs. However, current staffing pressures and lack of protected education time for other ACPs may mean surgeries are not be able to release staff for education to the same extent in future.

"They probably do see it as a luxury… Because like I say, they can't do any of their training. I mean, we are struggling at the minute to train the ANPs. So, I suppose, yeah, it's needed. It's beneficial. But that has been part of the program." Stakeholder 8

"if we had the new APPs to support different practices, we would be keen to support them. But yeah, I think it's the pressures of the staffing levels that may be a challenge, really…. The other issue, as well, is that they don't have protected education sessions." Stakeholder 1

"*They're getting access to far more than our ANPs would have done… But what I'd like to see is that it is expanded out to other professionals. If we are looking at developing our advanced practitioners, we know that this format works.*" Stakeholder 2

Current pressures mean that in a business as usual model, some practices would struggle to provide protected education time. There would be implications, either in a shift of work to colleagues, or finding locum funding to backfill the APP time.

"we're not even getting time to do our mandatory training, so we're really struggling. It's really tough. We're not getting any training. … the practicalities are that when you're down on the ground you've just got to get on with it and not always time to do all those extra bits, but you need to do them to improve your practice… to keep up to date." Stakeholder 6

"we'd all really enjoy education and things like that. …at the moment, last couple of months, there's no way, because of demands in Primary Care. It's just been too big. Unless we were able to get locum cover to do that, which would mean we'd need the funding… that's if you can get locum cover for half a day…. Otherwise, it all shifts across, really." Stakeholder 7

From the perspective of practice staff working alongside the APPs, similar levels of educational support had never been 'handed' to them, and there was an expectation to identify their own learning needs and set aside protected time.

"You have to find your own CPD. You have to find your own educational stuff. When you're doing ten clinical sessions a week, it's difficult to find that time, and especially find that motivation to do it. It's much more difficult if you don't have that time set aside." Stakeholder 4

"I'd be allowed to go and do it but there is a lack of study days or opportunities….we had to work for it, look for it, ourselves…Which is okay at this level, I suppose." Stakeholder 3

"I think the other thing is it's down to the person to engage with it … to make sure they have the time to do it, and use your time wisely. So, I would hope they would get time to do it, but it is about your own time management skills, as well." Stakeholder 11

However, they were appreciative of the resources and information that the APPs had been able to share from their education sessions.

"I think they really did enjoy them. In fact, they did offer to share that information with us and they actually signposted us to some of the resources that were available out there, which, you know, have been so beneficial. And things that we don't always hear about here…" Stakeholder 6

"he mentioned-. Oh, was it Red Whale or something? …I thought, 'Wow, that's really good.' So, it's good that he has backing to have that sort of development and continued support, really." Stakeholder 3

One of the nursing colleagues who had joined the education sessions with Cohort II, described the benefits of multi-professional learning and how it can influence their own learning and practice.

"you had that forum to be able to bat things off each other, and listen to experiences, and discuss how you would deal with things and manage things differently. … listening to other … Other practitioners' experience, really, does help inform your own judgment. You learn a lot through that." Stakeholder 11

Aside from the Pacesetter education, other multi-professional learning was cited as being beneficial and an opportunity to learn from other clinicians and expand their practice.

"It can be quite isolating because you're working with the same people. There aren't as many fresh, new things that you see. And if you get stuck within seeing usual things, you can … Lose parts of your practice if you stick to one thing that you feel safe in." Stakeholder 4

"it's the way forward, really. And maybe we could go together, that the advanced practitioner roles could find ways to develop together." Stakeholder 3

"we've also included the APPs in our education sessions. … So, ANP lead has picked a number of topics and my role has been to gather a GP lead to deliver that topic….It's also a good opportunity for her to come and train with our Primary Care staff. They get to know her, she gets to know them, and she gets to pick up some extra educational topics…. that's kind of quite nice, that they wanted to embed her in that way." Stakeholder 8

Managed vs independent

The Pacesetter APPs were placed in almost 30 different surgeries across seven Clusters over the two Phases of the project, including managed and independent practices. In some areas APPs worked exclusively in managed practices, and were felt to be well suited to the environment.

"We looked at where we could place them within the Cluster and we felt that they were best in the managed practices." Stakeholder 2

"I think that they're getting good experience in managed practices. I would favour anybody coming into managed practices." Stakeholder 5

For Managed Practices, Pacesetter was viewed as an opportunity to invest in their staff, diversify the workforce, and deliver high quality care. Whereas independent practices were seen as having more of a business or financially incentivised model.

"the problem with independent practices is, as with all Primary Care practices, we all struggle for staff, which is kind of why we're expanding, as well, into having these allied health professionals, to upskill in Primary Care…. that's why we took the paramedic practitioners and the Pacesetter into our managed practices, because we could kind of see the benefit of having them in the long term. …Because unless you invest in your new staff coming through, it's never going to change. …and I think this is what some of the independents struggle with, is they see the immediate and they don't see the long term." Stakeholder 2

"I see independent contractors looking to make quick bucks. They're more about the profit, …They're still focused on patient care but they're looking for any opportunities to generate income. And by doing that, they increase their workforce by paying clinicians to come and work for them at enhanced rates…. we tend to get sloppy seconds. … whereas Agenda for Change kind of dictates to us what we're allowed to pay. And that means that we can focus on delivering quality of patient care rather than increasing the number of people to see more people." Stakeholder 5

Elsewhere, APP allocation was coordinated from a Cluster perspective without regard to their status as managed or independent practice.

"I wouldn't separate them into managed and independent because, as a Cluster, they work together as a whole…. if you just gave that service to the managed practices, I don't think that would go down well because the other services would go, 'Why don't we get that? We could really be used-.'" Stakeholder 9

Uniform

From the outset, the option whether to wear WAST green uniform on Primary Care shifts was left to the practice and APP to agree. Wearing a WAST uniform was seen as a marker for patients to distinguish healthcare professional roles from each other.

"I actually think them wearing the uniform does distinguish them within the practice and it kind of adds more strings to the bow." Stakeholder 5

" from the patients' point of view … sometimes they know who you are by what uniform you're wearing?" Stakeholder 6

An argument against wearing WAST uniform was illustrated with by an experience with a care home patient who mistakenly though the APP was attending in an ambulance service capacity and would take them to hospital.

"I think initially the patients maybe weren't sure because-. … [APP] would go out in his uniform. And I think I went on one visit with him…He went to a care home and a resident there was like, 'Oh, no, you're not going to take me to hospital.' So I think, yeah, it's a perception. But I think once they get to know you, the patients, they're fine." Stakeholder 1

In contrast, as part of the proposed new model of Primary Care, individuals in some areas will be referred to as ACPs regardless of profession and it was therefore seen as important that they wear scrubs which

don't distinguish professional background. Since the COVID-19 outbreak, some APPs have started wearing standard scrubs like their Primary Care colleagues.

"I think we should all be advanced clinical practitioners, if that's the level that you're working. It doesn't actually matter what pathway you've trained in to get there…I think if we can stop confusing patients with, 'Well, this is a paramedic that you're seeing-.' … They don't understand it." Stakeholder 2

"I wear a uniform … I wear the same uniform as a band six or a band seven on a ward. That one bothers me a little bit because I'm an advanced practitioner so I should be recognised, at least to be in a different uniform that allows people to know that I am not within the managerial side of things. …I would like to be in a specialist uniform where I am able to be seen differently to just the banding." Stakeholder 11

It was also recognised that regardless of uniform, patients have reported a positive experience with APPs.

"They're still clinicians, regardless of the fact they're wearing a green jumpsuit, or whatever it is that they've got on, and a doctor would wear a white coat, or whatever it is. But when you actually get feedback later on, they say they're amazing. They're easy to talk to and you can actually have a-. You know, get everything across. Whereas the GP's time is always too-. Not enough." Stakeholder 5

Prescribing

Prescribing has been one of the most divisive topics with regards to the Pacesetter and APP role in Primary Care.

One of the arguments in favour of prescribing, is that APPs can provide rounded care, and deal with all elements of the consultation. It was perceived as making life easier for APPs and their colleagues, and improving care provided to patients. However, those making the case for APP prescribing have emphasised that it is not essential to the role nor a deal breaker for recruitment into Primary Care.

"I guess one of the big things that they lack is that prescribing, and that's quite a big element of being able to deal with a patient completely holistically. You deal with the whole lot, don't you? It's about assessing, it's diagnosing, it's planning, it's implementing. So, they're kind of missing a little element of that…. It's not essential but it does mean that they could close off the whole loop." Stakeholder 2

"The more people we can get to prescribe within their competency, the better service I think we'll be able to provide" Stakeholder 5

"I think it's useful practising some elements of prescribing, but I don't think it's essential in any at all." Stakeholder 7

"It did make a big difference, the prescribing, to be honest….having that prescribing helped, but I don't think it was the be-all and end-all. I think you could still work with people who don't have that prescribing but it just made it so much easier having the prescribing, I think. But I wouldn't say, if somebody wasn't a prescriber, oh, no, they can't come here." Stakeholder 6

Working in Primary Care in particular, it was thought that APPs should be given equal access to prescribing, as their ACP colleagues.

"I actually think that, if we have nurse practitioners and advanced nurse practitioners that can prescribe, then why can't a paramedic prescribe? … giving them a formulary for their prescribing that's relevant to their skillset. …but I'm very much an advocate of giving them the prescribing if they're capable and competent to do it." Stakeholder 5

"I think if you have the skills to take a history, and examine, and you have the knowledge, then you have made a decision that you should prescribe, and follow it through, I think it adds street credentials to the advanced role." Stakeholder 3

Non-prescribing APPs currently need prescriptions signed by another professional which was seen as generating work for other staff in the practice and can be frustrating for APPs.

"I think he would have generated more work for someone else if he wasn't a prescriber …and that person hasn't seen the patient, and they need to trust you that what you examined in right… It's the same with my role. I prescribe." Stakeholder 3

"I don't know if they would be more valuable. It would make their job easier. … because it is a pain having to go through the doctors every time in order for scripts to be done. And if they were able to do that then, obviously, they would not need to always be coming to the GPs." Stakeholder 11

"I think it's frustrating them but I don't think it's holding them back. But it's also frustrating the GPs, that they have to go ahead and do the second check and sign the prescription." Stakeholder 5

"that would take another pressure away from the GPs and them having to go back and get the prescription. Yeah. So, I think that would absolutely make a difference." Stakeholder 1

"to let them all have that prescribing qualification… reduces the amount of support they need in practice, which then allows them to deliver care to more patients and enhances their clinical knowledge… I think because [APP] had the prescribing, he didn't need that same level of support and there was a little bit more freedom there." Stakeholder 9

However, the process obtaining a signature was viewed by some as a learning opportunity, to look at what could be done differently, particularly whilst becoming established in Primary Care.

"It gives you that sort of enforced supervision, as well, the fact that you have to discuss it with somebody. It makes you feel that little bit more protected, because you've had to speak to somebody about it. So that's beneficial, as well, if you're still quite junior." Stakeholder 4

"[APP] wasn't able to prescribe, initially. He'd come to us and discuss his cases with us, and we'd go through what he'd triaged, and then discuss what treatment options there were or if we needed to bring patients in for assessments or examination. …Because, obviously, we've worked alongside them and having that conversation with somebody or a discussion about somebody's treatment was beneficial, I think, for both parties." Stakeholder 6

"And I think [GP] would probably be the first one to say…nine out of ten, there's never a problem. And the tenth one, it's not that it's a problem, it's more of a 'could he have done something slightly different' type of scenario." Stakeholder 5

Less in favour of prescribing, was the case that in practice, prescribing is 'overrated' as there are always colleagues available to sign prescriptions, although it may be more useful working across multiple practices or outside the surgery.

"If the idea was to be based in a practice, I think it wouldn't be a deal-breaker for me if they couldn't have their prescribing. But everyone wants to be prescribing….I don't think it's an issue. I think prescribing is perhaps a little bit over-rated as a need for practices. Because if you've got someone working next door who pops a prescription through and says, 'I've done the assessment, done this. What do you think?' … if you're working across multiple practices it becomes a much bigger positive." Stakeholder 10

"they come back to the surgery to write up the notes, anyway, so it doesn't make much of a difference for them to just ask the GP for a …it doesn't really make much of a difference. …It obviously has its benefits but I don't think it's like an essential need at all. I get on fine." Stakeholder 4

Practice pressures and benefits of Pacesetter

Some of the main pressures on practices which affect their workload and implementation of the Pacesetter programme were related to the COVID-19 pandemic. The timing was seen to be particularly difficult for new starters, to balance clinical demand with the need to upskill staff and prepare them for Primary Care.

"But I think, even for new staff into our managed practices, we've seen that we've struggled to actually get them upskilled, simply because we are that desperate for people to actually see patients." Stakeholder 2

"the biggest barrier, like I said, has been the GP support, which I think has been affected by capacity and practice. …it's just bad timing and the situation as a whole…they didn't have that spare capacity, even though they were taking more consultations off them, they didn't have that breathing room just to be able to bring in someone new." Stakeholder 9

Furthermore, longer term recruitment strategies and training need to be implemented in the near future to provide the necessary training and be ready for practice in the future.

"These people aren't just out there. There are no primary-care-trained people ready just to step into the job. So, we've got to develop programs like this which, yes, we might not reap the benefits for three years. But unless we start that programme and keep it going as a rolling program, we're never going to progress." Stakeholder 2

Despite wide acknowledgement of the APP skillset, there was concern that in some areas they were not utilised appropriately, or to their full potential due to staffing pressures, clinical need and poor understanding of the capability of the role.

"They did want to get them more involved in the clinics, but that didn't happen because, I think, the need was out in the community, really. Because in the [town] area in particular, there are so many care homes there, and I think that's where they wanted to focus the support. … yeah, I think it's the pressures of the staffing levels that may be a challenge, really." Stakeholder 1

"[APP] was placed in the hub along with an ANP, and they were kind of almost left to get on with it a little bit. I mean, he's more than capable, isn't he? But that was a bit of a shame, really, because I'm not sure that the Cluster there really used them appropriately, to be honest with you." Stakeholder 2

"They can be perceived as the extra pair of hands, so we'll just give them anything." Stakeholder 5

In terms of practical requirements, physical room space for APPs to consult has been a challenge in some areas.

"in order to train someone, you need to have the clinical space to do it, which we're a bit tight on, and the actual physical time to do it. And I think that's probably what the practices, certainly within our Clusters, might be struggling with at the moment in engaging that." Stakeholder 7

Across the different Clusters and range of Primary Care professionals interviewed, there was consensus in the benefits resulting from having an APP working in practice. The first was around home visiting, which drew on their core paramedic visiting skills and helped embed them in their new role in Primary Care. For the practice, an additional professional to undertake home visits, facilitated appointments earlier in the day and benefitted those who need treatment or onwards referral which can be arranged sooner.

"their expertise is going into people's homes, aren't they? That's what they do. So, the home visit service is really good when it works well." Stakeholder 11

"for phase one, they did mainly care home patients, which for the first few months … both APP …said that was really beneficial, it was really quite useful. Do you know, it's a good way to get them embedded into practice?" Stakeholder 9

"Obviously, they do the home visiting service, but I think they'd be beneficial clinicians in any form, really, if they could take it on. They're really flexible, and I think that's the beauty of it." Stakeholder 4

"that was a big help because, historically, we would have had to have waited for GPs to have finished in their clinics before they could go out and assess patients, unless, obviously, it was an urgent call." Stakeholder 6

The second was the utilisation of their skills in the assessment and treatment of acute presentations.

"we've kind of found their niche. The fact that they can deal with some of the acute situations that come into the practice. They can go and do the home visits and, very rarely, seek the advice of the GP. They only seek the advice of the GP if there's a drug that they need to administer to the patient, or order oxygen, or whatever it might be." Stakeholder 5

"Yeah. I think she's good at acute assessment. I think that's what their training is around, isn't it, really? Decision-making." Stakeholder 7

"[APP's] knowledge is phenomenal. So, she is genuinely amazing…. Yeah. Extremely knowledgeable." Stakeholder 10

"I think they have brought that kind of element of being able to deal with the acute presentations." Stakeholder 2

Thirdly, placing APPs in Primary Care has met one of the key project aims of increasing capacity, which in

turn has reduced pressure on GPs and released time to be able to focus on more complex cases or undertake some of their managerial or senior duties.

"Well, it's more feet on the ground, isn't it? More bums on seats, whatever you call it. So, it's increasing our capacity." Stakeholder 10

"I think in terms of her being able to be an extra-. In the nicest possible way, an extra resource, isn't she? She's there as … an extra body in the practice that they wouldn't generally have had. So, I think that can only be a good thing in helping sort of take the pressure off. … -. Maybe the less challenging ones for her to free up the GPs." Stakeholder 8

"They help, definitely, with the workload. Definitely. I'd say they prevent-. They protect the GPs. They protect the GPs' work-time, as well. They protect patients in more than just medical care but with social aspects, like I said earlier, as well. And they're just good to have around." Stakeholder 4

"in the past, they [GPs[would have had to have done all the home visits-. So, it could be straightforward things like a UTI or a chest infection, which we as nurse practitioners could have done but we didn't do home visits. …it just meant, then, that the … could deal with the more complex cases and the referrals, or just people that maybe needed a little bit more input from a GP, …admin and things that they have to do on top of their ordinary work. … I think it just made everything a little bit easier." Stakeholder 6

Linked to releasing time, the APPs had the capacity to spend more time on patient consultations than a GP would. In the longer term, it could potentially reduce re-contact with the practice, and prevent complications or future admissions to secondary care.

"They've got the time to spend with the patients, and I think that's good for the patients because, obviously, some patients might not be keen on ringing the doctors again or-. So, it can avoid complications later on down the line." Stakeholder 1

"But I do think there is a remit there for advanced-level care of these long-term conditions, as well. I think we might be able to actually divert some of the things away from secondary care if we developed that within our practices." Stakeholder 2

Continuity of care, linked to the APP rotation was described as offering multiple benefits. First, from the practice perspective and the importance of consistent staffing to ensure integration into the practice team.

"But in terms of continuity, employing them in Primary Care-. So, there's that same face that sees the same patients and the staff all know how to work with them. Because I think every time you bring somebody new in, everyone is a bit dubious: 'Well, I hope he's going to be good. I hope he's not going to be turning patients away'." Stakeholder 5

Secondly, following patients can be a learning experience, to see the patient through their journey and potentially identify new resources or pathways, which will help the APP with similar presentations in future.

"if you come back and say, 'Oh, the patient had this condition,' but you're then not following up on what happens next, you don't have the appropriate learning built in because you don't know how to deal with it. You don't know how it has progressed. So, when you next get a case like that, you deal with it in exactly the same way." Stakeholder 9

One individual perceived discussed the steep learning curve that came from taking responsibility for patients they would have previously handed over to a GP or secondary care. In data collection with APPs, this was seen as a critical point in executing their newly acquired safety netting and risk management skills, and thinking differently about patient management.

"normally, they would go, and they would do to a certain point, and they'd hand that patient over, you know, to ED or to wherever else. But now it's like, guys, the buck now stops with you. You've got to do the whole lot. We expect that when you leave that house, or when that patient walks out of the room, you'll have dealt with everything for them." Stakeholder 2

By providing holistic care, and managing both the social and medical presentations, the APPs have been able build relationships with patients over time. In one area, the APP worked collaboratively with an AHP to ensure that the patients were followed-up when they are away from Primary Care

"They do more than medical things, as well. They do the social aspect of it, as well, raise concerns of carer needs, the assessment of the home…they have their people that they know quite well. …If [APP is] worried about a patient, he'll go and see them. But if he's not in for the next few days, he'll just ask me to give them a call, just to see how they are. So, there is still that level of continuity there." Stakeholder 4

In addition, APP follow-up was seen as proactive rather than reactive, as they have fewer pressures than some of the other Primary Care staff.

"they're quite good, as well, at following up patients. I think if they'd been to see them in the previous week and they feel 'I need a sort of follow-up,' they'll go and see the patients. … Whereas, maybe, a GP, because of the pressures, may not have done that in the past. It would be more like, 'Oh, give us a ring if there are any problems'." Stakeholder 1

There was also continuity and crossover between Primary Care and WAST when APPs work in the same area for both shifts. They see the same patients, and may have insight into social or home circumstances that practice based staff do not.

"the days that they are here are very heavy. They're heavy. They do a lot. They work really hard. …[APP] has a patient that he sees when he's on call, anyway, on the first response, but he also sees them when he's in here." Stakeholder 4

"You sometimes forget, when you're sat in an office or a clinical room, about the home and what the home is. … they might have been to that patient with the ambulance service. You get a slightly different perspective. I think, sometimes, when you actually do go into somebody's home, it's more of a privilege, really, than them coming into your clinic. … you do think about things slightly differently. You're more aware of things. And obviously, sometimes, there's the unseen things that you might pick up when you're in somebody's home." Stakeholder 6

Patient experience, and perceptions of APPs in Primary Care

Having an APP in practice widens patients choice and offers them another professional they are able to consult with. However, work is needed more generally to educate the public about the consulting the 'right' professional for their needs, and changing the mind-set that every presentation needs to be seen by a GP.

"And it's about educating the patients that they don't have to see the GP about everything. we can almost-. Not blind the patients but convince them, actually, our Primary Care practitioners are the right people to see, because we've got to change the language in Primary Care." Stakeholder 5

"people rock up and expect to be seen by a GP, not even by a nurse. So, there is a lot of that educating of patients to be done about, 'when you come, you might see a paramedic', … you will see the most appropriate person to deal with your complaint. patients slowly are starting to learn that they don't necessarily need to see a GP, that we will filter them to the right person." Stakeholder 2

"Patients can often think, 'Oh, I'm seeing the wrong thing,' even though we know we've triaged them appropriately." Stakeholder 9

Current pressures in Primary Care mean some patients default to calling 999 when they having difficulty getting an appointment with their own practice. APP presence in Primary Care increases capacity, which could potentially reduce these calls and unnecessary ED visits.

"the more we can educate people and say, actually, I don't need to go to hospital. I don't need to go and see in the ED department. I can go into the GP surgery and I can see whoever I want." Stakeholder 5

"everybody going, 'Well, I can't get to my GP. I'm going to ring 999, then.' There's a lot of education needed out there, isn't there, for a lot of people?" Stakeholder 8

In some circumstances an ACP with a Primary Care specialism may actually have more recent knowledge of some medical presentations than experienced GPs.

"There are other clinicians in the practice that might have a specialism in the condition that that patient is presenting with, and they're probably more up-to-date with their competencies than a GP who trained 30 years ago. Yeah, okay, he might be a good GP but might not be aware of any of the modern techniques to deal with COPD patients." Stakeholder 5

In areas where a multi-professional model has worked well, patients have requested to see nursing or allied health professionals rather than a GP, as they have valued the holistic approach to care.

"And I think at the beginning they possibly felt a bit fobbed off when they didn't get to see a GP. But now, what we're finding is…that patients will request to see them again. 'Oh, no, I want to see an advanced nurse rather than a GP, because when I came they dealt with everything. They see the wider picture.'" Stakeholder 2

In addition, non-GP clinicians were perceived to be on an equal level with the patient. They were able to take more time with the patient to gain a better understanding of the some of the wider social issues.

"GPs have a couple of hours to do all the home visits, so it would be more of a flying visit, whereas the paramedics have a little bit more time to have a bit of a chat, and speak things through, and make sure that everything's all right, on more than one level, as well, and can have a bit of a moider with them." Stakeholder 4

"I think [APP]… had an understanding of the social situations… He seemed to be able to pitch it well with them." Stakeholder 3

A consultation with an APP in Primary Care was initially perceived to be a novelty, or that their complaint was regarded as serious, but patients have subsequently provided positive feedback on the experience.

"I think the patient perception of seeing a paramedic is seen as, 'Oh, wow. I was serious enough to see a paramedic, isn't that impressive?' And I think it can be really good from that perspective, that the patient doesn't feel downgraded. They feel like they've had a special service." Stakeholder 9

"I think that they find it quite novel, the, 'Oh, a paramedic seeing me in the GP surgery?' And they're a little bit dubious. …But when you actually get feedback later on, they say they're amazing. They're easy to talk to and you can actually have a-. You know, get everything across. Whereas the GP's time is always too-. Not enough." Stakeholder 5

"They all enjoyed a visit and were quite impressed that they were sent a paramedic to do this… 'Oh, a paramedic has been here to see me.' And some associate it with, 'I must be bad because they've sent a paramedic. But I've had a thorough investigation, now. I've been thoroughly examined, and he was very nice, and it went well." Stakeholder 3

For some patients, the role of the healthcare professional wasn't important, rather, they were grateful for the consultation and valued professional help.

"I think if you're somebody that can solve their problems or help them, they don't mind who you are, to be honest. And even if you can't help them but you can say to them, 'Look, I can't help you but ..Let's look at what the problem is … we'll involve this person, or that person' …. You don't have to solve it for them there and then." Stakeholder 6

"From just my little experience of the type of cohort I see at home, maybe the slightly older or chronic conditions…. They see me as a nurse listening to their chest and prescribing, …They don't know who was-. I don't think they're that bothered. Maybe the younger ones would." Stakeholder 3

"it's all about forming your own relationships with patients. That's part of what being in this sort of job role in Primary Care is about, especially when you're in a surgery, because you get to know your patients." Stakeholder 11

Furthermore, there was thought to be an element of gender stereotyping whereby patients (particularly elderly) had certain expectations assigned to the doctor and nurse roles.

"you always introduced yourself and tell them what your role is. I don't know whether they actually do differentiate between the professions….in practice, all the females tend to be called a nurse and all the males tend to be called a doctor… patients will say to me, 'Well, I saw the nurse last week'… and I'll say, 'Well, actually, that was a GP' … especially with the elderly, the older generations, the over 60's, they tend to think like that." Stakeholder 6

Overall, feedback from patients has been positive, and indicates that APPs have been well received by patients.

"They love them. They love them. Especially [APP], he's a sweet-talker. He loves little old ladies and they love him just as much…Patients know how difficult it is to get people out to them, so I think they're really grateful of the service. Because it can never be managed just with GPs." Stakeholder 4

"I haven't spoken to the patients personally on that to know it from that perspective. But yeah, I have not heard anything negative about that at all." Stakeholder 9

"all positive. All positive. All positive. He's seen a lot of my patients because they're the ones that would present acutely, then, with the chronic conditions, a lot of them. And they-. I think they value that visit very much." Stakeholder 3

"we've certainly not had any complaints about the paramedics. We've had lots of complaints about lots of other things in [surgery], but certainly none about our paramedics." Stakeholder 2

Feedback from staff has also been positive. As individuals, some of the APPs were praised by their primary colleagues for their professionalism, communication, willingness to get involved, and clinical skills.

"I'm sure he's used to going into all sorts of places, so he's-. …He has got open communication and professional." Stakeholder 3

"They've definitely fitted in really well with the team and they're part of the fixtures and fittings, now, really." Stakeholder 2

"And they just get on with it. And to be fair, they're all nice guys." Stakeholder 5

"They're not scared to see things they don't know because, whenever they're out on a call on the ambulance, they have no idea what they could be going out to. So, they're more than happy to go and see things because that's what they're used to in their job role." Stakeholder 4

"they were really forthcoming. They were so interested. I don't know whether we got lucky and we just had brilliant APPs working with us. …. I just felt that they really, really complemented us, here. So, I was really sad when [APP] had to leave. He was such a big, big asset." Stakeholder 6

"they said that they'd read some of her consultation papers and they were really pleased to read how in-depth and how, really, good her consultations were. And I think that gave them reassurance of her role and her capabilities." Stakeholder 8

"*It's down to the individual, isn't it? And [APP] is absolutely lovely. So, she has really embedded herself within our team…, she's been great.*" Stakeholder 10

Differences in personalities, skills and practice were observed between the APPs in the current Pacesetter Cohorts. For future Cohorts, there would be some hesitation taking on new APPs before knowing more about their capabilities and experience.

"There's definitely a difference between the paramedic practitioners… That can be on an individual basis in any type of clinical job, can't it?" Stakeholder 4

"If you gave us a new paramedic, now, I suppose, in reality, they would go, 'Oh, yeah, that's brilliant. Yeah, great'… But they could potentially be very different from [APP] and not have enough knowledge or experience. …we'd have to be very clear about what their capabilities were, or are, because I think they would expect another [APP]." Stakeholder 8

The APP practical skills were also noted, they were seen as being 'doers' both practically, and also in terms of questioning long-standing practices and procedures in surgery.

"I don't know whether it's a bloke thing but they're kind of-. All of the ones that we've got, they're quite practical. They don't think twice about-. If they need to lift somebody, they'll go and lift them more. If they see something wrong, they'll go and fix it. Whereas some of our nurses will look at it and then go to the practice manager and say, 'Well, the thing's fallen over in the consulting room. Should I be picking it up?'…It would be nice to see some women coming through it, though." Stakeholder 5

"And they're not afraid to challenge why things are done. I have been asked, 'Why do we do that?' So, that's good. They're not afraid to do that, to question… He's sent me a few e-mails of, 'I'm not quite sure. Why is this? Can you advise on this?' And that's fine. I'm always happy for people to ask." Stakeholder 2

Profession of choice

As part of the interview discussions, individuals were asked whether the APP role would be the profession of choice for Primary Care, having had experience working alongside them. Opinions were divided, with a split between those with strategic or oversight background, contrasting with the views of healthcare professionals working in practice.

From the perspective of practice colleagues, the experience was positive, and they would encourage recruitment of APPs.

"With our needs, yeah, definitely. Definitely….Home visiting… And for help with just general clinics, as well." Stakeholder 4

"If I had any choice, I'd definitely take on an APP, definitely….[APP] was just so knowledgeable and wouldn't have any qualms." Stakeholder 6

Elsewhere they would be a profession of choice, but not above nursing or AHP colleagues. APPs would be considered equally, but would not have been prior to Pacesetter.

"I don't have a preference. What I like to say is that I want a mix of everybody. So, I wouldn't say that I preferred APPs above anybody else, but I would definitely consider them in an equal standing to other allied health professionals. …I definitely wouldn't have thought of using paramedics before." Stakeholder 2

From GPs and those in strategic roles, the APP expertise was acknowledged but there was less certainty on whether an APP would be the profession of choice. It would need to be a business focused decision and consider the model of deployment where an APP could be best utilised such as acute visiting service.

"Maybe. So, I'm not sure how much employment they'd be able to offer, if that makes sense. I don't think you can have just a paramedic running your on-calls because there's too much complexity there. I do think you could have a paramedic as a visiting doctor doing the acute visits. I think that would be really handy. But I'm not sure about how you'd get the volume to justify employing them… It might be something you could do on a Cluster basis … I think that kind of thing would work quite well." Stakeholder 7

Financial considerations would also affect the decision. Pacesetter APPs were funded through the project, but there would be some reluctance to pay them from practice funds in future.

"I think our practices do like it but I think they wouldn't want the funding to come from their own pot, currently. … they'd say, 'This should be going to core funding because of how long it has been out there.' …but I think getting the whole Cluster to agree to fund it might be a challenge. I don't think it wouldn't be unanimously yes." Stakeholder 9

"It would depend on the individual a little bit. I think if you were taking on a paramedic… in that instance it becomes much more commercial. I think the advanced practitioner paramedic would have to dance to the practice's tune, rather than the other way around, if you see what I mean. … it would be different. We're the employer. We'd employ them ourselves, we'd pay for them, and we'd keep the APP for ourselves, like we would employ anyone else… if it's a paid-for service, we'd expect to be able to dictate when that happens, that would suit our Cluster and meet our demographics need." Stakeholder 10

For some, the current difficulties recruiting GPs would make the APP an appealing option, but they would look elsewhere for funding where possible and potentially build it into long term workforce planning strategies.

"I think practices probably would fund themselves if-. Especially if they were struggling to recruit a GP. But … the practices are businesses, aren't they? So I think, if they can get support and funding from other sources, that's what they'll do." Stakeholder 1

"when you come along and say, 'Actually, we'd love to have one of these paramedics but it's going to cost me this to have it'-. … that there is some support to help with the workforce planning about how they fit into the model." Stakeholder 5

Exit planning and life beyond Pacesetter

The APPs have been valued members of the Primary Care team for over two years in some practices. Beyond Pacesetter, there were a number of plans in place and recommended adaptations which could secure sustainability of APPs in Primary Care long term.

A number of interviewees spoke of their enthusiasm to keep them in practice beyond the end of the project and to expand the numbers of APPs in future.

"They really want to keep hold of them. We don't want to let them go. I don't want to not work with [APP] anymore." Stakeholder 4

"we want more of them. If the programme is successful …I'm keen to see as many coming through." Stakeholder 5

"it's definitely sustainable and definitely needed. I think it has just been a lot of bad luck with timing for now." Stakeholder 9

In future, the APP role would be developed in along with other AHPs to make advanced practice roles more equal across the professions. It would expand their knowledge and mean taking on new clinical responsibilities such as preventative medicine.

"I would like to see them doing everything that our ACPs would. So, from triage, to telephone consultations, to dealing with the things that come through on e-consult, the minor illness kind of stuff,

the acute presentations. And then, yeah, if people need home visits, you do that. But I would like to also see—and I think this is true of all advanced practitioners—doing more of the preventative work. Because at the moment, that gets left to other members of the team. …I would see that, in the future, there wouldn't be any difference." Stakeholder 2

"I'm quite creative when it comes to ideas and think, 'Well, why can't the paramedics do this?'…I think some people just need to be pushed to see what the scope of their role is. And I think, by identifying what that scope is, then we can go back and challenge the authority, or the powers, or whatever it might be, that say, 'Well, actually, shouldn't we be extending the scope of their role to incorporate this type of thing?" Stakeholder 5

The collaborative approach was cited as one of the key factors that contributed to successful implementation of Pacesetter and would also be the preferred model post-project. However, at the time the interviews were undertaken, further clarification was required particularly around finances, governance and deployment.

"I would definitely encourage either more of a collaborative approach with WAST… I also don't want to do is destabilise WAST… we'd be deskilling WAST if they just all came out… We've got to sort the politics out between the health board and WAST because, if these people do want to come and work for us, what does that model look like? Or are we just going to build an SLA and we're going to have a rotation of paramedics that keep coming in through the system. And how is that going to be paid for?." Stakeholder 5

"It is really difficult. I think there definitely is a helpful role in them, and I think that's going to be in the acute side of things. But I'm not sure what the health board and, I think, WAST want out of it, really. I mean, I guess I think there is an inherent value in them spending time in general practice anyway." Stakeholder 7

"We need to keep them rotated, definitely. But what it's going to take for that to happen is a really good working relationship between WAST and between, probably, the managed practices…that will require a proper, robust, agreed rotational working package for them. That's where it becomes a little bit more tricky." Stakeholder 2

"as far as we're aware, she's going to exit in March, and then we might not see her again." Stakeholder 8

There was also uncertainty on how a rotation may look in terms of timing and location.

"I would like to see them rotating. Maybe they do a block. Maybe they do a month in Primary Care, a month in the UPCCs, and a month for WAST, or they do so many days a week. I don't know how they feel it would work but I would really encourage them and want to see them continuing to work in all aspects." Stakeholder 2

"You've got to think of these as people, as well, in their careers. They obviously went in to be paramedics for a reason but they also then chose to continue their training and come and work in Primary Care for another reason. So, they're either career paramedics or they're career clinicians." Stakeholder 5

One important consideration is making sure that the rotation and Pacesetter isn't seen as 'another project' by Primary Care, as has been the case with previous initiatives.

"We've had that problem with OTs and people leaving, go and get other jobs, and then the practice are like, 'Oh, well, we've put so much into this and we're losing them.' It's a bit demoralising, really, having to start again. So, I think-. But if we had something permanent, that, obviously, would be better. Because all these projects are just projects, aren't they?" Stakeholder 1

"what I would hate to see is for this just to be a pilot and then have a break or it not carry on. We've shown it works, so it needs to just smoothly run on…if we don't develop something going forward for them after they've finished this scheme, it has all been for nothing, hasn't it?" Stakeholder 2

There was potential opportunity to attract professionals from outside the area if Clusters and practices can present themselves as multidisciplinary, training focused and forward looking.

"It's hard to attract people from outside. And what I'm hoping is that, as we can expand the practices and make them more these educational hubs that we're looking at, they then become more appealing to people from outside the area." Stakeholder 2

"We have an ambition as a Cluster to see ourselves as a Cluster that likes to train, … So, [Cluster] can be seen as a place to go and work for people who are ambitious, want to progress, that kind of thing. Pacesetter definitely feeds into that." Stakeholder 10

"I think that kind of needs to be very clear from the outset. What does the end of this programme look like for an individual? Whether they be a PA or an APP. And helping us to build them into the structure and do some financial modelling around what the benefits of having that person are, in terms of pounds, shillings, and pence." Stakeholder 5

To ensure long term sustainability of APPs in Primary Care, the current Cohorts will need to guide and lead future APPs as they start in Primary Care.

"the people that we have taken this time, we could almost do with some of them being employed as those supernumerary trainers to take the next lot through…whilst it's good for them to sit with other clinicians, to learn different skills, actually, sometimes it's really good to learn from a peer." Stakeholder 2

Some teams may look to review where an APP is placed to better accommodate population needs, and ensure that there is physical space to accommodate the APP in practice.

"I think, if the APP was based as part of our community resource teams, … as part of the home visiting service, …that would possibly meet the needs of our population better, given the rurality… and there's enough work. …I think that would play to their strengths quite naturally …The scheme very much wanted general practice experience." Stakeholder 10

" you need to have a room for them…we felt that she'd definitely have a role with the dealing with some of the more acute stuff and dealing with some visiting stuff… as a GP. So, if you've got really busy on-call, 20 or 30 patients, contact, and then you get a visit in the middle of it, and we're covering 200 square miles, so you've got to drive 15 minutes to 20 minutes back, then that is where there'd be a definite role for having someone who-. Like a paramedic to deal with that visit or take a few of your acute cases off you.." Stakeholder 7

Practices saw their time on Pacesetter as an investment and taking the APPs away, or replacing them with new colleagues would not be popular with some staff.

"I think to go brand new again, especially with the capacity challenges, that might be something they're a bit reluctant on, …for that to then be taken away from us would be like a slap in the face, to be given someone that was right at the beginning again. You're like, 'I've done all this training with them and then they're now gone when we're so stretched for capacity anyway.'" Stakeholder 9

"If we were pulled, if we had no funding, it would be a shame. Yeah. It would be a shame for the paramedics as well as us because I think they'd lose those skills… We've invested so much in them. To let them good with no funding, it would be a real shame." Stakeholder 1

In Phase I of Pacesetter, Clusters undertook evaluation at a local level but this wasn't carried on into Phase II. There was some regret that some of this data wasn't captured, and would look to implement evaluation tools in future.

"maybe that's something going forward would be a good idea, I think, as they moved. Because then we can find out, well, what did she learn from one practice that she didn't learn from another? They might come up with some sort of concerns, disadvantages, issues, anything, and I think that would be of benefit. … just sort of our own feedback, really, is to how she felt that we did in the Cluster. And could we do anything better? And maybe that's the questions we can put to her if we-." Stakeholder 8

Professional boundaries and hierarchy

Previous literature on new to Primary Care professionals had described some tension and conflict around role boundaries. The current group of staff interviewed reported that initially, some had preconceived ideas, and were 'sceptical' or unsure what the APP scope of practice would be in Primary Care.

"The paramedics were kind of a completely new entity in general practice, so there was nothing you could compare them to…I think right at the very beginning there were a lot of sceptical people … dubious about what they were going to be doing when they came into the practice, because what was the scope of what they could see, what they could do, compared to the existing staff in the practice who were on the same band?" Stakeholder 5

"I think initially, yeah, maybe wasn't sure how they would fit into the role, thinking of them as emergency-responder types, as you think of a paramedic, and I'm guilty, I do watch 'Ambulance.' I do love that program. So, obviously, my view of the paramedics of 'Ambulance' are from that program." Stakeholder 6

"There might have been initially, to start with, when, maybe, patients might have been referred to them where they're not able to-. You know, outside of their scope. They can't do things like prescribing and things like that. There are limitations. … I think after that people know what's appropriate for them and what's not." Stakeholder 1

Other colleagues could recognise aspects of overlap between roles, but it was the distinction between the professions that resulted in fewer tensions.

"I think the scope is similar but I think it's-. …we're different professions, really, that come from a different background, and what we would find as nurses important may not be the same for-. So, but no, not-. I wouldn't say 'treading on toes'." Stakeholder 11

"I think the understanding from the rest of our quite small team, and the understanding of what she does and her role, was pretty good. Yeah. … We don't have any other advanced practitioners in our practice, and we never have done. But there are no tensions in that way. I wonder if being an advanced paramedic rather than an advanced nurse might mean there are fewer tensions, really. I know sometimes with advanced nurse practitioners coming into practices, the registered general nurses can get a little bit toes-stepped-on.." Stakeholder 10

"You know, there's enough work for two of him and two more of me… I thought our work would overlap, which it did….I'm as clear as I am of my own role. Basically, you help with everyone that comes through, really. We all might have something a bit different to offer, which is okay...I can ask this and that to or soundboard and see what they would do about something. … or to half-reflect." Stakeholder 3

For practice colleagues, the APPs were seen as a generalist, able to consult a broader range of patients than some of their nursing colleagues, particularly with regards to mental health and social issues.

"They're happy to at least go and see anybody, and do an assessment, …I don't know specifically what they can't do, or their limitations. … They're not scared to see things they don't know because, whenever they're out on a call on the ambulance, they have no idea what they could be going out to. …There are more clearly defined lines with my own or with the advanced nurse practitioners' scope of practice. Lots of the ANPs have specific lists of things that they don't see, whereas I've never come across that with a paramedic." Stakeholder 4

"in some respects, they might be better than us nurses for certain aspects of what we do…I I'm a general nurse. So, I'm not mental health trained, so I don't have the same skills that I feel the paramedics have out there, because they deal with it day-to-day. Whereas you can imagine my workload is tailored to my skills, whereas when you're out there and you're having to just deal with it, they have to do everything, don't they?" Stakeholder 6

Linked to the discussion around the APP role boundaries, was the Primary Care hierarchy and where the APPs are seen as being placed structurally in the practice team. The APP clinical skills were recognised, but at present weren't seen performing to the same standard in the other three pillars of advanced clinical practice.

"they're not quite in that advanced practitioner-. They haven't quite got there yet but they're definitely working in what I would say, from a nursing side of things, would be a nurse practitioner kind of level…. when we talk about advanced practice, we need to consider that it's not just their clinical skills, that they should be then starting to take on that research, that audit, the leadership, the management. And at the moment, they haven't got the opportunity to do that because they're in a learning role." Stakeholder 2

Nurses who worked alongside the APPs, viewed them as being equal clinically but having had an easier induction into Primary Care due to the structure of the Pacesetter.

"I'd see him as like an equal, yes. Maybe not the same as a GP. …But I'd see him as the same as I got a

nurse practitioner colleague ….compared to how I was introduced to the advanced role, I feel that it was much better than mine… There's a structure for him to follow… I could make you a long list of problems other advancing roles have had when they've started in Primary Care." Stakeholder 3

"In the past, they would have thought, oh, yeah, I don't know whether a paramedic would fit in in the surgery. But now, I really, really can see that…I found them a little bit more on our level than, maybe, the doctors are. … they were really forthcoming. They were so interested….I just felt that they really, really complemented us, here. So, I was really sad when [APP] had to leave. He was such a big, big asset. initially, they worked alongside us, and then, as they became more confident, obviously, they do their home visits." Stakeholder 6

There was perceived to be some resentment from experienced nursing colleagues about the banding of new to Primary Care APPs and PAs, who were sometimes working at a slower rate or with fewer responsibilities.

"our practice nurses are band fives, and they, perhaps, do a lot more of the practical nursing, whereas the physician associates were kind of coming in as a six and possibly a seven. And they were not able to prescribe. They could diagnose but they couldn't necessarily treat. And it was the same with the paramedics." Stakeholder 5

"we know that pay is always a big issue, and that's why people tend to feel undervalued, is because if they don't feel that they're getting that correct financial remuneration it's probably the biggest thing to reduced morale. We see it with the physician associates, as well. There are nurses that have worked for years that have done loads and loads of educational courses and are just a big breadth of knowledge. And yeah, they won't be being paid the same. And they see this young person coming straight out of Uni into practice who can't do half of what they can but they may be being paid more, and that's something that we do need to look at." Stakeholder 2

Locally, the health board would look to implement a framework for Primary Care which would ensure all staff at a certain level are working to a specific standard and appropriately rewarded.

"There is definitely something to be said about developing a framework for Primary Care that is aligned with the multi-disciplinary team to make sure that people who have those skills and have worked for a number of years feel value and rewarded for the level that they're working at." Stakeholder 2

Aside from professional structures in the practice, the Primary Care workforce was described as a continuum with all staff equally respected and valued.

*"Primary Care isn't a hierarchy, it's a **continuum**, where every member of staff—from reception, to your cleaner, to your admin, to your healthcare, to your GP—are equally important and equally valued. So, until we start acknowledging that we're not really going to progressively move forward."* Stakeholder 2

One nurse viewed ACP roles as taking on additional responsibility and flattening the hierarchy for the whole Primary Care team, with advanced clinicians taking on roles equivalent to middle grade doctors.

*"We all have got our own skill sets, and we all have our own separate knowledge, and our backgrounds are different. … even though they're different disciplines **we are fundamentally going to be doing the***

same job role *and we can still make the same clinical decisions that the others can……we are sort of middle-grade doctors working at that level, making those decisions."* Stakeholder 11

This led to ill feeling, describing their work as cheap labour to fulfil the same role as a GP, without the remuneration to match.

"it's the way in which the profession and career is going. Cheap labour, basically. Cheap labour …we can still make the same clinical decisions that the others can. And in my eyes, very much, I'm expected to do what the GP does, really." Stakeholder 11

Despite describing APPs as part of the team, on an equal level some of the language used during interviews such as "giving them work" and" helping", questions whether they were truly embedded and seen as equals or slightly detached from the core practice team.

" I give them a clinic here. So, one of them will do a morning of home visits while the other one will be in clinic, doing an actual clinic, and then they'll swap in the afternoon. So, yeah. They could do anything…. They do what I ask them to do [laughs]… they don't-. Yeah. They call me 'the bossy one.'" Stakeholder 4

"You know, they'll do their bit, and then I'll then follow-up from them because I'm in surgery on a daily basis and they sort of are an outsource, aren't they?" Stakeholder 11

The Pacesetter APPs were described at working in a Primary Care 'trainee' role. As a speciality, Primary Care needs specific learning and education including filling some of the gaps between Masters and practice.

"we get lots of trainees. So, we're kind of used to people pitching up. No, I think now that-. You know, I think it took a little bit of time to work out where exactly she'd fit in. But now that we know that, it's okay. …I think they definitely need guidance, but that's not unexpected for us because we have registrars and they all vary in type." Stakeholder 7

"It's so broad. Primary Care is huge and it takes years to get there. So, although they've got academic skills they still need more time to consolidate that learning into practice." Stakeholder 2

The APP skills were a good fit for Primary Care and the APP role, and practices had procedures in place such as efficient triaging.

"So, I think[APP] has been really good … She's quite well-suited to the role, so I didn't find that a problem, actually. I think what I would say is that, if the wrong patients go to them, then they need much more supervision and guidance than if the right patient goes to them. …which is fine. I mean, that would be the same as any trainee, really." Stakeholder 7

Compared with GP registrar training, GP supervisors were realistic about the expectations of APPs, given that they were spending a smaller proportion of their time in practice.

"one of the big things in general practice is working at pace. …a GP registrar, …they'll be working full-time for 18 months, and they will start at, I don't know, half-hour appointments…, it's probably only in their last six months they get down to ten-minute appointments…"I think if we were to recruit an APP…

there would still be a process of twelve months, two years of that person really moulding into general practice…You'd expect to take time, really." Stakeholder 10

However, as an independent practice, and business there would be financial considerations around some of the expectations.

"But from a health economics point of view, you would want to be coming to ten-minute appointments at some point." Stakeholder 10

As part of the training role, there is an opportunity to develop the other pillars of advanced clinical practice, such as leadership, and which cannot always be taught using traditional learning methods.

"at the moment, … they're in a learning role… a bit like our trainee advanced practitioners. But they are not yet practising at advanced level." Stakeholder 2

"I think leadership's quite difficult to teach on an APP project. Again, I think leadership comes from the individual being a leader and applying morals to their practice." Stakeholder 11

Rotas

During Phase I, the APPs in each Cluster had regular days in Primary Care. However the addition of Cohort II APPs in Phase II meant they were working on a less regular rota, and with fewer days in practice per APP.

"It has been a bit hit-and-miss, recently. We've been having less cover recently but I think that's probably annual leave….you never know if you're going to walk in and they're going to be in or not, sometimes." Stakeholder 11

"It's completely random. We can't see that there's any pattern to when they're here or not here. There's a rota up. … they're not here more than they're here, if that makes sense. …It's just luck and it's a good day when they are here." Stakeholder 4

However, those working alongside APPs were grateful for the additional capacity, particularly during the challenges of COVID-19, and were keen to have them as often as possible.

"we're grateful for them whenever we can get them, really…they're also not here often enough. They're not here often enough. I'd prefer if they were here every day, but that's just me." Stakeholder 4

"I know this is really selfish but we just thought, God, it's an extra pair of hands to help us out. And, do you know what? I welcome anybody who is willing to help and come and work with us….it's super busy … But I think everywhere is the same, isn't it? The pandemic, I think, has just practically finished everybody off." Stakeholder 6

" it's great. It complements the whole team. But I don't see him or work alongside him often enough, really, if you see what I mean." Stakeholder 3

A consistent rota, and advanced planning would be beneficial for the practice, particularly as the demand in Primary Care is predictable, and APP presence could make a meaningful difference to the workload.

"a larger commitment and a more regular commitment would be more beneficial. So, having someone coming in on the odd-. You know, on some days and then not others, that doesn't necessarily fit with the practice. Whereas if you knew someone was coming three days a week every week, or four days a week every week, that would make a really meaningful difference. …And it allows you to plan." Stakeholder 10

"I understand that they work with different practices, so it can't be tailored to an individual practice's need. It needs to be considered across …we have some days where we could benefit from a home visit service more than others. Especially, say, a Monday or a Friday where it has been the weekend, or it's about to be the weekend, and you're just not quite happy to speak to them or, if they can't come in, just over that weekend." Stakeholder 4

"If it's all over the week, the practices find it really hard to plan them in, give them that support that's the same GP all the time. … if it's only four days a month, it's not the level of relationship. You have to keep going, really, in one practice for that to be sustainable." Stakeholder 9

This was particularly challenging where a Cluster approach had been adopted and APPs worked for multiple practices in the Cluster.

"I think it would be easier if they won't have to rotate between GP surgeries. I think if they were in one GP surgery it would give them that opportunity to be in that one place. I think that could be easier." Stakeholder 11

Rotation

The Pacesetter was thought to have met its aims of providing APPs with skills from each setting subsequently benefit the other two arms of the rotation.

"I think that them working on a rotation is brilliant. I think it's really, really good. Because WAST have invested in them, we've invested in them. So, they've got more skills. If they're doing both, they've got a wider range of skills. It benefits WAST because they are taking what they've learned from Primary Care and applying it to reduce the workload there, and they're bringing their WAST skills to Primary Care." Stakeholder 2

"It can only be positive, I think. …. But if he's seeing people in a different capacity, in their homes, and people with chronic conditions and stuff, he might look at things differently and be aware of the problems and obstacles we have in Primary Care… I would imagine that he would be more understanding than maybe he was before…And he would have an insight into what Primary Care needs and the information they need, as well." Stakeholder 3

"It's like everything, spending a bit of time in a few different places, …She probably gets a much better appreciation of what's going on in Primary Care, and what we can and can't do, and what the implications of decision-making from WAST are, from Primary Care, if that makes sense." Stakeholder 7

Colleagues in Primary Care were keen to keep the APP time on rotation in Primary Care but could recognise the importance of maintaining their practice in WAST.

"I think that's what makes the role exciting for them, as well. I've spoken to [APP] about it and he doesn't want to leave the acute ambulance service, but he likes the mix and the individual responsibility he has

clinically, as well. …it's just enough to keep it spicy for them. … Obviously, it might change as he gets older…But at the moment, the thrill and the excitement of the ambulance, and still being able to do that, is something that's really appealing to him." Stakeholder 4

"I think practices would like them there every day. But it is a fine balance because I do think some of the APPs do like to have...work for WAST, as well. I think they like that." Stakeholder 1

"they need to keep that to keep their skills in what their main role is. And yeah, maybe if they came to work in Primary Care and they were just in Primary Care, then we might de-skill them a little bit." Stakeholder 6

The share of time on rotation into Primary Care was important to build relationships, confidence, and become embedded in the practice team. The current provision wasn't thought to be enough to develop the APPs fully.

"I think the amount of time spent in general practice versus the amount of time spent with the WAST service commitment…isn't that great. …I think the practice getting to know APP, APP getting to know the practice when it's one or two days a week, it takes a little bit of time for that, for those confidences to build, really…. I think the general perceived wisdom is two days at a minimum just to keep-. Just to stand still, really. I would have thought more would be optimal." Stakeholder 10

"I think it's the relationships you build are stronger if you're in there more regularly…I think it does affect your confidence if you're not in all the time because it's not your day-in, day-out job, is it? If it's a couple of days a month, you can just feel a bit rusty." Stakeholder 9

Spending too little time in Primary Care could lead to potential for skill decay due to the specific nature of learning and complexities of Primary Care.

"they probably would lose some of those skills. I think because there is so much to learn, people with different complex conditions and stuff-. So, I think they would miss out, yeah." Stakeholder 1

The model of APP deployment was different in each area, and one Cluster developed a 'rotation within a rotation'. Here, the APP followed the three-part Pacesetter rotation, and also rotated between practices in the Cluster, spending two to three months in each before moving on.

"we wanted to see as much of general practice and working….the thoughts were for her to get a bit more broader experience at different general practices. I think also we kind of wanted her to be an asset to the Cluster, rather than just one practice within it." Stakeholder7

This model was also thought to be beneficial for the APP, in terms of what she can learn and gain from her time in each practice.

"as [APP] has moved around the practices, her experience and her knowledge has evolved, hasn't it? …it's just as much her program, isn't it, as the other way around." Stakeholder 8

The rationale was that the Cluster must provide an equal offer to all practices, and APP placement in each surgery was an essential part of the Cluster approach.

"from a Cluster point of view…, is that it's very difficult to have practices that have a service and practices that don't. And the risk is that sets practices against each other. The haves and have-nots. Well, why have you got this service and we haven't? And that's really divisive and can really upset the working relationships between practices that we've been fostering for the past eight/nine years since Clusters in localities came into existence. ….it's a really big deal. I can't stress how much of a big deal it is." Stakeholder 10

To support the additional rotational aspect, Cluster staff developed methods to ensure good communication and meant the APP had the opportunity to be embedded in practice, despite moving around surgeries.

"I've learned very quickly it has to be a bit of a win-win for the practices…. Before [APP] started on the whole rotation, we embedded her in all the services that operate, CRT, ANPS, Pharmacy, mental health, SPOA, MIU and community hospital…. before she moves into each practice, I've always suggested that the practice manager speaks to a previous practice manager to gain a little bit of information about what they did. I've got a little checklist …'You need to do- X, Y, and Z, make sure she's got access to systems. Has she got a room? Make sure she's got a mentor…. So, you just had to work it practice-by-practice, really, and sort of modify her transition to fit." Stakeholder 8

From a strategic perspective, the Cluster were aware of the need to raise the profile of the APPs and the project having recognised the significance and potential implications from Pacesetter.

"I think at the moment they're getting so many other services trying to chip in, … they either want space, or they want office space, or they want access to their systems. …I think it was important for them to understand that there was a bigger picture to this, and the reasons for doing it." Stakeholder 8
"The only challenge was that those surgeries who weren't involved in the initial sub-rotation, sometimes needed refreshing as to what the APP was doing in Primary Care." Stakeholder 10

"We've talked about this, say, at the beginning of a Cluster meeting…in October last year, … By the time we get to eight months down the line, some of the practice has kind of forgotten. …who? APP? What … They kind of need a little bit of a refresh." Stakeholder 8

A key benefit of rotating between practices was perceived to be the opportunity to share learning and best practice from other surgeries.

"she has that visibility that not many other people get to see or do. So, she would be a good advocate, really, for saying, 'Actually, none of you practices do this. And I think if you did that, it would help with this, or you could reduce that." Stakeholder 8

The model also ensured that the practices had some stability with a regular APP.

"They knew where they were for the next three months. They got to know the services, the practices, the people in the practice. And it just worked, rather than being in one practice today, another practice tomorrow, then back there. …I think it has given the practice stability and focus, as well, because they know they've got that WAST paramedic for that period of time. " Stakeholder 8

Supervision oversight of the training role

One of the topics which has been discussed repeatedly throughout the course of the Pacesetter has been the importance of clinical supervision for new to Primary Care professionals, and APPs.

"the biggest thing has to be making sure that they have that adequate supervision and on in-practice training." Stakeholder 2

"you have to invest that time and effort to get a good clinician out of the other end." Stakeholder 5

"I think we proved with this project that they can absolutely take on some of the tasks and support the GPs…They've got hard skills. It just needs a bit of-. Well, quite a lot of mentoring and support… in the first six months… obviously, it's just a different environment and a different role… It depends on the individual, as well…" Stakeholder 1

Historically, supervision offered in Primary Care was not well regarded despite the recognition of it as an essential component of the induction into Primary Care.

"Clinical supervision is pretty rubbish. It depends where you go and work. If you go and work in an independent, … if you were the only nurse coming in there, it's very much you've got to learn it for yourself because there's no one to teach you. … and it's not something that has been really kind of taken on board. … when you've got new people coming in who are skilled practitioners in their own right but they're learning something very new in Primary Care, it's making sure that they do get that clinical supervision. …clinical supervision in Primary Care is quite difficult." Stakeholder 2

In one Cluster area, the APPs had supervision provided exclusively by one GP which was thought to help build trust in the APP.

"if they had the same clinician it made things a lot easier because you've got that relationship. … and they've got the same level of support, that GP builds up a trust for them and goes, 'Oh, no, I trust you to handle that one. I don't need to go through that case in detail.'" Stakeholder 9

Some APPs have benefitted from informal learning opportunities which have presented in practice and can also act as a form of safety netting, particularly for APPs undertaking home visits.

"We normally do a debrief at the end of surgery, and that normally turns into a half-hour, in-depth tutorial on something that we've seen that morning." Stakeholder 10

"they went to the home visits. And then, they had to come back, and if they weren't sure about any patients, if they were a bit complex or they weren't sure about something, they would query that with the GP. So, there was always a safety mechanism in place." Stakeholder 1

Current pressures in Primary Care has limited the time and availability of GPs to supervise or teach new professionals, particularly practical skills. This means new starters can get filtered into "can do" roles in Primary Care, and act at a lower level for longer.

"what we struggle with in Primary Care is being able to provide that in-practice supervisory education element of, yeah, you've got the theory, but this is how it actually is in practice. … You can be taught how to do an abdominal examination but, actually, until you have actually put your hands on someone's abdomen, it doesn't mean a thing. …it's finding people to teach that in practice… because they're so pushed just seeing patients. It's allocating them time to teach and to mentor." Stakeholder 2

"it's actually quite draining on his [GP] capacity …I don't think they perhaps get the supervision that they would expect to get." Stakeholder 5

In addition, some of the challenges as a result of COVID-19 were also thought to have been a barrier to support, and the delivery of supervision.

"the level of support needed was definitely a barrier. It's not their fault. It is what is clinically needed…. the GP then needs to take some of the time out of her day to provide that support, where we have been-… They had been absolutely inundated over COVID." Stakeholder 9

"I think it has been an odd period, anyway, hasn't it? Because of COVID…we're getting lots of phone calls and we're kind of struggling with the workload, anyway." Stakeholder7

From the perspective of a GP providing supervision, the APPs followed a similar pathway to medical students training in Primary Care.

"it's a similar kind of model to what we do with our medical students, where a period of sitting in with a GP and then progressing to evaluating patients, and then with the GP review. And the more experience they get, the better that becomes, really. So I must say, the clinical assessment, there's no problem with that at all. It's absolutely brilliant. … But I think the additional bit is the diagnosis, and subsequent management, and taking those sorts of responsibilities." Stakeholder 10

However, there was some concern about the time and funding allocation for supervision, especially for independent practices.

"it's all very well me saying, 'Oh, this is going to happen.' They go, 'Oh, this is brilliant. That's a great idea.' And then I go and say, 'I'm going to need 60 hours of your time over a year,' and they kind of go, 'Oh, I don't know about that.' It's kind of that, kind of like they tend to back off a little bit. But usually, when these things are up and running and they're in place, they kind of just run themselves, don't they? It's just that initial kind of scare, isn't it?" Stakeholder8

"There should be money attached to that, to training places and people doing clinical supervision, by the way…. it does take time, and my time ain't free." Stakeholder 10

Conclusions

The interviews captured the views of a range of stakeholders who have either worked alongside, or have strategic oversight of the APP work in Primary Care.

The APPs have consistently been described as beginners or novice in the Primary Care setting. Despite this, their extensive clinical expertise and experience was recognised, and skills the APPs brought from the ambulance service were commended. Prior to Pacesetter, some staff had preconceived ideas about APPs and paramedics but there was a new appreciation for the profession having worked or studied alongside them. From the early days of Pacesetter, there has been enthusiasm to develop their role and prepare them for a future in Primary Care. For the APPs, the rotation was an opportunity to deliver aspects of care they would have handed responsibility over to a GP or secondary care. The data collection has indicated this has been one of the key changes affecting mind-set and thinking differently.

The only consistent negative feedback was with regards to feeling prepared and what to expect initially. With a project as large and far reaching as Pacesetter, it would be difficult to disseminate information directly to all who would be involved or affected. But for further rollout or future large scale projects, consideration may need to be given as to how staff could feel more prepared or involved. In addition, once in practice, the APPs soon proved themselves to be adaptable, competent professionals.

The interviews sought to understand more about some of the cultural influences on the rotation. The Welsh language and local geography were mentioned more often than other factors, but could be because the majority of interview participants were based in North West wales where these factors are more relevant. It was embraced as an opportunity to adopt innovative change and was one of the catalysts for the development of a multi-professional Primary Care workforce.

The education sessions were hugely valued, both by the APPs, and senior staff who saw it as bridging the gap between the Masters and practice. However, the current workload and staffing pressures mean it may be a challenge to release future Cohorts from the Primary Care rostered time. In addition, it was suggested the course could be offered to other professionals in Primary Care, whose learning needs are sometimes overlooked.

Whether the APPs should wear their ambulance uniform in Primary Care divided opinion. Some saw it as distinguishing the role from other Primary Care healthcare professionals. However, elsewhere a situation was described it caused confusion to the patient about the purpose of their attendance.

Prescribing has been another topic with splits opinion, those in favour make the case that APPs can provide a rounded, holistic consultation, and as Primary Care practitioners, APPs should have the same prescribing rights as their colleagues. However, less in favour is the case that seeking a signature from GP or Primary Care colleagues is a good learning opportunity, particular when starting in Primary Care. Also, prescribing is 'overrated' and APP preference rather than clinical need. It has also been emphasised that even those in favour of prescribing, say it is not essential for a Primary Care role.

The Primary Care rotation offered APPs and Primary Care colleagues to a unique opportunity for mutual learning, to gain skills and knowledge from each other, often through informal discussions. APPs had shared key practical skills such as their knowledge of acute care, and ECG interpretation. In turn, the APPs have benefitted from wider clinical knowledge and improved navigation of Primary Care, which they can also draw on during WAST shifts. Some of these discussions have contributed to the APP thinking differently, and subsequently managing patients in new ways such as safety netting, and enhanced perception of risk.

The multidisciplinary workforce has been developed in response to some of the challenges recruiting new GPs and nurses into Primary Care. It has presented an opportunity to work differently and employ a range of professionals. Following the success of Pacesetter, some projects are now looking specifically to employ WAST paramedics on a collaborative basis. The next step for the MDT workforce will be developing the ACP role, focusing on advanced practice rather than profession. It was hoped that the innovative rotation and multi-professional workforce may attract healthcare professionals from outside the local area.

Benefits of the APPs and rotation centred on provision of home visiting, utilising their acute skills, and meeting the aims of the project to increase capacity and release GP time to care for the most sick patients. APPs have the capacity to spend slightly longer consulting each patient than GPs do, which offers patients

rounded care, and can anecdotally reduce re-contacts, and future complications. The APPs were praised for their proactive, willing approach. However, there would be some hesitation with future Cohorts, and an expectation to perform to a certain standard. Continuity of care provided by the APPs also offered multiple benefits – consistency in staffing, as a learning opportunity to follow the patient pathway, and finally to build relationships and deliver holistic care.

From the perspective of Primary Care staff, Work was needed to educate patients about seeing the right practitioner, who isn't necessarily the GP. In areas where there is a multi-professional Primary Care workforce in operation, patients had an appreciation of their advanced skills, time and holistic care and requested further appointments with an ACP rather than the GP. However, it was thought that not all patients distinguish between roles, and placed value on other factors such as being seen sooner.

The question of whether APPs would be the profession of choice was discussed and there was a general split in responses between those working alongside APPs, and those in strategic roles. Primary Care colleagues were in favour of APPs. Elsewhere they would be considered equally, but not above other professions. For those with business or strategic focus, there would need to be more thought given to APP deployment in Primary Care and funding for the role.

Initially, there had been some misunderstandings about the APP role in Primary Care, but once established in practice, their remit was more clear. In contrast to some published literature, tensions around the role boundaries were not an issue between established practice staff and APPs. Rather, some recognised advanced skills APPs have such as managing social issues, which the nurses don't. At present APPs were not viewed as working to advanced practice in Primary Care as they don't currently fulfil all pillars of advanced practice for this aspect of the rotation. At a local level, nursing colleagues viewed them as equal professionally, although some of the terminology used indicated the APPs may not be truly seen as equal.

In addition, in the wider practice team there was thought to be some resentment around banding due to the rate of work and level of responsibility. This is to be expected for new to Primary Care professionals, and they are highly trained and experienced in paramedicine. GPs had realistic expectations about the time it would take to train an APP in Primary Care. However, as an independent practice and business, the financial implications would need to be considered.

There was some criticism around the inconsistency in the rota and it was described as being hit and miss whether to expect an APP on a given day. Primary Care demand is consistent week on week, and securing regular days would assist workload planning in Primary Care.

The benefits of a rotational model of working could be recognised, and WAST was thought to particularly benefit from additional clinical skills and navigation of Primary Care. There was a hope for a greater share of Primary Care time to benefit both the practice, and for the APP to develop and progress in the role. Equally, they acknowledged the importance of maintaining their clinical time in WAST and professional identity as a paramedic.

High quality GP supervision was seen as vital to supporting new to Primary Care professionals, but traditionally supervision in Primary Care has not been prioritised. It was also challenging to offer sufficient levels of support given the current pandemic, staffing and workload pressures. For some APPs this was thought to impact on quality of supervision and there was also the question of funding, and the need for

financial incentives. This was particularly true for independent practices, or GP interviewees whose vision was more business focussed.

As the Pacesetter draws to a close, and the exit planning begins, there was an enthusiasm to maintain the APPs on rotation, as well as the collaborative approach between BCUHB and WAST. It was important that the practice of rotational working isn't 'just another project' and that Primary Care continues to benefit, having invested in the APPs over the past few years. There was concern that removing APPs from practices they worked in during Pacesetter would not be a popular move. Going forwards training could shift focus to develop the leadership skills of early Pacesetter Cohorts so that they can train and supervise future APPs and ensure long term suitability of the model.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101.