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Invited paper

The primary care impact of 'Taking Healthcare to the Patient'

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A tale of two summers

Summer 2004

Each year between 300 000 and 500 000 holidaymakers visit Lincolnshire's east coast resorts of Skegness, Mablethorpe and Ingoldmells. The primary catchment areas for these visitors are the urban, industrial areas of the East Midlands (Leicestershire, Nottinghamshire, and Derbyshire) and South Yorkshire (Rotherham, Sheffield, and Leeds). The influx of visitors has a significant impact on local health services which, during high season, are required to respond to significant increases in demand. This increase in demand coupled with the a healthcare infrastructure designed to cater for a predominantly rural, low-density resident population results in overstretched services, with visitors unable to access already busy general practitioners (GPs) who have previously been the only source of local primary care provision. In this situation the local hospital's small accident and emergency department (A&E) becomes the default point of access to primary health care. At times during the summer this A&E is significantly busier than A&E in the large city centre hospital 35 miles away.

Summer 2005

Primary healthcare services are provided directly to visitors in the three main resorts. The service consists of a mobile health clinic staffed by a nurse practitioner provided by the primary care trust, and an emergency care practitioner provided by the ambulance trust. The mobile clinic runs for 8 weeks during the peak holiday season, visiting three sites twice a day for three days per week, and provides typical primary care services. Despite its limited availability, almost 300 patients are seen and treated by the clinic's staff, the Skegness A&E reports a reduction in attendances, local GPs have less demand from temporary residents requiring treatment, and the ambulance trust is provided with an additional key local emergency response resource.

The Bradley Report

The difference between these stories lies in the development of the ambulance service as a provider of primary care services and the creation of partnerships with primary care provision. This change in approach is a direct result of the organisational change in ambulance services that was reflected in the recent publication of *Taking Healthcare to the Patient* (The Bradley Report).[1] This report recommended a range of developments intended to transform ambulance services beyond the traditional 999 responses and transport to hospital role. The report sets out a clear strategic vision for the development of ambulance services to provide an increasing range of mobile health care, primary care, diagnostic services, and 'world class' telephone-based clinical advice.

The years prior to publication of the Bradley Report have seen rapid and significant change for ambulance services. The introduction of the 8 minute response time for Category A (presenting conditions which may be immediately life threatening) 999 calls resulted in many ambulance services making fundamental changes to the way in which ambulance response resources were configured and deployed. The evolutionary development of closer links with primary care trusts through commissioning has further driven organisational change and increased interest in the integration of services.

Drivers for organisational change

The main drivers and supporting arguments for organisational change in ambulance services are as follows:

- *closer integration within the NHS*: there is a clear opportunity for ambulance services to contribute to the shift towards community-based services within both primary and secondary care. The expertise of ambulance services in the delivery of acute care and the development of new, primary care-focused roles such as emergency care practitioners extends the potential range of services able to be delivered into services such as acute care for patients with long-term conditions, a wider range of assessment and diagnostic services and support for case managers in supporting patients with chronic disease; the overall impact of these being to reduce the levels of unplanned admissions to hospital
- *management of system-wide increases in activity*: increasing activity across the NHS highlights the need to review the way that services are organised. Traditional models of service delivery for hospitals, primary care and ambulance services may not offer the flexibility and range of services needed to cope with increased demand and patient expectations. New models of delivery providing additional options for care in the patient's home setting are required in order to reduce the length of time spent by patients in hospital and to reduce the likelihood of hospital attendance or admission following a call to 999 or GP services
- *review of the needs of patients accessing ambulance services*: a 999 call is often the easiest route into health care, however just 10% of patients ringing 999 have a life-threatening emergency; many patients actually present to the ambulance service with an urgent primary or social care need. Ambulance services therefore need to develop alternative interventions to ensure that the majority of patients receive a more effective and appropriate response to their call for help. In many cases the care needed can be delivered in the community setting, with a hospital admission or attendance thereby avoided
- *expansion of the skills and clinical interventions available to ambulance service clinicians*: redesign of ambulance service care delivery will necessitate a change in emphasis for clinician roles. Such changes have been seen in the development of the paramedic role, with an increased emphasis on clinical outcomes, the development of new national guidelines, additional skills and expanded drugs lists. Additionally new roles such as the emergency care practitioner and community paramedic (or practitioner) have been implemented. The development of such roles with their clear emphasis on minor illness and injury, provide valuable support for primary care services in ensuring that patients are more likely to be treated in the community setting
- *review of traditional care pathways – increasing direct referrals and decreasing conveyance to A&E*: providing an expanded range of care outside the acute setting requires not only the redesigned roles and models of delivery described above, it needs also to be supported by revised care pathways which are integrated across the relevant agencies and professions, and which have clear processes for direct referrals to relevant clinicians and services. This is an essential component required to reduce A&E attendances and admissions, as it ensures that from the first point of access to health care, the patient is provided with access to the service or clinician with the most appropriate skills.

The shift in the provision of care

Lincolnshire Ambulance Service's approach over the last three years has been to embrace the concept of the new ways of working enshrined in the drivers for change described above. The trust has introduced a range of developments to respond to the need to provide an extended range of services. In support of operational changes, the trust's strategic vision stresses the need for a number of fundamental changes in culture and structure, this 'paradigm shift' is summarised in Table 1.

The key developments in facilitating this shift have included the introduction of new clinician roles such as the community paramedic (practitioner) and the new national role of the emergency care practitioner. These new roles have a significant part to play in promoting the development of an integrated model of service delivery. From early 2004, the trust deployed community practitioners from local GP surgeries. These staff provide a dedicated local emergency response for a rural area of low 999 demand with additional value being gained by the practitioner's direct support for local primary care services. This support is in the form of providing domiciliary visits for GPs, health-promotion and disease-prevention clinics, and supervised care for those with long-term conditions. This approach has gained significant support from local primary care clinicians, and is welcomed by patients as it provides local support from a dedicated group of staff, with the practitioners quickly becoming trusted clinicians.

Since November 2004 the trust has provided out-of-hours home visiting services. Community and

Table 1 The 'paradigm shift' in ambulance service provision over the past decade

From	→	To
Ambulance service	→	Emergency care trust
Stand-alone	→	Networked
Specialist	→	Generalist
Transport	→	Assessment
Training	→	Education
Trade	→	Profession
Blame	→	Learning
Internal facing	→	External facing
Performance driven	→	Patient driven
Inflexible response	→	Flexible response

emergency care practitioners deliver services in patients' homes and support integrated out-of-hours primary care provision from local emergency care centres based in A&Es. This model of service delivery is supported centrally by integrated call handling and clinical triage. The whole 'out-of-hours' (OOH) pathway has been the subject of an ongoing patient satisfaction survey since April 2005. This has evaluated the service as highly successful, with the thoroughness of the practitioner's assessment, the time spent with patients and the appropriateness of the referrals being highlighted as the most positive aspects of the model.

The integrated pathway infrastructure that delivers OOH care is currently being extended to deliver services across a wider geographical area and for all unscheduled care services. This model of care will provide:

- 'hear and treat' services for patients calling out of hours and for non-serious 999 calls
- 'see and treat' interventions for all suitable patients
- a range of referral options to services such as intermediate care, district nursing, mental health, social services and palliative care
- integrated mobile healthcare teams incorporating ambulance service practitioners, primary care, community and intermediate care nurses and healthcare support workers
- a response hub which provides central co-ordination and clinically informed dispatch of integrated healthcare teams, call handling and advice services, and incorporates social services and mental health response teams alongside 999 and OOH services
- ambulance practitioner staff as integral members of acute trust teams ensuring that patients are streamed appropriately on presenting at A&E or the minor injuries units.

Early indicators of the effectiveness of the approach described above are found in the responses to the OOH patient survey which evaluates the entire OOH pathway from initial call handling to face-to-face consultation. As previously described, this is producing extremely positive results. A quantitative evaluation of the impact of community and emergency care practitioners is being carried out nationally by the University of Sheffield School of Health and Related Research (ScHARR).[2] Local results indicate that up to 80% of patients seen by such practitioners can be treated definitively at the scene or referred to more appropriate services in preference to being conveyed to A&E.[3] The benefits of this are being seen in the reduction in the proportions of patients conveyed to hospital by the ambulance service; this clearly helps to reduce A&E attendances and, by extrapolation, should reduce unscheduled admissions to hospital.

The effect of such changes on the quality of care for patients in the primary care setting remains to be evaluated. It is expected, however, that longitudinal studies will show that a wider range of support, increases in the availability of skilled practitioners and, most importantly, improved service delivery infrastructures which incorporate new combinations of skills and working relationships, can deliver significant enhancements in the care available for patients in the out-of-hospital setting. These benefits are likely to have a significant impact on patients with long-term conditions as they find that more support is available in the community to help prevent unplanned and emergency admissions to hospital.

Improvements in quality of care

Clear benefits are already arising from the improvement in the integration of ambulance services and primary care. Closer working relationships are helping to facilitate the development of community-wide integrated co-ordination of services and the development of multiprofessional, cross-organisational care pathways which will ensure that patients receive care that appears seamless, where handovers are minimised by enabling direct referrals. It is recognised that further benefits will emerge as ambulance service teams integrate more closely with services such as intermediate care, social services, mental health and palliative care; these benefits will come from direct improvements to patient care, as professionals work together to ensure that they deliver the right type of care. Benefits will also come from the provision of a single point of co-ordination for multiprofessional teams. This will ensure that the total healthcare resource capacity is fully and efficiently utilised at all times, and that the patient care workload is balanced across all appropriately skilled professionals in a community. The vision for Lincolnshire Ambulance Service is to act as a gateway to the NHS in providing patients with a single point of access to a range of appropriate services based on their clinical need. It will also co-ordinate responses from other providers, be they NHS organisations, the local authority or from the private sector. Figure 1 illustrates this concept.

In respect of the effects of this change on individuals within the ambulance service, it is clear that there has been, and continues to be, significant interest in this development from ambulance service staff. Individuals recognise the benefits in terms of career development and acquisition of new skills. The implementation of practitioner roles opens up a range of previously unavailable career options for ambulance service staff, offering the opportunity to increase the scope of practice. The new roles also offer the opportunity for health professionals such as nurses to join the ambulance service, bringing with them the potential for benefits arising from multidisciplinary working and diversity of skills and education.

The future for ambulance services

The future is likely to see ambulance services configured quite differently in terms of operational area. What is more certain for the future is that the change in models of service delivery will be sustained. Having begun the implementation of integrated teams and work to co-ordinate these teams, it will not be in the interests of patient care to revert to traditional models of service delivery for ambulance services.

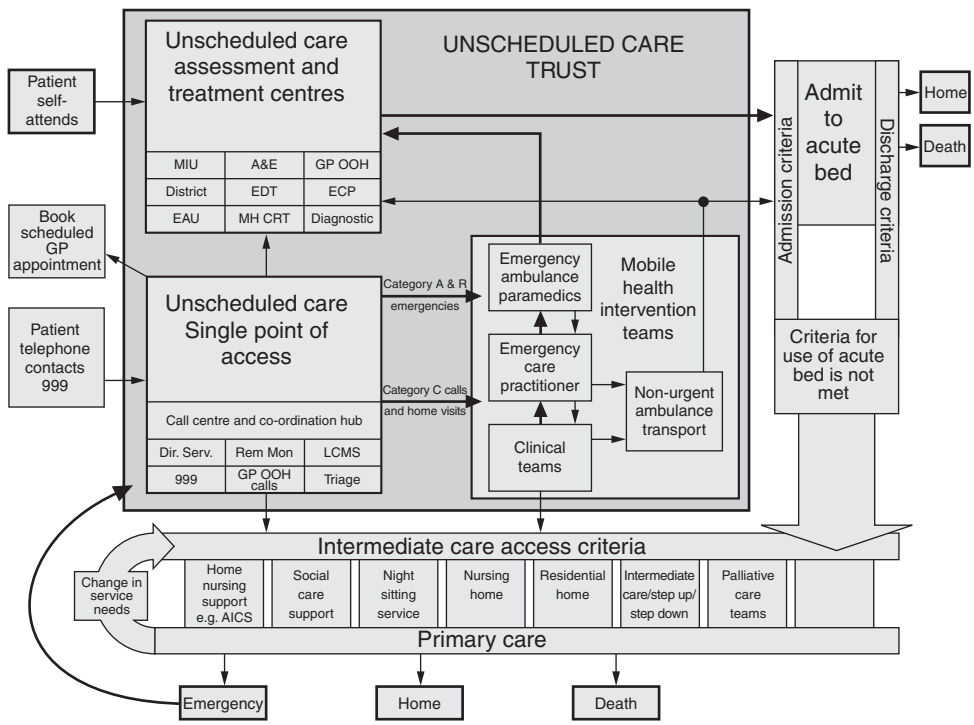

Figure 1 The unscheduled care system. MIU, minor injuries unit; EDT, emergency duty team; ECP, emergency care practitioner; EAU, emergency assessment/admissions unit; MH, mental health; CRT, crisis response team; AICS, area intermediate care services

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CONFLICTS OF INTEREST

None.

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