BACKGROUND AND CONTEXT INFORMING SAS RESPONSE

The Scottish Ambulance Service (SAS) is unique within the Health and Social Care system in Scotland, in that we provide a national front line clinical service, delivered locally in peoples’ homes and communities, 24 hours a day, 365 days per year. This means that we engage with all GP practices, every Health and Social Care Partnership and all NHS boards to support the effective delivery of high quality patient care.

This provides enormous potential for SAS to shape future care provision, but also illustrates the complex relationships that need to be developed and maintained, supported by the understanding of local variation in terms of demographics and rurality, and local priorities.

While maintaining a strong focus on the SAS traditional role in delivering emergency care and working with other emergency services, over recent times SAS has seen a significant increase in requirements and expectations to support urgent / unscheduled care need. This means that SAS is becoming more aligned to Health and Social Care Partnerships and primary care partners in and out of hours, while still developing and optimising traditional established relationships with emergency pathways within territorial health boards.

SAS now routinely contributes to primary and community care for people. Although we are traditionally seen as an emergency service, many of the people that present via 999 do not have emergency life threatening conditions but do require same-day or urgent care. Our focus is on providing quality care for people and this requires better collaborative working across all partners in health and social care so those people who can be best managed at home or in a community setting can access those pathways however they present to the health and social care system, i.e. whether they access traditional primary care services via a GP practice, or whether that is via SAS or NHS24, the same pathways of care are provided.

Over recent years we have introduced SAS clinicians working directly with primary care services, both GP practices and out of hours services, across the country (further details can be provided to the Committee if required). The contribution of the paramedic workforce as an integral component of the future primary care service has been recognised by the National Review of Primary Care Out of Hours Services, the Health and Social Care Delivery Plan and the 2018 Scottish General Medical Services Contract.

SAS clinicians can provide additional resource to primary care services, and largely carry out home visits on behalf of GPs. This provides the benefit of freeing up GP time to focus on patients with complex care needs. However, the broader benefits of this are when a
rotational model is in place so SAS clinicians spend part of their time in primary care and part of their time in SAS then the learning, exposure, experience and referral pathways that SAS clinicians have access to in primary care can be brought back to SAS to improve the quality of care provided to people presenting via 999. Wider system benefits also include providing more care at home or in a homely setting, more effective use of SAS resources and reduction in emergency department attendances.

Integrating SAS clinicians into primary care services, while supporting a hard pressed GP workforce, enables the provision of a multi-disciplinary primary care model that includes SAS, improving the care provided for people across the system, however they access that care.

Responses to specific questions

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities?

The Ambulance Service needs to work on understanding the underpinning complexities that determine the priorities of local communities. These characteristically relate to population demographics such as age profile, socio-economic deprivation and rurality. We need to be knowledgeable on the prevalent conditions being experienced by patients in communities and work closely with local partners to establish the best way to help these patients reducing the likelihood of experiencing an acute emergency, but if they do, ensure that they receive the optimal response, in the place the need it, at the time they need it.

We need to work closely with IJBs and GP clusters to improve the availability of patient level information from their records to our own systems, particularly the transfer of clinical data stored on areas of the Key Information Summary and other anticipatory care planning documentation, which is often not readily available to all Ambulance Service crews. Work needs to be undertaken on all patient data flow, as there is an expectation amongst a large group of patients that their clinical data is already being shared with all relevant services within NHS Scotland, and this is not always the case.

Further to the context provided above, there is a further step which is emerging based on robust SAS data analysed in terms of IJB locality and represents a real paradigm shift in SAS contribution. SAS is progressing not only its role as a responder to those in need, but also by sharing information about patient circumstances, SAS has a crucial role in improving population health by signposting patients to local services, enabling a prevention dimension to the SAS role. This allows SAS to have a key part in addressing Scotland’s public / population health challenges where they extend to reducing the number of people finding themselves in acute emergency situations. This could extend across a huge range
of patients to enable both a response and a (secondary) prevention agenda, for example, frail elderly people who fall, patients who present in acute mental health crisis and people who are treated due to accidental drug overdose. These are common scenarios for SAS response and represent high profile national health priorities all of which have a significant primary care dimension. SAS linking data with HSCP frailty/fall teams, Mental Health Teams and Alcohol and Drug partnerships adds benefit to patient experience beyond a high quality initial response.

Reciprocal sharing of SAS data with HSCP teams is crucial to enable this secondary prevention agenda. In addition, activity and outcome data relating to SAS contribution to primary care/HSCP activity should be incorporated into the emerging primary care datasets. ISD have 60 LIST (Local Information Support Team) analysts providing direct analytical support to IJBs. While SAS is engaged with ISD and IJBs we have had no additional analyst capacity to enable the crucial role envisaged above.

The Ambulance Service is one of the best placed organisations to help understand patient needs, both at their homes and in communities and has a role to play in shaping the future of care provision. To ensure primary care is delivered in a way that focuses on the health and public health priorities of local communities the membership of SAS local management on IJBs should be considered.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

There are a number of barriers to delivering sustainable primary care, which are outlined below. These could be reframed as areas around which to develop solutions collectively across HSCPs and NHS boards, including SAS as a key partner.

a. Public expectation and resistance to change
b. Professional expectation and resistance to change
c. Competing opportunities for key skilled staff
d. Retention of staff in high demand urban locations (deep end practices and ambulance stations) and in remote localities
e. As staff take on additional skills (eg Advanced Paramedics) they become increasingly marketable, impacting on service planning and retention
f. Lack of ability to share clinical data and refer patients simply (electronically) across primary care systems
g. Lack of joined up data between different parts of the NHS and social care
h. Relationships between NHS boards and IJBs - new working relationships will take time to establish, because widespread service change requires support from people at all levels and across organisational boundaries.
3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

Good quality data - and the ability to use it – are essential for evaluations of these models. This links back to the point made in the response to question 1 about better integrating datasets held across health and social care.

The multi-disciplinary team may be a virtual team cutting across various practices and clusters, and therefore potentially different systems. Work to achieve data sharing across traditional areas/organisations is required to fully understand the impact and effectiveness of multi-disciplinary teams (this is described as a barrier in response to question 2).

The effectiveness of MDTs and GP cluster working could be monitored and evaluated by a number of methods, including:

- **Patient experience** – this is essential to understand if the right professional is managing the right person at the right time. The use of questionnaires/feedback forms, patient interviews and the sharing of patient stories not only helps to understand the effectiveness of the MDT and cluster working, but also helps to share and shape the future potential with staff and the public.

- **Staff experience** - relationships are key to developing the MDT and cluster working.

- **Clinical outcome measures** – what is the quality of care that people are receiving? What is the recontact rate to various services, access to follow-up care, survivability etc. LifeCurve & Pre-LifeCurve can be used as an outcome measure in the effectiveness of prevention as well as interventions across health, care, 3rd sector and self management by patients.

- **Ongoing reviews** of how people are accessing and using services – are people able to get seen within the traditional primary care service, are they accessing primary care via NHS24 or SAS, how does integration of other healthcare professionals in to the MDT impact on the access route.

- **Commission specific academic research** to evaluate these service models, which can be published and shared widely, building the evidence and knowledge base on how to develop sustainable primary care services.