

The **Rotating Paramedic Programme** is a Health Education England funded programme building on the foundations of Health Education England's Paramedic Evidence-based Education Project (PEEP).

The programme explores the feasibility of a rotational model of paramedics in primary care. It aims to maximise the unique skill set of paramedics to improve patient care and relieve pressures on primary care, ambulance services and other parts of the NHS in a sustainable way.

The Rotating Paramedic model is being piloted in collaboration with four Ambulance Trusts and the first phase of the pilot ran from December 2017 – March 2018. Health Education England commissioned the University of Sheffield and the University of Hertfordshire, working as a collaborative, to evaluate the development of the pilots and the rotating paramedic model of care delivery.

This report '**An Evaluation of early stage development of rotating paramedic model pilot sites**' was the final report summarising the findings of the evaluation. The report concluded that:

“The rotational model represents a substantial change of service provision both in terms of scope and complexity. Rotating suitably qualified and experienced paramedics through a range of healthcare delivery settings is feasible and likely to herald benefits both in relation to recruitment and retention of Paramedics in ambulance services, as well as impacting on patient experience.”

The results of the report are being used to further develop the rotating paramedic model to inform the second phase of the pilots that are running from April 2018 and will help inform further rollout of the model.

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An Evaluation of early stage development of rotating paramedic model pilot sites

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Final Report

June 2018

Headline summary

What is this report about?

This report, commissioned by Health Education England, aims to evaluate the development of a rotating paramedic model of care delivery designed to address both the career aspirations of specialist paramedics and the combined workforce issues in ambulance services and primary care so that all, not just some, of the healthcare sectors can benefit. The fundamental principle of this model is that, rather than working within a single environment, a specialist or advanced paramedic can “rotate” through different sectors of the healthcare system whilst remaining employed by one employer.

What are the overall conclusions?

The rotational model represents a substantial change of service provision both in terms of scope and complexity. Rotating suitably qualified and experienced paramedics through a range of healthcare delivery settings is feasible and likely to herald benefits both in relation to recruitment and retention of Paramedics in ambulance services, as well as impacting on patient experience. This approach to integrated healthcare delivery will improve inter professional and multidisciplinary team working as well as facilitating paramedics to fully utilise their extensive skill set, knowledge and expertise without depleting ambulance services’ workforce. This can only be of benefit to patient management, experiences and potentially patient outcomes. However, there is currently insufficient data to estimate the net benefit of this work.

How did the authors reach these conclusions?

Four pilot sites were established and evaluated through a variety of means including:

- **Interviews with 30 participants from a variety of backgrounds.** Participants unanimously agreed that a rotational model should continue but there is a need for flexibility within the model to ensure that local needs are met, whether this be in choice of areas of rotation, length of rotation, or availability of model delivery. The interviews revealed that both paramedics and other healthcare professionals learned a great deal about their colleagues' individual professional roles and that paramedics easily integrated into multi-disciplinary healthcare teams bringing expertise, knowledge and skills that are extremely relevant and versatile. The biggest concerns highlighted by staff were:
 - That this model may not be adopted across the country, which if this were to be the case was identified as a wasted opportunity
 - The need to consider a new approach to funding healthcare provision to sustain these roles
 - Particular emphasis is needed to developing the EOC component by learning from services where this has been historically well established
 - Whether this type of role should attract a higher pay band than is currently indicated.
- **Quantitative analysis of pilot site activity.** Pilot sites provided aggregated early data on activity and associated processes of patient management (e.g. workload, conveyance rates, see and treat rates) as a snapshot of how rotational paramedics are managing the patients they attend. This showed, depending on call type and origin (primary care or ambulance) SPs manage a high proportion of calls in the community (70-93%) and there are early indications that hospital conveyance can be reduced within local populations where rotational paramedics are operating.

An economic evaluation has been reported separately.

Are there other specific findings?

- Freedom to develop creative and flexible rotational models has been central to the rapid implementation of the pilot sites.
- Different funding models seem to determine whether or not the paramedic will respond to Category 1 calls when not on an ambulance placement.
- No consensus as to whether this is a role for experienced paramedics or whether in the future this could be a role for new registrants as well
- Pre-registration education programmes should include placements within these settings to familiarise future workforce with working in alternative settings

- Paramedic prescribing was seen as an additional benefit to the model, although it was recognised that it may not make much difference in reality as with the expansion of the role of community pharmacist many of the issues could be managed through PGDs.
- Detailed planning for clinical governance processes, contracts and financial arrangements is needed to protect organisations and staff. Once set up these can be more easily replicated as schemes expand.
- Clarity of roles, activities and workload is crucial to developing manageable primary care and MDT components.
- Length of rotation in each component is not straightforward. Longer rotations, particularly in primary care support learning and relationship building but shorter rotations increase variety and better support shift rota patterns.

What does the report recommend?

Recommendations include:

- Extended funding to fully evaluate the impact of this new model of healthcare delivery
- Further consideration of the optimal timing and choice of rotational placements
- Further exploration as to whether this model will enhance paramedic retention and recruitment to ambulance services
- Develop some 'exemplar' sites of best practice, where a strong commitment to research and evaluation can help drive the most effective models that positively influence patient care.
- Establish work streams to promote national standards in education but maintain local control to develop relevant infrastructure and tailor the rotational model according to local healthcare need
- Carry out further research to understand the definitive impact on patient outcomes, patient experience and cost effectiveness.
- Collaborate with CCGs, STPs and other stakeholders to ensure the rotational paramedic model is integrated with strategic health plans.