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INSIDE…

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Message from the Chief Executive

Welcome the first issue of Paramedic INSIGHT of 2019 and the beginning of another progressive year for the College of Paramedics and the profession in general.

This year we will implement our new Information Technology (IT) system and the team are looking forward to the many benefits this will bring in terms of efficiency in operating the administrative system and meaningful communication with our members. A personal “hobby horse” for me is the ability to have a good quality membership with photographic ID attached, something that will now be achieved as part of this project.

This year also sees the end of our current five-year strategy and the development of our plan for the next five years. It will be a tall order to emulate the success we have enjoyed between 2014 to 2019 and I am confident we have the team in place to do so.

The political turmoil affecting the UK is likely to have wide-ranging impact in many areas; we will continue to discuss and monitor all issues that could affect the paramedic profession. The long-term plan for the NHS is interesting, especially with regard to the mental health subject and we are working with NHS England to explore how best we can engage and influence this agenda.

Continuing Professional Development is always a subject that generates a great deal of interest and we are currently in discussions with Elearning for Health and Health Education England (HEE) around funds to develop the next set of modules. It is an expensive process researching, writing and developing the content and ensuring the IT is suited to the purpose. We are hopeful funding from HEE will be available and thus enable the College to develop and complete the next set of planned modules.

Fitness-to-Practice (FtP) representation is now fully within the management of the College of Paramedics and I look forward to developing this work over the coming year so that we can provide a first-class service to our members whenever the need arises.

I am always aware that we are exist primarily for our members. Without you we would not have a professional body and I thank you for your continued support.

Best wishes

Gerry Egan QAM, FCPara,
DiplMC RCSEd, PgCert
Chief Executive
December issue of the British Paramedic Journal now available

The British Paramedic Journal (BPJ) is the College of Paramedics very own peer-reviewed research journal, aimed at increasing the evidence-base for the paramedic profession and contributing to enhanced patient care.

The BPJ, which is free to access for all members can be viewed electronically by logging onto the College of Paramedics’ website (www.collegeofparamedics.co.uk) and clicking on, ‘British Paramedic Journal’, which can be found under the ‘Member Services’ section.

The March issue includes:

A retrospective review of patients with significant traumatic brain injury transported by emergency medical services within the South East of England.
Jack William Barrett

Do paediatric early warning scores relate to emergency department outcomes for children aged 0–2 years brought in by ambulance?
William M. Broughton and Professor Ian K. Maconochie

Prophylactic uterotonics in the prevention of primary postpartum haemorrhage for unplanned out-of-hospital births: a literature review.
Molly Greenaway

Best BETs - Does dispatcher-assisted bystander CPR improve outcomes from adult out-of-hospital cardiac arrest?
Ffion Barham, Stephanie Bailey and Blair Graham

The impact of an ambulance vehicle preparation service on the presence of bacteria: a service evaluation.
Mo Mackenzie and Richard Pilbery

Do red arrest teams save lives? A service evaluation of an out-of-hospital cardiac arrest team in an English ambulance service.
Richard Pilbery, M. Dawn Teare and Daniel Lawton
If you have been following the guidance in this series so far, you should have an accurate, up-to-date, detailed list of all your CPD activities, which are a mixture of different types of CPD, and they will be supported by evidence. You should also have the basis of your 500 word summary of your practice history.

The only thing that remains, should you be selected by the HCPC to submit your CPD profile, is a 1,500-word supporting statement, a task which might appear quite daunting if you have not done much writing recently! It is important that you understand the purpose of the statement so that you can meet the expectations of the HCPC without it becoming too stressful an experience.

The primary purpose of completing a statement as part of your CPD profile is to show the CPD assessors how you have met standards 3 and 4, i.e. that registrants must:
1. Seek to ensure that their CPD has contributed to the quality of their practice and service delivery; and,
2. Seek to ensure that their CPD benefits the service user.

In some cases, it can be quite difficult for registrants to appreciate the difference between these two standards, which are very closely linked. Indeed, it is sometimes just as challenging for the CPD assessors to separate these two standards. When requests are made by the assessors for further information, they often combine these two standards in that they seek further information for both rather than one or the other. Following these ‘top tips’ should help you to meet the HCPC requirements.

Top Tips for writing your statement:

- Aim to discuss only four or five specific CPD activities. This means a word count of 300 to 375 for each activity discussed, potentially a much less daunting task than writing 1,500 words straight off. Any less than four limits your ability to present a mixture of activities and any more than five reduces your ability to fully demonstrate how you have met the standards;
- Ensure that the activities you are discussing are different types of CPD. This will support your meeting Standard 2 which requires a mixture of activities;
- The examples that you select must, clearly, be in your activities list and should be supported by evidence. You could use this evidence as a starting point, for example, if you have completed a reflective account then you can start by cutting and pasting elements from this into your statement;
- If you are discussing formal education or course attendance, where your evidence is a certificate of attendance or achievement, then you can use the statement to present a brief reflection on your CPD activity. If you have an example of how the activity has already influenced your practice, then you should include this. Describing how your learning has directly benefitted a service user gives a clear and unambiguous example of how you have met the standards. If you have not yet used the learning in practice, simply indicate how you feel the learning will benefit the service user at some point in the future;
- Although the HCPC guidance suggests the use of a professional development plan (PDP), or similar, as evidence of CPD, it is not advisable to use this as the basis for your statement. Registrants who submit PDPs as a way of meeting the statement requirement often fail to consider how the PDP meets the standards. It is generally focussed on their individual development needs and not on how those needs might improve the quality of their work or benefit service users;
- For each activity that you discuss, think about how the activity has developed your practice, and benefitted service users. It is easy to assume that developments in your practice will, inherently, benefit service users, but this does depend on the role that you have in your organisation;
- Depending on your role, the benefits to the service user may be less apparent than the contribution to the quality of your practice and service delivery, or vice versa. If you are not employed in a patient facing role, for example you are working in education or management, it may be that your ‘service users’ are students or members of staff. If this is the case, make it clear in your statement;
- Do not assume that the benefits to your practice and to service users are obvious. The CPD assessor may be able to see how the activities are beneficial, but the purpose of the statement is for you to demonstrate that you have considered this and that you can make explicit links;
- Avoid using your statement to vent about your circumstances. Some registrants will take this opportunity to comment on the lack of support given to them by employers in completing CPD activities. Although you may have genuine concerns about the lack of support that you have received, the CPD profile statement is not the place to share these; and,
- Make sure that you proof-read your statement before submitting. Ideally, share with a friend or colleague and ask them to read it through to make sure that it is clearly written and makes sense.
Gary Strong MCPara, National Education Lead for the College of Paramedics continues his reflection of Continuous Professional Development.

The statement offers a thought-provoking exposition of each of these principles (p.8 onwards) and it is worth highlighting some of the points made. For example, CPD is not always about planned events or courses: ‘valuable learning can happen in both planned and unplanned situations’. That’s good news for paramedics, most of whom work in an unplanned environment. Note that whilst actually doing CPD is your own individual responsibility, your employer has a responsibility to make sure that you are safe, up to date with current practices and can meet the needs of service users. Learning must of course be relevant to the needs of our service users, otherwise what use is it? Remembering of course, that those of us who work in education or management, for example, will have different CPD needs to those who are on the front line of care. If for example I work in health education, CPD should improve my learning and teaching skills, so that my students – who are in fact my own service users – are better equipped to meet the needs of their service users. My employer, who could in this instance be a university or a health provider, ‘is responsible for identifying the needs of service users to guide how relevant your learning is’. Quality improvement is a key element: learning from successes as well as errors to improve service user outcomes. My CPD should contribute to this; my employer’s role is to create the learning culture that facilitates improvement; the wider systems, such as policy makers, professional bodies and other influential national bodies, have an obligation to review the overall effectiveness of learning and quality improvement and drive changes where they are needed. Learning should be balanced as well as relevant, and of course recorded effectively. If you have read Vince Clarke’s articles recently, you will be well aware of the importance of this.

It is unlikely that many folks are going to disagree with these principles. A much bigger risk is that we, our employers and the ‘wider systems’ all say, ‘very good, very well written’ and then carry on as if nothing had changed. The health and social care professionals who put together the statement and the organisations they represent believe passionately that individuals, organisations and policy makers need to take this opportunity to put CPD right at the top of their agenda. I have argued before that there is a direct link between the quality of our CPD and the quality of care we offer to patients and service users. Not only this, but a link to numerous other benefits. Amongst the ten listed in the statement are: ‘makes you feel valued, motivated and confident;’ improves the quality of service delivery; and ‘improves performance’. Let me put it this way round: If we - individuals, employers, organisations and policy makers – follow these CPD principles, then we can all expect to reap the benefits. That is surely a good thing, because sooner or later, many of us will be a service user as well as a service provider.

There was a trailer on TV recently for the BBC’s ‘Hospital’ programme, and a line used as a soundbite resonated: ‘I don’t think anybody realises just how good the NHS is’. Now, before the College’s office becomes inundated with emails from members pointing out current problems with the NHS, or from non-NHS members asking for an article relevant to them, let us pause and make that statement more inclusive. Over three million people are employed in health and social care in the UK, which means that paramedics, wherever they work, are part of a large army of folk who turn up to a workplace where the key objective is to give help and support to their fellow human beings in time of need. We don’t often stop to realise what a good thing this is. If you are at all tempted to disagree, try imagining life without it.

Effective health and social care on this scale is only possible if the workforce comprises of employees who are motivated, competent and keen to develop and improve the service they offer to patients and clients. The sustainability of this arrangement depends very much on the availability of good CPD. But what is ‘good CPD’? In the previous issue I mentioned the publication of the Joint Position Statement on CPD entitled Principles for Continuing Professional Development and Lifelong learning in Health and Social Care. The development of this statement was led by the College of Paramedics and it can now be downloaded from our website at https://collegeofparamedics.co.uk/news/professional-bodies-and-unions-launch-a-set-of-cpd-and-lifelong-learning-principles. The document lists ten benefits of CPD and describes five principles for good CPD practice. Each of these principles requires the individual, the employer and the ‘wider systems’ of health and social care to acknowledge their own role and contribute to effective CPD. The principles are:

1: CPD and lifelong learning should be each person’s responsibility and be made possible and supported by your employer;
2: CPD and lifelong learning should benefit service users;
3: CPD and lifelong learning should improve the quality of service delivery;
4: CPD and lifelong learning should be balanced and relevant to each person’s area of practice or employment; and,
5: CPD and lifelong learning should be recorded and show the effect on each person’s area of practice.
Older Adults and Frailty

Carol Robertson MCPara, Community Specialist Paramedic, North West Ambulance Service discusses the importance of treating older adults.

Why is it important that we better understand and treat older adults you might ask? Well, hopefully by the end of the article you will realise your passion and drive to think a little differently when you next visit an older relative or go to the next green call to an older person on the floor.

Older adults represent the largest group of patients we respond to, whether we work for an ambulance service, within primary care or other generalist settings, with numbers increasing each year. Nevertheless, they are frequently a lower priority, yet present with more co-morbidities than many of the higher acuity responses, which increases the potential for complexity, especially for clinical decision-making. Within my ambulance service, calls for those over 65 years of age account for 43 percent of 999 incidents and 64 percent of patient transport service journeys, equating to over one million patient contacts per year. Whatever our reasons for becoming a paramedic, I think we need to think about the drive to improve our care for this group and make it personal. After all, these are our grandparents, parents, partners, colleagues, and this is our future.

So what is frailty? There are several definitions but the British Geriatrics Society (BGS) describes it as: ‘Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85’. [Turner, 2014]

What does that mean day-to-day? Here is a very basic example; if I fractured my right wrist this would affect my ability to drive, wash my hair, apply makeup and I would be off work but still be able to go out using public transport. However, consider Connie, an 85-year-old woman who uses a walking frame to move around her home and take her drinks and meals to her favourite chair. With the same injury, she now cannot put weight on her right hand, meaning she cannot push up very well from her chair; she struggles to walk with her frame and is unbalanced due to weight distribution. When she needs to go to the toilet, she cannot get there in time as everything takes longer, leading to incontinence; what’s more, her prescribed analgesics are making her drowsy, and sometimes confused. This is the difference – I have resilience through physical and mental reserves but Connie does not, therefore the same minor injury has an enormous and even life changing impact on her.

As health care professionals, we have a duty to do our utmost for all the Connies out there but we need help to do so. In 2018, Health Education England (HEE) and NHS England (NHSE) commissioned the Frailty Framework of Core Capabilities, which was the development of a framework facilitated by Skills for Health. The working group involved key stakeholders, including HEE, NHSE, Age UK, BGS, Royal College of GPs (RCGP), Allied Health Professions (AHPs) including the College of Paramedics, housing, local government and voluntary sector organisations. ‘The framework’s purposes is to identify and define the skills, knowledge and behaviours required to deliver high quality, holistic, compassionate care’ [Skills for Health, 2018]. Like the Dementia and End of Life Core Competencies, this document provides a single framework in which organisations or individuals can review and measure their practice. The framework comprises 14 capabilities, grouped into four domains: Understanding, identifying and assessing frailty; Person-centred collaborative working; Managing frailty; and, Underpinning principles. Within each of these domains, there are three tiers, which indicate at which level you can measure your capabilities. Tier-one is aimed at the general-public with a drive to ensure we all know how to help those more at risk, with Tier-two aimed at health, social care and other staff who regularly encounter people living with frailty within their working environment; this is where the majority of ambulance staff may find themselves. Finally, Tier-three is aimed at health, social care and other professionals who provide ‘expert care’ and lead services for people living with frailty.

Additionally, a framework is currently in progress, which is an addition to HEE’s Multiprofessional Framework for Advanced Clinical Practice (MFACP) in England. The framework is still in the planning stages but it aims to detail competencies expected of Advanced Clinical Practitioners (ACP) working with older adults. This again has had representation from BGS, HEE, Public Health, and AHPs including the College of Paramedics. This will allow organisations to understand that AHPs may also have the knowledge and competencies to work with older adults when considering workforce recruitment.

Continues on page 8 »
Let’s revisit Connie. When caring for an older adult at a non-time critical incident how can we recognise frailty? Frailty is often identified by the ‘Geriatric Giants’ or my preferred description ‘Frailty Syndromes’; these include falls, polypharmacy/medications, incontinence, immobility, delirium, social isolation, and loneliness (NHS England, 2019). With additional knowledge, we can identify those at a higher risk of developing frailty, which is underpinned by taking a comprehensive history. Significant factors include alcohol excess; cognitive impairment (new and or existing), functional impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy, smoking and vision problems (NHS England, 2019). Through those few lines about Connie, we can immediately identify that she needs to use a walking frame (mobility issues), is not able to get to the toilet in time (incontinence), her analgesics are making her drowsy (medications), and sometimes she is confused (possible delirium). Moreover, how did she fracture her wrist in the first place (was it following a fall?). Clearly, most clinicians could identify Connie is at risk of falls, yet identifying the causative agents may not be as clear.

There are several tools available to measure frailty but my preferred choice is the Rockwood/Dalhousie Clinical Frailty Scale (CFS) tool as this gives simple pictorials as well as a brief description about each level (see below).

![Clinical Frailty Scale](image)

So when should we apply a frailty score? If you work in the community or primary care, this will be at nearly every contact, as part of an initial assessment or for comparison at later appointments; however what about when it is a 999 call? As mentioned, this is something to consider once you have determined there is no time critical features, but this can help you make a decision regarding your treatment plan. This is why asking a patient about their normal day and especially their Activities of Daily Living (ADLs) can help you to determine the most appropriate score. The CFS model of frailty presumes an accumulation of deficits (including low mood, mobility and food preparation) which can occur with ageing and in turn will increase the risk of adverse outcomes. In an acute situation the diamond in the rough of this is discovering their CFS two weeks ago and what it is today after an acute event. When applying the CFS for their fitness you are not comparing the Connies to athletes but to other 85 year olds, therefore is Connie the fittest of all other 85 year olds? Once you decided that Connie is not of the fittest, you can work through the categories one to nine to decide on where she fits. What I find most interesting is to use the tool on yourself and your family - where would you fit? Personally, I am a three due to allergies, which mean several medications, but my husband is a one.

Furthermore, we can help our patients’ onward care within Primary Care (PC) because General Practitioners (GP’s) have an alert within their system to advise if a patient’s deficits add up to a risk of frailty; this system is called the Electronic Frailty Index (eFI). This system ‘is a strong predictor at population level but has low predictive value for individual risk of death’ this is why NHSE require direct validation of frailty in individuals (@runnermandoc, 2019). If we can identify a person’s frailty risk and share with our PC colleagues, we can highlight those requiring earlier detection and intervention to treat undiagnosed disorders.

Finally, the NHSE’s Long Term Plan and Older Adults: As with many government/NHSE papers they recognise that people are living much longer, but these added years of life are not always spent in good health. Many live with multiple long-term conditions, or live into old age with frailty or dementia; men on average now spend over two years and women three years with ‘substantial’ care needs (NHS England, 2019). Prevention is the only option, as a cure is not possible, therefore informing our patients how to better help themselves and reduce risk factors associated with poor health and frailty is essential. The changes proposed by the long-term plan relevant to ambulance clinicians include clinical support hubs and availability of more community teams, which will aim to help ambulance clinicians treat older adults appropriately within the community; this can help reduce the risk of deconditioning associated with hospital admissions (Gillis and MacDonald, 2005). One of the best questions you can ask when assessing an older adult is, ‘how acutely have they deviated from their normal baseline, both functionally and cognitively?’ Abrupt changes being more of a concern. With the moves to embed key concepts for the care of older adults in paramedic practice through the frameworks of care and education standards, we will be better equipped to make safer and balanced care decisions and recognise the significance of any reported changes to their baseline.

The average life expectancy in the UK for men is 79 and for women 83 (NHS England, 2019) therefore as a male turns 76 and a female 80, they are potentially heading into their last 1,000 days of life, so let us help contribute to the best 1,000 days of their lives!

References
- https://www.bgs.org.uk/resources/introduction-to-frailty
- https://soundcloud.com/bmjpodcasts/50-of-delirium-is-hypoactive-how-to-spot-it
- https://www.rcpsych.ac.uk/mental-health/problems-disorders/delirium
- Useful reading and learning aids
- PFI For Frailty (BGS) part one clinicians - https://www.bgs.org.uk/campaigns/8864722565_PFI_Full.pdf
- MDTea Podcasts
Mental health crises and the emergency services – Helping you help me

Liv Pontin, a service user in mental health, shares her experiences and contact with the emergency services.

From 2016 to 2018, I experienced a long period of mental health crisis, with multiple experiences of contact with police officers and paramedics, including being detained under the Mental Health Act and on one occasion receiving CPR from police. This article is based on a blog post I developed to share some thoughts on what can help from the emergency services attending to a person in mental health crisis.

“We’re here to help”

Firstly, even if you are with an individual who has been in crisis before, emergency service involvement is terrifying. I fear being in trouble, I am terrified that you think I am attention-seeking or wasting your time. Please reassure me that you are here to help me. Remind me that I am not well. This may seem obvious, especially if someone is diagnosed with a mental health problem, if you ‘know’ somebody who you see regularly, or if somebody is clearly distressed. But in crisis, we can lose insight. Please keep reminding me that this is my illness talking, and that I need some help to get well again. I may need to be told the same thing multiple times in order to take it in, but it does stick with me later.

Self-harm and suicidal thoughts

Self-harm and suicidal thoughts/acts are generally not attention-seeking or ‘cries for help’. For many, they are deeply private and shameful, and even for those cases which are ‘attention-seeking’ serious help is still needed if someone is turning to harming themselves. ‘Attention-seeking’ is not in itself necessarily a bad thing. We all desire human contact and interaction. Whilst many can communicate effectively with words, others may not be able to do so and may communicate their distress in other ways. We never know what has brought a person to that point, and those who need medical treatment as a result of a mental health problem deserve the same care, empathy and treatment as anyone else.

Suicide may seem objectively ‘selfish,’ but to a person in that state of mind, it often seems like the only option. Please do not try to make me feel guilty. Having said that, talking about the impacts on others – including the police or paramedics who are called out to deal with this – can be a very effective way of halting the intention to act on these immediate urges for some.

And thirdly, please do not ever tell somebody that ‘if you really wanted to die, you’d have done it.’ It is not the case, just as it is not true that ‘truly suicidal people don’t talk about it.’ Sometimes it simply means that somebody is taking every step to help themselves. I have always promised that I will do everything I can to avoid acting on my thoughts. It doesn’t mean I didn’t want to die at those times.

What it can help to say

In emergency situations it can be tempting to deal with things as quickly as possible and move on. But in mental health crisis, adopting a slower pace, being patient, taking the time to listen, understand and build up trust helps. That rapport is so important. Use that rapport as much as possible: for example, allowing the person who has got that rapport to accompany the individual in the back of an ambulance or to explain decisions.

One thing that can really help to build a rapport is just to talk about ‘normal’ things. We all have likes and dislikes, hobbies, interests, a sense of humour. These are the things that make us who we are, but sometimes it is hard to remember them in crisis point. Where appropriate, use your sense of humour. If you can make me smile, you have got me engaged. Remind me that there is hope, that I have a future and am a worthwhile person. Where appropriate, self-disclosure can also be beneficial. A lot of people suffer from mental health problems at some point, and it is so reassuring to know that people can get through these and find something they love in life.

Two of the most helpful phrases I have heard are ‘Focus on my voice’ and ‘I’m not going to let you hurt yourself.’ The sound of a calm, caring, firm and direct voice can help me to feel safe and grounded, to listen to your voice and to know that someone is in control of the situation.

The College of Paramedics is thankful and honoured that Liv has shared her story and insights with our members in this article.

For anyone needing support or advice:

The Ambulance Staff Charity (TASC) 0800 1032 999 support@theasc.org.uk

MIND Blue Light Infoline 0300 303 5999 (local rates) bluelightinfo@mind.org.uk Text: 84999

Samaritans 24-hour helpline: 116 123 jo@samaritans.org samaritans.org

British Association for Counselling and Psychotherapy (BACP) 01455 883 300 For local practitioners

Cruse Bereavement Care 0808 808 1677 cruse.org.uk

Rethink Advice and Information Service 0300 5000 927

www.collegeofparamedics.co.uk
After feedback from members, a Special Interest Group relating to Primary and Urgent Care has been formed (the PUCSIG), with a multi-professional membership from within the paramedic profession and other stakeholders. This group and its work plan will sit within the new Clinical Development Directorate of the College of Paramedics. The group has agreed the following key responsibilities:

- To actively promote the College as a professional body concerned with paramedic practice in primary and urgent care settings;
- To contribute to the development of College policy and strategy relating to paramedic practice in primary and urgent care;
- To advise and be consulted on activity relating to paramedic practice in primary and urgent care;
- To liaise and communicate with paramedics working in primary and urgent care settings, and put forward their views, ideas and concerns;
- To work in partnership with key stakeholders to develop paramedic practice in primary and urgent care settings;
- Through the Trustee for Clinical Development, ensure that issues specific to paramedics working in primary and urgent roles that may have a UK-wide impact, are raised with the Board of Trustees;
- To encourage, promote and facilitate the advancement of paramedic practice in primary and urgent care settings;
- To ensure that all members working in primary and urgent care settings are involved in the activities of the College at all levels: local, regional, national and international;
- To explore opportunities for collaboration with other organisations, professional bodies, colleges and key stakeholders in the wider health system; and,
- To share the work of the group with all members of the College at timely intervals and through a variety of media.

One of the first pieces of work identified through the initial meeting, was that of an employer’s guide to paramedics in primary and urgent care, helping to bring clarity, consistency and standards across this setting. This piece of work has been led by Georgette Eaton, Trustee for South Central and Dahrlene Tough, Trustee Official for Clinical Development, and is due for consultation in February with an expected publication date by the end of March 2019.

In 2018, the College announced that it will be delivering the Diploma in Primary and Urgent Care (DipPUC) examination for its members. This professional exam is an evolution of the work by South East Coast Ambulance Service and its Paramedic Practitioner programme. Members considering a move into primary and urgent care or for those looking for recognition of the skills and knowledge they have already acquired are encouraged to complete this professional examination.

A page on the College website is being created to provide regular updates to members and to share the work of this group. The group is only a small part of our commitment to supporting members and developing the paramedic profession. We would like to hear your ideas for how we can continue to achieve our aims and encourage you to write into the group (pucsig@collegeofparamedics.co.uk) with those ideas or comments on how we can best support you.
The Amber Review

By Ross Whitehead MCP, Assistant Director of Quality and Patient Experience, National Collaborative Commissioning Unit, NHS Wales and Co-author of the Amber Review.

In recent years, we have seen increasing divergence in the clinical response models for ambulance services across the UK, and whilst arguments can be made for and against each model, they all share common objectives: of prioritising the sickest patients and ensuring patients get the right type of response to meet their needs, even if it is not an ambulance or it is not the quickest. Ambulance services have been trying to meet these objectives against a backdrop of steadily increasing demand.

In October 2015, the Welsh Government took the step of introducing a new clinical response model with three categories, ‘Red’, ‘Amber’ and ‘Green’. Since the introduction of this model, the majority of incidents are now categorised as Amber, a broad category that includes chest pain, strokes, breathing difficulties and numerous other incident types. The most controversial aspect to the introduction of this Amber category, and contrary to other countries, was the complete removal of response time targets.

As a result of press, stakeholder and public concerns, there have been regular calls to review the model, and in particular to move individual conditions such as stroke, into the ‘Red’ category, which continues to have a response time target applied.

The Amber review, commissioned in April 2018 by Welsh Government and the NHS Wales Emergency Ambulance Services Committee, was led by clinicians within the National Collaborative Commissioning Unit and completed in October 2018. The review was commissioned to address two concerns: firstly, whether there was a systemic problem with the clinical response model that was leading to poorer service provision, and secondly: were patients categorised as Amber coming to harm whilst waiting for a response in the community.

Given the complexity of ambulance service delivery, the pre-conceived expectations of multiple stakeholders and short six-month timescale addressing these concerns would prove to be a challenging experience.

The small Amber review team developed methods for large scale linking of patient level data across the unscheduled care system, including CAD information and ambulance, emergency department and in-patient clinical records. We carried out road crew and control room staff focus groups and undertook an attitude survey with 1,000 members of the public. We also carried out research, engaged with external experts and worked closely with the Welsh Ambulance Service to understand operational systems and pressures.

In summary, the review found the following:

Explaining Amber
- The prioritisation of calls is complex;
- There is a range of different responses depending on the patient’s condition;
- Ambulance staff felt frustrated by the restrictive nature of the prioritisation system; and,
- The public felt that it was important to get the best response for their condition even if this was not the quickest.

Exploring Amber
- There was increased demand in the Amber category;
- Ambulance staff felt that expanding the numbers and roles of clinicians in the control room was essential;
- Receiving a quick ambulance response but ensuring this is the right response for your condition is important to the public;
- Further work is required to explore the relationship between cancellations and re-categorisations and ambulance response;
- Further work is required to explore the relationship between hoax calls, refusals and ambulance response;
- The public support ambulance services doing as much as possible to avoid the need for them to go to hospital;
- Ambulance staff require more information on alternative services;
- Measures of quality are as important as response times;
- Measurement of the ambulance service should be refined to reflect the whole patient journey;
- Measures should be developed in partnership with patients;
- Members of the public wish to be supported and be better informed when making a 999 call; and,
- More patients in the Amber category are having their incident resolved or closed over the phone.

Delivering Amber
- Funding for ambulance services has increased;
- The ambulance service does not always deliver sufficient resources to meet demand;
- The time ambulances are waiting outside hospitals has increased;
- Ambulance Service sickness levels remain high;
- Emotional and psychical wellbeing of ambulance staff is important;
- Call handlers should be supported, especially during periods of increased activity;
- Resource availability is the foremost factor in providing an appropriate response;
- A lack of resource availability can result in longer waits for some patients;
- There has been an increase in the number of Serious Adverse Incidents reported;
- The clinical response model is a valid and safe way of delivering ambulance services;
- Members of the public support the principles of the clinical model; and,
- The length of time you wait for an ambulance response in the Amber category, does not appear to correlate with worse outcomes.

Our main conclusion was that some patients in the Amber category are waiting far too long for a response, but that the cause of this was related to the availability and resourcing of ambulances and not the categorisation of incidents.

We acknowledge that there is more that needs to be done to enhance the delivery of the clinical model and ensure that all patients receive the appropriate and timely response that they require.

The Amber Review is well underway and more details and the full amber review can be found at www.wales.nhs.uk/easc/publications
Michael Holgate
MCPara, Trustee with Volunteer Medics discusses why and how paramedics can get involved in volunteering.

Have you ever thought about volunteering?

Michael Holgate with triplets delivered on his first day whilst volunteering in Cameroon in 2015.

The Health and Care Professions Council (2014) states within the opening lines of the Paramedic Standards of Proficiency that a paramedic must be able to work safely in challenging and unpredictable environments, including being able to take appropriate action to assess and manage risk. Whilst this is intended to relate to paramedic practice in the United Kingdom it defines perfectly operations and volunteering within a humanitarian and development aid context.

Volunteer Medics (VM) is a recently formed, UK based, Non-Governmental Organisation (NGO). Its founding team have many years of humanitarian experience all over the world and are made up of paramedics, ambulance service personnel and supporters.

Local interest in the humanitarian activities of the author, led to several colleagues expressing a desire to undertake some form of humanitarian or healthcare development expedition. This grew into a nine strong team, consisting mainly of paramedics, undertaking a project to rebuild and experience working in a remote rural health centre in Cameroon. Considerable efforts to fundraise and obtain medical consumables took place during the planning phase of the trip, and public support and interest were high. Whilst the trip was deemed to be very successful by organising partners it was apparent that an opportunity existed to develop a profession-focused response to humanitarian fieldwork. This opportunity is a natural progression of the general humanitarian and development work of the voluntourism sector and provides a conduit through which the professionalism of paramedics, their skill sets and a desire to extend care to wherever it is needed, can be channelled.

Following the successful conclusion of the Cameroon trip, members of the team were approached by a digital development agency, Thrive, based in the North of England. Thrive produced a web and social media presence along with a professional branding, pro bono. With encouragement from NGO partners keen to capture the benefits that working with paramedics brought, we progressed and completed the registration of Volunteer Medics as an NGO with the Charities Commission.

We aim to provide paramedics, ambulance colleagues and supporters with immersive, educational humanitarian opportunities which stay with them for life and hopefully make them want to become part of an expanding ambulance family involved in bringing health benefits regardless of country of birth. We are all volunteers, passionate about the role of paramedics and what we have to offer in the scope of humanitarian field operations. Importantly, as we are all volunteers, we can ensure that all the funds we raise go to the projects that we work on. Volunteer Medics (VM) exists for three main reasons. Firstly it provides an avenue through which the author and other members of the team can channel their own voluntary work and fundraising efforts. Secondly, in establishing VM the founding team were concerned about the levels of funds that were raised in humanitarian and development aid work and how much of this reaches the intended recipients, a concern which the wider public also share (Saxton, 2012). When VM was set up we insisted that volunteers pay their own flight costs and logistics with all fundraised monies going direct to the projects we work on, something our volunteers have been impressed by. Finally, we believe that the UK pre-hospital emergency medical profession has a lot to offer the wider world and that our skills, as with doctors and nurses more broadly, can improve global healthcare. Existing humanitarian medical response leans understandably towards the doctor and nurse relationship. Whilst paramedic practice in countries such as the UK, Canada and Australia has transformed (Givati et al, 2018), establishing a wider awareness in other countries of paramedic capabilities is challenging. Previous commentary within industry publications, and a lack of understanding by healthcare providers in the humanitarian context even within the UK (including one major organisation stating to the author that they only recruit clinicians and therefore paramedics don't count), can make accessing such roles, either as volunteers or salaried clinicians frustrating. As part of the ongoing development of the paramedic role it is natural to assume that this progression will lead to increased opportunity in fieldwork roles.

Operations in country are defined and often limited by the broader lack of understanding of the scope of practice of UK paramedics. As an organisation we work very closely to ensure that local state bodies, our partner organisations and our volunteers make the most of the opportunity to engage with clinical work. Membership of the College of Paramedics is a requirement for any paramedic or student volunteer. The insurance that membership includes is a valuable benefit and a necessity for any volunteers who operate with us.

We can, and do operate in remote and challenging environments with little by way of home comforts. We also believe that this appeals to paramedics wanting to genuinely engage with local communities. Our operations have four main aspects to them. Most of the funds we raise are utilised in improving infrastructure and are focused towards development assistance. This means repairing buildings, painting walls and floors, providing safe water and lighting to rural health facilities as well as toilets, beds and basic equipment etc. We particularly aim our work at improving the health of women, expectant mothers and children. Having witnessed pyrexic, expectant mothers walking ten miles with malaria to reach a midwife and accessing extremely basic facilities, as well as Caesarean Sections with no pain relief, we are keen to support
the inspiring local individuals who work as doctors, nurses and volunteers and are completely committed to improving the health of their own communities. Fundamental to our work is the belief in working as a partnership, alongside our partner NGOs and local communities. We believe that we can improve our own clinical practice through the work we do and are keen to see our volunteers not only help to meet the training needs of local clinicians and community workers but to also develop themselves. Our February 2019 trip to Tanzania training schedule provided by VM medics to local volunteers includes topics as broad as first aid, pulse oximetry, infection prevention and control as well as diabetes and high blood pressure management. All our volunteers are expected to be kept busy. We are open in our discussions with prospective volunteers that this is not a relaxing holiday and our website, which can be visited at www.volunteermedics.org sets out clearly what a volunteer should expect when they come with us. A particular focus and busy period takes place during the medical caravan, which we undertake alongside our local partners. We can expect to see upwards of 250 patients on the one day and both clinical and non-clinical staff are fully involved. Finally, as well as clinical engagement, training and infrastructure rebuilding we must look after ourselves and each other. This team work is an important part of our daily responsibilities and something we take both seriously and with a pinch of fun, expect to learn a little of the local dialect and do some cooking over an open fire as well as washing the pots and purifying the water!

There is considerable debate within the humanitarian fieldwork and academia as to the benefits and disadvantages of providing a narrow or broad focus to operations. In practice this equates to focusing upon a single community to develop local healthcare provision or to spreading resources across a number of locations. Through our partners we undertake both approaches. In Tanzania we work alongside another small NGO and a Spanish neuro-surgeon to develop health facilities in two villages within the Kilimanjaro area. Here we undertake the work outlined above identifying short to long term needs with the local community, collecting health data and formulating proposals for health development. The existing relationships of the founding team have also been expanded.

The current state of civil unrest in Cameroon has led to around one third of a million Internally Displaced Peoples (IDPs) or refugees. Whilst conditions are not at present considered safe by the Foreign and Commonwealth Office (FCO, 2018), fundraising has continued and we plan to return to Cameroon as soon as we are able. We also enjoy relationships with organisations in Nepal. Discussions are underway to identify a suitable rural health centre with which to form a long term relationship of a focused nature, similar to the one we enjoy in Tanzania.

Longer term we wish to see an increasing interest by our ambulance service colleagues in wanting to volunteer and work along side us. Put simply the more interest we can stimulate the more we can improve the health and lives of those we work with. We anticipate continuing our practice of forming teams made up of paramedics, non-paramedic ambulance staff and paramedic students as well as non-clinicians. We feel strongly that this provides a more balanced team and allows the broader objectives of health provision such as sports programmes and education to be delivered. At a professional level we hope that as the scope of the paramedic continues to develop, so too will exposure to humanitarian work become more widely available, including disaster relief.

We encourage any individual with an interest in what we are seeking to achieve to make contact either through the website, Facebook or to call us. Help us be the difference where it is needed most.

www.volunteermedics.org

References


The UK Student Paramedic Conference (UKSPC) was the brain child of nine University of Hertfordshire student paramedics and was first held in 2013. It has since gone from strength to strength, each year aiming to bridge the gap between education and practice. The committee is made up of student paramedics and those who have recently graduated, so that it is truly ‘by students for students’.

On the 10th November 2018 the fifth conference to date, saw the committee and College of Paramedics go into partnership and take the conference under the College’s banner. This gave the committee invaluable additional support and enabled the event to be the biggest yet. Bringing over 300 delegates through the doors of the one-day conference, it was the largest student event in Europe last year and the largest single day event for the College.

Aiming to incorporate the range and breadth of practice, the conference involved a cross-section of students and newly qualified paramedics, sharing the common objective of supporting progress for their future careers. The speakers took us on a non-stop tour of mental health, and the impact of rape and sexual assault and maternity and newborn resuscitation – ‘get in, get out, don’t fanny about!’ Insights into less traditional paramedic careers were enthusiastically soaked up; tactical civilian, military medicine, offshore care, wilderness provision. All of this was brought together by busting some myths commonly found in practice. The delegates had the opportunity to take part in primary research conducted by the 3rd year students from the University of Wolverhampton, to consider what is needed when thinking about publication, to learn about pre-hospital blood from an expert source-to-delivery panel and finally refresh those paediatric resuscitation skills.

It was exciting to see such engagement from the profession’s future, with all speakers Q&A’s over-running, the break workshops filled to capacity and the seats remaining full until the final curtain. With social media during the event going into overdrive, twitter saw #UKSPC18 trending and reaching far outside the conference venue. The participants also got a sneak peek at what is in the pipeline for the College’s student members; the chance to be involved, engage and volunteer in their future, with the imminent launch of the Student Advisory Committee.

If you couldn’t make it, catch up on the action #UKSPC18 and keep an eye out for the #UKSPC19 date, to be announced soon.

Photographic credits to Jonathan Street, with thanks.
Ambulance services in Mexico – and the rest of the world?

Esther Dittmar MCPara, Newly Qualified Paramedic at the Welsh Ambulance Service NHS Trust, shares her experiences of pre-hospital care in Mexico.

Freshly graduated, I had some spare time before life got serious as a paramedic, so why not step outside my comfort zone and into the global pre-hospital world – a place waiting to be explored in depth by our profession. Let me share some insights with you from the four-week placement abroad and the value this experience had for me.

Guadalajara was calling. Mexico’s second biggest city in the state Jalisco, home to 1.5 million people and an array of different ambulance services. Unforgettable cultural and culinary experiences aside, the questions below popped up frequently when I returned home, so I will use them to give you a brief overview.

Is pre-hospital care very different there?

Decide for yourselves: Imagine a UK ambulance service, without our special equipment, training and protocols, split it into two, backed by a diverse healthcare system. Why two? The two main ambulances services in Guadalajara are Cruz Roja (Red Cross charity) and Cruz Verde (Green Cross, funded by local municipalities), in both of which I observed shifts. Occasionally fire services respond to calls. In addition, there are private ambulance services, specialising in transfers.

Transfers form the core of emergency care in Mexico: Cruz Roja and Verde respond to calls and transport to their own emergency departments (EDs) for free, where basic care is provided. Ongoing care often involves a transfer to enhanced hospitals, e.g. for CT scans, depending on the patient’s insurance. In short, the focus is not on the Golden Hour but on transfers to specialised treatment.

Critical care is provided by SAMU (Sistema de Atención Médica de Urgencias), with a skill mix similar to our air ambulances. Funded by the government, they also specialise in transfers rather than attending scenes. It was a true privilege for me to be invited to the SAMU base in Guadalajara (covering Jalisco with extremely limited resources, unfortunately), since this was not officially part of the placement.

What scope of practice do paramedics have?

Theoretically, specific norms regulate this recognised profession, however, they are not strictly implemented, so this is a difficult question. Practically, it depends on available equipment, which differs hugely based on current leadership. Where I worked, we did not have monitors, therefore observations were obtained via pulsoximetry, manual blood pressure and occasionally blood glucose measuring. Airway and breathing support equipment, including intubation, is available, as are AEDs (life support follows American Heart Association recommendations).

Extrication and immobilisation kit includes spinal board, collar, head blocks etc. Furthermore they carry splints, basic wound dressings, a maternity pack and cannulation kit. In terms of drugs some old friends showed up like saline, adrenaline, IV paracetamol or furosemide, but also extras like tramadol, captopril and 50% glucose, however, most paramedics are not officially certified to administer them.

I bet there is lots of trauma there...

Definitely, but I must be the only observer who did not attend a proper trauma call – how I love our profession’s unpredictability. Road traffic collisions, work accidents and assaults with knives or firearms are very common. Emergency departments see more young people than in the UK. I was able to witness some severe cases with serious injuries and polytrauma while observing in EDs, which was an experience in itself. Medical calls happen frequently too, and these patients can present as very critical because calling an ambulance is often the last resort, possibly due to worries about associated costs. Nevertheless, medical calls are still important, often with very critical patients because an ambulance is called only once the patient deteriorated significantly, possibly for insurance reasons – it’s not the NHS. In less severe cases or when financial problems arise, they are left at scene.

What can we get out of it, since pre-hospital care here is more advanced?

While excellent equipment and training are still a privilege for some countries, knowledge and passion are not. I met some of the most skilled, empathetic and driven paramedics in Mexico fighting to improve pre-hospital care, whose mentorship and inspiration will guide my practice for a long time to come.

I realised that paramedics can benefit from international exchange programmes among ambulance services for several reasons [the majority of which applied to my placement], just like other medical professions do. For example:

- Broadening the clinical horizon, experiencing different pathologies, treatment options and skills;
- Observing and adapting effective practices to improve care;
- Becoming resilient and flexible through working in challenging environments;
- Understanding global and local health problems and how they impact care providers;
- Enabling professionals from less privileged countries to experience our ambulance system; and,
- Building relationships with professionals for future exchange and collaboration.

We have made a start, as previous Paramedic INSIGHT articles have highlighted [e.g. Swiss paramedic students, Vol.4 No.1]. I hope for the future of the profession that employers and the College of Paramedics find more ways to facilitate such exchanges. I hope that you as students and professionals can enjoy these experiences during your career, and I hope that one day I can see pre-hospital care in my home country, Germany.

I would love to hear from you if you have had similar experiences working abroad or if you know of similar programmes, so please get in touch!

Many thanks to Global Medical Projects who made this experience possible, and to José Luis Blas Murguía for facilitating my clinical and organisational understanding.

Esther Dittmar estherdittmar@web.de
Dying not to go to hospital...
Steven Short, Clinical Effectiveness Lead, Scottish Ambulance Service

The future of resuscitation in the UK
Prof Jonathan Wyllie, President, Resuscitation Council (UK)

Just what is patient advocacy in paramedicine?
Alan M. Batt, Adjunct Associate Professor of Paramedic Science, CQUniversity, and Professor in the paramedic programs at Fanshawe College, Canada

Urban and rural dementia the challenges and solution 2019
Ian Sherriff, Academic Partnership Lead for Dementia, Clinical Trials and Population Studies, University of Plymouth

A video analysis of clinical handovers between paramedics and emergency care staff
Ethan Shapiro, Associate Lecturer in Psychology, Edinburgh Napier University

Implementing a Paediatric Early Warning Score into Prehospital Practice
Martin Rolls MCPara, Advanced Paramedic, North West Ambulance Service

I shouldn’t laugh, but…
Joel Symonds MCPara, Trainee Advanced Critical Care Practitioner, Scotland

Cerebral Trauma in the Elderly – The Impact of Ageing
Adrian Langford, Student Paramedic, North East Ambulance Service

Falls Rapid Response Service: The benefits of Paramedic and Occupational Therapist Teams in responding to and preventing elderly falls at home
Matt Curtis FdSc MCPara, Paramedic, North East Ambulance Service

Acute Behavioural Disturbance: Perilous for patients and paramedics?
Alison Walker, Honorary Medical Advisor for WMAS University NHS FT, Consultant in Emergency Medicine with a Specialist Interest in Prehospital Care at Harrogate and District NHS FT and the JRCALC Committee lead for the ABD Guideline in development currently

Social Media Panel Discussion:
An opportunity or an obstacle?

Visit www.collegeofparamedics.co.uk for information and to book your places.
Wednesday 15th May

**AIRWAYS-2: Impacts on paramedics and practice**
Professor Jonathan Benger, Professor of Emergency Care, Faculty of Health and Applied Sciences, University of the West of England, Bristol

**How to be a paramedic super hero**
Professor Richard Lyon MBE, Professor of Pre-hospital Emergency Care, Royal Infirmary, Edinburgh, Kent, Surrey & Sussex Air Ambulance, University of Surrey

**Not drunk, dying!**
Sam Thompson MCPara, Forensic Paramedic, Kent Police & Senior Lecturer at St George’s, University of London

**London critical care advanced paramedic practitioner use of POCUS**
Nick Brown MCPara, Advanced Paramedic in Critical Care, London Ambulance Service

**What influences the effective practice and role optimisation of specialist/advanced paramedics working in emergency departments?**
Alan Clarke MCPara, Senior Lecturer Urgent & Emergency Care, University of Wolverhampton

**Why are paramedics leaving the ambulance service – what can trusts do about it?**
Yvonne Ormston, Chief Executive, North East Ambulance Service

**Challenging the Paramedic Paradigm: towards the future of practice**
Duncan Robertson MCPara, Consultant Paramedic, Welsh Ambulance Service

**Pre-hospital stroke assessment: the next 5 years**
Dr Lisa Shaw and Dr Chris Price

**Call the midwife ‘paramedic’ - A live birth simulation**

.... Many more speakers to be announced!

#ParaCon19
Following the retirement of Graham Harris in September 2018, as National CPD Lead, I was asked to take on the co-ordination of the ongoing development of the College of Paramedics’ Diploma in Primary and Urgent Care. It’s my own fault. The more I learned about the Diploma, the more I kept saying ‘this is the best piece of CPD we can offer’. So I suppose it was inevitable that when Graham retired, the finger would point in my direction. That’s fine, it is genuinely a privilege to oversee such a well designed and effective professional examination process. It’s also very much a team effort: the day to day work is undertaken by our examinations manager Yvonne Cooze, and we are ably supported and guided by the Trustee Officials and the Executive Team. The Objective Structured Clinical Examinations (OSCEs) and the applied knowledge test are designed and delivered by a highly experienced team of examiners.

Graham Harris and Stuart Rutland wrote about the Diploma in some detail in the June 2018 issue of Paramedic INSIGHT and their article is worth referring back to (see www.collegeofparamedics.co.uk/member-services/newsletters for previous issues), in order to understand something of the history behind ‘the exam’ – as we tend to call it - and the College’s motivation for taking it on board. One of the questions I get asked is ‘what is a professional exam’? It’s worth repeating a few lines here from the previous article: ‘professional examinations such as these are common across higher professional groups and important for benchmarking clinical practice and standards. This benchmarking provides a level of governance by assuring employers, employees, patients and insurers that clinical practitioners have reached required standards to practice in an environment that presents many challenges including uncertainty and ambiguity’.

Another common question is ‘why should I sit the exam?’ This may be followed by reference to the person’s experience and/or qualifications, which can vary enormously. Paramedics have been working in primary and urgent care since the early 2000s, and most have forged their own pathway, perhaps gaining a clinical MSc, perhaps attending a variety of courses, perhaps relying wholly on experiential learning, perhaps - as some now are – entering this field of practice directly from university. In spite of all the hard work the College of Paramedics has done on the Post Registration Career Framework, in primary care there is currently no standardisation of practice or qualifications, and even when we do start to achieve this, there will always be a degree of variety and innovation. After all, ‘primary and urgent care’ encompasses a wide range of contexts, there are very many types of possible patient presentations and the needs of employers differ.

Perhaps the most important contribution the Diploma offers is a benchmark that can cut across the plethora of different qualifications and allow the successful candidate to know that they have demonstrated competence in a representative range of primary care challenges. This is what the OSCEs and Applied Knowledge Test do. Whilst it will never be possible to test for competence in every possible primary and urgent care situation, the blue-printing process that lies behind the construction of the exam ensures that candidates are faced with a fair and indicative set of patient presentations. Put simply, passing this exam tells you, your colleagues, your patients and your present and future employers that you are good at what you do. It doesn't give you a new role or job title, it doesn't guarantee progression, but it will look very good on your CV, boost your own personal confidence and help you to develop your patient care. In the many positive comments we hear and receive, it is the quality of the feedback received by the candidates that is highlighted. Successful and unsuccessful candidates alike get clear and supportive guidance on their clinical performance, making the exam very much a learning experience as well as an assessment process.
In my clinical practice I am not a specialist paramedic, but most of my years in education have been spent trying to understand the educational needs of those who practice in primary care. The first specialist paramedics I worked with were then called Emergency Care Practitioners, and they worked closely with a team of out of hours doctors. They were developing ways of thinking and managing patients which were very different to my own training, and I became fascinated. Both practice and education have moved on apace, and these days if you are a primary care paramedic you could be working in an ambulance trust, a GP practice, a minor illness and injuries unit, a specialist home support service, a hospital or for a private provider. For me, the College of Paramedics' Diploma in Primary and Urgent Care, has an important role in relation to all these different contexts and challenges each candidate to demonstrate excellent clinical awareness and communication skills. Some of the OSCEs may not fit in to what you normally do when working for your particular employer, but they represent the broad spectrum of primary care, which makes a ‘pass’ a highly portable qualification. To date, 64 ‘pass’ certificates have been issued to candidates that have undertaken the exam since it was handed over to the College of Paramedics; 208 were issued previously by SECAmb. This represents an 83% pass rate overall. This year, those who passed the exam in its SECAmb iteration will be given the opportunity to ‘grandfather’ their certificates to the newly named qualification. Look out for details in a forthcoming News Digest.

Our belief is that the College of Paramedics’ Diploma in Primary and Urgent Care has all the qualities needed to become the ‘gold standard’ for paramedics and other non-medical professionals working in primary and urgent care. It’s early days yet, and there are a few challenges for us to manage, but we have inherited a high quality professional examination process and a superb CPD opportunity.

For further information about the College of Paramedics’ Diploma in Primary and Urgent Care, see https://collegeofparamedics.co.uk/publications/diploma-in-primary-and-urgent-care. At the time of writing, there are ten spaces left for the May 2019 exam sitting and anyone interested should contact yvonne.cooze@collegeofparamedics.co.uk for an application pack.
Research in the Paramedic Profession

Gary Strong MCPara, National CPD Lead, chats to Kim Kirby MCPara, research paramedic at South Western Ambulance Service NHS Trust and PhD student at the University of the West of England, about the developing role of the Research Paramedic and her experience co-ordinating a large clinical trial.

Gary: What was it that inspired you to want to become a research paramedic? How long have you been in the role?

Kim: I was frustrated at that time as there was so little research being completed out-of-hospital. I recognised the limitations of using research from other clinical areas and applying it to paramedic practice. I also really wanted out-of-hospital research to be led and inspired by paramedics.

Gary: Tell us about some of the studies you have been involved in. What does a typical working week involve for you?

Kim: I have been involved in a range of studies, the most notable is AIRWAYS-2, but I have been involved in studies that investigate shift work, dementia, frailty and post ROSC oxygenation, amongst others. Some are small pieces of qualitative work and AIRWAYS-2 was a multicentre randomised controlled trial. All are great to be involved with. There isn’t really a typical working week. I might be helping with research delivery, writing a funding application, applying for research approvals, analysing data or writing a paper for publication. It just depends what stages we are at with research projects, or applications and ideas for research. I also chair the SWASFT Patient and Public Involvement in Research Group. Currently we are busy setting up for the the Pre-hospital Evaluation of Sensitive Troponin (PRESTO) Study, which is exciting.

Gary: Why is it so important to have dedicated researchers in the paramedic profession?

Kim: Paramedic practice is unique and the opportunities for research are huge. It’s important to have paramedics leading research and being involved in research because paramedics understand their own profession and the uniqueness of their role. Paramedics can see the opportunities for research that will ultimately improve clinical practice and patient care. As a profession we need paramedics who have that understanding of the role and of the profession to bring those research ideas into action for the benefit of patients, paramedics, the profession and the NHS as a whole.

Gary: I have heard it argued that healthcare research is best done by clinicians rather than university academics. In reality don’t you have to be a bit of both?

Kim: I think that collaboration is key and university academics have a very important role in the research team. Everyone has something to bring to the research process and I have always found working with academics really positive and valuable.

Gary: Tell us a bit about Airw ays 2. How did you get involved, what was your role, and how big a job was it? Was there anything you particularly loved – or disliked – about it?

Kim: I was recruited into the Lead Research Paramedic role for AIRWAYS-2. My job was to coordinate the four AIRWAYS-2 research paramedics in the four NHS ambulance services and to make sure the trial was running well on the out-of-hospital side. I was working on AIRWAYS-2 part time. I enjoyed the role, it was great working with other research paramedics from other ambulance services and I thought we were a great team. The research paramedics had a huge job and their role was challenging, particularly around study documentation and keeping paramedic numbers up over the two years. Each ambulance service worked differently, but that made the job interesting and I always felt privileged to be involved in a well-designed and well run trial like AIRWAYS-2. I was very lucky to have that experience.

Gary: So, what is your next project?

Kim: I have recently been successful in obtaining an NIHR Clinical Doctoral Research Fellowship Award. I will start that full time in April. My PhD will focus on patients who are alive at the time of the 999 call, who then have a cardiac arrest during the prehospital phase of care. I will be looking at data and the call-taker and caller interaction. The main part of my research will use conversation analysis to investigate the caller-call taker interaction. The aim is to improve the recognition of this patient group on the 999 call and to improve outcomes in this patient group.

Gary: Finally, what are your thoughts on the future of the research paramedic role? Any tips for budding researchers?

Kim: I think the future is incredibly bright for paramedic research. There are a growing number of paramedic researchers in the UK and internationally and many paramedics have been involved in research trials and found their involvement to be extremely positive. As a profession we have proved that challenging trials like AIRWAYS-2 and PARAMEDIC-2 can be completed, and completed well, out-of-hospital. There is a lot of enthusiasm around paramedic research and there are a growing number of paramedics completing PhDs. As a profession we need to concentrate on producing the paramedic research leaders of the future and making sure that research is a core part of the paramedic role going forward. We need to make sure that the evidence that is informing our practice is coming from our practice.

Gary: Thanks so much for taking the time to share your experiences with us Kim.

Tips for budding researchers

- Feed your curiosity
- Explore the questions you are curious about
- Start writing
- Get to know your local research paramedics and research paramedics nationally and internationally
- Along the research journey you will face plenty of rejection, keep going and do not get disheartened
- Get involved in ongoing research studies
- Make friends with your clinical data department
- Attend a research conference with a paramedic focus
- Start small and gain experience
Laura Blair in Nashville

Laura Blair MCPara shares her experiences of presenting her research at the EMS World Expo conference in Nashville.

I have recently returned from the EMS World Expo conference in Nashville, Tennessee, where I had the privilege (yet slightly daunting task) of presenting a piece of research work. The research was published in the College of Paramedics’ British Paramedic Journal.

The background to this is that whilst being seconded to the research paramedic role for the Paramedic 1 study (Perkins et al. [2015] ‘Mechanical versus manual chest compression for out-of-hospital cardiac arrest (PARAMEDIC): a pragmatic, cluster randomised controlled trial’, The Lancet, 385, pp. 947-955) my colleagues and I designed a separate piece of work which involved having paramedics volunteer to participate in simulated out of hospital cardiac arrest scenarios where they were providing CPR on scene and then in a moving ambulance. In these same scenarios we compared one and two person CPR and also manual and mechanical compressions. We predominantly set out to assess whether the quality of CPR is affected by moving a patient, and also if there are differences to that quality, when provided manually versus mechanically and with one or two persons.

As mentioned, the paper was published in the British Paramedic Journal (Blair et al. [2017] ‘Comparison of manual and mechanical cardiopulmonary resuscitation on the move using a manikin: a service evaluation’, British Paramedic Journal, 2(3), pp. 6–15). Following that submission, it was then selected to be presented in person at the College of Paramedics’ National Conference in May last year. At this conference the paper was presented by myself, in a section with two others from other ambulance services in a segment titled ‘British Paramedic Journal ‘Golden Nuggets;’ a 10 minute presentation of the main ‘golden nuggets’ of the research. Our paper was then selected as the winning one, with the prize being to attend the EMS World Expo conference in Nashville to do a repeat of the presentation.

I presented the paper at the EMS World Expo on 1st November 2018 in one of the International Scientific Symposium (ISS) sessions and a poster of the work was displayed for the duration of the conference. The ISS sessions showcased the most important EMS research from countries across the globe – speakers were present from the USA, Australia and New Zealand and Europe. The ISS sessions were made possible by the Pre-Hospital Care Research Forum (PCRF), based at the University of California, Los Angeles which aims to promote, educate and disseminate pre-hospital research. It appeared that pre-hospital research is still gaining ground in the USA and all the American colleagues I spoke to were very complimentary about, and in admiration of UK pre-hospital research. My presentation and poster were well received and prompted many questions. In discussion with colleagues from the USA and various other countries it appears mechanical compression devices are used on a fairly regular basis, although incorporated into their protocols in many different ways; for example some services use them routinely for cardiac arrests, others just when transporting a patient and others use it but only after all other interventions (defibrillation, airway management etc) have been completed. During the visit I also spent a few hours doing a ride-along with one of the Nashville ambulances and this variation in practice was also apparent there. The practice within each state, and even each region within a state is set by each relevant medical director, meaning practice can change from one neighbouring region to the next. There are also multiple [at times in the hundreds] ambulance service providers within each state, again meaning can be wide variations in practice. Despite these differences, the cases I attended with the ambulance crew were surprisingly similar to the ones we attend in the UK (I was expecting to attend more traumatic injuries and time-critical calls). Their vehicles are very different, but some similarities in the equipment – this provider had Zoll defibrillators and used Toughbooks for their documentation. At the conference there was an extensive programme of presentations and sessions; around half a dozen parallel sessions on at a time. Most of the sessions I attended were about outcomes from cardiac arrest. Two systems (Rialto, California and Lawrence-Douglas County, Kansas) report marked increases in ROSC after implementing a toolbox of interventions. Some of these (use of an impedance threshold device and 30 degree head-up CPR) are gaining interest and momentum in the UK too so it will be interesting to see where these interventions lead. During the session I presented in, a colleague from Copenhagen spoke about his work using Artificial Intelligence to detect cardiac arrests at the point of the call. In preliminary work 107 more cardiac arrests were detected by this system rather than by a person, with the call-takers finding this an added benefit and supportive safety net, suggesting gains into cardiac arrest outcomes can be found across the whole chain of survival.

I thoroughly enjoyed the whole experience of this conference and so give huge thanks to the British Paramedic Journal and College of Paramedics for the opportunity and to David Page at the PCRF for the invitation.
1. What has been your career pathway that has led you to this role?

My career in the NHS started in 1997 when I became a member of what was then the Royal Berkshire Ambulance Service, now South Central Ambulance Service NHS Foundation Trust (SCAS). I qualified as a paramedic in 2000 and worked as an assessor and operational clinical supervisor. In 2007 I successfully applied for the team leader role for the newly commissioned Hampshire and Isle of Wight Air Ambulance based at Thruxton aerodrome in Hampshire.

Part of my Team Leader duties was to liaise with other emergency service partners, which included the Search and Rescue (SAR) Coastguard helicopter based in Hampshire. It was during this liaison that I became interested in a potential future career as a winchman-paramedic. I made this transition in 2014, having successfully passed the winchman selection process. The winchman training programme provides survival skills alongside short-term air supply drills, dunker tank scenarios, firefighting training, helicopter awareness and winchman core skills. SAR aircrew must be multifunctional, with skills in radio operation, navigation and flight systems such as forward facing infrared camera operation and all-weather competencies etc.

As part of a SAR team I had to adapt my paramedic ethos and was given a new approach to patient handling. Aircraft safety is of the utmost priority and each job will have its own fuel and location dependent timescale for the rescue phase, this can lead to on-scene time constraints. It is vital that the patient is packaged as quickly as possible and transferred onto the aircraft, where further assessment and treatment can be made.

My first operational post as a fully trained winchman-paramedic was in Dorset, but due to government restructuring the base closed in June 2017. This led to a very exciting opportunity to work abroad, something I have always aspired to do.

I have now been working overseas in Brunei for a year and have added responsibilities as the Unit Medical Trainer. I am working to help improve clinical governance and aspects of paramedic training within the unit, with emphasis on training in the classroom and aircraft environments.

2. What do I like most about my role?

It would have to be the adrenaline rush I get from winching, then the added rush from being able to help people, and to be paid for doing both these things. Working in Brunei has given me the chance to see how other countries and cultures deliver health care in the work environment and public domain, especially pre-hospital care pathways. I am part of a multi-cultural workforce in a diverse part of the world. There are opportunities to enhance my aircrewman career further and Brunei offers a very healthy work-life balance.

3. What do I like least about my role?

Living a long way from family and friends.

4. What skills do I think are important to my role?

It’s important to be flexible and resourceful and have the ability to fluidly focus on different roles in quick succession. I have deployed to several incidents as a solo paramedic in remote locations and have quickly found that providing enhanced care singlehanded requires the skills to switch from being an air crewman, to rescuer, to paramedic, in quick succession.

5. What are the biggest challenges facing paramedics today?

In the UK, with an ever-increasing elderly population, paramedics have to know about and be able to implement different pathways, often involving multi-disciplinary teams, which can be very time consuming in a job that is already time-pressured and at capacity. The scope of knowledge now required to be able to perform as a paramedic has increased considerably since I joined back in 1997, this is a testimony to our development and profession, but it is important that all paramedics are equipped to deal with such a vast range of scenarios.

6. What is your one most important benefit of being a member of the College of Paramedics and why?

For me, the opportunity to engage in the CPD online lectures and presentations which helps keep my skills and knowledge current. HCPC registration and education are a key aspect in my job role working overseas and the CPD HUB on the College of Paramedics website is a beneficial tool for CPD engagement and supportive evidence for my CPD log.

7. How would you like to see the College develop over the next five years?

Reflecting on the current paramedic retention rates in the UK, I would like to see the College become more involved in offering different training courses for upskilling or side-stepping in an ever-expanding role. I would like to think the College could become a hub for job opportunities around the world, which could help towards making our career one that is chosen for a lifetime.
Organised by Georgette Eaton MCPara, South Central regional Trustee, and Justin Orme MCPara, Ambulance Service Educator from the Isle of Wight Ambulance Service, the first College of Paramedics CPD event was hosted on the Isle of Wight at the start of this year. Together with clinical educators from South Central Ambulance Service and Oxford Brookes University, the four agencies worked together to create a fantastic event.

A blend of theoretical and practical sessions were led by Mark Ainsworth-Smith (MaS) and Paul Grant from South Central Ambulance Service (SCAS) and Nick Groom MCPara from Oxford Brookes University. Starting off, MaS delivered a session discussing the changes in trauma care since the introduction of trauma networks and the positive impact this has had on outcomes for patients. This was followed with several updates on paramedic practice based on best evidence such as the positive impact of early administration of tranexamic acid, updating the assessment of patients with neck injuries and the evidence behind ‘silver trauma’ from studies of the TARN (trauma audit research network) data.

This led onto Paul’s session around completing a detailed patient assessment; leading into a discussion about the specific equipment available to manage catastrophic haemorrhages, including evidence supporting their use, application and potential devices coming to paramedic practice in the future.

After a break the group split into two practical sessions with Paul demonstrating the indications and correct use of tourniquets, haemorrhage dressings and haemostatic agents. While Nick demonstrated a respiratory assessment and needle decompression, concluding with the groups merging and practicing the application of a pelvic splint.

Before the ferry home the team was able to accomplish their final goal, finding ice creams at -2°C! This event received very positive feedback and Georgette is incredibly grateful to MaS, Paul and Nick for running the event, and the whole team are very grateful for the Isle of Wight for welcoming the College and hosting the event.

More CPD events are planned for this year across the South Central region (including the Isle of Wight).

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