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Welcome to Paramedic Insight

This will be the last article I write for the newsletter as Chief Executive of the College of Paramedics. My five years as Chief Executive have been hugely interesting, exciting, and very rewarding. As an organisation, the College looks quite different to when the immediate past Chair, Professor Malcolm Woollard, invited me to meet with the Executive to be interviewed for the position.

Among others, Malcolm Woollard, the late Roland Furber (inaugural Chief Executive), and Bob Fellows (a previous and long-serving Chair) had all worked tirelessly since the formation of the British Paramedic Association through its transition to the College of Paramedics to establish a professional body capable of effectively representing the paramedic profession in the UK.

Since then, I have had the great pleasure of working with the current Chair, Professor Andy Newton, the members of the Executive team and Governing Council, and the administrative staff to develop and grow the organisation further. In those five years we have seen an increase of membership in combined categories from around 1,000 to 7,500 and importantly the percentage of full members has grown from 10 to 25 percent of the paramedics registered with the HCPC.

The innovate thinking and commitment of Executive and Council members has provided the membership with access to a range of benefits including CPD events, guidance on research activities and insurance packages to name a few. The wider and strategic benefits of having an effective professional body have included representation on national bodies, presence and input at significant events, the establishment and updating of curricula guidance and career and competencies frameworks, responses to consultations and important contributions such as the Paramedic Evidence-based Education Project (PEEP) and the paramedic independent prescribing project. All of these have gone a long way to ensuring the College is increasingly seen as the primary and authoritative point of reference for the views and formal positions of the paramedic profession.

But the profession still has some way to go and a large factor in how it gets there and how quickly will depend on continuing to grow and increase membership. When the College speaks, there should be no doubt whatsoever, that it is speaking on behalf of the whole of the paramedic profession in the UK.

I would like to thank all those I have worked with including past and present Council members many of whom have given enormous amounts of their own time and effort. But the profession still has some way to go and a large factor in how it gets there and how quickly will depend on continuing to grow and increase membership. When the College speaks, there should be no doubt whatsoever, that it is speaking on behalf of the whole of the paramedic profession in the UK.

I have every confidence that the College will continue to prosper under the guidance of Gerry Egan who has been appointed as Chief Executive until a permanent full-time appointment is made next year and I have absolutely no doubt that the College will reach the goals it has set in its strategic plan. My very best wishes to all members for the future development and success of the paramedic profession.

Dave Hodge
Chief Executive
In this edition we review the Wales region’s latest event, titled ‘Midwives and Mannequins’, which took place on 11th May at The University of South Wales (USW).

The day focused on ‘Emergency Maternity Care’ in the community for paramedics and was led by Midwife lecturers from the University and covered everything from the basic pre-hospital practice through to maternity emergencies.

Delegates were asked what they would like to achieve throughout the day. Due to ‘de-skilling’ from lack of on the road exposure, delegates were keen to refresh on ‘normal’ delivery skills and not just concentrate on complications. One fear raised after a day of maternity CPD, was that ‘we would be expected to know everything’. The lecturers reassured us throughout the day that while our skills, equipment and drugs are limited and that the best place for a complicated birth is no doubt in hospital, after the CPD event they hoped we would have more confidence when attending births in the community as well as recognising and managing complications within our scope of practice.

Classroom based lectures got the day off to a start with examples of some key learning points below:

- **Law:** we learnt the mother has the right to give birth wherever they choose despite the risks and the opinions of health care professionals and that the fetus has no legal rights until birth.
- **Common maternity related 999 calls:**
  - labour
  - hemorrhage
  - abdominal pain
  - eclampsia
  - cord prolapse
  - transfers
- **LEADING CAUSE OF MATERNAL DEATH IS SEPSIS!!!**

Lecturers acted out a home birth scenario, prompting discussion on not only the medical aspect of birth, but also other considerations such as confidentiality, managing relatives and ethical factors. One common question frequently raised by paramedics when attending a ‘normal’ birth is; “when do I cut the cord?” The general message given was; “follow your guidelines and stop stressing” we should concentrate much more on keeping the baby WARM and stop worrying about cord cutting!

The University has a dedicated midwifery teaching facility complete with Clinical Simulation Centre; including birthing simulators and an ambulance. Practical sessions during the day received very good feedback due to the advanced simulation equipment allowing delegates to have ‘hands on’ experience of dealing with situations such as breech births and shoulder dystocia.

Constructive suggestions for future CPD days at USW were encouraged. Suggestions made included: more practical stations and more time on pregnancy complications i.e. miscarriage, eclampsia etc. The College of Paramedics is planning to hold future CPD events at USW which I have no doubt will be equally as well supported, especially following such positive feedback.

If you would like to help support your regional council member with organising CPD in your region, please do not hesitate to get in touch. Ian Purchase, Marketing Manager, ian.purchase@collegeofparamedics.co.uk
The concept of Trauma: Who Comes? is based on a review of pre-hospital trauma management focused on data from the North East since the NCEPOD report ‘Trauma: Who Cares?’ [2007] and the NAO report ‘Major Trauma in England’ [2010]. Both of these reports detailed a number of areas where care could be improved in the pre hospital phase and highlighted the need for more advanced airway management to be available for critically injured patients.

One of the key findings of ‘Major Trauma in England’ was the ‘unacceptable variation’ seen in the hospital phase of major trauma management. The level of care was generally found to be higher when consultants were available and so with the advent of centralised, specialised ‘Major Trauma Centres’ we are seeing consultant-led care delivered all hours on all days. The ambulance services across the UK have undergone huge change during the 8 years since ‘Trauma: Who Cares?’ One such line roles that have been developed and area of change has been the number of front-line roles that have been developed and utilised; from Emergency Care Technicians, Emergency Care Support Workers and Urgent Care Assistants to the use of Voluntary Agencies and the private sector. (This infers an increasingly diverse range of clinical skill sets and experience now responding to major trauma, potentially without any paramedic input). As one of the most senior pre-hospital roles paramedics should be deployed to all critical patients but due to ever increasing pressure on ambulance services nationally there are occasions where a paramedic simply will not be available.

Basic research found that although the North East Ambulance Service did get a paramedic to most incidents of major trauma [fig 1] by reviewing the current skill set of UK paramedics it was found that there are a number of reversible pathologies that cannot currently be appropriately managed – agitated head injuries, hypovolaemic instability, tension pneumothoraces and this is compounded by the very low incidence of critically ill/injured patients encountered by road crews. Ironically those patients that are the most injured are the ones that morphine is contra-indicated due to lower GCS and/or hypotension. A recommendation is made for each Ambulance Service to have access to a well governed HEMS team based on the physician/paramedic model. Conceptually we can apply a multidisciplinary approach to these critical patients with road crews undertaking the ‘initial actions’ of scene management, extrication, haemorrhage control, oxygenation, IV/IO access and some patient ‘packaging’ to then be followed by ‘critical interventions’ delivered by the HEMS team such as blood transfusion, RSI and any surgical interventions.

Timeframes for both urban and rural incidents (fig 2 and 3) were then mapped out based on average scene and transport times to illustrate how much earlier the patient receives these critical interventions when HEMS is deployed to these incidents. The red arrows indicate the time at which the patient receives these interventions. This shows the benefit of road and HEMS crews working together with clearly defined roles to deliver two phases of pre-hospital care to the most sick of patients.

As hospitals have developed MTCs to centralise skill and experience so HEMS teams should be regarded in the same way. The HEMS skill set is very much about critical care and by virtue of helicopter transport these teams can provide a regional response covering larger areas thereby increasing exposure and experience to critically ill/injured patients. Due to the higher frequency of major trauma that HEMS teams respond to they are able to improve the care they deliver through robust clinical governance, development of S.O.Ps, thorough debriefing and patient follow ups.

The scope and boundaries of paramedic practice is continuing to expand and paramedics will always be at the forefront of pre-hospital care. Currently however there remains a need for physician/paramedic teams to work in partnership with other crews to deliver timely interventions that can reverse some of the rapidly fatal pathologies that result in death or life-changing injuries.

**FIG 1**

**FIG 2**

**FIG 3**


1. When did your career in the ambulance service begin and what have been the most significant development steps on the journey to your present position?

I began my career in 1987 with the Patient Transport Service in Essex, where I gained valuable experience in caring for and communicating with patients. I qualified as a Technician and then Paramedic and worked on double crewed ambulances as well as a response car. In 1996 I was awarded a Master of Business Administration which assisted in taking my career to the next level. It helped me to achieve my first senior role as Director of Accident and Emergency Operations in Lancashire Ambulance Service.

Over the next few years I continued with my studies and gained an MSc in Strategic Leadership, and also worked as the Director of Operations for Greater Manchester Ambulance Service, which finally led me to my goal of being Chief Ambulance Officer in Essex, where I achieved a 3 star rating for the Trust. My experience as an Operational Paramedic and Manager, combined with my university studies led me to be able to lead a major transformation project in the West Midlands Ambulance Service as well as lead the AACE as Chair and advise nationally on Ambulance Service matters.

The CQC has begun to inspect Ambulance Services nationally. We all need to work hard to ensure that the highest ratings are achieved, which reflect the professionalism of our staff and the quality of care delivered.

The UK currently has a significant terrorist threat. The Ambulance Service needs to continue to be ready to respond to this. The continued development and training of our HART, SORT and Commanders is essential in delivering a safe and robust response to any such incident that also protects our staff.

We also need to do more to support staff who are busier than ever before, helping more patients and saving more lives often in difficult and challenging circumstances.

3. What is your vision for the NHS ambulance services?

I would like NHS Ambulance Services to set the example to other NHS organisations in terms of delivery of outstanding patient care, efficiency and good quality leadership. This country’s Ambulance Services should be seen as world class and lead other countries to adopt our best practice.

Ambulance front-line operations have always been supplied 7 days a week. I want to see all key departments working 7 days a week, in order to support front line operations and ensure that patients receive the same, high quality service, no matter what day of the week.

I want to see a paramedic on every NHS emergency ambulance and rapid response car. There is also a strong case for advanced trained paramedics to be based on response cars to treat more patients at home, thus reducing conveyance rates and specialist paramedics trained in critical care to save more lives of seriously injured patients. Alongside this, I would like all of our ambulances and response cars to be less than 5 years old.

NHS Ambulance Services have the potential to do so much more than respond to 999 emergencies. I would like to see NHS Ambulance Services being the biggest provider of out of hours and NHS 111 services. I would like to see us providing primary care services, such as community nurses, staff walk in centres, minor injury units etc.

Many hospitals have chosen to award their patient transport contracts to the private ambulance sector. I want to see the NHS ambulance services winning back these contracts. We can absolutely provide the best patient care and service for the hospital at a cost effective overall price.
4. How do you see the NHS ambulance services in particular and the wider NHS in general contributing to the development of the paramedic profession?

The Ambulance Service has come a long way in a relatively short period of time. It’s not that long ago that emergency ambulance staff would hold the ‘Miller Badge’ qualification. From that grounding we now have paramedics, whom year on year are able to perform new procedures and administer new drugs many of which were only previously provided in hospital.

We have only just started to scratch the surface when it comes to development for paramedics. Experienced staff rightly want to increase their clinical skills. NHS Ambulance Services need to seriously look at roles for primary care and critical care paramedics. I mentioned earlier that Ambulance Services could provide primary care and staff walk in centres etc, we will need to create specialist and advanced practitioners to staff these. This will be done with ambulance services working in conjunction with other NHS organisations and other partners.

5. What do you see as the most important areas in which the NHS ambulance services and the College should work together?

It is absolutely vital that the College of Paramedics and NHS ambulance services continue to work together to further improve patient care and safety by improving training, support, developing new equipment and enhancing clinical skills. I, like the College, am passionate about the paramedic profession and wish to see us amongst the most well respected of clinicians.

Subscribing members may claim tax relief on subscriptions paid to the College. There are three different ways of claiming tax relief on your membership fees.

1. If you complete a self-assessment tax return, you can claim tax relief from your registration fees on the employment page of the return.

2. If you do not file a tax return, you can claim tax relief using form P87: Tax relief for expenses of employment, available to download from the HMRC website.


3. You can telephone HMRC and ask for relief on your fees. Contact details can be found on the HMRC website.

https://www.gov.uk/government/organisations/hm-revenue-customs/contact

See the HMRC website for further details, including allowable expenses, eligibility and claiming back tax for past years.

https://www.gov.uk/tax-relief-for-employees/how-to-claim
Council Elections
The results of the 2015 elections for Council Representatives on to the College’s Council were announced at the AGM on 19th June, the complete list is shown below (* denotes elected or re-elected in 2015).

<table>
<thead>
<tr>
<th>National or regional area</th>
<th>Council Member</th>
<th>Council Alternate(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Ireland</td>
<td>Andy McFarlane</td>
<td>Ciaran McKenna</td>
</tr>
<tr>
<td>Scotland</td>
<td>Dahrlene Tough*</td>
<td>Isobel Donaldson*</td>
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<td></td>
<td></td>
<td>Neil Sinclair*</td>
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<tr>
<td>Wales</td>
<td>Andy Jones*</td>
<td>Alison Woodyatt*</td>
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<td>Ross Whitehead*</td>
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<tr>
<td>North East</td>
<td>Dan Haworth*</td>
<td>vacant</td>
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<tr>
<td>North West</td>
<td>Chris Veevers*</td>
<td>Glenny Harley</td>
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<tr>
<td>Yorkshire</td>
<td>Liz Harris</td>
<td>Shaun Knott</td>
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<tr>
<td>East Midlands</td>
<td>Dave Saxby*</td>
<td>Steve Porter</td>
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<tr>
<td>West Midlands</td>
<td>Andrew Rosser*</td>
<td>Simon Greenfield</td>
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<tr>
<td>East of England</td>
<td>Tracy Nicholls</td>
<td>Graham Clark*</td>
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<tr>
<td>South Central</td>
<td>Ursula Rolfe</td>
<td>Els Freshwater*</td>
</tr>
<tr>
<td>London</td>
<td>William Broughton*</td>
<td>Jonathan Street*</td>
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<tr>
<td>South East Coast</td>
<td>Florian Breitenbach</td>
<td>Michael Fletcher*</td>
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<tr>
<td>Great Western</td>
<td>Jim Petter</td>
<td>William Lee*</td>
</tr>
<tr>
<td>South West</td>
<td>Kris Lethbridge*</td>
<td>Richard Steggall</td>
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<tr>
<td>Independent</td>
<td>David Reed</td>
<td>Vacant</td>
</tr>
<tr>
<td>Military</td>
<td>Kevin Swift</td>
<td>Andy Smith*</td>
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<tr>
<td></td>
<td></td>
<td>Vacant</td>
</tr>
<tr>
<td>Student</td>
<td>Michael Stevens*</td>
<td>Kate Jackson</td>
</tr>
</tbody>
</table>

Graham Harris MSc. BSc. PGCE. Advanced BTEC. Chartered MCIPD. FCPa.
Graham has a total of 43 years expertise in pre and out-of-hospital care in the clinical, education, management and research pathways, of which 25 have been as a paramedic. He has taught paramedics over the past three decades, with 12 of these years teaching paramedic science in higher education.

Graham passionately believes in the development of the paramedic profession through higher education and continuing professional development. He holds an Executive position as the College of Paramedics Director of Professional Standards, and is the College representative on the Health Education England Allied Health Professionals Advisory Group. He is also a Partner Visitor with the Health and Care Professions Council (HCPC). His experience of curriculum development for paramedic educational provision includes the development of the College of Paramedics’ Paramedic Curriculum Guidance 3rd edition and 3rd edition (Revised), the College of Paramedics’ Paramedic Post Registration – Career Framework. He is also currently Chair of the Post Graduate Curriculum Guidance Group developing the education standards for specialist and advanced paramedics. During the past six years as a Senior Lecturer Programme Leader/Professional Lead in Higher Education he successfully oversaw the review of the FdSc Paramedic Science programme and the development of three Bsc (Hons) Paramedic Science programmes, two at pre-registration and one post-registration, plus the development of continuing professional development modules related to paramedic practice.

Liam receives Carol Furber Award
Liam Hamilton won the Carol Furber Award for his case study ‘Hide and Seek with Sepsis.’ Liam’s name will be inscribed on the Award, which is a silver plate, and he receives £50 of book tokens from the College, in partnership with corporate partner, Class Professional Publishing.

The Carol Furber Award was formally established by Council in late 2009 in memory of Carol’s significant contribution to the College of Paramedics. Entrants were invited to submit an original case study in no more than 1000 words.

Speaking about the winning entry, Lizi Hickson, Chair of the Education Advisory Committee said: “Liam contributed a very interesting reflection. He considered many salient issues which focused on his patient and how she was presenting. He engaged with relevant theory and showed throughout his work how he was working through an evidence based approach. The marking team all enjoyed reading his work and congratulate him on his award. Hopefully we will see further contributions from him in the near future.”

An extract of Liam’s case study can be found on the opposite page.
Sepsis causes around 37,000 UK deaths costing the NHS £2.5 billion annually [UK Sepsis Trust, 2015; Daniels, 2012 cited by Hilditch, 2015]. This case study discusses a pre-hospital, atypical case of sepsis.

We were dispatched to a 61 year old lady who was C/O abdominal pain. It was discovered that the patient was receiving radiotherapy treatment for oesophageal cancer. Her past medical history included hemiplegia, COPD, diabetes and recent recovery from a chest infection. She presented as alert, perfused and communicating in full sentences. Further history identified the patient had not eaten or drunk adequately due to a sore throat and had not opened her bowels for a week.

On examination, her respiratory rate was 16, oxygen saturations 92%, radial pulse 91 and regular; blood pressure 143/89mmHg, temperature 36.9°C, pain score 9/10, and glucose levels 10.3mmol/l. Auscultation showed bilateral reduced breath sounds and she had a soft abdomen with diffused abdominal pain. Care notes showed similar observations over the previous 4 days. Pain relief was refused due to needle phobia and sore throat. En-route to hospital she became restless with increasing abdominal pain. Oxygen saturations reduced and oxygen therapy was administered but had little effect due to poor patient compliance. Tachypnoea with a shallow respiratory effort developed. She was re-triaged and taken to hospital as a priority where she was diagnosed with severe sepsis.

Sepsis is an inflammatory response to infection that has gone into overdrive and can no longer be controlled by the body. Untreated, the disease can cause multi organ failure and death [Marieb et al, 2007]. Sepsis can be grouped into sepsis, severe sepsis and septic shock [UKST, 2015]. UK Sepsis Trust [2015] has a ‘Prehospital Sepsis Screening and Action Tool’ [UKST, 2015] to guide clinicians. This toolkit can diagnose sepsis using the systemic inflammatory response [SIRS] criteria (temperature >38.3°C or <36°C; respiratory rate >20 per minute; heart rate >90 per minute; acute confusion/reduced LOC; glucose >7.7mmol/1 unless already diagnosis diabetes mellitus) and possible routes of infection (pneumonia; UTI; Abdominal pain; meningitis; cellulitis, septic arthritis, infected wound). SIRS is a universally accepted set of clinical indicators that indicate an inflammatory response has occurred. If two SIRS criteria are present with a route of infection, sepsis can be diagnosed and treatment commenced. Untreated, sepsis can develop into severe sepsis (defined by the presence of one end organ dysfunction) or full septic shock (treatment is unresponsive to fluid therapy). The Joint Royal Ambulance Liaison Committee (JRCALC, 2013) state sepsis should be considered in patients who have a history of infection, a systolic blood pressure below 90mmHg and tachypnoea. JRCALC [2013] list clinical criteria as temperature >36°C or above >38°C; tachycardia; altered mental status; mottled skin; and prolonged capillary refill (>2seconds).

One clinical sign that could potentially indicate sepsis was her heart rate of 91 [UKST, 2015]. The fact she had diabetes ruled out the high blood sugar as one of the SIRS indicators. This meant the patient did not meet two or more of the SIRS criteria indicating sepsis [UKST, 2015]. Sepsis was considered and discussed but a diagnosis not made for the aforementioned reasons. Evidence suggesting using SIRS criteria to initiate sepsis screening can fail in certain patient groups. Kaukonen [2015] shows one in eight patients can be missed. En-route, she was reassessed as her changing condition was evident. She was SIRS positive with two or more of the criteria (tachycardia and tachypnoea), a route of infection [chest infection/abdominal pain] and a ‘red flag’ [oxygen saturation <91%]. The ‘Prehospital Sepsis Screening and Action Tool’ [UKST, 2015] lists red flags indicating a time critical patient [SBP <90mmHg; lactate >2 mmol/l; heart rate >130/min; respiratory rate >25/min; oxygen saturations <91%; responds only to voice/pain/unresponsive; purpuric rash]. If any red flags are present then resuscitation is indicated, including 250mls boluses of intravenous (IV) crystalloid fluids (max 2000mls), oxygen 15L/min non-rebreathing (NRB) mask [British Thoracic Society, 2008], IV antibiotics (if available), and record lactate (if available). The patient was given 15L/min NRB but refused IV access meaning no fluids were administered. Currently, appropriate IV antibiotics and recording a lactate is not available within the local ambulance service.

NHS Trust, despite the potential benefit identified in other pre-hospital trusts [Kirby, K. 2013]. It should be noted that this patient would not have met the JRCALC [2013] sepsis criteria for treatment.

Consideration was given to her cancer treatment and the risks of neutropenic sepsis. She received radiotherapy and not chemotherapy. In rare occasions, radiotherapy can make patients susceptible to neutropenic sepsis, but usually when large amounts of bone marrow have been targeted [Simon et al, 2014]. Had this information been known at the time, we may have had a higher level of suspicion. Due to not receiving chemotherapy [the most common cause for neutropenic sepsis] it was deemed unlikely to be a factor. Barrett et al [2010] highlights an increased awareness towards chemotherapy patients and neutropenic sepsis, but does not mention radiotherapy, further indicating the lack of awareness of the part it plays in the condition.

This case study highlights the need for an increased awareness of all contributing factors when considering sepsis. Using robust prehospital assessment tools to triage sepsis will increase awareness, education, and confidence in treating the disease. Introduction of lactate screening tools and appropriate antibiotics in all ambulance service NHS Trusts may increase this further. Paramedics have the ability to identify patients with sepsis or patients at risk and treat and triage them appropriately.

REFERENCES:
Mystical. Spiritual. Breath-taking scenery. Full of culture and vibrant. Just a few of the words to describe the landlocked country with China to the North and India to the South; home of the highest mountain in the world and the land of the Gurkha. Nepal. And it is where on 25th April 2015, an earthquake measuring 7.8M occurred approximately 80km northwest of the capital Kathmandu. Within a few short minutes the Global Disaster Alert and Coordination System (GDACS) issued a “Red” alert meaning that due to the depth, magnitude and vulnerability of the population a high humanitarian impact would possibly occur. Reports soon came in of heavy damage to roads and buildings and multiple casualties and it quickly became apparent that the hospitals were struggling to cope, and with the multitude of aftershocks and damage to the roads delaying search and rescue operations, the Nepalese government put in a call for international assistance.

The first day was spent at Humanity First HQ in London where all the team got together, equipment sorted and a full briefing was held. The team was made up of twelve people including surgeons, a GP, A&E consultant, paramedics, a firefighter, pharmacist and a logistics support member. We set off to Heathrow, our spirits high, confident and hopeful that we would be able to do all that we could for the people of Nepal.

Twelve hours later, we were in Kathmandu and registered with the government as a UK Foreign Medical Team (FMT). We were given accommodation on the outskirts of the city, a local family providing us with a roof over our heads while we checked equipment and gained as much information as possible about the country, infrastructure and casualties. It’s important to note that in a disaster a foreign team can’t just “turn up”. The affected country has to ask for help and once there it isn’t just a case of picking where you want to go, go there and get on with your job. If only it was that simple. Time was spent form filling, registering with the Health Ministry and attending meetings (hosted by various United Nations departments and the World Health Organisation).

A walk around Kathmandu was eye opening. A city full of history and culture where the force of nature had shown no mercy and did not discriminate. Ancient temples and modern buildings destroyed, people sleeping in open spaces, scared of going inside in case there were further aftershocks, buildings cordoned off in case of further collapse, the smell of funeral pyres where the mass cremation of those killed had taken place. Yet everyday life went on, people going about their business in the markets and tourist areas selling trinkets. All of this was mixed in with groups of police and soldiers searching buildings and clearing debris, dust filling the air. Seeing all of this was sobering. The myriad of thoughts filling my mind of what we would encounter over the next few days.

Within a couple of days we were on a hired bus, the roof loaded with our medical kit, tents and supplies heading into the province of Gorkha at the request of the Health Ministry, close to the epicentre. After a few hours travelling along winding roads we reached the town of Gorkha where we went to the local hospital. A Swiss Red Cross team were already at the hospital working closely with the staff. The hospital was well maintained, staffed and with a steady flow of patients all appeared in good order. After a few discussions it was decided to carry on deeper into the province, higher into the mountains to a village called Badasse. We had no idea what we would find but reports stated that there was significant damage, that a high number of casualties were likely and that so far, no medical teams had yet reached the area. This was the place to get to. However getting there was the issue. The tarmac had run out in Gorkha. We were faced with dirt track roads barely wide enough for a single vehicle, rutted, rocky and crumbling. The only way to get there was by a mountain bus in a treacherous three hour journey.

My Nepal Earthquake Experience

Member Simon Greenfield gives his insight into the Nepal Earthquake relief efforts he experienced with Humanity First Medical.
The hazards to the team were high. Aftershocks, landslides, poorly maintained vehicles and the risk of an accident were to name just a few. But the benefits far outweighed the risks. We were there to do a job and we intended to get on with it.

When we arrived at Badasse we were met by some villagers and a small unit from the Nepalese army who were helping to clear damaged buildings. The school had been damaged and many of the houses had been destroyed. We were told that those that had been injured had already been cared for by the locals or had been taken by their families to the hospital in Gorkha. However, it was possible that there was a need for medical assistance in the area. As time was getting on and the sun was setting we decided to make camp for our first night under canvas, the first of many.

Word had spread throughout the area that a medical team had arrived and early the next morning we were met by a small group of villagers requiring medical assistance. This group steadily grew and it quickly became apparent that we would be doing what we came to do. We built our medical centre with tarpaulins, para-cord and bamboo sticks with the help of the locals and the army, and by lunchtime over a hundred people with a whole host of injuries and illnesses were waiting patiently to be seen; young babies and the elderly, mobile and infirm, male and female. Our makeshift medical centre had a reception and seating area, triage and basic assessment, pharmacy, consultation and a majors area with full resuscitation facilities. On that hillside deep in Nepal, we were providing an A&E department with a full scope of medical care to people who had been subjected to one of the Earth’s most powerful and destructive events.

By the end of that first day there was a quiet sense of achievement and comfort knowing that we had given help, support and treatment to well over one hundred people. Some of the patients told us that medical aid was still needed further on.

The next few days were physically and mentally challenging. Ninety degree heat, humidity, a hole in the ground as a toilet, dodgy bellies and a tap to wash under were minor discomforts compared to what the Nepalese had been through, and given that on that hillside we had provided care to over a thousand people we didn’t mind the discomforts. The majority of patients presented with medical problems such as respiratory and mental health. People were scared about further quakes and many didn’t know what had happened to their families. There were traumatic injuries, infected wounds and dental problems. Whatever the injury or illness, concern or anxiety, we did all that we could. IV fluids and pain relief or simply holding a hand, we gave what was needed. The strength and resilience of the people was humbling. They walked through the mountains overnight for many miles or were carried on peoples’ backs or on makeshift stretchers to reach us. No one complained, no one pushed or shoved. They waited patiently to be seen and gave their thanks when they left.

Why did I do it? We are lucky in this country. We have the resources, knowledge and expertise. We have a health care and welfare system. We have a special number that anyone can call at any time in times of distress in the knowledge that someone will come to help. And we have our families who support us on every step when we go into the unknown. Our families will always have that help and support when needed. Many countries, for whatever reason don’t have that due to politics, economy or geography. Would I do it again? Try and stop me.

About Simon

Simon has spent the last nineteen years in the ambulance service before training to become a Specialist Paramedic (Primary Care). In 2008 he joined the Hazardous Area Response Team with the newly amalgamated West Midlands Ambulance Service which is where he has been ever since. He joined Humanity First Medical in 2010 after seeing their report about the Haiti earthquake. He is now part of the faculty and has been involved in a development project in The Gambia before deploying to Nepal in April 2015. www.uk.humanityfirst.org
On the 28th May 2015, the College of Paramedics held its first national research conference. This event sold out in advance and 106 delegates attended on the day.

The conference was designed to offer a platform for discussion of contemporary issues related to the development, funding and undertaking of research relevant to the paramedic profession. It was intended to increase networking between research interested paramedics, other ambulance staff and different healthcare professionals no matter whether they are novice or expert – or somewhere in-between.

The programme included both invited speakers who explored challenges to paramedic research, and paramedics presenting about their own individual research studies. The latter were selected through open competition via abstract submission and included a wide range of topics including paramedic practitioners and non-medical prescribing; the patient’s wishes in decision making approaching their end of life; accuracy of pre-hospital sepsis recognition; recognising and responding to dementia; paramedic professionalism; airway management in cardiac arrest; and critical care paramedics’ psychological wellbeing.

It was the first time that a College of Paramedics’ conference had invited paramedics to submit abstracts for consideration for an oral presentation, and this certainly worked well and we intend to expand on this practice in the future. The quality of the presentations was fantastic and it was tremendously exciting to hear about the variety of research that is being undertaken within ambulance services across the UK.

Although everyone should be congratulated for the standard of their presentations, a panel of judges identified three presentations to be awarded prizes:

Graham McClelland presenting: A pilot study exploring the accuracy of pre-hospital sepsis recognition in the North East Ambulance Service

Tim Edwards presenting: The AMICABLE study – Airway Management in Cardiac Arrest – Basic, Laryngeal mask, Endotracheal intubation

Emma Relf presenting: An exploration of the effects that frequent exposure to life-threatening events may have on a Critical Care Paramedic’s psychological wellbeing?

In addition there were poster presentations relating to current paramedic research. Delegates who attended the conference were asked to vote for the best poster and this prize was awarded to Els Freshwater for her work on Enhancing pre-hospital triage of potential major trauma patients with the use of smartphone technology. Again, all the posters added to the success of this research event enabling delegates to find out more about current research relating to ambulance staff and services in the UK.

An additional activity that added another dimension to our conference was the first meeting of post-graduate research students which was facilitated by Els Freshwater and supported by Ursula Rolfe. The idea here was to improve networking for ambulance staff undertaking post graduate research programmes and the group have come up with several suggestions which are being explored – so please look out for news of further developments in relation to this in the near future.

In summary the research conference was extremely successful providing an opportunity for people to come together to learn more about opportunities within paramedic research, and to hear about current paramedic research in the UK.

Special thanks should be given to all the presenters and poster owners for their submissions, the working party who have worked really hard to make this conference a reality, and of course to all the delegates who attended.

The feedback has been so positive that preparations are already underway for a repeat event in 2016 – there is so much more to come!
The Impact of Working Shifts: Exploring the views of UK paramedics

Authors: Kim Kirby
Research Paramedic, South Western
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Funded By: The College of Paramedics Small Grants Research Award

Abstract

Introduction

There is limited research within the UK investigating the effects of shiftwork on paramedics. Paramedics have relatively high rates of sickness levels and there are links between shiftwork and health. This study explores UK paramedics’ perceptions of the impact of working shifts.

Methods

Exploratory qualitative research was utilised to investigate the perceptions of UK paramedics on the impacts of working shifts. Two focus groups were completed involving 11 paramedics. The transcriptions were analysed using thematic analysis.

Results

Paramedics described factors associated with working shifts that mirror research already completed within different occupations: effects on physical health, fatigue, family life, safety and performance; but paramedics additionally described factors that are more limited to working in the paramedic profession such as a broader range of psychological stressors and organisational factors. Psychological health was a wider theme that went beyond shiftwork and encompassed the overall paramedic role and the unique and stressful nature of the work.

Conclusions

This research has allowed an insight into the perceived effects of shiftwork on UK paramedics and exposes the challenges paramedics face in their working environment. There is a suggested link between the relatively high rates of sickness and the effects of shiftwork and paramedics’ overall working environment. Further exploration and recognition of the effects of shiftwork on UK paramedics is recommended.

A Pilot Study into the sensitivity and specificity of pre-hospital sepsis screening in the North East – Final Report

Researchers: Graham McClelland [North East Ambulance Service], Jacqui Jones [South Tees NHS Hospitals Foundation Trust]

Research question: How sensitive and specific is the pre-hospital sepsis screening tool (SST) used by North East Ambulance Service NHS Foundation Trust (NEAS) for detecting severe sepsis?

Project aims: This project addressed the following aims:

1. Estimate the sensitivity of the SST for detecting severe sepsis
2. Estimate the specificity of the SST for detecting severe sepsis
3. Explore the effect of paramedic detection and treatment of severe sepsis
4. Inform the development of a larger, regional trial

We calculated the sensitivity and specificity of NEAS staff using the SST in practice which addressed aims 1 and 2. We changed the focus slightly as we realised that investigating the sensitivity and specificity of the SST was impractical in the sample we were able to collect. We also realised we were using the hospital SST as the gold standard to judge the pre-hospital SST against and as these are based on the same tool this would be meaningless. We documented the impact of NEAS detection of sepsis and NEAS pre-alerting for sepsis which addressed aim 3. Lessons have been learnt through the conduct of the project which can be used to continue this work on a larger scale which would address aim 4.

Results

The sample included 49 patients from January 2014. NEAS correctly identified 18/42 patients with sepsis (43% sensitivity, 14% specificity). NEAS correctly identified 8/27 patients with severe sepsis (30% sensitivity, 77% specificity). An issue was identified with the SST used in that NEAS staff don’t have access to lactate or white cell count which are both included in the tool. Many patients were identified as severe sepsis based on lactate measured at hospital.

Conclusions

It is evident that NEAS clinicians diagnose sepsis without consistently using the SST. Triggering symptoms for sepsis and severe sepsis are documented but sepsis is not being recognised or documented. Point-of-care lactate may improve identification of severe sepsis.

Outputs

The results of this project have been shared within NEAS and JCUH, submitted to the Journal of Paramedic Practice for publication and presented as a poster at the Sepsis Unplugged conference and as an oral presentation at Sepsis Unplugged and the College of Paramedics Research Conference.

Finances

Funded by the College of Paramedics’ Small Grants Research Award
The 1st June 2015 marked the start of the biennial event that affects every paramedic across the United Kingdom (UK), the Health and Care Professions Council (HCPC) renewal process. This is something that for many paramedics causes a certain degree of anticipation and trepidation and inevitably begs the question; ‘shall I get one envelope through the letterbox or two?’ We have all been part of the work-based discussion of who is within the 5% threshold and who has been picked for audit. While this is enough for any well mannered and best intentioned paramedic to be getting on with, this year there was something else to occupy our minds.

From the 1st April 2015 and for the first time, all registrants of the HCPC (excluding Social Workers) are now asked to confirm that:

- “You have a professional indemnity arrangement in place which provides appropriate cover; or
- If you are not practising at that time, you understand the requirement and will have an arrangement in place when you begin to practice.”

(HCPC, 2015)

The reason that this has come about is because in 2014 amendments were made to the Medical Act (1983) stipulating that all registrants (excluding Social Workers) must have a professional indemnity arrangement in place. The purpose of The Health Care and Associated Professions (Indemnity Arrangements) Order (2014) was to ensure that if any service user were brought to harm through the negligence of a registrant, they would have a method to recover compensation that they may be entitled to. These changes in legislation symbolises a significant shift in our obligations as healthcare professionals and how we view our duties towards our patients.

The HCPC make it very clear that you are personally responsible for meeting their standards for registration and therefore paramedics are now, as a result, responsible for ensuring that they have an appropriate indemnity arrangement in place. This unavoidably asks the question, what is appropriate? Ultimately it is up to the registrant to decide what is appropriate cover for them, taking into account the nature and extent of the risk involved within your scope of practice. There is however information and support out there to aid you in navigating this daunting maze of insurance terminology, policy and legislation.

Most paramedics in the UK will have some sort of medical professional liability and public liability insurance through their employer. If registrants are working within their scope of employment, their employer should have appropriate indemnity arrangements in place to cover both themselves and their employees. This is true of both employment through the National Health Service (NHS) and the private sector. While all NHS employers, such as Ambulance Service Trusts are ‘vicariously liable’ for the actions of their employees and any claims arising from their wrong-doing while working within their scope of employment and while at their place of work, it is strongly advised that you check with your employer that such indemnity is current for the work undertaken. This is especially true within the private sector.

The College of Paramedics as the professional body strongly believes that paramedics should be supported in all aspects of their practice. This is why the College undertook the task of forming a policy to work separately to any indemnity arrangements that are already in place through your main employment. From the 1st June 2015 all College of Paramedics Full members benefit from a new medical malpractice and public liability insurance policy included in their membership subscription fees, which provides cover for the following:

- Medical malpractice with public liability insurance
- Limit of £5 million per claim
- All private work included within the individual scope of practice, subject to annual earnings not exceeding £5,000 per annum
- Good Samaritan acts and voluntary work
- Teaching within the members’ individual scope of practice (including Paramedic Science and First Aid)
- Separate policies available to members requiring more individual cover.

The limit of £5m is also the total for all claims per member in any period of Insurance.

In addition to the policy that is now part of Full membership, members have the option to add additional cover to expand the scope of cover that has already been provided. This may for example be to extend the amount of paid private work beyond the £5,000 limit. We have also provided the option for our non-paramedic members to apply for quotes on medical malpractice indemnity cover through our insurance brokers; Graybrook. For both of these circumstances, simply visit www.graybrook.co.uk/paramedics and use the online application.
process for a quote. We believe that our members will benefit from receiving very competitive quotes thanks to the amount of cover that is already provided through Full membership.

I would finally like to thank all the individuals who have supported the rollout of this new membership benefit. Particularly to our Vice-Chair Paul Younger and all the team at Graybrook who have worked tirelessly to provide the very best product available. We will continue to review and will seek to provide new ways to support our members in the future.

More information is available via:
www.collegeofparamedics.co.uk/insurance.

Also further information regarding the HCPC renewal process can be accessed via:
www.hcpc-uk.org/registrants/indemnity.

References

Medical Act 1983. (c54). London: HMSO.

The Health Care and Associated Professions (Indemnity Arrangements) Order 2014. (c44). London: HMSO.

Sally Armond works full-time as a paramedic for North West Ambulance Service and is an active volunteer paramedic team member and Search Dog Handler for Ogwen Valley Mountain Rescue Team (OVMRT). The team's remit includes Search and Rescue (SAR) within a range of hazardous environments, including technical rope rescue on steep mountain crags, swift water rescue and terrain searches including coastal areas, forestry, moorland and mountain ridges. All OVMRT members, including 'Spin' the Search Dog, are helicopter winch trained and due to the local geography, they regularly work closely alongside SAR aircrews to facilitate the rapid location, access, treatment and evacuation of casualties in difficult to reach locations. The team also assist the Police, Welsh Ambulance Service and HM Coastguard by providing SAR expertise for complex incidents in urban and rural areas. All team members are experienced mountaineers who are on-call day and night, 365 days a year, in all weather conditions.

“We are one of the busiest Mountain Rescue Teams in the UK and consequently we have to be on top of our game when it comes to setting high standards for the delivery of patient care. We have three paramedics in the team who have each been issued with full paramedic equipment and drugs kits. It is essential therefore, that we are appropriately insured to work up to our full scope of practice.”

“Consequently, it was fantastic news to hear that the College of Paramedics full membership benefits now include £5 million professional indemnity insurance for paramedic volunteers including those involved in Mountain Rescue work. Full membership and insurance costs only £94.80 per annum (£790 per month), this is excellent value compared to the private broker premiums exceeding £500 per policy that we have previously been quoted. The added bonus of this new insurance policy is that it also provides me with cover for my part-time paid medical teaching work, as well as all of my voluntary work.”

“Since the launch of its indemnity cover for volunteers, the College of Paramedics has seen its membership grow significantly, reflecting the very real demand for reliable and affordable cover for the significant number of paramedics who provide a huge range of voluntary medical services outside of their day-to-day paid employment.”
Traumatic Cardiac Arrest – A contemporary approach for paramedics

Andy Thomas, Academic Research Fellow, (Paramedic), Department of Academic Emergency Medicine, James Cook University Hospital, summarises his presentation (of the same name as this article) from the 16th International Trauma Care Conference, which took place in Telford in April earlier this year.

Introduction

Major trauma is the leading cause of death in people under the age of 40 within the United Kingdom. This equates to approximately 5,400 deaths annually, of which 2,400 occur prior to hospital admission. This article aims to explore the management of this smaller group of OHCA with trauma aetiology from the presentation given during the paramedic programme at the 16th International Trauma Care UK conference in April 2015.

Background

Traumatic Cardiac Arrest has historically had poor outcomes with ROSC rates ranging from 0 to 3.7%1,2. TCA is diagnosed when patients present unresponsive, apnoeic and have no palpable pulse with evidence of a traumatic injury3. Current routine paramedic practice is to initiate Advanced Life Support including airway management, Cardio Pulmonary Resuscitation, Intravenous fluids (crystalloids) and rapid transport to definitive care in penetrating trauma, and a vague idea that attempts to address the reversible causes and cease resuscitation after 20 minutes in blunt force trauma4. The National Association of Emergency Medical Service Physicians and the American College of Surgeons Committee on Trauma recommended various criteria to withhold treatment in this patient group on futility grounds5, however these recommendations may now be invalid.

More recent studies from retrospective analysis with London HEMS showed survival rates of 75% can be achieved6, and a smaller prospective military study from Afghanistan showed survival of 8%7. Both these studies involved advanced pre hospital care teams and often the patients received a resuscitative thoracotomy.

Discussion

Paramedic practice continues to advance and with clear guidance now laid out by the College of Paramedics with a career framework for specialist, advanced and consultant paramedics8. Paramedics continue to respond to TCA outside of advanced medical teams, often first on scene and will have a vital role to play in sustaining patients viability, whilst aggressively addressing the reversible causes until surgical intervention is available. This was defined in the presentation by the TCA survival triangle, sustain, slice and survive (Figure 1).

Figure 1 – TCA Survival Triangle

The triangle refers to a concept within existing UK systems of how the patient might survive. Most paramedics will be providing initial resuscitative attempts, in which they must concentrate efforts on addressing reversible causes such as hypoxia, hypovolaemia and tension pneumothorax. This will improve patient outcomes and also sustain the patient until more definitive care arrives such as HEMS or MERIT to perform advanced surgical interventions such as resuscitative thoracotomy (Slice) or the administration of blood products. By sustaining the patient until advanced interventions the presentation argued the patient’s chance of survival would improve.

The presentation argued 3 areas of controversy in the TCA patient of External Chest Compressions, Adrenaline use and airway and ventilation.

External Chest Compression (ECC)

The importance of ECC has long been the focus of resuscitation attempts but may not always be effective in TCA, whilst it remains essential in the medical arrest. Luna and colleagues noted in 1989 that in patients suffering TCA from severe hypovolaemia, chest compressions are likely to be ineffective due to poor cardiac filling and compressing an empty heart9. More recently ultrasound has noted that despite the lack of a palpable pulse the heart may still be contracting and in a “low flow state”10.

It was argued that the hypovolaemic patient, a heart suffering a cardiac tamponade, or a patient with a tension pneumothorax would benefit from rapidly addressing the reversible cause as a priority over performing ECC. In these instances due to the aetiology involved compressing the heart may be ineffective.

Adrenaline

Current evidence suggests using adrenaline in cardiac arrest may result in potentially worse patient outcomes11. In trauma a massive surge of endogenous catecholamine has already been released as a result of any life-threatening injury and thus supplemental adrenaline will have no use and is likely to worsen outcome.

Airway and ventilation

The need to maximise oxygenation, have an adequate airway and the use of surgical airways were discussed. Substantial evidence exists showing assisted ventilation using excessive tidal volumes can be detrimental to any patient. Increases in intra-thoracic pressure leads to a marked reduction in venous return to the heart as well as precipitating barotrauma to the alveoli12. It is therefore essential not to over ventilate the TCA patient as this may significantly worsen outcome.

Conclusion

Paramedics continue to be at the forefront of pre hospital care and although a rare occurrence, the patient in TCA will present a significant challenge. Paramedics will need to be decisive and intervene quickly to improve patient outcomes in this group. Addressing the reversible causes of the TCA, ensure definitive care is provided by specialist teams and acting free from fear in the best interests of the patients may ultimately improve outcomes in this small patient group who may have been deemed futile in the past.
References

In the Lab with…. Ben Mays

In this edition we catch up with student member Ben Mays to find out how he’s getting on during his course.

Name: Ben Mays
Course: Paramedic Science
University: Wolverhampton University

My name’s Ben Mays and I joined the Dip He in Paramedic Science at Wolverhampton University for their first intake of students in May this year. Being a paramedic isn’t something I’ve always wanted to do and prior to this I gained a BSc (Hons) in Sports Science and a Masters in Sports Therapy before spending three years working for the University of Leeds. When I first applied to become a paramedic I had a rude awakening at the fierce level of competition for places and was initially unsuccessful. When I was offered a place at Wolverhampton I was over the moon but naturally somewhat cautious given the fact it was a new course and my experience working at universities had told me that there were likely to be “teething problems”. This however, has proved not to be the case, my pre university checks were carried out quickly and promptly and I was soon ready to make the move. Since I’ve arrived the quality of teaching has been first class and has encouraged me to think in a totally different way. We are encouraged to not merely accept current practice but to challenge it and think in an abstract manner. I am already being encouraged to conduct my own research and look to prove myself as an academic as well as a potential paramedic. Teaching is at a fast pace and we have already learnt a large amount of practical and theory, the low numbers provide a great environment to learn in and I really get the individual help I need, with regular extra sessions for me to work on my weaknesses.

After 5 weeks we were out on our placements with WMAS and I, like every student before me, was very nervous. The University had however prepared me as well as possible and before my first day of placement I’d already been taken to a hub to see how they worked and to make my first day that little bit easier. Since I have started placement the blended approach of 2 days in university and 2 days on placement has worked perfectly for me and allows me to consolidate the skills I have learnt almost immediately. Although hard work, I am really excited for the next 2 years and the knowledge that will be passed on to me.
Being stranded on a dessert island was not what I expected when enrolling on my Paramedic Science course back in 2007. I’d come to know that the ambulance service was more about helping the elderly and those with minor health presentations than it was about major trauma and cardiac arrest. However, I’d certainly given no thought whatsoever to survival or remote healthcare.

Having completed my degree last year I felt I wanted to take on a fresh challenge. Prior to applying, I’d been involved with a pilot scheme called the ‘Acute Visiting Service’, which saw paramedics conducting GP home visits in Leicestershire. The scheme was fantastic but it had affected ambulance service performance figures so it was stopped with immediate effect. I was left gutted. Unhappy and looking for the next adventure, I submitted an application to the second series of the ‘The Island with Bear Grylls’.

I’d seen the first series and, in short, I loved it. I don’t watch much TV and would certainly steer well clear of ‘reality’ TV, however there was something refreshingly normal about those on the show and it looked real – not contrived or filled with fame-hungry, controversial figures. The premise is simple – maroon 14 men on an island for six weeks, documenting their own survival by filming each other. Between us, we could take the clothes we stood up in, three machetes, three knives and a medical kit. Four of the ‘contributors’ were TV professionals, one a doctor, and the others a cross section of society – from a farmer to an IT consultant.

From start to finish, I couldn’t believe my luck. I never thought during the application process that I would get selected. They had 80,000 people apply including a few hundred paramedics – people in my view who would have been far better than me. To this day, I still don’t know why I was chosen for the programme but just felt incredibly grateful for the opportunity.

Perhaps one of my biggest concerns was about representing my profession on a national and international platform. The show is sold to many different countries and attracts high viewing figures and media attention. I’ve been a member of the College of Paramedics since qualifying and am passionate about the development of the paramedic profession. Knowing I’d be defined as ‘the paramedic’, I felt I had a duty to represent my colleagues well and was ultimately vulnerable and at the mercy of the edit. I’d seen enough medical shows to realise paramedics can embarrass the profession nationally depending on conduct and how they’re represented and I knew I wasn’t totally immune from this – especially in an unpredictable setting on a starvation diet.

Describing the ensuing six weeks is almost impossible to do in a few hundred words. I knew it was going to be hard, but had no idea how hard. After two weeks without any food other than a handful of limpets, I was homesick, profoundly weak and (I felt) no good to anyone. I’d never felt so desperate in my life and it put what matters in life into stark contrast. I was angry at myself for having taken my family and friends for granted. It was without doubt the most humbling experience I’d ever had and gave me a renewed appreciation for everything around me – from food to clean running water. When you’ve spent a day working solidly just to get enough water, turning on a tap is a bizarre feeling.

From a medical point of view we were very well supported by ‘Remote Trauma’ a company specialising in paramedic-led remote medicine and risk management. Their multi skilled staff were a 15 minute powerboat-journey away, on a neighbouring island. It was therefore up to the doctor and me to manage emergencies as they arose. There were ongoing issues around malnourishment and refeeding syndrome, as well as injuries from knives, falls and scorpion stings. I lost over three stone in weight, had worryingly high liver enzymes and contracted salmonella. I wouldn’t have changed it for the world though.

It’s definitely given me a different perspective of emergency care and a good insight into remote medicine, but for now I’m happy being back on home soil.
What has been your career pathway that has led you to this role:
Shortly after joining the army I came across a RTC where a biker had come off his machine. He wasn't breathing so I removed his helmet did a jaw thrust manoeuvre and he started to breath. At this point I realised I wanted to be a paramedic. After completing 14 years in the army and a spell as a contractor in Iraq I decided to come back to the UK and work for the NHS. I worked for two private ambulance services before I joined the Great Western Ambulance Service, which ultimately merged with the South Western Ambulance Service. I enjoyed my time in the NHS but the rota didn't suite my work life balance so I went back to Iraq on a contract.

What do you like most about your role?
Working in Iraq I get to meet people with amazing and interesting stories and the medical system is different in so many ways. I teach quite a lot, and enjoy hearing about home remedies for various wounds and accidents. The pace of life is slower here, and everyone loves a cup of tea.

What do you like least about your role?
Being away from my friends and family, missing weekend BBQs. The weather is unforgiving, with the temperature reaching 55C in the summer for weeks at a time.

What skills do you think are important to your role?
IT skills, as communication back to my family is extremely important. Most of the time I am the only qualified medical person for 50 miles, so remaining calm under pressure is a must. Flexibility, in all approaches - sometimes a sandstorm will hit the airport, and this can cause you to be 2 or 3 days late in getting home.

What are the biggest challenges facing paramedics today?
The UK paramedic is currently experiencing a massively changing landscape, keeping up with the latest treatment regimes, CPD and more job opportunities. We have, in such a small amount of time come from being ‘ambulance drivers’ with 12 weeks of paramedic training to degree level and further, clinical advisers with 111, working in urgent care centres, custody suites, with sub specialities opening up all the time.

What is your one most important benefit of being a member of the College and why?
The College is changing the way our profession is not only viewed but interacted with. Being a member gives me the opportunity to be part of that change. I don't want any other profession steering my profession and I want paramedics driving the paramedic profession forward.

How would you like to see the College develop over the next five years?
I think online CPD. Whilst there is a very important place for face to face CPD, I think there has to be an e-learning/CPD component. I like the Irish system that PHECC uses with videos, tutorials and quizzes to cement learning. I also think we underuse social media and eforums as an organisation which could be used to discuss issues and canvass opinions etc.
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