## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>The role of the College of Paramedics</td>
<td>4</td>
</tr>
<tr>
<td>Paramedic prescribing – are we there yet?</td>
<td>5</td>
</tr>
<tr>
<td>The future of urgent and emergency care – unlocking the potential of the paramedic</td>
<td>7</td>
</tr>
<tr>
<td>“I want to die at home” paramedics and end-of-life care</td>
<td>9</td>
</tr>
<tr>
<td>Close of day one and honours ceremony</td>
<td>11</td>
</tr>
<tr>
<td>Cutting-edge resuscitation</td>
<td>12</td>
</tr>
<tr>
<td>The American dream? The dilemma of the community paramedic</td>
<td>13</td>
</tr>
<tr>
<td>Cardiac emergencies - are schools prepared?</td>
<td>15</td>
</tr>
<tr>
<td>‘Help me get my feet back on the ground’</td>
<td>16</td>
</tr>
<tr>
<td>Chocolate, cheese and cuckoo clocks - but what about pre-hospital emergency care in Switzerland?</td>
<td>17</td>
</tr>
<tr>
<td>Research presentations</td>
<td>19</td>
</tr>
<tr>
<td>Summary of international speakers</td>
<td>21</td>
</tr>
<tr>
<td>How police and paramedic roles overlap when called to assess and convey mental health patients on the frontline</td>
<td>22</td>
</tr>
<tr>
<td>The value of the College of Paramedics</td>
<td>25</td>
</tr>
<tr>
<td>Putting together the pieces of the paramedic profession</td>
<td>26</td>
</tr>
<tr>
<td>YAS Online Learning Centre</td>
<td>30</td>
</tr>
</tbody>
</table>
Introduction

Liz Harris, Yorkshire Council Member, College of Paramedics

Welcome to the unofficial report about the College of Paramedics’ National Conference held at the University of Warwick on 6 and 7 October 2014.

In August 2014, a funded opportunity to attend the National Conference was advertised in internal Yorkshire Ambulance Service (YAS) newsletter, Operational Update, with applicants required to write a short piece detailing why they should be considered. Six staff demonstrated commitment to their own development and a desire to share their experience with colleagues and were therefore successful in achieving a free place at the conference.

This report has been put together by Paramedic Lee Murphy to share information, developments and learning from the two days. I would like to thank Lee, Jodie, Matt, Caroline, Kim and Davy for their note-taking and giving their own time to write articles in the weeks that followed the conference. Thanks to Imogen who also agreed to contribute to this report. I was very pleased to see many other YAS faces at the conference.

The final thank you is to Angela Harris, Lead Nurse for Urgent Care, for her unwavering support for the paramedic profession and for providing this development opportunity.

I have provided some background information about the College of Paramedics in this report and promoted some of the work the College is undertaking on behalf of the paramedic profession.

My vision in the next few years is ‘Royal College’ status for paramedics, to equal that of the other health and medical colleges, such as the Royal College of Nursing or the Royal College of General Practitioners. However, to achieve this we must have the majority of registered paramedics as members, so do please carry on reading, enjoy and consider joining your professional body because then and only then, will paramedics have a credible, clear and strong voice in local and national decisions that affect our clinical practice today and in the future.
The role of the College of Paramedics

All professions have recognised professional bodies, for example the Royal College of Nursing (RCN), the Royal College of Midwifery (RCM), the Royal College of Speech and Language Therapists etc. The role of a professional body is to promote and develop the profession, both to regulatory bodies (the Health and Care Professions Council (HCPC)) and more broadly. For example, when the HCPC reviews the ‘Standards of Proficiency’ and the ‘Standards of Conduct, Performance and Ethics’, it works in collaboration with the College of Paramedics. This allows members of the College of Paramedics to take responsibility for the future development of the profession.

It has to be remembered that many of the other healthcare professional bodies have been around for a very long time in comparison; therefore they have established strong roots and structures due to their proportionately large memberships, some at almost 100% of all registrants. This has enabled them to gain credibility and respect amongst employers and other organisations and an ability to voice the views or concerns of the majority of registrants as they are regarded as the authoritative source for opinion.

In short, the role of the College of Paramedics is to provide a voice for the UK paramedic and to develop and sustain the paramedic profession for the future. The College of Paramedics has published its five-year strategic plan which will guide the College’s activity over the coming years. This is available to download from www.collegeofparamedics.co.uk

The College of Paramedics; our mission is to:

- Promote clinical excellence by enhancing the quality of education and training of paramedics.
- Influence and shape policy in the UK that relates to emergency and unscheduled care.
- Ensure that the voice of the paramedic profession is promoted and that the important contribution of paramedic practice to patient and public health is fully recognised.
- Lead on the continuing advancement of the profession required to shape and influence the future delivery of paramedic services.
- Address the issues that are important to members in order to enhance their job satisfaction and professional reward.
- Promote the development of the knowledge and evidence base for paramedic practice.
Paramedic prescribing - are we there yet?

Andy Collen, Medicines and Prescribing Team, College of Paramedics

Prescribing for paramedics has long seemed like a bit of a pipe dream but recent news from the College of Paramedics, following months and years of hard work to get to this point, has heralded a significant step forward in realising this goal.

The benefits of a change in legislation to enable independent prescribing by paramedics are many and varied but would include:

- a broader scope of practice
- increase in multi-disciplinary working
- better professional recognition
- more opportunities to provide definitive care
- access to a wider range of academic activities
- annotation of the professional register for prescribers.

Non-medical prescribing (prescribing by someone other than a doctor) has a relatively short history. What began in 1994 with the introduction of a limited Nurse Prescribers’ Formulary for district nurses and health visitors, has now been expanded to include supplementary prescribing for professions such as physiotherapists, chiropodists/podiatrists, radiographers and optometrists in 2005. In 2006, the legislation was altered again to enable independent prescribing for nurses and pharmacists.

The project involving prescribing for paramedics began in 2008-09 and came on the back of recommendations made in the Department of Health document ‘Taking Healthcare to the Patient’ (2005), which advocated the transformation of ambulance services to meet modern demands.
This included significant development of the paramedic profession in enabling more patients to be treated out of hospital in their own homes or the community. The Urgent and Emergency Care Reform, which is currently underway, also recognises the potential of paramedics and has called for a professional ‘up-skilling’. The case for paramedic prescribing has received overwhelming support from the senior management team at NHS England and work has been done involving NHS England and the College of Paramedics to document curriculum outlines.

NHS England, in partnership with the College of Paramedics, has developed a case of need for independent prescribing by paramedics based on improving the quality of care for patients in relation to safety, clinical outcomes and experience, whilst also improving efficiency of service delivery and value for money.

The Department of Health’s Non-medical Prescribing Board approved the cases of need in July 2014, allowing the proposals to move forward to a 12-week public consultation starting early 2015. The consultation documents will include practice guidance, an outline curriculum framework and impact assessments pertaining to both patients and economics.

The work done so far represents a small but exciting piece of the jigsaw. There has been a firm mandate for change from NHS England and patient groups have reacted positively. However, there is still a lot of work to be done, not least in overcoming the challenges listed below:

- Developing a new scope of practice for paramedics.
- Ensuring patient safety (in conjunction with the Commission for Human Medicines).
- Prescribing in emergency and critical care.
- Developing a career framework.
- Accessing mentorship and supervision - clinicians would need a medical mentor during the prescribing course.
- Rationalising confusing role titles (and encouraging employers to assist).
- Agreeing on eligible paramedics - specialist/advanced etc. Other prescribers generally have MSc level qualifications.
- Medicines management in ambulance services.
- Research and evaluation.
- Professional indemnity.

The College of Paramedics continues to work with NHS England and the other three Allied Health Professions involved (radiographers, dieticians and orthoptists) to move the project forward to the next stages.

**Report by Caroline MacKenzie,**
_Urgent Care Practitioner (Paramedic specialising in urgent care), Middlewood_

_Public consultation on proposals to introduce independent prescribing by paramedics across the UK has begun. The consultation will close on 22 May 2015. You are encouraged to review the supporting documents at www.engage.england.nhs.uk and to respond to this consultation._
The future of urgent and emergency care - unlocking the potential of the paramedic

Professor Keith Willet, NHS England

We are all aware of the current challenges facing the NHS. Barely a day goes by without some newspaper headline referring to emergency departments bursting at the seams or GP surgeries unable to cope with demand. We in the ambulance service are more aware of this than most, with our demand continuing to increase by 5-6% year on year and our resources and staff ever more thinly spread. What we also know in the ambulance service is that patients now use us not only when there is threat to life and limb, but also as an alternative to other primary care providers. As a result, many patients are conveyed to hospitals who do not necessarily need to be there and who, were there sufficient pathways and community services, could be safely treated out of hospital.

‘Things are tough in the NHS but momentum is beginning to build to change urgent and emergency care and this time it looks like it’ll run’

Professor Keith Willet, a consultant orthopaedic surgeon by background, is leading the Urgent and Emergency Care Review (UECR) for NHS England. He describes the challenges facing the UECR as considerable. There are over 100 million calls or visits to urgent or emergency care each year in England with many patients unnecessarily ending up in the emergency system when urgent care is more appropriate. He envisions a system in which urgent care is a ‘highly responsive service delivered in, or as close as possible to the patient’s home’, and where ‘emergency care is delivered in specialist centres where the best possible treatment is available’.

As head of the Major Trauma Review, he oversaw the inception of major trauma centres and the pathways that we now use when treating patients with major trauma. This review succeeded in delivering considerable improvements in patient care by focusing resources and skills into specialist centres - indeed, the odds of surviving major trauma have increased by 30% in two years.

Money is also a major factor. Budget cuts and deficits litter the headlines and the NHS is not exempt. Professor Willet sees this as an opportunity though - ‘more fundamental changes happen in the NHS when there is no money’. He has a small team of three and they are managing to bring people together. In order for this to work he says it has to be done in public and involve all the stakeholders. So now, because everyone has a common interest in saving money and delivering a more efficient, patient-centred service, progress has been made.
‘All of a sudden everyone is coming together: commissioners, providers, patients, the third sector...’

Professor Willet sees paramedics playing a key role in this review. Sitting between the two powerhouses of acute hospitals and primary care we are in a unique position to be able to expand professionally into the space of ‘see and treat’ and ‘hear and treat’. In some areas this has begun to happen. The services we provide as a profession are changing rapidly and our employing organisations will need to adapt in light of this.

Specialist and advanced paramedics are already treating many patients with urgent care needs in the community and using alternative pathways to prevent inappropriate hospital attendances and admissions. A rapid increase in this part of the workforce seems imminent and will provide paramedics with long overdue opportunities for career progression and expansion out of traditional ambulance service employment. Indeed, Yorkshire Ambulance Service has recently secured funding for a significant expansion of urgent care practitioner (UCP) teams across the Trust and we should expect this part of the service to continue to expand over the coming years. In line with this potential, a review is underway to look at the paramedic curriculum of the future and how we best train paramedics to meet the needs of the future.

‘If information is shared, admission and attendance rates are dramatically reduced’

Many of the problems we face and indeed the reason for inappropriate hospital attendances and admissions can be attributed to lack of information regarding patients. 43 million out of 56 million people in England now have a summary care record, yet unscheduled healthcare providers have little or no access to these.

Patients say they are frustrated and don’t understand why we don’t communicate between GPs, hospitals and other providers. The clinical hubs of the future will have access to these records to assist clinicians when formulating a treatment plan. The hub would also have access to a range of professionals from pharmacists, mental health nurses, dental nurses, paramedics, GPs and medical specialists to provide 24/7 clinical support to clinicians in the community such as paramedics.

‘The ambulance service is arguably best sited to steer direction’

NHS 111 is another area highlighted for development. Believe it or not, the NHS 111 system is working well in many areas (Yorkshire in particular) and seeing huge increases in the number of calls being made to it which indicates patient satisfaction and increased take-up.

Nationally, the outlook is promising in that the service has begun to reduce the overall number of ambulance responses, only 11% of calls are redirected to the 999 system. The next step for NHS 111 is to provide more clinical advice from different professionals (as with the clinical hub concept) and to have access to bookable systems so that patients can be advised and booked in for follow-up review or further treatment in the appropriate setting all in one phone call.

‘Paramedics need to expand professionally into the space of ‘see and treat’ and ‘hear and treat’”

Urgent care centres will be a big part of the future plan and they will need to be supported to succeed. Urgent care networks are being established and consist of local groups of clinicians working together to achieve best outcomes. Support in clinical decision-making from hospital specialists to clinicians in the community will enable more patients to be treated and supported at home.

‘If we don’t make this change we have an insoluble problem’

The UECR is moving from the design phase into delivery and organisations now need to seize the moment and work together for changes to happen. As the interface between acute hospitals and primary care, paramedics need to be involved and our voices heard. The future looks bright for the paramedic profession – we have an opportunity to promote our skills and potential within this review and grow into a new space within the sphere of urgent healthcare. With the potential of paramedic prescribing on the horizon, the development of a new curriculum and improving professionalism, we are taking our profession to the next stage.

Report by Caroline MacKenzie, UCP, Middlewood
“I want to die at home” - paramedics and end-of-life care

Jonathan Bracken, Legal Counsel, Health and Care Professions Council

Jonathan Bracken gave an up lifting speech on the subject feared by many paramedics - people dying at home and when, and more importantly when not to instigate treatment.

As a Fellow of the College of Paramedics who spends time out with paramedics, Jonathan Bracken understands that death can be a difficult and emotive part of our job and said, as a profession, we have to ‘encourage and engage others with responsibilities to make a difference’.

Death is a taboo subject to us Brits and many are uncomfortable discussing it especially with their loved ones. According to the Dying Matters survey carried out in 2014, 83% of British people interviewed were uncomfortable discussing death and dying, 51% were unaware of their partner’s end-of-life wishes and only 6% had recorded some form of future care plan.

Good end-of-life care requires excellent co-ordination. As end of life approaches, members of the multi-disciplinary team, the patient and ideally their family members should be involved in an open discussion about what will happen, their roles and their feelings. Any plans from these discussions and their subsequent care needs should be assessed and regularly reviewed.

As 76% of a week is classed as ‘out of hours’, this mean that on regular occasions members of the multi-disciplinary team are not going to be available. These type of calls are frequent and are passed to an ambulance crew for a terminal patient possibly in the dying phase. This crew will not have been part of the multi-disciplinary team and they will probably have never met the patient or their family before.

If they are lucky they may have access to a care record with varying levels of information about the patient’s history, how their illness has progressed, what was discussed by the multi-disciplinary team and, importantly, what the patient’s wishes are. What makes things even more difficult for the clinician making this complicated clinical decision is their limited access to someone with the patient’s care plan to support informed decisions on behalf of the patient. Then add to this the possibility of conflicting views and opinions from carers and family members when emotions are high, making time-critical clinical decisions hard.

Jonathan Bracken advises us to act professionally at all times with a big emphasis on good communication, exercising sound ethical and clinical judgement and to learn from others.
In the absence of a clear plan as the end of life approaches, we are reminded that any decision we make as clinicians should be made in a patient’s best interests and that we need to consider all relevant circumstances including whether the decision can or should be delayed. If a patient has previously expressed a wish on what should happen in a particular circumstance, then this needs to be supported as should their feelings, beliefs and values around a particular course of action. At the same time we should also take into account views of others with an interest in the patient’s welfare even if they include resistance and disagreement.

Ashley Shreves MD, an expert in palliative care, suggests there are three things we should refrain from saying to a patient's loved ones - “Do you want us to do everything?”, “Do you want us to resuscitate her/him?” and “There is nothing more we can do”. All these can be replaced by “What do you think your loved one would want us to do?”.

Educating people that it is acceptable to discuss death and what can happen in the terminal phase and, more importantly, what they want is at the forefront of person-centred care.

How these wishes are documented and accessed by ambulance clinicians is a definite work-in-progress but clinicians should be prepared to ask about care plans, the patient’s preferences and advanced wishes.

As appropriate documentation can help clinicians decide on what is appropriate for a patient, Jonathan Bracken discussed how a ‘Do Not Attempt Resuscitation’ document is not a statutory document but an ‘expert opinion’ on whether CPR would be appropriate for a particular patient. He stressed it does not need a red border and may present in a number of formats including as an entry in the patient’s care record.

It is not necessary for a paramedic to physically see one, being informed by an Emergency Operations Centre member of staff or another health care professional is enough. However, the paramedic does need to be satisfied it is valid, it is for the patient that they are attending, that it is valid for the circumstances of the call and there is an absolute need to document all conversations on the Patient Report Form (PRF).

Advanced Decisions (AD) should be recorded while the patient has capacity but can be withdrawn by the patient either in writing or verbally. This document can specify the refusal of treatment and also the circumstances when to give or withhold a particular course of treatment. If the AD is in the form of a written document it should be signed by (or on behalf of) the patient and also by a witness. If a patient has granted someone Legal Power of Attorney since making these decisions, then this needs to be considered. It is not however feasible to check if a Legal Power of Attorney states who has the power to say if the patient is resuscitated or not, purely due to the size and technical jargon within the document.

Jonathan Bracken reassures us that we are not under any obligation to provide or withhold treatment in these circumstances as it is a clinical decision personal to the paramedic on scene with the clinical responsibility for making the decisions at that time but should be backed up with a good PRF. If there is any doubt then it is better to commence resuscitation; however be aware if there is a valid DNACPR or AD then not attempting CPR is the right decision.

Report by Kim Toon, MCPara, Paramedic Clinical Advisor
Close of day one and honours ceremony

The end of the first day approached... although for many it had been an early start and long day, you could sense that people had both enjoyed the event so far and were very much looking forward to the following day.

The conference was brought to a close by Professor Andrew Newton (Consultant Paramedic and Chair). Andrew took the opportunity to thank all the delegates for their attendance and contributions to a successful day. Appreciation was given to the speakers, sponsors and delegates. He explained that, throughout the day, he had spoken to many people and college staff and it was concluded that this national conference will become an annual event due to its success and the positive feedback. Many people applauded this news - and there was a deep intake of breath from the exhausted organisers whose efforts had been relentless in producing this event!

After closing the conference, Professor Newton continued to the honours ceremony.

Each year, the College of Paramedics considers nominations for fellowships and honorary fellowships. This year an honorary fellowship was awarded and presented to Paul Gowens.

Paul has been a paramedic for over 24 years. After qualifying in 1993, Paul spent 10 years working as a paramedic before moving into management roles at the Scottish Ambulance Service. From 2002-2004, he was Clinical Development Manager for Special Operations and from 2004-2010 he held the position of Head of Risk. He also continues to work regular clinical shifts as an air ambulance paramedic.

Paul has a Diploma in Immediate Medical Care from the Royal College of Surgeons Edinburgh, an SVQ Level Five Diploma in Management from the Chartered Management Institute and a Postgraduate Certificate in Implementing Clinical Governance from Glasgow Caledonian University. He has previously completed the Scottish government’s Delivering the Future programme for senior clinical leaders and the Scottish Patient Safety Programme.

In his role at the Scottish Ambulance Service, Paul was very interested in exploring issues around how healthcare professionals in different settings recognise and respond to critically-ill and deteriorating patients, as well as the role of paramedics in major trauma care.

Now he’s working within the Scottish government and is embracing the opportunity to consider quality improvement on a national level. “I’m keen to continue examining issues like the treatment of critically-ill patients and pre-hospital major trauma care on a national scale, but also to examine some of the questions arising from the Francis Report, such as wilful neglect and duty of candour.”

Paul is also the College of Paramedics’ Scottish Council Member and continues to play an active part in promoting and working with the college, dedicating much of his time to assisting the college in its aims and ambitions.

It is due to Paul’s continued excellence in the field of paramedic science and efforts for the profession that he was awarded this fellowship and it was agreed that Paul is a great assist to the paramedic profession and the College. Well done Paul!

Report by Davy Bradshaw, BSc (Hons), PGCCE, MCPara
Cutting-edge resuscitation

Mark Whitbread, Consultant Paramedic and Director of Paramedic Education, London Ambulance Service

Ambulance services are the key player in cardiac arrest, especially with the current move to increase survival rates. Although this cannot be done alone, paramedics and the ambulance service are one part of a system which needs to be robust, rehearsed and in a state of preparedness. One change alone in this system won't increase survival rates. The key to success is a complete package of treatment, transportation, intervention and care.

Clinical judgment still remains fundamental around when to transport a patient and this is perhaps when tools such as mechanical CPR devices come in to play, although they shouldn’t replace the number of staff responding to patients in cardiac arrest.

Part of the system to save patients currently being practiced by London Ambulance Service (LAS) is the implementation of a Pit Crew concept. The Pit Crew approach involves many aspects; equipment should be ready, checked and familiar to staff. LAS dispatch a minimum of three resources to each Red 1 detail (at least four staff) and all these have allocated roles to undertake.

This concept starts in the classroom, with scenario training in a real-world environment, using the Prepare - Plan - Practice technique. Once 360° access to the patient has been established, the team leader should place themselves at the foot-end of the patient, taking an overview of the situation ensuring good direct communication, not leaving any ‘thin air comments’ with staff not knowing who’s been requested to do specific tasks.

One rescuer should be at either side of the patient with alternating CPR, performing defibrillation and IV/IO access and leaving the final rescuer to manage the airway. Four members of staff is a minimal response, ideally up to six people for minimal time off the chest to be achieved. A checklist approach has been adopted for the team leader to ensure that no elements have been missed, even down to caring for and informing the relatives.

Mark also talked about some interesting work around further diagnosing Pulseless Electrical Activity (PEA) into two groups, PEA with cardiac output and those with only Electrical-Mechanical Disassociation (EMD). The use of a bedside hand-held ultrasound can be used to determine if there is any cardiac muscular movement. If so, the patient should be actively resuscitated and transported. When no muscular movement is found, this is traditional EMD and CPR can be ceased.

Report by Matt Boocock, Student Paramedic, Keighley
The American dream?  
The dilemma of the community paramedic

Jerry Overton, Chair for the International Academies of Emergency Dispatch, and the leading commentator on EMS in the US

I have to admit to thinking that the conference programme sounded a bit dry. However, I always find attending conferences beneficial, not least because it’s great to know that there are others out there who want the profession to move forward and keep our skill-set and knowledge developing.

I would have preferred less international speakers because I feel that we still have a long way to go to get our own house in order. But it is good to learn from what others are doing better - and that was what I was expecting to do - hear one speaker after another say that they were doing things well and that we could learn from them.

Much to my surprise the first speaker - Jerry Overton from the USA - set a different scene which flowed through the whole conference. This showed what we are doing in the UK with specialist paramedics, see and treat and hear and treat, working more closely with other health professionals, was being considered by others as the future that they would like to see for themselves. This was great to hear.

The US and UK are both subject to what is a global increase in pre-hospital demand and that this increase is made up, across the board, of low acuity calls - what in the UK is called urgent care and many on the road call something else entirely.
However, the US Emergency Medical Services (EMS) suffers from a familiar legacy; the expectation of responding primarily to emergency/life-threatening calls, that expectation is evident in how frontline staff think and feel, their training and education and commissioning.

As well as this legacy and despite the US having the highest spending on healthcare globally, the EMS system has a number of other problems:

- no equality of access to care
- no standards of quality and procedures of care
- no emphasis on outcomes
- no research.

The system is also very fragmented with no federal agency that is responsible for EMS nationally.

Jerry and his colleagues are trying to drive a change agenda as follows:

*Change the culture away from response times and the focus only on life-threatening incidents*

He argued that a system built around response times for emergencies leads to a system that does not provide for its communities’ demand and that the time performance indicator was chosen for its ability to be measured and to apportion blame easily when it isn’t achieved.

Jerry placed EMS firmly in the category of healthcare and, as it sits in the crossover of healthcare, public health and public safety, it is not purely an emergency service.

*Change recruitment*

Recruit people who expect and want to work on more than just life-threatening incidents.

*Change training*

Develop EMS responders who can do complex multi-system assessments and thus deal with all the relevant clinical, environmental, social and cultural issues of their patients.

*Increase integration with other healthcare providers, community resources, fire departments and private and public health systems*

Incredibly, there is currently only one state in the US with community paramedics. They work in partnership with community services and provide hear and treat and see and treat.

Those who are pushing an increase of this sort of provision across the US also recommend the introduction of point-of-care lab tests and self-care advice.

*Measure outcomes*

There are currently 300,000 premature deaths in the US and there are increasing calls due to homelessness, ageing and obesity resulting in complex multi-morbidity incidents. An EMS system that responds quickly but is not prepared to address what they find is a bad EMS system.

Jerry is hopeful that these changes will take place on the back of ‘Obama care’ and is taking notes from the UK system; both its present and its future as presented by Keith Willet and David Farrelly at this conference. This includes the integral part the ambulance service will be playing in the new Urgent Care System and the Paramedic Evidence based Education Project (PEEP).

I found Jerry’s presentation worth hearing as it made me feel positive about the progress the paramedic profession is making in the UK even though we have more ‘housework’ to do.
Cardiac emergencies - are schools prepared?

Anne Jolly, SADS UK

“Children can suffer cardiac arrests” - words spoken by a lady who knows. Anne Jolly is the founder of Sudden Arrhythmic Death Syndrome (SADS UK) and Ashley Jolly Sudden Adult Death Trust UK. Her normally fit and well son died of a sudden cardiac arrest in his sleep and Anne works tirelessly to raise awareness of the causes of sudden cardiac arrests and treatments.

She told us that one in 500 people suffer from cardiomyopathy and many are undiagnosed until the patient has suffered a cardiac arrest. This, along with other electrical problems of the heart, choking, drowning and blunt force trauma, mean that in excess of 270 children can have a sudden cardiac arrest each year.

In 2000 the Department of Health launched a campaign to increase the number of defibrillators in public places, however these were not put into schools which led SADS UK to petition the government to change this. As more and more young people are diagnosed with cardiac problems, their families are keen to know that the appropriate equipment is in the school and that people are trained in CPR in order to save these childrens’ lives.

Since the ‘Big Shock’ campaign was launched, SADS UK has sent petitions to Downing Street, attended a Parliamentary reception in 2012 and provided Lord Nash with evidence to support getting defibrillators in schools. This led to the Department of Education writing to schools in April 2014 to encourage them to consider a defibrillator as part of their first aid equipment.

SADS UK attends school nurse and headteacher conferences to speak about its campaign and the difference a defibrillator and early CPR can make as well as trying to raise awareness of the warning signs in people at risk.

The charity has close links with ambulance trusts within the UK to endorse its message and the College of Paramedics supports its community awards.

Since his own sudden cardiac arrest, retired footballer Fabrice Muamba now works closely with SADS UK to promote and support its work as does Dame Helen Mirren, Dr Hilary Jones and Professor Douglas Chamberlain.

More schools are looking to install defibrillators and more are involving their children in learning CPR - something that the children say they enjoy. The schools already involved in the campaign have voiced their relief when they realise how easy the equipment is to use. This is great progress but SADS UK says there is still a lot of room for further improvement.

Report by Kim Toon
MCPara, Paramedic Clinical Advisor

Restart a Heart Day 2015

Yorkshire Ambulance Service is will be teaching CPR to thousands of secondary schoolchildren across Yorkshire again this year as part of Restart a Heart Day on Friday 16 October 2015. If you would like to volunteer to help with the training on the day, please register at http://intranet.yas.nhs.uk/Surveys/Pages/RestartaHeart/default.aspx
‘Help me get my feet back on the ground’ - the Beatles generation, a challenge to EMS.
A comparison of ‘simple’ ambulance calls in selected European ambulance services

Professor Christoph Redelsteiner, University of Applied Sciences St Pölten

Professor Redelsteiner took delegates on a journey through the typical calls experienced by the Austrian EMS system and how they respond.

The Professor used the discography of The Beatles to demonstrate ‘classic’ ambulance calls, for example ‘Hot as sun’ for fever, ‘Help me get my feet back on the ground’ for falls and the ‘The long and winding road’ for urinary tract infections.

In Austria there are several enclaves (counties) that have different levels of EMS provision, this ranges from BLS ambulances, ALS ambulances, GP cover (without any formal commitment to the ambulance services) and helicopter-only cover in some areas. He explained how each of the different enclaves would respond to these calls and this clearly demonstrated the high level of variation in care provided across the country. Some enclaves only have one ambulance and with journey times to hospital that can reach 90 minutes; this often leaves huge areas without any ambulance cover for some time.

The social security system in Austria only pays the ambulance service if they transport the patient to hospital. A reference to the ‘Lonely Hearts Club’ was made to explain how 75% of Austrian GPs are due to retire by 2025. 80% of calls are from people over 60 years of age and the system was described as a mobile community healthcare provider which rarely saves lives. The Professor finally spoke about the future, highlighting that discussions need to take place and decisions need to be made about what the citizens, the state and the healthcare community expects the levels of care to be and how the provision of care can be more equitable. ‘You may say that I’m a dreamer, but I’m not the only one’.

Report by Liz Harris, Yorkshire Council Member, College of Paramedics
Chocolate, cheese and cuckoo clocks - but what about pre-hospital emergency care in Switzerland

Kai Kranz, Swiss Paramedic Association

Here are some Swiss facts:

- Despite Switzerland being located in the middle of Europe, it is not part of the European Union.
- The capital is Bern.
- The population of 8.1 million (equivalent to Scotland and Wales combined) with both rural/mountainous and urban areas.
- 170 tonnes of chocolate are produced per year and each person eats 12 kg per year.
- 700,000 cows produce 180,000 tonnes of cheese every year.
- There are 26 cantons (counties) and four official languages, French, German, Italian and Romansh (similar to Italian) which are generally aligned to four regions.

Healthcare differs vastly across these four regions and cantons, not least because of the different languages and cultures. The different languages and cantons mean that to achieve any national standard in healthcare is a complicated process. The Italian-speaking part of Switzerland is considered to be the most advanced part in terms of pre-hospital emergency care but their standards and practices are not shared with other regions.
Healthcare is not a ‘national issue’, it is a ‘regional issue’, regulated by each of the cantons which leads to fragmentation. This hinders the development of their healthcare systems, particularly the pre-hospital emergency system. Switzerland has a mandatory insurance system for some aspects of healthcare, the individual pays for conditions not covered by their insurance and there are other aspects of healthcare that are paid for by taxes.

Switzerland has 112 emergency ambulance services and most are affiliated and based within hospitals or are even an actual department within a hospital. In total these services respond to between 300,000-400,000 calls per year, some ambulance services respond to 60 calls per year and some respond to 35,000 calls per year. Switzerland has 18 dispatch/call centres using the 144 emergency number (the same number as Austria). Response time targets (for the most serious calls) vary from 15-30 minutes depending on the region. The many ambulance services have huge differences in organisational structures and levels of clinical care and they currently do not provide any primary care.

Paramedics are the largest staff group working in pre-hospital care, there are also technicians and some doctors (mostly in urban areas). Some ambulance services are solely a paramedic-based system, some are paramedic and doctor, some remote area services are volunteer-based and some also have technicians.

Swiss paramedic education is currently not an academic qualification but it is aligned with degree-level education. It has a large practical aspect which can lack theoretical knowledge and also there is currently little research being carried out. However, the programme involves 5,400 hours of training over three years, it is based on a national curriculum and includes a large proportion of time on an internship (operational placement) with ambulance services and placements within critical care, emergency and fire departments.

The majority of paramedics can perform defibrillation, cardio version, pacing, have other ALS skills and can administer many drugs including Fentanyl, Ketamine, Morphine and Midazolam.

The Swiss Paramedic Association (SPA) is the recognised professional body for paramedics and technicians in Switzerland. The SPA promotes the development of the profession of both paramedics and technicians and helps to develop the field of pre-hospital emergency care. High influence and high political power of doctors makes some of their work difficult as the doctors have a great deal of control over the profession.

There are many organisations in Switzerland able to influence pre-hospital care but this adds to the difficulty in reaching consensus decisions. The National Committee of Pre-hospital Care is the umbrella organisation for all organisations involved in pre-hospital care and they provide some quality assurance for all ambulance services.

Switzerland has a shortage of professional healthcare workers including paramedics, increasing healthcare costs and on-going centralisation of healthcare. All these factors can adversely affect the provision of healthcare, particularly in the rural areas. There is a lack of career choices for Swiss paramedics, only training or operational options are available. No research or advanced-level education (MSc or PhD) is currently available either. The SPA is working to develop the professional status of paramedics and technicians, to improve the academic component of Swiss paramedic education and contribute to a move into primary/urgent care. The SPA strives to be an open but independent profession and also one that is not under the control of other healthcare professionals.

Report by Liz Harris, Yorkshire Council Member, College of Paramedics
Research presentations

This session was dedicated to raising awareness of the College’s Research and Development Advisory Committee (RDAC) and its current projects.

The RDAC provides expert advice and guidance to the College of Paramedics’ membership on engaging in research activities and relevant topics for research and has a strategic role in shaping research policy and activity on behalf of the College.

Its members attend national research groups to ensure the paramedic profession is represented and kept up-to-date with developments and opportunities relevant to paramedics.

The RDAC provides advice and guidance to external bodies and individuals who want to develop research related to the paramedic profession. The RDAC offers small research grants to paramedics through a competitive process in which submissions are reviewed. In 2013, it made its first awards to research relating to sepsis, substance users (the emergency care perspective) and the impact of working shifts.

Currently Professor Julia Williams is leading two workstreams involving other research interested members of the College of Paramedics. Work stream one is focusing on the organisation of a national research development event scheduled for early 2015. The second workstream is developing a programme of bi-monthly webinars to be hosted by the College of Paramedics starting in June 2015 related to research and development within out-of-hospital urgent and unscheduled care.

During this session we heard from two fellow paramedics who had been successful in gaining grants through the RDAC and with their support were well on their way to producing creditably paramedic-lead research. They both addressed the conference and gave a short presentation on their work to date.

**Kim Kirby - Paramedics and Shift Work: The Perceived Impacts**

Kim explained that although there has been extensive studies surrounding shift work in healthcare (most of which not in the UK) there has only been one study to date conducted around paramedics’ shift work and this was subject to speculation as it only had one paramedic in the study!

It was acknowledged that the work carried out by paramedics is unique and has many challenges; currently paramedics have the highest levels of sickness throughout the whole NHS. This is the reason why Kim wanted to explore this field and produce viable and creditable research in this area.

Kim and her team have conducted a small expository qualitative study with two focus groups of paramedics using convenience sampling which has produced some good data. The data is being analysed and it is hoped the results will be published by the end of the year.
Paul Jones - Substance User: Paramedic Accountability

Paul is a paramedic for North West Ambulance Service and was also awarded a grant to conduct research into his chosen topic (substance misuse). Paul explained that a high number of calls attended by paramedics involved patients who were either intoxicated or under the influence of other substances.

On the whole, as a profession, we are limited to what care we can offer these patients and where we can take them. Paul wanted to find out from clinicians how we can treat this patient group better, resulting in offering an improved service and reducing the risk to ourselves as clinicians. Paul has posed a number of challenging questions to paramedics and asked for questionnaires to be completed as a means of collecting data on this topic. He explained that he has encountered a number of problems along the way with regards to ethics and governance. He is currently collecting data from these questionnaires and will be looking at forming small focus groups to further generate data for his project. Paul concluded by saying his research is ‘by us, for us, and for the benefit of us’. He urged anyone interested in research to get involved and as a profession, we can start leading and shaping our own future.

These are both evolving and pioneering examples of how paramedics are now taking their own profession forward in the field of research and how the College is facilitating this. If any member wishes to get involved in any aspect of research and development please get in touch with the RDAC Team which will be happy to help and as Paul stated, let’s start shaping and making our profession leaders in all aspects of healthcare.

The RDAC Team can be contacted via email at research@collegeofparamedics.co.uk
Summary of international speakers

I found there were two common themes throughout all the presentations given by our international speakers. One was the emphasis that all ambulance services across the globe face the same predicament of addressing the issue of increasing workloads, specifically the urgent, non-life-threatening cases.

Jerry Overton argued that the eight-minute response time, based on Dr Eisenberg’s research in 1980, was flawed and obsolete. Yet, the US and UK had based their response times on this one article. He concluded by emphasising that the ‘elephant in the room’ was getting the eight-minute issue addressed so that we could deal with the increasing, less acute incidents better.

The second common theme mentioned by our international colleagues was around improving the continuity and standards of patient care through the creation of their own professional bodies. With other countries having multiple ambulance providers, an example of this being Sweden with 112 different providers, it became apparent that they are having difficulty creating an agreeable national body to represent their profession. Subsequently, they confirmed that there were variations in education and training.

It was apparent throughout the presentations and the subsequent discussions that they would all like to emulate what the UK’s College of Paramedics has already achieved.

*Report by Peter Shaw, Paramedic Practitioner*
How police and paramedic roles overlap when called to assess and convey mental health patients on the frontline

**Inspector Michael Brown**

When he started his career, he received just four hours of mental health training. However, in his first 10 arrests as a police officer, mental health played a part in six of them. He quickly acknowledged that there was a massive training gap. From 1 September 2014, Michael started a new role for the College of Policing. The role, similar to the role in the College of Paramedics, looks at mental health best practice and how to provide training that works for us all; giving us a better understanding on the UK legal frame of how we must work in order protect these vulnerable patients.

Michael felt that the link between the police and the health system sometimes isn’t really understood. Police officers and ambulance service clinicians find themselves working through a process that is not user-friendly or orientated to either service.

It is vital to remember that the police and ambulance service will be the emergency services who join together to provide a level of input of care for patients who are at serious clinical risk due to mental health problems. It is unfortunate that in England some services delivered by wider healthcare organisations are set up in a way which means they deliberately breach the mental health code of practice. Some structures can’t be complied with and police can’t access a non-police method of transport.

One of the key messages Michael receives from doing this type of conference with paramedics and teaching undergraduates from university, is that many frustrations link to a lack of clear understanding around how the law framework should be used between the police and wider healthcare sector.
It is ironic that the police have direct access to specialist mental health assessment units using section 136 to remove patients to place of safety, however the same can’t be said about paramedics and the ambulance service.

In the North West of England, a mental health trust faced a law suit where the final outcome reached the Supreme Court. It was made clear that a code of practice is not just advice; it is in fact statutory guidelines and must be followed unless there are cogent reasons for departure from it.

**Current best practice schemes**

The government is supporting and funding pilot initiatives around the country that see paramedics involved in mental health ‘Street Triage Schemes’. These schemes aim to reduce patients detained using a section 136 by having an approved mental health professional with access to pathways that are not available to the police or paramedics to improve outcomes for patients.

These schemes bring together a partnership of the police, ambulance and acute mental health services who share a response vehicle and can quickly carry out assessments under the Mental Health Act.

As paramedics, we always work in pre-hospital healthcare, often in an emergency interface in the community. We work at night, often in ambiguous circumstances, not knowing where and who some people are. We operate with the ability to make black and white decisions under difficult circumstances using the appropriate clinical skills and equipment. As such we are well-placed to be heavily involved in these schemes.

**Patients suffering from an acute mental health episode should be conveyed by non-police methods**

Whilst dealing with a patient, an unnamed NHS ambulance paramedic asked Michael, “Why should an intensive care unit on wheels be conveying such patients?” Here is his response to try and clear up why patients sectioned under 136 should be transported in an ambulance when they appear to be perfectly stable and don’t appear to need any immediate intervention.
On average two people a year die in custody under a section 136; all investigations are done around the law not what visions ambulance trusts and others have for what’s best for their organisations. The first question from the Independent Police Complaints Commission in these cases is regularly, why didn’t you call an ambulance?

Covered in section 11 of the code of practice, which must be followed unless there are cogent reasons for departure, any detainee under the Mental Health Act should be moved by means of non-police transport. Patients have previously died away from the ability to urgently intervene when transported by other means. It comes down to the legal framework we have to operate within due to case law, inquests, deaths in custody and human rights challenges that say all these patients are to be regarded as a medical emergency and should not be transported in police vehicles.

When detained under the Mental Health Act and conveyed by other means, the police and other professionals involved are open to being accused of neglectfully discharging the duty of care and officers can then be investigated for manslaughter, wilful neglect in public and health and safety violations.

Repeatedly, paramedics have prevented disaster by spotting signs and symptoms that the patient actually needed to be conveyed to the nearest emergency department rather than bypassing to a specialist unit. Examples include agitation and confusion from hypoglycaemia in an undiagnosed diabetic and a patient who was suffering from brain tumour-type symptoms that mimicked her long-standing post-natal depression.

Place of Safety

Places of safety should typically be the patient’s home address, a residential care home or the home of a relative or friend of the person. A police station should only be used as a ‘place of safety’ as a last resort.

Guidance

- Wherever possible police should defer decision-making around mental capacity to healthcare professionals. It may also be possible or necessary to contact mental health crisis services or out-of-hours GPs, depending on circumstances.
- When a police officer has detained someone under section 136, they cannot hand the patient over to you. They should accompany the person to whichever place of safety is deemed most appropriate as the person remains in police custody until they are delivered into the detention of someone who is willing to take ongoing responsibility for detention and arrange appropriate assessment.
- It is a criminal offence to obstruct or hinder a paramedic/technician in the course of their work, contrary to Section 1 of the Emergency Workers (Obstruction) Act 2006.

Paramedic Series: Posts written specifically for crews about the various aspects of how we interact with the police:

http://mentalhealthcop.wordpress.com/full-index/the-paramedic-series/

Useful links

- Mental Health Cop - https://mentalhealthcop.wordpress.com/
- Mental Health Act Section 136 YAS Guidance - which can be found in the News section of the YAS intranet (Operational Update: Issue 360 – 13 December 2013 – Attachment 1a)
- Mental Health Act Section 136 YAS Red Flag Criteria - which can be found in the News section of the YAS intranet (Operational Update: Issue 360 – 13 December 2013 – Attachment 1b)
- Mental Health Act Section 136 - Police support during transport to place of safety - which can be found in the News section of the YAS intranet (Operational Update: Issue 360 – 13 December 2013 – Attachment 1c)
The value of the College of Paramedics

“I joined the College of Paramedics because I am passionate about my profession and I believe that it should have a voice, an ability to stand up and be counted amongst the Colleges and Councils of its fellow medical professionals. I know that by standing together with fellow paramedics with similar aspirations and views (as a member of the College of Paramedics) I can contribute towards the voice that my profession needs in order to evolve and grow.”

“I think in general people don’t really understand what we do, how unpredictable it can be and how challenging the circumstances often are. The College of Paramedics raises our profile and most importantly for me, increases our credibility amongst other healthcare professionals.”

“To apply for ‘Royal College’ status we need the majority of registered paramedics to become members and only then can we stand as equals alongside the rest of the Royal Colleges out there.”

“I feel the College should be supported as we as a profession should be represented by us (paramedics). Our clinical practice has historically been driven by the medical profession but in the future paramedics aim to take more responsibility for the development of the profession. I believe all colleagues should support and push to achieve Royal College status to indeed strengthen the paramedic profession looking forward.”

“I believe the College is our voice when agencies such as the HCPC, JRCALC and Department of Health require consultation on our scope of practice both present and within the future. Only by gaining Royal College status will paramedics nationwide receive the recognition and developmental opportunities that we all rightfully deserve.”

“I principally joined as a means to give the College momentum and strength with regards to influencing the development of the paramedic profession at a national level.”
Putting together the pieces of the paramedic profession

Curriculum Guidance: Developing pre-registration education

The College of Paramedics published the Paramedic Curriculum Guidance to provide universities (HEIs) with a comprehensive curriculum for the education and training of paramedics throughout the UK. This document represents an important contribution by the professional body to the quality framework used to prepare paramedics as they move through education, training and into the early stages of professional practice. The College of Paramedics is also working to get paramedic students access to the NHS Student Bursary Scheme in line with students of the other non-medical NHS professions.

Paramedic Evidence-based Education Project (The PEEP report)

In 2013 the College of Paramedics funded the production of the PEEP report in conjunction with the Department of Health (England) and the National Allied Health Professional Advisory Board. Published in August, the report highlighted the potential contribution that a well-educated and highly-trained paramedic workforce can make to healthcare, through its unique field of practice that intersects healthcare, public health, social care and public safety. Yet this is still to be fully appreciated and understood. Paramedics are very well regarded by the general population. The report made six recommendations:

- standardised approach to education and training
- pre-registration education development model leading to an all graduate profession
- knowledge and skills enhancement
- partnership model
- paramedic leadership for England
- standardised approach to identification of paramedics.

There is now a National Paramedic Education and Training Board which has six sub-groups working on each of the recommendations. The College of Paramedics has representation on all these groups.

Degree level profession by 2016

Currently paramedics are the only Allied Health Professional group still at certificate level for entry onto the HCPC register. Following recommendations from the PEEP report, the College of Paramedics is working with the HCPC and Health Education England to move towards degree level entry by 2016. The HCPC will continue to recognise the IHCD paramedic qualification and therefore this development will only affect newly-qualified paramedics.
Career and Competency Framework and Scope of Practice: Developing post-registration education

Currently there is a lot of work going into the completion of the Career and Competencies Framework. This document will clearly set out our vision for paramedic career progression, including specialist paramedic, advanced and consultant level with the appropriate academic qualifications. This document could be described as the final piece in the jigsaw that forms the backbone of our profession. We have the HCPC Standards of Proficiency and Conduct, Performance and Ethics, the QAA benchmark for HEIs, the Curriculum Guidelines and then very soon this Career Framework. Everything else going forward for the profession takes its lead from and hangs off all these documents.

Continued Professional Development

The College of Paramedics provides access to high-quality CPD through the regional groups and of course, the first national conference this year. Working in partnership with the US’s out-of-hospital carer’s professional body, the National Association of Emergency Medical Technicians, the College of Paramedics is delivering the two-day Advanced Medical Life Support course in the UK. Here in Yorkshire the regular CPD sessions provide an excellent opportunity for engaged learning and sharing of experiences in an informal and relaxed environment away from the demands of the frontline.

The Best Practice Events held in partnership with YAS are always very successful and well-attended by staff. The next joint YAS and College of Paramedics’ Best Practice Event will be on Tuesday 9 June 2015 at Cave Castle, Brough, East Yorkshire. Full programme information and details of how to book will be released soon.

The Yorkshire Regional Group plans to hold evening CPD sessions across more areas of YAS in 2015 as well as exploring collaborative sessions with partner organisations. If you have any suggestions or are interested in getting involved please email: collegeofparamedicsCPD@yas.nhs.uk

Research and development

The College of Paramedics has a Research and Development Advisory Committee which provides guidance and support, including annual grants to paramedics who are undertaking research and provides awards and recognition to those paramedics who have completed research.

Consultation and collaboration

The College of Paramedics represents members’ interests and provides opinion and guidance with regard to profession-related issues to a range of government bodies and wider organisations.

A few examples are as follows:

- Lobbying government about the unrealistic and potentially unachievable current pensionable age of paramedics.
- Providing a parliamentary submission to the Home Affairs Committee for their review of Mental Health and Policing.
- Consultation on profession-specific opinion on the potential rescheduling of Ketamine to a Schedule 2 drug under the Misuse of Drugs Regulations 2001.
- Carrying out an evidence-based review of Advanced Airway Care currently provided by paramedics with a view to publishing a position statement on paramedic intubation.
- Working in collaboration with AACE and the Health Informatics Unit of the Royal College of Physicians to write the standards for Ambulance Patient Records which has been approved by over 25 organisations and the Professional Records Standards Body.
- Ongoing work on many clinical workstreams to advance clinical care, including sepsis with the UK Sepsis Trust, mental health and stroke.
Are you interested in becoming a College Liaison and promoting the College of Paramedics amongst your colleagues?

The College Liaison role is a non-elected voluntary position which is about promoting awareness of the College of Paramedics within the working environment. The role also provides paramedics and student paramedics throughout YAS with access to a recognisable point of contact for information on the College's purpose, aims and objectives or an avenue through which they will be able to feed views and comments back to the College. College Liaisons will be regularly updated regarding College initiatives and developments, areas of work and achievements and you will be asked to ensure that such information is made available to your colleagues.

If this sounds like something you would be interested in then please contact: membership@collegeofparamedics.co.uk

If you are a paramedic reading this, don’t forget to show evidence of reflection in your CPD portfolio. If you can’t face the Gibb’s Model of Reflective Practice, then try the Driscoll/Borton one; it’s simple, “What? So what? Now what?”