Paramedic INSIGHT

March 2024

COLLEGE OF paramedics™

Hip Hip Hooray!

Introducing fascia iliaca compartment blocks to prehospital practice

Independent Prescribing

The road to obtaining paramedic prescribing has been a long and often challenging process.

Esme's Story: Raising Awareness of Sepsis in Paediatrics Through Lived Experience

Leadership: Developing Roles in Primary Care

Student Paramedic Practice Placement Wellbeing

Welcome

Message from the Chief Executive

Welcome to our latest edition of INSIGHT as we look forward to the hopefulness that Spring brings. We want to acknowledge that those of you working in front-line services will feel the pressures have ramped up again as demand for services rise and the inability to create flow through hospitals remain. Your commitment to those who use our services remains compassionate, professional and I send my heartfelt thanks to for your dedication.

The College's Board of Trustees has agreed that we will embark on a revision of our current Strategy over the next year, and we will be seeking your views on what you want from the College and how we can best represent you as we navigate through the next few years. Your views matter and I will be setting up opportunities to speak to many more of you, including our College Liaisons who do a fantastic job, and I will be creating a network for Associate members of the College to hear your views and use the broad expertise we have in this category of our membership.

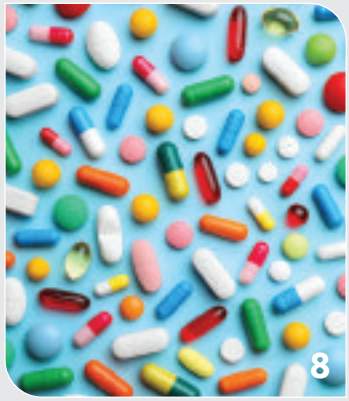
We will also be seeking your views on the recent government consultation on nurse pay, reflecting your views in our response. Please contact us with your thoughts and we will publish the response on our web site once concluded. Furthermore, we have started to seek our Scottish members' views as we gear up to attend the Scottish COVID-19 Inquiry in March. We want to reflect a balanced account and would appreciate your returns to enable as many of you as possible to be heard.

I encourage you to look at saving the dates for our Research Conference (21st May) and National Conference (22nd and 23rd May). There will be a wide range of opportunities for you to explore the identity of paramedics with what looks to be a great representation of speakers and offer you the chance to network and come together.

Lastly, I thank you for your support. We never forget as it enables us to continue our work as a whole team.

Stay safe and look after one another,
Tracy Nicholls OBE FCPara

Stay up to date with regular news, content and industry updates via our social media channels:



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Please feel free to send any suggestions for any future articles.
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2. Controlled Drugs; Legislation Changes This video looks into the recent announcement regarding regulatory changes to the Misuse of Drugs Regulations 2001 to allow paramedic independent prescribers to prescribe and administer, and direct others to administer, the following five controlled drugs: Morphine sulfate, Diazepam, Midazolam Lorazepam and Codeine phosphate

3. Silver Trauma, Gold Standard: Older people commonly experience trauma, including major trauma, with outcomes worse than in younger people. Presented By Dr Jonathan Treml, Consultant Geriatrician, this talk focuses on prehospital assessment and management. Available only to members, the CPD hub is free to access from the website once you've logged in.

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Scan the QR code to visit The CPD Hub.

Associate Head of Education

> "It's amazing to think that the 6th edition of the CoP curriculum could be the first mandatory paramedic curriculum since the 1980s."

Hello, I'm Lawrence. I'm the College of Paramedics' new Associate Head of Education, a one day per week role working alongside the Head of Education, Kirsty Lowery-Richardson.

I'm very proud of our profession, and of being able to influence paramedic education in the UK. I am also conscious that, with that pride comes a great responsibility – as the title of paramedic does for all of us.

I started my paramedic education in 2005, registering as a paramedic in 2009. I worked for the London Ambulance Service as an EMT, paramedic, and practice educator between 2006 and 2016. In 2013 I joined the University of Hertfordshire as a lecturer and completed my PGCert in Education. My passion for education saw me complete an MSc. in Medical and Healthcare Simulation in 2018, and I am currently studying for a ProfD part-time at the University of East Anglia (UEA). My doctoral research project explores how professional identity emerges from the experiences we have on the road to becoming and being paramedics. I am due to submit later this year...

I currently work as an Associate Professor at the UEA, where I am the Programme Lead for Paramedic Science, organise post-graduate modules specialising in PHEM (delivered in partnership with the East Anglian Air Ambulance), and chair a cross-faculty simulation-based education group.

I am delighted to be joining the team at the College of Paramedics. One of the things I'm going to be exploring first is devising and implementing a new endorsement process for pre-registration paramedic programmes that will reflect the 6th edition of the College of Paramedics Curriculum.

It is always an exciting time to be involved in education but never more so than now – it is amazing to think that the 6th edition of the CoP curriculum could be the first mandatory paramedic curriculum since the old IHCD "Blue Book" of the 1980s. It seems to me as though the arc of paramedic education has been tracking towards this point for nearly three decades.

We are on the cusp of a bright and intriguing chapter in our profession's educational history, as employment opportunities for paramedics increase and diversify at seemingly exponential speed. Paramedic education must facilitate the delivery of our future capability whilst also retaining the essence of who we are as a profession – which is no mean feat.

As part of my interview process, I was asked to present how I might reduce unwarranted variation in paramedic education. I think we need to find a way of containing the expectations placed on new students and early career paramedics, without constraining the enormous capacity of the paramedic profession to do good for society, and without causing individual paramedics to feel pigeon-holed into an historic or conventional notion of what paramedic work looks like.

So, although there will be bumps in the road ahead, the obstacle is the way, and I look forward to working with you, and for you, in the months and years to come.

Yours,
Lawrence Hill
Associate Head of Education

Leadership: Developing Roles in Primary Care

My name is Michael and I am a specialist paramedic working in primary care, having over 22 years' experience working as a paramedic, the last 6 of those have all been in primary care. I left the ambulance service in 2017.

Over the last four years I have worked at a GP surgery in West Yorkshire with a patient list of around 5,600 patients. I am lucky to be supported by a fantastic team of GP's and nurses. I am the only allied health professional at the practice, and my team have helped me blossom and develop.

I first started working here as a Locum and I could see the potential benefits of my role and was fortunate to be able to develop this. My employer is a forward-thinking organisation and encourage the organic development of their staff and value their staff satisfaction and development. I am the Frailty lead at our practice and as such this means that over time, I have slowly developed a specialist interest in all aspects of frailty, osteoporosis and the prevention of its complications naturally falling within this remit.

Osteoporosis is a "silent" disease. Patients do not have symptoms, and may not even know they have osteoporosis until they break a bone.

It is the major cause of fractures in postmenopausal women and in older men (NIAMS, 2022). Osteoporotic bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or a deficiency of calcium or vitamin D.

In my role as Frailty lead, I have my own case list of patients and manage those patients diagnosed with osteoporosis or osteopenia (the precursor to osteoporosis). This work may range from calculating the risk posed by osteoporosis (by way of bone density scans and FRAX prediction tools), routine monitoring to giving holistic advice on falls prevention. Preventing falls is arguably the most important part in avoiding fragility fractures.

I also undertake some of the more complex work such as diagnosis and the introduction of bisphosphonate treatment, or pausing of bisphosphonate treatment (drug holidays). and when needed, I liaise with colleagues in Endocrinology or Rheumatology bone health clinics, for further guidance.

In my former role as a road paramedic, I realised how devastating a fragility fracture could be. Undoubtedly, there will not be a single paramedic who hasn't attended a neck of femur fracture in a frail elderly person and witnessed the misery and agony associated with this tragedy. Hip fractures are life changing and devastating due to multiple factors.

A hip fracture is the most common reason for admission to an orthopaedic ward (Freeman and Clarke, 2016). It is vital to prevent fragility fractures arising in our ageing population. Most of those older people admitted will have osteoporosis or osteopenia.

In an ageing and increasingly frail population, osteoporosis will become a growing diagnosis alongside other more commonly discussed conditions such as Heart Failure. Given the extensive costs of fragility fractures to the NHS, the importance of trying to prevent these fragility fractures occurring is vital.

An important part of this process is having some indication of how successful your work is, and that you can quantify this process. I continually audit my practice and retain quantitative data which record the number of patients to whom I have made a difference. To date this totals 85 people. Some of the successful outcomes may only be very small, such as encouraging people to take medication or they can be much greater. For example, I have made unexpected diagnoses of osteoporosis post FRAX assessments and DEXA scans in two patients who are in their 50's and was pleased I was able to start preventative treatment. Being our practice Frailty Lead fills me with an enormous sense of pride as I feel I make a real difference to patients' lives. I would strongly encourage other primary care paramedics with an interest in Frailty to explore this further in their roles.

Michael Good, Frailty Lead, Specialist Paramedic

Some facts:

- Mortality is high – about 10% of people with a hip fracture die within 1 month, and about one third within 12 months.
- The average age of a person with hip fracture is 77 years (NICE, 2009).
- In England and Wales, it is estimated that annually around 180,000 fractures occur as a result of osteoporosis. Of those around 70–75,000 are hip fractures (NICE, 2023).

References: Freeman, N. and Clarke, J., 2016. Perioperative pain management for hip fracture patients, Orthopaedics and Trauma, 30(2). Available from: Perioperative pain management for hip fracture patients (researchgate.net)
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Burnout

More than half of NHS paramedics suffering from burnout

'More than half of NHS paramedics suffering from burnout' one national newspaper headline states (The Guardian, 2022). 'Ambulance crews 'stretched to breaking point' as mental health sick days soar', reads another, from last year (The Independent, 2023). Although written months apart, both articles comment on the impact of increasingly stressful and overwhelming working conditions that have been attributed to heightened demands, staff shortages, and reduced capacity associated with excessive waits to handover patients at hospital. Both articles mention the effects of working in these intense conditions, with ambulance staff and paramedics undertaking long, and often extended shifts, whereby not receiving a rest break had become normalised. Both articles report working environments which are unequivocal with wellbeing, and indeed talk of the perils of a workforce that is facing burnout and mental ill health conditions as a result. And, this is, of course, off the back of the largest crisis our country has seen in years; the coronavirus pandemic, which, as we know, tested healthcare professionals to their limits.

Today, the challenges paramedics face in their work, have not resided, and these challenges are not limited to those working within the NHS or even in the United Kingdom. Feeling the pressures of your work and your role can have a wide ranging impact upon people. This can range from experiencing a reduced sense of empathy with patients, relatives, or even work colleagues, to feeling emotionally and physically overwhelmed and exhausted. It can also mean feeling indifferent about your work, such that it no longer gives you a sense of satisfaction or you've become disengaged with it. This can also extend towards patients, whereby you may find yourself interacting in an impersonal and objectifying way. Alternatively, it may be that you perceive that others do not recognise your own humanity.

Whilst the syndrome of 'burnout' encompasses these component feelings (WHO, 2019), and is a term representative of 'a [chronic] negative response to continued emotional stress' (Maslach et al, 2001), it is not the only reaction that we may experience when under pressure. Needless to say, I'm sure that many of us will have encountered other effects such as low mood, anxiousness, or stress, or physical responses such as insomnia, headaches, muscle tension, GI upset and repeated minor infections or illnesses.

So, what can help if we're feeling exhausted, worn out, and/or feeling the pressures of our work? Well, research tells us that aside from addressing the causes, one of the key resources available to us is actually, one of the best mediators for burnout, stress, and low mood. That is, our friends, family, and those who we share a connection with. Having the opportunity to talk and off-load to someone who listens and gets where we're coming from, is vital when we're under strain.

Recognising this, the College's Rejuvenate. Thrive. Breathe paramedic wellness programme has connected with a trusted partner, the health professionals charity, 'Doctors in Distress' to offer full members the opportunity to join a paramedic-only safe, confidential virtual meet up that is led by a trained facilitator, who is not only familiar with the pressures that we face but will also guide the discussions, ensuring a supportive and constructive, non-judgemental atmosphere. The meet up's offer a secure place to share your experiences, what's on your mind, how things are for you at work, and hear from others, your peers, who understand these challenges and quite likely, will be experiencing similar themselves. The saying, 'what's said in the cab, stays in the cab' applies – what's said in the meet up's, stays in the meet up's – and we really emphasise this so that you can trust this to be a safe, contained environment.

Because the meet up's are virtual, it means that wherever you are in the country, or even if you're abroad, you're able to join. Furthermore, the meet up's are flexible – you can join every week, or just whenever suits you. They will be running between March 12th and May 14th, every Tuesday between 12.30 – 13.30. *If you'd like to know more, just see our events page or contact Jo, the College's Paramedic Psychological Health & Wellbeing Manager, at Jo.Mildenhall@collegeofparamedics.co.uk.*

Jo Mildenhall
Paramedic Psychological Health & Wellbeing Manager

References: Maslach C, Schaufeli WB, and Leiter MP (2001) Job Burnout, Annual Review Psychol, 52, 397 – 422.
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> Ambulance crews 'stretched to breaking point' as mental health sick days soar.

Independent Prescribing

The road to obtaining paramedic prescribing has been a long and often challenging process the article aims to explore the history of the challenges faced by paramedics as well as the future for non-medical prescribing within the paramedic profession in the future.

History of Non-Medical Prescribing

The concept of non-medical prescribing was first proposed in 1986 in the Cumberledge Report. This was furthered in the Crown report in 1989 with an aim to improve patient access to medication and in 1992 legislation was approved to allow district nurses and health visitors to independently prescribe from a limited list formulary.

Between 1999 and 2002 pharmacists and nurse supplementary prescribing was approved and in 2006 this was extended to pharmacist and nurse independent prescribing. In 2012 pharmacist and nurse independent prescriber were granted authority to independently prescribe controlled drugs.

In 2005 supplementary prescribing was added for physiotherapist and podiatrists, with independent prescribing added in 2013. Optometrists gained independent prescribing in 2007 and more recently independent prescribing by therapeutic radiographers and supplementary prescribing by dietitians.

In professional terms paramedics are relatively new. The first paramedics registered with the Health and Care Professions Council in 1999 with the current academic level of BSc (Hons) degree required to qualify for registration. The role has evolved from "ambulance driver" to paramedics and for some members of the profession to advanced and specialist practitioners. The legal ability to be able to prescribe along with other health care professionals further enhances the professional standing of paramedics and grants us the ability to work alongside

The Timelines of Professionals in the UK with regards to prescribing rights	
1841	Pharmaceutical Society of Great Britain established
1843	Pharmaceutical Society of Great Britain receives Royal Charter
1858	General Medical Council established
1894	Chartered Society of Physiotherapists established (under a different name)
1916	College of Nursing established
1920	Chartered Society of Physiotherapists receive Royal Charter
1939	College of Nursing receives Royal Charter
1971	First paramedics trained
2000	Formation of paramedic professional register
1986	Cumberledge Report
1989	Crown report
1992	Nurses obtain independent prescribing from a limited list of medicines and dressings
2002	Nurses and pharmacists obtain supplementary prescribing
2005	Physiotherapists and podiatrists obtain supplementary prescribing
2006	Nurses and pharmacists obtain independent prescribing (No CDs)
2012	Nurses and pharmacists obtain CD prescribing
2013	Physiotherapists and podiatrists obtain independent prescribing
2018	Paramedics obtain both independent and supplementary prescribing (No CDs).
2023	Paramedics obtain limited list CD prescribing.

other health care professionals and the ability to provide a more comprehensive range of services to the patient.

The concept of prescribing by paramedics was consulted on in 2015. Initially the approval for paramedic prescribing rejected by the medicines and health regulatory authority (MHRA) Due to lack of assurance around advanced practise. The college returned to MHRA with their revised proposal including the definition of advanced practise and in 2018 legislation was approved to allow paramedic supplementary and independent prescribing.

On the 1st April 2018 new laws came into force which allowed advanced paramedics to prescribe. This change brought appropriately trained paramedics who have completed a HCPC prescribing course in line with other professionals who have completed prescriber training. Unlike pharmacist and nurse prescribers however paramedics were only allowed to prescribe from a limited list of controlled drugs.

The authority to prescribe medicines in the United Kingdom comes from 2 pieces of legislation. The first is the human medicines regulations 2012 at the second which covers controlled drugs prescribing is the Misuse of Drugs Act.

In order to obtain prescribing rights for controlled drugs both the human medicines regulations and the Misuse of Drugs Act must be amended. Any amendment to the Misuse of Drugs regulations must be consulted on with the advisory committee for the Misuse of Drugs (ACMD).

In April 2019 the College, along with representatives from NHS England attended a meeting with a CMD where we presented evidence and addressed any concerns recounting paramedic prescribing of the limited list of controlled drugs.

In October 2019 the AMCD formally wrote to the Home Office stating their support for the amendment of the misuse approved regulations. Due to external factors such as Brexit and COVID-19 there was a delay. The College remained in regular contact with NHS England and in the summer of 2023 met with both Lord Butler and later Lord Patel to express our concern about the continuing delays to the amendment of the act.

Following this meeting Lord Butler, with the support of other peers led the House of Lords debate in which they obtained a definitive timeline for the amendment of the regulation.

The College then worked closely with both the Home Office and the Department of Health and Social Care to provide case studies as well as cost benefit analysis to further support the amendment of the regulations.

Current practice – supply and administration of medicines

At present paramedics are allowed under an exemption (Part 3, schedule 17 of the 2012 Human Medicines act) to administer a range of medicines for the immediate treatment of a sick or injured person. Paramedics are also able to administer and supply drugs under patient group directives and a specific exemption is in place to allow paramedic to use ketamine and midazolam.

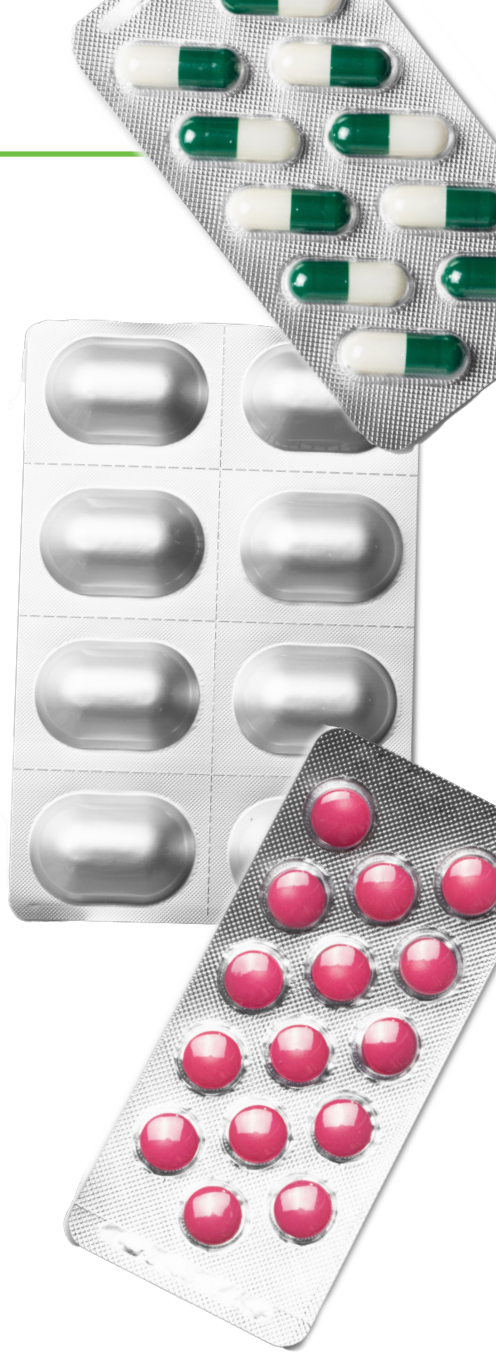
Neither patient group directions or exemptions allow paramedics to delegate the administration of medicines to any other person.

Paramedic Prescribers and Prospective Prescribers

The prescribing course is undertaken at level seven and is open to advanced paramedics. The decision to prescribe a medicine is not an isolated process but must consider additional skills including a good history taking, appropriate patient examination, knowledge of pharmacology, pathophysiology and therapeutic effects of the medicine on both the current and existing disease processes as well as medicines side effects and interactions with patients existing medicines.

Benefit to the patient is the most important consideration. Within the health care the paramedic role is moving away from pure pre hospital and emergency care and extending into urgent and unscheduled care and the paramedic role moving away from purely operating on front line ambulances to providing health care to patients in out of hours services, general practice surgeries, minor injuries centres as well as accident and emergency departments and on hospital ward.

Time of writing this article there were all the 2100 registered paramedic



prescribers on the HEPC register. These paramedics operate in a variety of healthcare settings including general practise emergency department's on wards within out of our services as well as hospices community positive care teams and critical care teams.

The Future

We are aware of the current limitations on controlled drugs prescribing and the College fully intends to put forward their case for full independent prescribing rights including unlicensed medication for all paramedic prescribers. The College will continue to support both paramedic prescribers and prospective paramedic prescribers by providing access to robust information and advice on all aspects of prescribing.

David Rovardi MRPharmS, MCPara

Beyond Borders: Team India

Team India's Mission to Elevate Healthcare Standards

In 2014, Dennis Moss was part of a team helping to set up water pumps across different villages in India, with the Asian Fire Service association (AFSA) who helped to fund the project installing 6 water pumps. Whilst on this trip, a 15-year-old Indian student, from Dennis' hometown, tragically passed away after choking on his lunch. After hearing this devastating news Dennis asked to visit the school so he could speak to the principal to try and gain some insight as to how such an event could happen. From the talk it became apparent that the situation could have been prevented had someone known basic first aid skills, Dennis promised to help, and the idea of Team India was born.

In 2015 Team India was officially set up by Dennis using his contacts throughout the NHS Ambulance Services. He put together his first group of volunteers, including serving paramedics, fire fighters and a police officer. In 2015 they made their first trip to the country, and so far over 5000 people have been trained at an array of schools across different areas of India as well as villages, hospitals and even the golden temple in Amritsar, Punjab.

Now every 18 months Dennis and his team of volunteers fly out to India with a collective aim to help and train the local communities to make sure an incident like the one that took place in 2014, never happens again. Through donations from different ambulance services, they have managed to donate a range of medical equipment across the country, including West Midlands Fire and rescue who donated 4 AED defibrillators.

Reflecting on his proudest achievements from the trips, Dennis mentions "One of the things that stands out is when they recently had the floods in Darjeeling, we had trained the rescuers that had gone out to help... It's so rewarding, I know we pay a lot of money to go up (to India), but it is suddenly forgotten about when you go there because after the training, what they do for us, and how they greet us in the schools where they have kids singing and all this stuff, and they give us small gifts, we are crying because how much these people appreciate it."

Touching on the difference in lifestyle across the country Dennis says, "When you see India, there are two different scenarios, I was watching a programe yesterday on a millionaire in Bombay and I'm thinking; Hang on, there's all this money here and there's people on the streets who are struggling, and it gets to me and that's why we do it".

The trip does come with some difficulties however, Dennis spoke on some of the challenges he had faced whilst on the trips "The language barrier can initially be a challenge but after a while you get to break the ice with them and make them feel more comfortable around everyone and they come out of their shells, we get them to do the Mexican wave and when they go on lunch and they are playing football we will get involved and then they start to relate to us".

"When the volunteers come back, they get such a good feeling about the experience and they share it with everybody as well, and then they want to go next time, they say we want to go and do it again! 'I have doctors that want to come with me and want to be part of this group because they love what we do. They ask; how they can get involved because they want to do it and help."

Get Involved

This year's Team India will take place in multiple different locations and communities across the country including Amritsar, Kalimpong, Jamshedpur, Kolkata, Chennai, Tamil Nadu. The volunteering period is set for three weeks and has been provisionally scheduled between the 16th of October and the 4th of November 2024. Volunteers will undergo a comprehensive training program to ensure proficiency in delivering first aid training.

If you are interested in getting involved in this amazing project, you can contact Dennis Moss at dmoss999@hotmail.com to register your interest and find out more about the experience. If you are interested in helping the 'Team India' project but unable to make the trip you can help by donating old equipment or sending donations so that equipment can be purchased.

Volunteers are expected to self-fund their trip. Details of expenditures will be sent to every member of the team. Volunteers must be able to commit time off work, either through their employer's support or annual leave.

Esme's Story:
Raising Awareness of Sepsis in Paediatrics Through Lived Experience

Issy Millbank, Year 2 Student Paramedic, University of Greenwich.

"This piece comes straight from the heart and shares beautifully the personal, tragic story of a young life taken too soon. I would like to thank Issy and her mum Emma for sharing their experience and commend their bravery, I hope they agree this is a lovely tribute to Esme whilst also providing a thoughtful opportunity for learning amongst our professional community".

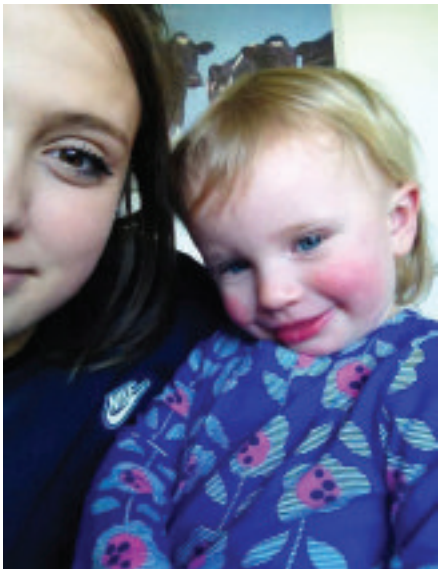
Kirsty Lowery-Richardson, Head of Education, College of Paramedics.

The day I found out I was going to be a big sister, I was 12 years old. Sat in the dentist waiting room with my Mum, I watched as she filled out her forms and ticked 'yes' to the question 'are you pregnant?'. My Mum was 44 at the time and her pregnancy was still in the early stages. She warned me of the risks and to not get too excited yet. Of course, that didn't stop me. I was so excited. That evening, I saw my first shooting star in the sky flash before me. I remember closing my eyes and just wishing for everything to be okay.

On the 16th of June 2012, my wish came true. My little sister Esme Williams, was born perfect and healthy. Esme brought so much happiness into our lives and we had so much to look forward to. I felt a love I had never experienced before. We had the privilege of watching her blossom into a funny and happy little girl, who loved nature and her family. We spent many days together, often at the playground or at the beach. She used to sneak into my bed in the morning for a cuddle, her cuddles were the best. She never failed to make us laugh and everyday was made brighter when Esme was there. We loved every single moment, but you never truly realise the value of those moments until they become a memory.

On the 5th of February 2016, Mum chose to not send Esme into nursery. She had been unsettled in the night and had developed a slightly hoarse voice. Esme instead spent the day at our grandparents house. Esme had seemed okay that morning, she ate her breakfast and played with her toys. However, as the day progressed Esme appeared to become a little more poorly and the area above her lips had turned blue for a short period of time. My Grandparents became alarmed and called Mum home from work. She picked Esme up and took her straight to see the GP that afternoon. At the GP surgery, Esme had appeared to become breathless and was visibly using accessory muscles with each breath she took. The GP removed Esme's top to listen to her chest and whilst doing so noticed a rash. He rubbed his hand across her chest and explained to Mum that it had felt like a 'sandpaper' rash, a symptom of scarlet fever. The GP had evidently felt concerned as he chose to ring for an ambulance, however it was felt communication wasn't clear and no differential diagnosis was actually stated when making this call. Mum says they waited in the waiting room for around 90 minutes and in this time Esme became more restless and short of breath. She seemed as though she could not get comfortable, one minute pacing around the room, the next she was curling up into Mum's arms and lethargic. This was abnormal for Esme.

When the ambulance arrived, Mum asked Esme if she would like to be carried. Esme declined and walked her way onto the ambulance. Paramedics checked Esme's vital signs, but had queried whether their equipment was working due to abnormal results. They had decided this was not time critical and Esme was conveyed to the Emergency Department without blue lights. They arrived at hospital, where Esme's Dad was waiting for them. Again, Esme strolled her way into A&E, appearing to seem 'okay'. A doctor came and assessed Esme and upon checking



> "Every hour of delay in sepsis treatment increases a person's mortality by 7.6%"

her throat said 'this looks like tonsillitis'. It was late into the evening at this point and it was decided that Esme would be admitted onto the children's ward. A short while later, as she laid quietly in her bed, Mum explains that the colour in her skin suddenly washed away and she became grey. Nurses became alarmed. It was at this moment healthcare professionals rushed to her side and crowded around her to figure out what was happening. All Mum and Dad could do was helplessly watch on, as they rapidly tried to help their little girl. After what had felt like a lifetime, a Doctor approached and explained that Esme was in septic shock. She needed to be anesthetised so they could stabilise her. The Doctor said 'I think you should prepare yourselves for the worst'. They went to Esme's side and told her how deeply loved she was. Esme replied 'I love everybody'.

The South Thames Retrieval Service arrived to rapidly transfer Esme to the paediatric intensive care unit at St Thomas' Hospital in London. Once at the hospital, healthcare professionals had worked hard to stabilise Esme. It was around 3am and Mum was told that Esme was stable enough for them to try and get a little bit of rest. They were both exhausted. As they kissed Esme goodnight, a single tear rolled down her cheek. No more than 20 minutes later, Esme went into cardiac arrest. Nurses and doctors worked tirelessly to save her but on the 6th of February 2016, our beautiful Esme, aged just 3 years old, passed away.

I was 16 years old at the time, but I remember receiving the news like it was yesterday. It had felt like someone had pulled the ground from beneath my feet. Esme had been ripped away from us with no warning. I was confused how this could happen to such a healthy little girl, so pure and innocent in this world. I recall reading her death certificate: Group A Streptococcal Septic Shock and Pneumonia with Empyema. I still couldn't understand it. It felt so unfair.

It was during this painful time that I decided I wanted to pursue a career in healthcare. I got myself a job at my local hospital and worked as a healthcare assistant. It was here that I saw first-hand how often sepsis was occurring. A few years later, I gained myself a place at university to study paramedic science.

Last year, after receiving a lecture on paediatric assessments, I made the decision to share Esme's story. My lecturer felt passionate about me sharing her story further. However, I felt I still did not truly understand what had happened to Esme. That evening I went home and felt compelled to find more answers. I spent days talking to Mum, researching, reading journals, watching webinars and making notes. Together, with the further understanding I had grown, my lecturer and I turned Esme's story into a case study and presented it to the cohort. It was truly moving to hear how this had affected not only my fellow students, but teachers too. Upon receiving feedback, my peers mentioned how thought-provoking the session was, how it had helped them to recognise early warning signs, and how they felt it had a significant impact on how they practice in the future. I felt it was important to raise the awareness of the way in which sepsis affects children because it can be so difficult to recognise initially when they compensate so well.

My Mum had been told after Esme had died, that had she taken her to hospital a day earlier, it would've been unlikely that anything sinister would have been recognised and she may have been sent home with no treatment at all. However, when Esme was taken in to the hospital, it seemed to be too late. It felt like a lose-lose situation. Surely this should not have had to have been Esme's fate.

Sepsis causes approximately 1 in 5 deaths globally. In 2023, an Ombudsman report showed that even after a decade of campaigns and improvements, there were still serious failings found. This included: unnecessary delays in diagnosis, failures to start treatment quickly, delayed referrals to critical care and insufficient staff training. The progression to organ failure and shock is often extremely quick, so early recognition and treatment is crucial. Every hour of delay in sepsis treatment increases a person's mortality by 7.6%.

It has also been shown that around a third of patients with sepsis show signs of mental dysfunction, such as confusion and agitation. Sometimes a change in mental state may present first before any obvious changes in vital signs occur, particularly in children. According to NICE guidelines, in children under the age of five, a history of new onset changing behaviour or change in mental state, as reported by the child

or a relative, can indicate a high risk of serious illness or death from sepsis. In addition, the occurrence of mottled or ashen appearance, cyanosis of the skin, lips or tongue, decreased oxygen saturation and an elevated respiratory rate were also highlighted as high risk. Esme presented with all of these critical signs, yet diagnosis and treatment were still delayed. What went wrong?

Although rapid diagnosis is crucial in sepsis patients, it is without a doubt difficult. Unlike adults, children can compensate very well during the early stages of illness. They may appear 'well' on the outside, but it is imperative to not let this deceive our judgement. Paediatrics have the ability to maintain the perfusion of major organs while sacrificing other parts of the body, for example reducing blood flow to their hands and feet. Cold extremities and a prolonged capillary refill time, particularly in children under 5, can subsequently indicate early signs of serious illness. Decompensation happens when the body's compensatory processes have been exhausted, and when left untreated, can rapidly result in multiple organ failure. Early recognition and treatment of sepsis can massively decrease chances of mortality for patients. Sepsis is time critical and if suspected, it is crucial this information is clearly communicated and acted upon.

I feel it is necessary to emphasise the importance of listening to parents. Dr Mike Durkin said "Time and time again, and in some cases tragically too late, we see that some children could have received better care if healthcare providers worked with parents to understand and treat deterioration in health". Martha's Rule proposed in 2023, will give all patients and their families the right to receive a second opinion whilst in hospital. This rule was introduced after 13 year old Martha Mills died from sepsis, after her parents had repeatedly been dismissed after raising concerns about their daughter's health. Sadly, this is not the only case in which parent's worries have been unheard, and subsequently children have died. It is without a doubt that parents and carers know their child far better than the health professionals. When a parent feels their child is just not right, even in the absence of any specific reason, their concerns should absolutely be heard.

I think many lessons can be learnt from Esme's death. The pain of losing her will be with me forever, but so will the passion to make a change. If sharing Esme's story saved just one person's life, I feel comforted knowing that her death was not in vain. I believe sharing these raw and painful experiences can massively influence changes in practice; it certainly has for me.

'It's incredibly brave of Issy to share Esme's story – the story of a vibrant little girl with a bright future taken away from her by sepsis. Her story reminds us how sepsis can strike anyone at any time, and that we all need to be aware of the signs and symptoms, and how and when to access healthcare. It's all the more poignant because Issy has taken her horrific experience and turned it into a determination to help others, to raise much-needed awareness and to saving other families from her trauma. The UK Sepsis Trust is on a mission to prevent avoidable harm from sepsis through public awareness, health professional education and patient and family support – and we are so grateful to Issy for her part in this'.

Dr Ron Daniels BEM, Founder and Joint CEO: UK Sepsis Trust. Vice President: Global Sepsis Alliance. Senior Lecturer in Intensive Care Medicine: Queen Mary's, London

Issy's story is heart breaking. It is also important. Sepsis remains the most common avoidable cause of death in children in the UK. Sadly every year thousands of families, just like Esme's, are left wondering 'could more have been done to prevent this'. Around a third of children presenting acutely to hospital have a fever but only one percent have sepsis. Issy powerfully highlights important aspects of care including listening to the family, thinking 'could this be sepsis', and acting on it urgently if suspected. Good clinical observations; the assessment of trends; referring to age specific sepsis tools; and clear and timely communication between professionals are all essential. As professionals we must do this well and do it consistently. Esme's death then would not have been in vain'.

Mathew Mathai
Consultant Paediatrician, Bradford Teaching Hospitals NHS Foundation Trust.

Just ask: Could it be Sepsis?

An Inclusive Route to Paramedicine

The Paramedic Higher Education Team at St George's University of London (SGUL) have been working with the College of Paramedics on a pilot project to create and introduce a more inclusive route to paramedicine. The intention is to invite applications from a small number of students who, for a variety of reasons, would not be likely to take up roles within the ambulance service upon registration but rather consider roles within primary and urgent care and alternative health and care settings. Individuals for whom neurodiversity or physicality may impact their ability to gain the relevant driving licence, or limit their lifting or moving and handling ability, would still be considered for the programme wherever possible.

The rationale came from scenarios where students who were already on the SGUL paramedic programme found themselves in situations where they would not be able to drive an emergency ambulance upon completion of their studies and had to find alternative employment as a paramedic. As educational colleagues appreciate, this is an exceedingly difficult time for students who realise that they will not be able to commence the Newly Qualified Paramedic (NQP) programme with an ambulance trust, and with limited other openings for paramedics to begin their career, new registrants have struggled to gain employment.

The idea came from Senior Lecturers Paul Burke and Chris Baker, both undertaking research into inclusion as part of their Doctoral studies, and from a conversation with Kirsty Lowery-Richardson relating to widening participation within the profession. Initial meetings to develop the programme were held in July of 2023, involving leads for disability and inclusion within the College, and leads from SGUL. It soon became apparent that this should not be a change requiring a huge fanfare, but rather a case of minor alterations to accommodate those who the course is aimed at recruiting.

Initially the possibility was a separate programme with places for up to 10 students, it soon became apparent that this would lead to 'othering' of students, the exact opposite of the team's hopes and intentions. As the discussions progressed the project team realised that this needed to be more a natural development of the paramedic programme, with the application process remaining the same, but with greater consideration for the individual needs of applicants, including occupational health and educational support to ensure that students of all backgrounds had a similar experience and opportunity to register with the Health and Care Professions Council (HCPC) upon graduation.

The paramedic course at SGUL recruits 110 UCAS students each year, with ambulance placement provided by London Ambulance Service (LAS) and a variety of clinical placements in settings both hospital based and within the community. The programme has already increased the number of wider placement opportunities whilst seeking to increase student numbers, such placements would be an integral requirement when expanding the number of students with wider placement needs. Intake numbers could increase to 120 to facilitate the additional learners. Students undertaking the programme will be individually assessed for needs and ability, with a hope that all will still be able to experience ambulance placement, even if they may not be undertaking an ambulance role upon graduation.

This has positive benefits for our placement manager, who can offer placement providers paramedic students

> "The main aim is to ensure that all students on the programme are provided with wider employment opportunities upon completion.

for longer periods than they currently undertake, as feedback is often that short placement periods in non-traditional settings have limited benefits for both students and providers. Providers may also be more likely to accommodate paramedic students on placement as they realise that, upon graduation, these students will be looking to step into roles outside of the ambulance service. Providers may therefore wish to consider how they can support the development of these whilst on placement with a view to offering permanent positions upon graduation. SGUL is working with some of the local Integrated Care Systems (ICS) to potentially develop an ICS NQP programme.

As with any changes to a regulated Higher Education programme, these were presented to the HCPC as well as undergoing internal scrutiny for approval at SGUL, receiving favourable support. The programme outline was presented at the Forum for higher Education in Paramedic Science (FHEPS) meeting in December 2023 to garner interest and obtain feedback from educational leads of programmes across the UK. It was invaluable to gain opinions from fellow professionals, considering both benefits and potential pitfalls of commencing such a programme. Mentimeter slides were used to ensure feedback was collated for review to support the considerations already in place from the project team.

At the heart of the project lies the desire not only to make the course more inclusive but also to ensure that students were not being set up to fail. To do so the programme team are considering what suitable adaptations would need to be made to practical delivery and simulation, and what would be the appropriate changes to make to assessment which would be suitable for all students. This does promote the conversation regarding Advanced Life Support, an area which could demand several pages of discussion within this publication! However, the subject has been discussed at length, with suitable conclusions believed to be provided.

The representatives of FHEPS provided feedback that will be utilised to support the introduction of the inclusive paramedic route. The feedback is being reviewed and used to provide final updates to the programme design, prior to this being advertised later this year (and possibly by the time Paramedic Insight has been published) ideally for a 2025 implementation. The main aim is to ensure that all students on the programme are provided with wider employment opportunities upon completion but recognising that most students will still undertake the traditional NQP route initially. However, some who may previously have considered their career to be ambulance based upon graduation may change their minds, whilst some who are not initially able to join the NQP programme may take up employment in ambulance services later in their career, bringing more experience to roles when they do so, a positive for the ambulance services across the UK.

Chris Baker FHEA MCPara, and Paul Burke FHEA MCPara, St Georges University London

Clinical Development

Tips and Considerations When Prescribing at End of Life

Our Paramedic and wider ambulance teams have been incredible throughout the pandemic and continue to work under tremendous pressures in our communities day and night. With an ageing population, workforce limitations and the needs to support our Palliative & End of Life Care patients at all hours, often in remote places within their own home or in the care home, as well as in transit to hospitals, the ability to administer and or prescribe certain end of life care medications is very much a welcome addition to their immense skillset. We only have one chance to get any individual's end of life care right and the dying moments remain forever in the hearts of the loved ones. However, it is also true to acknowledge that though Palliative & End of Life Care is clinically everyone's responsibility, it is something we as a nation and health and care system have not done as well as we would all like to do. Paramedics are used to dealing with urgent life saving, serious hospital requiring and many accidents requiring urgent care.

Being a new prescriber requires mindful practice to navigate the uncertainties involved with a patient who may be approaching end of life, but equally who may have reversibility of their deterioration despite having a terminal illness. Paramedics are excellent at recognising seriously ill patients whose NEWS score may indicate potential sepsis but, equally one must remember that a dying patient may similarly present with a similar picture and the last the last thing we should be doing is conveying such patient to the emergency department. Also, administering end of life care medications or concluding someone is end of life in a rushed manor without all the information, could deprive someone of precious life time, and the paramedic immense professional regret. Remember to navigate these uncertainties wisely.

Speaking as an experienced GP with interest in P&EOLC, I am keen that we all must as a system, identify our end-of-life care patients early, code them such on our clinical systems, assess them with a patient centric ethos, write up a personalised care plan such as ReSPECT and ensure it is shared on all interfaces. Sharing such plans so it is absolutely clear what really matters to the patient is as critical for the patient as it is for the attending crew at 3 o'clock in the morning. Adapting a checklist can be helpful:

1. Is this patient coming to end of life as expected and is this sudden deterioration, and is there reversibility despite their terminal illness?
2. Is the high NEWS Score relevant if the person is coming to end of life and what does the advanced care plan such as ReSPECT state? If none are available, do I think the patient is dying and if so who else can help deliver on their wishes at the time?
3. If I need to administer pain relief such as Morphine, do I have any indication of their renal function. Should the patient have an eGFR below 30, please exercise caution as you will need to reduce the dose. This may be the case even if they are dehydrated and you are not aware of the eGFR. This applies to other medications as well.
4. Prescribing any opiates without laxatives will cause constipation that could be so problematic in a frail dying patient, so always check their natural bowel habit and aid it! Additionally, they can feel nauseous and covering any such needs as well as explaining to the patient is crucial.
5. Any drug related queries can be checked with our supportive hospices who are always so helpful at any time of the day or night.
6. More than the drugs we prescribe, the words we use are so crucial in maintaining our professionalism and I would urge everyone to always be mindful of any comments we make in this context.
7. Advanced Care Planning, resuscitation status and patient care wishes matter most in our P&EOLC patients. We should all work together to meet the needs of our patients, professional and system a priority by developing our clinical and communication skills.
8. Many of our patients have pacemakers but some have an ICD and having a magnet to deactivate this is something worth being proficient at and having it in your toolkit.
9. Finally, we provide the best care by carefully first eliciting the history, examining the patient and listening to the family and carers first, as death and dying is something we will all face and ultimately, we only have to ask ourselves what would we want for our loved ones or ourselves?

Dr Rakesh Koria MBBS MRCGP
Acute Response Team Macmillan GP
NHS Kent and Medway ICB Ageing and Dying Well Clinical Lead
NHS England SE P&EOLC Clinical Lead
NHS England GP Appraiser

A Manifesto for the Future

The College has recently shared its first manifesto, our list of some of the key issues we need politicians and decision makers to be aware of and work with us to achieve.

With a UK general election due to be held this year, we've worked with colleagues and representatives, including consulting our Board and Student Council, to develop some keys asks for the next UK Government.

Our manifesto is an advocacy document predominately aimed at politicians, as well as listing key issues in the paramedic profession, it gives an introduction to the roles and skills of paramedics to highlight the breadth of the profession. We have sent it to all the main political parties as part of our policy and public affairs engagement work.

We have identified 9 key areas that we believe the next UK Government needs to be aware of and work with us and our colleagues to address.

1. **Parity for paramedics across the UK:** Health is a devolved matter, and we need all parties and Governments to work together to ensure the skills of paramedics are recognised and supported equally across the UK.
2. **Improved data sharing to aid learning and development:** Although access to patient records has improved, more needs to be done to enable paramedics to have timely access to patient data to ensure continuity of care, and to aid learning.
3. **Impactful investment in mental health and wellbeing support for frontline and high intensity clinical settings:** We are calling on decision makers to invest in long-term mental health and wellbeing support for staff in the healthcare sector especially those working in high stress situation.
4. **Expansion of prescribing rights for paramedic independent prescribers:** The recent changes to legislation to allow paramedic independent prescribers to prescribe a list of approved controlled drugs came after a long campaign from the College of Paramedics. More work needs to be done to expand prescribing rights, including amendments to allow student paramedics the right to administer injectable medication.
5. **Understanding the role of paramedic in hospital handover and patient flow:** Undifferentiated patients awaiting ambulance response in the community presents the greatest patient safety risk during times of increased pressure. We need decision makers to work with us and our healthcare colleagues to address the challenges and support the ambulance sector's capacity to deliver a safe and effective service to those most in need.
6. **Support investment in professional growth:** In order to ensure a continuous stream of new professionals, Higher Education Institutions need support with funding for undergraduate courses, and support for the recruitment and retention of paramedic educators.
7. **Appropriate funding for resources to meet demand within Urgent and Emergency Care:** The College would support a full commissioning review to enable a modern provision of care to better meet the needs of patients.
8. **Support integrated community care to reduce avoidable conveyance to hospital:** Paramedics work autonomously with undifferentiated and undiagnosed presentations. It is this pluripotential nature that can be used to support integrated community care and reduce further admissions to hospital for patients where this is avoidable.
9. **Greater definition and support of Advanced Practice roles:** Supporting advanced practice helps other services, such as freeing up emergency ambulances to answer the most life threating call. Greater clarity of the scope of roles will also support the development of paramedics as healthcare professionals.

You can read the full manifesto on our website, and as we get closer to the general election we will share more resources with our members, including a guide to contacting your local representative and summaries of the party manifestoes.

Our manifesto is just part of our ongoing policy and public affairs work with governments and stakeholders across the UK. We will keep members informed and involved with our developments, including our progress on developing an All Party Parliamentary Group on Paramedicine.

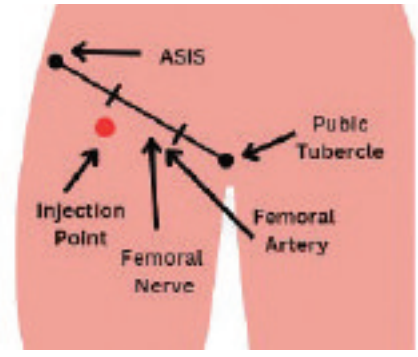
Mandy Powell,
Policy & Public Affairs Manager

Hip Hip Hooray!

Introducing fascia iliaca compartment blocks to prehospital practice. **Emma Duncan, Mark Kingston, Simon Ford** on behalf of the RAPID2 trial team.

Fascia iliaca compartment block (FICB)

FICB is a local anaesthetic injection given directly into the hip region. The local anaesthetic is injected into the fascia illiaca compartment, where the femoral nerve and lateral cutaneous nerve of the thigh lie. These nerves are therefore bathed in a high volume of local anaesthetic to provide analgesic effects.



(Image 2) – paramedic undertaking RAPID2 training using a custom-made groin model.

FICB is already routinely used in hospitals, including in Emergency Departments as pain relief for hip fracture patients.

Benefits and risks of FICB

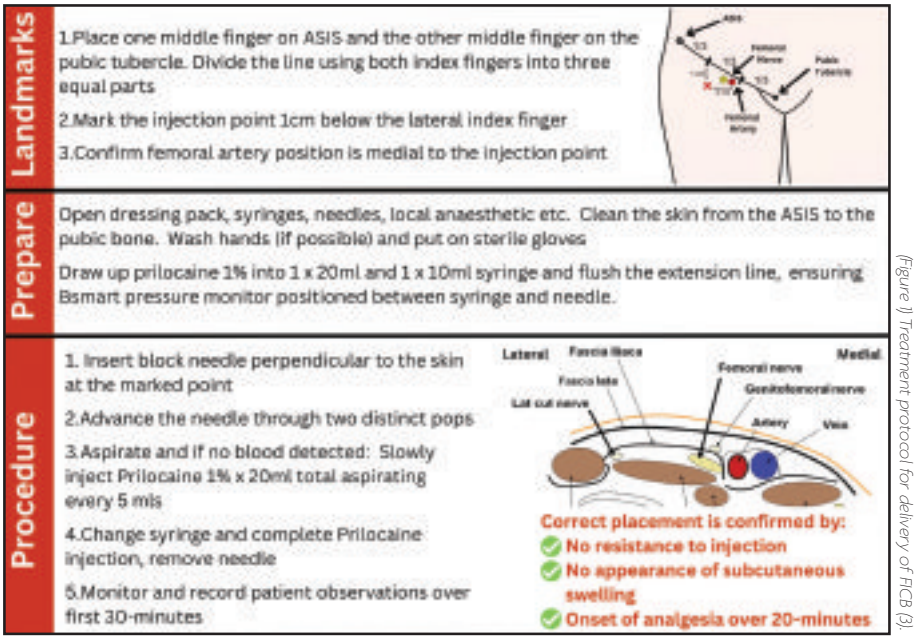
Research undertaken in hospital settings has shown that FICB provides effective pain relief for hip fractures, particularly reducing pain on movement. FICB is increasingly being administered by practitioners from a range of backgrounds, and is inexpensive to provide, with the administering technique easy to learn.

Current prehospital practice includes the administration of Morphine for pain management in suspected hip fracture, however opiate analgesics, such as morphine, can cause a range of side effects including sedation, nausea and respiratory depression. Evidence suggests that FICB provides superior analgesia with minimal side effects. Reducing side effects expedites surgical intervention following guidance by the Association of Anaesthetists, promoting FICB as the best analgesia for hip fracture. Providing adequate analgesia improves patient outcomes following hip fracture, including mortality.

Although a relatively safe procedure, FICB does come with some risks, including block failure (up to 20%), nerve damage, bleeding, infection and local anaesthetic toxicity.

Use in prehospital practice

At present FICB is not routinely available within UK ambulance services outside of critical care provisions. However, a systematic review in 2023 concluded that FICB may be suitable for use in the prehospital setting and may improve patient outcomes. In addition, the RAPID1 feasibility study found paramedics believed FICB fitted into their working practice and welcomed an alternative option for pre-hospital analgesia. The



(Figure 1) Treatment protocol for delivery of FICB (3).

study also found FICB delivered by paramedics in the prehospital setting was acceptable to patients. Therefore, the RAPID2 trial was designed to further investigate the use of FICB in the prehospital environment.

RAPID2

RAPID2 is a randomised control trial aiming to test the safety, clinical and cost-effectiveness of paramedics providing fascia iliaca compartment blocks as pain relief to patients with suspected hip fractures in the pre-hospital environment.

Working with up to five ambulances services, RAPID2 aims to train 200 paramedics, and recruit 1400 patients.

Paramedics involved in the study will be trained to deliver FICB using the landmark or 'two pop technique' (Figure 1). The complete training is delivered in three stages and includes online learning, classroom sessions and opportunities to deliver FICBs in hospitals, overseen by anaesthetists.

For more information about the RAPID2 trail, please contact rapid2@swansea.ac.uk.

Delivering FICB

Whilst ultrasound is commonly used for FICB procedures, the RAPID2 trial uses the landmark technique for the following reasons:

- The learning period for conducting blocks using ultrasound is significantly longer (15-20 attempts required before skill acquired in anaesthetic community).
- Prohibitive cost of providing ultrasound scanner equipment to every vehicle/ paramedic involved.
- Increased difficulty in the prehospital environment to balance all equipment whilst maintaining sterility of injection.
- FICB is relatively safe, and evidence suggests limited difference in failure rate using ultrasound.

(Image 3) – paramedics with RAPID2 merchandise

- As part of the RAPID2 trial FICB will be delivered using the technique described in Figure 1.

Disclaimer: This study is funded by the NIHR Health Technology Assessment programme, project number 129972. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

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Student Paramedic Practice Placement Wellbeing

The crucial issue of mental health and wellbeing of healthcare staff is of national priority (NHS England, 2021), and for ambulance services this has arguably never been more relevant. Ambulance clinicians are more likely than other emergency services personnel to experience poor wellbeing and mental health challenges (Mind 2019) and are at an increased risk of death by suicide (AACE 2021). Contributing factors include repeated exposure to traumatic and emotionally laborious incidents, shift work and operational pressures (Hong & Pelzer 2017) with pre-registration and newly qualified staff being identified as significant risk groups.

NHS England (previously Health Education England) commissioned the College of Paramedics to undertake the 'Future Workforce Mental Health Project' in response to the ongoing psychological risks to those entering the ambulance profession. Academic leads Emma Geis and Katie Pavoni have been working on multiple interventions as part of this project including new curriculum guidance on personal mental health and wellbeing in pre-registration paramedic training and the development of a wellbeing and recovery support tool. The aim of the project is to ensure that mental health and wellbeing is integrated into the entire student educational journey and to create a network of support throughout the undergraduate period and into the workforce.

As part of the project a literature review was undertaken as it is unclear what kind of information is available in publications about the mental health and wellbeing of undergraduate pre-registration paramedic students during their practice placements, and what kind of support they require. For these reasons, a scoping review was completed to systematically map the research done around student paramedic practice placement experience and to identify existing gaps in knowledge in this area. The following review questions were formulated:

- Does practice placement, during the undergraduate paramedic programme, affect the mental health and wellbeing of pre-registration paramedic student?
- What are the main causes of stress during practice placement for undergraduate pre-registration paramedic students?
- What mental health and wellbeing preparation and support are available to undergraduate pre-registration paramedic students prior to and during ambulance-based practice placement?

Results of this scoping review have highlighted several themes in the literature that were relevant to the research questions. The themes identified are:

- Theme 1: mental health and wellbeing support and preparation for paramedic student ambulance-based practice placement.
- Theme 2: culture and environment of the placement provider for student paramedics.
- Theme 3: work related stress and its impact on student paramedic mental health and wellbeing.
- Theme 4: the benefits and value of support for paramedic students during practice placement.

Based on these themes and the progression of the project, a student paramedic survey has been developed to explore the experiences of student paramedics while on practice placement. The focus of the survey is to find out from student paramedics if there is an effect on individual mental health and wellbeing during student paramedic practice placement periods within an undergraduate pre-registration paramedic programme and what support mechanisms are currently available and accessed by students during and after practice placement. This survey will be available soon to complete and will be a valuable insight into the student experience while on practice placement. With information from the scoping review and the student placement survey, it is hoped this will further inform the 'Future Workforce Mental Health Project' around the specific mental health challenges faced by paramedic students during practice placement and offer further insight into the guidance and support that can be provided both during the course and into the workplace.

For further information please contact: Jennifer Elliott – Jennifer.elliott@collegeofparamedics.co.uk
By Jennifer Elliott MCPara, Senior Research Fellow, College of Paramedics.

SAVE THE DATE

COLLEGE OF paramedics™

College of Paramedics National Conference;

Being a paramedic: unique, diverse, evolving

The College of Paramedics National Conference 2024, will be taking place at the **Leonardo Hotel**, Hinckley near Leicester on the **22nd** and **23rd of May**.

Themed around "Paramedic Identity," the conference will provide a platform for attendees to appreciate the pivotal role paramedics play in patient care. Discover the pioneering spirit that drives paramedics in their roles across health and care systems, showcasing their fearlessness in pushing the boundaries of evidence-based practice.

2024 College of Paramedics' Annual Research Conference

We are delighted to announce that the College of Paramedics Research Conference will be taking place on **Tuesday 21st May**, the day before our National Conference, at the same venue.

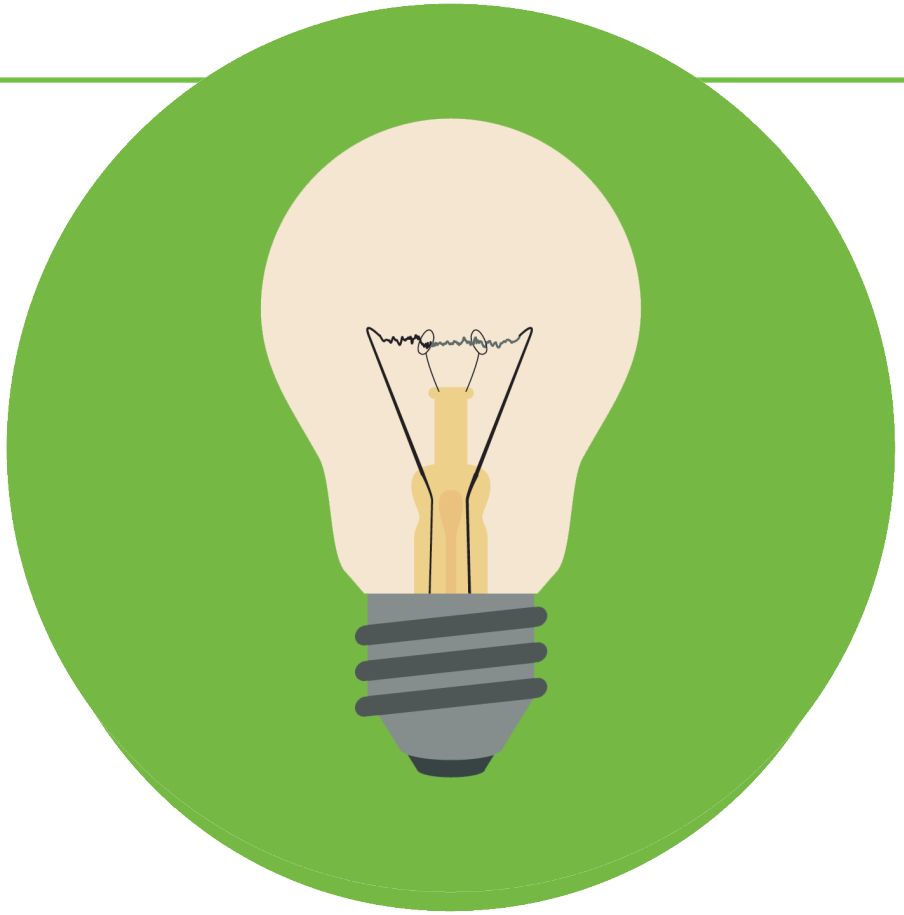
Dive into the dynamic world of paramedic research as we spotlight groundbreaking research and advancements shaping the future of unscheduled urgent and emergency care across the UK.

Do you want to present your research at this conference?
Abstract Submission Opens - Monday 12th February 2024
Abstract Submission Deadline - Friday 22nd March 2024 at 23:59

Registration for both conferences will open in March.

CPD Thoughts

March 2024



There are times when CPD becomes a process of unlearning and relearning. As the evidence base for paramedic practice grows, techniques, treatments and behaviours which were once thought to be 'gold standard' need to be re-examined. What we have always done is not always what we should continue to do. New evidence emerges that suggests that it is time to disregard old mantras and think again, especially when that evidence is considered in the light of patient values and preferences and our own clinical experience and judgement.

One such area for reconsideration is the process of extrication of patients from vehicles after road traffic collisions (RTCs). The EXIT Project was founded in 2007 by Dr Tim Nutbeam and Nurse Rob Fenwick with aim of improving patient outcomes from RTCs. At that time, and for the best part of two decades previously, the absolute need for rescuers to apply rigid immobilisation prior to extrication was drummed into us, on the assumption that in all but the lowest speed-of-impact collisions, the slightest patient movement might precipitate serious and irreparable spinal injury. The assumption was that patients were 'medically trapped', i.e. should not be allowed to move themselves because the damage to vehicles and speed of impact were suggestive of hidden injury. To minimise risk, even patients who had got out of their vehicles and were walking around were often immobilised using the 'standing takedown' technique.

Years of detailed and wide ranging research by the EXIT project team have led to a different and much more patient centred approach to practice. Combining data from a systematic scoping review, retrospective cohort studies, biomechanical analysis of movement experiments, qualitative patient interviews and expert clinical judgment, the team discovered that little (if any) evidence had been produced for an approach to extrication based upon movement minimisation, that over 99% of extricated patients do not have spinal cord injury, that self-extrication produces significantly less spinal motion than any other well established method and that unsurprisingly, patients wanted better communication at these very stressful incidents. In the light of these findings, the expert consensus group recommended that self-extrication or minimally assisted extrication should be the standard first line approach, unless contraindicated by an inability to understand instructions or injuries that prevent standing (on at least one leg). This guidance is now established in JRCALC for paramedics and ambulance staff and recommended by the National Fire Chiefs Council for Fire and Rescue Services.

But old habits die hard. Translating evidence into practice can be a frustratingly long process, with cultural and sociological factors at play in our organisations and teams. Add to this the shortage of available time for update training and simulation, plus the infrequency with which most paramedics attend RTCs, and the process of unlearning and relearning, in order to offer best care to our patients, takes time. But it must be done. Best practice needs its champions to lead us forward, and we thank Tim and Rob and the team for doing just that. Around the time that they founded the EXIT Project, I attended a Resuscitation Council (UK) Symposium. One of the speakers – I cannot recall who – said that the role of educators is to try to close the gap between what science tells us is correct and what clinicians actually do. This is one mantra that will always hold true. Perhaps that's why professional development is always 'continuing'.

The EXIT project may be found at www.theexitproject.co.uk. Look out for a more detailed discussion of the project with Dr Tim Nutbeam in a future edition of Paramedic Insight.

Gary Strong,
National CPD Lead

Human Factors

Putting the Human in Human Factors

Wednesday 31 January saw the coming together of months of planning to undertake the filming to create an exciting new e-learning module. The piece is Gary Strong's (National CPD Lead for the College of Paramedics) creation, a labour of love that unfortunately had to be shelved due to the Covid 19 pandemic but is now finally back in production. Claire Craft, Consultant Practitioner Urgent and Emergency Care at Yorkshire Ambulance Service has pulled out all the stops to support the college in creating this piece.

Funded by NHS England and destined for the E Learning for Health platform when completed this e-learning is set to explore the human side of human factors.

We were joined by a cast of 7 YAS colleagues, giving up their precious down time to try their hand at acting! All were tremendous and we're sure you agree when the finished product is ready. Produced by the fabulous team at Dynamic, based in Leeds, we're certain this is going to be brilliant, keep an eye out for its release!

Massive thanks again to all involved, and if you'd be interested in supporting any future work in this area please get in touch at: Education@collegeofparamedics.co.uk

INTERNATIONAL PARAMEDICS DAY

MONDAY JULY 8, 2024

NOW IN ITS 3RD YEAR, INTERNATIONAL PARAMEDICS DAY IS A GLOBAL CELEBRATION OF PARAMEDICS AND FIRST RESPONDERS AND THE VITAL ROLE THEY PLAY.

Held on 8th of July each year; the anniversary of the birth of Dominique-Jean Larrey, the man often referred to as the 'father of modern-day ambulance services it's grown from strength to strength with people participating and sharing their stories from 27 different countries in 2023.

We hope that this year's celebration will be even bigger, and will soon be sharing the theme along with ways that you can get involved.
To find out more you can visit the dedicated International Paramedics Day website or follow us on X, Instagram or Facebook.

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