AES SURVEY REPORT MARCH/APRIL 2013

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Supported by Unison

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AES Survey Report March/April 2013

Introduction

Since joining the LAS as an AES team member we believe the Senior Management should be aware of a list of concerns identified within this document. There is low self-esteem within the AES team relating to how AES are regarded, trained and paid within the LAS. The significant negativity of fellow AES colleagues lies in their unhappiness with their role due to unfairness in two main areas; the frequency at which they are asked to **work outside of their remit** and also the **lack of accessible career progression** available. Over time it is arguably evident that management are either not listening or cannot act to rectify this discord. The communication between management and staff has been unsatisfactory and staff have remained unhappy. The communication structure within the LAS is strong in many respects but there is a big divide between management and staff, especially with AES employees, on the ground. The lack of a designated line manager for the AES sector has exacerbated this and led to frustration and real problems within the role. The AES role has also changed beyond recognition since its implementation changing from a non-clinical, non-emergency role not too dissimilar from PTS to an emergency and clinically responsible role where the AES are expected to make a variety of decisions about patient care in frequent complex cases. This change over time should have triggered a full re-banding exercise under Agenda for Change (AfC) guidelines.

The two AES employees that have written this survey feel positive towards change and are supportive of change for AES but feel that these problems have not been looked into in any depth. The AES role has not been given a thorough appraisal and AES staff opinions are not getting heard. It is the intention that the information from this exercise will help staff express their concerns to management and for the new Chief Executive to have a more in-depth profile of the AES workforce. There are valuable, hardworking staff out there with good ideas that could be utilised. We sincerely hope that the information from this survey will be considered before any changes to the AES role take place.

The survey

The survey was designed by two AES staff on the basis that Senior Management are due to change the AES working model from two AES staff in an emergency vehicle to an AES plus a paramedic in an emergency vehicle. Nine questions were asked in a way that we feel was unbiased allowing staff to give their opinions in what we hope was an open and free manner. The survey was shown to Unison and was fully supported by Unison. The survey was sent out on 25th March 2013 to 283 AES staff members which was the best list that could be obtained from the LAS at that time. Staff were given different methods to reply either via the website that was set up: www.aes-survey.co.uk and also on hard copy returning it via email or internal post. So far 100 staff replied representing approximately 35% of the AES workforce. This survey was conducted on self-initiative with limited resources.

Survey written by: Amanda Jones and Tracy Ward, AES employees, Homerton Station April 2013

Background

The AES role within the LAS has changed dramatically since its conception and implementation a number of years ago. The role started initially as green only calls and the AES role was banded in 2006 was given 240 points under AfC band 3 which is the same as PTS. AES were not employed to take a major clinical role in the assessment and treatment of emergency patients and would carry out work of a non-urgent nature. AES would only assist paramedics in a supportive role. Since then AES find themselves as the first responder to the majority of clinical incidents and have to make difficult decisions without the support of the paramedic. Furthermore in October 2009 the number of determinants that AES could attend went up from 4 to 11 including, for example, Mental Health, pregnancies and miscarriages and AES also routinely complete Vulnerable Adult and Child forms. AES have to be responsible for making decisions of patient welfare and appropriate clinical routes, thus they are routinely responsible for ensuring the patient receives the correct clinical care under various pathways available. This alone should have prompted a full re-banding exercise under AfC guidelines, 'where a job has changed there should be a re-match or re-evaluation and the whole job should be assessed, albeit with a reference back to the original match or evaluation. Just dealing with some of the factors could lead to inconsistencies' (NHS Job Evaluation Handbook, February 2010).

In recent years staff employed as AES have been issued different job descriptions and been given different training skills depending on when they were employed but at no point has the job description ever been re-evaluated and re-banded under AfC. AES staff have been voicing their opinions to management about the problems within their roles, namely working outside of their remit, for many years. In October 2010, for example, evidence was submitted to Greg Masters (via Chris Howden) who is the Senior HR Lead for Job Evaluation and he promised in a series of meetings to re-evaluate the job description but later retracted/ignored this promise even though evidence submitted warranted a re-branding exercise. The role was 'reviewed only' in November 2008 but no further action was taken even though the AES role is close to banding boundaries in many aspects of their role. Following workshop meetings in June 2011 AES staff were assured by Caron Hitchin that once they had finalised the current review of the role they would submit the revised details for a further banding process. No outcome has ever been relayed to staff. This is is contrary to AfC guidelines, 'Where a request for re-evaluation has been made, the post-holder must submit evidence showing which skills and responsibilities applicable to the post, have changed. They should also provide details of the changed job demands that have led them to believe there is a change in factor levels' (NHS Job Evaluation Handbook, February 2010). A request with evidence has been submitted in the past, but a re-evaluation has not been done.

As there is no clear line management for AES there has been no support for this problem and no monitoring of reported remit issues has been implemented. There has been the introduction of the Clinical Telephone Advice system (CTA), but this has proved to be only partially effective and there has been evidence of the patient not receiving a ring back even though the MDT states to the contrary. Work has been done by a group in Homerton and Camden on separate occasions where evidence has been submitted to management that this model is being incorrectly used. However there has still not been to date a satisfactory solution and the calls AES are attending have continued to be inappropriate for their banding and skill set. The Chief Executive road shows were conducted by Peter Bradley in 2011, but no follow up or outcome from this was ever conducted so they

arguably became a management exercise rather than a constructive tool that could have ensured problems were listened to and acted upon. No feedback to staff has ever been given.

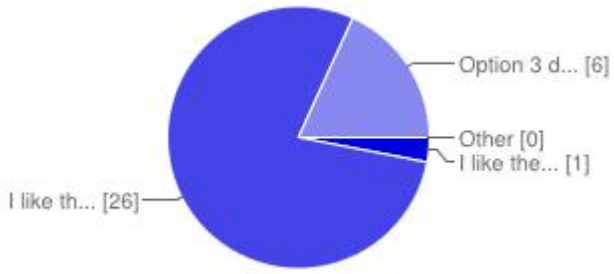
Staff morale amongst AES workers has been low for considerable time. With no accessible career structure in place to progress within the service, low pay and working outside of their remit AES are put all too often in clinically difficult and emotionally stressful conditions, having to make decisions that they are not trained and not paid to make.

This report aims to help Senior Management understand the role of AES and understand this sector of the workforce in greater depth before they make decisions about the future of AES. There is a talented and willing workforce out there that can often feel demoralised, underpaid and taken advantage of. With a new Chief Executive in place, who values listening with action, we hope that this will now be the time for positive, honest and fair change for AES workers.

Survey - Results Summary

We asked 8 key questions to obtain statistics about how AES staff feel about the future of their role. Here are the 8 key statistics and a summary of the comments made, the comments are as given and provide an open and honest view from staff.

Question 1a. How do you feel about working as the second crewmate with a paramedic?



I like the idea of working with a paramedic with a short bridging course and working under pay band 3	1	3%
I like the idea of working with a paramedics but want more extensive training and be under pay band 4	26	79%
Option 3 do not like the idea of working as part of a paramedic crew	6	18%
Other	0	0%

1b. Can you list you opinions both why working with a paramedic is a good idea and why it is not.

Good idea:

In theory you do not need 2 paramedics on each truck for each job.

Enjoy the challenge of working with a paramedic.

Enjoy the chance to learn new skills

My job would feel more worthwhile

We will be able to do overtime

There is ignorance about what we can do – so if we were all retrained this would solve this problem

Beneficial for both the service and the patients

It makes more sense to have an A&E Support worker with a paramedic it would negate the need to keep calling for back up.

Able to leave more patients at home

Save on response times as multiple units will not have to be sent

Free up front line vehicles to attend the more serious calls.

More job satisfaction

It will provide necessary training for AES who are at present under trained.

A lot of skills within AES that are not getting recognised

Up-skilling and upgrading (banding) AES will save the LAS money in the long run

It will provide a clear career path is there is proper internal progression.

Morale will be better.

It would show that we are valued more than PTS who are on the same band if we had more training and re-banded.

It would boost staff morale if investment was paid in training and in pay.

It would stop AES routinely getting used by control to work outside of our remit especially when the service is under pressure.

We get a better defined role within the LAS

More than happy to work with a Paramedic as long as we get trained and paid accordingly

A good idea so long as there is a choice to do the new role and some of us can remain on AES+AES support trucks

It would be a more enjoyable job but ONLY if we were trained properly and rewarded fairly with an upgrade in banding.

Yes if we get trained up to a pay band 4, we would be more help to the paramedic and the patient.

It would be great as long as it is pay band 4 as there is no career pathway for AES at the moment.

Learning new skills and go to more interesting jobs.

If new grade is recognised and new responsibilities acknowledged then it would be fair.

I am happy to work as 'front line' but we need to be compensated properly for it.

It will stop the LAS using private ambulances

Having technicians back although more expensive initially will be able to go to most of the calls so money will be saved.

More opportunity to work overtime and public events

Feel more valued by management

Improve my confidence

Possible career progression

More experience

It will save time and distance to jobs therefore saving money.

<u>Bad Idea:</u>

Would actually deskill AES as they would become drivers only

It should not happen unless we are trained to at least tech level 3.

I would not be able to focus on the elderly as I can now

The pay difference between band 3 and 4 is approximately £5000 surely this is not as expensive as management state.

EMT level is needed much more in the service than paramedics and is the majority of calls that we go to paramedics are not needed.

The pay and skill gap between paramedic and AES is far too big to neither like working with the other due to this fact.

I do not like the idea of being put in a position of which I am not trained to do, for example, multiple RTC.

I would like to have more training with a qualification that I can pass as I want to be confident that I can do the job.

Put AES in a morally and legal difficult position when not trained adequately.

AES + Paramedic not a good idea as the Paramedic will feel the need to attend most of the time as senior clinician (refer to the HCO letter on the Pulse (See Appendices 6)

I do not want to be just a driver.

I do not think it is safe or fair to attend jobs you are not trained or paid for.

I would like further training and stay as AES+AES crew as if I worked with a paramedic I would still be asked to continually work outside my remit.

It may be expected of the AES to attend to a patient when we are not paid or trained to do so.

It may be some time before another crew arrive therefore with multiple patients we could be often placed in a situation where we are working outside of our remit.

If they intend to train us the same as the Paramedic Assist course last year, then this is not adequate – I attended and learnt nothing new. We were constantly told 'don't worry the paramedic will do that' when in reality this is just not the case.

If there is a disciplinary about patient treatment will we get penalised even though we are not qualified?

Do we have to keep having the same conversation with the paramedic? 'I am sorry but I am not trained or paid to do that'.

No matter what anyone says we will be asked to keep working outside of our remit if we stayed on band 3, which would be very unfair.

Having worked with step down paramedics and techs I do not wish to work at that intensity on the jobs they deal with without further training and a recognised national qualification and an additional pay band upgrade.

We will become cheap labour for the LAS.

It is a good idea as long as we get the right training; otherwise we will be no more than just a driver for the LAS.

We would be getting paid the same as PTS who do not do shifts, nights or drive on blue lights or take simple observations.

If we work alongside a paramedic then the role has to be re-banded under agenda for change and as we are already working outside of our remit under band 3 and close to the band boundary then we MUST be upgraded to a band 4.

It will backfire on the LAS if AES are expected to work under more stressful conditions and technical abilities for no extra pay. AES are already poorly paid and over utilised.

If we work with a paramedic they need to know that we have the right skills to back them up in difficult circumstances.

The argument that we should be in line with the rest of the nation of band 3 crewing with the paramedic does not hold. London is a different entity and should no be compared to anywhere else.

If we stay on band 3 then we cannot be expected to work outside of our remit.

The rumours of AES getting one weeks extra training and staying on the same band 3 is a joke.

PTS are paid the same as AES and are not required to do 75% of the tasks we do, no PRFs. No Obs, no lifting etc. The service cannot expect us to stay on band 3.

The workload that AES do is already so much more than PTS and we get paid the same, to ask us to do more with no extra pay is ridiculous.

Do not want to do it unless they bring back some IHCD qualification.

The reason why I applied for AES is because I wanted to do green calls not front line work.

I think the paramedics will not welcome us.

We will feel added pressure as we will not be trained adequately.

To use AES as cheap labour with little training is dangerous.

It is too much responsibility for the paramedic.

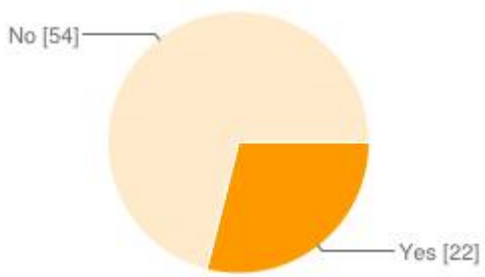
I do not wish to do nights especially if they will not pay us more.

The service already does not appreciate the role that we play.

The skill gap and pay gap will be too big when we are faced with the same jobs.

I believe there is a place for Urgent Care and I do not wish to be front line.

Question 2a: Do you think that the current A&E Support role works and is the right solution for the LAS?



Yes 22 29%

No 54 71%

2b. If you don't think it is the right solution, can you give your reasons here?

An intermediate skilled tier is the correct solution with a clear progression.

People do not know our remit.

We are all taught different things on our training course so there is confusion as some AES can do certain things and others can't.

There is no consistency between stations of what AES do.

AES was employed to initially to keep the PTS staff at no point was a proper working model thought about of how it would work and the AES model has been a shambles over the years since its inception.

There should be a place for 'green' or 'white' work but the failure to fully integrate PTS into the 999 arm of the service is the main failure (for example wheel chair users – we have no service we can call upon for this).

I believe that sending a first response to all calls to be triaged first is possibly the most expensive but the best solution for London.

We are a wasted resource as we have to call out other crews even though we know what we are doing – we are much too under skilled for capable employees.

We are currently going to call using Band 4 skills – so no the current model that we are does not work.

We currently go to so many calls that we can not give proper patient care, giving glucagon, paracetomol, leaving patients at home for very simple cases, give a nebuliser – AES are undertrained – therefore waste the LAS money.

The criteria of what we can and can cannot go to changes to often and no one including ourselves know what calls we are meant to be responding to. EMTs and Paramedics have clear guidelines and procedures – why don't we?

There is no career progression for those that are unable to do the OU course, either because they ant for family commitments, money or because it is not a fair or safe career path.

We end up costing the same as a Band 4 with all the money that is being wasted on petrol for long distance calls.

Currently the management have a complete lack of regard to AES policy and staff welfare. We have no remit as it is being constantly overruled by CTA and EOC, regardless if they have had a ring back or not (most have not even though is states to the contrary on the MDT). Fed up of being asked to 'go and make an assessment'. Even though we are not trained enough to make an assessment – that in itself is a band 4 criteria.

Fed up of being told that the policy has changed even though we are not properly informed or trained – we never see these changes on paper and only told about it via EOC. There is often heated debates with EOC thus delaying getting to calls.

Our concerns about jobs that we get sent should lead to ensuring that a car or paramedic crew is sent as we are SUPPORT not told from EOC that we have to go alone therefore we are actually FRONT LINE.

We have taken on all this extra work, anxiety and stress without any extra training or pay and have to rely on wit and experience under moral obligation of which the LAS have benefited.

We are used and abused.

Other services and countries have adopted methods that ensure that all of their crews are better trained and qualified i.e. ECSW are far better skilled and in a better position to progress in their pathway.

It is the right solution if we go to the right calls.

We are a danger to the public in our current role. We use the same vehicles and wear the same uniform as paramedic crews but woefully undertrained in comparison. Explaining why you cannot assist on a running call is embarrassing and unacceptable.

How can EOC ever assess calls accurately? Therefore to assume that we only go to calls within our remit and are not Front Line crew is unacceptable practice by management.

We have too low skills to be on an Emergency Vehicle.

I think the paramedic and AES model is the right one for the LAS.

I think the AES is right but we should be upgraded and up skilled so we can go to more job determinants – this will take the pressure off.

The minimum skills in the service to emergency calls should be Tech 4.

Now we are sent on pretty much anything and there is no clear remit for AES and everyone is confused so no, it does not work properly.

AES should be retrained under band 3 and specialise in GP referrals and elderly care. I witness many elderly patients who are scared of the LAS as they have had bad experiences with paramedics and likewise paramedics who have no patience with the elderly. The elderly make up 65% of all A&E cases. If we had a specialised arm of the service that could treat the elderly and GP referrals appropriately this would relieve a lot of pressure from the 'front line'. At the moment AES are not meant to go to patients over 75 and also cannot use the GP referral pathway or leave patients at home.

EOC do not use AES correctly.

We have to call on another crew to assist us as we do not have the skills this is a waste of resources and money, if we were up skilled then we would not have to do this and therefore solve the problem of limited resources.

AES are sent to everything which is inappropriate and so yes it does not currently work.

AES have never had a definitive role.

It would make sense to bring back the EMT role to allow AES to have proper training a career progression.

No as there is no career path.

AES is a wasted resource that could easily be up skilled to a tech level and sent to more calls.

Agenda for Change clearly states that anyone doing regular frontline work should be under band 4 so the current AES system is not appropriate.

AES is a good solution for the green work and there should still be AES crews only which will also benefit those who do not wish to progress.

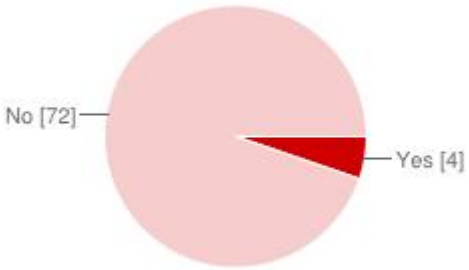
It could be the right solution if better training, a clearly defined role and pay was put in place.

I think the AES is the right solution. The problem is that calls are incorrectly triaged.

AES cannot be as effective as we should be as we can not use alternative pathways or leave patients at home which wastes time, money and resources.

The AES remit is too confusing as we have been constantly 'updated' within our own stations, which effectively is given more skills, but not officially. Every AES worker does something different.

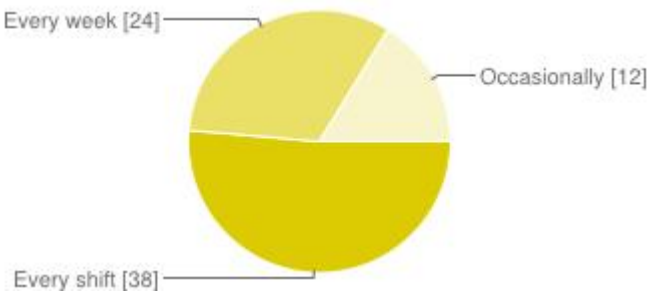
Question 3a: Do you feel that your job description currently covers all jobs that you are sent by control?



Yes 4 5%

No 72 95%

Question 3b: (If you have answered No to 3a) then can you state how often you are required to work outside of your remit.



Every shift	38	51%
Every week	24	32%
Occasionally	12	16%

Question 3c: If you have answered No to 3a) then please provide some examples of jobs allocated to you by control that is outside your remit?

On many occasions we have called EOC to find out what was said during the CTA ring back as the job does not come through as suitable, only to find out that CTA have advised an 'on-scene' assessment, which AES are sent to and asked to require back up if needed. This is totally inappropriate for band 3 trained staff.

Sometimes it states CTA when we are dispatched the call immediately when there has clearly been no time for a ring back.

No back up is sent even though requested a lot of the time.

We have asked numerous patients is they have had a ring back and most often the answer is always no.

The point is it is hard to triage, so the reality is that we get sent to calls outside of the limited remit frequently either intentionally or not. Due to this fact alone we should be regarded as front line crew and paid accordingly.

I don't mind being sent to calls outside of my remit.

Too many calls outside of remit to list

We may go to one job per shift where we are working within our official remit.

Been asked to check capacity which we are not trained to do. Often should be filling in capacity forms for elderly in care homes, but cant so don't and this is not good practice.

Palliative care – we have little/no training on how to deal with patients close to death and not able to fill out the paperwork upon death.

Table showing a list of some calls AES go to outside of their remit

COPD patients that need nebulising	Constantly sent C2's and often Red 2 and Red 1's
Children under 5 yrs old	Firearms incident
Maternity over 1st trimester	DIB
Psychiatric patients	Chest pain
A lot of Bravo Override jobs sent down the MDT.	Miscarriage outside of 1st trimester
Diabetic patients with a high BM	Viral meningitis
A fitting 2 year old girl (no back up sent even though requested).	Patients with a history of violence
Seizures	Purple Plus
Shooting	Patients that require collar and boarding
Stabbing	First on scene to a 3 year old that was not breathing.
Running calls	Vomiting coffee granules (blood)
Suicide	CVA's
Rape	Over 70's
Elderly fallers who need an ECG.	BBA
RTC's	Fainting of which all require ECG
Drugs overdose	Head injury
Hanging	Fall from height
Hospital transfers where they have requested a paramedic crew	Epistaxis over 20 minutes
Collapse behind closed doors	Serious lacerations over 6 inches

Question 4a: Are you happy with the current pathway (Open University) to progress within the LAS?

Yes I am happy with the current pathway	3	4%
No I am not happy with the current pathway	70	96%

Question 4b. If you are answered No (Not happy) Do you have any suggestions on how this could be improved or new pathways offered?

Five years is too long.

A stable pathway needs to be established.

The service has never given any adequate information for the OU course so how are we expected to make a decision about our future when we don't know anything about the course (asking us to resign based on no information is ridiculous).

Being a 42 year old home owner, I cannot afford the instability of resigning from my job and paying for my career progression. I fell that there should be room to progress within the LAS without having to have this as the only option.

A qualification that is recognised between trusts.

No other choice but to resign to progress is not adequate from the LAS and not law abiding.

Best alternative off the FdS Paramedic Science for AES, which is 3 years part-time with the LAS allowing adequate time off for study and payment for training – with a binding contract that you must work for the LAS afterwards for a set period, otherwise pay the monies back (see appendices)

A modular route.

Bring back something similar to the technician route.

All AES staff should have had the opportunity to progress before the LAS went to external applicants.

Internal pathway would give more credit to those with talent rather than those with money.

There should be 'tech' or equivalent in between AES and paramedic the skill and pay gap is too big.

Resigning from the AES with no safety net or guarantee of your old job back is too much of a risk.

In house tech route is the right pathway for the LAS, it worked fine before.

I think it is unfair to expect us to pay for training and to do it on top of our full time job.

It needs on the job training and teaching.

A 2-year degree is the best route that they have in other parts of the country.

Why can there not be a gradual increase towards being a paramedic?

Many AES have family and cannot possibly resign from their job and work full time for 5 years at a reduced pay on a relief rota and study for 5 years outside of work as well. Impossible and not inclusive of an organisation that pride themselves on diversity and equality.

The LAS should treat us as their greatest asset not their greatest burden and reward us with a proper career progression accordingly.

They should invest in their staff and Paramedics and Team Leaders should put through those AES who they think are good enough on a sponsored mentored pathway.

It could be written into the contract that you have to work for the LAS for X amount of years after qualifying if there is an argument of investing in people who then leave.

It should be LAS funded with an agreement that you have to work for the LAS for x years otherwise you have to pay them back.

Our wages are not adequate to expect us to pay for our own training.

Get trained to a tech 4 level until you are deemed competent to sit a paramedic examination to get your degree.

The current pathway is discriminatory against staff that have children.

I do not like the idea of resigning from my current role to progress.

I would like to have the opportunity to be higher trained but I do not wish to do a paramedic degree.

Recognise technicians like the rest of the UK and private companies.

Paying for your progression is wrong.

A 5 year course is too long and does not take into account any prior learning.

There should be an in-house pathway.

Scotland currently has techs on pay band 4 and paramedics – we should do the same.

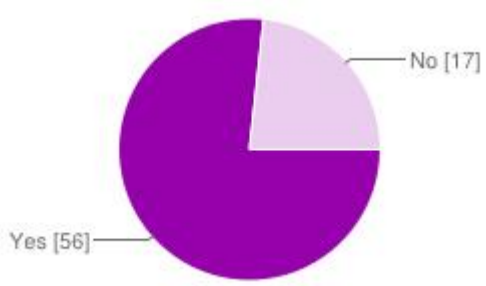
Psychometric tests are outdated and shown not to be a good way of measuring a person's ability.

You can be a doctor in five years so why would anyone wish to spend 5 years studying and whilst having to work full time as well?

Technicians don't have to resign from their job to up skill to a paramedic why do AES?

To do the current course available you have to be young, with no family commitments and devote all your spare time to studying as there is no time off currently to study. How are people who wish to do this course expected to afford childcare?

Question 5a. If A&E Support worked alongside paramedics would you expect a different pathway for progression?



Yes 56 77%

No 17 23%

Question 5b. If you answered yes to 5a, do you have suggestions about what this should be?

It would be nice to have as an option, but this should not be compulsory for all staff

There would need to be tests that have to be passed to progress to the next level

EMT or equivalent – a 3 tier system. AES, Tech (or advanced AES etc) paramedic

THE Las should have the confidence to make their own pathway as London is unique and it would be rewarded by dedicated staff.

New modules every 3 months that move you up pay band spine points.

Modular.

Bridging and gradual learning.

Be offered training to the equivalent EMT level without having to resign.

People do not have to progress if they don't want to

18 months as AE Support two year as Technician and 18 months Paramedic conversion

Paramedics and Team Leaders should try to put the people that they feel are good enough to become a Paramedics on a Mentored Pathway. You can be assessed and marked as you gain more skills

Partnering with Greenwich, St. George's or Hertford universities to accredit the course through the old Student paramedic courses structure so it's managed in house.

New modules linked to spine points in band 3 or 4 and done every 3 months.

Revert back to the EMT pathway with internal training courses.

Very few calls actually require Paramedic intervention, so why are LAS so insistent on everyone being a Paramedic! AES just need more training and better pay and then they can comfortably work alongside a Paramedic.

Not as in the current Apprentice Paramedic, or the old Student Paramedic system and not to be treated like an external applicant.

An apprenticeship that is signed off by the paramedic, gradually covering all aspects of what is required.

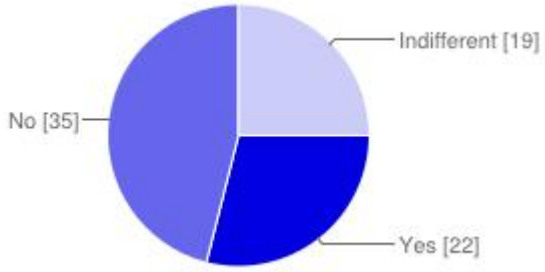
Greater work with the HPC to accredit a program of working on the job

Working alongside a paramedic every shift is an ideal way of on the Job training and this would be the best way of teaching the skills needed to work through a pathway.

ICHD course to become EMT on band 4

If you asked 300 AES staff if they would like the Tech scheme back in place they would say ''yes''.

Question 6a. Are you happy within your role?



Yes	22	29%
No	35	46%
Indifferent	19	25%

Question 6b. Please list positive aspects as well as those areas that you feel need improving with your current role

Positive Aspects:

I love my job.

Do not have to work nights.

I am happy in my current role only if I go to jobs I am trained/paid for.

Working with great people. Meeting different people every day.

I love my job as I can interact with the public and it is a sound way to start your career within the LAS.

Ability to make a difference to someone.

I feel that AES offers invaluable service to the elderly.

The job itself is rewarding. Working with people who are in need and being there for them.

Helping people; solving problems; getting appropriate treatment or referrals for patients.

Working for a busy and respected service.

Contact with patients, feeling that sometimes you help someone,

Perhaps bringing back the trial would be a way forward, AE Support where utilised far more when calls were being assessed by a car driver first and staff had a much busier shift, meaning less crews sitting around wasting time not being us

Good support from managers if you are having difficulties.

Good access to Physiotherapy and counselling, being referred to an osteopath would be better for serious back problems

We work well when treating elderly people as we have a lot of experience and knowledge in this area. We work well with palliative care transfers as we also have a lot of experience and knowledge in this area.

Variety of different pathways for work, such as HART/Central Ops, Cycle Response.

<u>Negative:</u>

Lack of support from EOC

Over the past 3yrs, the role of AES has changed for the better. I feel, on a whole, the jobs we attend are more consistent

The introduction of private crews has now posed a new problem. An example of this is attending an RTC as a second crew to a private ambulance. They asked if we could attend a male passenger who was out of the car that needed immobilising. We said we can only assist with immobilisation. This example leaves you feeling slightly silly that you have turned up at an RTC as a second crew.

I like my job but I am frustrated by the lack of progression offered.

Too much inequality when it comes to over time or training.

Frustrated with the lack of a fair non-discriminatory career pathway.

Getting a chance to spend slightly more time with patients, particularly the elderly, who welcome the chance to talk to someone & who generally need a bit of TLC

There is also a larger age range within AE Support which I feel is a positive aspect and may be a balancing feature as the new paramedics, on the whole, are generally in the under 30 age range.

Survey written by: Amanda Jones and Tracy Ward, AES employees, Homerton Station April 2013

The public see a big yellow ambulance and wave us down for help thinking we are highly trained, when we are not. I feel we need to be trusted and invested in.

By asking people to leave there current posts and go on to a OU course with no guarantee of your job back when you qualify is not the way forward

Terrible management communication with no staff meetings.

It is frustrating that we are not trained on simple procedures that could save time and money. To give a nebuliser, Collar and boarding. Paracetomol provision etc.

Too many call outs to people who could have made their own way in to hospital.

Often our role is not understood by other road staff and also by EOC .

Not being used by EOC when a higher skill level is already on scene and an ambulance is needed to convey.

Unable to attend a wide variety of calls due to lower skill level.

There are numerous aspects, starting with the grading, more skills and being paid for them.

Being used as a clock stopper on jobs.

Apart from the monthly pay cheque, I feel generally drained, poorly equipped and under constant threat.

As AES there is nothing I can do within service as every new opening advertised requires at least the minimum of EMT3 or above

We deal with the chronically sick mostly as opposed to acute. The pay scale does not reflect the job.

Being sent on jobs miles from where you are, and having to get there on blue lights driving 10,15,20 miles or more.

I believe that we are lacking certain training that is critical to have when attending certain calls and this is evident in most elderly calls due to their vast medical problems.

We are not provided with enough resources to work with. Critical equipment is frequently not available for us to use. We often find ourselves short of certain equipment.

Even though we go to seriously ill patients we are still not regarded as front line.

I don't think all AE Support should be made to work with medics - some who are older/used to be PTS do not want frontline work - maybe they should have the option to go back to PTS.

No one knows exactly what we do or allowed to do.

Frustrated that I am capable of doing more than I am permitted.

Missing out on overtime.

Lack of motivation as there is too much inequality when it comes to training and overtime.

Not paid enough for what we have to deal with on a daily basis.

Lack of training and respect given to us by the service

Management getting us to work on up skilled vehicles without asking.

Do not feel as if we are treated as equal

Denial from management that there are issues with the calls that we attend.

Question 7. Do you have ideas on how AES role could be improved or changed?

When EOC are GB'ing a job for an ambulance to assist an FRU, 80% of the time it is mealy transport to convey to hospital So why not offer the FRU AES as 99% of FRU's are more than happy to have AES and they can travel with us if necessary.

If call are an emergency of any level then a technician/equivalent should be sent out.

More skills and more money.

For AES who want to progress then the application process should be changed – more assessed work than numeracy examinations.

Since we mainly do frontline work anyway we should be trained up to a tech 3 level.

Reintroduce old tech system.

Train us up to a band 4 so we are confident to go on most of the calls

EOC shouldn’t being using the REAP levels as an excuse to get us to do the calls, it is not fair.

We are not getting paid to up-skill to paramedic/tech level when single so stop doing it, it is too stressful.

Change the name of AES it is degrading.

To be able to give aspiring, paracetomol, nebulise and hyper stop.

Invest in your staff!

AES should be the entry level for anyone joining the service (Apprentice Paramedics) they should do at least a year on the road before they start their pathway.

I don't really know how it can be improved without more training and a new remit that everyone adhere too.

This communication-led type of organisation certainly seems difficult for the LAS at present. To start with working with paramedics, it would make the job far easier to do without so many boundaries that are currently in place and we would then be able to improve patient care.

We should provide our own bariatric vehicles one in the north and one in the south, crewed by three people to cover 24/7.

Provide us with extra skills, such as board and collar- administer glucagon, nebs and chests sounds, with these extra skills we would justify band 4 plus.

Equal overtime which will Increase work moral, meet national targets as all ambulances have qualified staff members on them.

I would like to see A&E support changed to Elder Urgent Care specialists. Most elderly do not get treated correctly by the LAS. A lot of A&E Support sees frightened elderly patients who tell of their bad experiences with the LAS who have not treated them correctly. I feel that A&E Support is the right fit for this with alternative training. This way they could stay under band 3 and relieve a lot of the pressure from front line.

Improvements to availability of equipment or personal issue.

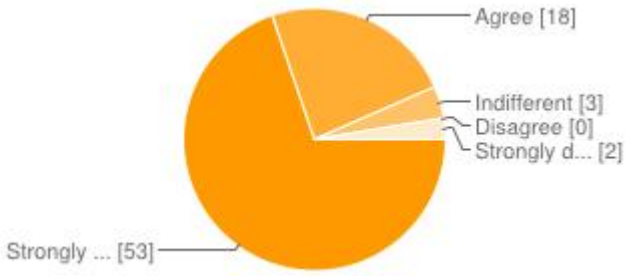
We are sent frequently out of our area this causes problems Time wasting due to travelling a longer millage in between calls, Waste of fuel for the vehicles as we are travelling further distance. - Waste of available crew as we spend more time travelling then attending to calls

Training towards better use of AES Change the name back to EMT1 and give us a nationally recognised qualification somewhere on the nursing scale knowledge and people skills, structured training days advanced level of AES (AES 2).

I am happy with my current role, I just believe the LAS needs to better recognise us.

Maybe an AOM who deals solely with AES and our training, ways of working, moral issues etc, would be a step forward. It seems to depend at which station you are attached to as to how much continuation training you get.

Question 8. Some staff and the Unions feel that if A&E Support were to work alongside a paramedic then the position should be a band 4 with adequate training. Do you agree with this?



Strongly agree	53	70%
Agree	18	24%
Indifferent	3	4%
Disagree	0	0%
Strongly disagree	2	3%

Question 9. Please write here any other comments that you feel hasn't been covered by this survey.

AES are treated like they are insignificant and sent to jobs outside of their skill set and pay.

Always left out of overtime opportunities which creates ill feeling as we mainly do front line work.

Politicians and senior managers are under the impression that everyone beyond AES should have a degree in order to do the job. This is ridiculous and exclusive. We do not need to write essays.

There are too many rumours in the LAS. This process has been going on too long and has been very damaging to ourselves and the service. Management say we are important but do use and wish to continue to use AES as cheap front line.

Unison need to make a statement ASAP about the future plans and what the management are proposing.

Training must be IHCD or EDXEL.

I think we should consider strike action and seek legal advice on how we have been treated so far, in terms of inadequate pay for so many years.

Private ambulances are offering far better training which is shocking if the Las wish to be a 'world class service'.

I am worried that we will be replaced by private ambulances.

I would have preferred to have ticked a box stating that 'I like the idea of working with a paramedic after having firstly been given adequate training and remain for the time being under pay band 3'

Until the service has changed the working policy for AES to work with paramedics officially then if we are asked to upgrade to work with a paramedic then we should get paid accordingly for that shift.

Will we work with a different person on each shift or will we have a regular crewmate?

AES not been offered overtime.

Why has it taken so long for Unison to act on behalf of AES?

GMB or Unison has not supported the staff at AE Support level for a long time. This seems from my point of view to be the kind of "we don't like that skill level so we'll pretend it doesn't exist" attitude...less than helpful.

That does not mean I disagree with Unions and I fully support any positive outcome to this survey and any negotiations made over the changes to come.

Thanks for trying personally I don't think anyone will take much notice of our ramblings

I believe the unfair scenario between EMT1 and AE Support pay scales has not been covered adequately. They do not do anything different to us

A very good idea to have this survey- to get a picture of what A E workers actually would like to see happen to their role.

I feel the whole matter of A&E Support and Paramedics working together is just a cheap gimmick to get more frontline trucks on the road without paying any more money and diluting Paramedic crew skill.

I have worked as a secondment with a paramedic. It is the single best thing I have ever done in the job. The AES role really comes into its own when working with a paramedic and I look forward to being given the chance to be crewed with one again.

Thank you for organising this. The union has not had a voice for A&E support and their issues and needs a special representative on unison to uphold their interests. After the Though it would be unpopular I think 10 hour shifts would help moral as tiredness is a never ending battle in this job, especially as your shift more often than runs into overtime.

Discussion of survey results

AES and a Paramedic working as a crew

The support for this idea is extremely positive 85% of AES who responded would welcome this change. However, 79% state that they would only be happy to do so if they were provided with extensive training and a pay band scale 4. 94% of AES who responded strongly agree or agree that this should be the case.

The reasoning behind this is not a simple case of staff wanting more money. The comments made about these questions provide clear evidence that staff have genuine arguments as to why they should be rewarded appropriately for the work that they do and will have to do. Currently AES have been working outside of their remit for some time now. AES go to front line calls on most of their shifts, 95% of staff who responded state that their job description does not cover all the work that they are asked to do, with a further 83% stating that they go to jobs outside of their remit either every shift or every week. If AES were asked to work alongside a paramedic they would be going to exactly the same jobs as front line crew all of the time, which will leave them exposed to higher stress and emotionally upsetting situations. The skill gap between a band 3 and a paramedic is too great for the reality of them to work fairly side by side. The paramedic will not be able to rely on AES to undertake many tasks, unless the AES works outside of their remit. Either scenario is unfair on both parties concerned. In practice the AES will be put in a morally difficult and stressful situation where they will be 'forced or obliged' to work outside of their remit all too often.

One argument that has been proposed previously by management is that Nationally other Ambulance Trusts use the Paramedic and HCA/AES model so the LAS are falling in line with the rest of the country. However this view arguably does not hold significance. London is an entirely different entity demographically and socially with 'London having 29% poverty rate compared to 21% for the rest of England and continues to grow' (London Poverty Profile, 2010-2011). Furthermore, the working age poverty rate for London is 33%, whilst the rest of England is 21% and the pension age poverty rate is 27% for inner London compared with 15% for the rest of the country (London Poverty Profile, 2010-2011). These are just some of the statistics available and the evidence is sound. With a direct link between poverty and poor health (WHO, 2010) it is therefore reasonable

to assume that the LAS deal with more clinically and socially complicated calls and a greater volume of serious calls (Red 1) than other ambulance Trust in the UK. With this in mind the crews are exposed to a higher level of stress and emotionally challenging situations that require more complex skills from the employee.

The London Ambulance Executives should be confident in standing up to their peers in other services and government bodies and support the argument that we should NOT be compared to the rest of the country in the work that we do and the skills that it requires to work in London.

Supportive evidence for up-skilling to a Pay Band 4

Although mentioned above it is worth here looking in more detail of why AES should be up skilled and up graded to a band 4 using the job match reports under AfC. As AES we are currently banded with 240 points which matches PTS Higher Level (see appendices 1and appendices 3, *page 4*). However there are vital aspects of our role that have been left out of the job match banding process (see appendices 5). When checking though the EMT 1 and Ambulance Practitioner job matches (appendices 2 and appendices 4, *page 5*) you can see that there are clear areas which were not taken into account. For example:

FACTOR 1: Communication & Relationship Skills. We are currently matched to level 3a (21 points). AES actually fulfil the role of a 4a match (32 points). 'Communicates condition related information to patients/clients, relatives and clinical staff; requires empathetic and reassurance skills.

SUPPORT FOR BAND 4: AES have to relate information to senior clinical personnel at hospitals, as well as patients, clients (health care/social workers) and relatives. This is a daily occurrence for every job.

FACTOR 3: Analytical & Judgement Skills. We are currently matched to level 2 (15 points). AES actually fulfil the role of a 3 match (27 points). 'Assesses situation, decides courses of action in accordance with guidelines and protocols.

SUPPORT FOR BAND 4: AES are mainly first on scene and need to assess the clinical or safety situation in order to call for back up either via paramedic, HEMS or the Police. We need to ascertain if we need to go to designated hospitals for example, cath labs, stoke units and maternity units.

FACTOR 14: Mental Effort. We are currently matched to level 2a (7 points). AES actually fulfil the role of match 3a (12 points). 'Concentration on driving, delivering emergency medical care/may be switched to other emergency situation'.

SUPPORT FOR BAND 4: AES respond to emergency calls just like a front line crew. Often we are cancelled off calls or have to attend a running call whilst on the way to a job or back to station. We have to often deal with multiple tasks whilst driving and can be driving under blue lights whilst emergency care is taking place in the vehicle. We do not drive to a daily schedule.

FACTOR 15: Emotional Effort. We are currently matched to level 3a (18 points). AES actually fulfil the role of match 4ab (25 points). ' Arriving at and dealing with e.g. families at the scene of accidents.

SUPPORT FOR BAND 4: AES have to attend to running calls which are most often accidents. Also we deal frequently with terminally ill patients and their carers.

FACTOR 16. Working Conditions. We are currently matched to level 4 (18 points). AES actually fulfil the role of match 5 (25 points). 'Unavoidable exposure to physically dangerous situations on a regular basis.

SUPPORT FOR BAND 4: AES have to go to various degrees of mental health patients who are physically violent/aggressive. We have to be in patient's homes where there are dangerous animals or a hazardous and unstable environment. We are often placed in confined spaces with alcoholic patients who are frequently abusive and threatening. AES are also required to declare a major incident.

Calculating the extra points here gives an extra: 42 points, thus added to the 240 points (where AES is currently graded) = 282 points and a pay band 4 outcome.

Appendices 5 does take the re-banding process further. However it is clear from these examples that the AES role should be upgraded on non-clinical aspects alone.

The case is strong supporting that the AES should already be on a pay band 4. AES are exposed to all of these factors as commonplace within our role and AES will be exposed to them more frequently if we are placed with a paramedic as part of a front line crew. It is not possible to conceive that we would be given extra training but stay on pay band 3. The case that the paramedic would take on more responsibility clinically may be true but it **does not** negate from the factors above which alone support the case that AES should be on a pay band 4 which are not related to the clinical side of the role at all.

Not only is it unfair but it is unsafe to provide us with the necessary skills and training that it requires to be confident and safe within our role as AES and a paramedic crew in the London environment. A one-week course (for example, the paramedic assist pilot scheme tested in 2012) that works by 'broadening' our skills rather than up-skilling us is not satisfactory either ethically or for patient and staff safety.

Career Progression

There has been much disappointment over the lack of any accessible career structure for AES in recent years. AES have not been trained to any recognised qualification and have limited skills and abilities to be readily equipped for life on the road in an emergency vehicle. Much of the training that has happened has been ad hoc, inconsistent and varies greatly between each station. It is not

recognised as 'skills' rather as 'awareness' which is both confusing and demoralising for AES staff who feel that they are being asked to do more unofficially without any honest recognition.

The EMT route for gradual progression was stopped, although most employees found it to work extremely well for them. It is understood that this was perhaps the most expensive route for the LAS and perhaps not feasible. However to only have a 5 year Apprentice Paramedic programme which the staff member has to pay for, study on outside of their full time hours and potentially work on a relief rota seems like an impossible task for most, in fact 96% of staff who responded to the survey are not happy with the current pathway on offer. Those with families or who are older and do not feel confident in studying for that length of time and are unable to justify and cope with the job insecurity and thus feel undervalued and discriminated against by the LAS as there is no career structure at all for them.

Upon reading the comments made by staff there shows to be some good ideas out there that could help the LAS find a middle ground. For example, having a higher trained AES – perhaps renamed as something else Paramedic Assistant, Paramedic Technician etc and indeed a pathway from St Georges University that offers a 3 year course for AES to become a fully qualified paramedic perhaps seem more reasonable. On both counts the payment for the courses could be written into a contract with the member of staff who are then obliged to remain within the LAS for X period of time otherwise they are required to pay back the costs. This is just one idea and it seems that more work by management together with staff is needed, perhaps in working groups, to settle a fair and appropriate pathway could be the solution.

Conclusion

There is potentially more that this survey can reveal, especially if the survey runs for a longer period of time. However the findings are significant in that staff are not happy with their current situation both with their working conditions and in their career progression. Management have now proposed plans for AES to work with paramedics which seems like an excellent solution for the service and one that AES seem happy with according to this survey. However we implore you to look carefully at the results which show a strong and valid argument that AES should be up-skilled and re-banded to pay band 4.

This survey should be regarded as evidence supporting a formal request to re-evaluate the role with a re-banding exercise. The AES role should be fully researched and monitored with the changes identified and verified further in an open manner with the post holder (as proposed within the NHS Job Evaluation handbook 201, *Page 12*). Also when conducting the banding process for the new AES position of working with a paramedic, we request that at least two representatives chosen by the AES employees should be included on the banding panel.

There could arguably be a cost saving when up-skilling AES staff to a band 4. If staff are satisfied, confident and motivated they would be a more productive workforce and would stay with the LAS. Has there been a cost analysis with future forecasting done for a pay band 4 scenario as compared to a band 3 scenario, bearing in mind?

We would like the opportunity for AES to work in partnership with management with regards to our findings. We would like your comments and feedback. We hope that there will be a new career

structure proposed by management that will include an accessible pathway for **ALL** staff and we encourage that this pathway should be conceived with the assistance of AES staff by forming working group working with management.

We hope that this survey and subsequent report shows significant evidence and has been interesting and useful for Management.

References:

NHS Job Evaluation handbook (Third Edition, February 2010)

London's poverty Profile, 2010-2011 (Trust for London and New Policy Institute) http://www.londonspovertyprofile.org.uk

Dying for Change (World Health Organisation, 2010)

Appendices:

1. AES Support (November 2008) job match with PTS Patient/Carer Higher Level
2. Matched Job report EMT 1 UCS
3. National Profiles for Ambulance Services (using page 4 and 5)
4. Job Evaluation weighting scheme – scoring chart
5. AES Matched Job Draft Proposal
6. HCP letter: Driving v Attending, July 2011 (as quoted by one of the survey responders)

Appendix 1

Job ID:	4704
Job Title:	A&E Support (November 2008)
Job Statement:	
Profile ID matched	Patient Transport Services (PTS) Patient/Carer Higher Level –
Panel:	

Factor	Level	Sub	Score	Match?	Rationale	Panel Notes
1. Communication & Relationship Skills	3		21		Reassure confused and/or distressed patients, relatives and/or carers	
2. Knowledge, Training & Experience	2		36		Blue light driving; CPR, basic first aid; blood pressure, blood glucose and temperature readings. Protocols for action clearly defined.	
3. Analytical & Judgemental Skills	2	[redacted]	15		Assess patient conditions within scope of training. Decisions on how certain patients need to be moved.	
4. Planning & Organisational Skills	2	[redacted]	15		Plan routes etc	
5. Physical Skills	3	a	27		Blue light driving	
6. Patient/Client Care	3	a	15		Administers restricted treatment; provides transportaion for patients	
7. Policy/Service Development	1	[redacted]	5		Follows all service protocols set by the service	
8. Financial & Physical Resources	2	abc	12		Care of patients' valuables etc; LAS vehicle and equipment	
9. Human Resources	1		5	V	No specific responsibilities	
10. Information Resources	1		4		Vehicle checks, PRFs etc	

11. Research & Development	1		5		No evidence	
12. Freedom to Act	2		12		Works on own initiative but supervisor available by phone or radio	
13. Physical Effort	5		25	V	Lifts heavy patients on regular basis	
14. Mental Effort	2	a	7		Concentartion for driving etc	
15. Emotional Effort	3	a	18		May deal with terminally ill patients; behavioural problems and young babies	
16. Working Conditions	4	ab	18		Frequent exposure to highly unpleasant working condilions, bodily fluids etc	
			240		Band 3	

Appendix 2.

Matched Job Report

Job Title	EMT 1 (Urgent Care Service)
Job ID	RRU/959
Score	304
Band	Band 4
Status	Profile Matched
Matched To	Ambulance Practitioner
Job Statement	Responsible for the effective treatment, care and transportation of patients classified as urgent and non-urgent within the tiered response categories operated by LAS.

Relevant Job Information	National Profile	Profile	Factor Status	Score
1. Communication & Relationship Skills				
Communicates with healthcare practitioners and patients about healthcare related information. Has to provide emotional support to relieve anxiety of patients and carers	4a	4	Matched	32
2. Knowledge, Training & Experience				
LAS training in emergency procedures towards IHCD technician level	3	3	Matched	60
3. Analytical & Judgemental Skills				
Assessment of patient on scene in line with LAS protocols, provides appropriate treatment or seeks additional assistance where necessary	3	3	Matched	27
4. Planning & Organisational Skills				
Economic route planning	1-2	1	Matched	6
5. Physical Skills				
Blue light driving. There is a need to move and lift patients in confined areas	3(a)(b)	3	Matched	27
6. Patient / Client Care				
Assesses patient needs on scene and establish appropriate treatment for varied medical conditions	4(a)(c)	4	Matched	22
7. Policy & Service				
Follows LAS policy, procedure and protocol	1	1	Matched	5
8. Financial & Physical				
Handles patients cash and valuables, ensures ambulance equipment is safe	2abce	2	Matched	12
9. Human Resources				
No evidence	1	1	Matched	5
10. Information Resources				
Complete documentation relating to patients attended and journeys undertaken in accordance with service protocols	1	1	Matched	4
11. Research & Development				
No evidence	1	1	Matched	5
12. Freedom To Act				
Works in line with LAS protocol, support and advice can be obtained from more senior healthcare practitioners	2	2	Matched	12
13. Physical Effort				
Frequent requirement to lift heavy patients at times in limited physical space	4c-5b	5	Matched	25
14. Mental Effort				
Concentration required for blue light driving. Requirement to swap from one call to another as directed by control	2a-3a	3	Matched	12
15. Emotional Effort				
May have to deal with traumatic incidents on running calls. Frequent requirement to deal with distressing circumstances when dealing with critically ill patients and their carers	4ab	4	Matched	25
16. Working Conditions				
Requirement to provide emergency provision	5	5	Matched	25

Appendix 3

NATIONAL PROFILES FOR AMBULANCE SERVICES

CONTENTS

Profile Title	AfC Banding	Page
Emergency Service Call Taker*	2	2
Patient Transport Services (PTS) Driver	2	3
Ambulance Services Driver (PTS) Higher Level*	3	4
Ambulance Practitioner	4	5
Ambulance Practitioner Specialist	5	6
Ambulance Practitioner Advanced	6	7
Emergency Services Team Leader*	6	8
Emergency Services Area Manager*	7	9

*New in April 2007.
Please note: these are reviewed profiles and replace those below which have been withdrawn and in some cases the reviewed profiles have an amended profile label.

The following profiles have been withdrawn:

Profile Title	AfC Banding	Date of Publication
(Ambulance) Call Taker/Control Assistant	2	March 03
Patient Transport Services (PTS) Driver/Carer Higher Level	3	April 04
Ambulance Station Officer (Team Leader)	6	March 03
Ambulance Service Area Manager	7	March 03

Profile Label: **Emergency Service Call Taker**

Job Statement:
1. Takes emergency calls from members of the public, other emergency services
2. Inputs key information into computerised system; provides advice from protocols
3. Dispatches one or more ambulances to emergency by radio control

Factor	Relevant Job Information	JE Level	JE Score
1. Communication & Relationship Skills	**Provide and receive routine information requiring tact or persuasive skills** Exchanges information with callers: gives advice, empathy & reassurance, callers may be distressed, have English as a second language	3(a)	21
2. Knowledge, Training & Experience	**Range of work procedures requiring job training** Procedures for responding to calls, use of medical protocols acquired through job training on medical priority system such as AMPDS or CBD	2	36
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis** Skills for assessing emergency calls to determine which protocol to follow	2	15
4. Planning & Organisational Skills	**Organise own day to day work tasks or activities** Plans own activities around incoming calls	1	6
5. Physical Skills	**Physical skills obtained through practice** Dexterity, co-ordination & sensory skills for use of keyboard to input information	2	15
6. Responsibility for Patient/Client Care	**Provides basic clinical advice** Provides advice from protocols	3(c)	15
7. Responsibility for Policy/Service Development	**Follows policies in own role, may be required to comment** Follows control room policies	1	5
8. Responsibility for Financial & Physical Resources	**Personal duty of care in relation to equipment, resources** Careful use of computer equipment	1	5
9. Responsibility for Human Resources	**Demonstrate own activities to new or less experienced employees** Demonstrate duties to new staff, short periods	1	5
10. Responsibility for Information Resources	**Data entry, text processing, storage of data** Inputs patient information into computer system	2(a)	9
11. Responsibility for Research & Development	**Occasionally participate in equipment testing** Tests call equipment	1	5
12. Freedom to Act	**Well established procedures, supervision close by** Supervision available when required	1	5
13. Physical Effort	**Frequent sitting or standing in restricted position** Sits at keyboard or radio most of each shift	2(a)	7
14. Mental Effort	**Frequent concentration; work pattern predictable/ occasional prolonged concentration** Takes calls, response job/ prolonged concentration during busy spells	2(a)- 3(b)	7-12
15. Emotional Effort	**Frequent distressing or emotional; occasional highly distressing or emotional circumstances** Calls concerning patient problems	3(a) (b)	18
16. Working Conditions	**Use VDU equipment more or less continuously** Sits at VDU for all or most of shift	2(e)	7
JE Score/Band		Band 2	181 - 186

Job Title: Patient Transport Services (PTS) Driver

Job Statement:
1 Collects patients and escorts to vehicle
2 Drives vehicle to and from hospitals, clinics, departments
3 Escorts patients to appropriate clinic or department

Factor	Relevant Job Information	JE Level
Communication & Relationship Skills	Persuasive skills, barriers to understanding Exchanges condition related information with patients, relatives, empathy & reassurance	3(a)
Knowledge, Training & Experience	Range of procedures, induction training Procedures for collecting and conveying patients; training over weeks	2
Analytical & Judgemental Skills	Straightforward job related facts Responds to route, appointment problems	1
Planning & Organisational Skills	Planning & Organisational Skills Plans route, adjusts for road, traffic conditions	2
Physical Skills	Skills acquired through practice Dexterity, co-ordination & sensory skills for driving	2
Responsibility for Patient/Client Care	Provides basic care to patients Provides transport, escort services	3(a)
Responsibility for Policy/Service Development	Follows policies, may comment	1
Responsibility for Financial & Physical Resources	Personal duty of care in relation to equipment Responsible for vehicle & equipment	1
Responsibility for Human Resources	Demonstrates own duties to others May demonstrate duties to new staff	1
Responsibility for Information Resources	Records personally generated information Maintains records	1
Responsibility for Research & Development	Little or no responsibility	1
Freedom to Act	Standard operating procedures, supervision available Supervision available by radio	2
Physical Effort	Frequent requirement to exert moderate effort for several short periods during shift Lifts, pushes & pulls patients several times, daily	3(c)
Mental Effort	Frequent requirement for concentration, work pattern predictable Drives patients, daily schedule	2(a)
Emotional Effort	Occasional distressing circumstances Patients with serious or disfiguring injuries	2
Working Conditions	Occasional unpleasant conditions; frequent requirement to drive	2(a)(c)
JE Score/Band	JE Score 181	Band 2

Profile Label: **Ambulance Services Driver (PTS) Higher Level**

Job Statement:
1. Transports patients for appointments and treatment at a variety of locations
2. Assists patients as required, e.g. administers medical gases, first aid
3. May supervise a small team of patient transport drivers

Factor	Relevant Job Information	JE Level	JE Score
1. Communication & Relationship Skills	**Provide and receive routine information requiring tact or persuasive skills; barriers to understanding** Exchanges information with patients, relatives requiring empathy and reassurance	3 (a)	21
2. Knowledge, Training & Experience	**Range of routine work procedures, requiring job training** Procedures for driving, collecting and conveying patients and giving basic first aid, acquired through job training for IHCD care assistant or equivalent	2	36
3. Analytical & Judgemental Skills	**Judgements involving facts or situations, some requiring analysis** Assess patient safety	2	15
4. Planning & Organisational Skills	**Plan and organise straightforward activities, some ongoing** Plan route, adjusts for road, traffic conditions	2	15
5. Physical Skills	**Developed physical skills; advanced or high speed driving** Advanced skills for minibus/ ambulance driving	3 (a)	27
6. Responsibility for Patient/Client Care	**Provides personal care to patients/ clients** Provides patient transport services and basic care	3 (a)	15
7. Responsibility for Policy/Service Development	**Follow policies in own role, may be required to comment** Follows ambulance service policies	1	5
8. Responsibility for Financial & Physical Resources	**Handles cash, valuables; safe use of expensive equipment** Handles patients valuables; Responsible for vehicles & equipment	2 (a)(e)	12
9. Responsibility for Human Resources	**Demonstrates own duties to new or less experienced employees/ day to day supervision** May demonstrate own duties to staff/ supervises a small team of patient carers	1-2 (a)	5-12
10. Responsibility for Information Resources	**Record personally generated information** Maintains records	1	4
11. Responsibility for Research & Development	**Undertakes surveys or audits, as necessary to own work** Completes e.g. staff surveys	1	5
12. Freedom to Act	**Standard operating procedures, someone available for reference** Works on own initiative, clinical supervision available via radio	2	12
13. Physical Effort	**Frequent moderate effort for several short/ long periods; occasional intense** Moving patients in wheelchairs, with aids; lifting patients	3(c)-4(b)(c)	12-18
14. Mental Effort	**Frequent concentration; work pattern predictable** Concentration for driving, daily schedule	2 (a)	7
15. Emotional Effort	**Frequent distressing or emotional circumstances** Patients with medical or mental health conditions	3 (a)	18
16. Working Conditions	**Frequent unpleasant conditions** Smells, body odours, verbal aggression	3 (a)	12
JE Score/Band		**Band 3**	**221 - 234**

Profile label	Ambulance Practitioner
Job Statement:	1. Responds to emergency, urgent and routine calls, delivers treatment 2. Undertakes emergency driving; lifts and carries patients 3. Undertakes daily vehicle checks, check and re-stock equipment and supplies

Factor	Relevant Job Information	JE Level
1. Communications	**Provide and receive complex, sensitive information; barriers to understanding** Communicates condition related information to patients/clients, relatives and clinical staff; requires empathetic and reassurance skills	4a
2. Knowledge Training and Experience	**Range of work procedures and practices, base level theoretical knowledge** Knowledge of procedures for emergency and other situations; acquired through training for IHCD technician qualification or equivalent	3
3. Analytical and Judgement	**Range of facts or situations requiring analysis, comparison of range of options** Assesses situation, decides courses of action in accordance with guidelines and protocols	3
4. Planning and Organising	**Organise own day to day work tasks or activities** Plans, organises own tasks/ plans, organises on-scene activities	1-2
5. Physical Skills	**Developed physical skills, manipulation of objects, people; narrow margins for error; highly developed physical skills, accuracy important, manipulation of fine tools, materials** Dexterity, co-ordination & sensory skills for driving, lifting & moving patients, clinical procedures e.g. intra-muscular injections while moving	3(a) (b)
6. Patient Care	**Implement clinical care, care packages/ provide advice in relation to care** Assesses and delivers emergency and medical treatment within clinical guidelines; provides advice to patients, carers	4(a) (c)
7. Policy and Service Development	**Follow policies in own role, may be required to comment** Follows ambulance service policies, may comment on proposals for change	1
8. Financial and Physical Resources	**Handle cash, valuables; safe use of equipment other than that used personally; maintain stock control; safe use of expensive equipment** Removes and passes patient belongings to clinical staff; ensure ambulance equipment is safe; maintains and secures stocks of drugs; safe use of ambulance & equipment	2abce
9. Human Resources	**Demonstrate own activities to new or less experienced employees** May demonstrate own duties to new members of staff, including students	1
10. Information Resources	**Record personally generated information** Keeps records of emergency and other treatment, incidents	1
11. Research and Development	**Complete surveys or audits as necessary to own work** Completes e.g. staff surveys, occasionally involved in equipment trials, clinical audits	1
12. Freedom to Act	**Standard operating procedures, someone available for reference** Works within relevant emergency medical treatment protocols and procedures, advice is available from more senior healthcare practitioners	2
13. Physical Effort	**Occasional/ frequent intense effort for several short periods** Lifting and carrying patients/clients in limited physical space	4c-5b
14. Mental Effort	**Frequent concentration, work pattern pattern/unpredictable** Concentration on driving, delivering emergency medical care/ may be switched to other emergency situations	2a-3a
15. Emotional Effort	**Occasional trauma; frequent highly distressing or emotional circumstances** Arriving at and dealing with e.g. families at the scene of accidents	4ab
16. Working Conditions	**Considerable exposure to hazards** Unavoidable exposure to physically dangerous situations on a regular basis	5
JE Score/Band	**JE Score 292-313**	**Band 4**

Profile label: Ambulance Practitioner Specialist

Job Statement:
1. Responds to emergency, urgent and routine calls; delivers treatment, including drug therapies
2. Undertakes emergency driving; lifts and carries patients
3. Undertakes daily vehicle checks, checks and re-stocks equipment and supplies

Factor	Relevant Job Information	JE Level
1. Communications	**Provide and receive complex, sensitive information; barriers to understanding** Communicates condition related information to patients/clients, relatives and clinical staff; requires empathetic and reassurance skills	4a
2. Knowledge Training and Experience	**Range of work procedures and practices, majority non-routine; intermediate level theoretical knowledge** Knowledge of clinical procedures for responding to emergency and other situations, including drug therapy, ECG acquired through training for full IHCD qualification or equivalent theoretical study and experience	4
3. Analytical and Judgement	**Range of facts or situations requiring analysis, comparison of range of options** Assesses situation, decides courses of action in accordance with guidelines and protocols	3
4. Planning and Organising	**Plan and organise straightforward activities, some ongoing** Plans, organises on-scene activities	2
5. Physical Skills	**Developed physical skills, manipulation of objects, people; narrow margins for error; highly developed physical skills, accuracy important, manipulation of fine tools, materials/ highly developed physical skills, high degree of precision** Dexterity, co-ordination & sensory skills for driving, lifting & moving patients. clinical procedures e.g. intra-muscular injections while moving/ skills for advanced clinical interventions e.g. intubation, cricothyroidotomy	3(a) (b)-4
6. Patient Care	**Implement clinical care, care packages/ provide advice in relation to care** Assesses and delivers emergency and medical treatment within clinical guidelines; provides advice to patients, carers	4(a) (c)
7. Policy and Service Development	**Follow policies in own role, may be required to comment** Follows ambulance service policies, may comment on proposals for change	1
8. Financial and Physical Resources	**Handle cash, valuables; safe use of equipment other than that used personally; maintain stock control; safe use of expensive equipment** Removes and passes patient belongings to clinical staff; ensure ambulance equipment is safe; maintains and secures stocks of drugs; safe use of ambulance & equipment	2abce
9. Human Resources	**Professional/clinical supervision; provide training in own discipline** Provides clinical supervision; job training to less experienced members of the care team	2bc
10. Information Resources	**Record personally generated information** Keeps records of emergency and other treatment, incidents	1
11. Research and Development	**Complete surveys or audits as necessary to own work** Completes e.g. staff surveys, occasionally involved in equipment trials, clinical audits	1
12. Freedom to Act	**Clearly defined occupational policies, work is managed rather than supervised** Works within relevant emergency medical treatment guidelines and procedures, work is managed rather than supervised	3
13. Physical Effort	**Occasional/ frequent intense effort for several short periods** Lifting and carrying patients/clients in limited physical space	4c-5b
14. Mental Effort	**Frequent concentration, work pattern pattern/unpredictable** Concentration on driving, delivering emergency medical care/ may be switched to other emergency situations	2a-3a
15. Emotional Effort	**Occasional trauma; frequent highly distressing or emotional circumstances** Arriving at and dealing with e.g. families at the scene of accidents	4ab
16. Working Conditions	**Considerable exposure to hazards** Unavoidable exposure to physically dangerous situations on a regular basis	5
JE Score/Band	**JE Score 345-372**	**Band 5**

NOTE: This profile is appropriate to Ambulance Paramedic roles. It is also appropriate to those Ambulance Technician roles requiring knowledge developed to an equivalent level to the full IHCD and carrying out duties as described in this profile.

Profile label: Ambulance Practitioner Advanced

Job Statement:
1. Responds to emergency and urgent calls; provides advanced clinical interventions, including drug therapies, at scene; may work as sole practitioner; may prescribe within PGD (Patient Group Directive) guidelines
2. Undertakes emergency driving
3 Undertakes daily vehicle checks, checks and re-stocks equipment and supplies

Factor	Relevant Job Information	JE Level
1. Communications	**Provide and receive complex, sensitive information; barriers to understanding** Communicates condition related information to patients/clients, relatives and clinical staff; requires empathetic and reassurance skills	4a
2. Knowledge Training and Experience	**Expertise within specialism underpinned by practical experience** Knowledge of procedures for advanced clinical intervention at scene; acquired through diploma level qualification plus additional theoretical study and experience to degree or equivalent level	5
3. Analytical and Judgement	**Range of facts or situations requiring analysis, comparison of range of options/Complex facts or situations requiring analysis, interpretation, comparison of range of options** Assesses patient situations, decides on courses of action in accordance with guidelines and protocols/assesses complex patient conditions	3/4
4. Planning and Organising	**Plan and organise straightforward activities, some ongoing** Plans, organises on-scene activities	2
5. Physical Skills	**Highly developed physical skills, high degree of precision** Highly developed dexterity, co-ordination and sensory skills for advanced clinical interventions e.g. advanced airway management including intubation, cricothyroidotomy, suturing	4
6. Patient Care	**Develop programmes of care, care packages/ provide specialist advice in relation to care** Provides packages and programmes of emergency and medical care; provides specialist advice to patients, carers	5(a) (c)
7. Policy and Service Development	**Follow policies in own role, may be required to comment/ implement policies and proposes changes to practices, procedures for own area** Follows policies for provision of medical treatment, may comment on proposals for change/ proposes changes to practices and procedures	1-2
8. Financial and Physical Resources	**Handle cash, valuable; safe use of equipment other than that used personally; maintain stock control; safe use of expensive equipment** Removes and passes patient belongings to clinical staff; ensure ambulance equipment is safe; maintains and secures stocks of drugs; safe use of vehicles and clinical equipment	2abce
9. Human Resources	**Clinical supervision; provide training in own discipline** Provides clinical supervision, provides job training to less experienced members of the care team	2bc
10. Information Resources	**Record personally generated information** Keeps records of emergency and other treatment, incidents	1
11. Research and Development	**Complete surveys or audits as necessary to own work/Occasionally participates in equipment testing** Completes e.g. staff surveys, occasionally involved in equipment trials/clinical audits	1
12. Freedom to Act	**Clearly defined occupational policies, work is managed rather than supervised** Works within emergency protocols and guidelines, work is managed rather than supervised	3
13. Physical Effort	**Occasional/ frequent intense effort for several short periods** Lifting and carrying patients/clients in limited physical space	4c-5b
14. Mental Effort	**Frequent concentration, work pattern pattern/unpredictable** Concentration on driving, delivering emergency medical care/ may be switched to other emergency situations	2a-3a
15. Emotional Effort	**Occasional trauma; frequent highly distressing or emotional circumstances** Arriving at and dealing with e.g. families at the scene of accidents	4ab
16. Working Conditions	**Considerable exposure to hazards** Unavoidable exposure to physically dangerous situations on a regular basis	5
JE Score/Band	**JE Score 400 – 434**	**Band 6**

Profile Label:	Emergency Services Team Leader		
Job Statement:	1. Provides emergency care, responds to emergency, urgent & routine calls 2. Provides clinical leadership of a team in all aspects of emergency work; monitors staff attendance, deals with staffing & resource issues 3. Investigates and deals with complaints		
Factor	Relevant Job Information	JE Level	JE Score
1. Communication & Relationship Skills	**Provide and receive complex information; persuasive, motivational, negotiating, training skills are required** Communicates condition related information to patients, relatives, requiring empathy & reassurance	4 (a)	32
2. Knowledge, Training & Experience	**Range of work procedures and practices, majority non-routine; intermediate level theoretical knowledge** Knowledge of clinical procedures for responding to emergency and other situations, including drug therapy, ECG, acquired through training for full IHCD qualification or equivalent theoretical study and experience	4	88
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Attends incidents to assess and treat patients and advise on additional support required.	4	42
4. Planning & Organisational Skills	**Plan & organise complex activities or programmes, requiring formulation, adjustment** Plans staff assessments and implementation of clinical practice standards	3	27
5. Physical Skills	**Highly developed physical skills, high degree of precision** Dexterity, co-ordination & sensory skills for surgical procedures e.g. intubation, tracheotomy	4	42
6. Responsibility for Patient/Client Care	**Implements clinical care/ care programmes; provide advice in relation to care** Assesses and delivers emergency and medical treatment within clinical guidelines; provides advice to patients, carers	4(a)(c)	22
7. Responsibility for Policy/Service Development	**Implement policies and proposes changes to practices, procedures for own area** Contributes to policy reviews	2	12
8. Responsibility for Financial & Physical Resources	**Safe use of expensive equipment** Safe use of ambulance and equipment	2(e)	12
9. Responsibility for Human Resources	**Day to day supervision** Supervises, appraises team members	2(a)	12
10. Responsibility for Information Resources	**Records personally generated information** Maintains incident records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to won work** Occasionally participates in equipment, clinical trials	1	5
12. Freedom to Act	**Clearly defined occupational policies, work managed, rather than supervised/ broad occupational policies** Organises work of team/ works within broad paramedic policies and trust procedures	3-4	21-32
13. Physical Effort	**Occasional/ frequent requirement to exert intense effort, several short periods each shift** Pushes, pulls/ lifts patients in awkward, difficult positions	4(c)-5(b)	18-25
14. Mental Effort	**Frequent concentration; work pattern unpredictable** Concentration for emergency care, responds to emergency situations	3(a)	12
15. Emotional Effort	**Occasional traumatic circumstances, frequent highly distressing or emotional circumstances** Attends incidents	4(a)(b)	25
16. Working Conditions	**Considerable exposure to hazards** Incidents, aggressive patients	5	25
JE Score/Band		**Band 6**	**399 - 417**

Profile Label:	Emergency Services Area Manager		
Job Statement:	1. Manages area service, deals with staffing & resource issues; provides clinical leadership, manages external relationships, accountable for performance and patient outcome targets 2. Attends major incidents, emergency, urgent & routine calls 3. Investigates and deals with complaints		
Factor	Relevant Job Information	JE Level	JE Score
1. Communication & Relationship Skills	**Provide and receive complex information; persuasive, motivational, negotiating, training skills are required** Communicates condition related information to patients, relatives, requiring empathy & reassurance	4 (a)	32
2. Knowledge, Training & Experience	**Expertise within specialism, underpinned by practical experience** Procedures for responding to emergency & other situations, major incidents and staff management knowledge acquired through training and experience to degree level equivalent	5	120
3. Analytical & Judgemental Skills	**Complex facts or situations requiring analysis, interpretation, comparison of a range of options** Assess major incidents, care requirements, resources needed	4	42
4. Planning & Organisational Skills	**Plan, organise complex activities or programmes, requiring formulation, adjustment** Plans resource usage and clinical standards compliance	3	27
5. Physical Skills	**Highly developed physical skills, high degree of precision** Dexterity, co-ordination & sensory skills for surgical interventions e.g. intubation, tracheotomy	4	42
6. Responsibility for Patient/Client Care	**Accountable for direct delivery of clinical, clinical technical, or social care services** Responsible for delivery of area service	6(d)	39
7. Responsibility for Policy/Service Development	**Implement policies and propose changes to practices, procedures for own area/ propose policy or service changes, impact beyond own area** Review policies for own area/ impact on wider area	2-3	12-21
8. Responsibility for Financial & Physical Resources	**Safe use of expensive equipment/ major budgets or financial initiatives** Responsible for ambulance and equipment/ monitors, holds area budget	2(e)-3(c)	12-21
9. Responsibility for Human Resources	**Line management for single function or department** Management of area team including recruitment, performance, development	4(a)	32
10. Responsibility for Information Resources	**Records personally generated information** Maintains area records	1	4
11. Responsibility for Research & Development	**Undertake surveys or audits, as necessary to own work** Occasionally participates in equipment, clinical trials	1	5
12. Freedom to Act	**Broad occupational policies** Interpret and implements policies and clinical guidelines for area, discretion to work within broad service/organisation policies.	4	32
13. Physical Effort	**Frequent moderate effort for several short periods/ occasional intense effort for several short periods** Moves equipment/ patients when attending incidents	3(c) 4(c)	12-18
14. Mental Effort	**Frequent concentration; work Pattern unpredictable** Concentration for emergency care, responds to incidents	3(a)	12
15. Emotional Effort	**Frequent highly distressing or emotional circumstances** Dealing with major incidents, complaints	4(b)	25
16. Working Conditions	**Some exposure to hazards; Frequent highly unpleasant conditions** Attends incidents	4a)b)	18
JE Score/Band		**Band7**	**466 - 490**

7. Job Evaluation weighting scheme - scoring chart

Appendix 4.

Factor	1	2	3	4	5	6	7	8
1. Communication and relationship skills	5	12	21	32	45	60		
2. Knowledge, training and experience	16	36	60	88	120	156	196	240
3. Analytical skills	6	15	27	42	60			
4. Planning and organisation skills	6	15	27	42	60			
5. Physical skills	6	15	27	42	60			
6. Responsibility – patient/client care	4	9	15	22	30	39	49	60
7. Responsibility – policy and service	5	12	21	32	45	60		
8. Responsibility – finance and physical	5	12	21	32	45	60		
9. Responsibility – staff/HR/leadership/training	5	12	21	32	45	60		
10. Responsibility – information resources	4	9	16	24	34	46	60	
11. Responsibility – research and development	5	12	21	32	45	60		
12. Freedom to act	5	12	21	32	45	60		
13. Physical effort	3	7	12	18	25			
14. Mental effort	3	7	12	18	25			
15. Emotional effort	5	11	18	25				
16. Working conditions	3	7	12	18	25			

Appendix 5.

AES Matched Job Report Draft Proposal

NB: This document was created by staff only and has not been through AFC job banding exercise.

Note:
Black description: Original and current job match for AES
Red description: Vital information left out for job match score

Factor	Level	Sub	Score	Rationale	Panel notes
1.Communication & Relationship Skills	3		21	On the current A&E Support evaluation it states reassure confused and/or distressed patients, relatives and/or carers. To provide emotional support to relieve anxiety of patients and carers. Communicates condition related information to patients/clients, relatives and clinical staff; requires empathetic and reassurance skills.	32
2. Knowledge Training & Experience	2		36	Blue light driving; CPR, Basic First aid, Blood Pressure, Glucose and Temperatures Reading. Protocols for action clearly defined. There is no reference to LAS in Emergency procedures towards IHCD student paramedic, which is now our pathway since the Technician role no longer exists	60
3. Analytical & Judgemental Skills	2		15	Assess patients conditions within scope of training. Decisions on how certain patients need to be moved. There is no reference to provide appropriate treatment and actions, which best suits the needs of the patient.	27
4. Planning & Organisation Skills	2		15	Plan Routes ETC. There is no reference to planning of tasks on scene.	15
5. Physical Skills	3	a	27	Blue light driving. There is no reference to move and lift patients in confined spaces, Clinical procedures e.g using monitoring equipment while moving.	27
6. Patient/client Care	3	a	15	Administers restricted treatment; provides transportation for patients.	22

				There is no reference to Assesses patient needs on scene for varied medical treatments, provides advice to patients and carers.	
7. Policy/service Development	1		5	Follows all service protocols set by the service.	Correct evaluation . .
8. Financial & Physical Resources	2	abc	12	Care of patients valuables etc; LAS vehicle equipment.	Correct evaluation .
9. Human Resources	1		5	No specific responsibilities.	Correct evaluation .
10. Information Resources	1		4	Vehicle checks, PRFs etc. There is no reference to Incident reports, other Treatments, Vulnerable Adult and Child reports in line with trust policy.	4
11. Research & Development	1		5	No evidence.	Correct evaluation .
12.Freedom to Act	2		12	Works on initiative but supervisor available by phone or radio.	Correct evaluation
13. Physical Effort	5		25	Lifts heavy patients on regular basis. There is no reference to lifting and carrying patients in limited physical spaces.	25
14. Mental Effort	2	a	7	Concentration on driving. Concentration on blue light driving over a long period time. Requirements to swap from one call to another as directed by control.	25
15. Emotional Effort	3	a	18	May deal with terminally ill patients; behaviour problems and young babies: There is no reference to May have to deal with traumatic incidents on running calls. Frequent requirements to deal with distressing circumstances when dealing with critically ill patients and their carer. It should also state frequently deal with terminally ill patients.	25

AES Matched Job Report Draft Proposal

16. Working Conditions	4	ab	18	A&E Support: Frequent exposure to highly unpleasant working conditions bodily fluids etc. There is no reference to physically dangerous situations on occasions. Requirement to provide emergency provisions.	25

TOTAL: 240 (Band 3) 326 (Band 5)

Table showing banding and point scales for Agenda for Change.

Band	Job weight Points
1	0–160
2	161–215
3	216–270
4	271–325
5	326–395
6	396–465
7	466–539
8a	540–584
8b	585–629
8c	630–674
8d	675–720
9	721–765

Appendix 6.

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hpc health professions council

27 July 2011

To: Chief Executives: English Ambulance Service NHS Trusts
Isle of Wight PCT
Northern Ireland Ambulance Service HSC Trust
Scottish Ambulance Service
Welsh Ambulance Service NHS Trust

Copy: Chief Officers: Guernsey Ambulance and Rescue Service
Isle of Man Ambulance, Paramedic and PT Service
States of Jersey Ambulance Service

Dear Colleague

Paramedics: Driving v Attending

I am writing to you about the long-standing practice for ambulance crews to share driving duties.

The HPC is receiving fitness to practise allegations against paramedics which arise from or involve a decision by the paramedic in question to drive the ambulance and leave a patient in the care of a less qualified ambulance clinician.

We recognise that it is a long-standing practice for ambulance crews to share driving duties, but that practice began at a time when both crew members would have had similar levels of clinical competence. Today, paramedics have clinical skills which exceed those of other ambulance clinicians by a significant margin. Consequently, paramedics need to consider carefully, on a case by case basis, whether they drive or attend patients.

The HPC is not suggesting that paramedics should cease to share driving duties with their colleagues, nor that less qualified ambulance personnel should cease treating patients. However, paramedics have a professional obligation to act in the best interests of patients and, where they are the senior ambulance clinician on scene, must use sound clinical reasoning to ensure that patients receive care from the most appropriate and available ambulance clinician.

The issue is encapsulated in Standard 1 of the HPC's Standards of Conduct, Performance and Ethics, which apply to all paramedics:

> ***"1 You must act in the best interests of service users.***
>
> *You are personally responsible for making sure that you promote and protect the best interests of your service users…*
>
> *You must not do anything, or allow someone else to do anything, that you have good reason to believe will put the health or safety of a service user in danger. This includes both your own actions and those of other people…*
>
> *You are responsible for your professional conduct, any care or advice you provide, and any failure to act. You are responsible for the appropriateness of your decision to delegate a task. You must be able to justify your decisions if asked to…"*

In practice, complaints to the HPC about this issue arise from two scenarios:

- where the paramedic is driving en route to a call and the attending, less qualified ambulance clinician, is the first person to reach the patient; and
- where, in conveying a patient to hospital, the paramedic drives the ambulance and leaves the patient in the care of a less qualified colleague.

In relation to the first scenario, if there is, or is likely to be, any delay in the paramedic reaching the patient – for example, because of the need to retrieve additional equipment from the ambulance or to manoeuvre the vehicle so that it is ready for rapid departure from scene – the paramedic must consider whether he or she should perform the task or leave the other crew member to do so, thereby ensuring that the paramedic reaches the patient first.

We recognise that the patient's presentation on scene will often not correspond with that described to the 999 call taker, but where the overall nature of a call suggests that it is life-threatening or otherwise serious, paramedics should consider whether they need to be the first on scene and if so, to leave tasks which may delay their arrival to less qualified colleagues.

In respect of the second scenario - deciding who attends the patient during conveyance - we equally recognise that, in many cases, a non-paramedic ambulance clinician will be more than capable of caring for the patient. However, it is important that paramedics give proper consideration to the care that the patient may need en route, particularly if it is care which only a paramedic can provide.

That consideration needs to include any potential deterioration in the patient's condition and take account of the fact that a less qualified ambulance clinician will only be able to call for assistance if he or she is aware of the need for such assistance. Paramedics should ensure that they do not endanger patients by putting their colleagues in situations where they may not be able to recognise or respond to subtle but significant changes in the patient's condition.

We recognise that the composition of ambulance crews may vary considerably from service to service and have no doubt that much of what we suggest here is already being done by many paramedics. Nonetheless, I would be grateful if you will bring the points raised in this letter to the attention of the paramedics who work for your service, in an effort to avoid unnecessary allegations being made against them.

If you have any questions or points of clarification, please do not hesitate to contact me.

Yours sincerely

Marc Seale

Marc Seale
Chief Executive and Registrar

AES Survey

A Unison Survey put together by a group of AES Staff for AES Staff…..

We are a group of A&E Support workers who have put together this survey with the support of Unison. The purpose of the survey is to try and provide an opportunity for A&E Support workers across the service to voice our opinions about our present and future role.

There is a widespread feeling across the L.A.S. that A&E Support does not get fairly represented or heard. Please help us put together a cohesive and comprehensive report on your views that can then help us and the Union/s deal with any potential changes.

As you may already know the current thinking amongst the Senior Executives is the idea that A&E Support should work alongside paramedics as part of a mixed crew.

This is a great opportunity to have our say and hopefully make positive changes before changes are made for us!

Please take part in the survey regardless of whether you are in a Union or not, your views matter.

We have asked for personal information but if you wish to submit anonymously please do.....

Please try and submit this form as soon as you can.

Name:

Station:

Length of Service:

Question 1a:
How do you feel about working as the second crewmate with a paramedic?

- ○ I like the idea of working with a paramedic with a short bridging course and working under pay band 3.
- ○ I like the idea of working with a paramedic but want more extensive training and to be under pay band 4.
- ○ I do not like the idea of working as part of a paramedic crew
- ○ Other:

Question 1b.
Can you list your opinions on this idea, both why you think it is a good idea and why it is not.

Question 2a:
Do you think that the current A&E Support role works and is the right solution for the LAS?

- ○ Yes
- ○ No

Question 2b.
If you don't think it is the right solution, can you give your reasons here?

Question 3a:
Do you feel that your job description currently covers all jobs that you are sent by control?

If you answer yes please continue to question 4. If you answer no please answer 3B and 3C

- Yes
- No

Question 3b:
(If you have answered No to 3a) then can you state how often you are required to work outside of your remit.

- Every shift
- Every week
- Occasionally

Question 3c:
If you have answered No to 3a) then please provide some examples of jobs allocated to you by control that is outside your remit?

Question 4a:
Are you happy with the current pathway (Open University) to progress within the LAS?

- ○ Yes I am happy with the current pathway
- ○ No I am not happy with the current pathway

Question 4b.
If you are answered No (not happy) Do you have any suggestions on how this could be improved or new pathways offered?

Question 5a:
If A and E Support worked alongside paramedics would you expect a different pathway for progression?

- ○ Yes
- ○ No

Question 5b.
If you answered Yes to 5a do you have suggestions about what this should be?

Question 6a:
Are you happy within your role?

- ○ Yes
- ○ No
- ○ Indifferent

Question 6b:
Please list positive and negative feelings you have about your role.

Question 7:
Do you have ideas on how A&E Support role could be improved or changed? If yes would you share them with us?

Question 8:
Some staff and the Unions feel that if A&E Support were to work alongside a paramedic then the position should be a band 4 with adequate training. Do you agree with this?

- ○ Strongly agree
- ○ Agree
- ○ Indifferent
- ○ Disagree
- ○ Strongly disagree

Question 9:
Are you a Union member?

- ○ Yes, Unison
- ○ Yes, GMB
- ○ Yes, I am in a different Union
- ○ No, I am not in a Union
- ◉ I would rather not disclose

Please write here any other comments that you feel hasn't been covered by this survey.

Thank you kindly for you time and your help.

We look forward to publishing the results.

Please send this back on email to:

Amanda.mary-jones@lond-amb.nhs.uk and tracy.lynnward@lond-amb.nhs.uk

Or by hard copy via your Administration Office

To: **HOMERTON ADMINISTRATION OFFICE**