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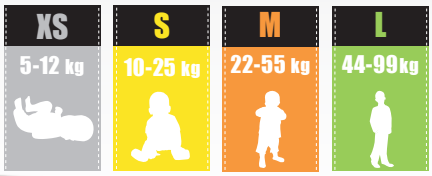

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This edition of *Ambulance Today* is dedicated to the memory of our good friend Eric Roberts

In tribute to our good friend Eric Roberts

There'll be one friend less at *Ambulance Today*'s Christmas dinner this year because one of our guests, Eric Roberts of UNISON, has passed away unexpectedly.

Eric was the Secretary of London Ambulance UNISON's branch and for many years the chair of UNISON's national ambulance sector. He was also the President of UNISON - the first ambulance worker to hold this post. Despite his many achievements though, Eric remained a no-nonsense and friendly Scouse ambulance guy and a passionate Liverpool FC fan who cared deeply about his fellow ambulance workers. From the time when I invited UNISON to be a part of *Ambulance Today* before its launch, he gave me support, encouragement, and wise advice. Over the years he educated me in a very real sense - always warm and witty, he gave me many shrewd and thoughtful insights, explaining to me why ambulance workers across the world matter so much and why you should all be treated with care and respect at all times.It's people like Eric who have given all ambulance staff such a strong voice in the NHS!

Eric passed away suddenly at the end of November, having just been diagnosed with cancer. In the days before his passing I was speaking with him by phone and email about an interview we had planned with him for this very edition. Instead we'll be running a tribute to him in Spring. In recent months Eric worked tirelessly to fulfil his role as President of UNISON and despite the toll it must have been taking on him, he not once complained about fatigue or pain. On the contrary, I've never seen him happier or more fulfilled. For while he was rightly delighted at the honour of being voted UNISON's President, he wasn't egotistical and he didn't look on it as solely a personal tribute. He was just thrilled that this influential position allowed him to better galvanize those within UNISON and those they negotiate with in support of their membership. Eric's constant thought was: 'What issue must we focus on next to improve working conditions for the people we represent?'

It was another good friend (also a very popular figure within the UK ambulance service's staff-side) Maggie Dunn, who did me the great favour of introducing me to Eric. Though now long retired as UNISON's National Officer for ambulance, like Eric, Maggie has dedicated her life to striving for better conditions for NHS staff so she's stayed in touch with her ambulance friends.

Maggie and Eric were great mates. Both of them true unionists. Their friendship began when Maggie as a relatively new regional rep at the time of the historical ambulance dispute of '89-'90, needed advice and support. Eric, already highly-experienced and immensely well-respected across the UK union movement, responded to Maggie's request for help when she spotted that while a substantial amount of on-street fundraising was taking place successfully in London in support of the ambulance workers (many of whom were at risk of losing their homes due to the dispute), ambulance workers in rural areas weren't able to attract the same levels of financial support, due to lower populations. Without hesitation Eric, then NUPE branch secretary at LAS, immediately spoke with Roger Poole, the leader of the ambulance dispute, and together they urged the national fundraising committee to ensure that all donations raised in big cities would be shared equally with workers in rural areas. To Eric it was simple: Good unionists look after their members equally because sharing care equally is the fundamental basis of socialism.

But Eric's commitment to ambulance workers didn't end with the ambulance dispute. He was also one of the founders of the roles of the modern paramedic and EMT, sensibly arguing that with the advances in clinical skills of frontline ambulance crews, to pigeon-hole them as 'drivers' sold them short. He was also a leading campaigner for gender equality in the ambulance workplace. Our Spring 2010 front-cover led on an article by Eric reflecting back on the dispute. You'll notice that while he's on the rostrum declaiming away with microphone in hand, he purposefully included female co-workers. Eric went on to lead successful campaigns to improve pay and promotion prospects for women workers in first PTS and Control and then across the board. To Eric it didn't matter what gender you were, it only mattered that your skills were recognised.

It was in '93 after the ambulance dispute that UNISON was created and Eric, Roger and Maggie all went on to achieve even greater things. Roger Poole, who became UNISON Assistant General Secretary, sadly passed away only last year, also of cancer. But he's still regularly fondly remembered by his many UNISON peers; as in: "Do you remember how Roger negotiated such-and-such during the ambulance dispute?' It's a special thing when somebody dedicates so much of their energy and intelligence to helping those around them that they live on after they have passed on. As with Roger, I feel certain that Eric's warm but wise voice will live on.

Eric championed many causes over the years – too many to list. For many years he headed UNISON's Welfare Fund. In particular he was a loyal supporter of the Cuban ambulance service so when the news came over the radio just 48 hours after he'd passed away that so also had the elderly General Castro, who Eric admired, I was struck by the strangeness of this coincidence. Eric was a visionary who saw the irony of Cuba having so many highly-trained medical workers but, due to political embargo, scant physical resources. His sole focus was to ensure that Cuba received the resources it needed to operate a working ambulance system. After sending out a cargo ship loaded with refurbished ambulances he also helped upgrade their control system and obtain them donations of equipment and medicines.

You see: to Eric, it didn't matter whether you lived in Cuba or Catford. Whether you were a worker or unemployed. Just so long as you were in need or if you found yourself suffering under somebody else's unfair labour system - He'd be there for you… and no questions asked!

It only remains to say that myself and all the team here at *Ambulance Today* send our heart-felt condolences to Eric's family and loved ones. You are all in our thoughts at this sad time. Eric will be sorely missed by good ambulance people the world over because he made a huge difference - and how many people can you truly say that of?

Declan Heneghan
Editor, *Ambulance Today*

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Health and wellbeing: UNISON is in this for the long haul

At the end of October, a national group met to discuss the current state of health and wellbeing of ambulance staff. We heard from groups with different perspectives on existing issues. The group was brought together as part of the government's commitment to improving the experience of ambulance staff at work, reducing the levels of violence and aggression, bullying and harassment and looking at the challenges of engaging diverse groups of staff.

By Alan Lofthouse National Ambulance Officer, UNISON

Zeal Solutions, an organisation that explores organisational psychology, presented on a significant amount of work undertaken with NHS Ambulance Trusts across the country evaluating what Trusts do and providing evidence based interventions to help improve the support available for their staff. We heard from NHS Protect, the organisation that aims to educate and inform people about crime and the impact of violence and aggression against NHS staff, including ambulance staff. The mental health charity Mind presented about the fantastic work they are doing on the Blue Light Project and how their evaluations can inform work to improve mental health support.

NHS Employers outlined information and ideas from across the NHS on staff engagement, staff retention and the existing support available. We also heard from an ambulance service Chief Executive about the importance of improving health and wellbeing and the challenges employers face balancing this against delivering ambulance services. An ambulance Human Resource Director spoke about how health and wellbeing is an important factor in staff engagement, job satisfaction, performance and productivity and that the NHS Constitution sets out what staff can expect as their rights at work. Finally, the joint ambulance Trade Unions set out their position on health and wellbeing stating their frustrations about historic issues that remain difficult to resolve and that a better balance between health and wellbeing and performance needs to be found to make a real difference.

It is no understatement to say this piece of work is significant. We know that each ambulance service provides a range of support mechanisms, from counselling to physiotherapy and even pastoral services in the East Midlands. However, this is the first time that parties have come together to look at the national picture. We have the evidence, gained from many different sources, such as the NHS Staff Survey, TU surveys and NHS Protect data, that paints a picture of a workforce under pressure. We also know that we are looking at this in a period where the NHS is facing its biggest challenges. Finances are tight, demand is up, and staffing levels are under pressure from poor staff retention. This is not solely an ambulance problem but it seems to be worse for ambulance staff.

There is a genuine will to improve health and wellbeing. We have the start of a strategic action plan, developed in partnership, which is being supported by the Ambulance Association of Chief Executives and ultimately delivered by local employer and trade union partnerships with support from their Board of Directors and governance from our national group. It is an ambitious plan covering actions over the next two years.

What strikes me is that our goals are so similar. There is no disagreement over the problem of health and wellbeing and the need to take decisive action. We might have different ideas about some of the solutions but, by working together, we will find a way to overcome them.

We all agree that there is a cultural shift needed in the NHS around ambulance services. Not just in individual ambulance employers but also in the organisations they report to and those that inspect them. The NHS runs on performance statistics. I have written before about the difference between time targets and clinical care so I will not repeat those arguments again; however, it is important to recognise that ambulance staff are motivated by their desire to deliver high quality clinical care – not by hitting a time target.

When ambulance services are not meeting their performance targets other organisations start to breathe down their necks. Operational plans kick in. The grim REAP(er) actions kick in. It is all about performance then. However, at the coalface the problems occur. EOC staff struggle to deal with the demand on 999 or 111 services. EOC staff stacking calls without crews to cover, trying where possible to get staff on a break or let them finish on time but knowing that might be their only resource covering a huge area. Ambulance crews feel the relentless pressure of needing to be there for patients and trying to balance their own health, safety and wellbeing. Do I refuse the job? Can I give any more? Communication breaks down, disputes arise and tensions build.

So, if we are to change the culture we need to get a balance between performance and staff welfare. Ambulance staff are human beings, not robots, and they can only give so much. If we ask too much of them for a prolonged period they will break, physically and/or mentally.

We heard a lot about the resources people have at work to cope with pressure. These resources are both physical and mental and our ability to access these resources when we need them are influenced by many factors. If we are pushed beyond our ability to cope with pressure, the effects are stress and ill health.

What the evidence tells us is that the best measure to help with this lies with the line manager. They hold the key to helping staff find and maintain their resources, through supportive team cultures, reducing fear and anxiety and providing clear and accountable leadership. However, line managers need to be supported by their Trust and this culture needs to be led from Chief Executive and Board down. Therein lies the challenge. Ambulance Trust boards need to balance performance, finance and risk with improving the health and wellbeing of their staff.

The cost of not doing this was summed up succinctly at the meeting. Worsening morale, rising costs of dealing with ill health and employment related issues, dysfunctional culture and the organisation's reputation as a place to work. Cultural change takes time, but it must happen. We all have a role to play in that, speaking up, campaigning, organising and challenging the status quo.

We are clear. UNISON is in this for the long haul for our members and for patients but also for the long term sustainability of ambulance services

Alan welcomes feedback from ambulance staff and can be contacted at: a.lofthouse@unison.co.uk

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And you say, 'Oh my God, am I here all alone?' - "Ballad of a Thin Man"

'There must be some kind of way outta here
Said the joker to the thief
There's too much confusion
I can't get no relief'
- "All Along the Watchtower"

Ah, tis the holiday season, the bright lights are lit, candles burning, and the smells of home cooking come wafting from the kitchens across the country. But NOT, unfortunately, for all. Though it is never quite clear the true meaning of the lyrics written by the latest Nobel Prize winner for Literature, Bob Dylan, one truth is clear; in this holiday season, for EMS, the demand will again rise and many of those patients will be those that are "here all alone" or in "too much confusion" and "can't get no relief." These are our mental health patients.

Over the next several weeks, this will become more and more challenging, as always. First, just a few facts from the U. S. National Alliance for Mental Health.

- *Approximately 1 in 5 adults in the U.S.—43.8 million, or 18.5%—experiences mental illness in a given year.*

- *Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.*

- *6.9% of adults in the U.S.—16 million—had at least one major depressive episode in the past year.*

- *18.1% of adults in the U.S. experienced an anxiety disorder such as post-traumatic stress disorder, obsessive-compulsive disorder and specific phobias.*

- *Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5%—10.2 million adults—had a co-occurring mental illness.*

And, oh yes, the consequences . . .

- *Individuals living with serious mental illness face an increased risk of having chronic medical conditions. Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.*

- *Over one-third (37%) of students with a mental health condition age 14–21 and older who are served by special education drop out—the highest dropout rate of any disability group.*

- *Suicide is the 10th leading cause of death in the U.S., the 3rd leading cause of death for people aged 10–24 and the 2nd leading cause of death for people aged 15–24.*

- *More than 90% of children who die by suicide have a mental health condition.*

- *Each day an estimated 18-22 veterans die by suicide.*

And, it is not going way. In Utah, the state where I live, the teen suicide rates have tripled (yes, tripled) from 2007 to 2016. Of course, that goes along with the other alarming statistic, there is a lack of access.

So, you must be now wondering why I am writing this instead of sending you "glad tidings of comfort and joy." It is because, in the end, we have very little training or experience in how to handle these patients. Nor does the EMS system.

Think back to your educational days and just how many hours were committed to mental health patients and how to treat them. Not that many. And think about your destination protocols and where they go, not to a clinic but to an A &E.

The solutions are not that simple, but they must be found. This patient population is one of the fastest growing as a percentage of our EMS responses. Interestingly, because we lack any definitive care destinations

Image by Daniel Sundahl for EMS World

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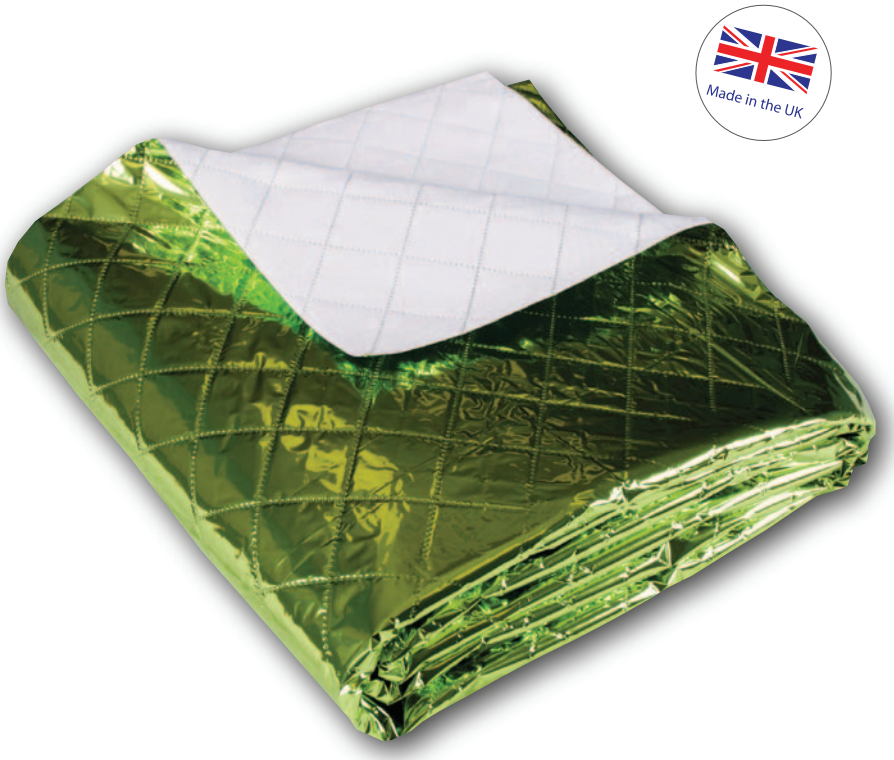

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besides the A & E, our time on task to provide them the resources to meet their need is the longest.

Until recently mental health has not been a priority. But that is changing in some systems. As a result of the implementation of "hear and treat" in some dispatch centers, direct "mental health hot lines," similar to "poison control hot lines" have been established for the non-violent suicidal patients. Advanced paramedics are also receiving more training in this area.

Perhaps one of the more innovative programs I have seen is in Adelaide, Australia. At the South Australia Ambulance Service (SAAS), the local mental health agency has professionals located in a room adjoining the EMS dispatch center. It is not all that much space, but it is yielding excellent results.

But I have another motive in writing this column at this time of year. The stressors that are on you every day can easily be overwhelming. You take care of the sickest of the sick. You truly take care to the patient's side, whether it be in the streets or in the home. You are threatened and assaulted, and those stressors are AFTER the response. BEFORE the response comes the pressure of response times, scene times, turnaround times and driving safely.

It is no wonder that suicide rates for paramedics are the highest amongst emergency workers. Australia's *The Herald Sun* reported Victoria's suicide rate for paramedics at 35.6 per 100,000 workers, three and one half time higher than police and fire. A survey published by JEMS in the United States revealed that a staggering 37 percent of the respondents had contemplated suicide and six percent had actually attempted it.

It is time for you to recognize that you need to take care of you. If you do not take care of you, there is no way in hell that you can take care of your patients. It is NOT easy, that I know. In fact, I might go so far as to write that we are the worst when it comes to paying attention to what we need, both physically and mentally.

And, by the way, just so you know, starting anew with a New Year's Resolution or two is not the answer. As if you did not know

from your previous resolutions, they in all probability will not be kept. In fact, a study done in 2007 at the University of Bristol showed the 88 percent of those set failed. So much for that.

This "Letter to America" is not meant to lecture, nor will it. Just know that there are those of us who give a damn about you, not only during the holidays, but all year round. This is the festive season and take time to celebrate what matters. EMS has changed, our patients have changed, and we can change, because, as Dylan penned in one of his most famous lines, "the times, they are a-changing."

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Steve Shaw Cartwright's new Commercial & Operations Director

Ambulance Today's Assistant Editor Joe Smith visited Cartwright's new Doncaster site recently to meet their new Commercial and Operations Director, Steve Shaw, and discuss his plans to corner the market in Patient Transport Service vehicles:

Known for his easy-going but direct manner, Steve Shaw didn't waste any time in outlining his vision for Cartwright's as they move forward from their Doncaster build facility. "I want us to develop into the main supplier of each of the types of conversions we produce, be it PTS, A&E or welfare. Whatever the customer wants I want their first thought to be: 'Cartwright's.'"

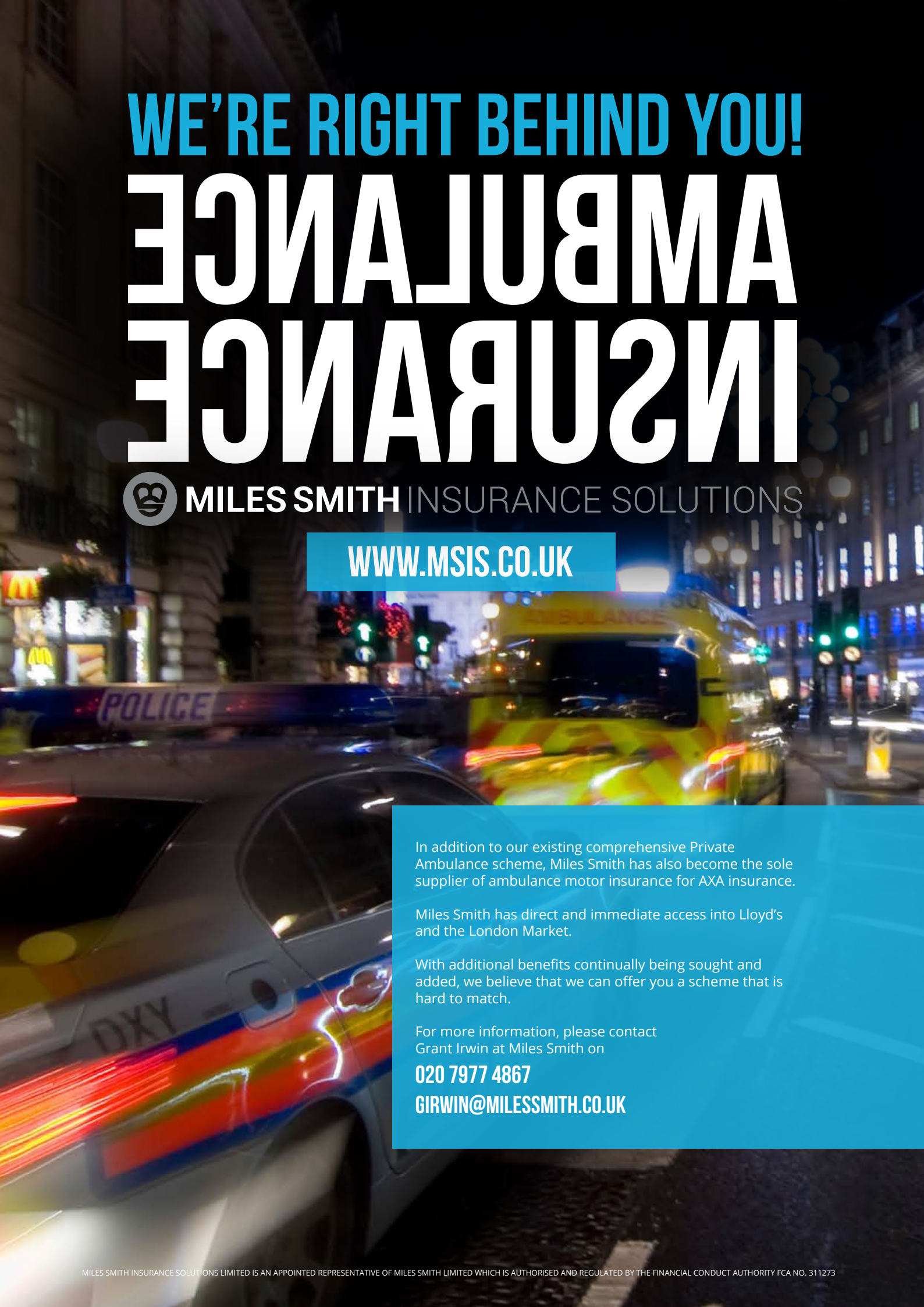
When it comes to bespoke conversion vehicles, there's no bigger name in the industry than Cartwright's. For 60 years, the British manufacturer has been turning out quality specialised HGVs, so its recent move into A&E, PTS and other specialist ambulance vehicles was, by any measure, a logical move, and, after only five years in the UK ambulance market it's already supplying fleet to some of the country's biggest ambulance providers including London Ambulance. Now, under the guidance of its ambitious new Commercial and Operations Director, Steve Shaw, Cartwright's is ready to corner the market in Patient Transport Service (PTS) Vehicles. So when I travelled out to the company's new Doncaster site to see some of the new PTS conversions

first-hand and speak to Steve and the staff my expectations were, unsurprisingly, already high.

On arrival, I immediately felt a buzz about the place. Based in rural Doncaster, the new site opened for operations back in March and is now alive with activity. The 36,000 square-foot factory floor is supported by a large storeroom, linking offices, a boardroom and an impressive workspace for the on-site coach builders and electricians. Steve was right; there was a real sense of excitement and purpose amongst the staff. Thanks to Cartwright's long-standing reputation and status, they seem to have had no problem in quickly assembling a team of some of the best vehicle-builders in the business. Anyone in the ambulance build industry knows that it's a small world and many of the staff had worked together before at various companies.

Paul Wilson, General Manager

General Manager, Paul Wilson joined the team in July: "That's one of the reasons that made me come – because I knew the quality of people who I'd worked with in the past. There's a good team here which is a massive plus."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Gary Stephenson, Engineering Manager

When you combine a pre-established mutual-respect with a strong sense of pride for the job, the scope of Cartwright's future projects seems only to be limited by the customers' needs. Enthusiastic Engineering Manager Gary Stephenson has been with the firm for two years and was, as he explained, the very first member of staff to be assigned to the new site:

"The whole premise was to get the right people in the right environment. It's like a big family; the lads here will work all the hours that they need to because they want to. Picking the right people is our Number One priority.

"One key member of our team is our Electrical Manager, Jason Barker. He's well-known within the industry as being one of the top electricians. He's a real investment to have; these days all new ambulance

Jason Barker, Electrical Manager

vehicles are electrically heavy, at the design stage, so it's a great reassurance to have someone at that skill-level at hand, designing and overseeing the installation."

Jason's job highlights one of the ongoing challenges when building high specification Ambulances, explaining: "While accelerating advances in technology open so many doors in terms of what an ambulance can do… telematics, GPS, integrated systems, etc… on-board technology has quickly become the heaviest build element when creating new vehicles. Not only does this affect available space, but our engineers are always running up against the weight-limit that paramedics and EMS workers can drive at with their particular licenses."

With such a great team, and with decades of experience behind them, it's no wonder that Cartwright's were the first ambulance builder to take a keen and active interest in the Royal College of Art's-conceived Smart Ambulance Redesign Project, a scheme which has grown into a pan-European consortium and which, despite recent set-backs in European funding caused by the Brexit result, still intends to harness the latest in ITC technologies to build the ambulances of the 21st century; when this project does move onto the next stage, Steve hopes it will be people like Gary, Paul and Jason who will be realising the ambitious vision of the European consortium.

One of the primary growth targets for Cartwright's will be establishing a strong foot-hold in the important PTS market which will include PTS Hire vehicles. Cartwrights have committed to building new hire vehicles each month for the foreseeable future with the eventual goal of becoming one of the main competitors within the industry.

At a time when British manufacturing is enjoying a boost, Cartwright's is currently producing 3,000 vehicles a year, with the majority of these being HGV's built at their enormous Altrincham site, and although the true build-capacity of its two build-facilities depends heavily upon the nature of the individual order (at the time of my visit some of the staff were engaged in constructing an interesting secure vehicle), the new PTS hire-vehicle project is currently producing five vehicles a month. With plans afoot to reorganise the factory floor in two in order to effectively double the production lines and add a new section to handle Wheelchair Access vehicles. As demand increases, I'm told, there is plenty of room to extend the site or even to buy a new building.

Investment for the future doesn't just come in the form of expansion and cutting-edge new facilities; at the time of writing Cartwright's have recently added two new apprentices to the staff of their Doncaster site. The young apprentices will gain hands-on experience, working around some of the best fleet engineers the country has to offer. The decision to foster the next generation

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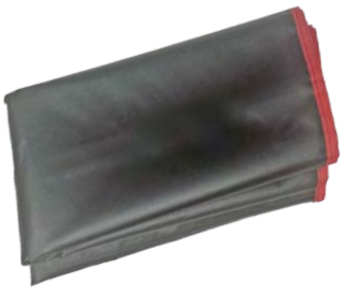
Rollboards



Patient restraint systems for all stretchers

Suitable for the transport of kids with a body weight of **3,5 kg up to 22 kg**

Restraint systems crash tested according to EN 1789

Safety requirements for all carrying systems

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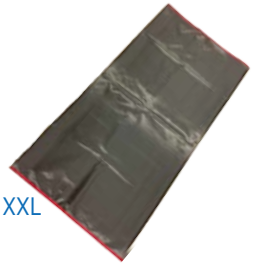
Obesity counseling

Staircase sliding sheets

Rollbords XXL



Vacuum mattresses

of industry professionals serves to underline Cartwright's long term commitment, not just to the local area, but to developing the industry as a whole.

"If the vehicles are going to the hire fleet, flexibility is extremely important. The end-user needs to be able to use it for whatever their need happens to be. Whether that's for patients in wheel-chairs, seated passengers or transporting stretchers; we're going to make the vehicle as flexible as possible."

Cartwright's account managers and engineers work closely with their customers, from the design stage right through to the final decals, to make sure that the end-result is completely bespoke and fully meets the customer's unique needs. The PTS vehicles come with a wide-range of options, from specialist bariatric capabilities to accessibility ramps, and if it doesn't exist yet Gary and his team are always up for the challenge of identifying and building the design solution presented by their customer's individual requirement.

Paul Wilson explained how the two sites pool their resources to maximum effect: "Cartwright's do a lot of fabricating. With a box-body, for instance, the box is made at our Altrincham site but is then fitted to the chassis here and final fit out completed here."

One massive advantage of hiring a vehicle directly from such a well-established British manufacturer as Cartwright's is the resource of after-care maintenance. Cartwright's adopt a holistic approach intended to provide everything the customer needs; these vehicles are made to clock up serious mileage and each of the purchased vehicles currently comes with a warranty. Vehicles that are hired can enjoy the support of both build facilities, as well as the support of teams of expert engineers from all over the UK. The Doncaster site also produces specialist fleet maintenance vehicles that are dispersed all over the country meaning that no matter where you are in the UK, if you're driving a Cartwright's hire vehicle you're never left on your own. Directors like Steve not only ensure that their vehicles are ahead of the competition, they also play an important part in raising the bar for quality and safety standards across the whole ambulance build industry.

"Next year we'll be continuing to work on the PTS fleet and we'll be making sure our hire vehicles are in the right places, developing them both as a product and as a market. We'll be at exhibitions spreading the word, meeting people all over the country and introducing some of our new vehicles to their intended end-users.

"Like I said earlier, the whole team want Cartwright's to be *the* place to go to for PTS vehicles and, hopefully, that's just a matter of time."

Conversions

To find out more about Cartwright's PTS hire vehicles, go to their website:
www.cartwrightconversions.co.uk

Or call:
01302 279265

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

ALF 2017 Ambulance Leadership Forum

Two world-class conferences under one roof: ALF 2017 and IRCP 2017

ALF: 7-8 Feb 2017 * IRCP: 9-10 Feb 2017 * Chesford Grange, Warwickshire, UK

The countdown has begun to one of the most significant dates in the ambulance service calendar as we rapidly approach February 2017 and the start of the next Ambulance Leadership Forum (ALF), hosted and run by the Association of Ambulance Chief Executives.

This year's event will also see the co-location of the International Roundtable on Community Paramedicine (IRCP) which arrives at ALF this year for its annual worldwide conference stop.

It's certainly not mandatory for delegates to visit both conferences but they are welcome to do so if they're able to devote four days to their personal development and learning. Just sign up for both conference streams!

ALF 2017

This high-level conference and networking event is open to all with an interest in pre-hospital urgent and emergency care – clinicians and senior managers through to directors and board members of NHS and associated healthcare bodies. As in previous years, AACE members' ambulance services receive subsidised places and these bookings are co-ordinated through the trust CEOs' office.

Reserve 7-8 February in your diary now, and book online at www.aace.org.uk.

We are delighted that confirmed speakers already include the Secretary of State for Health Jeremy Hunt MP, Jim Mackey, CEO of NHS Improvement, Nigel Edwards, CEO of The Nuffield Trust and Chris Hopson, CEO of NHS Providers.

Over the two days of ALF 2017 (7-8 February) guests will have the opportunity

to hear from a range of important speakers, network with a broad spectrum of healthcare colleagues, participate in workshop sessions and applaud excellence at the ever-popular ALF Gala Awards Dinner.

While Day One will see plenary conference sessions in the traditional format, Day Two will see a choice of three concurrent conference and workshop streams – with twelve sessions focused on the most topical issues and challenges facing UK ambulance services today.

Keynote speaker on Day Two is Pauline Philip, National Director from NHS England for Urgent and Emergency Care who will add strategic context to challenges and opportunities for 2017 and round off the conference agenda.

Martin Flaherty, Managing Director of AACE says: "The ambulance community looks forward to the annual ALF event eagerly as its now the main place to be for stimulating debate and ideas about the ongoing development of emergency and urgent care and the contribution made by UK ambulance services. The 2017 event looks like it is going to be better than ever, but places are limited so I'd advise people to book now and avoid disappointment."

Martin Flaherty, Managing Director of AACE

IRCP 2017

The International Roundtable on Community Paramedicine (IRCP) is an organisation of delegates from various countries and regions dedicated to exploring the promotion and better delivery of healthcare through the utilisation of traditional and non-traditional models of care.

Each year the organisation visits a related international body in different countries around the world, to hold its annual conference. This year, IRCP 2017 comes to ALF in the UK, offering UK delegates the chance to make new contacts and learn lessons from successful initiatives overseas.

There are several sessions delivered by 33 speakers from 4 nations (Australia, Canada, UK, USA) falling into the following topic categories: four sessions on Standards

and Data; five sessions on Integration; four sessions on Innovation; two sessions on Evaluation; six sessions on Research.

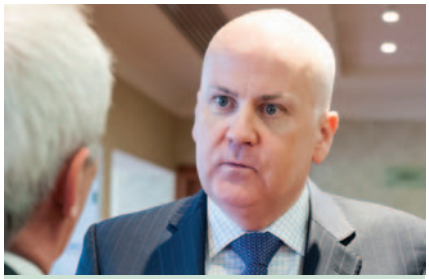
This is the first time that research has dominated an IRCP meeting and there is excitement around the concept of the shift from data gathering to evaluation to research. There are qualitative and observational studies, literature reviews and randomized controlled trials within the research section. It is also the first time that standards have been injected into the programme.

The IRCP conference will be preceded by a welcome reception on the evening of 8 Feb and AACE look forward to hosting a 'Best of British' social evening on 9 Feb.

Reserve 9-10 February in your diary now, and book online at www.aace.org.uk.

Notable sessions include:

- The development of an ANSI standard for community paramedicine programs across North America.
- Creative integration and innovation in very rural & remote settings.
- Urban innovation of placing Community Paramedics in clinics, grocery stores, mental health settings and alcohol intoxication settings.
- The development and availability of an internationally standardized Community Paramedic exam.
- A model career pathway for Community Paramedics from diploma to all degree levels up to and including PhD.



Dr Anthony Marsh, Chairman of AACE

THE ALF GALA AWARDS DINNER

On the evening of Tuesday 7 February, AACE is delighted to host the ALF Gala Awards Dinner to which all are welcome either by separate registration or included in their ALF package. Dress code is business suit / smart casual (uniform or black tie NOT required).

The Gala Awards Dinner will be an excellent opportunity for Ambulance Leadership Forum attendees to applaud excellence, discuss developments from the last year, and network with colleagues. We anticipate a great opportunity for social and business engagement.

However, most importantly, the evening provides an opportunity for AACE and colleagues to recognise members of staff from across all trusts who have provided truly outstanding service, going above and beyond the call of duty in a variety of categories that represent the whole breadth of service delivery.

THE VENUE

As conference hotels go, Chesford Grange is one of the most accessible and well-appointed conference venues in the west Midlands, being close to major road networks including the M40, M42, M6, M69 and M1. It has been traditionally popular with ALF delegates.

Over 650 free car parking spaces and high quality free WiFi for all delegates help ensure that ALF delegates can stay relaxed and connected during their stay.

National Groups

Following the main ALF conference, national groups (by prior arrangement) will have the opportunity to hold business meetings, hosted by AACE from 14.30 through till 17.30. NDOG and NASMeD have requested a joint meeting agenda.

SPONSORS AND EXHIBITORS

AACE is proud to welcome and extend sincere thanks to the following sponsors who help ensure that ALF remains an affordable and enjoyable event for all delegates:

- Class Publishing
- FutureQuals
- Kainos Evolve
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- Lightfoot
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For further information about any aspect of ALF 2017 please visit: www.aace.org.uk/alf

Or contact AACE Executive Officer, Steve Irving: Steve.irving@aace.org.uk

Book your place at ALF 2017 now!

SPONSORS AND EXHIBITORS

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We also look forward to welcoming a number of other partner organisations and exhibitors who contribute to the success of our ALF event.

The cost of attending the ALF is subsidised for delegates from AACE member trusts. Registration for ambulance service delegates is coordinated by their Trust CEO's office in the first instance.

General registration for both the ALF & IRCP events can be achieved on line with a variety of pricing options being available. For those interested in attending the IRCP conference this will be £60 per day with packages covering both conferences' days, sundry events and accommodation. For the ALF conference registration can be for a single day or for the whole 4 days of the event

Agenda

The agenda is being finalised as we go to press with more sessions and speakers to be announced.
Up to the minute information of the event agenda and timings will be available on the ALF website.

Book your place today and keep up-to-date with ALF 2017 news at: www.aace.org.uk/alf


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Bringing 21st Century EMS to India:

GVK EMRI's new 108 service is revolutionizing ambulance care across the Indian sub-continent, read on to find out more...

By Dr G.V. Ramana Rao

Background:

The GVK EMRI (Emergency Management and Research Institute) is one of the most important social initiatives of GVK. GVK is a leading Indian conglomerate with diversified interests across various sectors including energy, resources, airports, transportation, hospitality and life sciences.

GVK EMRI (Emergency Management and Research Institute) is one of the pioneering professional organizations providing integrated emergency response services (Medical, Police and Fire) in Public Private Partnership (PPP) mode in India today. April 2005 saw the dawn of India's first integrated emergency service provider and marked the turning point for emergency medical services in India. The organization was conceived with the objective of delivering comprehensive, speedy, reliable and quality Emergency Care Services. This has been done by establishing an Emergency Response System that coordinates every emergency through a single toll free number **1-0-8** which when called in an emergency ensures prompt communication and activation of a response that includes, assessment of the emergency, dispatch of the ambulances, along with a well trained Emergency Medical Technician to render quality pre-hospital care and transport of the patient to the appropriate health care facility. The system has also put in place the strategic principle of "right patient to the right hospital in the shortest possible time," all built on a high-end technology platform.

Dr GVK Reddy, Chairman, GVK EMRI

Vision:

- Provide Emergency Response Services under PPP (Public Private Partnership) framework. Respond to 30 million emergencies and save 1 million lives annually.
- To deliver services at global standards through Leadership, Innovation, Technology and Research and Training.

How 108 works:

Every life saved at GVK EMRI is a reflection of the combined efforts of a team of dedicated professionals. GVK EMRI has in place, meticulously chalked-out processes that ensure speedy, effective emergency services designed to save lives. A three-pronged approach-SENSE-REACH-CARE

Biography: Dr G.V. Ramana Rao

Dr G.V. Ramana Rao is Director of Emergency Medicine Learning Center and Research at "108" GVK Emergency Management Research Institute, Hyderabad, India. He is In charge of Training, Pre-hospital care and Research at 108 GVK EMRI.
He has been with 108 emergency response services since April, 2006. He is Chief Editor of Indian Emergency Journal. Dr Rao is the Principal of the 2-year Advanced Post Graduate Program (APGDEC) in Emergency Care affiliated to Osmania University, Hyderabad conducted by GVK EMRI. Dr Rao is a member of the international editorial board for JEMS (Journal of EMS) and executive committee member of Pan-Asian Resuscitation Outcomes Study (PAROS). Dr Rao is representing GVK EMRI in the Global Resuscitation Alliance (GRA).
Dr Rao has authored over 50 national and international publications and has spoken at over 15 international conferences and many national conferences. Dr Ramana Rao underwent specialized training in London (LSE and LSH), Bangkok, Singapore, Australia and USA. He has visited China, Srilnaka, Singapore, Denmark, Norway, Egypt, Australia and Germany, USA representing GVK EMRI.
Dr Rao was co-author along with faculty from Stanford School of Medicine and developed India's first evidence based EMS protocol manual. He is a member of the National Ambulance Code Committee and member of Committee on National Guidelines for pre-hospital Trauma Care formed by WHO/Government of India.
Dr Ramana Rao is recipient of Society of Emergency Medicine (SEMI) Excellence Award 2014 for his contributions to Emergency Medical Services. Dr Rao is also recognized by Stanford School of Medicine, USA towards development of EMS in India.

is aimed at a holistic delivery of the most sophisticated Emergency Management Services.

108 Emergency Response Process (Sense-Reach- Care- 48 hour follow up)

Sense: The objective is to provide an appropriate response to the person in emergency and deliver suitable and speedy emergency services. **Reach:** Reach is the vital thread of connectivity between Sense and Care. The reach team arrives at the emergency location and provides necessary Emergency Care within the golden hour. **Care:** Care is the life-saving stage in the Emergency operations. Emergency care, if required, is imparted to the victim on-site and also on the way to the Health Center. The Ambulance Team ensures speedy and efficient transfer of the victim from the site. **Emergency Response Center Physician (ERCP):** Pre-hospital care is provided by EMT based on protocols and under the directions of the ERCP. Instructions are provided by the ERCPs after collecting all the vital information about the emergency. Throughout, the ERO, EMT and ERCP are on conference call constantly monitoring the victim until he/she is admitted in a Health Center. **Follow Up-48 Hours:** Feedback on the service is collected by calling the patient's relative or patient after 48 hours to assess the quality of the emergency Care provided.

Our Presence: GVK EMRI is currently operational in 15 States and 2 Union Territories i.e. Andhra Pradesh, Telangana, Assam, Gujarat, Uttarakhand, Goa, Tamil Nadu, Karnataka, Meghalaya, Himachal Pradesh, Chhattisgarh, Uttar Pradesh, Rajasthan, West Bengal, Arunachal Pradesh and 2 Union Territories, Dadra & Nagar Haveli and Daman & Diu. Appreciating GVK EMRI's services across India, the Government of Sri Lanka has approached the Indian Government to replicate similar services in Sri Lanka. GVK EMRI was appointed as nodal implementing agency for establishment and operationalization with emergency number **1990** ERS in Sri Lanka under this India –

Sri Lanka partnership project. GVK EMRI launched 1990 service in Srilanka on 28th July 2016.

(As on 30th September, 2016)

Technology:

GVK EMRI cuts above the rest by leveraging the latest technology to enable precise, speedy and effective Emergency Response Services. GVK EMRI has, through Tech Mahindra as its technological partner, been able to develop a comprehensive Emergency Management System which enables the organization in providing:

- Ensuring 24/7 availability of Network and Systems
- Managing the Golden Hour efficiently.
- Ensuring a promptly assessed and hassle free helpline
- Harnessing strong linkages/ partnerships/ alliances with hospitals, doctors, police, fire stations etc.
- Allows tracking of call based on location of caller.
- Enables Dispatch Officer to access the GIS Vector data (maps) provided by Government agencies and identify the incident location.
- Identifying the exact location of ambulance on real time basis.

The application has won Tech Mahindra the **MICROSOFT 2007 CITIZENSHIP PARTNER OF THE YEAR AWARD.**

The centralized Emergency Management System integrates all the key functions of taking the call, defining the problem, coordinating the response and providing Emergency Care. Automation of the processes involves the following major components of technology:

- Telecom Switch with automatic call distribution features & IVR facility
- Computer Telephony Integration
- Voice Loggers
- GIS/GPRS Software
- AVLT – Automatic Vehicle Location and Tracking
- Mobile Application

GVK EMRI has developed the 108 app, launched for the general public recently. The app will make the access to the 108 National Ambulance Service (NAS) much faster and does not require sharing of information such as name and location. Himachal Pradesh has become the first state in India to launch any such app. 108 app is now getting ready to be scaled up in all the operating states.

Winter is coming

Short and long lease **ambulances** now **in stock**

DLL offers short and long term leases on a range of new, used, refurbished and remounted emergency service vehicles.

DLL have many years of experience as a leading finance partner in the supply of ambulances and other specialist vehicles to both public and private organisations.

Whether you need short or long term hire, please contact us today so that we can help fulfil your requirements and tailor a rental solution that suits yours needs.
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Emergency Medicine Learning Center (EMLC): GVK EMRI has a specialized department of Emergency Medicine learning Center (EMLC) focusing on developing skills in emergency management to individual emergencies, Multi-casualty Incidents (MCI) and Disasters.GVK EMRI has a state-of-art Emergency Medicine Learning Center (EMLC) and a dedicated team of highly qualified Emergency medical professionals, clinical educators who aim to cascade contemporary principles and practices of emergency medicine to all health care professionals and community response providers. The prodigious task of creating skilled manpower, in the form of Emergency Medical Technicians (EMTs) and Pilots (Drivers), was efficiently and effectively accomplished by EMLC throughout expansion and stabilization of 108 operations.

Furthermore, with a vision to take quality of emergency care to the next level to ensure global standards, GVK EMRI has collaborated with world opinion leaders in emergency care such as **Stanford School of Medicine –USA, National Trauma Research Institute, MONASH University, Melbourne, Victoria Australia, American Academy of Family Physicians (AAFP), American Heart Association (AHA), American College of Emergency Physicians (ACEP).**

Training Institute

Special status of EMTs at GVK EMRI

EMTs at GVK EMRI are trained in institutional, hospital and ambulance phases for 52 days (nearly 450 Hours) including BLS- AHA, ITLS and Basic Life Support in Obstetrics global certifications. Every EMT is given a specially-developed learning kit containing pre-hospital text book, EMS protocol manual, work book, medical equipment maintenance manual, soft skills booklets, drug book and EMRI values booklet.

All the EMTs are provided with annual refresher training. Objectively Structured

Clinical Evaluation (OSCE) methodology is used for evaluation of skills acquisition. Ambulance Drivers at GVK EMRI are referred to as 'Pilots' and are trained in safe driving, ambulance maintenance, CPR, First Responder certification, extrication etc.

Emergency Medical Services at GVK EMRI are provided by EMTs with different levels of competencies. They are broadly grouped as Basic and Advanced EMTs. To some extent, these will be determined by country and setting, with each individual country having its own 'approach' to how EMS should be provided, and by whom. In GVK EMRI the following categories of EMTs are providing services: Basic Life Support (BLS) Ambulance EMTs, Advanced Life Support (ALS) Ambulance EMTs, Neonatal Life Support (NLS) Ambulance EMTs, Emergency Care Centers (ECC) EMTs, Inter Facility Transfers (IFT) EMTs, Boat Ambulance Services EMTs, Hospital Based (HB) EMTs, Advanced Post Graduate Diploma in Emergency Care (Advanced EMTS).

Two-year trained Advanced EMTs obtain an APGDEC certificate from Osmania University, Hyderabad and a registration number from Telangana State Paramedic Board. Advanced EMT can carry out interventions like endotracheal intubation, interpret ECG and initiate ACLS protocols using defibrillator. In addition, Advanced EMTs will also have higher levels of critical thinking and the ability to manage pediatric, medical, and obstetric and trauma emergencies. EMTs working in various states who have shown commitment and exceptionally high levels of knowledge are nominated for a two-year Advanced EMT course at GVK EMRI with the permission of respective state governments.

Operations: GVK EMRI has come a long way as the largest emergency service provider in India. Transporting the patient from the scene to the nearest suitable hospital requires the operator to maintain the rolling stock free from break downs. The key objectives of reliability, comfort, cleanliness, hygiene, timely arrival and financial viability are to be met with utmost precision. We endeavor to reach patients in distress and provide pre hospital care and

admission to hospital within the Golden Hour via a well-focused and healthy transport system.

Average Response Times:

- Urban – 15 minutes
- Rural – 25 minutes

One Day at GVK EMRI

- 171,228 calls answered
- 26,631 emergencies responded
- Emergency Ambulances travel a distance of 1,057,981 km per day with nearly 46,000 associates across the organization
- 907 lives are saved out of the critical cases benefited (as per working definition of GVK EMRI- validated under the guidance of ERC Physicians)
- 142 deliveries are assisted by EMTs

CUMULATIVELY

- 4,7,260, 500 emergencies responded
- 18,27,474 lives saved since inception

O&H Vehicle Conversions are one of the leading vehicle converters in the UK.

Established for over 25 years, specialising in the conversion of Patient Transport Service (PTS) Ambulances, A&E Ambulances, NHS Training Vehicles, Paramedic Practitioners Vehicles, Wheelchair Access Vehicles (WAV's) & Welfare Vehicles.

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- 4,33,484 deliveries assisted by EMTs

Type of Emergencies served (top 7 types) (Rest are miscellaneous including fever etc):

1 Pregnancy related- 35%

2 Vehicular Trauma -12%

3 Acute Abdomen 13%

4 Cardiac -4%

5 Respiratory -4%

6 Suicidal-4%

7 Animal bites-2%

Special Ambulance Services/Projects:

a. Neo Natal Ambulances

Neo Natal ambulances are launched in order to ensure emergency transfer for the very sick neonate who require more specialist treatment at another hospital. It is primarily launched to reduce the Neonatal mortality rate. This specialized service is operated in Tamilnadu and Goa as part of 108 emergency response.

b. Boat Ambulance

In order to improve response efficiency while also reducing the scene to hospital time, boat ambulances are operated in areas which are better accessible by waterways than roadways. Boat ambulances operate as an integral part of 108 Emergency Response services with 5 boat ambulances in Assam and 1 in Uttarakhand state

c. Advanced Dedicated Ambulances for Inter-Facility Transfer

The objective of these ambulances are to provide timely transportation to patients who require next level of medical treatment in higher healthcare facility. This facilitates an integrated and comprehensive health care management providing high-end ambulatory transportation for appropriate care. While 450 dedicated inter facility transfer ambulances are operated in Assam, special initiatives in some other states ambulances have been dedicated for this purpose as part of 108 Emergency Response Service

c. Motorcycle ambulances: In large metropolitan cities of Bangalore and Chennai, 2- wheeler ambulances were introduced in 2016 to enable quick response time in road crashes and overcome the traffic issues.

e. Emergency Stabilization Centre (ESC)

The role and mission of ESC is to provide stabilization to Patients/victims in the Golden hour and ensure safe transport to the nearby hospital for definitive care. These ESCs will ideally be located closer to accident hotspots and also in areas where facilities to treat medical emergencies are poor or don't exist. The choice of location is supported by authentic data, culled out from the databases of GVK EMRI.

Research Department activities:
GVK EMRI has invested considerably in research to ensure that it delivers the best Emergency Services and establishes benchmarks in its category. GVK EMRI is the only Emergency Response Service provider that conducts clinical Research, Systems Research and Operational Research to continually improve their emergency response services. EMS research aims to:

- Analyze, interpret and estimate the trends of technology, education systems, training, standards in the speed and quality of patient care in emergencies
- Assist in policy making and in integrate developments, impact policies, and help in resource deployment
- Transfer knowledge
- Study patient impact.

Unique EMS research:

Online Medical Research (OLMR) is a process through which we will collect near real time required data from EMTs and patient attendees on chief complaints pertaining to the study on *RED Cap Application* provided by Stanford University School of Medicine.

The GVK EMRI maternal and neonatal transport system in India: A mega plan for a mammoth problem:
GVK EMRI has partnered with the government of Tamil Nadu and deployed specialized neonatal ambulances to ensure safe transport of newborns. The safe transport of sick, vulnerable neonates and the improvement in survival of transported neonates over the years advocates the scaling up of this program to other states, which would greatly contribute towards reducing infant and neonatal mortality.

Kumutha J, et al., The GVK EMRI maternal and neonatal transport system in India: A mega plan for a mammoth problem, Seminars in Fetal & Neonatal Medicine (2015), http://dx.doi.org/10.1016/j.siny.2015.07.003)

To find out more about EMRI please visit their website: www.emri.in

Join our team

Emergency Care Assistants - Bank

Falck First Response are looking for qualified bank Emergency Care Assistants to join our First Response bank team supporting our lead Clinicians with front line work. You will need to be passionate about delivering a caring, effective and safe service to patients. Candidates will need to be accessible, competent, efficient, helpful and reliable and embody these values in their day to day roles.

To be considered for the role will need to hold an approved Emergence Care Assistant qualification, a current IHCD D1 & D2 driving qualification, a full UK manual driving licence (with no more than 6 points) and an up to date CPD portfolio. This role is subject to an Enhanced DBS disclosure.

We offer a rewarding role with the opportunity of developing your skills and experience in an organisation renown for its global expertise in emergency services. Rates are dependent on area and roles are either through PAYE bank or a Personal Services Company arrangement.

Ambulance Care Assistants - Bank

Falck Medical Services are looking for bank Ambulance Care Assistants to support our non-emergency patient transport contracts in London and Watford.

Falck Medical Services are looking for bank Ambulance Care Assistants individuals who will be able to provide and maintain a caring environment for non-emergency patients and provide a transport service as appropriate for the needs of the patient. Candidates will need to be accessible, competent, efficient, helpful and reliable and embody these values in their day to day roles.

To be considered for this role you will need a full UK manual driving licence with minimum of 3 years driving experience with no more than 6 points. This role is subject to an Enhanced DBS disclosure

We offer an ACA training course which includes First Aid at Work certification, and ongoing training and development opportunities. We offer a rewarding role with the opportunity of developing your skills and experience in an organisation renown for its global expertise in patient transport services.

Dispatcher & Senior Dispatcher - Bow

Falck Medical Services are looking for Dispatchers and a Senior Dispatcher to support our Dispatch centre in Bow, East London. Candidates for both roles will need excellent customer service skills coupled with strong analytical and financial ability. These posts are key to the smooth running of our Dispatch centre and attention to detail and the ability to remain calm under pressure is essential.

If you would like to apply of any of these roles then please visit:
www.medicalservicesuk.com/careers/ or contact recruitment at Recruitment@medicalservicesuk.com

Falck

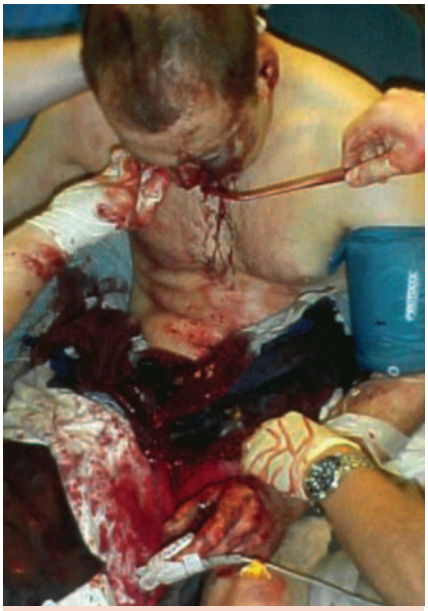
MEDICAL SERVICES

Facial injuries - how safe are they to transfer?

By Mr Mike Perry

Facial injuries present a broad spectrum, from the relatively insignificant, to those that are potentially life and sight-threatening. Very often their appearances can be deceptive and their management difficult, especially in those patients that need to be transferred on a spine board. By their very nature, patients with significant injuries will often want to sit upright and lean forwards - a natural protective response which helps keep the airway clear. This of course goes against our current wisdom of transferring patients supine in order to protect the torso and spine. If we add to this the frequent association of alcohol intoxication, head injuries and a full stomach, how best to stabilise and transfer these patients can sometimes be very difficult. However the good news, is that in most cases patients can be safely managed using a simple triage process and possession of a few skills. The key message is that…

Although very dramatic in appearance most facial injuries do not require urgent or complex intervention - so long as the airway is secure and there is no active bleeding.



This patient sustained a direct blow to his face when the doors of a lorry swung round. He was bleeding from the face and becoming increasingly swollen. A good example where laying the patient down would have put his airway at high risk.

Some initial considerations

Facial injuries form a large group of patients and will commonly be seen, either in isolation, or combined with other injuries. In the UK it has been estimated they comprise about 4% of all attendances to the emergency department. However, there are wide geographical variations in both incidences and types of injuries. In the UK, the incidence of gun-related facial injuries is relatively low. However interpersonal violence resulting in blunt trauma is relatively high, particularly in large towns and cities (approximately 25%). In the US in 2007, 407,167 emergency department attendances had sustained a facial fracture. Not surprisingly the common groups are young adult males and children. Frequently reported causes of injuries included assaults, falls (especially in children and the eldery), sporting injuries and motor vehicle collisions. The nasal bones are perhaps the commonest facial fracture, followed by mandibular and zygomatic (cheek) fractures. Soft tissue lacerations are also common, either in isolation, or associated with underlying fractures. It is therefore highly likely that ambulance crews / paramedics and other first responders will encounter these patients regularly and whilst most patients will have relatively minor injuries, there will be those with more significant and potentially serious ones.

Widespread injuries to the face. If kept supine the airway would be at risk and bleeding from the face would not be recognised.

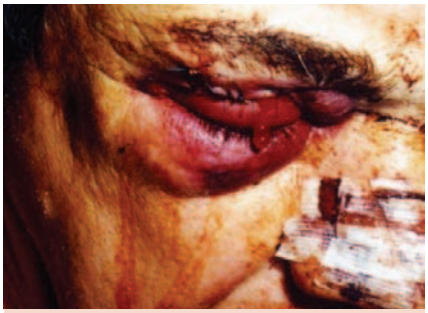
The patient with facial injuries poses three important "Ds" in management - deception, distraction and difficulty.

1 Deception - Even seemingly minor injuries can progressively deteriorate, or remain unrecognised unless they are specifically considered. This is especially the case in the supine and perhaps restrained patient.

i) Nasal bleeding and CSF leaks may not be apparent if the patient can swallow.

ii) Just like facial burns, progressive swelling of the face may quickly interfere with the airway. Patients on anticoagulant medication are at particular risk.

These have obvious implications when transferring patients long distances. A clue to an impending threat to the airway is repeated requests or attempts by the patient to sit up.

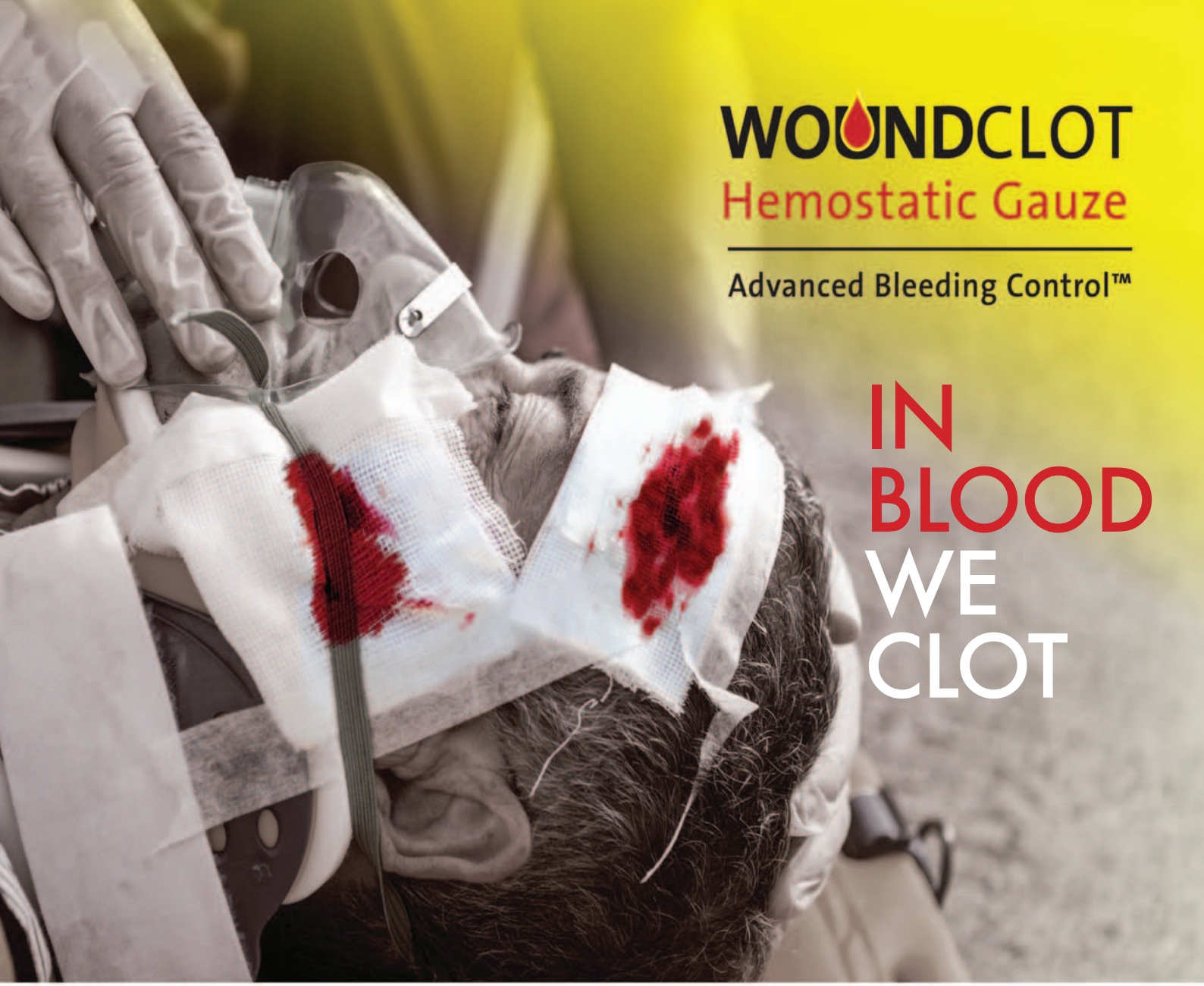


If you look closely you can see CSF dripping from the upper eyelid wound. This rare sign has significant implications - it indicates a skull fracture.

2 Distracting. Because of their obvious nature one can often be drawn towards the face when carrying out an initial assessment. Nevertheless we must always be mindful of the presence of occult and perhaps more severe injuries to the brain, cervical spine or below the collarbones. Life-threatening facial haemorrhage is relatively uncommon and in the shocked patient it is important to consider the possibility of blood loss elsewhere.

Biography: Mike Perry

Mr Perry is medically and dentally qualified in the UK. In 2011 he was listed in The Times Magazine as one of the country's 50 top surgeons.
He completed surgical and dental fellowship training (FRCS and FDS) in the North East of England before training in maxillofacial surgery in and around London. Further experience was gained abroad at both a leading trauma unit (Sunnybrook Hospital, Canada) and leading craniofacial unit (Sahlgrenska University Hospital, Sweden).
Mr Perry has over 15-years hands-on experience in the management of facial injuries of all kinds (both facial fractures and facial lacerations) and currently clinical lead in facial trauma. He has over 45 peer-reviewed publications, including several texts.
First appointed as a consultant to the University Hospital of North Staffordshire in 2001, Mr Perry later relocated to Belfast in September 2004, due to his trauma interest, gaining over 10 years of experience as clinical lead in craniofacial trauma for the entire province. In 2014 he was recruited back to London to develop the trauma / deformity / skin cancer service.
Mr Perry is actively involved in education, runs several courses and has lectured both nationally and internationally.



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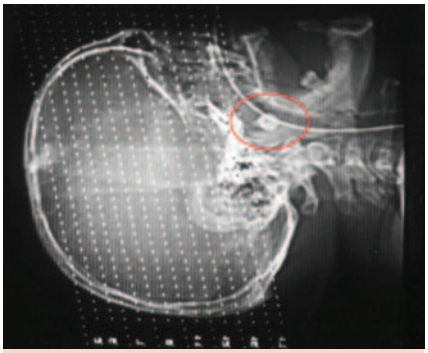


An overlooked tooth in the throat. A potential airway issue.

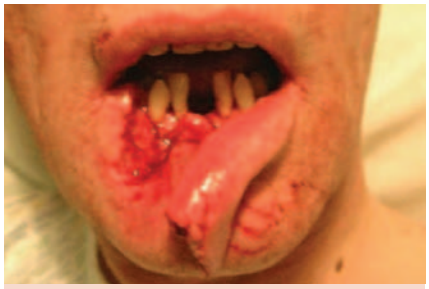
3 Difficulties. In the early stages of assessment, facial injuries can pose difficult management decisions. This is seen, for example, when deciding the best way to manage an alert patient who is at risk of spinal injuries but with significant facial injuries. Such patients will instinctively want to sit up.

i) Placing them supine to protect the spine puts the airway at risk and may necessitate endotracheal intubation. This then results loss of the ability to regularly reassess them.

ii) Placing them supine and observing and maintaining the airway places the patient at risk from unexpected vomiting.

iii) Allowing the patient to sit up will protect the airway but axially loads the spine and torso.

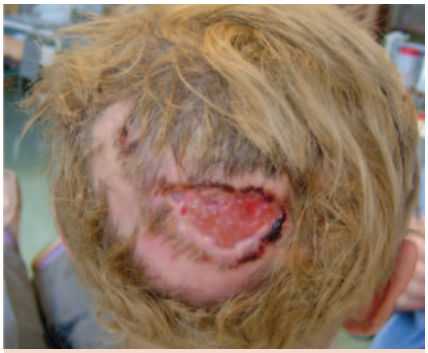
Medico-legally there are issues too. Surgical emphysema from nose blowing can extend into the mediastinum and occasionally intracranially or into the orbit. This places the patient at risk of severe infection. All patients with suspected mid face or skull fractures should therefore be advised not to blow their nose. Loss of partially avulsed and highly mobile teeth and visual impairment can also result in claims of medical negligence later, in our increasingly litigious society.



Although a relatively trivial injury, the lip tissue hanging down needs to be carefully realigned and supported to prevent loss of its blood supply. If any of the tissue had died the reconstruction would have been very difficult. This would potentially have been a litigious case.

A simple approach to triaging facial injuries

As with all trauma, effective triage in facial trauma is important. From a surgeon's perspective, facial injuries can be broadly placed into one of four groups, based on the severity of their injuries (See Table 1).



A complication of prolonged at spinal immobilisation. This patient developed a pressure sore on her scalp - another cause for litigation.

From a prehospital perspective the main issues relate to the safe transfer of patients and whilst this approach may be of some help in roadside assessment, a more practical method of triage focuses on to the early detection and management of life-threatening conditions (airway issues and blood loss). Although there are multiple scoring systems which can be applied to the injured patient, there are currently none that can be applied specifically to the face as a reliable predictive tool. This is probably for a number of reasons (such as the precise nature of the injuries are unknown, including the presence of brain injury. Also, that swelling - a major risk factor - is unpredictable and can occur with minor injuries, as can bleeding). One must also consider sight-threatening conditions, many of which can be temporised using simple measures during transfer. As long as the airway is secure and the patient is not actively bleeding, all facial injuries, although dramatic in appearance can be safely left while the entire patient is assessed, stabilised and transferred.

On this basis the simple ABCDE approach will quickly and effectively triage these patients.

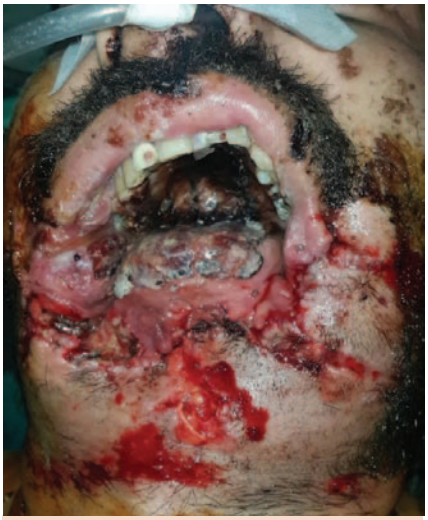
1 A (airway) - Sir William Kelsey Fry (1889 - 1963) has been attributed to the apocryphal saying that 'if you leave the patient facing towards heaven, it won't be long before they get there'. This referred to the high mortality seen in stretchered patients with facial injuries during the First World War. This observation subsequently resulted in their transfer in the prone position.

Therefore, when assessing patients with facial injuries the first consideration should be does the airway need to be secured, or can the patient maintain their own airway adequately during the transfer process?

Important considerations include

i) Unexpected vomiting is an ever present risk in many patients. This is particularly so in those with facial injuries since swallowed blood is a stimulus to vomiting. In alert, supine patients facial bleeding may not be obvious if the blood is swallowed. But if it continues it places the patient at risk of vomiting later.

Table 1
Immediate treatment Interventions are resuscitative / emergent (life or sight-preserving). These include placement of surgical airways, control of significant haemorrhage and release of any orbital tension. Definitive repair of these injuries is usually carried out 5-10 days later when the swelling has resolved.
Treatment within a few hours Interventions are aimed at preventing infection and protecting the globe (heavily contaminated wounds and some open fractures). Once the patient has been stabilised, wounds are carefully debrided and cleaned. Definitive repair of the injury may then be undertaken, or it may be deferred pending further investigations.
Treatment can wait 24 h This and the final group make up the majority of facial injuries. Examples include clean lacerations and fractures of the jaws.
Treatment can wait over 24 h Treatment can be safely deferred for several days, or weeks. Examples include nasal, orbital and cheek fractures.



An avulsive injury to the lower jaw following explosion. The airway would be at high risk.

ii) Bleeding, swelling, alcohol intoxication and brain injury by themselves are potentially significant risk factors, but when combined increase the risks to the airway significantly.

iii) Airway compromise may not always occur immediately. It can develop later as a result of swelling and bleeding. In fractures of the lower jaw, swallowing may be painful and not effective in keeping the airway clear.

iv) Even simple manoeuvres such as a jaw thrust and mask ventilation may be difficult if there is widespread swelling, or mobile and painful fractures. Forceful ventilation through a tightly fitting mask may result in surgical emphysema, whilst limitation of mouth opening may further restrict access.

Does he need a trauma centre or the local hospital?

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[1]Acosta JA, et al. Journal of the American College of Surgeons. 1998;186(5):528-533.

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v) Finally, does the patient need to be transferred with full spinal protection? If so intubation prior to transfer should be considered.

Assessing the airway - Although a talking patient is encouraging, when facial injuries are evident this is no safeguard against airway threats. The mouth and throat should always be inspected. Oral and nasal bleeding can continue unseen. Foreign and loose bodies (especially dentures and detached teeth) should be removed. Unfortunately, correctly fitting rigid collars restrict mouth opening and make assessment difficult, but if the potential for airway compromise exists, these should be loosened enough to enable examination (during which, in-line manual immobilisation of the neck can be performed).

If the risk of spinal injury is considered low, the airway is best managed by allowing the patient to position themselves upright, thereby maintaining their own airway patency. However, following high-energy trauma, the presence of actual or potential injuries elsewhere may preclude this approach and the airway may need to be secured prior to transfer. The presence of coexisting brain injury and the need to maintain effective ventilation are other important considerations.

Current guidelines for intubation in maxillofacial injuries are a little vague and can be misleading. For example, bilateral fractures of the mandible are a common injury, frequently cited as an indication for intubation. But they rarely require this. It is only when they occur in combination with a reduced Glasgow coma scale (GCS) or spinal immobilisation that they become a significant risk. Other indications related specifically to facial trauma would include i) when gross swelling is anticipated, ii) in order to facilitate control of haemorrhage or iii) in 'significant' facial injuries where a long duration transfer is expected. However, the definition of 'significant' requires clinical judgement on a case-by-case basis and is often based on the mechanism of injury.

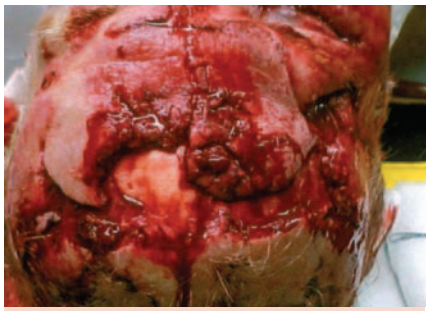
If all else fails advanced airway management techniques may be necessary, including surgical airways. These are well described elsewhere and are therefore not detailed here.

2 B (breathing). Aside from the need for oxygen administration and monitoring, breathing problems are rarely associated with facial trauma. However avulsed teeth and dentures can be occasionally aspirated, resulting in partial blockage of the bronchial tree. This should be considered in any patient with isolated facial injuries but who appears to have asymmetric signs of respiration.

3 C (circulation). Life-threatening blood loss arising from scalp lacerations and facial injuries is relatively uncommon, although bleeding can still be significant, especially in children.

i) In the hypotensive patient, active bleeding may be minimal when first encountered, and it is only when the blood pressure improves during resuscitation that bleeding, both obvious and occult, recommences. This may have significant implications with transfers.

ii) Blood loss from occipital scalp lacerations and even relatively 'minor' facial injuries such as nasal fractures can be missed in supine immobilised patients and although haemorrhage may not necessarily be rapid, it may continue uncontrolled over a prolonged period of time.



A large scalp laceration. Unless pressure is applied this would result in significant blood loss. Care would be required with tight dressings, in case there were large skull fractures underneath.

iii) Control of haemorrhage can be very difficult, even within the relative safety of the emergency department. Intubation may often be required in order to facilitate effective control. This takes the form of packing of the oral cavity and nose - the latter of which is a concern if skull base fractures are present. Nevertheless, some form of tamponade is required and the patient should not be left to slowly exsanguinate on the basis of a perceived risk. This is a very difficult area of clinical practice.

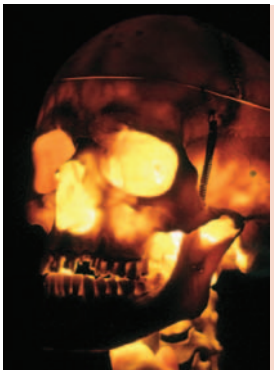
iv) Packing of the oral cavity also requires unrestricted access to the oral cavity, necessitating the unfastening of the cervical collar - the cervical spine must remain carefully immobilised, making this (at the least) a two person job.

v) Actively bleeding cutaneous wounds, such as the scalp, can simply be closed with staples, any strong suture to hand, or by applying a pressure bandage.

vi) Epistaxis, either in isolation or associated with midface fractures, may be controlled using a variety of specifically designed nasal balloons or packs. These must be used with care if there are mobile midface fractures - overpacking can distract the fractures further resulting in further tissue damage and bleeding. Nasal packs are not without risk - toxic shock, sinusitis, meningitis, and brain abscess are all potential complications. Blindness has also been reported.

If haemorrhage persists despite these interventions, it is important to consider pre-existing or acquired coagulation abnormalities; only rarely is operative surgical control of facial bleeding required in theatres during the primary survey (following blunt trauma).

4 D (disability). By virtue of their close proximity to the skull, high energy facial fractures are frequently associated with varying degrees of brain injury or disruption of the skull base. Therefore it is important that the Glasgow Coma Scale or AVPU score is carefully noted and regularly reassessed. The management of patients with coexisting head injuries is not discussed in this article. Interestingly, the geometry of the facial skeleton has been likened to the chassis of a car. At the moment of impact, horizontal struts of bone "buttresses" collapse, thereby preventing the kinetic energy being transferred to the brain (the 'driver'). Effectively, it is argued, the facial skeleton has evolved into a "crumple zone". Despite this survival advantage, the combination of extensive vascularity of the face and its lack of deep fascia can still result in significant blood loss and swelling.



A real skull, showing how fragile many of the bones of the face are. Light can easily pass, especially though the orbits and anterior skull base'.

E (eyes) - Although "E" normally refers to exposure, from a maxillofacial perspective visual loss is the next priority once i) the airway has been secured, ii) facial bleeding controlled and iii) any significant brain injury treated or excluded. Arguably, vision-threatening injuries are just as important to the patient as limb-threatening problems, especially if they involve both eyes. Early identification of sight-threatening conditions may be possible when the pupils are assessed along with the GCS. At this time the vision can be checked and obvious ocular findings can be noted. At the roadside, vision-threatening injuries that need rapid identification are perforated or ruptured globes, significant bulging of the eye (proptosis - in essence a compartment syndrome of the eye socket), and loss of eyelid protection. Whilst other conditions exist, there is little that can be done at this stage. Useful symptoms and signs of significant globe injury include.

i) Loss of vision

ii) Severe pain in or around the eye

iii) An agitated patient with signs of injury around the eye

iv) Significant proptosis of the globe

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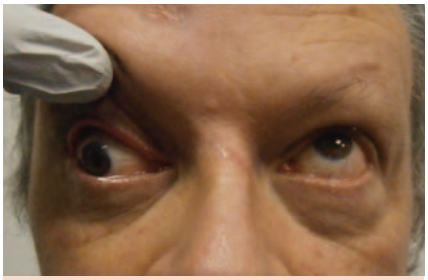


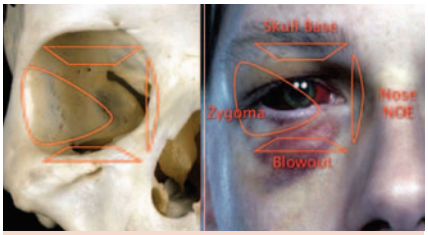
This patient sustained an injury to his forehead when he fell off a moped. You can see the right eye is looking in a different direction to the left. The eye didn't move very much. This represents a significant injury at the back of the eye socket.

v) Hyphaema (fresh blood in front of the Iris)

vi) Irregular pupil

vii) Obvious eyelid wound

viii) Collapsed or severely distorted globe



A well-defined blackeye usually indicates a fracture involving the eye socket.

Unfortunately, visual assessment in the unconscious patient is extremely difficult. Assessment can only rely on pupillary size and reaction to light and careful assessment of globe pressure by palpation, if there is proptosis. Because of the close proximity to the brain, penetrating intracranial injury should always be considered in all penetrating orbital injuries, even if not immediately apparent.

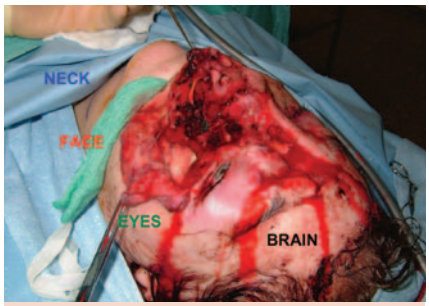
Loss of the eyelids. This, or the inability to effectively close the eyelids, quickly results in drying of the cornea, ulceration, and potentially loss of sight. Appropriate protection during transfer is therefore very important as failure to do so could result in litigation. This is especially important in the unconscious patient. Eyelid lacerations may also indicate the presence of a serious underlying ocular injury. If possible, eyelid remnants should be pulled together to provide corneal cover. Liberal application of chloramphenicol ointment or should be administered and the whole area covered with a protective, non-adherent cover, such as an eye shield of plastic galipot. The tetanus status should also be checked.

Proptosis of the eye requires prompt treatment. Like any compartment syndrome, the longer the raised pressure remains, the worse the outcome. Ideally lateral canthotomy and cantholysis should be undertaken. This effectively detaches the supporting, suspensory ligament of the eye from the eyesocket, thereby allowing the eye to move forwards, reducing the pressure behind it.

Finally, as elsewhere, mobile facial fractures should be temporarily stabilised whenever possible. Separation of fractures and movement between them is not only painful, but can result in continued bleeding and swelling. Often a well fitting collar will do much to support the facial skeleton during the transfer process, but this does come at the price of restricting mouth opening and airway protection.

Some useful mechanisms of injury

Understanding mechanisms of injury is an important part of the assessment of any injured patient, especially when considering the possibility of occult (hidden) injuries. This is equally so in maxillofacial trauma. It is perhaps useful therefore to think of the head and neck region as four separate, but interconnected anatomical sites. A useful mindset of 'think brain, neck, eyes and face' will serve us well – when we see an injury in one, think of the possibility of injuries in the others – they do often co-exist. Of all these sites, the face is the lowest priority, so long as the airway is secure and there is no ongoing haemorrhage.



Although this patient has sustained obvious facial injuries, it is important to remember injuries to the brain, eyes and neck are also likely to be present.

Specific injury patterns reported to be associated with certain mechanisms of injury include:

i) Hyperextension injuries to the neck in the elderly, following a fall onto the face.

ii) Blindness has been reported following blunt trauma to the forehead in the absence of fractures. Interestingly, this was first noticed by Hippocrates.

iii) Successful airbag deployment has been reported to result in severe ocular injuries.

iv) High energy projectiles can penetrate both the eye and the brain as the intervening bone is very thin.

v) Compressed air / blast injuries can result in extensive facial emphysema.

vi) Blows to the chin can result in remote fractures in the mandibular hinge joint and tears of the external auditory meatus. Bleeding from the ear may result in diagnostic confusion.

vii) Fractures following an impact to the bridge of nose can extend deeply to involve the skull base and orbit, with risks of CSF leaks and blindness.

viii) Rapid deceleration as seen in bungee jumping has been associated with retinal haemorrhage.

ix) Prolonged hypotension (from any cause) has been reported to result in blindness.

x) Penetrating injuries to the palate, typically seen following a fall with a pen / pencil in the mouth, have been reported to result in carotid injury and stroke.

xi) Widespread ("Panfacial") fractures are associated with bleeding, swelling and airway compromise. However these complications can also occur in the absence of any fractures, in patients taking anticoagulants or with clotting abnormalities. Swelling worsens when supine, from elevated venous pressures and reduced lymphatic drainage.

xii) Hypertension during resuscitation may precipitate intraocular bleeding. In the elderly patient a dilated pupil may precipitate ocular problems. Acute angle closure glaucoma can be precipitated by drugs and general anaesthesia—this should be considered in any tense, painful, red eye.

Conclusions

Facial injuries are common and it is likely ambulance crews / paramedics will encounter them - probably frequently. Whilst most injuries are minor, initial appearances can be deceptive and they require careful assessment, especially if the patient needs to be transferred supine on a spine board. The emphasis of assessment is on the patency of the airway and the likelihood this may be lost as swelling develops, and on the presence of ongoing haemorrhage which in alert supine patients will be swallowed. The mechanism of injury is a useful guide to predicting some injuries, particularly in the unconscious or confused patient. Because of its anatomical location it is prudent to actively consider the possible association of cervical spine, brain and ocular injuries. Whilst there is not much that can be done for the latter, failure to carry out simple measures can result in significant visual problems and possible litigation.

To find out more about Mike's work and to access great resources for trauma enthusiasts everywhere, please visit the website of the International Society of Head and Neck Trauma: www.headandnecktrauma.org

and youtube channel (headandnecktrauma org)/ www.youtube.com/channel/UC_kh2MVLAOwyXkiW2dDq4qw?view_as=subscriber

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MIME Technologies launch on scene patient data capture and analysis solution for first response.

Innovative company MIME Technologies Ltd design next generation wireless software solutions for out of hospital care. MIME® itself stands for Managing Information in Medical Emergencies, and their newly launched MIME® Pro system has been developed through years of research at the University of Aberdeen, Scotland. MIME® Pro, is designed to expedite patient data on scene, streamline communication, audit and enhance clinical governance.

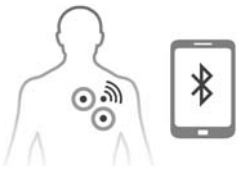
MIME Technologies are based in Inverness, a life science hub and capital of the Scottish Highlands. The team have considerable expertise in first response, medicine and medical sensor technology.

Director of Customer Development Anne Roberts has specialist knowledge in e-health having published in international journals in the area of pre-hospital response.

Anne described the challenges their technology addresses:

"We know that being the first person on scene at a medical emergency is tough. Pre-hospital care is often time-critical; accurate assessment, data recording and communication of information can be crucial to outcomes. Our innovative data capture, reporting and analytics help communicate information, enhance clinical governance and streamline time-consuming audit. This is why we are working with customers in a range of pre-hospital environments, such as first response, humanitarian aid, first responder schemes, co-response units off-shore and the aviation industry."

The new MIME® Pro software works across mobile devices to aid in almost every aspect of first response. It acts as a useful aide memoire to first responder training, helping to enhance competency. The software can also link with some of the latest wireless Bluetooth® medical sensors, helping to deliver real time vital signs data for identifying patient improvement/deterioration. CEO Dr Alasdair Mort explains:



"Globally we are seeing a significant increase in first responders attending out of hospital emergencies across many industries. So, being able to accurately and quickly articulate the impact of their responder activities is incredibly important. Having an accurate patient record is also vital for clinical governance and audit. Despite best efforts, this isn't always the case currently."

MIME® Pro integrates vital signs to deliver a National Early Warning Score (NEWS). The technology also helps users to quickly access and communicate patient status in an easy to read "red, amber, green" colour coding. At the touch of a button MIME® Pro produces an English Language patient report, quickly summarising each episode of care. Designed to clearly communicate on scene patient information. Also, the secure cloud solution helps to distribute and enhance the visibility and impact of the data. MIME Pro complies with Medical Device Directive (93/42/EEC) and EN62304 – Medical Device Software. Various purchasing options are including a one-off fee or a low-cost monthly subscription.

Biography:
Dr Alasdair Mort, CEO, MIME Technologies Ltd

An inventor of MIME® and a human physiologist, Dr Mort has a long-term interest in exploring technologies for monitoring casualty health, a medical device PhD from the University of Aberdeen and a Royal Society of Edinburgh Enterprise Fellow. Dr Mort has worked in industry previously for QinetiQ Ltd, evaluating life-support technologies for air, land and sea. He is passionate about MIME Technologies Ltd, developing innovative wireless solutions for pre-hospital environments.

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Do ambulance crews kill? Yes, we do…and sometimes it is a laughing matter!

Ambulance Today's fearless Dutch reporter-at-large, Thijs Gras, is known for his softly-spoken charm and his direct communications style - both of which qualities can be found in abundance among the plain-speaking but warm-hearted people of the Netherlands. Below Thijs employs his direct communications skills to explain why, apart from 'killing time', a more useful type of 'killing' for ambulance crews is the killing pain!

It gives one a good feeling when one succeeds in reducing or even eliminating pain that is bothering a patient. In the old days, we only had simple means like splinting, careful handling and, not to forget, humour. Jokes and distraction are still excellent tools to rely on when someone is in pain but nowadays, thankfully, we have more options.

In the seventies, Entonox gas was introduced to Dutch ambulances - thanks to the UK! I have been able to make good use of this. I will never forget the soccer player suffering from a lower leg fracture who lay on the field, his fellow players gathered around him. We gave Entonox to reduce the pain caused by the necessary aligning and splinting of his leg. We explained he might feel funny after inhaling the gas. After a few litres he started to smile and told us some bedroom secrets related to his girlfriend, enthusiastically encouraged by his teammates who did not stop laughing. Now I understood why this gas is also known as "laughing gas". I have always found it a very nice and safe product to use: it works quickly, has very few side effects (apart from some usually-funny but mild mental reactions) and is quickly flushed out. For repositioning a fracture or 'luxation', splinting, or transferring to stretcher, Entonox is ideal. It is odd to see that it is nowadays widely used as a party drug! In a way, it is a pity we stopped using it in Amsterdam because of some far-fetched articles about the risks of the gas, but these tests were done in clinical surroundings with people being exposed to the gas on a nearly daily basis. Quite different from the use on a soccer field!

After that we were blessed with Fentanyl and Ketanest. Fentanyl is a fairly strong painkiller, with mild mental effects that can be used to relieve pain in both trauma and non-trauma cases. It does the trick in a short time, but also just for a short time. Last week I used it with a lady with a broken underarm. I told her I was going to administer it through her nose to spare her an IV (for which we had to undress her, which was not very practical outside in the cold weather). While preparing the medication I used a needle to suck the Fentanyl from the ampulla. The lady looked at me in fright: "Are you going to stick that needle into my nose?"

"No ma'am," I reassured her. "For that we have something else."

With Ketanest I have had some good and some less good experiences. There is no discussion about its effectiveness; pain is killed, but the side effects may be strong. This can be positive. Once I was called to a man with a hernia. He was in extreme pain and already spoiled by morphine-like medication. Fentanyl did not have any impact anymore. Every movement was extremely painful for him, so I proposed to give him something very strong but with some risks of mental side effects. He did not care. I gave him an IV and administered Ketanest in a half-dosage. He was delighted, stood up by himself, laid down on the stretcher and when we were in the elevator going down, he said with a peaceful smile: "Wow, this is fantastic! Am I in Star Trek?"

Recently we had a similar case: a man in extreme pain was lying on a bed on the first floor. The cause of the pain was unclear. I tried Fentanyl first: no effect. Then I resorted to Esketamine. The man looked at my colleague and me, his eyes changed and he started screaming his lungs out of his thorax. "Arghhhh! Ahhhh, I'm going to die! Ahhhhhh!!!!!!!!" This reaction took us completely by surprise. His wife turned pale with fear. What had happened to her husband? She was almost paralyzed. But in the end she had to admit that it worked out quite well and we would not have been able to do this without the Esketamine.

How on earth do you manage to pierce a spear into your upper leg while running with it? A twenty-year-old girl succeeded in doing this and we were called to the rescue. About 50 cm (20 inches) of the over 2 meters long iron spear came out of the inside of her leg, the rest was sticking out on the other side. There wasn't much bleeding and the femur bone was not hit. No major blood vessels were involved; only the skin and muscles were affected. I decided the best option was to pull out the spear on-scene - but for this we had to give her adequate analgesia. Fentanyl and IV Paracetamol (1000 mg) were already in so for the removal of the spear we gave her extra Esketamine. She had a very good time and was even laughing a lot with her teammates: "Wow, this feels good!" Without any cry from her I was able to pull out the spear. Along with her new souvenir picture we brought her to the hospital for further treatment.

To close I would like to share with you another positive experience with Esketamine, this time in a non-emergency situation. We were called to transfer an elderly lady from one hospital to another. She suffered from a broken femur. Since she was in the last phase of her life with untreatable cancer there was no call to operate on her. However, the leg was causing her extreme pain despite high doses of Morphine given by the hospital staff. We proposed to make use of Esketamine and since she fell under our responsibility, we fetched it from our ambulance. She already had an IV, and I started with a half-dose. The transfer to our stretcher was still a little painful, but nothing compared to her earlier experiences. During the ride, despite the unavoidable bumps (paving a street is also an art, I always say), she had no pain and shortly before we arrived I gave her the other half. The transfer in the receiving hospital went very smoothly and practically without pain.

Analgesia is an important feature of ambulance care so I am glad we have very effective medication in The Netherlands for immediate pain-relief. But as with all good ambulance care, let's not forget that treating the patient with kindness, dignity and, when called for, a little good humour, is also vital. Sometimes for ambulance crews pain…or at least pain-management…can be a laughing matter!

I wish you all a painless Christmas and a very Happy New Year. Till 2017!

Tell Thijs what you think about this article, or just wish him a Merry Christmas, by emailing him at: thijsgras@upcmail.nl

PAC – Ensuring Quality Paramedic Care in Canada

Canada's ten provinces and three territories extend from the Atlantic to the Pacific and northward into the Arctic Ocean, covering 3.85 million square miles. With a population of over 35M people Canada needs one heck of a good EMS system. Thanks to decades of investment, education and training, that's exactly what it has. Ambulance Today takes enormous pride in welcoming the Paramedic Association of Canada (PAC) into our family. From 2017 onwards they will contribute news and features on their paramedic activities to our pages and circulate this magazine to all of their 20,000 + paramedic members.

About the Paramedic Association of Canada (PAC)

PAC represents over 20,000 paramedic professionals across Canada, with participation in every province and territory in the country. Our mission is to advance the profession and its representation throughout Canada. The association promotes collegiality and advocates for the professional interests of paramedic practitioners across the spectrum of policy areas and practice settings.

The Paramedic Association of Canada is comprised of Provincial Chapters, along with the Canadian Armed Forces, Royal Canadian Medical Service and paramedic educators.

PAC is overseen by a Board of Directors, composed of representatives from every Chapter. The Board of Directors sets the direction. Charged with putting into motion the Board's direction is the Executive Committee: the President, the Chair of the Board of Directors, the Secretary/Treasurer and the Executive Director. We rely upon many hundreds of dedicated professionals across the country to deliver high quality programs and services.

PAC's Vision is to have Paramedicine recognized as primary health care in legislation and policy. Our Mission is to provide quality care for the public through leadership in the advancement of the profession of paramedicine.

History

PAC was founded in June 1988 as the Canadian Society of Ambulance Personnel (CSAP). In 1997, CASP became the Paramedic Association of Canada. This name change reflected the changing scope and functions of paramedics, in addition to providing ambulance services.

Strategic Plan

We are pursuing three ambitious streams in our strategic plan:

1. Membership services – including the provision of professional liability insurance in cooperation with Marsh Canada; advocacy for the improved mental health of practitioners, including those experiencing Post Traumatic Stress Disorder; and quality continuing professional development opportunities, such as the PACE 2017 conference.

2. Improving professional practice – through the creation of the new Canadian Paramedic Profile, formerly the National Occupational Competency Profile. This is being accompanied by a new Code of Ethics and Standards of Practice.

We are proud to collaborate with many partners in setting increased educational standards for entry to practice in Canada.

We work with the Paramedic Chiefs of Canada (representing employers) and the Canadian Organization of Paramedic Regulators. We are engaged with the Canadian Patient Safety Institute, and the Canadian Standards Association – notably in establishing competency standards for community paramedics.

We also have relationships with the Canadian Association of Emergency Physicians, the Canadian Medical Association, the Canadian Safety and Security Program, and the Domestic (Canadian) Group on Emergency Management) and others.

The Paramedic Association of Canada offers practitioners opportunities for continuing education with our international congress Paramedicine Across Canada Expo (PACE). See the editorial in this issue for information on our next PACE congress, August 18 and 19, 2017 in Quebec City, Quebec.

3. Support for the Profession – with the development of national examinations, and supporting provincial applications for regulatory self-governance.

We are actively promoting the development of baccalaureate and advanced degree programs in paramedicine.

Special Projects of Interest to our U.K. Colleagues

- **Mental Health**

Given the stresses inherent in paramedic and first responder practices, PAC has worked closely with many stakeholders to address Post Traumatic Stress Disease (PTSD), mental health issues such as depression and anxiety, and suicides.

A Canadian organization Tema Conter Memorial Trust began tracking the number of suicides in all emergency services. At the time of this writing, there tragically have been at least 17 Paramedics who have committed suicide.

A recent survey of over 6,000 paramedics discovered that at least 30% of paramedics had contemplated suicide at some time in their career. PAC took the initiative to reduce these disturbing numbers by forming a committee of Paramedics and Mental Health professionals.

PAC engaged in lobbying efforts continued with many levels of governments to secure funding for research, assessment and treatment. PAC collaborated with the

PAC President Chris Hood

Members of the PAC Board with Prime Minister Trudeau

Canadian Standards Association to develop guidelines for dealing with mental health issues and strategies for development of resiliencies.

- **Community Paramedicine**

PAC has been instrumental, in collaboration with the Canadian Standards Association and many stakeholders in developing the draft standards "Community Paramedicine: Framework for Program Development." Excerpting from these draft Standards:

"Community Paramedicine Programs" have emerged throughout Canada in an effort to maximize efficiencies in patient care and resources. These programs provide an innovative model of care that helps to improve access to additional support services for seniors and patients with chronic health and social issues.

The development and expansion of these programs allows paramedics to apply their education and skills beyond the traditional role of emergency medical responders. These programs help to support high users of paramedic services to avoid emergency room visits and hospitalizations and can potentially delay entry to long-term care. The aim of these programs is to improve patient outcomes and decrease costs in a way that supplements, but does not replace services delivered by other health care providers. These programs can help to provide a more sustainable, integrated, patient-centred system.

While many paramedic services and jurisdictions are developing and expanding these programs there are no nationally or internationally accepted guidelines for the development of community paramedicine programs. This Standard addresses the elements that experience has shown to be the most critical in developing an effective community paramedicine program."

Consultation on these draft Standards will begin this month - December 2016.

- **Advocacy**

PAC members participate in advocacy with Members of Parliament. The most recent government relations day occurred in Ottawa, Ontario on May 17, 2016. Joined by 30 paramedics from each of the provincial Chapters across Canada, PAC met with many Members of Parliament to discuss four important topics:

- Community Paramedicine
- Mental Health and Wellness
- Temper-Resistance/Abuse-Deterrent Drug Legislation
- Heavy Urban Search and Rescue.

PAC members were enthusiastically received in the House of Commons, including by Prime Minister Justin Trudeau. The Prime Minister was presented with a Benevolent pin representing the men and women who have paid the ultimate sacrifice while providing medical care in our communities.

Here is an excerpt from the welcoming address:

"These dedicated men and women serve on the front line of health care delivery and public safety across Canada and are proud members of the first responder community. They serve in our municipalities, remote communities, and our Armed Forces.

We cannot forget the daily challenges of their profession and are reminded of this when talking about paramedic wellness and the high rates of PTSD suffered by first responders.

They are everyday heroes and it is an honour for us to host them in the House of Commons today. Please join me in welcoming them."

For further information about PAC, please contact Dwayne Forsman, PAC's Chief Administrative Officer at: dwayne.forsman@paramedic.ca

Keep up to PACE with Global EMS Developments Next Summer in Beautiful Quebec

Greetings from Canada. The Paramedic Association of Canada invites Paramedics and Paramedic Educators from across the globe to join your Canadian colleagues at Paramedicine Across Canada Expo (PACE) 2017, August 18 and 19, 2017 in beautiful Quebec City, Quebec.

The Paramedicine Across Canada Expo 2017 is designed to bring together front-line Paramedics, Educators and Leaders from all EMS settings to learn and network with each other. Regardless of your location, background, or experience, the various tracks that this conference offers (clinical, education, specialty, as well as mental health and wellness) ensure there will be something of interest for everyone.

All paramedics take their continuing professional development and training obligations seriously. Here is an excellent opportunity to partially fulfill your continuing education credits.

The PACE congress looks to shrink boundaries globally and across the paramedicine discipline - by providing education, networking and knowledge-sharing opportunities, regardless of your practice setting. The educator, clinical and specialty tracks will ensure that you can learn more about the unique aspects of patient care in diverse practice settings from a variety of first-hand sources, including:

- Front-line paramedics, who are the mainstay of ground ambulance, providing care in the out-of-hospital continuum - emergency care, palliative pain management, community care and other settings
- Paramedics providing occupational health and emergency care and safety services, often in remote and rural sites
- Paramedic-firefighters and tactical paramedics providing disaster or scene support
- Military paramedics embedded at the military front line.

For educators, this premiere conference is designed to support knowledge sharing and being current in practice - whether you are a full-time instructor, occasional preceptor or senior paramedic who works with the local educational program to provide clinical practice sessions.

The educator tracks are intended to improve understanding of adult learning theory and key aspects of evaluation in the field and classroom, as well as provide sessions to support preceptors who teach and are taught by students on a daily basis. The PACE congress educator sessions

are designed to support all practitioners who are committed to understanding accountability for evaluation of competence including their own competence.

The volunteers and staff preparing for the PACE conference are committed to honouring each of our practitioners through a high quality educational and networking event. Based on our very successful PACE 2015 Conference in Edmonton, Alberta, we anticipate over 1,000 participants in August 2017.

Plan to travel to Eastern Canada in August 2017. Better still, bring your family to enjoy the beauty of our country and make new friends. We look forward to seeing you!

To find out more about the Paramedicine Across Canada Expo visit: www.pacexpo.ca

IAEMSC prepared for 2016 Annual Leadership conference

After months of planning the IAEMSC has recently announced its annual Leadership Summit schedule. Held at the Washington Hilton Hotel, Washington D.C on December 12-14, 2016, this year's event is co-located with the National Healthcare Coalition Preparedness Conference. Attendees will have more than 60 different sessions to choose from as well as ample time to network with sponsors, vendors and other particpants.

In keeping with IAEMSC tradition, the Summit will include many Federal partners and subject matter experts from the Department of Homeland Security, Department of Health and Human Services, National Highway Traffic Safety Administration, the Office of the Inspector General, the Centers for Medicare and Medicaid and many more.

Helicopter Pilot Sergeant Kenneth Burchell, United States Park Police (USPP) discusses the USPP air response to the Washington D.C Navy Yard shootings

From candid panel discussions with representatives that have faced a variety of disasters to planning sessions for large scale events, the summit offers EMS leaders the opportunity to learn from those with first-hand experience!

Additional featured speakers include, Frederik Siem, Norwegian Red Cross Senior Advisor on the Protection of

Unites States Park Police (USPP) Rescue Technician Sergeant David Tolson, IAEMSC Past President, Lawrence Tan, IAEMSC Past President James Robinson and USPP Helicopter Pilot Sergeant Kenneth Burchell at the annual IAEMSC Leadership Summit

Leadership and Management panel discussion at IAEMSC Summit

Healthcare in Insecure Environments and Rodney Eid, Assistant Director, Crisis Management, Lebanese Red Cross. Together they will discuss the ***Healthcare in Danger, Community of Action Project,*** a global initiative to combat violence against healthcare providers.

IAEMSC Immediate Past President James Robinson and Dr. David Marcozzi, MD, Director of Population Health at the University of Maryland School of Medicine will review the recent recommendations from the National Academies of Science, Engineering and Medicine report entitled

Edward Gabriel, Principal Deputy , Assistant Secretary for Preparedness and Response (ASPR), US Department of Health and Humans Services

A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury. Both Robinson and Marcozzi were committee members and worked diligently on this project.

On December 14th the IAEMSC Summit will wrap up with its very popular **Labor & Management Panel Discussion.** Any question is fair game in this interactive and robust discussion between Labor and Management personnel and audience participation is highly encouraged!

IAEMSC Group Photo

Washington Hilton Presidents Walk

As in the past, the summit concludes with the extremely popular networking dinner which will be held Wednesday evening at Restorante La Perala. This iconic Washington D.C restaurant is a favorite destination for sponsors and attendees alike!

Brian Kamoie, Assistant Administrator of the Federal Emergency Management Agency (FEMA) for grants discusses funding opportunities at IAEMSC Summit

For more information please visit: www.iaemsc.org

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The Coperforma Lesson:

Below, Joe Sheehan, former MD of Medical Services Ltd (now part of Falck UK), discusses the importance of the psychological contract that should exist between employers and staff responsible for the delivery of Patient Transport Services, arguing that the Coperforma business model operated in Sussex, which failed so spectacularly earlier this year, could have been avoided if this vital element of service delivery was not omitted

The recent news that NHS Commissioners in Sussex and Coperforma had agreed to discontinue with the patient transport contract has been unsurprising given the circumstances.

Opinions differ about managed-services-provider contracts and the relative advantages or disadvantages over a directly-operated service. Certainly, the top team at Coperforma, who I am sure honestly believed the new model of service was operable and genuinely aspired to deliver a quality patient transport service might have a different viewpoint to mine.

As often happens to pioneers, once you have a first chance to fully test your new concept you are just as likely to end up going back to the drawing board and coming back later with something better. I am not arguing that all the component parts of the Coperforma managed-service offering are unworkable - but I certainly believe the strategy toward the staff delivering the service is structurally flawed, which is why I maintain that, without the patient-transport staff's full support and emotional commitment, the contract would never have performed to the required level anyway.

We are seeing a number of variances of this new type of organisational model (Uber, Deliveroo etc…) whereby technology appears to have the ability to move workers away from an obligated or responsible employer (either by degrees of separation or completely) to affect a risk and a liability transfer. Both Uber and Coperforma are using advanced algorithmic transport management software at the centre of their business model.

But there is a choice here: patient-transport providers have the option of deploying this new technology and choosing to maintain a committed direct workforce as a matter of business strategy.

On one level, the business strategy of Coperforma is that they would enjoy some of the profits for providing software and some contract-management to the service. Any subcontractors could also enjoy some of the profits, but do so by shouldering nearly all of the risk of employer obligations to staff as well as the significant vehicle investment liabilities and attendant contract running costs.

At least one consequence of a service-delivery-model which outsources workers and divorces the obligations and responsibilities of organisations for those workers is that you cannot really expect the same men and women to have shared ownership of the problem when the service runs into operational difficulties.

In this case, the patient-transport staff who had been comfortably employed inside the NHS found themselves distanced by the Tupe transfer process and two tiers removed from their preferred NHS employment status. They did not transfer to Coperforma along with the award of the new contract, but were "double-outsourced" and parked with third-party subcontractors. The legal framework is I suppose, arguably correct but that's not my point. My view is that the psychological contract between the provider of the patient transport service and the staff employed to deliver the service was clearly broken.

I doubt Uber taxi drivers feel any (intrinsic) emotional reward on top of the cash fare (an extrinsic reward) the passenger pays. In sharp contrast to taxi drivers many patient transport staff choose the job because they see themselves as part of a socially valuable service and have an emotional commitment as well, which is expressed in the quality of patient care they provide.

I have managed the process of ambulance staff transferring into the independent sector in the past. In all instances the transferring staff worked directly for the new service provider; and I am not sharing any secrets when I say that this was challenging. Some transferring staff needed to see genuine commitment from the new employer over a long period before the kind of relationships were built that support high-performing teams. It works in the other direction as well: a year or so ago in Shropshire, a number of patient transport staff transferred across on zero-hours contracts from the previous independent sector provider and were immediately offered permanent full-time employment contracts. Consequently, relationships, emotional commitment and better performance outcomes were built more quickly.

When the TV news showed patient transport staff involved in industrial action, it was Coperforma and the CCG the staff were angry with, not the unheard-

Biography: Joe Sheehan

With back to back, build and sell successes, most notably as Managing Director of Medical Services Ltd, Joe Sheehan is a results-orientated strategic thinker and a motivated management professional with over thirty years' experience in the transport management, logistics and healthcare transport industries.

With a strong operational focus Joe built a successful career in express logistics and control centre management. He was part of the entrepreneurial team behind LDT PLC, which was acquired by Addison Lee in 2011. Subsequently, he developed and led Medical Services Ltd into the UK's largest independent sector ambulance service, delivering over a million patient journeys a year for the NHS until sold to a global healthcare brand in 2014. Joe is currently undertaking an MBA at the the University of Kent and retains a strong interest in the development of UK and global ambulance delivery.

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of financially unstable subcontractor where they were parked for contractual convenience.

For the transferred patient transport staff with an emotional commitment to the NHS this transfer of obligations was not comparable to an amicable divorce. They certainly did not feel they were to blame for the breakdown in their employment relationship with the NHS; in their eyes Coperforma were an adulterous third-party and the CCG a poor judge.

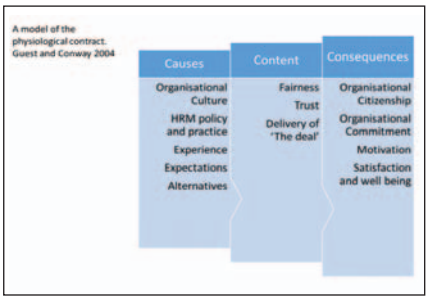
The likelihood of these recent and angry divorcees rallying around and going the extra mile to support Coperforma when they could not get the new software to work optimally in the early fumbling days of their new contract is nil.

Though probably for employment contract reasons, in this situation, the transferred staff would (through gritted teeth) do at least the minimum required. They certainly danced and cheered when Coperforma fell out of the marital bed and are now no doubt hoping to get back with their ex as soon as is decently possible.

Working in patient transport, I learned over the years and perhaps Coperforma have also learned recently, that the staff actually are the service - and I am not saying that in an emotional or patronising tone, but in an economic sense - they are the organisation's core "capability." Advanced software, new technology and new ambulances are all well and good and of course they have a place, but it's the staff who deliver and define the service.

This commissioning failure will provide a deep pool of lessons learned for all concerned. I have no doubt the CCGs in Sussex will look to the future and commission an improved patient transport service and perhaps Coperforma will come back with an improved model, but I would advocate that this time around both consider the patient transport staff's psychological contract and give it some weight in the contract-award process.

Any patient transport provider with a mature strategic view of human-resource management that commits to developing and valuing its core employees (and crucially the rewards of the patient transport provider are aligned to the rewards that



the staff receive) will create a competitive advantage and deliver patients a superior service.

It does not matter (to me) if these key attributes are found in an NHS, an independent sector or a third sector provider, but what is clear to me is that they are missing from the offer that Coperforma sold to the CCG and that's why I did not think it would succeed from the very outset.

The views in this opinion piece are those of Joe Sheehan and are not necessarily endorsed by *Ambulance Today*. If you would like to discuss this article with Joe Sheehan please email him at: JPSS2@kent.ac.uk

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Dispatch and NAVIGATOR belong together

Emergency dispatch protocols and NAVIGATOR are continent-specific. The Academy hosts eight NAVIGATOR conferences annually: three in Asia, three in Europe, one in Australia, and one in the U.S. In all, there are 62,000 protocol users worldwide in more than 3,000 centers. Keeping it all in motion are Academy-certified emergency medical, fire, and police dispatchers, attending the conferences, receiving Dispatcher of the Year awards, and helping people 24/7.

The IAED™ Dispatcher of the Year award honors significant contributions to further the Academy's values through personal action, protocol compliance, teamwork, educational and professional initiative, and ability to function well under stress.

Nomination packets submitted must include an audio file demonstrating how the dispatcher dealt with a difficult caller, extraordinary circumstance, or achieved a positive outcome.

China NAVIGATOR

EMD Xia Ying was chosen among 18 nominees, representing 14 agencies, submitted for the Dispatcher of the Year award in China.

Wuxi Emergency Center Manager Chen Jielian said Xia Jing has an overall EMD compliance rate of above 98 percent for the year. Her nomination included two cases involving successful bystander resuscitation of patients in cardiac arrest, using Medical Priority Dispatch System™ (MPDS®) PAIs for CPR.

The 2016 China NAVIGATOR takes accolades for having the fastest-growing NAVIGATOR and the highest percentages of ACEs per centers in China using protocol the world. New EMD-accredited centers included Jimo 120 Emergency Command Center and Jinan Medical Emergency Center (both in Shandong province). Wuxi Emergency Center re-accredited as an EFD Center of Excellence; the communication center was also spotlighted for its role as China's MPDS Training Center.

There are 10 ACEs in China and nearly an 11th; Ganzhou Emergency Center (Jiangxi province) submitted its ACE application the week following China NAVIGATOR.

"ACE is a natural part of their expectations in using the MPDS," said Jerry Overton, Chair, IAED Board of Accreditation. "They are committed and understand the value. As a result, they initiate a structure that can support the processes of completing the Twenty Points."

Priority Dispatch Corp.™ (PDC™) presented a "Contributions to EMD Award" to four centers in recognition of their comprehensive and significant accomplishments in use of the protocol system: Wuhan Medical Emergency Center (Hubei province); Wuxi Emergency Center; Hangzhou Ambulance Center (Zhejiang province); and Suzhou Emergency Center (Jiangsu province).

A record 315 people attended the conference held Oct. 11–12 in Wuxi, Jiangsu province.

UK NAVIGATOR

EMD Louisa Ansell was named IAED Dispatcher of the Year at UK NAVIGATOR.

Ansell, with the Welsh Ambulance Service's South East Clinical Contact Centre, has been with the ambulance service communication center for three years.

In addition to high protocol compliance and her professional manner, Ansell was singled out for a call involving a patient found unresponsive and having difficulty breathing.

"I've done so many CPRs, and they're not easy calls by any standard, but you just want the best outcome for the patient," Ansell said. "The longer you do it, the more you become in tune to it by constantly monitoring the situation."

Four other Welsh Ambulance Service dispatchers were also among the 15 emergency dispatchers nominated for the award.

"For so many Emergency Medical Dispatchers from the same ambulance service to be shortlisted is unprecedented, and it's a testament to all who were nominated," said Brian Jarvis, South East Ambulance Clinical Contact Centre Manager. "We are all really proud of Louisa's achievement, and her award is highly deserved."

James Gummett was honored as an Emeritus Lifetime Member of the IAED College of Fellows. Gummett is the Quality Assurance Manager at London Ambulance Service. He is a contributor and co-author of dispatch-related research articles, quality assurance speaker at NAVIGATOR conferences worldwide, and representative for England on the IAED College of Fellows.

Yorkshire Ambulance Service NHS Trust was recognized for ACE re-accreditation.

There were 130 attendees at UK NAVIGATOR, held Sept. 20–22 in Bristol, U.K.

EURO NAVIGATOR

EMD Harald Sulzbach was selected as the Euro NAVIGATOR 2016 Dispatcher of the Year. Sulzbach was cited for his exemplary use of the MPDS, as demonstrated in a call providing childbirth-delivery PAIs to assist a 36-week pregnant woman and the patient's mother in the delivery of a healthy baby.

Sulzbach said he was honored to receive the recognition.

"When my name was called, I was of course very happy to receive the award," Sulzbach said. "The reaction of my colleagues at Euro NAVIGATOR was overwhelming. Just everybody's response and congratulations helped me realize that I had done something special."

Gernot Vergeiner received the Academy's Emeritus Award for Lifetime Service for his many contributions over the years in furthering the mission of the IAED, the protocols, and the emergency communications industry. Vergeiner has been in emergency dispatch for 25 years, most recently as director of the Tirol Communication Center, Innsbruck, Austria. He is a crew resource management trainer for public safety personnel with New Training Institute in Austria.

Meldkamer Ambulancezorg Brabant Noord in the Netherlands was noted for achieving ACE status, representing the third agency in continental Europe to become a medical ACE.

Euro NAVIGATOR 2016 hosted 131 attendees representing a variety of countries, including the Netherlands, Germany, Austria, Italy, United Kingdom, Ireland, USA, and Switzerland, in Salzburg, Austria, Sept. 14–16.

Australasia NAVIGATOR

EMD Bethany O'Leary received the 2016 Australasia EMD of the Year award at Australasia NAVIGATOR.

O'Leary, who has been with New South Wales Ambulance Service in Australia for close to five years, was recognized for her high protocol compliance, calming and confident presence, and ease in coordinating

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response, as demonstrated in a call involving suspected cardiac arrest, which was played at the conference.

O'Leary deftly led the patient's daughter through compressions and, when a second family member arrived, that person took over, again following O'Leary's instructions. For 14 minutes, O'Leary counted until response arrived on scene.

Dr. Andrew Bacon received the Academy's Emeritus Award for Lifetime Service. Dr. Bacon is a medical adviser to Ambulance Victoria and considered a subject matter expert in issues relating to airway and ventilation equipment procurement, and medical procedures and clinical practice. He is known for his support of calltaking processes used in ambulance communication centers across Victoria and is an acknowledged expert in the field of calltaking and dispatch systems and understanding effective ways to improve patient outcomes.

Australasia NAVIGATOR was held Nov. 7–9 in Adelaide, Australia. The 88 people attending the conference hailed from Hawaii, New Zealand, Australia, and Kuwait.

U.S. NAVIGATOR

Ricardo Martinez, of the popular podcast "Within the Trenches," will make his NAVIGATOR debut as a speaker and will broadcast a live episode of WTT during NAVIGATOR, interviewing IAED officials and NAVIGATOR attendees. He will also be presenting a session about his dispatch story and how he got into podcasting.

NAVIGATOR is scheduled for April 12–14, at the Hilton New Orleans Riverside, New Orleans, La. Pre-conference workshops will be held earlier the same week.

For NAVIGATOR 2017, the Academy is offering an exceptional number and variety of educational tracks: Quality Assurance, Leadership, Management, Research, Motivation, Stress Management, CDE & Training, Special Interest, Operations, Human Resources, Fire Protocol, Medical Protocol, Police Protocol, and an International track that connects the continents.

Sessions include solutions to workplace drama, shift strategies, problem employees, morale issues, critical incident planning, training, social media, assisting callers with disabilities, and the hot seat of news reporting. Madeline Marks, of the University of California's Center for Research and Treatment on Response to Extreme Stressors, will present a Leadership session outlining the lessons learned from the Pulse Nightclub shooting.

And it's all happening where it all started.

Charity Hospital in New Orleans is where, as a young emergency room resident, Jeff Clawson, M.D., came upon the idea of the emergency dispatch system when the chief resident handed him a cookbook for handling patient flow.

The rest, as they say, is history.

Charity Hospital was closed three weeks after Hurricane Katrina, in September 2005, and was incorporated into the city's new medical center, University Medical Center New Orleans, which opened in August 2015.

To find out more about IAED or to get involved visit: www.emergencydispatch.org

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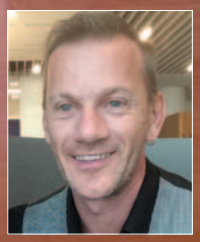
I was injected with HIV at the age of 12



By Mark Ward

Back in the dark ages of the early 1970's I was diagnosed with severe haemophilia. It's a rare genetic blood disorder which prevents the body's natural blood clotting protein, Factor VIII, from being produced. We all suffer bumps and cuts sometimes in everyday life, but if you are haemophiliac, the bleeding does not stop.

This can be life-threatening in some situations. The treatment used to control my bleeding episodes used products made from whole blood.

Unfortunately, during the 1970s and 80s the mega rich pharmaceutical companies did not care where they got the blood from.

In the USA they paid vulnerable and desperate people to sell their blood. Drug addicts, prostitutes and prisoners were frequently used.

They would even wait in mobile blood transfusion trucks outside gay saunas or bath houses, in cities like San Francisco and New York, then offer the guys money to sell their blood.

There were even cases of using blood from dead bodies.

All the blood gathered from the various sources was mixed together in huge vats and processed to separate it into different components, like Factor VIII.

This would be freeze-dried, bottled and shipped around the world and then injected straight into the veins of babies, children, teenagers - in fact anybody who required these blood products.

The dangers of viruses, such as hepatitis, were known and governments, including the United Kingdom, were warned of these infection risks. But even warnings from the World Health Organization were ignored.

At that time there were approximately 5,000 haemophiliacs in the UK and almost all were infected with Hepatitis C and 1249 infected with HIV.

I was told I'd be dead by 18

I was given my first injection of the deadly contaminated Factor VIII in the middle of the night, against my parents' wishes, in 1976. By the age of 10, I had been infected with millions of pathogens, multiple strains of various contaminants including hepatitis viruses A, B, C, and G. Then at the age of 12, I was infected, almost on a daily basis with treatment contaminated with HIV, the virus that leads to AIDS.

I was told at the age of 14, I probably would not leave school, certainly not living long enough to see my 18th birthday. The entire world was full of hatred towards anyone with HIV, regardless of their infection circumstances.

Across the USA families feared for their lives, little boys were treated worse than lepers, even having their homes set on fire. They were referred to as members of the "4H Club" (Heroin addicts, Homosexuals, Haemophiliac's and Haitian's). Ryan White, an infected American haemophiliac, became famous for standing up to his abusers, but sadly lost his fight for life aged just 18.

The UK, was no different. We lived in fear of the 'Gay Plague' as the British media

named it and the government did nothing to protect us. Many lives were destroyed due to the stigma of AIDS. I'd like you to imagine what it was like growing up with all that terror, hatred, stigma and discrimination. Still being injected with the deadly treatment. Friends dying, used for research by doctors like laboratory rats.

Then on top of that realizing you are not just different from 'normal' people because of your disability but you are also gay.

That's what happened to me.

Anti-gay prejudice

And after more than 2,000 haemophiliacs died, with thousands more 'superinfected,' homosexuality is still a taboo subject in the haemophilia world today.

In most countries, including the UK, no information or support is offered to people with a bleeding disorder who identify as LGBT. The CEO of one national haemophilia society in Europe told me: 'We have not identified any gay haemophiliacs, therefore we do not need to provide information.'

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Advancing Acute Pain Management

At last, PENTHROX® is here...

Fast, effective pain management designed for fast, efficient patient management.

PENTHROX is indicated for the emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain[1]

Now there's a PCA* in a non-invasive, lightweight, portable, handheld inhaler for the emergency relief of moderate to severe pain in conscious adults with trauma. With easy set-up, administration and proven pain relief within 6-10 inhalations,[1,2] PENTHROX quickly controls patient pain without the need for canisters, cannulas or opioid-related ED attendances.

PENTHROX▼ 3mL inhalation vapour, liquid: Please refer to the Summary of Product Characteristics (SPC) before prescribing. Abbreviated Prescribing Information. Presentation: Each vial of PENTHROX contains 3mL of methoxyflurane 99.9%, a clear, almost colourless, volatile liquid, with a characteristic fruity odour. Each PENTHROX combination pack consists of one 3mL bottle, one PENTHROX Inhaler and one Activated Carbon (AC) chamber. **Indications:** Emergency relief of moderate to severe pain in conscious adult patients with trauma and associated pain. **Dosage and administration:** PENTHROX should be self-administered under supervision of a person trained in its administration, using the hand held PENTHROX Inhaler. **Adults:** One bottle of 3mL PENTHROX to be vaporised in a PENTHROX Inhaler. On finishing the 3mL dose, another 3mL may be used. The dose should not exceed 6mL in a single administration. Methoxyflurane may cause renal failure if the recommended dose is exceeded. The lowest effective dosage to provide analgesia should be used. Onset of pain relief is rapid and occurs after 6-10 inhalations. Patients are able to titrate the amount of PENTHROX inhaled and should be instructed to inhale intermittently to achieve adequate analgesia. Continuous inhalation provides analgesic relief for up to 25-30 minutes; intermittent inhalation may provide longer analgesic relief. Administration on consecutive days is not recommended and the total dose to a patient in a week should not exceed 15mL. **Children:** PENTHROX should not be used in children under 18 years. For detailed information on the method of administration refer to the SPC. **Contraindications:** Use as an anaesthetic agent. Hypersensitivity to PENTHROX or any fluorinated anaesthetic. Patients with known or genetically susceptible to malignant hyperthermia or a history of severe adverse reactions in either patient or relatives. Patients who have a history of showing signs of liver damage after previous methoxyflurane use or halogenated hydrocarbon anaesthesia. Clinically significant renal impairment. Altered level of consciousness due to any cause including head injury, drugs or alcohol. Clinically evident cardiovascular instability. Clinically evident respiratory depression. **Warnings and Precautions:** Methoxyflurane causes significant nephrotoxicity at high doses. Nephrotoxicity is also related to the rate of metabolism. Factors that increase the rate of metabolism such as drugs that induce hepatic enzymes can increase the risk of toxicity with methoxyflurane as well as sub-groups of people with genetic variations that may result in fast metaboliser status. The lowest effective dose should be administered, especially in the elderly or patients with other known risk factors of renal disease. Methoxyflurane should be cautiously used in patients with conditions that would pre-dispose to renal injury. Methoxyflurane is metabolised in the liver, therefore increased exposures in patients with hepatic impairment can cause toxicity. PENTHROX should be used with care in patients with underlying hepatic conditions or with risks for hepatic dysfunction. Previous exposure to halogenated hydrocarbon anaesthetics (including methoxyflurane when used as an anaesthetic agent), especially if the interval is less than 3 months, may increase the potential for hepatic injury. Cautious clinical judgement should be exercised when PENTHROX is to be used more frequently than on one occasion every 3 months. Potential effects on blood pressure and heart rate are known class-effects of high-dose methoxyflurane used in anaesthesia and other anaesthetics. Caution required in elderly due to possible reduction in blood pressure. Potential CNS effects such as sedation, euphoria, amnesia, ability to concentrate, altered sensorimotor co-ordination and change in mood are known class-effects. The CNS effects can be a risk factor for potential abuse. To reduce occupational exposure to methoxyflurane, the PENTHROX Inhaler should always be used with the AC Chamber which adsorbs exhaled methoxyflurane. Multiple use of PENTHROX Inhaler without the AC Chamber creates additional risk. Elevation of liver enzymes, blood urea nitrogen and serum uric acid have been reported in exposed maternity ward staff when methoxyflurane was used in the past at the time of labour and delivery. PENTHROX is not appropriate for providing relief of break-through pain/exacerbations in chronic pain conditions or for the relief of trauma related pain in closely repeated episodes for the same patient. **Interactions:** Methoxyflurane is metabolised by the CYP 450 enzymes, particularly CYP 2E1 and to some extent CYP 2A6. It is possible that enzyme inducers (such as alcohol or isoniazid for CYP 2E1 and phenobarbital or rifampicin for CYP 2A6) which increase the rate of methoxyflurane metabolism might increase its potential toxicity and they should be avoided concomitantly with methoxyflurane. Concomitant use of PENTHROX with CNS depressants, such as opioids, sedatives or hypnotics, general anaesthetics, phenothiazines, tranquillisers, skeletal muscle relaxants, sedating antihistamines and alcohol may produce additive depressant effects. If opioids are given concomitantly with PENTHROX, the patient should be observed closely. Concomitant use of methoxyflurane with medicines (eg contrast agents and some antibiotics) which are known to have a nephrotoxic effect should be avoided as there may be an additive effect on nephrotoxicity, tetracycline, gentamicin, colistin, polymyxin B and amphotericin B have known nephrotoxic potential. Sevoflurane anaesthesia should be avoided following methoxyflurane analgesia, as sevoflurane increases serum fluoride levels and methoxyflurane nephrotoxicity is associated with raised serum fluoride. When methoxyflurane was used for anaesthesia at the higher doses of 40–60mL, there were reports of drug interaction with hepatic enzyme inducers (eg barbiturates) increasing metabolism of methoxyflurane and resulting in a few reported cases of nephrotoxicity; reduction of renal blood flow and hence anticipated enhanced renal effect when used in combination with drugs (eg barbiturates) reducing cardiac output; and class effect on cardiac depression, which may be enhanced by other cardiac depressant drugs, eg intravenous practolol during cardiac surgery. **Fertility, pregnancy and lactation:** No clinical data on effects of methoxyflurane on fertility are available. As with all medicines care should be exercised when administered during pregnancy especially the first trimester. There is insufficient information on the excretion of methoxyflurane in human milk. Caution should be exercised when methoxyflurane is administered to a nursing mother. **Effects on ability to drive and use machines:** Methoxyflurane may have a minor influence on the ability to drive and use machines. Patients should be advised not to drive or operate machinery if they are feeling drowsy or dizzy. **Undesirable effects:** The most common non-serious reactions are CNS type reactions such as dizziness and somnolence (≥1/100 to <1/10) and are generally easily reversible. Serious dose-related nephrotoxicity has only been associated with methoxyflurane when used in large doses over prolonged periods during general anaesthesia. Adverse drug reactions observed in PENTHROX clinical trials in analgesia: **Common (≥1/100 to <1/10):** Amnesia, anxiety, depression, dizziness, dysarthria, dysgeusia, euphoria, headache, sensory neuropathy, somnolence, hypotension, coughing, dry mouth, nausea, feeling drunk, sweating; **uncommon (≥1/1,000 to <1/100):** paraesthesia, diplopia, oral discomfort, fatigue, feeling abnormal, increased appetite and shivering. Post-marketing experience: rare (≥1/10,000 to <1/1,000) reports of hepatic failure/hepatitis have been observed with analgesic use of methoxyflurane. Other events linked to methoxyflurane use in analgesia include drowsiness, agitation, restlessness, dissociation, affect lability, disorientation, altered state of consciousness, choking, hypoxia, oxygen saturation decreased, blood pressure fluctuation, vomiting, hepatitis, increased liver enzymes, jaundice, liver injury, increased serum uric acid, urea nitrogen and creatinine, renal failure, blurred vision and nystagmus. **Overdose:** Refer to SPC. **Legal Category:** POM. **NHS Price:** £17.89. **Marketing Authorisation Holder:** Medical Developments UK Limited c/o Price Bailey LLP, Causeway House, 1 Dane Street, Bishop's Stortford, Herts, CM23 3BT, United Kingdom. **MA Number:** PL 42467/0001. **Full prescribing information available from:** Galen Limited, Seagoe Industrial Estate, Craigavon, BT63 5UA, United Kingdom. **Date of Preparation:** November 2015.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Galen Limited on 028 3833 4974 and select the customer services option, or e-mail customer.services@galen-pharma.com. Medical information enquiries should also be directed to Galen Limited.

Reference: 1. Penthrox Summary of Product Characteristics. May 2016. 2. Coffey F et al. Emerg Med J 2014; 31: 613-618.
Date of preparation: December 2016. PMR-NOV-2016-0379

Before administering PENTHROX, make sure you have read and fully understood the SmPC and educational materials, which provide important information about how to safely use the device to minimise risk of serious side effects. PENTHROX educational materials and training on its administration are available from Galen on request.
*PENTHROX should be self-administered under supervision of a person trained in its administration, using the handheld PENTHROX Inhaler.[1]

GALEN

Homophobic incidents are not always taken seriously or properly investigated, leaving patients feeling worthless, traumatised and unsafe.

I believe by implementing education and sexual health information for all people within the bleeding disorder community, we have the ability to really save lives. The threat from viruses like hepatitis and HIV has not gone away from the world. It has simply shifted to a different infection route – sex.

We must not allow institutionalised homophobia coupled with ignorance to continue putting lives at risk. This means we have to take action now, grow up and talk about sexual health. Simply refusing to accept mounting scientific data of other life-threatening conditions, such as testicular cancer or other cancers related to HPV (Human papilloma virus) is completely unacceptable, as well as negligent.

Alain Weill, WFH President gave a passionate speech at this year's World Federation of Hemophilia Congress held in Orlando, back in July. He said:

"When we educate people to see that being a patient of a rare bleeding disorder does not define who that individual is, and instead see them as an active member of society who enriches their community, we will show that it is indeed true that the highest result of education is tolerance."

As Haemosexual becomes more established the same shared goals can be achieved: equality, education and better healthcare for everyone with a bleeding disorder no matter what their sexual orientation is.

Are you Haemosexual?

As the subject of sexual health is seen to be 'too explicit' by some, I am now reaching out to those who are at risk by setting up my own project.

Haemosexual has been designed to offer practical advice and information, along with providing education to patients, medical professionals and other organizations.

We want vulnerable people to get proper protection – and that means communicating with them.

Safety information and support on sexual health is much more effective if it is provided in a way people feel comfortable with.

Speaking to like-minded people makes it easier to talk openly about your lives, body, physical and mental health.

Haemosexual will stand for equality, education and better healthcare for everyone with a bleeding disorder no matter what their sexual orientation is.

It is in memory of all my friends.

I hope it will also highlight how a small, vulnerable group of disabled people were so cruelly treated by those who inflicted these death sentences and compounded the suffering for more than 40 years.

I cannot stand by and watch another generation, condemned to suffer with the same homophobic and ignorant attitudes.

The views expressed in this article are those of Mark Ward and are not necessarily endorsed by *Ambulance Today*. To find out more or to get involved, you can reach Mark via the Haemosexual website: www.haemosexual.com

Auxilium Systems gives "Reader" status Free to all First Responders

First Responders are the front line and are therefore best placed to become Auxilium Systems Readers

What is a 'Reader'?

A Readers is an authorised person who logs on to the system and is able to bring up the details about a specific Auxilium Number. The system is accessed by an Auxilium Number for safeguarding. The information you can see is what they have entered into the system – at a minimum it will be their name, date of birth and emergency contact telephone numbers.

Who can become a 'Reader"?

The emergency services are given automatic rights by the Auxilium to be a reader and see all the information that a person puts into the system about themselves. Other organisations can ask to see the persons information or the person can give permission to other organisations but it is has to be authorised by the user. Please email info@auxsys.uk for more information.

Why should people use the Auxilium System?

From the outset we have worked with the Ambulance Service to ensure that the system created would be

- Free for all Emergency Services to Use
- Easy for the Emergency Services to use
- Information stored on the system is secure.
- As cheap as possible for everyone else at £1.00 per year
- No additional costs to add or amend your information

Emergency Personnel … did you know that Any emergency personnel can have

Type in the Auxilium Number of the person you need to view

Contact numbers / emails are on the first page

Next of Kin Information on the second

Medical conditions / allergies / medicines currently taking on the third

an Auxilium Number for FREE FOR LIFE – email info@auxsys.uk stating your name, job title and authority you work in. In return we will give you a number and keyring tag with your Auxilium Number on.

How are people using the Auxilium System?

When the system was created it was envisaged that people would add their information ready to be use the number in an emergency. And that was it.

However people are amazing and are already adapting the system to suit their own unique needs and requirements. As part of the £1.00 per year registration fee, you can log on as many times as you require without any extra charge.

We have had feedback from users informed us that they have been logging onto the Auxilium System at least once a day to make a note of their vital readings and/or other health issues that have occurred eg seizures, spasms, asthma attacks, their times, length etc. Thus allowing them a clear record of what has been happening. Rather than writing it in a book, which they often forget to carry with them, the Auxilium System allows them to log on anyway, and on any device, and add a comment. We have even heard of one person used the doctor's laptop to logged on and show them the information!

We love the way that people are adapting the system to use in this way.

Recent we were invited to discuss this way of using the system with the several Transplant Co-Ordinators. Who thought the system would be very useful to their patients, and in the New Year are happy for us to leave information about the Auxilium System in their waiting rooms.

If you know of someone who would find this way of using the system useful please tell them about the Auxilium System.

As you can guess with the product costing £1.00 per year the Auxilium System directors are not in it to become millionaires. We are passionate about having a system that everyone can afford, that can provide support to people in a crisis situation. Have you got your Auxilium Number?

If you want to talk us more about how we can work with you and if you would like the system email : info@auxys.uk or have a look at our website: www.theauxiliumsystem.co.uk

Ambulance personnel pay tribute to the fallen at National Memorial Service

Senior representatives of ambulance services from around the country attended a moving national Ambulance Remembrance Service to honour colleagues who have died while on duty and in service.

The biennial service, which took place at the National Memorial Arboretum in Alrewas, Staffordshire, is an Act of Remembrance to honour the memory of all those who served and died while working for the ambulance services of England, Scotland, Wales, Northern Ireland, the Republic of Ireland, Guernsey and Jersey.

The event, organised by TASC, The Ambulance Staff Charity, was attended by around 160 people including representatives of ambulance services, retirement associations, the Independent Ambulance Association, charities, Unison, and relatives of ambulance personnel on the Roll of Honour.

The event began with a private service at the Arboretum's Chapel of Peace by Rev Paul Fermor, Deputy Senior Chaplain at South East Coast Ambulance Service NHS Foundation Trust. The service also included readings from the Bible by Violet Hornby, an ambulance technician with Scottish Ambulance Service, and Marie Fisher, operational services manager at North West Ambulance Service, together with music from TASC trustee Cliff Randall, accompanied by his brother Paul.

A procession led by a piper then moved from the chapel to the Ambulance Services Garden of Remembrance within the Arboretum grounds where the Roll of Honour, currently consisting of 93 names of ambulance personnel, was read out by John Eames and Steven Rust from West Midlands Ambulance Service.

Line-up at the Memorial Stone

The Garden of Remembrance service, which took place alongside the Ambulance Memorial, also included a reading from retired West Midlands Ambulance Service paramedic Carl Ledbury, who delivered Laurence Binyon's famous World War One poem, For The Fallen.

This was followed by the laying of 14 wreaths and floral tributes on behalf of ambulance trusts, retirement associations, relatives of those on the Roll of Honour, Unison and TASC. The Last Post was then played by Marcus Main from the Welsh Ambulance Service before the Rev Fermor concluded the memorial service with a final prayer which was followed by a two-minute silence.

Rev Fermor, who is also chaplain for Kent, said following the service: "It was a great honour to conduct the service and we were really pleased with the way it went. A number of people came up to me afterwards to say how much it had helped them."

The chaplain's brother, Simon Fermor, had previously helped organise the memorial service in his role as Secretary of the Ambulance Service Benevolent Fund, which has now become TASC.

Rev Paul Fermor begins service in the garden

Carl Ledbury retired from West Midlands Ambulance Service in 2012 after a 36-year career. He said: "It was an excellent event, remembering ambulance personnel who have fallen in the line of duty and in service, and I was honoured to be a speaker. It is a special tribute for the family of loved ones who have died whilst in service."

Steve Rust, who is based at Stoke-on-Trent, said: "It was an honour to be asked to help read out the Roll of Honour. But it was also an emotional thing to do because there were names on the list who I was both colleagues and friends with, so that was hard."

Marie Fisher, who helped read out the Roll of Honour two years ago, said: "It was a very moving ceremony and it was a huge honour to be involved in this way." And Violet Hornby, who joined Marie in reading the Roll of Honour in 2014, agreed it had been a "real honour" to again be involved.

The National Memorial Arboretum comprises around 30,000 trees on a 150-acre site dotted with more than 300 memorials, including the Armed Forces Memorial and Basra Wall, dedicated to those who have served and continue to serve their country.

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Supporting present and past ambulance staff and their families in time of need

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CLARION EVENTS

Good luck, Chuck!

As Conrad (Chuck) T. Kearns steps down as president of NAEMT, Ambulance Today's Joe Smith caught up with him for a quick review of his time as president and his wishes for NAEMT as it goes forward under NAEMT president-elect Dennis Rowe. Ambulance Today would like to wish Chuck all the best in the future!

Joe Smith: How have you enjoyed your time as President of NAEMT – can you tell us a little about what the role involves and the demands it makes on you?

Chuck Kearns: I have greatly enjoyed my time as NAEMT President - I must admit however that the time demands were greater than I anticipated. Between the frequent trips to attend meetings with other associations, to signing contracts, chairing meetings and making many phone calls, being a volunteer leader of such a large and dynamic organization is quite challenging.

JS: NAEMT is going through a period of notable growth right now and is, for example, offering an even wider menu of training development options to its members. So, what have been the highlights of your presidency in terms of NAEMT's development?

CK: The growth in our world-wide membership and the expansion of our educational courses. We've added thousands of members and almost doubled our course offerings in the last several years.

JS: How has American prehospital care changed during your presidency? Does NAEMT face the same challenges representing its membership now or are new issues appearing which change the focus of your organisation? I ask this in light of developments such as the implementation of Obama-care and the impact this has been having on EMS deliverers across the states.

CK: On the positive side, we've seen rapid growth in Mobile Integrated Healthcare – Community Paramedics and their practice to reduce unnecessary ambulance runs and hospital readmissions. On the negative side, the Affordable Care Act (ACA), which many of us call the UN-affordable Care Act,

has caused a rise in insurance deductible amounts. A patient's insurance doesn't engage until patients pay higher amounts out of pocket up front. So, ambulance providers have found it harder to collect payment for our services and it has increased our bad debt.

JS: What do you think are going to be the major challenges for American EMS in the immediate future?

CK: We have to be looking for more ways to be safer in our medical practices and be more efficient in the face of shrinking reimbursements.

JS: What are your own plans for the future - will you remain active in NAEMT as past-president?

CK: Yes, I look forward to the next two years serving as Immediate Past President and helping President Rowe advance his agenda and our association's goals.

To find out more about NAEMT visit: www.naemt.org

Visit the only daily ambulance news site on the net at:
www.ambulancetoday.co.uk

'No excuse' for attacking ambulance staff after new EEAST figures show 19% increase in assaults

"She was drunk."

"He had taken drugs."

"She cannot remember."

"He is very sorry and regrets his actions."

These are statements made by defendants in court. However, there is no excuse for attacking ambulance staff.

That's the message from bosses at the region's ambulance service, which has experienced a 19% increase in reported violence in the last year.

New figures reveal that there were 232 physical assaults against East of England Ambulance Service NHS Trust (EEAST) staff in 2015/16, compared to 195 in 2014/15.

Criminal sanctions were brought against 66 people in the last year.

Chief Executive Robert Morton said: "It is appalling that some people are violent towards our staff when they are trying to help and provide the best possible care to patients. There's no excuse for attacks on our staff.

"One assault against a colleague is one too many and can have a devastating impact on individuals and their families.

"It is unacceptable and we work closely with police to ensure that criminal proceedings are brought against those who attack front-line staff."

Case studies

Southend senior paramedic Dil Patel has worked for the ambulance service for 12 years.

"I was on a night shift last summer and I was called to an altercation outside some shops. As I arrived the patient was quite aggressive and was being held back by his mates. He was diabetic and agreed to be checked over, but he didn't like it when I told him that I was not giving him a lift home.

"He walked towards me and at that stage the police turned up because he had smashed some windows. He was in the ambulance swearing and he struggled from three police officers and punched me and bit one of the police officers. I had a graze on my chin and I gave a statement to the police."

The man was given an unpaid work order and ordered to pay £100 compensation.

"On average I'm being assaulted at least once a year and it is becoming more common because we are going to more of these types of jobs. You try and do everything you can to avoid being assaulted, but sadly it is part of the job."

Bedfordshire paramedic Lola Arch was assaulted by a man in Luton last July. He was ordered to pay fines and compensation in court. She's worked for the ambulance service since 1999.

"It was July 2015 in Luton and we were given a verbal warning by control about this individual.

"We were so cautious when we went in, but it was a very cramped environment and it was hard to get away. It was horrible and frightening because I thought he was going to strangle me. He pushed me against a wall causing bruising to my head and he threw the heart monitor at my colleague.

"It was not nice giving evidence in court to be near him and to look at him again.

"I had three weeks off work because my confidence crashed and when I came back to work, I did not want to work on my own and my line manager worked with me to build my confidence up. I was fearful of going to similar patients and scenarios. I did not expect it to happen to me."

Emergency Medical Technician Graham Hillman was on duty in Huntingdon, Cambridgeshire, last October when he was called to an intoxicated patient who lashed out and broke his glasses. He was then spat at. His attacker was jailed for 16 weeks and ordered to pay £125 compensation

"It is one of the most disgusting things that one person can do to another. Lashing out is bad enough, but spitting is disgusting. It makes me more wary and realise that not everyone is grateful to see us or fully in control.

"It is not the first time I have experienced violence, but is the first time I felt it needed to be reported and press charges. The sentence validates the view that this behaviour is totally unacceptable. We were off the road for four hours because of what he did.

"As 999 emergency ambulance staff, our only concern for our patients is to help them in every way that we can. We should be able to do this without fear of being attacked, assaulted or having our personal property damaged in the process of doing so."

UNISON pays tribute to ambulance giant Eric Roberts

Eric Roberts, lifelong trade unionist and a giant in the ambulance world, has died after a brief struggle with cancer. He was the President of UNISON, the branch secretary for London Ambulance UNISON branch and a true and loyal friend to so many.

Born in Litherland, a proud Scouser and Liverpool fan, Eric was a man who lived enough – and had stories to tell – for more than one lifetime. From fixing drums for the Beatles, to wine waiter, baker and pots and pans seller – Eric eventually found his way to London. And one day, seeing an ambulance shooting down Oxford Street, he decided that's what he'd like to do. He had found his calling.

For 42 years he served the London Ambulance Service with the passion

and dedication for which he became well-known and was the first ambulance person to be elected as UNISON President – something that was a source of immense pride to Eric, his branch, his family and everyone who knew him.

For many years, Eric was the chair of UNISON's national ambulance sector proving UNISON with a clear vision of how best to protect and represent the UK's ambulance workers during times of rapid change. Just looking through the messages from around the whole country, from fellow activists to chief executives, they are clear testimony to his abilities and skills as a leader within the ambulance service.

But Eric wasn't someone who sought out high office. Ambition wasn't what drove him. Instead, it was an unstoppable desire – a need – to serve people and help people. To represent them and to do his best for them.

To Eric, everyone in the union and the ambulance service had a part to play – and every day he did his job to the best of his ability, and brought out the best in others at the same time. His loyalty to this union was as unquestionable and unswerving as his love for its members.

On a personal note, it is true to say that without Eric I wouldn't be in the position I am representing ambulance workers on a national level. He offered me his guidance, wisdom and counsel when the way forward was not clear and he offered his humour and kindness when times were difficult.

Eric, you will be missed by so many people in so many ways. Rest in peace.

Alan Lofthouse
National Officer I UNISON Health Group

Bravery award for saving great grandmother's life

A Suffolk boy has received a bravery award after helping to save his great grandmother's life.

Nine-year-old George Clarke was staying at Sandra Newton's home in Carlton Colville, near Lowestoft, on 6th August when he heard her shouting in the middle of the night. She was confused and adamant that she didn't need medical help.

However, George phoned his dad who dialled 999 for the 71-year-old who had fallen out of bed and was having a diabetes emergency.

Paramedic Luke Jones, from the East of England Ambulance Service NHS Trust (EEAST) who treated Sandra for her dangerously low blood sugar levels, presented a certificate to the Carlton Colville Primary pupil this week (21st November) praising his life-saving actions.

George said: "She was shouting and had fallen on the floor and I could not make out what she was saying."

Sandra, who has had diabetes for 11 years, was having a severe hypo.

Luke praised George for being "cool and calm" during the emergency.

Following treatment at the scene, he managed to raise her blood sugar levels.

"Had it not been for his quick actions, it would have been a very different outcome," he said.

Sandra added: "I was very lucky. If I had gone to the morning they reckon I would not have woken up. George was brilliant."

From left to right: Paramedic Luke Jones, George Clarke and Sandra Newton

Superbike Legend Returns To Bike4Life

Midlands Air Ambulance Charity, organiser of the much-anticipated Bike4Life Ride Out and Festival 2017, has announced former World Superbike champion and racing legend, Carl Fogarty, is returning to lead the Ride Out on Sunday 30th April 2017.

Now in its seventh year, Bike4Life has grown to become one of the country's most popular biker events. Now over 6,000 bikers take part in

the Ride Out which runs 23 miles from Meole Brace in Shrewsbury to RAF Cosford, home to the Bike4Life Festival, which attracts a further 6,000 people.

Carl Fogarty was the star of Bike4Life in 2015, and is returning in 2017 as part of his continued commitment to Midlands Air Ambulance Charity, which sadly airlifts motorcyclists on a regular basis.

Carl said: "Bike4Life is one of the best biker events in the calendar, and it's all in aid of a very important cause. When I took part previously the atmosphere on the day was fantastic and it was great to so many with bikers, fans and Midlands Air Ambulance Charity's own supporters.

"I'm really looking forward to once again leading the Ride Out, and as registration is now open, I'd urge people to sign up as there are limited places in the Ride Out."

Jason Levy from Midlands Air Ambulance Charity, and chair of the Bike4Life organising committee, added: "We are honoured Carl is returning to the Bike4Life Ride Out and Festival. His career achievements are legendary, and we know he will really help make Bike4Life 2017 be a great success. As well as being a great day out, Bike4Life also aims to raise vitally important funds for our lifesaving service, so I'd encourage anyone thinking of getting involved, to support our event and register now for the Ride Out."

To take part in the Ride Out, led by Carl Fogarty, simply visit www.bike4lifefest.com. It only costs £10 per motorbike (pillions ride for free) to register with all proceeds raised going to Midlands Air Ambulance Charity. For those who don't take part in the Ride Out, entrance to the Bike4Life Festival is £5 per person and under 16s go free.

Bike4Life is run in collaboration with Safer Roads Partnership and West Mercia Police who work tirelessly to promote road safety and to help reduce the number of road traffic collisions across West Mercia. The event is supported by the Central Motorway Police Group, Highways England, West Mercia Police Shropshire County Council, the RAF Museum Cosford and RAF Cosford.

Keep up to date on social media by following Bike4LifeFest on Facebook and Twitter.

Find out more information about the Midlands Air Ambulance Charity by visiting www.midlandsairambulance.com or for more information on the Safer Roads Partnership visit www.srpwestmercia.org.uk

Visit the only daily ambulance news site on the net at:
www.ambulancetoday.co.uk

Paramedic's half-century of saving lives in London

One of the longest serving paramedics in the UK is still saving lives in the capital after 50 years at London Ambulance Service.

Kevin Walker, 70, still rides his bike to from his nearby home to Ilford Ambulance Station where he has spent his whole career, having returned to work part-time after just one month spent in retirement.

"The highlights have definitely been resuscitating people," said Kevin, who was awarded in the Queen's Birthday Honours list for his work as a paramedic. "I joined up because I wanted to try and help people and I still enjoy the job. Being a paramedic makes you feel you're doing something worthwhile."

One of his most memorable moments was saving the life of a woman he knew as a receptionist in one of the hospitals he took patients to.

"When you see someone you know in cardiac arrest, it's not nice," said Kevin. "Thankfully we brought her back and when I was out shopping she came up to my wife and said 'your husband saved my life'."

Before the city had fully felt the effects of a series of clean air acts it was subject to thick 'pea soup fogs' and Kevin recalled how they had to navigate the streets with burning torches to reach patients and take them to hospital in the late 1960s.

He said: "They used to put a third man on the ambulance who would walk in front with a foot-long wax taper. Between walking to the patient and then to hospital they could end up walking about seven miles.

"In those days we didn't do so much treatment; if the patient was badly injured we just had to try and stop the bleeding and get them to hospital as quickly as we could."

The state-of-the art ambulances Kevin uses today, fully equipped to deal with a range of emergencies and navigate quickly through the city streets, are a far cry from the original fleet.

He added: "The vehicles then were old diesels; you could do about 50 miles an hour going downhill with the wind behind you. In the winter they wouldn't start so we had to put a mattress on the only petrol coach in our fleet then push the diesel ambulances around the yard until they started."

Assistant Director of Operations Ian Johns said: "By any measure Kevin is an extraordinary man who has committed his life to making sure people are taken care of."

Bellringer appeals for support to thank Yorkshire Air Ambulance

A bell ringer who suffered serious injuries in a bell tower fall is appealing for support for a special sponsored challenge to thank Yorkshire Air Ambulance.

Robert Wood was doing maintenance work on the 116-year-old bells at Middleham Parish Church, in Wensleydale, when he slipped and fell several feet onto part of the mechanism, impaling his chin on a metal peg.

The impact smashed Robert's jaw and narrowly missed the major blood vessels in his neck. Amazingly, the 62-year-old managed to make his way down the tower to a shocked colleague who called the emergency services.

Fearing major blood vessel and nerve damage, Yorkshire Air Ambulance airlifted the retired environmental health officer to the major trauma centre at James Cook University Hospital, Middlesbrough.

Robert, a regular bell ringer at Ripon Cathedral, underwent a four-hour operation to repair his shattered jaw, which is now held together by metal plates, and spent five days in hospital.

Robert from Ripon said: "The land and then air ambulance were there very quickly and I was just so grateful to be flown to hospital within minutes.."

Robert is attempting a special bell ringing marathon on November 26 at St Thomas-a-Becket Church, Stockton, in a bid to raise the estimated £4,000 cost of his air ambulance flight.

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www.ambulancetoday.co.uk

WAST honours colleagues at Staff Awards 2016

The Welsh Ambulance Service honoured its staff and volunteers at an awards ceremony in Cardiff.

The Lord Lieutenant for South Glamorgan, Mrs Morfudd Meredith, presented awards for Her Majesty the Queen's Long Service and Good Conduct Medal for staff with more than 20 years in the Emergency Medical Service (EMS).

Retirees were also recognised at the service at the SWALEC Stadium, as well as non-EMS staff who had dedicated 20 years or more.

This year, as well as those traditional awards, the Trust introduced category awards – six in total – which are aligned to its new behaviours.

Time was also taken to honour colleagues who have died while on duty and in service.

Speaking at the ceremony, Chief Executive Tracy Myhill said: "I never cease to be amazed and inspired by the professionalism and excellence our staff and volunteers display across all aspects of their work with the Welsh Ambulance Service.

"Our staff awards are a fabulous way to show our appreciation and recognise the sterling efforts of our people."

The recent ceremony also saw the presentation of two special awards.

The Gail Williams Award, which is sponsored by Michael Williams and his daughters Megan and Sioned in memory of his wife and their mother, Gail Williams, pays tribute to those who have provided clinical excellence in the pre-hospital setting.

Chief Executive Tracy Myhill.

This year it was presented to EMS staff Nick Ozzati, Phil Watts and Helen Collins who are all based in Llanelli.

In April they responded to a group call to a young baby in cardiac arrest.

Through their joint efforts they achieved a return of spontaneous circulation and thanks to their actions, the child has now left hospital.

Wiltshire Air Ambulance awarded £1 million towards custom-built new airbase

Wiltshire Air Ambulance (WAA) has been awarded £1 million towards its new airbase.

A 3D image of Wiltshire Air Ambulance's proposed new airbase on land at Outmarsh Farm, Semington.

The £1 million is from the LIBOR fund and was announced by the Chancellor of the Exchequer, the Rt Hon Philip Hammond, during the Autumn Statement in the House of Commons today (23 Nov. 2016).

The LIBOR fund is monies from fines levied on the banking industry for manipulating the LIBOR rate.

The charity is proposing to build the airbase on land at Outmarsh Farm, Semington, near Melksham. It will consist of an Operations Centre for its helicopter and aircrew and base for the Charity Team.

The charity has already been granted outline planning permission for the Outmarsh Farm site and has submitted its detailed plans for the project to Wiltshire Council.

David Philpott, Chief Executive of WAA, said: "We are delighted to have been awarded this £1 million grant from Her Majesty's Treasury towards our new airbase. The funding will be used to complete the building, equipping and fitting out of our purpose-built Operations Centre and will bring together the aircrew, helicopter and charity team onto one site for the first time.

"As has been the case since the charity was established, we continue to rely on donations and grants and make no demands upon the taxpayer to fund our vital service."

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IAA announces March 2017 Conference date

The IAA (Independent Ambulance Association) will be hosting its annual conference on 31st March 2017, to include an AGM for members, in partnership with Healthcare Conferences.


Alan Howson, IAA Executive Chairman

IAA Executive Chairman, Alan Howson is confident that next year's event will build well upon the success of recent IAA conferences which attracted an impressive mix of UK and overseas ambulance delegates from all parts of the ambulance sector. "Creating a forum for healthy debate and sharing ideas among ambulance deliverers is a key function of the IAA, so we're looking forward to a day of robust and frank dialogue between our members and our many other healthcare partners", he said.

The morning session will feature presentations from:

- Brendan Fatchett (Chief Executive) - 365 Response and the HealthCab Platform
- Grant de Jongh (Chief Executive, HPA) - The Health Practice Associates Register
- Kate Lawson (Consultant) - Care Quality Commission new approach to inspection
- Julian Rhodes (Chairman, NENAS) -Trailblazer Apprenticeships

The afternoon is planned as a networking opportunity for delegates, exhibitors and Speakers, the latter available for one-to-one conversations and/or 'clinics' for interested delegates to pick up any specific points or questions.

More detailed information and booking arrangements can be found at: www.iaauk.org/Events

EEAST launches new dementia strategy

An ambitious strategy has been launched by the region's ambulance service to improve the care and experience for people with dementia.

Bosses at the East of England Ambulance Service NHS Trust (EEAST) say it will develop a skilled and effective workforce able to champion compassionate person-centred care and recognise the early signs of dementia.

And it has pledged to become a dementia-friendly organisation.

The strategy was launched at the latest Board meeting in public by one of the service's area clinical leads Duncan Moore, with support from the Alzheimer's Society.

It's been implemented to support the Government's National Dementia Strategy to ensure all people living with dementia and their carers should live well with dementia. Dementia is incurable and symptoms can include severe memory loss, mood and personality changes and behaviour that challenges others such as serious confusion, agitation and aggression.

The work over three years will be done in partnership with charities and health and social care statutory dementia care providers, as well as clinical commissioning groups and voluntary organisations.

Duncan said the collaborations will aid and support the work and contribute to improving the health and outcomes of those with dementia, and their carers: "Dementia is one of the greatest challenges facing our ageing society – there are more than 82,500 people in the East of England living with a diagnosis of dementia.

"Our patient transport services routinely work with people living with dementia, and of course we have to make emergency responses in the community to affected families and individuals so in our capacity as an ambulance service and seeing people living with dementia every single day we needed to put it at the centre of our work. It's the right thing for us to put a massive emphasis on developing our organisation to become dementia-friendly."

Visit: www.alzheimers.org.uk/ or www.dementiauk.org/

Winners! The nation's finest clinicians, aviators and fundraisers are celebrated at the Air Ambulance Awards of Excellence

Over 250 guests celebrated the best and brightest from the air ambulance community last night at the national Air Ambulance Awards of Excellence 2016.

Awards hosts, BBC News reporter and presenter Sophie Long and Helicopter Heroes presenter Rav Wilding handed out 11 Awards to outstanding individuals and teams, whose stories were inspirational, astonishing and humbling. The awards, which are independently judged, went to pilots, paramedics, doctors, fundraisers and volunteers who collected their trophies at a ceremony held in central London last night.

An enthusiastic audience listened to the remarkable stories of each shortlisted nominee, all of whom demonstrated excellence and commitment well above and beyond the call of duty. Every winner was cheered to and from the stage, not least 6 year old Isobel Pilsworth, winner of the Outstanding Young Person Award, whose incredible fundraising activities after her Dad survived a cardiac arrest captured the hearts of the audience.

Chair of the Judging Panel, Jim Fitzpatrick MP, said: "The stories we heard about the work being done by the nation's air ambulance services were truly remarkable. What a tonic these stories are in turbulent political times. I would like to congratulate every single one of the nominees and send a message to the winners of the Awards that they truly are examples of what can be achieved through teamwork, expertise, courage and determination."

Below is a list of all the winners:

Air Ambulance Campaign Award
WINNER: Hampshire and Isle of Wight Air Ambulance
Sponsor: Lottery Fundraising Services

Charity Staff Member of the Year
WINNER: Susie Croft
Sponsor: Milestone Aviation Group Ltd

Charity Volunteer of the Year
WINNER: Jamie Edghill
Sponsor: Tower Lotteries

Air Ambulance Doctor of the Year
WINNER: Dr Mark Wilson
Sponsor: Leonardo Helicopters

Innovation of the Year Award
WINNER: Devon Air Ambulance Trust
Sponsor: Sloane Helicopters

Lifetime Achievement Award
WINNER: Alastair Wilson
Sponsor: Specialist Aviation Services

Air Ambulance Paramedic of the Year
WINNER: Erica Ley
Sponsor: BMW Government and Authorities Division

Air Ambulance Pilot of the Year
WINNER: Steven Norris
Sponsor: Safran UK

Special Incident Award
WINNER: Wales Air Ambulance
Sponsor: Airbus Helicopters

Outstanding Young Person Award
WINNER: Isobel Pilsworth
Sponsor: Babcock MCS Onshore

AAA Chairman's Award
WINNER: Bill Sivewright

Air ambulance chief executive condemns pranksters who blinded flying medic with laser

The head of the Wales Air Ambulance has condemned pranksters who shone a laser beam into the cockpit of its helicopter as it flew on an emergency mission, temporarily blinding its on-board doctor.

The aircraft was attending an emergency call on the evening of Saturday 5 November (Bonfire Night) when it was targeted several times over Swansea by an apparently commercial-strength laser beam.

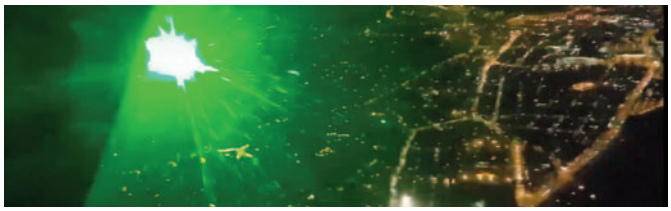
The aircraft's flying doctor was temporarily blinded in the incident, from which he took several days to recover.

Video footage captured the moment the green laser beam illuminated the inside of the cockpit.

The video file captured by the on-board camera, has now been provided to South Wales Police.

Wales Air Ambulance chief executive Angela Hughes said: "Our aircraft was flying a rescue mission and the doctor on board was temporarily blinded. This could have been catastrophic. People get laser burns to their eyes and are blinded for life. It is beyond belief how anyone thinks it is clever to do this."

"The pilot managed to avert his eyes in time and could carry on flying the aircraft."



The incident happened after dark on Bonfire Night, as the air ambulance was returning to its base in Dafen, Llanelli, following a call-out in Cardiff.

She added: "The aircraft was flying at 2,500 ft over Swansea Bay. The fact a laser reached it at that height shows the beam was much stronger than any produced by a standard pen laser.

"Someone set out deliberately to try to disable our aircraft.

"We have passed the video footage to South Wales Police and I appeal to anyone who knows who did this to contact the police."

Benzodiazepine and related drug use increases hip fractures in persons with Alzheimer's disease

The use of benzodiazepines and related drugs increases the risk of hip fracture by 43% in persons with Alzheimer's disease, according to a new study from the University of Eastern Finland. The hip fracture risk was investigated in community-dwelling Finnish persons with Alzheimer's disease.

In total, 21% of persons with Alzheimer's disease initiated benzodiazepine and related drug use during the study. During benzodiazepine and related drug use, 2.5 hip fractures occurred per 100 person-years whereas without drug use, the incidence was 1.4 hip fractures per 100 person-years. The use of benzodiazepines and related drugs increased the hip fracture risk especially during the first six months of drug use. There was no difference within the drug group, as benzodiazepines increased the hip fracture risk as much as benzodiazepine-related drugs.

Additionally, long-term hospital stays exceeding four months after hip fracture were more common in persons with Alzheimer's disease who used benzodiazepines and related drugs at the time of hip fracture than in persons who did not use such drugs.

Treatment guidelines in different countries recommend that behavioral and psychological symptoms of dementia should be treated with nonpharmacological options. Benzodiazepines and related drugs can be used in infrequent or short-term treatment of symptoms. The results of this study highlight the importance of the guidelines to avoid adverse events associated with benzodiazepine and related drug use.

The study was based on the MEDALZ (MEDication use and ALZheimer's disease) cohort, including all Finnish persons diagnosed with Alzheimer's disease between 2005 and 2011, amounting to 70,718 persons. This study involved 46,373 persons who had no history of hip fractures and who had not used benzodiazepines and related drugs during the year preceding the study. The follow-up time in the study was up to five years.

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St John New Zealand responds to third major earthquake in 6 years

St John New Zealand faced its biggest incident since the 2010 and 2011 Canterbury earthquakes when a 7.8 magnitude earthquake struck the South Island at two minutes after midnight on Monday 14 November. The incident was rapidly escalated to national level with Civil Defence issuing a tsunami warning and land threat. Much of New Zealand was affected, including the capital, Wellington, where many high rise buildings in the central city have since been demolished. A state of emergency was subsequently declared in the worst affected areas.

St John's National Crisis Coordination Centre was activated in the early hours of Monday morning led by Director of Clinical Operations Norma Lane, and worked closely with Civil Defence, Government and emergency and health agencies. Local St John Emergency Operation Centres had been set up in the South Island to manage the response on a local level.

There were two fatalities as a result of the quake, and infrastructure damage was extensive. The worst affected was Kaikoura, a South Island town of around 2,000 people and 1,000 tourists, where road access was cut off for several days, and the community was without power, water and telecommunications.

A team of St John emergency medical technicians, paramedics and intensive care paramedics travelled with the HMNZS Canterbury to provide medical support.

Kaikoura ambulance personnel moved their families to higher ground, before heading back into the town to help with the rescue and recovery effort.

As the scale of the damage in Kaikoura became known extra ambulance personnel were transported into the area by helicopter (there was no road access) to support local St John personnel and other health professionals. Air ambulance cover was maintained in the area 24/7 and St John supported a large scale evacuation of trapped residents and tourists from Kaikoura by naval vessel the HMNZS Canterbury two days after the quake.

Other challenges for St John included the immediate need to relocate staff, resources and emergency equipment to higher ground in order to maintain response capability in the event of a significant tsunami. A major weather event hit a different part of the South Island, requiring extra resourcing, and the quake damaged communications infrastructure.

A strong focus on emergency planning, and lessons learned in Canterbury ensured St John New Zealand was ready to respond quickly and effectively when the Kaikoura quake hit.

Photographs courtesy Blair Andrews

Physio-Control launches Automated External Defibrillator (AED)

Physio-Control, a part of Stryker, is launching the company's newest Automated external Defibrillator (AED) in various european countries: the LIFEPAK® CR2 Defibrillator with LIFELINKcentral AED Program Manager.

Sudden cardiac arrest is a leading cause of death globally. Early cardiopulmonary resuscitation (CPR) and quick access to defibrillation

can improve survival rates. The new LIFEPAK® AED Response System offers new technology and tools for CPR and defibrillation and…

- Introduces an attractive new design – designed to be extremely easy to use by bystanders and rescuers
- Launches new technology that supports high quality CPR
- Has been demonstrated to offer faster time-to-first-shock
- Deploys a new remote monitoring and connectivity capability – Using the online LIFELINKcentral™ AED Program Manager, the CR2 can be remotely monitored and can even, in some areas, transmit a heart rhythm to EMS professionals before they arrive on the scene.

Find more technical information about the product: www.physio-control.com/cr2

Reduce laundry costs with Orvecare

Patient specific linens are ideal for today's Ambulance Service and A&E Departments where linen resources are constantly stretched.

Orvecare patient specific linens are designed to stay with the patient from collection to either discharge or ward admittance. This reduces infection control and cross contamination risks whilst negating the use of a hospitals laundry resources. The fitted cot sheet is able to laterally transfer up to 35 stone in weight.

At a recent city 10k run the hospital providing A&E cover had stockpiled linen in readiness of the event. In reality no laundered linen was required. Patient specific linen stayed with each patient from collection to initial treatment centre, during transfer, and into A&E should further treatment be required. This reduces the need for the hospitals laundered linen resource.

Working with clinicians has aided product developments to include packing and storage. All products are individually packaged, enabling each patient to receive the products that will offer them the most benefits during their initial treatment and evaluation process. Ambulances can be cleaned and redressed using their own linen reserves, alleviating the need to search for clean laundered linen from an already overstretched A&E Department.

Also ideal for event and festival work where one set of linen, rather than multiple laundered items, would be used. With indefinite storage times patient specific linens are ideal for emergency preparedness, resilience and response planning.

Used linen can be disposed of, as long as it is not clinically soiled, in the recyclable waste stream.

For further information visit: www.orvecare.com
or telephone: 01482 625355
Malmo Road, Sutton Fields, Hull, HU7 0YF

Winter Pressures Removed by Bluelight UK

Bluelight UK Ltd has a number of Patient Transport Service (PTS) Units available in stock at their depot near Manchester. These vehicles are ready for use and come in varying O&H configurations.

Fitted with removable stretchers, the floor can be readied for extra wheelchairs or seats and with a maximum age of 3 years, these vehicles should fit nicely into any ambulance service's fleet. These vehicles are available for hire or sale with the usual peace of mind you would expect from one of the UK's leading suppliers.

Bluelight UK has many vehicles also for sale on site and can arrange delivery to your premises anywhere in the world.

Bluelight UK Ltd would like to take this opportunity to wish its customers and Ambulance Today readers a Merry Christmas and a Happy New Year

If you have a vehicle off the road, need a vehicle as a stopgap or just need a vehicle, log onto their website: www.bluelightuk.co.uk for upto date stocking information.

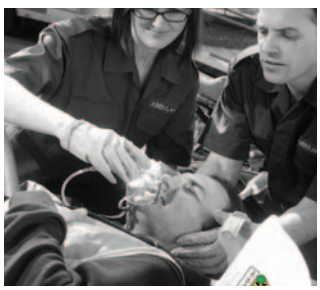
Auxilium Systems team up with Security Firm to support their staff

Auxilium Systems is now providing cover and support for a Bournemouth based security firm, PPE - www.ppesecurity.co.uk.

As a security firm, their staff are based all over the southwest and all work remotely. They feel that our system enables them to provide a higher level of support to their staff, for them to enter information into the system.

Edit

All PPE Security staff have been provided with an Auxilium Number, which they then complete. When the staff are entering their information, they give PPE permission to see their information as an authorised reader. Therefore if there is an accident or if a member of their staff is taken sick



PPE can easily look at the system, and contact the person's emergency contact and let them know.

PPE are in the process of changing their uniform so that the Auxilium Logo is displayed. This is a prototype of the ID badge which their staff will also carry.

They value their staff and believe that this system will provide them with extra support. It won't be used very often but when it is, it will save time, money and potentially lives!

If you know of a company that could use this system in a similar way please do tell them about us or ask them to get in touch:

info@auxsys.uk

www.theauxuilumsystem.co.uk

Visit the only daily ambulance news site on the net at:
www.ambulancetoday.co.uk

Stryker Power-LOAD Clinical Experience Vehicle: Moving Forward

Stryker EMS is a global provider of patient transport products. If you are working in emergency services, you may be at risk of injury. Whether caused by sudden, traumatic acute failure or cumulative trauma failure, injury cannot only shorten careers but may also reduce operational efficiency.

Stryker EMS is dedicated to delivering solutions for real industry issues that help reduce risk of injuries to the caregiver and patients alike. We have focused our efforts to address high risk injury areas including: transferring a patient up and down stairs, raising and lowering a patient on the cot, and loading and unloading into and out of an ambulance.

Power-LOAD System: Loading and unloading at the touch of a button

The Power-LOAD cot fastener system improves operator and patient safety by supporting the cot throughout the loading and unloading process. The reduction in spinal load helps prevent cumulative trauma injuries.[1] Power-LOAD wirelessly communicates with Power-PRO cots for ease of operation and operator convenience.

Stryker Power-LOAD Clinical Experience Vehicle ready to be trialed in the field

Stryker Power-LOAD Clinical Experience Vehicle made its debut at Emergency Services Show 2016.

The Stryker Clinical Experience Vehicle has been designed as a state of the art ambulance and is fully equipped with Power-LOAD System and a Power-PRO XT with XPS-expandable patient surface.

Our goal is to offer a simple, efficient and accessible opportunity for EMS Services in the UK to experience the benefits of this advanced power loading solution in the field; without the need for a donor vehicle.

1. Evaluation of Medical Cot Design Considering the Biomechanical Impact on Emergency Response Personnel 2013 – T.K. Fredericks, S.E. Butt, K.S. Harms, J.D. Burns XXVth Annual Occupational Ergonomics and Safety. Conference.

For further information please contact your local representative at: ems.info@stryker.com

Body Worn Camera solutions for first responders

Edesix is a leading supplier of Body Worn Camera solutions designed to help solve complex industry challenges for Emergency Services workers.

Its all-encompassing solution, which includes the VideoBadge paired with VideoManager software, has proven to deter aggression and protect those working on the frontline, but also facilitates the creation of secure, tamper-proof video and audio evidence when required.

Body Worn Cameras from Edesix are currently used by Police, Firefighters, Paramedics and Air Ambulance crew to audit new protocols, identify best practice and evaluate new equipment. Edesix VideoBadges have been described as enabling "truly ground-breaking work" work by paramedics at the Resuscitation Research Group.

"VideoBadge is revolutionising the way we optimise high performance emergency teams" Gareth Cleg, Resuscitation Research Group

If you'd like to learn more about the Edesix Body Worn Camera solution, then contact:

Email: sales@edesix.com

Tel: 0131 510 0232

for more information, or to request a trial.

Are your vehicles ready for snowy weather?

Winter has arrived and now is the time to ensure that your vehicles are prepared.

UK snow is occasional and usually arrives without much notice. When it does come, even if only for a day, it's almost always disruptive. The main highways will be ploughed and salted but rural side roads and housing estates probably won't be.

AutoSock are already being carried by many fire, police and ambulance services as an affordable solution for keeping the show on the road, including for use on vehicles which are using all-season or winter tyres.

AutoSock are textile 'socks' which are pulled over the driving wheels of vehicles which need extra grip on ice or snow, before or after they've got stuck. The grip is achieved through maximising the dry friction available, using specially developed hard-wearing textiles. There's only one possible way to fit AutoSock, so no special training is needed. AutoSock are supplied in pairs, are reusable time and again, weigh less than 1kg, and take up minimal space – a set of AutoSock is about the size of a folded shirt.

Vehicles which carry AutoSock should be able to rescue themselves if they get stuck in snow. They'll also be ideal for getting your key people to work in snowy weather, and getting them safely home again.

For more information: AutoSock are distributed in the UK and the Republic of Ireland by John Jordan Limited. See www.autosock.co.uk for more details, or contact our Fleet Sales Manager, Andy Greensmith, via andy.greensmith@john-jordan.co.uk or 01539 622406.

Exciting End to 2016 for Jigsaw Medical

2016 has been a special year for Jigsaw Medical but the final 6 months have been particularly impressive with multi-million-pound investment, new appointments and unprecedented growth.

Firstly, Jigsaw is delighted to announce the appointment of Paul Jones as Director of Education and Training. Paul has an extensive CV; including as an NHS Paramedic Tutor, Programme Lead for a higher education Paramedic course, as well as authoring several publications and sitting on the Research & Development Committee at the College of Paramedics.

With over twenty years in clinical practice and more than a decade delivering and managing in education, Paul brings a wealth of experience and expertise to Jigsaw.

Paul will be directly responsible for leading, developing and growing our Training Division and his skills and expertise will facilitate new courses within the division.

Furthermore, we are also delighted to announce that we have relocated our head office to Cheshire Oaks in Ellesmere Port.

All teams will make the move, however, given the extra capacity, Jigsaw will be able to position teams much more strategically, improving internal communication and external efficiency.

The increased size and investment will also mean that Jigsaw can introduce essential office facilities and services that weren't previously possible, such as an increased number of meeting rooms, a reception area, and a kitchen and dining area as well as other features.

Jigsaw is also delighted to confirm that the Education and Training team will also make the move from their training centre in Chester to a brand-new Training Academy.

For further information, contact Jigsaw Medical:

Tel: 01829 732615

Email: info@jigsawmedical.com

Web: www.jigsawmedical.com

Visit the only daily ambulance news site on the net at:
www.ambulancetoday.co.uk

FERNO IPTS is the Future of EMS

We cannot thank the people of our Ambulance Services enough for the genuine interest that has been given to our Integrated Patient Transport System (IPTS). Having something so different, with so much more advanced innovation meant that we needed to think outside the box, so for the first time in FERNO UK's history we expanded our team to include an AMBULANCE FLEET expert.

Richard Smith, who was previously Head of Fleet at YAS with over 20 years vehicle experience, a keen mind for fleet transformation and with the brief to design and create the first UK IPTS Ambulance. Together we can change the delivery of emergency care for the better.

We are looking forward to the exciting times ahead and if you have not already checked out our IPTS Ambulance to see the future delivery of EMS, please call us on +4(0) 1274 851999,

Here's wishing you a Happy Christmas and a Prosperous & Healthy 2017

KTIB insurance for the independent ambulance sector

is an exciting insurance initiative designed for the rapidly expanding Independent Ambulance market.

Covers

It's essential that your cover is appropriate for your needs and will respond in the event of a claim. We believe that this can only be accurately assessed by working in close partnership with our clients to fully understand the complex requirements of your business. We are able to provide cover for your whole insurance portfolio including, but not limited to

- Motor Fleet
- Motor Insurance
- Medical Malpractice
- Professional Indemnity
- Employers Liability
- Public & Products Liability
- Directors & Officers Liability
- Airside Liability
- Commercial Combined, including All Risks
- Group Personal Accident
- Cyber Liability

Services

We tailor your insurance needs and offer the following enhanced services

- RIAMT
- Fleet Risk
- In-depth Claims Analysis
- Online claims reporting
- Dedicated team
- Premium Payment Plans

For further information contact Rob Rowley:
Telephone: 01603 218230
E-mail: rob.rowley @ktibambulance.co.uk
Or visit: www.ktibambulance.co.uk

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Code Blue Specialist Vehicles: the new force in Ambulance and Specialist vehicle supply

We offer a range of designs, on a multitude of chassis options, complete with European Community Whole Vehicle Type Approval.

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Code Blue Specialist Vehicles individually tailor the design of every vehicle around our customers' requirements, giving medical professionals a clinical workspace which has unparalleled ergonomics, exceeds the highest safety standards, and is easy to clean.

Due to the vast manufacturing capability of our conversion facility we can produce in excess of 2000 units per year, with very short build times. We can also research, develop, and certify vehicle engineering solutions for our customers where required. Most parts that go into our conversions are built in house, from seats to circuit boards, ensuring that our stringent quality standards are met.

Code Blue SV also offer a range of selected patient handling and treatment equipment from our partners at Promeba Medical and Rescue.

To find out more about why Code Blue Specialist vehicles are becoming the 'go to' choice for medical professionals in the UK and overseas, contact us on: 0800 061 4785 Email-chris@codebluesv.com www.codebluesv.com

ERDT providing driver training world-wide

FutureQuals Level 3 Certificate in Emergency Ambulance Driving across the UK and Internationally accredited training Worldwide at your location to meet your needs.

Emergency Response Driver Training Ltd (ERDT) is a FutureQuals approved centre providing the Level 3 Certificate in Emergency Ambulance Driving (QCF) and the Level 2 Award in Ambulance Driving (QCF). These qualifications have been developed to meet the requirements of the UK NHS Ambulance Trusts, it also meets the requirement for ambulance service drivers to claim exemptions under the Road Traffic Act and to operate to the specification of the high speed driver training regulations of the Department for Transport.

In October 2016 ERDT delivered the first International Diploma in Emergency Response Driving Instruction accredited by The Royal Society for the Prevention of Accidents (RoSPA) to the Gibraltar Ambulance Service. The course is designed to provide the knowledge and skills required to deliver and assess advanced driving techniques and Ambulance emergency response driving training, it is based on individual competencies as per the UK High Speed Driver Training codes of practice.

We currently deliver training to over 55 Emergency Services across the UK and worldwide, including Ambulance Services in the UK, Isle of Man, Gibraltar, Malaysia and Qatar.

We provide a free theoretical on-line pre-course study facility which is designed to assist the candidate pre-course and post course learning.

If we can assist you with your training needs at your location please email: mail@erdt.co.uk or visit: www.emergencyresponse drivertraining.co.uk

Email: mediapack2017@ambulancetoday.co.uk to get your free *Ambulance Today* 2017 digital media pack

Visit the only daily ambulance news site on the net at:
www.ambulancetoday.co.uk

Rugged tech leader Xplore launches R12 tablet

Xplore Technologies, the manufacturer of the world's widest range of high-quality rugged tablet computers, has launched the XSLATE R12 detachable rugged tablet PC in the UK - and it is seen as being ideal for emergency services applications.

Key features include advanced communications capability, and noteworthy is the ease with which it transforms from a tablet, to a notebook or desktop with a keyboard, and back.

Xplore incorporated specific customer feedback into the 12.5" rugged tablet design making it highly suitable as the primary computing device for emergency services.

The XSLATE R12's customer-requested features include antenna pass-through capabilities, an RJ-45 + Serial Port dongle and a Bluetooth-enabled keyboard that magnetically stows on the back of the tablet even when docked. It has an optically bonded 800 Nit "View Anywhere Display". It is also designed to sync with existing back office systems and software to deliver real-time data via multi-authentication access.

It has pen and touch capabilities, and backed by a Bluetooth-connected

keyboard , and the standard hot-swappable battery is critical for long shifts while the large, outdoor-viewable display is protected by Corning Gorilla Glass for damage-resistant, day-and-night viewing.

"The antenna pass-through technology will allow ambulance services to prepare and share incident response plans from vehicles with a greater efficiency and effectiveness than ever before," said Steve Priestley of Xplore.

Xplore has been exclusively manufacturing powerful, long-lasting, and customer-defined rugged tablet PCs since 1996.

For more info please contact:
www.xploretech.com/uk/

First Call for Equipment Resale/ Disposals

What does your Emergency Services Organisation do with redundant equipment? You could be missing out on a source of Revenue! The Hilditch Group has been selling redundant medical and general assets for the emergency services and government departments for 25 years. Whilst most ambulance and hospital trusts already use the company, they are less well known to the Fire and Rescue Services who may not be maximising their returns on the disposal of equipment. Items like mobile generators, water pumps, decontamination trailers etc. as well as vehicles

are in high demand with Hilditch's International buyers.

When you mention auctions most people think of antiques, or cars with "interesting" histories, along with gloomy auctions rooms and dealers in sheep skin coats; but Hilditch have been instrumental in developing the market for emergency services and healthcare devices over the last 25 years. They offer a sophisticated service, which is backed by their medical engineering division.

Hilditch Marketing Manager Barney Greig says "We have a strong offering for the emergency services sector, and having worked with Ambulance and Hospital Trusts for 25 years are looking to provide our services to the wider Emergency Services and Rescue sector. The resale of medical devices and emergency services equipment provides a significant revenue stream to many organisations".

Their sales are a great way to buy used medical equipment and machinery at excellent prices. All sales are featured on their website www.hilditchgroup.co.uk/Sales. Their Medical Engineering Department offers servicing and repairs of equipment if required to assist buyers.

They hold a number of medical and general auctions every month and have some excellent product coming in the next few months – including Zoll E Series defibrillators and significant ambulance lease fleet disposals.

Contact the team at Hilditch to discuss the sale of your equipment:
T: 1666 822 577
E: sales@hilditchgroup.com
or view their sales online at:
www.hilditchgroup.com

Oli to Oil the Wheels for NMI's Ambulance Activity

NMI Safety Systems have recently announced the arrival of Oliver Shaw who has joined the sales team to be part of their Ambulance and PTS project.

Speaking about the new appointment, MD, Ilan Alfassa said "We are very pleased to be able to bring Oli on-board, his appointment allows NMI to be more proactive in both the Ambulance and Community Transport markets."

NMI are a family owned business and one of the leading suppliers of products for both seated and wheelchair users. Their products are currently in operation with multiple Ambulance Trusts, Private Ambulance companies and Community Transport Services.

All products are manufactured and tested on site to the highest standard, earning them the Queens Award for Enterprise in Innovation 2008.

Oliver expressed his delight at joining NMI, saying "I am thrilled to be part of such a well-established company and I look forward to helping push NMI to be the preferred supplier within this industry."

For more information contact us on:
020 8801 5339
or sales@nmisafety.com
or visit www.nmisafety.com

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