August 2019

FPHC Newsletter

Welcome to the Faculty of Pre-Hospital Care newsletter! Focus is on Police and Students this quarter, two groups heavily involved in pre-hospital activities on a day-to-day basis.

CONTENTS

Lakshmi's HEMS Elective experience

RING RING. RING RING. 'Hi, I've got a case for you, multi-casualty RTC in Essex'.

With limited details, myself and the EHAAT team swiftly put our helmets on, boarded the aircraft, and made our way to the scene. Once we arrived, the critical care paramedic (CCP) and pre-hospital doctor made a rapid evaluation of the scene, triaged the casualties, and got handovers from the road paramedics and the fire & rescue team already present.

One of the cars involved contained an entire family and was completely smashed on the driver's side, thankfully all the patients had self-extricated from the vehicle and none were in a critical state. The fear and worry amongst the family members and spectators was palpable, and I could not help but sympathise with the shock and anguish they were experiencing. The other car involved in the collision had received most of the impact. When we had arrived, the patient was in the process of getting extricated by the fire and rescue team, whilst simultaneously being managed medically, as we were trying to get a clear history, establish pain levels and ascertain the type of injuries the patient had sustained. Whilst this was happening, the police had arrived, we handed over to them and they began to close the road and block access.

Once the patient was safely extricated from the car, he was placed on the trolley and an A-E assessment was initiated. We placed monitoring on him, cannulated him and gave him fentanyl to manage his pain. From the initial assessment, it seemed that this patient had sustained a femoral fracture.

On initial assessment of the family, there were no immediate concerns, however, one of the family members began to complain of worsening abdominal pain. After discussion, we decided to take the suspected femoral fracture patient to the local emergency department (as opposed to a major trauma centre [MTC] for definitive management) and the family were directed here as well.

When we arrived on scene, it was busy and I felt overwhelmed. Intriguingly, I did wonder how we as a HEMS service would slot into the present situation, as there were already so many teams present. However, the HEMS team I was on shift with, calmly assessed the entire scene, got a handover from the paramedics and fire service already on scene, and began directing and delegating tasks, slotting into the situation seamlessly.

I liked the encouragement and support between our HEMS team and the other medical teams present, as these big cases provide valuable learning opportunities for clinicians. Despite the chaos, this was not neglected, and learning was still achieved, especially as the road ambulance team was relatively junior.

Some of the challenges that came to light, were the difficulty in keeping tabs on the entire situation, and other casualties present, whilst not getting drawn into the one patient you are treating. This is an added layer of complexity I did not fully appreciate until now.

From this case, I have noted that qualities such as being perceptive, remaining calm, thinking rationally, being a clear communicator, as you will be dealing with various teams, patients and relatives are critical in succeeding in a career in PHEM.

RING RING. RING RING. 'Hi, I've got a case for you, a 45-year-old female has fallen out of the third floor of a building.

As it was past day light hours, the helicopter was offline, however, the rapid response vehicle (RRV) was online, therefore we made our way to the RRV, and blue lighted our way to the scene.

Once we arrived, we received a handover from the road paramedics, who had transferred the patient from the ground into the ambulance, put her on monitoring and put a pelvic binder on her. We assessed this lady, who was intoxicated, and gave her analgesia. However, we were worried about head injury due to the suspected mechanism of injury, and as she had Glasgow coma score (GCS) of 13. After discussion with the on-call consultant, we took her to a MTC for her definitive management.

This case highlighted to me the complexities in assessing GCS in patient. Not only is it subjective to a certain extent, but specific to this patient, her reduced GCS could have been attributable to intoxication or head injury. This is turn clouded the root pathology of this patient, and rendered difficulty in the decisions surrounding her further management.

I have found handing over well challenging during my years at medical school. However, as I develop more clinical experience, I look forward to being able to convey salient points in a timely coherent manner, and having the knowledge of what I can safely omit when I handover to other teams.

Read Laskhmi's full report and watch an exciting video relating her experience on our website!

Week in Edinburgh

The week I spent in Edinburgh was incredibly insightful and enabled me to see first-hand what happens behind the scenes at the Royal College of Surgeons. The first day was spent with the admin team, who kindly showed me around the college and I learnt about the Intercollegiate Board of Training in Pre-Hospital Emergency Medicine (IBTPHEM) from an administrative perspective (and found out what I can do to make the administrative process easier!) and learnt about various diplomas and courses available, which is incredibly exciting and has highlighted the endless possibilities within PHEM. I also sat in on the examiners meeting, and the IBTPHEM training committee meeting which discussed PHEM training across the different deaneries.

However, what I found most useful was supporting the Diploma in Immediate Medical Care (DIMC) and Fellowship in Medical Immediate Care (FIMC) exams. I was an actor for both exams, which was incredibly insightful, as I had the unique experience of encountering first-hand what the examiners are looking for in the OSPEs and what marks are allocated for, which was very useful as I hope to sit these exams in the future. Additionally, I now have an appreciation for all the work that goes into preparing the exams to ensure fairness yet clinical rigor. It was a genuine privilege to support and be a part of these exams, and I look forward to doing it again in January.

Lakshmi Ananth

Photo caption: During one of my flying shifts, I left my thermal top at my accommodation, so EHAAT kindly gave me one, however under one condition… This was, when I did my other elective placement and travels abroad in Central America, I would make sure to wear it, even if it was 35 °C! And that I did, that I did.

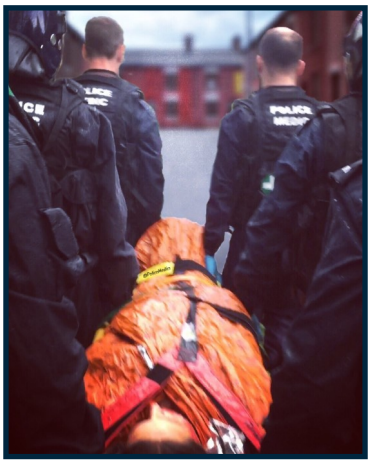
Police medics

The term ‘D13’ has become synonymous with advanced first aid in the police over the last decade, but in reality this is the one module of a three month-long initial firearms course that is concerned with pre-hospital care in the tactical environment, and delivery of casualty care in a policing context extends well beyond the firearms arena.

The first documented police first aid courses took place in London in 1878[1], and by the introduction of the National Health Service in the late 1940s the police in many areas had been responsible for the provision of ambulance services for seventy years[2].

It was the cumulative effect of the professionalisation of firearms policing, the volume of officers injured in the urban riots of the early 1980s and the poor first-aid decisions made at the murder of Stephen Lawrence in 1993[3] that prompted the national police First Aid Learning Programme (FALP) we see today. Initially consisting of four modules, the highest of which was at First Aid at Work level, it soon became apparent that there were areas of policing where the risk was such that higher skillsets were required. Forces developed these on an individual basis until, assisted by the Faculty of Pre-Hospital Care, the then Association of Chief Police Officers and National Police Improvement Agency eventually introduced a fifth module. FALP Module 5 now provides a ‘menu of options’ from which forces can train officers working in higher risk environments to provide casualty care[4].

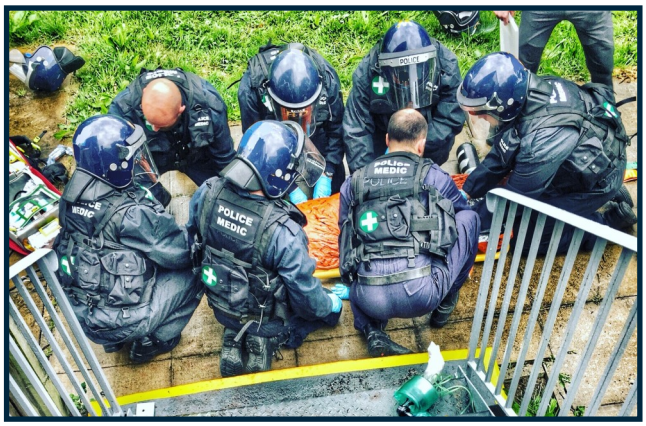
It is probably pertinent at this juncture to look at why the police need to be able to give first aid – it may not be as obvious as many would think. Until the late 1990s the police were not subject to the same health and safety legislation as other organisations, but they are now obliged to make first aid arrangements for employees who may become ill or injured[5]. The law does not make any exemption for difficult circumstances or level of injury, so the police must be able to ‘look after their own’ in every policing environment, and the level of first aid provided must be commensurate to the risk they face. There is also an obligation in law and internal policy, that the police consider those affected by their work, in reality this is primarily those they use force on[6]. The police have a core duty to save life and have a positive duty around



the right to life under human rights legislation[7], although the extent to which they do this is a matter of some debate, given that to take it to its ultimate conclusion would see the reintroduction of police ambulances.

Delivering on the Police Medic mantra 'the basics, done well, always', officers with pre-hospital care skills at Levels D and E of the FPHC's skills framework can now be found across public order (riot) policing, marine policing, working at height, covert units and roads policing teams – all environments where the injury potential to the police, or to the public as a result of the police action, is deemed to be higher risk. This has been recognised by the FPHC who in 2013 moved away from using 'D13' as a title, re-designating their training as 'Clinical Material for Police Officers in Specialist Roles'. Such is the positive development in police first aid that in a public order context we may see officers deployed in a protected vehicle – one designed to withstand thrown objects and petrol bomb attack – with a full trauma pack, oxygen, AED, scoop stretcher, vacuum mattress and inhaled analgesia supporting injured officers on the front line of a riot, provide basic life-saving interventions, then packaging and transporting a casualty to a rendezvous point with healthcare professionals away from the threat area.

Whilst the College of Policing's core syllabus provides a minimum standard for officers, under clinical governance some forces have progressed beyond this, and some officers have taken external qualifications such as the FPHC's postgraduate level Diploma in Remote and Offshore Medicine. Because governance is done on a force by force basis, exact skills and equipment used does vary across the country.



When not engaged in their specialist roles, the police officers trained and equipped to deliver advanced levels of first aid routinely use these skills for the benefit of the public at 'routine' police incidents such as road traffic collisions, assaults at the like; in fact these deployments account for more medic interventions than in the specialist roles for which they were intended[8], continuing a proud 141 year tradition of the police saving lives.

Nick M.

Nick is a police officer, and the operational lead for medics in his force. On a national level he seeks to encourage evidence-based practice within the specialism, and to build interoperability with other pre-hospital care providers.

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[5]Health and Safety at Work Act 1974, available at https://www.legislation.gov.uk/ukpga/1974/37, accessed on 15th November 2018
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[8]Hartley, F.L., Howells, A., Thurgood, A, Hall, F.J. and Porter, K.M. (2017), Medical training for police officers in specialist role (D13): A retrospective review of patient report forms from 2010 – 2015, *Trauma*, available at https://journals.sagepub.com/doi/full/10.1177/1460408617707548, accessed on 15th November 2018

Live from the FPHC Office

A new manual

The Faculty of Pre-Hospital Care is pleased to announce that the review of the FPHC Generic Core Manual has been completed earlier this year. The manual has undergone substantial improvements and has come back with a new name: the **Foundation Material For Immediate Care** has arrived and is available to purchase in hard copy or as an e-manual.

What's new: Many organisations provide training for responders starting off on their prehospital careers and on-going continued professional development. This manual has been designed to provide the foundation material and additional references for their training or on-going study.

This latest edition has taken in to account many well recognised sources of high-quality clinical reference points and best practice, for example, the British Thoracic Society, Joint Royal Colleges Ambulance Liaison Committee and UK Resuscitation Council guidelines to name a few. In addition, it includes, where appropriate, extracts from consensus statements issued by The Faculty of Pre-Hospital Care.

For full information on the manual, please visit this page. To order a hard or e-copy, please get in touch with the Faculty office directly at fphc@rcsed.ac.uk

PHEMNET

In January of this year, we introduced PHEMNET online portfolio as a membership benefit.

PHEMnet provides a web based pre-hospital care portfolio and enables FPHC members to input anonymised details of incidents attended, patients treated, drugs delivered and procedures carried out. Work-place based assessments can be completed on PHEMnet, or alternatively, paper based assessments can be scanned into PHEMnet and stored within members' portfolios, mapping them to the PHEM curriculum. Members are able to record reflections about courses and self-directed learning and map them to the PHEM curriculum. The curriculum that has been covered by each member is summarised by shifts, patients, supervision, curriculum, element, procedure/intervention and condition/diagnosis.
To take advantage of this benefit, please contact the Faculty office by e-mail at membership-fphc@rcsed.ac.uk with your membership reference number. We will create an online profile for you on PHEMnet and you will then be able to access the platform via the link they send you.

The only information shared between PHEMnet and FPHC will be your FPHC membership number, first name, last name, email address and if you are a member in good standing.

International endeavours

It is now a year since Dr David Bruce was appointed as the FPHC International Development Lead and we are pleased to report on progress in this area. There is an international appetite for input from the FPHC, and we have been approached by Nepal, Sri Lanka, China and India for support and (non-monetary) contributions. The FPHC's main challenge is lack of manpower and resource but cooperative working with other charitable organisations may allow us to contribute to improved PHC in the international arena. Greater international involvement is consistent with the aspirations of the President of the Royal College of Surgeons of Edinburgh.

The main focus for work at the moment is a desire to deliver a PHC Course in India and China. A successful overseas visit to India took place in February by the International Developments Lead and discussions are underway on how the Faculty may be able to support International endeavours. As a first step towards this, we have been working on an Overseas Endorsement Matrix, which will allow some flexibility while aiming to assure educational and content standards sensitive to the local capabilities. The hope is that overseas course delivery organisations may also apply for course endorsement, thereby extending the FPHC's influence with the aim of improving PHC and patient outcomes.

Coming next

More new manuals: work will progress on a new Police and Firearms manual as well as the Fire Services manual.

Scientific Conference: work has already started for the return of this event to Edinburgh in 2020. Check p. 10 for more details.

Projects: Psycho-social project and Expedition Medicine in the pipeline, more details in the next Newsletter!

British Transport Police Civil Protection Command

British Transport Police Civil Protection Command (CPC) is part of the Forces B-Division which covers London and south east United Kingdom from Somerset to Norfolk. Within the Division the Command is part of Central sub-Division headed by a Superintendent and covers the Transport for London (TfL) parts of the Division.

The Command is headed by a Police Inspector and operates from three main locations, Camden, Stratford and Broadway/St. James's Park where it is headquartered, with two satellite locations at Acton and Battersea which are crewed when necessary.

CPC comprises three main components; namely the Network Incident Response Team (NIRT), Emergency Response Unit (ERU) and the Resilience Planning Unit (RPU) with each Section being headed by a Sergeant or Police Staff equivalent. The separate components were combined into one Command in early 2017 in order to enhance the capabilities of the individual elements and to build resilience within the Service having previously existed as largely autonomous sections. The Police Officers within the Command have been trained as Medics by London Ambulance Service (LAS) whith whom they work very closely, as they also do with the London Air Ambulance (LAA/Helicopter Emergency Medical Service (HEMS)) and London Fire Brigade (LFB).

> *"BTP has a very different set of priorities to other forces in the UK. In particular, it has to be acutely aware of how its actions impact on the running of the railway."*
>
> Chief Constable Paul Crowther OBE

The Command also collaborates on training with the School of Paramedic Science at St. George's Hospital University of London. The Civil Protection Command Police Officers are additionally trained in JESIP Incident Management and Forensic Body Recovery, with some of the Team having additional skills as Public Safety Cycle Responders or Policing at Heights.

One of the functions of Civil Protection Command (CPC) is to help BTP, as a Category One Responder, discharge part of its Civil Contingency Act 2004 obligations in a structured way which enhances day to day incident management. From a London Underground perspective, as a Category Two Responder they assist the cooperation process by providing a Network Incident Response Manager (NIRM) to join with the BTP Police Officer. It is the combined capabilities of the NIRM with the Police Officer that together creates a Network Incident Response Team (NIRT).

The Network Incident Response Team (NIRT) based at Broadway in Westminster operate vehicles which carry the various specialist medical equipment utilised by the Police Medics and LAS for dealing with

Underground related Emergencies, (such as persons struck by trains), in addition to some lineside equipment which may be used by the NIRM for creating a safe system of work on the railway. The vehicles can also be supplemented by the use of Police Mountain bikes; which are very well received by the public/staff and are very effective in reducing response times alongside being a welfare safety valve.

Welfare is a key issue for the Command given that the forty personnel who comprise it deal with some of the most physically and mentally traumatic incidents which can be encountered in the UK urban environment. With much of the trauma they deal with being akin to battlefield injuries; some of which prove fatal, but the majority of which result in horrific life changing injuries. Additionally cardiac arrests and Passengers Ill on Trains are routine calls to which Officers are deployed.

Alongside the day to day incidents the Command also deployed to the Terrorist incidents of 2017 and the tragedy of Grenfell Tower. The Command is regularly supported by the Railway Mission Chaplaincy and the Forces Wellbeing Services which have some special protocols/monitoring of personnel in the Command due to the level of exposure to challenging incidents.

> *"The need to minimise disruption will become even more important on an expanding, busier railway. Even greater emphasis will have to be placed on preventing unnecessary cost and disruption from temporary closures of stations or railway lines without compromising our duties".*
>
> BTPA Strategic Plan, 2012-19

The police aspect of the Emergency Response Unit (ERU) is another component of the Command, which has existed in its current form following the Lady Justice Hallett inquiry into the response to the 7/7 London Bombings and in preparation for the 2012 Olympics/Paralympics. The ERU without Police Officers was initially created by London Underground in 1993. The addition of the BTP CPC Officers 24/7 at Camden and Stratford has not only significantly reduced response times to life threatening blue light emergencies but has also supported greater cooperation across all of London's Emergency Services.

The ERU was first formed to combine in a standing team the emergency engineering support and technical expertise necessary to keep London Underground on the move. In addition to helping to reduce the human impact the initiative has also saved hundreds of thousands of pounds for TfL as well as London business as a whole that would have been adversely affected by delays to the transport network.

The third Component of the Command is the Resilience Planning Unit (RPU) – which engages with all the Local Resilience Fora (LRF) within the Division. In support of this some of the RPO's are also trained National Inter-Agency Liaison Officers, (NILO), as are the Police Officer Managers within the Command. The NILO structure is invaluable when dealing with incidents from adverse weather to Extinction Rebellion and day to day more routine emergency matters. This facet has also supported the integration and joint working with LAS and LFB, which in turn supports wider London Resilience.

Additionally London Ambulance Service Cycle Response Unit teams operate from BTP facilities, not only reducing response times to LU related incidents but also benefitting all through the exchange of knowledge and building teamwork in a cost neutral way.

Civil Protection Command brings together the specialist policing for the railway, with Medical skills tailored to the railway environment and close working with London Underground plus blue light partner agencies in an efficient cost effective way completely in line with JESIP – "Working Together to save Lives and Reduce Harm".

Inspector Stuart Downs BA PGCE
B-Division Central
OIC – Civil Protection Command
@BTPNetworkResp

FPHC Message Board

Student volunteers

The Faculty of Pre-Hospital Care trialled a new initiative in July 2019 and welcomed 15 student volunteers at the Royal College of Surgeons from 10th –12th July to support the DIMC & FIMC exams diet. This was a huge success as best related by the students themselves:

'*Helping out has definitely confirmed that the pre-hospital route is the path for me in my medical career and I've learned so much that I wouldn't otherwise have been taught in the conventional curriculum at med school.*' EC

'Being a part of the exams was a great learning experience […] in particular during my role in the FIMC simulation, in which I had to be very familiar with the details of the case in order to accurately respond to the actions of the candidates.' FW

'I also very much enjoyed the opportunity to chat to the examiners, who all have great stories to tell about their time working in pre-hospital medicine.' AS

'Throughout the day, you pick up what makes the difference between a competent doctor and a great doctor, and I hope that I can go on to use the skills that made the latter stand out.' JP

The programme will repeat for the next exams diet in January 2020 and we all hope for the same enthusiasm and success! Thanks to all!

Save the dates!

The **FPHC Annual General Meeting** will take place after the Faculty Advisory Board on **21st January 2020 in Edinburgh**— further information will be communicated to members in due time.

The next diet for the **Diploma in Urgent Medical Care** will take place on **10th &11th March 2020**.

The **FPHC Scientific Conference** is returning to Edinburgh on **17/18 March 2020**. Programme, rates and much more will be posted on our website early Autumn 2019, stay tuned!

DipROM September intake

We are currently accepting applications for the September intake of the Remote and Offshore Medicine programme. Application deadline: **23 August 2019**.

For further information visit our website, read our latest DipROM newsletter or email diprom@rcsed.ac.uk.

Student & Junior Trainee Group

The Group has elected a new Executive Committee for 2019-2020:

Chair: **Molly Greenaway**
Secretary: **Tatiana Zhelezniakova**
Treasurer: **Luke Flower**

They will officially take position in October 2019.

Get involved with the Faculty!

As a Fellow or Member of the Faculty, you will have opportunities to become a member of one of our committees or groups, which actively influence developments not only within the Faculty but also across the profession as a whole. If you are interested then please contact the Faculty office on fphc@rcsed.ac.uk or call on 0131 527 1732.

Editorial

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Next issue: February 2019

Editorial articles must be supplied as Word document (500 words max.).

Images must be supplied in high resolution (300 dpi) preferably as JPG and with full credits when applicable.

Please send to fphc@rcsed.ac.uk by **30th November 2019.**

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