



FACULTY OF  
**PRE-HOSPITAL  
CARE**

STUDENT & TRAINEE GROUP

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*Career* Insight

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# Career Insight:

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## Steven Short

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### **Please tell me about your career pathway?**

**I** am a nurse to trade – it's 30 years ago this year since I started my training. I was a "Project 2000" nurse, which was sort of the step between nursing being entirely vocational to moving into an entirely higher education programme. I trained down in the Borders at the Scottish Borders College of Nursing. It was brilliant. We got placements that other nursing students at that time didn't get, such as paediatrics, maternity and labour ward, and lots in mental health, even though it was an adult nursing programme. Pretty early on I realised I quite like the emergency care side of things. My first job was in medical high dependency and cardiology. That was where I predominantly spent my early clinical practice, as well as a little bit of Accident & Emergency (as we called it in those days). As part of one of my roles in cardiology, I did an ALS course and got put forward for

instructor potential. That's where it all started to go sideways for me. I became an ALS instructor, which led me to moving up to NHS Lothian and as a resus officer now, and spent quite a long time in various settings, in St. John's for several years and in Edinburgh Royal Infirmary as a resus officer. And that's where my interest in out of hospital cardiac arrest started really. I did some work with two names that will be very familiar, Gareth [Clegg] and Richard [Lyon]. We were the three founding members of what is now the Resuscitation Research Group. We did lots of early work, such as the TOPCAT and ICECAP studies, and that led to us doing some improvement work in Edinburgh, which in a strange twist of fate, almost became a career for me. I've now been in the ambulance service for almost 10 years as the programme lead for out of hospital cardiac arrest. I've transitioned from very much being a hospital practitioner to working in an ambulance service which I don't think was entirely planned but is very welcome I have to say.



I've always had this, some people would say slightly strange, interest in improving cardiac arrest outcomes and have shamelessly turned it into a career for quite a long time now.

**What opportunities are available for nurses within Pre-Hospital care?**

It varies. There are certainly some specialist roles that are open to nurses within ambulance services. So the obvious one (and actually which most ambulance services in the UK utilise) would be mental health. Lots of ambulance service mental health programmes are led by mental health nurses. There is also the managerial route, with nurses transferring into higher up managerial roles as lots of their skills are transferable. Within Scotland, some of our advanced practitioners in urgent care are from a nursing background but also a couple of our critical care practitioners come from a nursing background as well. There is one ambulance service in the UK that has nurses who are frontline ambulance nurses, so they have come in generally from an emergency nursing background, who've then gone through a training course to be able to work frontline. But there's only one ambulance service that does that. So it's not unusual, but it tends to be in quite specific roles.

**What does your day-to-day look like? What does your work look like now?**

It's a real mix of clinical practice combined with guidance, policy, strategy and everything that comes with that. One day will be spent entirely in meetings, another day I

can be responding to cardiac arrest or other clinical things, another day I can be writing a new guideline. I also work with our education department and meet with stakeholders in the Scottish Government and the clinical director. One particularly exciting domain is working with partner agencies, such as Police Scotland and the Scottish Fire and Rescue Service on policy and guidance to ensure uniformity. It's a really varied role that I have, very different but very exciting.

**What inspired you to become involved in Pre-Hospital Care?**

Yes, it's an interesting one.

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The day before my interview for nursing college, I actually had an interview for the Scottish Ambulance Service. So I always had that interest in ambulance service work.

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When I was in the Borders we used to do quite a lot of CPD and education alongside our ambulance service colleagues and I really enjoyed it. It wasn't planned. Gareth [Clegg] approached me to ask if I would get involved with training paramedics for a project they were doing, which became part of the TOPCAT study, and then from that I would shadow various members of the ambulance service. So I guess it was this little nagging thought that never left me, and now it's a job.



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**What advice would you give to someone at the start of their training, looking to get involved in Pre-Hospital Care?**

Yeah, it's a great question. There is two bits of advice that I would give to someone interested in Pre-Hospital Care. The first one, and biggest one, is brace yourself.

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If you come from an in-hospital background, the out of hospital environment is a huge contrast to the very clinical and clean hospital with lots of help immediately available to you, and it can come as quite a shock.

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When you're standing in someone's house who live in the most impoverished conditions and that is impossible to imagine actually for most of us, it really brings you back down to Earth. Or if you're at the side of the road in July and you've got wasps dive bombing you, or you're kneeling in a field of mud. It ain't glamorous at times and it's dirty and the kinds of death and destruction you see is very different from what you see in hospital as well. Don't underestimate (what I sometimes refer to as) dirty death, because it's unlike anything you will have seen before. So the first part of advice is be prepared for that, and don't underestimate the impact it can have on you if you've never seen it before. The second one is leave your ego at the door. It's

never welcome anywhere.

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You can be confident without being arrogant and confidence is important at times, because sometimes you need someone with confidence to be able to step into that leadership role.

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But bring your ego out in front of a group of ambulance clinicians at your peril, as very quickly you'll be shoved back in your box.

**What do you think the greatest challenges are for Pre-Hospital Care and especially for cardiac arrest?**

There's lots of challenges out there. As I mentioned earlier, the environment is really difficult. It's not just the weather, but also the pressure you can feel with the environment – you can be the first person at a scene with 10 patients, and you need to be able to categorise, calm yourself and think logically without losing your situational awareness. It's a genuine challenge. I think the other challenge is we mis-sell pre hospital and out of hospital care. It's miles from all being blue lights, emergencies and excitement, which we often try to sell it as. Increasingly, there's a lot of social care and pathways, and it's not uncommon to do a 12.5 hour shift and not deliver treatment to a single person. That in itself is a challenge because sometimes what



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you expect to be doing for a job actually doesn't transpire that way. All in all, the systems under pressure and ambulance service is no different.

### **Where do you see Pre-Hospital Care developing in the future?**

It's almost an easy question to answer.

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**It's not all blue lights and sirens. Pre-Hospital Care is predominantly always going to be in the domain of the paramedic and that's right. Paramedics are brilliant.**

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I love the fact that I'm surrounded by loads of them on a daily basis and they all wind me up something rotten for being the big nurse and the team and all that kind of stuff. But what they do is brilliant. They are literally jacks of all trade - helping a ninety year old off the floor and the next call delivering a baby. There's not many people in healthcare can have the bandwidth to be able to jump from one case to another in that way. And the way that they do utterly seamlessly. Its right that it should always be in the domain of paramedics and other ambulance clinicians, because they're the experts in that world. But there is always going to be the need for extra stuff. There's a vanishingly tiny number of people in Scotland that need a rapid

sequence intubation at the side of the road, but when they need it they need it, so there is always going to be a role for PHEM as well. It's the bit in between where paramedics probably can't manage the condition that's happening, but the wrong thing to do is to take into the emergency department. Increasingly, I think, where do we go in the future? It's the access to other care, especially since the population health frameworks have just been published by the Scottish Government. We would never have thought a decade ago that we would have GPs in our ambulance control centre to do clinical triage over the phone, but they're hugely valuable. The future I think is going to look very different and it will be a shift away from emergency care to unscheduled care increasingly. The challenge to this is the system being under such pressure all the time.

### **How do you see cardiac arrest care developing in Scotland?**

I think there's a number of big ticket items out there. CPR education being rolled out brings such benefit to the whole community. Many of those having VF arrests are in their 50s, young and they've got a life ahead of them. For them, when they're in their refractory VF arrest, ECMO is unquestionably life-saving. That's the "exciting" end of the stick. At the other end of the stick is that right across the world, we horrifically over-resuscitate people. Far too many people are having Advanced Life Support attempted on them, in an entirely inappropriate way because its only ever going to be futile. We can definitely save more people, but we probably need to stop trying to save the people for whom it is not appropriate to. It's a



conversation that we've been having for two decades.

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The best care happens in the community before anyone from an emergency service arrives. We need to make sure they get good bystander CPR, but also that there is equitable access to public access defibrillators, whether they live in the middle of nowhere or in a highly deprived part of the city.

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It's not difficult on paper. But achieving it is really, really difficult. We've done well in Scotland – in a relatively short space of time, we doubled survival and increased bystander CPR rates by 25%. There is still a long way to go though, and it can feel like Groundhog Day when you're trying to sell the same story. The world is obsessed with public access defibs. They're not necessarily the answer to all cause. Most of the public don't even know what they are yet, let alone have the confidence to use them most of the time. But they're part of the solution.

**To finish, what is something positive within cardiac arrest care in Scotland?**

We work within a system in Scotland. That's pretty cool in terms of cardiac arrest. We don't

claim to be the best, but what we do get recognised for internationally is having our strategy. It's one of the best out there in terms of trying to improve things. We have an amazing partnership (I won't even try to mention all of the partners as I would miss out at least 3). The Save a Life for Scotland partnership is an awesome group of individuals, as well as organisations who want to make this better and we do improve stuff, and that can be seen with our survival rates and bystander aftercare. We don't rest on our laurels. There's more to do and we're not done yet.

**Acronyms:**

**ALS:** Advanced Life Support

**CPD:** Continuing Professional Development

**CPR:** Cardio-pulmonary Resuscitation

**ECMO:** Extra-Corporeal Membrane Oxygenation

**GP:** General Practitioner

**PHEM:** Pre-Hospital Emergency Medicine