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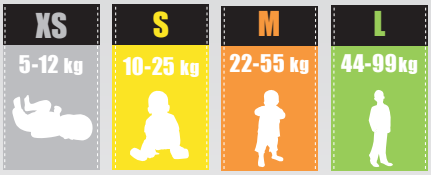

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Declan Heneghan
Editor, Ambulance Today

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Courage, Kindness and Leadership in the Ambulance World

The lead feature item in this edition is a fascinating and very informative case study on the dreadful Paris terror attacks of 13 November last year from the perspective of Samu du Paris (Service d'Aide Médicale Urgente), the French emergency ambulance response organisation which led the medical response across all seven attack sites on that fateful night. Written by Professor Pierre Carli, Director and Chairman of Samu and his two colleagues Dr Caroline Telion, a senior staff physician, and Barbara Mantz, a Chief Nurse. Their co-written article provides an excellent blueprint on how to provide strong leadership in a large-scale triage response to an unexpected major terrorist attack. All three medics were on-scene on the night, either coordinating response or overseeing the treatment of casualties. Of course, it goes without saying that nobody ever wants to find their own EMS organisations and frontline staff in a similar position. However, as the massacre at the Pulse nightclub in Orlando, Florida in Dallas in June showed once again, evil comes in many forms but it rarely, if ever, gives EMS front-line staff and leaders advance warning of the death and destruction it will wreak.

In both Paris and Orlando a distinguishing feature of both incidents was the outstanding courage and professionalism of the EMS staff who responded - some of whom put themselves directly in the life-threatening line of terrorist fire in order to secure and treat shooting victims. They did so without a moment's thought for their own safety. When Professor Carli first explained this horrifying aspect of the Samu response during the superb presentation he gave in Copenhagen recently, upon which this article is based, there was an audible intake of breath among all delegates in the crowded auditorium. Looking around the room, you didn't have to be a mind-reader to realise that every medic present was instantly going through the same reflective thought-process, wondering: "What would I do in the same situation? Would I exhibit the same courage? Would I be capable of administering clinical care in such a calm manner amidst such utter mayhem?"

But let's not forget that another aspect of ambulance life is the amazing kindness and compassion shown by ambulance people the world over on a daily basis. There are two great examples of this in this edition and I'm proud to say they both come from the UK. The first is an article focusing on a first-aid training initiative which took place in Namibia in July led by East Midlands paramedic, Claire Griffin. Claire first trained a group of enthusiastic young people from across her region in basic first-aid and CPR and then took them out to Nambia to pass on their new-found skills to other youngsters in remote communities. As if this isn't enough, Claire continues to seek donations of kit, equipment and medicines to send out to Namibia. So if you're an ambulance provider of any type or if you're involved in the supply chain in any way and you have any items you can possibly spare, please contact Claire and she'll get them out to Namibia where they could be saving lives. You can reach Claire at:
www.youcaring.com/eagle-christian-ambulance-charity-namibia-627461

The second example comes from the staff of South Western NHS Ambulance Service Foundation Trust. You may recall that in our last edition (and on our website) we reported on the sad situation faced by one of their paramedics, stepmother of three, Kath Osmond, who is undergoing what we hope will be life-saving treatment for stage 4 skin cancer. In just a couple of weeks her fantastic friends and colleagues at SWASFT, led by Kath's mate and fellow paramedic, Sasha Johnston, helped raise the £70K required for Kath to continue vital treatment. As I write this Kath is still receiving TILs (Tumor-infiltrating lymphocytes) treatment at the Christie hospital in Manchester. Kath's condition is serious so if the treatment isn't a success she may only have months left. Whatever happens next though, Kath will battle on bravely, and due to the generosity of her workmates and that of the great British public, at least her treatment has been funded. However, please remember that Kath and her family still need additional financial support just to keep them afloat. So, please read the update article on her treatment, read her own fantastic and touching blog and please visit her site **(www.runningman4kath.com)** to make a donation!

Finally, inside this very busy edition you'll find a feature announcing that the International Association of EMS Chiefs has joined the growing band of leading global ambulance organisations who circulate this magazine to their staff online and use us as their primary platform to get their message across to ambulance colleagues around the world. In recent months both St John New Zealand and the Canadian Association of Paramedics have also joined our family. Formed in the 1970s IAEMSC is growing rapidly right now and, from its base in Missouri, it will be working with Ambulance Today to bring as many EMS leaders as possible from across the globe into its fold. As shown by Pierre Carli, good leadership is essential to the delivery of good ambulance care, so if you're an EMS chief anywhere in the world who is not aware of this forward-thinking organisation and the many ways it can help you share your knowledge and best practice with each other, please look them up at: **www.iaemsc.org** or email them at: **info@iaemsc.org.**

Declan Heneghan
Editor, *Ambulance Today*

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EDITOR: Declan Heneghan email: editor@ambulancetoday.co.uk CORRESPONDENCE: All correspondence should be sent to: The Editor, Ambulance Today, 41 Canning Street, Liverpool L8 7NN BUSINESS DEVELOPMENT MANAGER (Europe): Joseph Heneghan CALL: +31 2977 853 95 ASSISTANT-EDITOR: Joseph Smith
FOR EDITORIAL CALL: +44 (0)151 708 8864 FOR ADVERTISING ENQUIRIES CALL: Advertising Sales Manager: Paul Ellis: +44 (0)151 703 0598 OR: +44 (0)7980 539 481
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Violence and aggression

We see reports of violence and aggression against ambulance staff all too commonly in the news. In recent months, UNISON has had a few enquiries about how body worn cameras might help reduce incidents of violence and aggression, as the number of people reporting incidents is on the increase – a sadly perennial headline.

By Alan Lofthouse National Ambulance Officer, UNISON

What is it about violence and aggression that makes it so hard to tackle? Each year we get a new set of figures showing an increase in attacks. The NHS Staff Survey reports the levels of physical violence, harassment, bullying or abuse from patients. The figures over the last ten years are tragic. This year, 32% of ambulance staff experienced physical violence from patients, relatives or the public. That's one in every three ambulance staff being physically assaulted. In fact, as only 57% of ambulance staff reported the most recent experience of violence, this figure could be much higher.

Compare the number of ambulance assaults to the 12% average across the NHS and it stands out. In preparation for this article I looked at the NHS Staff Survey results for the last 10 years. Apart from 2010, when the numbers dropped to 19%, they have remained stubbornly high. Do we just accept this level of violence against ambulance staff; is this now the norm?

The other recorded statistic is the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. In 2015, 45% of ambulance staff reported these incidents compared to 25% across the NHS.

We are regularly contacted by ambulance staff seeking support following assaults against them and one of the problems with statistics is that they fail to capture the personal story. They don't tell the extent of the physical or mental injury or the journey to recovery that each and every one of these incidents forces someone to go through.

Like many ambulance staff I was once assaulted along with a colleague in a nightclub. A young man high on drink and drugs assaulted us and ended up spending 4 hours in our company as no one was willing to treat him. In some ways, the psychological side to this incident was worse than the physical injuries he caused. My crewmate had trouble sleeping, was suspicious and less trusting of patients and had to go through blood tests due to the patient spitting his blood on us.

So my question is: will body worn cameras reduce the number of violent incidents, and from a personal perspective would it have prevented the assault I suffered? Personally, I don't think so. Cameras might provide good evidence for a prosecution but I don't know how effective they are as a deterrent.

Ambulance staff hold a very special and trusted position in society. The public need to have confidence that they can disclose very personal and confidential issues such as child abuse and domestic violence and it is possible that surveillance equipment may erode that trust. We have also heard concerns from our members that body cameras may make them more likely to be a target of violence.

The jury is still out and we will want to see more robust evidence of their benefits. Yes, securing a prosecution is really important but at what cost? Will patients seek to get the recorded video in order to pursue a clinical negligence claim against the NHS? There are too many questions and not enough answers.

In the meantime, UNISON wants more done on prevention, reporting, prosecution and support for staff assaulted.

They're WORTH it

What more can employers do to prevent assaults on their staff? The conflict resolution training gets mixed reviews, but training is a part of the jigsaw, including regular refresher training. In addition, employers must support and encourage reporting of minor incidents, no matter how small, to predict patterns of behaviour.

Staff need to be given the confidence to decide whether it is safe to approach an incident and, importantly, know the organisation will back them up if they withdraw over safety fears. Employers need to support delays in attendance for suspected violent incidents until police back up is available – even if performance is negatively impacted.

Whilst withdrawing and delaying a response is a difficult one as ambulance staff are pre-programmed to get in and help people, sometimes the situation is just too volatile or the risk is too great. I would welcome strong positive messages from employers to tell their staff they will get their support.

Sadly, cuts to police numbers mean they are not always able to respond to calls for back up to ambulance leaving them to deal with a violent patient or a crime in progress – sometimes as a lone worker on a fast response car.

We promote a zero tolerance approach to dealing with incidents of violence and support stronger sentencing of offenders. The public need a clear signal from the police, the CPS and the government that assaulting ANY emergency services worker is a crime and will be dealt with under the criminal system. The alternative is for Ambulance services or NHS Protect to deal with the matter through the civil courts.

With the numbers remaining so high for so long, UNISON is calling for a government led task force to look specifically at violence and aggression against ambulance staff.

More needs to be done to reduce assaults before body cameras - it isn't a silver bullet.

Contact Alan Lofthouse with your views…

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

Facebook: Facebook.com/unisonambulance

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UNISON Ambulance - there when you need us

IAEMSC members pose for a group photo at the 2015 annual summit. Paul Brennan, President, IAEMSC in center (brown uniform) James Robinson, Immediate past president to Brennan's right

IAEMSC - Building a Network of Knowledge and Co-operation Among EMS Chiefs Globally

The International Association of Emergency Medical Service Chiefs (IAEMSC) is a professional Association of EMS Chiefs, executives and aspiring leaders. IAEMSC is guided by its mission to support, promote and advance the leadership of EMS response entities and to advocate for the EMS profession. IAEMSC membership consists of leaders from both career and volunteer EMS organizations and proudly represents and embraces the diversity of EMS agencies throughout the world.
Since its inception in 2008, the Association has been committed to improving the provision of pre-hospital emergency medical care, and serving Chief Officers representing the many various service types which exist in the Emergency Medical Services community.

Our Goals:

To represent the EMS Chief Executive Officers responsible for direct delivery of EMS to their communities

To effectively address the issues pertinent to the contemporary EMS Commander

To support the needs of patients, and providers by providing support to current EMS executives mentoring future leaders, and advocating for all EMS systems

Paul Brennan, President

Governing Body:

The governing body is the executive board and consists of the officers of the Association and six at-large members serving as directors. Five are elected by general election and one is elected to the Metro-Chiefs Section as the Section Chair. The Section Chair serves as a member of the Board of Directors representing the Metropolitan Chiefs. All at-large members are elected to a term of two years. Terms are staggered to help facilitate and sustain corporate memory beginning with one person being elected in the off year.

The President of the Association serves as the presiding officer of the Board of Directors and the Association. If the President is unable to temporarily preside then the President-Elect shall serve in the place of the President in his/her absence or disability.

Current Executive Board Officers:

Paul Brennan, President: Director of Pre-Hospital EMS and Emergency Management, Lawrence General Hospital, Lawrence Massachusetts

Peter Dworksy, President Elect: Corporate Director of Support Services MONOC, Neptune, New Jersey

James Robinson, Immediate Past President: Assistant Chief for Denver Health EMS, Denver Colorado

Brendan Kearney, Vice President: Superintendent-in-chief, Boston EMS, Boston Massachusetts

Chris Callsen, Treasurer: (Ret) Assistant Chief of Operations Austin-Travis County, Austin Texas

Vice President, EMS / Public Safety Solutions at the Intermedix Corporation

Daniel Gerard: Secretary: EMS Coordinator for EMS, Alameda Fire Department, Alameda California

The strength of the IAEMSC is its members. The association offers an amazing opportunity for both leaders and aspiring leaders to discuss a variety of issues with other industry executives and experts. Members are encouraged to utilize the IAEMSC EMS Chiefs association listserv to post questions, share best practices and lessons learned. In conjunction with the member listserv is the IAEMSC news feed listserv. This provides news and information about EMS agencies around the world as well as after action reports, special bulletins and other essential information. The IAEMSC website is user friendly and host a file repository in the "members only" section which holds multiple documents, references, policies and other information.

IAEMSC works closely with numerous international, federal and state organizations. This includes, the Department of Homeland Security, the Department of Defense, the Federal Emergency Management Agency (FEMA), the Assistant Secretary for Preparedness and Response (ASPR) the National Association of State EMS Officers, (NASEMSO), the Joint National EMS Leadership Forum (JNEMSLF) and many, many more.

Kathryn Brinsfield MD, Assistant Secretary for Health Affairs and Chief Medical Officer, Department of Homeland Security speaks at the annual IAEMSC summit

The association has participated in numerous initiatives since its inception including The National Highway Traffic Safety Agency (NHTSA) "EMS Culture of Safety Project," the NHTSA EMS Compass initiative, Fatigue in EMS workers, Active Shooter planning initiatives as well as The Department of Homeland Security "Stop the Bleed" campaign just to name a few. In 2011, IAEMSC in partnership with Intermedix launched the National EMS Health and Safety Surveillance system to gather and analyze data regarding occupational illness, injuries and fatalities.

IAEMSC executive officers have testified before congress on such important topics as medical counter measures for emergency response and responding to the threat of chemical weapons. In addition to testimony the association has authored position statements on a number of topics including, the stockpiling of neutralizing and decontamination agents for chemical warfare, and weapons of mass destruction.

Craig Fugate : Administrator of the Federal Emergency Management Agency (FEMA) delivers the keynote address at the annual IAEMSC summit

The IAEMSC remains a committed proponent and advocate of the EMS profession. IAEMSC in conjunction with the Emergency Medical Service Labor Alliance (EMSLA) published a white paper entitled "Consolidated Federal Leadership for Emergency Medical Services- An essential Step to Improve National Preparedness." This was submitted to the special assistant to the president of the United States for Homeland Security and the senior director for Resilience Policy. IAEMSC is a staunch supporter of the National EMS Memorial Foundation and their efforts to establish a permanent EMS memorial in Washington D.C. to honor, recognize and remember those American EMS professionals that have died in the line of duty.

Internationally, the IAEMSC has a close working relationship with the Paramedic Chiefs of Canada (PCC) and frequently enjoys PCC members in attendance at our annual summit. In addition to the United States and Canada, IAEMSC members have also resided in the United Kingdom, Ireland, Finland, Kuwait, Afghanistan, Qatar, the United Arab Emirates and many other countries.

James Robinson, IAEMSC Immediate past president speaks with Washington D.C. Fire and EMS Chief Gregory Dean (to Robinsons right), IAEMSC past president (2012-2014) William Sugiyama (on Robinsons left side) looks on

The IAEMSC is honored to be engaged in the International Committee of the Red Cross, Health Care in Danger project. On May 10-12, 2016, IAEMSC was the only North American EMS organization that took part in the International Red Cross and Red Crescent Societies' "Community of Action" work group meeting in Oslo Norway. Hosted by the Norwegian Red Cross, this event included individuals from 5 continents whose purpose was to develop a "community of action" for ambulance and pre-hospital providers. The ultimate goal of the community of action work group is to reduce barriers to patient care by improving the safety and security of all ambulance and EMS providers. IAEMSC looks forward to continuing our relationship with the Norwegian Red cross and the International Red Cross and Red Crescent Societies in this most important endeavor.

Each year through a competitive process, the IAEMSC is privileged to offer one member of the association a fellowship to attend the Harvard University Kennedy School of Government, Senior Executives in State and Local Government program. The cost of this intense 18-day program including all housing and meals is fully funded by Intermedix, a longtime supporter of IAEMSC.

Alexander P. Isakov, MD, MPH, the Executive Director of Critical Event Preparedness and Response (CEPAR) and an Associate Professor of Emergency Medicine, Emory Hospital Atlanta, Georgia discusses Ebola preparedness and response at IAEMSC summit

In addition to the yearly Harvard Fellowship, IAEMSC also holds an annual 3-day summit in Washington DC. This exciting event includes a one day pre-conference that engages audience members in current topics and trends and is followed by a two day conference. Typical presenters include industry leaders and subject matter experts as well as government officials and medical authorities. Last year's IAEMSC summit brought together EMS leaders whose agencies cover more than 26 million residents, responded to more than six million 9-1-1 calls and conduct approximately 1100 ambulance tours a day.

IAEMSC members receive a private tour of the U.S. Capital Building

This year the IAEMSC is pleased to announce we will be co-locating our annual summit with the 2016 National Healthcare Preparedness Conference (NHCPC). This event will also include the National Pediatric Disaster Coalition and the Veterans Emergency Management Evaluation Center. The 2016 summit conference will be held at the Washington Hilton Hotel on December 12-14, and is expected to attract over 1000 attendees from a variety of entities.

For more information about IAEMSC please visit us at: www.iaemsc.org

or email info@iaemsc.org.

IAEMSC can also be found on Facebook at International Association of EMS Chiefs-IAEMSC as well as Linkedin and Twitter@emschiefs

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Paris Terror Attacks 13th November 2015: The SAMU Perspective

By Pierre CARLI, Professor and Chairman, SAMU de Paris

Caroline TELION, MD, Staff physician

Barbara MANTZ, Chief nurse

Hôpital Necker 149 rue de Sèvres Paris 75015

In November of last year, the world watched in horror as one of the worst terror attacks in living memory broke out on the streets of Paris. Faced with multiple attacks on a scale that nobody had expected, the response of SAMU de Paris was critical. Pierre Carli, SAMU de Paris' chairman, gives us an exclusive overview on the decisions that saved countless lives and will have critical implications on how similar situations are handled in the future:

1 – EMS system in France: The SAMU

The SAMU (Service d'aide Médicale Urgente) is the French national EMS system staffed by physicians. This system includes:

- MICU (mobile intensive care unit). Any time a life threatening problem is identified or suspected a MICU staffed by a medical team is sent to the out of hospital scene.

- Medical regulation at the Center "15": all the emergency calls received by the free national number "15" are analyzed by a physician. The answer is then adapted to the severity of the emergency. The physician is also in charge of the choice of the hospital for admission of the patient. He must notify hospital team of the patient status to prepare its management on arrival. Direct admission in specialized wards (cathlab, Trauma Unit, ER…) bypassing the ER is possible.

SAMU is not directly in charge of EMT teams, but coordinates them. EMT's are mostly provided by Fire Brigade. Paramedics teams are not developed in France. The Paris area has a population of 12 M served by 8 SAMU centers receiving the "15" calls and 60 MICU 24/24 are available. The EMT's in the Paris city are members of the BSPP (Brigade des Sapeurs-Pompiers de Paris) a military unit, who also deploy several military MICU associated with the SAMU. In case of disaster or terrorist attack, the SAMU de Paris is in charge of the coordination of the seven other SAMU of the region.

2 - Disaster Preparedness:

SAMU teams are indeed trained in disaster management. The curriculum of the SAMU Physicians includes a Disaster Medicine Course. Several disasters drills are organized every year. After the terrorist attacks in 1995-96, plans to respond to terrorist attacks were implemented. The lessons from other cities' major attacks (like London and Madrid) were incorporated. More recently the multisite "multimodal" attacks in Mumbaï, in 2008, was considered to be the most terrible scenario. Medical management was adapted to these new threats:

- Improvement of the pre-hospital and in hospital organization of care for mass casualties: The White Plan to mobilize the hospital resources and the Camembert strategy for the regional back up of SAMU MICU articulated with the Red Plan of the fire brigade

- Improvement of the care of victims of assault rifles: The military "damage control"

Biography: Professor Pierre Carli

Since 1998, Pierre Carli has been professor and chairman of the EMS of Paris (SAMU de Paris) and the Anesthesiology and Critical Care Department of Hospital Necker (a national tertiary reference centre for Pediatrics). Pierre is a national and international expert in the area of the prehospital care, cardiac arrest, emergency and disaster medicine. He is the president of French Resuscitation Council (CFRC) and the vice-president of SAMU - Urgences de France (the French EMS organization). He has been personally involved in the management of the terrorist attacks in Paris in 1995 -1996, the major heat wave in Paris in summer 2003, the H1N1 outbreak in 2009, the Ebola pandemic in 2014 and more recently in the terrorist attacks in Paris in January and November 2015. Since 2009, he has been appointed by the Minister of Health Chairman of National Board of Hospital Emergencies (Conseil National de l'Urgence Hospitalière) and in charge of several national reports for this Minister ("Propositions for the organization of French HEMS" in 2013, "Emergency department overcrowding" in 2014). In Hospital Necker, Pierre CARLI is the Chairman of the Medical Board, elected since 2004. At Paris Descartes University he is in charge of the program of Emergency Medicine (90 residents per year) for the Paris region, and the Disasters Medicine program for the EMS (SAMU) physicians and nurses. Pierre Carli is member of several editorial boards and the author of many articles related to Emergency Medicine, cardiac arrest, Disaster Medicine and critical care. In 2015 Pierre CARLI has been promoted Commander in the Order of the Legion of Honour.

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management was adapted to pre-hospital care and extended to civilian practice (1).

In January 2015, The Charlie Hebdo shooting and the hostage taking (Hyper Casher grocery store) in Paris confirmed that France was under attack. Planning and care organization were again adapted to this new experience and several drills were organized. The last of these drills was performed Friday November 13 at 9.30am, 12 hours before the terrorist attacks.

3 - Paris: Friday November 13, 2015

At 9.20pm the most important terrorist attack in Paris since WWII begins by explosions of kamikaze bombings in the "Stade de France." Within 30 minutes, three bombs explode at the stadium, the gates and the restaurants nearby. A few minutes later a second terrorist team opens fire on terraces of bars and restaurants in the center of Paris (10ème arrondissement). Twenty minutes later a third terrorist team enters the Bataclan shooting into the audience and taking hostages.

The response of all Emergency services (Police, Fire Brigade, SAMU) was very quick in the "Stade de France" and the involvement of terrorists immediately confirmed. Consequently the Red plan of the Fire Brigade and the White Plan of APHP ("Assistance Publique Hôpitaux de Paris") were immediately activated. All the SAMU teams of the region were alerted and notified by the SAMU de Paris to follow the "Camembert" strategy for backup and sites allocation.

4 – The "Stade de France" site:

This site was located a few kilometers out of the Paris city limits in the North sector of the "Camembert" plan. Consequently, the

SAMU de Paris MICU were not dispatched to the stadium. According to the plan, MICU from other SAMU units (SAMU 93, SAMU 95 and SAMU 92) were engaged in this sector. This attack was potentially extremely dangerous. The stadium was full of 70,000 attendants and multiple VIP (Including the President of the French Republic and several ministers). The decision to not evacuate the stadium and keep the public inside under Police and Army protection was taken. This important decision taken by the Police authorities avoids panic in the public and exposure to the terrorist attacks outside the stadium. The 3 kamikaze bombs exploded after the beginning of the football match, away from the crowd already in the stadium, creating a limited number of casualties: 4 dead, 57 injured triaged as 7 Absolute Emergency (AE) and 50 Relative Emergency RE). Eleven MICU Teams were involved on scene.

5 - The East Sector:

In the 10ème and 11ème arrondissement of Paris, in a zone of around 3 km^2, five different terrorist attacks occurred, coordinated with the Stadium Bombings.

A terrorist team moving in a black car opens fire randomly on the pavement and on the terraces of bars and restaurants overcrowded that Friday night.

On scene, although the EMT fire Brigade Teams arrived in a few minutes several casualties were dead or died very quickly. Lethal wounds were mostly related to head, precordial chest wounds or the multiple impact of Kalashnikov bullets. On each site a team of 3 specialists was in charge of the organization of Rescue and Care including a fire Brigade Officer and a senior physician of the SAMU. Victims were triaged and treated according to the pre-hospital Damage Control protocol. Patients taken from the scene in groups of 5 to 8 in the hospitals designated by the SAMU medical regulation. Evacuation was performed under Army or Police protection. All the patients found on scene were triaged and tagged before evacuation. AE, the most severe cases, were transported to Level I trauma centres (University hospital with cardio-thoracic surgery wards) for damage control surgery and RE to Level II trauma centers.

The situation on scene in this sector was complex. For example, in Rue Bichat, the site of the attack was just in front of the St Louis Hospital (a hospital dedicated to Oncology and hematology) several walking casualties (RE) step in the emergency room and others (AE) were transported into the hospital by bystanders, before any contact with Police or EMT or any notification by the SAMU (2). However, this hospital was

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not overcrowded and implemented the "White Plan" for mass casualties. Surgical teams for backup were sent in the evening to help the AE management.

Opposite the Hospital St Antoine, a level II trauma center, not far away from the Rue de Charonne site, received victims after notification by the SAMU and the statuses of these victims were adapted to the hospital medical resources.

The most complex problem was the safety on scene. Access to victims was difficult and unsafe. The terrorist squad was still moving in the area and continuing to shoot groups of people in the streets. Evacuation and escape routes were consequently unsafe and a large zone was cordoned off by the Police and the Army.

6 - The Bataclan site:

There was a combination of difficulties observed that night: multiple casualties related to shootings and kamikaze bombings; hostages taken by terrorists in a stand-off lasting more than 2 tours in a theater with around 1,500 persons attending.

Victims including extremely severely injured patients escaped from the theatre and took shelter in nearby narrow streets and courtyards, creating "victims' nests" in the middle of a dangerous area. However, many victims died inside the theatre, executed by terrorists before the assault of the Police or any possibility of extraction. The organization of rescue and pre-hospital care had to be adapted to the Bataclan site. Two advanced medical posts were implemented on scene by SAMU teams. They were very helpful to triage and give the first emergency care to the victims extracted from the theatre by the Police or running out to the improvised shelters. All the patients were transported to adapted hospitals notified by the SAMU Medical Regulation.

7 - The Medical Regulation:

During these terrorist attacks medical regulation was coordinated by the "control tower" of the SAMU teams deployed on scene. In the regional crisis room several tasks were performed simultaneously:

- Alerting all of the SAMU centres and hospitals of the region. Answering the surge of emergency calls received by the SAMU on the "15" lines. A peak activity of 400 % was observed during the evening in the hour following the first attack.
- Dispatch and allocation of MICU teams on the sites.
- Permanent contact with physicians of MICU on scene to provide the hospital destinations quickly, ready to take care of the victims.
- Notification of hospitals of the number and severity of the incoming victims in order to prioritize the victims needing damage control surgery on arrival.

Telephone activity and the national encrypted radio system activity were intense. Incredibly, the cell phone network remained functional and consequently was pragmatically often used for direct contact between physicians.

8 - Hospital admissions

The definitive counting of victims hospitalized showed: 76 AE and 302 RE, in the 16 Public hospitals. Mortality of these patients at day 7 was 1.3 % (3). At the same time the two military hospitals in Paris received 18 AE and 34 RE. No inter-hospital transfer was needed in the emergency due to the efficient medical regulation of hospital admission.

9 - An outstanding mobilization

Up to 60 MICU teams were mobilized that night. 45 were dispatched on the various scenes and 15 were kept in reserve due to the fact that the evolution of a multisite attack was unpredictable. For the SAMU de Paris MICU and Medical Regulation centre, 70% of the total amount of personnel was mobilized and came back to work that night.

In addition to the Paris region units 11 HEMS were also available from other regions near Paris, but were not utilized.

10 - Psychological impact

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incredible burst of violence, in a very safe city were strict gun control laws are observed. For many young doctors and EMTs it was the first time they were involved in such a hostile environment. Unfortunately, a SAMU physician, not on duty that night, was one of the victims of the Rue Bichat shooting. Psychological assistance was offered to all the SAMU staff on scene that night.

11 - New improvements

Several analyses of the 13th November terrorist attack were performed immediately after and later by external specialist. Lessons and areas of improvement were identified in three directions :

- Improvement and safety of communication between the scene and the headquarters, and between the headquarters of all the emergency services in order to share as instantly as possible all of the incoming information.

- Improvement of safety on scene for victim extraction, for evacuation and transport. Safety of the facilities receiving the casualties was also an issue.

- Improvement of victim identifications including the dead on scene.

12 - Conclusion

The terrorist attacks in Paris were complex and probably partially failed. Other attacks were scheduled and thwarted by Police and Special Services interventions. The EMS role during the attacks was crucial to save lives and improved care. Coordination of services was extremely helpful. This outlines the importance of training and the mutual trust of the emergency services.

To find out more about SAMU de Paris email: samudeparis.info@nck.aphp.fr

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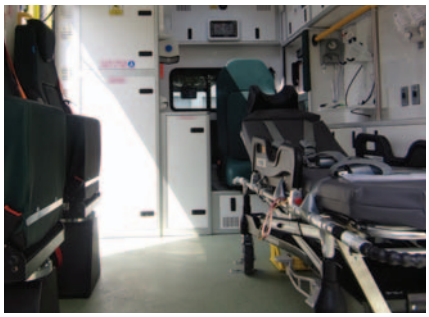

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NWAS Races to the Lead in Fleet & Logistics Management

As the saying goes, sometimes less is more. This was certainly the thinking when North West Ambulance Service decided to consolidate five small and ageing ambulance workshops into a state-of the-art, 20,000 square foot Fleet and Logistics Centre in Haydock, up until now famous only for its world-renowned race-course. The new facility was already bringing down costs and smashing performance goals when Ambulance Today came to visit in August of this year:

By Joseph Smith, Assistant Editor

When NWAS was established in 2006 through the merging of previous trusts, ambulance maintenance for the Cheshire and Merseyside area was handled by workshops situated all over the region. The sheer number of these facilities represented a logistical challenge in terms of resourcing and equipment; some were housed in 1940s buildings not suited to the purpose and some were manned by a crew of just two people and rendered non-operational if a mechanic became sick. An NWAS ambulance will travel 250 miles a day on average and will need servicing every eight weeks. An ever-increasing demand on ambulance services means an ever increasing demand on ambulances and so a step into the 21st century was much needed.

The new fleet and logistics centre is the vision of Assistant Director of Estates, Fleet and Support Services Neil Maher, a man who immediately strikes you as extremely practical and, like everyone who works in fleet, is very passionate about ambulance vehicles. He is also, once you get him talking on the subject, extremely proud of the new project – and for good reason! It's not often that NHS projects are mentioned in the same breath as phrases like "under-budget" and "ahead-of-schedule." Neil:

"The new centre is the result of a purely strategic intent to improve our service to the frontline and also to provide greater operating hours – a two-man workshop is never going to work seven days a week. It's a major project and you expect some hiccups but we do daily performance figures and so far, for Cheshire and Merseyside the results are much better than we expected!

"The new service runs shifts - you can't run shifts if you've spread your resources across nineteen workshops. There were a lot of problems stemming from the dividing of resources as well as maintaining and equipping the workshops. It was a logistical and financial headache when it came to training staff and supporting them.

"By consolidating our workshops we're able to run operations 365 days a year. It's given us a lot better service provision; it gives us greater ability to maintain our equipment and also to train our staff. It's a lot easier to bring trainers to our training centre on-site than to send staff out across the country. This gives us a major resource advantage of maintaining just one workshop."

The new site covers the area of half a football pitch, allowing the team to currently service 25 vehicles a day. The new facility boasts equipment for MOT Testing, fully equipped vehicle maintenance service bays, engineering, welding and fabrication bay, a central stores function for bulk volume purchases. As we learnt from staff, some of the older workshops were so small that it was necessary to work outside in order to accommodate some of the larger vehicles (in one case the ceiling had to be cut out!).

As Neil mentioned, there is also a state-of-the-art staff training suite which has the added benefit of keeping staff close in the event of an all-hands-on-deck emergency. As well as maintenance in the fleet workshop the centre will also be responsible for resources like fuel management, central stores and even ambulance insurance. The new telematics system installed on all new vehicles will also be managed on site at Haydock.

Instrumental in taking the centre from its initial design considerations right through to its completion was Project Manager, Gill Phillips:

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"This is one of the first major changes to the Fleet Workshop function - the site location was of importance offering excellent road and motorway networks while the new building offered a cleaner and brighter environment to work in with the added benefit of a BREEAM (Building Research Establishment Environmental Assessment Method) Certification influencing factors such as low impact design, carbon reduction and biodiversity protection. This is a major improvement in an ageing NHS Estate."

The pooling of resources now makes it possible for 37 staff to work in two shifts, twelve hours a day, seven days a week, 365 days a year. The trust has 288 ambulance vehicles operating in the Cheshire and Merseyside area, and the new centre is more than capable of keeping them all maintained with plenty of room to expand operations if and when demand increases. It goes without saying that the £2 million the trust put into the facility is already proving to be a sound investment.

Another important figure in bringing the nuts and bolts of the project together was Head of Fleet Services, Mick Sweetmore:

"I'm immensely proud of what our entire team across the fleet division has achieved with this project. It's been long, complex and demanding and has required a lot of hard work and flexibility from everybody that's been involved. As everyone who is involved in NHS Ambulance Delivery knows only too well, modern ambulance fleet consists of a wide range of varied and highly technological vehicles; keeping fleet on the road, in good condition, with a minimum of time lost to maintenance and repairs is vital in terms of allowing frontline crews to do their job effectively.

"This new centre represents the very best in terms of fleet maintenance and logistical delivery and we're already seeing significant improvements in keeping our vehicles out and active on the frontline, which is where we and the general public want them to be."

One of the biggest hurdles in centralising so many services under one roof is that for some staff it meant travelling further to work and/or leaving somewhere they've worked for a long time. There was no way of getting around it but once the staff had arrived and settled into the facilities their attitudes soon changed. The staff came from five smaller workshops that were no longer fit for purpose in Anfield, Runcorn, Northwich, Macclesfield and St Helens. Staff were transferred from the previous sites directly to the new location and no job losses were incurred as part of the move. Neil Maher:

"Naturally, there's always a concern. Not everybody, but a number of staff were concerned about the relocation because they'd been comfortable where they already worked for umpteen years, so there's always that apprehension about change. But now that they've settled in they are overjoyed. They're – well… you can ask them yourself."

And that I did!

I found them to be unanimous in their positivity and enthusiasm for the site. Apart from the vastly improved facilities enjoyed by the workshop mechanics, over on the logistics side there is the benefit of working in a spacey, comfortable, well-lit, modern office. The clever innovation of having multiple canteens means that the workshop has its own and mechanics don't have to spend half of their lunch break on cleaning-up before entering; in fact, it was lunch hour when we came in to say hello to the fleet workforce who were cheerfully enjoying the state-of-the-art tea-making facilities and watching the Olympics on a HD screen (we found no complaints there!). The staff were happy and I really got the sense that it wasn't only for the across-the-board upgrades in working environment, it was also down to the obvious benefits represented to NHS customers – after all, those performance figures don't lie.

Fleet Area Service Manager Tony Deus joined the trust in February after working in fleet logistics for the private sector. Like Neil and the other staff he was passionate about the job and brimming with enthusiasm for the new centre:

"This workshop is priceless. To have a facility as big as this just wouldn't be viable in the private sector and it's the way that things should be. It is an expectation of the NHS and the ambulance service that when you walk into the workshop it should be like this."

The workshop floor takes up the majority of the facility and it's an impressive sight: a huge, well-lit, well-ventilated, garage with one vast ceiling. Something that none of the previous workshops had is the room and capability to lift up the larger vehicles and

work beneath them in a way that just wasn't possible before.

Tony Deus: "Having smaller workshops just didn't work, and it wasn't even limited to the issue of manpower; if you have five workshops you need five torque-wrenches, you need five sets of jacks, five sets of axel-stands, five of everything. And of course it's more expensive to heat five older workshops that are older buildings."

One of the most impressive feats of the new centre is that it has been assessed at BREEAM excellence in sustainability for its continued commitment towards energy-saving, the correct handling of clinical waste, general waste and recycling. As Neil pointed out, this is hard enough when you run an office building but to achieve this while running a busy 20,000-square-foot modern garage is nothing short of miraculous and as far as we know it's an industry first. The consideration for environmentalism is just one more way in which this project is representing a long-term solution rather than just a quick fix for existing problems.

The workshop became operational in February but the official opening took place on 23rd June, with special guests from Sts

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Peter & Paul Catholic Primary School, St Helens. To give the reception area a bit of colour, year 3 pupils from the school designed an ambulance themed collage which has been framed and still stands proudly in the entrance area. Five pupils, their teachers and members of the NWAS Board attended the unveiling and were given a tour of the site by managers. At the time of our visit the Fleet and Logistics Centre had already taken on a young apprentice from the local area and it was good to see that the future of our ambulance service is already being taken care of!

When NWAS was established it inherited nineteen workshops providing for 109 ambulance stations across the large geographical area of the North West. The success of the new centre is set to lead the way and is "the first piece of the jigsaw puzzle" in consolidating all of these

workshops into 3 larger main hubs. The second of these hubs will be operational by the end of this financial year and the search for a third site in Manchester is already underway. If the Haydock site is anything to go by, the new standardised system will offer better communication between staff, more efficient services and the ability to keep our Ambulances on the road where we need them.

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Alcohol Intoxication Management Services (AIMS): What are they and what can they do?

UK NHS Ambulance services are greatly affected by the need to treat patients who are intoxicated by alcohol. Ambulance personnel have estimated that 37% of their time is spent managing alcohol-related incidents, with peaks in demand on Friday and Saturday nights. [1] Abuse (physical and verbal) directed towards ambulance service staff was recorded in 7.6% alcohol related call outs. [2] This level of abuse is likely to have a significant impact on staff morale.

Urgent and emergency care services in the United Kingdom (UK), in common with many other countries, face a substantial burden from patients who are intoxicated by alcohol. Approximately 70% of attendances at Emergency Departments (ED) are alcohol-related at peak times.[3,4] ED attendances for alcohol poisoning in England approximately doubled between 2008 and 2014. [5] These attendances peak in the early hours of the morning when ED resources are often at their most stretched. [3] Additional attendances cause overcrowding and affect other patients, staff and the community. Patients waiting in the same area can become anxious and fearful. [4] Patients experience prolonged pain and suffering, increases in waiting times and decreased satisfaction [6-9] Alcohol related admissions can cause the clinical environment to suffer, decreases physician productivity, increases stress and frustration among staff which causes a detriment to care [10] and promotes violence [6-9]. ED

bottlenecks, coupled with a general increase of pressure on available resources [11], contribute to reduced ambulance capacity and undermine the provision of care in the ED [11].

Alcohol affects judgement and increases the likelihood of accidents, injury, violence and antisocial behaviour. The UK Association of Chief Police Officers' (ACPO) recommends that the intoxicated cannot be admitted into custody until a clinical decision maker,

typically in the ED, has determined that it is safe to do so [12]. Evidence suggests that police officers, working in pairs, are often required to escort patients to ED and can also be delayed when EDs are busy. This reduces police capacity in the night time environment.

Since at least the 1980s city centres have become increasingly characterised by

Biography: Simon Moore

Simon Moore is Professor of Public Health Research at Cardiff University. He leads several large projects mostly in the area of alcohol, alcohol-related harm and substance use. Through this work he aims to bring a multidisciplinary perspective that identifies pathways to misuse and opportunities to reduce harm. He is publicly pointed as Alcohol Lead for the Welsh Government's Advisory Panel on Substance Misuse; co-investigator on DECIPHer (the Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement), a fellow of the Cardiff Crime and Security University Research Institute, and Senior Associate of the Royal College of Medicine.

Biography: Andy Irving Twitter: @irvingad82

Andy Irving is a research associate at the University of Sheffield, School of Health and Related Research (ScHARR) and lead for the Sheffield Addiction Recovery Research Panel (ShARRP) Patient and Public Involvement (PPI) group. His work background is in drug and alcohol treatment and he continues his research interests in this field through involvement in the Sheffield Addiction Recovery Research Group (SARRG). His recent major research projects include the PaInTED study, and the PhoEBE programme which is developing new ambulance performance measures. His role in the EDARA project is Project Manager and lead for PPI within the study.

https://www.sheffield.ac.uk/scharr/sections/hsr/cure/staff/irving

Biography: Steve Goodacre

Steve Goodacre is Professor of Emergency Medicine at the University of Sheffield, Consultant at the Northern General Hospital in Sheffield, Chair of the National Institute for Health Research Health Technology Assessment Clinical Evaluation and Trials Board and a National Institute for Health Research Senior Investigator. His research interests include organisation of emergency care, economic analysis, clinical trials in emergency medicine and developing evaluation methods for emergency care. His recent major research projects include the 3Mg trial, the RATPAC trial, the DiPEP study and evaluation of the UK National Infarct Angioplasty Pilots. His other roles include Chair of the BREATHE and MACS Trial Steering Committees and Consulting Editor for Annals of Emergency Medicine.

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premises licensed for the on-site sale and consumption of alcohol. The effect is that acute intoxication is now one of the most common reasons why patients attend ED on Friday and Saturday evenings. It is unlikely that this will change substantially in the coming decade (Minimum Unit Pricing, for example, would not substantively affect the price of alcohol in licensed premises).

There are numerous immediate risks associated with acute alcohol intoxication. Alcohol is a central nervous system depressant and therefore promotes irregular breathing, confusion and if left untreated it ultimately leads to seizures, coma, respiratory, cardiac arrhythmia and arrest. Due to these risks alcohol related admissions may be prioritized, placing additional demand on majors routes within an ED. However, most cases of alcohol intoxication resolve without treatment or only require observation and simple supportive care. They could therefore be managed more efficiently in a lower dependency setting if appropriate observation and the ability to escalate care were available.

What are Alcohol Intoxication Management Services (AIMS)?

AIMS, sometimes referred to as Alcohol Treatment Centres, Alcohol Recovery Centres, Alcohol Welfare Centres and, in the media, "Drunk Tanks", are designed

Cardiff ATC New Premises

to receive, treat and monitor intoxicated patients who would normally attend EDs and to lessen the burden that alcohol-misuse, an avoidable healthcare cost, places on unscheduled care. They are usually located close to areas characterised by excessive intoxication and are open at times when the number of people drinking to excess peaks (e.g. Friday and Saturday evenings) as well as significant events (e.g. student nights), sporting occasions and national holidays.

Table 1. Examples of AIMS

AIMS	Description
Cardiff Alcohol Treatment Centre ATC	• Opened 2012 • Based in a building in the city centre • Commissioned by Cardiff and Vale Area Planning Board (APB) • Open: Friday and Saturday, 8pm until 8am, plus additional high-activity nights Staff: • Police officer • Nurse practitioner • Paramedic • Urgent Care Service Care Assistant • Substance misuse / alcohol worker
Birmingham City Centre Treatment Unit (CCTU))	• Opened 2011 • Based in a static ambulance in the city centre • Run by West Midlands Ambulance Service NHS Foundation Trust • Open: 9pm to 4am Fridays and Saturdays and on days of 'high demand' Staff: • Paramedic • Emergency Medical Technician • Supported by two RRVs and two double-crewed ambulances.
Manchester Safe Haven (Nexus Art Café)	• Opened 2015 • Based in a community café/ church building • Run by Greater Manchester Police volunteers and Nexus café staff. • Open: Saturdays 11pm to 6am, some Fridays. Staff: • Café volunteer staff • North West Ambulance Service paramedic (if requested)

AIMS can take a number of different forms and vary in structure, staffing, organisation and ability to deliver clinical care. The different types of AIMS are outlined in the box below.

What are the potential benefits of AIMS?

There are four potential benefits from AIMS.

1. AIMS potentially offer a cost-effective means of improving the provision of care in ED by managing intoxicated patients elsewhere. Having fewer intoxicated patients in the ED may reduce the number of violent incidents thereby improving the ED environment and other patient's sense of safety and general wellbeing.

2. AIMS may improve ambulance handover at ED and by implication ambulance capacity in the community. Increasing ambulance capacity is likely to improve opportunities to respond promptly to calls from the community, increase opportunities for prompt medical treatment, improve rapid transport of patients to specialists, and potentially improve survival rates and the better use of existing resources.

3. Police officers can become caught up in ED when they seek a clinical opinion on an offender's health or respond to an incident in ED (e.g. assault on a member of staff). There is evidence that police presence can prevent significant injury in the cause of violent assault through early intervention [12]. The availability of the AIMS would mean officers are able to return to duties more rapidly. Increasing police capacity is likely to decrease the risk of assault with injury in patrons of the night time.

4. AIMS offer a good opportunity to address problem drinking, particularly as the point where patients are safe to be discharged as they are likely to be in a "teachable moment," a period when brief interventions are most effective [13]. AIMS

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have the potential therefore to reduce alcohol related harm which can yield tangible benefits for both patients and the local community.

What is the evidence for AIMS?

Preliminary evaluations [14] suggest reallocating clinical and other resources can yield a substantial improvement in the provision of unscheduled care, but few formal studies have been undertaken. An initial evaluation in Wales has been completed and showed that the AIMS successfully diverted patients away from the ED, but also suggested that the additional capacity provided by the AIMS was associated with an increase in demand for health services, possibly due to pre-existing unmet need in the night time economy.[15] Similar innovations have been described in Australia, Eastern Europe, Russia, North America, the former Czechoslovakia [16-19], although evaluations are again lacking.

Alcohol Treatment Centre

Formal evaluation is therefore required to determine the impact of AIMS on health service provision, patient well-being and the community generally and what, if any, improvement in the delivery of healthcare AIMS can offer.

Evaluating the Diversion of Alcohol Related Attendances (EDARA)

EDARA is a multicentre study funded by the UK National Institute for Health Research to evaluate the impact of AIMS. The proposed evaluation method is that of a natural experiment, comparing areas in which AIMS have been implemented or are planned to control cities without AIMS. The project will evaluate the acceptability, effectiveness and cost effectiveness of AIMS involving observations and interviews with key stakeholders, frontline staff and people using AIMS, questionnaire surveys of people using AIMS and people using EDs (as they may benefit through reducing the number of drunk people in shared waiting areas), analysis of AIMS activity and outcomes, comparison of ambulance service and hospital key performance indicators, and simulation modelling of cost-effectiveness. The findings are intended to determine whether AIMS should be rolled out as a standard means of managing patients with alcohol intoxication presenting to the emergency services at times of peak incidence.

Alcohol Treatment Centre

This study is funded by the National Institute for Health Research HS&DR (project number 14/04/25). The views and opinions expressed are those of the authors and do not necessarily reflect those of the Health Service and Delivery Research Programme, the NIHR, NHS or the Department of Health.

To get in touch and find out more visit their website:
www.cardiff.ac. uk/violence-research-group/ research-projects/an- evaluation-of-alcohol- treatment-centres

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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. October 2015. Date of preparation: December 2015. PMR-JUL-2015-0239

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]

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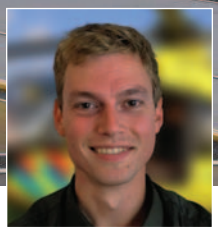
The Lifeliner 4, Mobile Medical Team Groningen at the UMCG helicopter platform. Source: University Medical Centre Groningen

Let's fly

An integrated approach to HEMS networks



By Renco Porton – Data Scientist at UMCG Ambulancezorg

Remote areas are always a challenge for ambulance providers. These areas tend to be on the edge of the map and are notoriously difficult to provide quality care for. The Frisian Isles illustrate this problem of coverage. Located north of the Dutch mainland, in the rural province of Friesland, these four islands have no major health facilities. Patients often need to be transported to the mainland either by boat or helicopter. For the past 50 years, the 303 SAR squadron of the Royal Netherlands Air Force was tasked with these transports. Defense budget-cuts have recently led to the decommissioning of this unit. Extensive research in the anticipated workload for an ambulance helicopter have led to the introduction of a dedicated ambulance helicopter service for the Frisian Isles. The ambulance helicopter will be added to the ground ambulance fleet of the regional ambulance provider, RAV Fryslân.

The 303 Search and Rescue (SAR) Squadron in action. Source: https://www.defensie.nl/actueel/nieuws/2014/09/25/begin-van-het-einde-voor-303-search-and-rescue-squadron

Hence, RAV Fryslân wanted to gain a better understanding on how ground ambulance operations and air operations would work together in a hybrid air-ground operational model. The analysis of the specific regional model was part of my master thesis in Industrial Engineering and Management. The main questions were *"where in the entire pre-hospital process could the ambulance helicopter add value?"*, and, "how can the helicopter be optimally integrated with the already existing ground and trauma helicopter network?"

The first question requires one to look at the bigger picture and discern all the possible uses of a medical helicopter. This should be combined with some type of effectiveness matrix which can score the value of certain uses of a helicopter for a specific region. Unsurprisingly, the value of a certain use is highly dependent on geography and demand characteristics. Other aspects such as politics and available budget also play an important role in this matrix. Medical helicopter operations can be categorized into three groups: firstly, operations that bring care services to a location, secondly, operations that transport patients and medical supplies between locations, and lastly, search and rescue missions.

The value of helicopters in search and rescue missions are clear: they can quickly scan large areas by allowing for a bird's eye view and reach places that are otherwise impossible or difficult to enter. Likewise, the transport of patients and medical supplies are beneficial as helicopters provide a clear advantage in terms of accessibility. Their ability to fly in straight lines to a location and not be restrained by road or sea conditions allow helicopters to prevail over alternative vehicles, especially for patients with time critical conditions.

Vast remote areas, mountainous terrain, and islands are prime examples of places that benefit from ambulance helicopters. Despite these obvious gains, the real advantage of an ambulance helicopter should be measured against alternative means of transportation, and against time targets that have been set, by using quantifiable methods.

The best example of bringing care services towards a location can be seen in the large number of physician staffed helicopters that are part of trauma networks around the globe. The main purpose of these services is to provide advanced medical care by a physician to the location of an incident - the transport of patients to a medical facility is often not the first priority of these operations.

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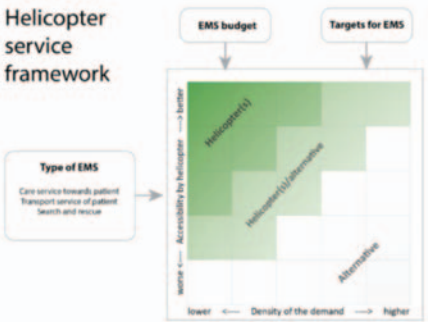
The Netherlands provides this service in the form of the Mobile Medical Team network, which consists of 4 helicopters that cover the Netherlands. Helicopters are most suited for this task as time is an essential factor, and physicians are expensive and scarce. The demand for such operations is relatively low and often spread out over a large geographical area. Or in other words, the 'demand density' is low.

Mobile Medical Team coverage areas
Source: ANWB- Medical Air Assistance

Demand density is an important factor which influences a helicopter's effectiveness. Achieving the same response times using a ground network would require many specially dedicated physician-staffed ambulance stations. This would not only be very expensive, but also these units would have an extremely low workload.

If the demand in a certain region -thus, the demand density - increases, there will be a point at which many helicopters will be needed to meet that demand, so much so that it surpasses the costs of a ground network. Having a low demand density and a high performance in terms of accessibility for certain operations ensures the effectiveness of using a helicopter.

It quickly became clear that the second question, of how to setup a completely integrated HEMS network and predict its performance, resulted in an endless number of sub-questions relating to all aspects of the network. These questions, in turn, were all somehow interconnected with each other. Where is the best location to station the helicopter? How will the performance relate to a growing workload? Can the existing trauma helicopter network act as a backup for island transports in case the ambulance helicopter is unavailable? What would this influence be on its own performance? The myriad of questions meant that it was necessary to devise a tool that would answer these questions.



A proposed framework to assess a helicopter's effectiveness

The simulation tool has been further developed and now integrates the complete helicopter, ground and emergency department network in the Northern Netherlands

What resulted was the development of a simulation tool that combined both a simplified ground network and the complete helicopter network, including the current trauma helicopter in the Northern Netherlands, the LifeLiner4. This tool made it possible to understand how the complete HEMS network would perform under varying conditions accompanied by so many uncertainties, within the various network setups. It proved to be very useful in testing different network configurations, and measuring performance from utilization, to service times, flight hours and served and unserved demand. The tool also proved useful in getting me my degree and a job as a data scientist at UMCG Ambulancezorg.

The biggest advantage of a tool that integrates all the different resources is the possibility to measure the effects of interaction. These valuable insights can further change the way we perceive the added value of an expensive resource, such as a helicopter. My research started with a simple and general notion that the new ambulance helicopter would have a far greater capacity to perform numerous types of operations, alongside the 'only' 250 estimated yearly patient transports from the islands. At the same time, the LifeLiner4 could easily act as a backup, as this helicopter 'only' has an average utilization rate of 13%, which is about 1300 missions a year. These notions were challenged by the simulation results.

The model showed that with the current demand patterns, the ambulance helicopter would already be unavailable in 5% out of 250 transport requests due to overlapping missions. This number rises to almost 10% should these requests grow to 450 missions a year. If the LifeLiner4 were to take on these transports, the chance of being unavailable for trauma patients would increase significantly. In turn, these patients would have to wait for one of the other - much further away - LifeLiner helicopters. As the added value of the LifeLiner4's physician is especially high for a select group of trauma patients, one might argue whether performing backups for non-trauma patients is worth the risk of the helicopter being unavailable for a time-critical situation in which they are really needed. The actual likelihood of these scenarios happening were difficult to estimate without the model.

If we were to manage a helicopter unit without these insights, we would probably have guessed that a 30% utilization rate would strike us as a good balance between utilization and availability. At that point the cost per mission feels acceptable, so the helicopter unit appears to be affordable and thus more valuable. Higher utilization rates might even be preferred if the motivation is to further lower the mission costs. However, the real value of a helicopter service is revealed when it is available for the patients who truly need it, and high utilization rates lower the chances of that happening. It becomes apparent that we are struggling with understanding the trade-off between utilization and availability. Due to the fact that this tradeoff is dependent on many network characteristics, simulation is an effective and essential tool for every helicopter unit to fully understand the dynamics at play here. Following this, the biggest challenge then becomes identifying which patients really need the helicopter – which is another question altogether.

For more information, please contact Renco by email at: r.porton@rav.nl

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The demands on healthcare professionals have never been greater—heavier patients, longer transports, demanding patients, and an expectation to perform with fewer hands on deck. Caregivers are forced to do more with less. At the same time, hospitals are now under increasing pressure to improve efficiency and capitalise on cost- and time-saving activities.

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Nursing injuries are expensive for healthcare organizations and can shorten careers. Most injuries occur while repositioning, lifting or moving patients. Stryker Prime is designed to help reduce or eliminate awkward body positions that can lead to injury, by incorporating ergonomic and electric functionality. Prime series stretchers offer three mobility options and unprecedented patient comfort. A variety of available support surfaces and configuration options give Prime the versatility and reliability you need

Most recent product launches

Prime TC: Transform Transport with the Prime Transport Chair

When it comes to the patient experience, details matter. That is why every aspect of the Prime TC Transport Chair is designed to create a welcoming environment that speaks volumes to caregivers, patients and their family members. Obvious touchpoints help make operation intuitive for all users. BackSmart® ergonomics have been incorporated into the design to reduce the bending and reaching associated with caregiver injury. A rigid frame helps enhance durability while reducing the risk of theft. This investment in the well-being of patients and caregivers tells them you care about their comfort and safety – it tells them that they matter.

Stryker Patient Care

When it comes to choosing products for patient rooms, it is important to select a product that represents the standard of care.

Stryker's Patient Care portfolio focuses on quality and prevention with a proven, performance based approach that impacts both clinical and financial outcomes for healthcare facilities. Stryker has launched over 10 new Patient Care products in the past 3 years, including a new hospital bed that can be versatilely used in both general ward and critical care settings, support surfaces with pressure ulcer solutions, and patient room furniture.

Most recent product launch

Stryker SV1: Versatile Patient Care Bed, Your New Standard of Care

As the newest bed in Stryker's Patient Care portfolio, the Stryker SV1 bed is designed with a featurerich platform that offers easy-to-use electronic controls for both caregivers and patients. The safe and durable bed design includes full-coverage, tuck-away siderails with minimal transfer gap, a four section litter deck, under bed light and battery backup as standard features. The nurse control pendant at the foot end of the bed includes one-button positioning which allows caregivers to easily configure the bed into a variety of positions, including: cardiac chair and emergency CPR. LED indicators are included on the nurse control pendant to signal motion lockouts, power connection, and battery charge. With performance and safety certifications from UL-qualified testing facilities, the Stryker SV1 bed is truly a safe, simple, and durable innovation.

This Stryker SV1 bed has been tested to a variety of compliance standards, including but not limited to: IEC 60601 3rd Edition, RoHS2 Directive 2011/65/EU on the restriction of the use of certain hazardous substances in electrical and electronic equipment; IEC 60601-2-52 Ed. 1.0 B: 2009 Medical electrical equipment - Part 2-52: Particular requirements for the basic safety and essential performance of medical beds; and European Directive 94/62/EC on Packaging and Packaging Waste.

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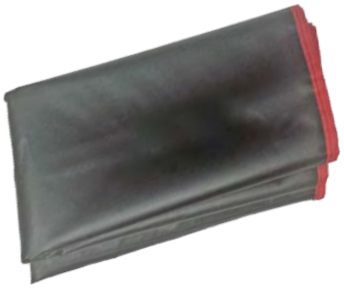

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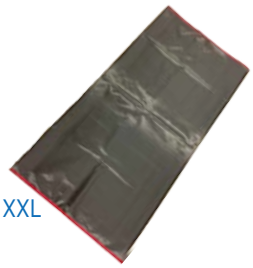


Vacuum mattresses

Text Messaging that Means Business!

Effective communication to staff, officers and volunteers is a key part of rising to the challenge of improving the efficiency of operations and emergency response. PageOne's range of critical messaging services are assisting many blue-light organisations communicate swiftly and securely in emergency and life-saving situations.

PageOne's Connect messaging services are tried and trusted by major private and public sector organisations across the UK. Designed to support a range of mobile messaging networks and technologies PageOne Connect delivers multi-channel messaging and alerting when it matters, be it via paging, SMS, email, smartphone, or voice.

Critical alerting

Northern Ireland Ambulance Service have used PageOne services to alert and direct Community First Responders for over 15 years. Network coverage, speed, communications resilience and broadcast capability meant that PageOne's national paging was the ideal network to alert local volunteer and improve paramedic response time.

The service must act quickly when life-threatening conditions such as heart attacks and electrocutions strike especially for those living in remote and rural parts of Northern Ireland. The Community First Responder (CFR) scheme relies heavily on local volunteers trained in skills such as resuscitation and the use of defibrillators, which can stabilise patients whilst awaiting the ambulance crew. Whenever a call is received, the system automatically pages all CFRs within a locally defined area of the address.

PageOne's paging network has extensive coverage across Northern Ireland and with paging signals propagating further than mobile signals it allows critical alerts to be delivered across the widest area.

Closing the Loop

Whereas traditional paging is one-way the advent of two-way paging services is opening up new ways to communicate and helping improve management of field resources and response times. PageOne's Responder two-way pagers are capable of using both paging network and the GSM mobile networks to deliver critical messages. Using a unique 'fall-back' capability, if the pager is out of coverage of the paging network, messages are automatically transmitted via the GSM mobile networks, extending the effective coverage and providing further resilience

Scottish Ambulance are using two-way pagers to communicate with officers and provide resilient communications alongside their Tetra radio system. The ability to broadcast incident alerts to either regional, specialist or national groups allows alerts to be targeted and with officers able to confirm back whether they are attending it is helping Control Rooms in managing incident response more effectively.

Specialist teams are also benefitting from the resilient communications afforded by the Responder pagers, which also support a GPS location capability. South Central Ambulance Service's Resilience & Specialist Ops team are using Responder pagers that allow the Control Room to check who is nearest to an incident and for staff to confirm they are responding.

Text messaging that means business

The fact that SMS is ubiquitous and works on any GSM mobile handset means text messaging is helping many NHS Trust and ambulance authorities communicate with staff and customers alike, particularly for non-critical applications as diverse as Patient Transport coordination, staff overtime scheduling and patient appointment reminders.

London Ambulance are using SMS messages delivered via PageOne's text-to-speech service to alert trained personnel with access to defibrillators registered to its 'Shockingly Easy' accreditation scheme. Mobilising local first-aiders trained to use defibrillators can significantly improve the survival chance of a cardiac arrest in a public place from 32% to 80%.

With a plethora of alerting technologies and networks available today PageOne can help you select the right mix of services to improve operational efficiencies and response. PageOne's secure web-based Connect messaging suite allows businesses full control of their messaging from the desktop, or third-party software systems can integrate with PageOne's messaging gateway for seamless automated alerting.

To find out more about how PageOne services can help your organisation contact Raymond Fegan, National Sales Manager

Email: raymond.fegan@pageone.co.uk

Phone: 0333 200 5033

Web: www.pageone.co.uk/contact-us

Auxilium Live in the Isle of Wight

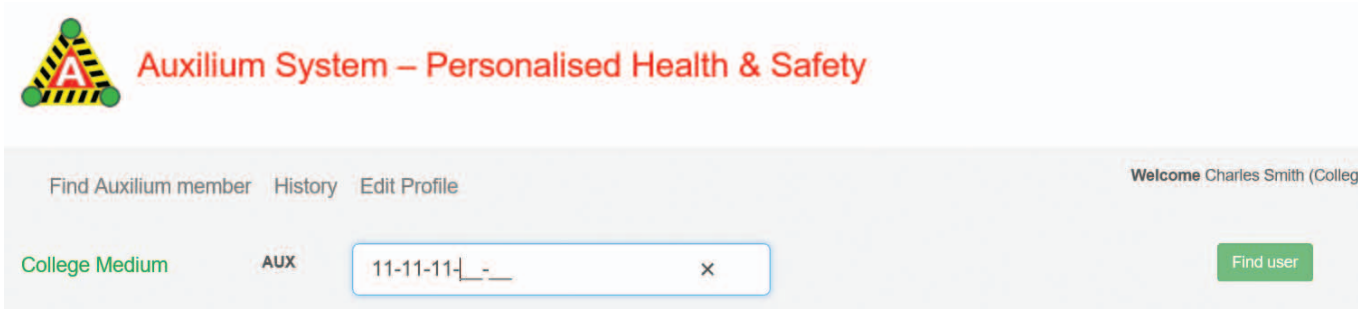
Signing up to an Auxilium Number costs £1.00 a year with amendments costing you nothing for as many as you want as often as you want, unlike other systems. So there is no excuse for the user to have out of date information.

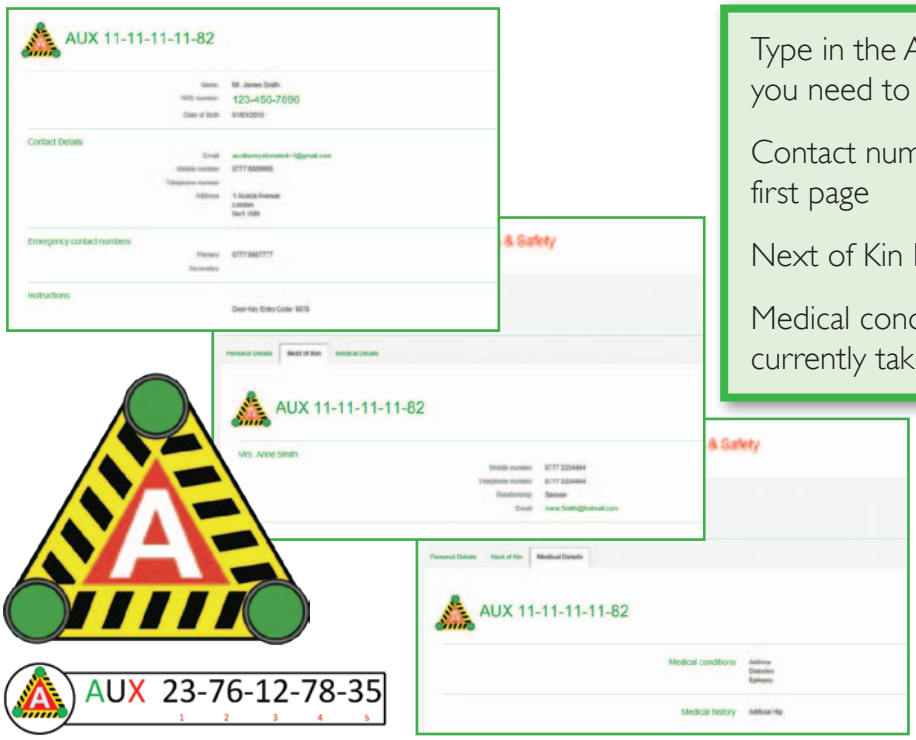
In its consultation and design stage we created a system that could be used across the ambulance trusts but also as a standalone within organisations, business, schools, colleges and events. It means that the Auxilium System works across the country and also as a 'bubble'.

We thought it time for you to see what how it works, what a 'reader' of the system would be able to see. A Reader is an organisation that has been given permission to view the user's data by the user. A Reader could be

- In a school – tracking accidents/instances and up to date contact information
- At a festival / events / shows / concerts, especially if it is an overnight event
- On 'lost children' wrist bands – providing better safeguarding than a scribbled number
- In a business to log health and safety issues and to have up to date staff records

In some instances you may wish to keep a register with numbers beside each name, whereas in other instances you would get the number from the person via a wristband / id badge etc.





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

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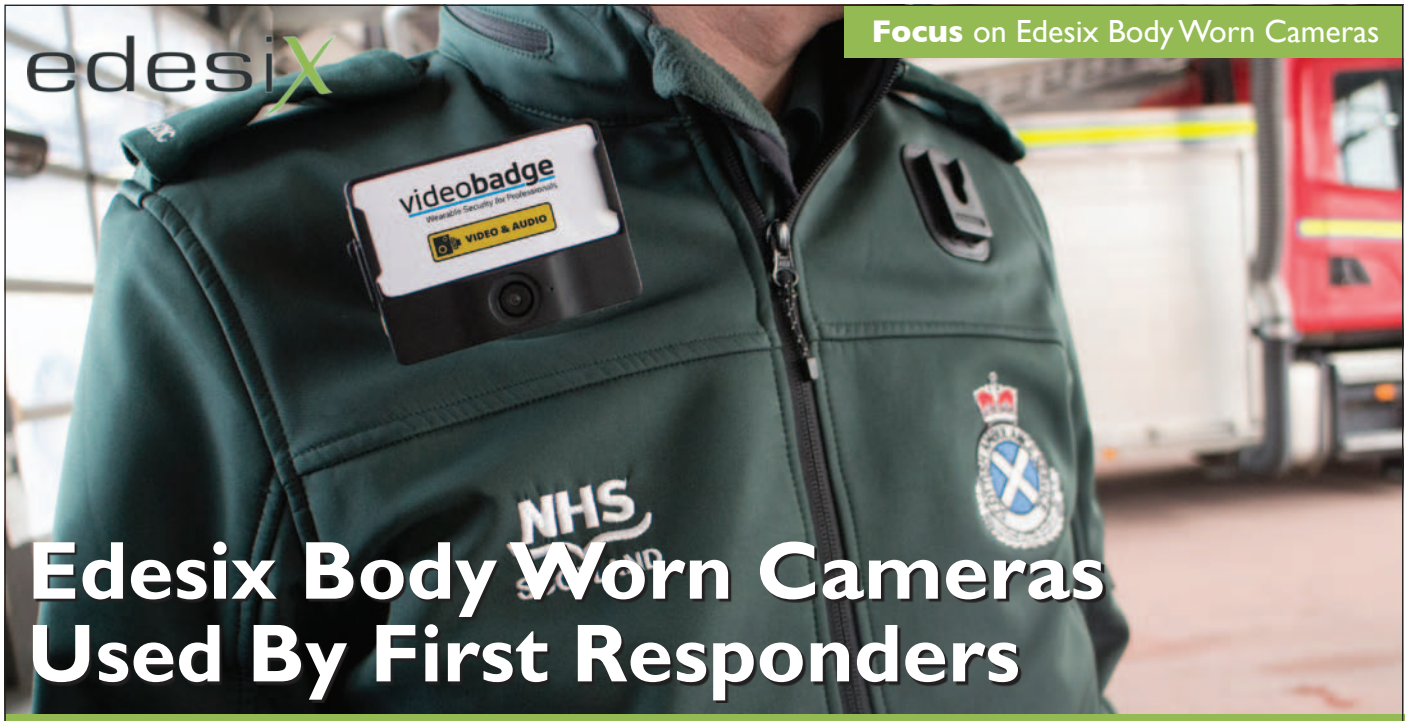

Edesix Body Worn Cameras Used By First Responders

Use of VideoBadge Body Worn Cameras is becoming more prevalent among air ambulances and first responders -including the Resuscitation Research Group based in Edinburgh- for training and auditing.

Body Worn Cameras (BWCs) have proven themselves to be much more than just an evidence gathering tool for law enforcement. Many frontline ambulance staff, paramedics and air ambulance crews now use Body Worn Cameras to help save lives in the field.

Edesix VideoBadge BWCs are currently used by advanced emergency response teams across the UK to audit out-of-hospital outcomes, evaluate new equipment, and train upcoming paramedics or support staff. The Resuscitation Research Group, whose aim is to conduct quality research into Resuscitation Medicine, deployed VideoBadges to improve their processes and techniques out in the field.

The Resuscitation Research Group at the Royal Infirmary Edinburgh

The Resuscitation Research Group (RRG) chose Edesix VB-300s for their Resuscitation Rapid Response Unit. The team needed a camera that was unobtrusive with a low impact footprint, and capable of preserving patient and medical confidentiality.

The VideoBadge can be securely attached to the paramedic's uniform, requiring only a single-touch to start recording, leaving their hands and concentration free to focus on clinical tasks. The RRG paramedics could then record responses in full HD audio and video, so that the footage could be reviewed at a later time.

Dr Gareth Clegg, RRG lead, commented on the effectiveness of Edesix VideoBadges for improving emergency response outcomes:

"VideoBadge is revolutionising the way we optimise high performance emergency teams. We can measure key aspects of performance in ways which were not previously possible."

All Edesix VideoBadges come with the corresponding web-based VideoManager software which offers a secure, scalable and intuitive system for managing both devices and videos. The RRG keeps videos within VideoManager, in a secured footage room, thus providing the requisite level of medical confidentiality. The software also allows the implementation of an automatic deletion policy ensuring that footage is not retained unnecessarily. Only authorised users can log on to view, edit and share footage which considerably reduces the risk of sensitive data falling into the wrong hands.

In addition, every Edesix BWC is encrypted so videos can only be downloaded at PCs or docking stations containing specific encrypted keys. This means that any footage stored on a VideoBadge is secure even if the device was lost.

In the near future, the RRG are planning to take advantage of the VB-300's Wi-Fi live streaming capabilities. Live streams from the paramedics' point-of-view would be viewed by support personnel in a control room, who may then provide vital advice concerning how to best handle a patient.

Wider Use Within Emergency Response Teams

Many other response teams and air ambulances throughout the UK have looked to Edesix VideoBadges to improve their out-of-hospital outcomes. The Great North Air Ambulance Service, which covers the North-East, North Yorkshire and Cumbria, equipped its paramedics with VideoBadges to help improve their standards.

Grahame Pickering, GNAAS chief executive, said:

"This development allows us to share experiences in an audio-visual way that will continue to drive standards upwards throughout our organisation. It will enable all of our clinical team to experience the challenging rescues, advanced medical procedures and unusual scenarios that they might not otherwise be able to witness".

About Edesix:

Edesix is an Edinburgh based BWC solutions provider, established in 2002. Unlike many other BWC manufacturers, Edesix focusses on encompassing Body Worn Solutions; utilising its range of products and software applications to work with customers to provide a system which delivers results, is simple to use, and – most importantly – is completely secure.

Further information:
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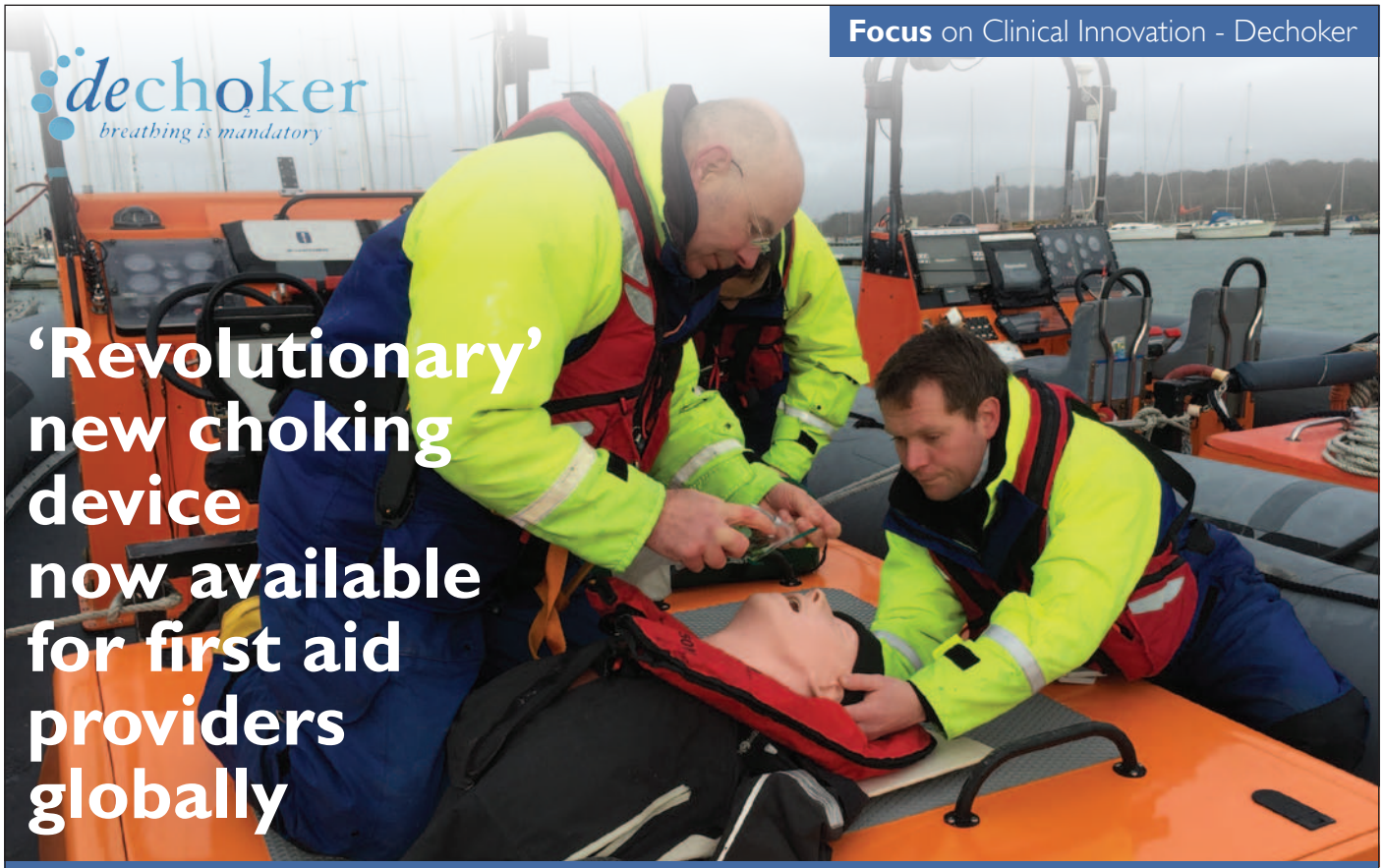

'Revolutionary' new choking device now available for first aid providers globally

A new emergency first aid device designed specifically to deal with choking is now available as an essential piece of emergency kit. The aptly named 'Dechoker' has been developed with a view to it becoming a part of all first aid kits across homes and businesses globally.

Choking is the leading cause of death in children, and is also a common occurrence in everyday life, across the age spectrum. The Dechoker device provides those with even a basic level of first aid training with a means to effectively resolve the emergency situation that could otherwise lead to death.

The principles behind the Dechoker are simple: the device sucks the air from a patient's airway (behind the obstruction) in turn sucking out the debris which has been blocking it. The mouthpiece attached to the Dechoker resembles a traditional oxygen mask but has an additional inbuilt tube, which, when the mask is placed over the nose and mouth, depresses the victim's tongue allowing maximum access close to the obstruction.

Once the mask is sealed around the person's face, the first aider gently pumps the air out through the attached respirator for up to 3 seconds. It is important to

note that any debris removed cannot be reintroduced into the patient's airway because of an integral one-way valve that prevents this.

Its simplicity of use and high success rate makes the Dechoker a crucial piece of emergency first aid kit for paramedics, A&E staff, emergency first responders, public places and businesses.

Dechoker Europe Ltd spokesman, Alan Walton commented: "We've been developing the Dechoker in close consultation with the medical world for years and now we're finally in a position to get this device in to the hands of people who really need it. We're hopeful that it'll soon become common place in every first aid kit around the globe – considerably reducing choking related deaths."

The Dechoker has been approved by the FDA in the United States and CE registered for Europe. It is also endorsed by a leading UK anaesthetist and Advance Life Support tutor Dr Biswas, FRCA.

A video explaining and demonstrating the Dechoker was made at a Nottingham hospital and can be seen at: www.youtube.com/watch?v=dY2EJNFRDH4&feature=youtu.be

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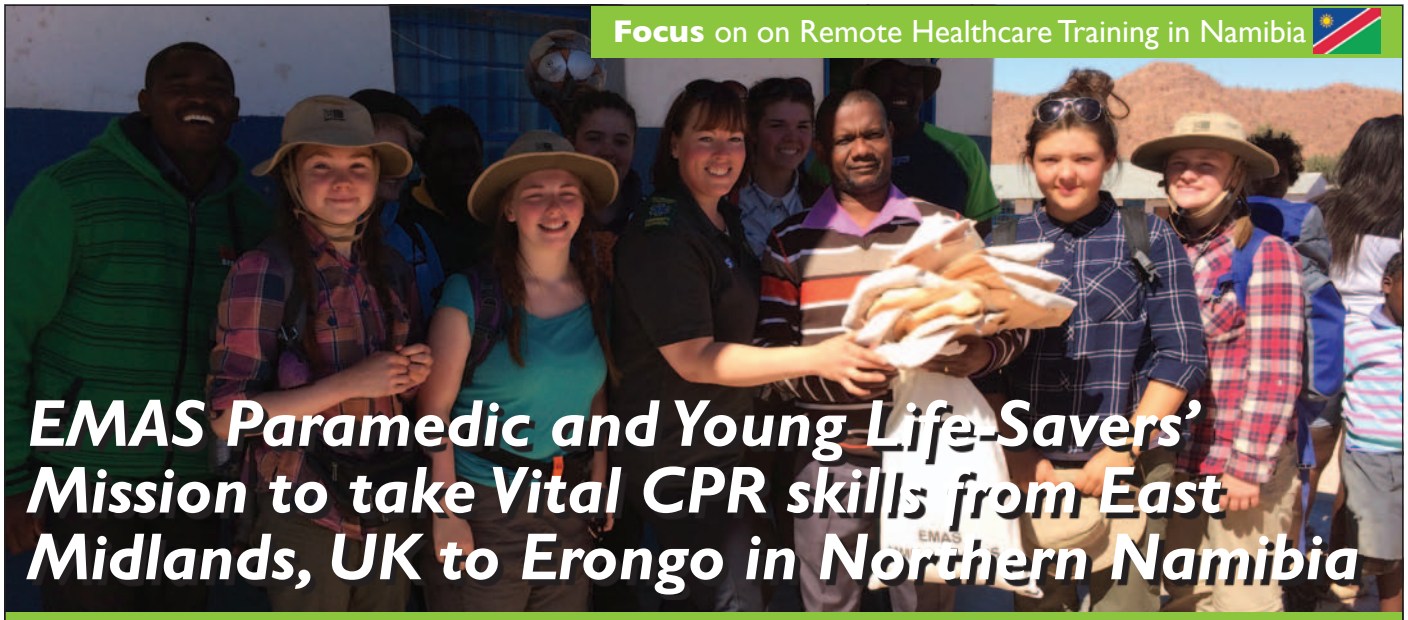

EMAS Paramedic and Young Life-Savers' Mission to take Vital CPR skills from East Midlands, UK to Erongo in Northern Namibia

A Paramedic and a group of Derbyshire schoolchildren have returned from a trip to Namibia where they've been teaching lifesaving first aid skills. The 30 students were taking part in the British Exploring Society (BES) initiative, along with East Midlands Ambulance Service (EMAS) paramedic Claire Griffin, 34 who is based at Mickleover Ambulance Station. The children first learnt Cardio Pulmonary Resuscitation skills before heading abroad to pass on their skills to the children from Abraham Goriseb School in Erongo Province, Northern Namibia.

British Exploring Society (BES) Namibia Bound expedition is a unique collaborative venture between the schools, Bolsover Partnership, SNaP, Derbyshire CountyCouncil, BES and NHS Hardwick Clinical Commissioning Group, with the students raising a significant element of the funding themselves through charitable deeds.

Speaking about the voluntary trip of a lifetime, Claire said: "BES made this trip an amazing opportunity for young people in our own country to grow and learn in an environment very different to what they're used to. The community life saving project gave us all a shared focus that allowed new learning to take place. It also developed the confidence and career choices of the young people involved at the same time as changing lives.

"The Namibian community is bursting with pride now they've had our training and the confidence within our young explorers was palpable. I am so very grateful to be part of a fantastic BES and school leader team. As a pastoral care worker within EMAS and also an associate clinical tutor I was able to develop my own skills in these areas and enjoyed supporting the children in this venture. I look forward to being involved in continuation training and follow-up support to see this project change the way emergencies are responded to in these remote areas."

The trip was funded by sponsors and charity events organised by the six schools in North Derbyshire that the children attend; The Frederick Gent school, Heritage High school, Bolsover school, Stubbin Wood school, Shirebrook Academy and Tibshelf Community school.

Dr Steve Lloyd, Chair of NHS Hardwick Clinical Commissioning Group began the Namibia bound expedition in 2014 and led the expedition this year. He explains the broader purpose of the expedition:

"The expedition was as much about delivering basic life support training to Derbyshire and Namibian students as developing confidence and raising aspirations. Many of the young people on the expedition have had to deal with difficult circumstances in their lives and the expedition gave them the opportunity to experience a place and life very different to their own.

"It was wonderful to see the expedition grow in confidence as they passed on the lifesaving skills they had been taught and of course it contributed greatly to the overall health and wellbeing of Erongo Province. The expedition also enjoyed treks into the superb wilderness and learnt valuable desert survival skills.

"All those involved in leading the expedition are delighted with how it has gone this year and now it is important to continue to build on this success and develop plans

over the next 12 months for the next Namibia bound expedition to ensure this collaborative programme continues in the future."

Steve is keen to talk to anyone who is interested in how they might contribute to supporting the efforts of the Eagle Christian Centre Ambulance to expand their community training programmes and also individuals who are passionate about supporting the development and aspirations of young people. He can be reached at: Steven.Lloyd@hardwickccg.nhs.uk

Following the expedition Claire is now fundraising to buy a defibrillator and other medical equipment for the Namibian school so if you're an ambulance provider of any type, a defib manufacturer or a supplier and you are able to help this worthwhile project in any way, big or small, please visit Claire's fundraising page at: www.youcaring.com/eagle-christian-ambulance-charity-namibia-627461

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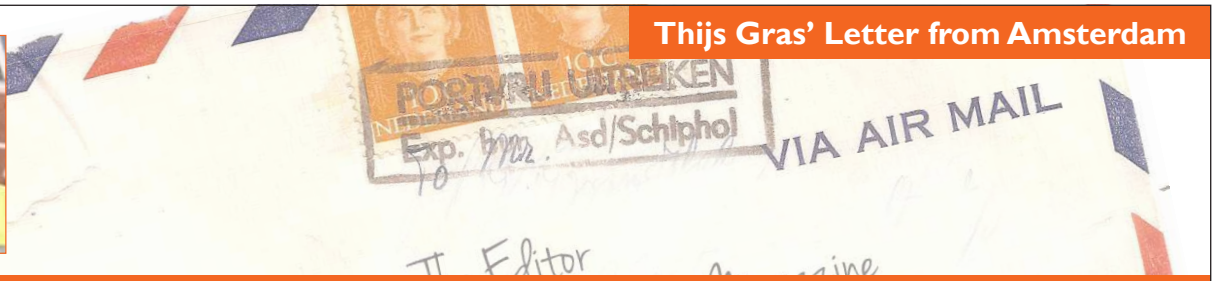


The Sorcerer's Apprentice

Ambulance Today's marvellous and mystical expert on all things EMS in the Netherlands, Thijs Gras, is a practising ambulance nurse with a great many years experience and, despite his many other professional commitments, he takes great pride in maintaining his full-time role as a hard-working ambulance nurse in hectic Amsterdam. Below Thijs reflects on one of the more satisfying aspects of being a seasoned ambulance nurse or paramedic - the opportunity to pass on your unique set of field skills to younger colleagues - those special 'tricks-of-the-trade' which you only learn from being out there on the street.

One of the privileges of being a little older and having experience is that you sometimes get the chance to introduce a colleague-to-be to the secrets of our trade. This is a very refreshing experience and one of the most interesting aspects is that you have to explain what you do and why you do it this way.

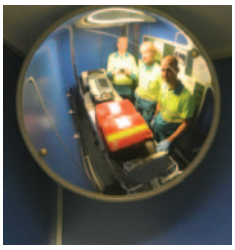
Normally this goes without saying, but by explaining where I started thinking from, which possibilities crossed my mind and why I chose a particular one, I now see more clearly just how much knowledge and experience is involved. I see a parallel with playing a musical instrument; professional players make it seem so easy so it's only when you listen to an amateur, or even worse - when you try it yourself, that you realise just how much technique and training has been spent to reach that level. The guy I have with me is an experienced IC-unit nurse with nine years in IC and some years in the resuscitation team in his hospital.

On our first shift together we had a couple of very complicated situations including a poor, 85-year-old lady sitting in a wheel chair, who had fallen down a set of concrete stairs, knees and head-first, ending up on her belly with her legs halfway-up the stairs and her head around the corner in a pool of blood. We were surprised to be able to talk with her; both her legs were not looking good and showed open wounds and instability. We gave her an IV, ample pain medication and gently manoeuvred her with the help of a scoop stretcher to our vacuum mattress for definitive immobilization. In the hospital it turned out she had broken both her femurs and her right ankle with a compound fracture. Her head was not so bad and, thankfully, she appeared to have no brain injury.

The next one was just as challenging, if only in a social and psychological sense. A man of 87-years could not walk anymore. He lived with his 78-year-old wife in a typical Dutch interior. He himself said everything was OK, but his wife had called us; she could not cope with the situation any longer. Being old and suffering from back pain herself, she was not able to escort her husband to the bed and the toilet. To make things worse a not-so-smart, 56-year-old son was also there because

he had a temporary care problem (he had fallen too and had an injury to his jaw) and his mother had taken him in; he was not married and had no one else to look after him. He asked for our attention too, so actually we had three patients on our hands. There was one other more normal and intelligent son living elsewhere, but when his mother had called him for help, he said he could not come because he had to work. We were glad to hand this problem over to the family doctor who could provide for an emergency nursing-home place. This situation required a great deal of coordination of care, knowing who to call and how to quickly and clearly sketch-out the problem to other professionals involved in the chain-of-care.

To top it off, that day we were sent to a 93-year-old woman who was found on the floor by an emergency home-care organization with some blood from a head injury. When we arrived we found a nice, not-so-clean lady lying on her bed with a cat next to her. A small wound stained some of her grey hairs red but it was not bleeding anymore. Apart from that she had a laceration on her leg. She could not tell us why she had fallen. All the other findings, including an ECG, were normal; she had practically no pain. When we, according to our standing orders, proposed a visit to the hospital she pleasantly but categorically refused: "Oh no, just wipe away the blood and be off with you!" We insisted, but she did too. No way was she going to the hospital! We found the phone number of her son and I called him. He gave a good picture of the situation: his mother was done with life and wanted to die sooner rather than later. She was mentally quite stable and he painted a very good picture of the woman we had been talking to. His message: please do not take her. While my colleagues (the driver and the trainee) attended her injuries cleaning and covering them, I called the family doctor to leave a message.



We in the Netherlands have a system whereby every person is obliged to have his or her own family doctor and this doctor serves as an important gateway and filter for care. The family doctor's care is free (that is to say, covered by the health insurance companies and not costing you your 'own-risk' contribution). Of course one doctor cannot work 24-hours, so outside of office hours there is an emergency family doctor service to provide care and inform the patient's own family doctor about things happening that s/he should know about. They create a message so that when the doctor opens their files the next working day, s/he sees which of their patients were seen by the emergency family doctor service and what was the matter.

I wrote a comprehensive report in the home care folder and the old lady was glad to see us off. She was quite friendly and judging by her library, not at all stupid. This is a rare privilege not afforded to hospital staff: we get a glimpse of a person's living situation and can take this into account when making an assessment.

I am really looking forward to initiating this apprentice into the secrets of ambulance thaumaturgy. He will be quite surprised by the magical tricks he will encounter (for example the use of the Cunningham-method to correct a dislocated shoulder: he was the witness of my first attempt and it worked very well!). But I will learn from him too: he has very recent clinical experience so he can teach me about new insights and developments too; but just as importantly for me, I hope he will be a critical-mirror for my own reasoning and solutions.

Tell Thijs what you think about this article by emailing him at: thijsgras@upcmail.nl

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IAED Presents Inaugural Award

Scottish symposium embraces dispatch in OHCA survival

The recipient of the inaugural dispatcher award at the Scottish Cardiac Symposium for emergency communication dispatch had less to say in her acceptance speech on stage than the presenters. That's because Gillian Ferguson is accustomed to staying out of the eyes of the public and, quite honestly, she definitely prefers it that way.

"I'm a shy person," Ferguson said after she received the award on June 24. "I'm not one for stages. That's not the nature of our job. We're in the background."

Talking to Ferguson it's easy to understand why her team at the Scottish Ambulance Control Centre (ACC) nominated her. A dispatcher for 13 years, and a call-taker for one year before that, she is clearly enthusiastic and conscientious about what she does.

"I am very happy in my job," she said. "We make a difference. I can go away from my shift knowing I helped a patient and the family and when the crew says 'we're glad we have you today,' that's nice. It's a good thing."

The Academy Award, as it is named, is a joint sponsorship between the Resuscitation Research Group at the University of Edinburgh, Scotland, and the International Academies of Emergency Dispatch® (IAED™), in Salt Lake City, Utah, and established in recognition of the emergency dispatch profession and partnership forged between the two organizations.

"The partnership is incredibly important to the Academies," said Jerry Overton, IAED Accreditation Board Chair (and *Ambulance Today* columnist), who with Dr. Jim Ward, Medical Director of the Scottish Ambulance Service, presented the award. "This is the first partnership of this type for the Academies and with an award that acknowledges our joint dedication to increasing the survival from Out of Hospital Cardiac Arrest."

Ferguson was among five from the Scottish Ambulance Service control centres nominated. The service has three centres in Scotland (Edinburgh, Glasgow, and Inverness) and each uses the Academy's Medical Priority Dispatch System (MPDS). She had been notified about the nomination and, on the day of the symposium she was told she would be going on stage to accept the award.

"I was quite shocked," she said. "You don't do this job for the recognition. We are the first contact but, for the most part, the public doesn't know what we do."

Facebook posts congratulating Ferguson prompted her to thank everyone in return:

"Can I just say a massive thank you to everyone for all your kind messages today, I'm really honoured. As the saying goes there is no 'I' in 'Team' so a special big thanks to all my team mates for their support today and every day in ACC and also the nominations! Go team!"

Award-winner Gillian Ferguson

According to her nomination: *Gillian is an outstanding dispatcher and her whole team would love to see her get the recognition she most definitely deserves. [She is] very attentive when dealing with OHCA. Understands the process and need for allocating appropriate*

resources and does everything she can for the patient and crews attending. Gillian always puts patients first and goes out of her way to ensure they are getting the best possible response. She is a very active member of the team, supporting them when necessary, especially during major incidents. She is sure to check on a patient's condition once the crew has cleared from the incident as she is genuinely concerned for their welfare. She is also conscious to check on the welfare of her crews when dealing with difficult incidents and is well known by the staff across all east divisions as being incredibly helpful, friendly, and professional.

Jerry Overton acknowledged the critical link that every EMD automatically assumes in the chain of emergency response.

Jerry Overton

"There is no one real winner of the award," he said. "Every dispatcher is a winner. This is an incredibly stressful job just like it is stressful for those in the field delivering the care. EMS is a team approach and your careful use of the protocol has saved countless lives."

Ward echoed Jerry Overton's remarks prior to naming the two runners up and first place awardee Ferguson.

"You guys do an amazing job," he said. "You're not generally visible on the frontline but absolutely critical to the chain of survival and the successful outcomes of patients."

Scottish Ambulance Service runners-up for the award included Robert Pearson, an Ambulance Control Centre (ACC) Supervisor, and Caroline Shand, an Emergency Call Handler. Rounding out the exceptional group of nominees were Linda Burns and Alistair Strachan, who are both Call Handlers.

A second major honoree, Fiona Laing, received the Newton Award, established by Gregor and Judy Newton to recognize the outstanding work of EMS in Scotland.

About the International Academies of Emergency Dispatch

The IAED is a non-profit standard-setting organization promoting safe and effective emergency dispatch services world-wide. Comprised of three allied Academies for medical, fire and police dispatching, the IAED supports first-responder related research, unified protocol application, legislation for emergency call center regulation, and strengthening the emergency dispatch community through education, certification, and accreditation.

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TASC urges Ambulance Service Community to sign up to its Supporter scheme

TASC, The Ambulance Services Charity exists to offer vital support to all members of the ambulance service in times of need but without receiving greater support the aid it can offer ambulance workers in need is obviously limited. Which is why it needs as many ambulance people as possible to sign up to it's Supporter Scheme.

Although officially launched in March 2015, TASC has grown from its predecessor The Ambulance Services Benevolent Fund, and is the only UK ambulance services charity providing essential support to ambulance staff AND their families in times of urgent need due to injury, ill health, stress or bereavement, and which can also lead to financial difficulty.

Ambulance services across the UK provide a dedicated, responsive service which fully meets the needs of those who call upon it for help. But ambulance staff sometimes need help and support themselves and, on occasion, their own health and well-being can be affected due to stress, injury, or other issues.

The Ambulance Services Charity exists to help provide support and advice to serving and retired members and their families in their time of need by offering a range of services for a variety of difficulties, delivered by professionally qualified staff.

Financial support and advice is available, including access to free bespoke debt advice services in the event of financial problems getting out of control. TASC may also be able to assist with financial grants during periods of real difficulty or hardship to help pay for things ranging from essential household bills to disability equipment and convalescent breaks. TASC is also able to work with partners to maximise the level of support available.

TASC may be able to provide access to rehabilitation for those suffering injuries, such as musculoskeletal damage, in the line of duty by working with the Police Treatment Centres and Fire Fighters Charity. And The Ambulance Services Charity is currently developing services to support those staff suffering with stress related and other mental health illness including Post-Traumatic Stress Disorder.

In addition, bereavement support is on hand to families of ambulance personnel who have died whilst in service, for those who have recently left the service owing to terminal illness, or for those in service who have lost a loved one.

TASC is now calling on the UK ambulance services community to enable it to make a real difference to the lives of ambulance staff and their families who turn to the charity for help by signing up to its Supporter scheme.

There are two ways of becoming a regular TASC Supporter. One is by standing order - TASC requests a minimum of £4 per month plus a signed Gift Aid declaration. Or you can pay through your employer's Give As You Earn (GAYE) scheme if they have one.

TASC's preferred method would be to use GAYE via the Giveall2charity platform provider. Your employer will have information about Giveall2charity. TASC requests a minimum donation of £5 (which actually costs you £4) with 100% of your kind donation going to TASC through Giveall2charity.

Your Trust fully supports TASC and hopes that you will do so too. Once an individual becomes a TASC Supporter they will receive a Welcome Letter from the charity.

For more information about becoming a TASC Supporter please visit: www.theasc.org.uk/support-us/donate-support-tasc.

Should you, or someone you know, need help, a member of TASC Support Services will be happy to talk to you and advise you on what the charity can do to help.

Please contact TASC on: 0800 1032 999/0247 7987 922

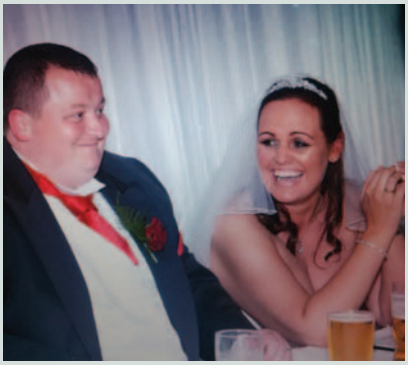
or visit: www.theasc.org.uk/need-our-help.

TASC
THE AMBULANCE SERVICES CHARITY

How TASC helps

People like Lesley, a member of the A&E Dispatch staff at North East Ambulance Service, who after just six months of marriage found a lump in her breast which was cancerous. This resulted in months of intensive cancer treatment and time off work meaning a reduction in salary and increased bills owing to frequent hospital visits. Lesley was struggling financially so her manager contacted TASC on her behalf to see what help was available for her. TASC was able to support her with a grant to assist with household bills, and also secured match funding from The Butchers & Drovers Charitable Institution, as her husband is a butcher.

Lesley and her husband are both planning for the future and hoping to put all this behind them. They are grateful for the support they received saying 'when you are ill you don't realise how much extra money you're spending on top of your normal bills for things such as heating, petrol getting to and from hospital, and hospital parking charges.'



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NAEMT National Survey Finds Data Use Growing in EMS, But Large Gaps Remain

THE USE OF ELECTRONIC PATIENT CARE REPORTING (ePCR) to collect data on patient care, operations and finances has become widespread in EMS, according to the results of a new national survey by NAEMT.

But actually putting that data to use in improving the quality of patient care, or to enhance practitioner and patient safety, still has a long way to go. While 79% of EMS managers said they used their data to assess agency performance and 61% reported using data to assess employee performance, many EMS practitioners and managers report that their agencies lack the resources, time and expertise to manage and analyze data.

Only about half (50%) said that they employ a data manager who is trained and responsible for overseeing agency data collection and conducting the analyses that would enable the data to be used more fully.

And data exchange – in which EMS both provides and receives patient information to and from other healthcare entities – is still in its earliest stages.

Nationwide, there are a few examples of EMS agencies participating in Health Information Exchanges (HIE) or other coordinated efforts to share patient information among multiple healthcare entities, with the goal of improving the quality and efficiency of healthcare. Yet most survey respondents reported significant barriers. Those included a lack of integration between software systems, perceived privacy concerns, and a lack of interest from other healthcare sectors in EMS data.

"This survey reveals that data collection, use and exchange in EMS is improving but we still have a lot of work to do," said Matt Zavadsky, chair of NAEMT's EMS Data Committee. "That work includes doing better to educate EMS practitioners about the importance of quality data collection to guide us in improving how we take care of our patients, and encouraging EMS agencies to allocate resources to managing and analyzing the data so it can be put to use demonstrating the value our profession brings to the patient and the healthcare system."

THE DATA REVOLUTION IN HEALTHCARE

Over the past decade, the urgent need to control healthcare costs, along with improved health information technology, has led policy-makers and insurers to put increasing emphasis on the "meaningful use" of data. The goal is to demonstrate

which healthcare services have value – and then to pay for those services, rather than simply paying for a series of services with no evidence that patient outcomes are improved.

Across the healthcare system, hospitals and physicians are increasingly required to report to the Centers for Medicare and Medicaid (CMS) and commercial insurers on their performance related to patient care and costs. Though there are many different kinds of arrangements for what is required and how it's reimbursed, put simply, healthcare providers that perform well are rewarded, while those that fail to measure up are penalized.

CHANGES AHEAD FOR EMS

Thus far, EMS is not yet required to report on measures of performance or costs. EMS is still paid a fee-for-service (or fee-for-transport). But many in EMS believe that changes in reporting requirements and reimbursement are coming soon.

Several government reports in the past few years have shone a spotlight on the costs associated with fraud in non- emergency ambulance transports, while high profile medical journal articles have criticized the reimbursement system that financially incentivizes EMS for taking people to the emergency department, where they receive

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high cost care, even when it may be obvious that those patients may be better served elsewhere, such as in the home or by their primary care doctor.

At the national level, organizations including NAEMT and large ambulance services have advocated for EMS to begin reporting on measures of cost and performance in exchange for reimbursement incentives that would enable EMS to remain financially viable and continue to innovate through programs such as mobile integrated healthcare and community paramedicine (MIH-CP) in the years to come.

ABOUT THE SURVEY

With so much at stake for the EMS profession, in late 2015, the EMS Data Committee created a survey to provide a snapshot of the state of data in EMS today. The goal is to better understand how the EMS industry can ensure that data can be collected, analyzed, used and exchanged to demonstrate value to payers and improve the quality of care.

More than 2,400 EMTs, paramedics, EMS managers and medical directors from all 50

states responded. View the report by clicking the link in the Featured Resources listing on naemt.org.

IN CONCLUSION

"To fully realize EMS's potential as an integrated component of the healthcare continuum, EMS must continue to work toward developing better systems of data collection and exchange," Zavadsky said.

But EMS can't do it alone. Hospitals and other healthcare providers are much further along than EMS in analyzing and exchanging data in part because they have received sizeable grants and reimbursement incentives to make the meaningful use of data a reality. "To date, almost none of the billions of dollars of funding that has flowed from the federal government to build America's health information technology infrastructure has been allocated to EMS," Zavadsky said. "That has to change, and NAEMT along with other national EMS organizations are advocating for that to happen."

In addition to this survey, NAEMT has also sponsored research examining how EMS practitioners use and interact with ePCR technology. The results of the study, being conducted by St. Louis University, will be published later this year. The goal of both surveys is to have the information needed for the EMS profession to come together to articulate a clear vision and strategy for what the future of EMS data collection, analysis and exchange should be.

"Collaboration is key. National EMS associations, leading EMS agencies and other stakeholders must then work together to make it a reality," Zavadsky said.

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

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New Compliance Tools Protecting Reputations

"People don't fail infection control audits because they're using the wrong products, they usually fail because they haven't ingrained IPC in the culture" according to Chemex UK's scientific director, Sean Derrig.

And he should know: Chemex are the pre-eminent hygiene chemical supplier to the ambulance sector where their products are used to decontaminate thousands of vehicles daily in the UK and abroad.

"We see ever more people buying in to plausible-sounding magic that claims it will deliver total environmental sterility, and then get caught out because they ignore the basics".

But for a long-established manufacturer in an industry not traditionally renowned for inventiveness, Chemex is no slouch on that score either. They recently won an HSBC award for innovation: not for their products but for the e-tools they now offer customers an integral part of their service.

"It's all about engagement." says Derrig. "You can tell your people to wash their hands until you're blue in the face but if you haven't made it relevant to them personally and put an effective audit process in behind it you're wasting your time".

After Chemex has trained customers' staff in hygiene, IPC or the many other courses on offer, each delegate gets a link to a simple exam they can do on a smart phone – and the employer gets a copy proving each team member has understood the training.

"Smart phones and tablets are revolutionising the industry" says Derrig. "Customers want value but they need peace of mind more: if one of our people is delivering to a site on the other side of the country - or the other side of the world – they'll look for non-conformances, record any they find on an app and you get an email instantly with the suggested corrective action. This is not a big investment in time for us, we're there anyway. Our customers place immense value on our picking these things up long before a formal inspection might".

So what of innovations on the decontamination front? According to Derrig anything that seems too good to be true usually is. "Whether it's healthcare or food hygiene you can't ignore basic principles and the number one is quite simple: you can't disinfect dirt. The only exception is an autoclave which isn't terribly practical with an ambulance. We see systems all the time that claim to break this fundamental law but the data never really stands up to proper scrutiny – and if it did we'd be selling it to our customers.

"It's not glamourous but study after study has shown the most effective approach is still proper cleaning with audited systems, effective training and relentless follow up. And if you get the training and auditing wrong it doesn't matter how good the products are, people will get preventable infections.

"The premise on which most novel disinfection systems are based is also fundamentally flawed. One-off interventions claiming to deliver total environmental sterility aren't just hopelessly optimistic, even if they worked the effect would be incredibly short-lived. Most members of the microbial world are completely indifferent to us so we shouldn't be concerned about them. The art is to specifically target the problematic ones."

So, what is his advice for implementing infection control or hygiene systems to keep your operation – and your reputation – spotless? "Don't. Any reputable supplier will be doing all that for you. And expect far more than a file with COSHH sheets; they should be writing the schedules and procedures, training your people, putting in proper dosing systems and auditing it all regularly so you can concentrate on your business, your customers and the service users".

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How Pokémon Go Technology could help save lives

Earlier this year the Pokémon Go game was launched and quickly became one of the most downloaded applications for smartphones in history. In the process it also introduced augmented reality into the public consciousness. But augmented reality is more than just a clever piece of technology that entertains people; it can also have serious applications that can benefit society. An innovative small tech company Aligned Assets, based in Woking, Surrey, has developed a practical application for augmented reality for use within the public sector, with further versions for the private sector to follow.

Whenever staff from the emergency services or social services visit an address, a lack of knowledge of what is at that address could be putting them at risk. Perhaps it is occupied by someone who has previously demonstrated aggressive behaviour to someone in uniform. Perhaps there is a dangerous animal such as an aggressive dog, or the building contains hazardous materials. There could be vulnerable people living in or near the property, whose safety needs to be prioritised. Equally relevant would be the presence of potential hazards in neighbouring properties. For instance, if flammable or explosive materials are held in an adjacent property, firefighters handling a fire will want to know about them. Being aware of these factors before entering a property can help reduce such risks. The visitor can approach the visit with extra caution or make necessary adjustments to the way they enter the property.

Such vital information may already be held within the service's IT system, but the staff member will need to be informed, or make a specific request for information from a control room or system administrator. If they fail to make that request or someone fails to inform them of a particular risk, that information will be wasted.

And this is where augmented reality can help. Address-management specialist Aligned Assets has developed an augmented reality application that enables someone on the ground to visualise these hazards as images that are superimposed on the actual properties they are viewing. The app operates on an Android platform so the user can view it via smart glasses, a tablet or simply a smart phone, according to the particular situation.

The picture above shows what a visitor from the emergency or social services might see, when using the app to view a property they were about the enter

The visitor can see all the information recorded about the property and any other property within a range that they choose. The image and related hazard or risk is pinned to the relevant property. If a property contains explosive material, this is instantly visible. This real-time visual information gives a person a more immediate sense of any potential hazards than would be provided by a conventional data system or a paper map.

The same piece of information can be provided written or printed on a piece of paper, or as an entry in a computer system. This can be further enhanced by it appearing on a map, the perspective developing from one dimension (a single line) to two dimensions. But augmented reality takes the information to the next stage, placing it in a three-dimensional context. The human mind will intuitively process it in context and use it to make more informed decisions. Augmented reality's pictorial nature also helps convey a lot of information very quickly. And the information is likely to be more up to date as it will be retrieved from a central repository of the most current information at the moment the user needs it.

In the case of the ambulance service, a member of staff will be able to use augmented reality to determine if there was a threat to their safety from a dangerous dog and call for assistance before entering the property. Or better understand the medical condition of a resident at an early stage, possibly saving valuable time when assessing a plan of action. Having all this information to hand while on site provides a more effective solution than other methods currently being used.

Inevitably the adoption of such a system could lead to concerns of an increasing 'Big Brother' style surveillance society. But all the information this app uses is already held by the relevant services. It simply uses it more effectively.

The adoption of augmented reality into our increasingly technology driven world seems unstoppable, and previous hardware and software limitations have significantly improved. Aligned Assets' simple yet innovative solution will allow its customers to deliver real social benefit.

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Why you should use the Nasal Alar SpO2 Sensor

The Nasal Alar SpO2™ Sensor provides accurate pulse oximetry monitoring even in low perfusion cases, with greater patient comfort, lower cost and benefits in the emergency care services

In the world of emergency services (EMS), speed is everything. Making quick, informed decisions can be the difference in patient outcomes. The Assurance® Nasal Alar SpO2™ Sensor is your 'one and done' solution for fast, accurate and dependable SpO2 readings.

The nasal ala measurement site means: better perfusion resulting is faster acquisition of oxygen saturation readings and faster detection of desaturation resulting in more dependable monitoring. This site is also easy to access, less susceptible to high noise and vibration environments, immune to ambient light interference and allows easy repositioning if necessary, due to non-adhesive attachment.

Easy to use and cost effective

Placement of the Assurance® Nasal Alar SpO2™ Sensor is simple. The ease of accessibility can be very important in EMS vehicles. In addition, this single-patient-use sensor maintains its placement on the nasal ala comfortably, without adhesives.

As a result, the sensor is easily removed and reapplied, eliminating the waste associated with trying multiple sensors to get a good signal.

Because the sensor's receiver is inside the nose, it is naturally shaded, protecting it from the interferences of ambient light. The Assurance® Nasal Alar SpO2™ Sensor is also less susceptible to dropout caused by the noise and vibrations associated with EMS transportation.

The sensor is single-patient-use, for use for up to 7 continuous days. A usability and acceptance study in a non-hospital setting showed that 50 subjects could wear the sensor for seven days [4], and when compared to a finger pulse oximeter, the Nasal Alar SpO2™ Sensor was more comfortable and interfered less with daily living activities [4]. Furthermore, there were no reported complications associated with skin pressure complications [5,6].

As the Nasal Alar SpO2™ Sensor is licensed for long term continuous use, the emergency care patient can be transferred to hospital care whilst the sensor remains with the patient. This can be cost effective, particularly if use of adhesive sensors were necessary to obtain a signal. This also reduces infection risks from any lapse in protocol using reusable sensors.

Better perfusion; Dependable signal

The Assurance® Nasal Alar SpO2™ Sensor is less prone to signal drop out because it is placed on the nasal ala, a central site with a highly consistent blood supply, it is unaffected by many of the most common patient conditions that cause diminished perfusion to the digits resulting in failure to provide an accurate pulse oximetry reading. Traditional finger monitoring may also be limited by injury, presence on the surgical field, non- invasive blood pressure cuff interruption, arm tucking and shivering.

General use and advantages

Unlike fingertip sensors, where signals can Unlike fingertip sensors, where signals can easily be lost [2], the Nasal Alar SpO2™ Sensor detects changes in oxygen saturation from the nasal ala, a highly vascular region that is fed by both the external and internal carotid arteries, providing strong and reliable photoplethysmography signals that respond rapidly to changes in arterial oxygen saturation.

The nasal alar site is very robust. The lack of sympathetic tone means no signal loss due to reduced temperature or anxiety and minimal effects by diminished peripheral perfusion, ensuring consistent, accurate and reliable monitoring, even at very low oxygen saturations.

The sensor is less likely to be dislodged as the design allows the connecting cable to run over and behind the ear, the ala is also comfortable and easily removed and reapplied for use during the patient's hospital stay [1].

This new sensor is compatible with the majority of pulse oximetry monitors used in many healthcare settings. Established in the USA as a first choice for a variety of low perfusion conditions, Pentland Medical is now marketing this product in the UK.

See the Nasal Alar SpO2™ sensor and other unique products for emergency care, on Stand M77, the Emergency Services Show at the NEC, Birmingham, September 21 & 22.

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Glittering Night Raises £158,000 For Midlands Air Ambulance Charity

Midlands Air Ambulance Charity hosted its AIR25 Celebration Party, Recognition Awards and Charity Ball on Friday 8th July at Edgbaston Stadium, and raised a staggering £158,000 which will fund 63 lifesaving air ambulance missions.

In association with corporate partner, Concept Resourcing, the evening which was attended by supporters from across the Midlands, acknowledged and celebrated the people that have played a vital part in the charity's 25 years of operation.

The spectacular evening commenced at 6.30pm with a three course meal and award ceremony, before guests made their way to the Celebration Party room to be entertained by a live band, stilt walkers, jugglers, an acrobatic display, a fire eater and an LED hula girl.

Hanna Sebright, chief executive of Midlands Air Ambulance Charity, says: "Our annual Recognition Awards and Charity Ball is always a very special evening, but this year, it surpassed our expectations. We are extremely grateful to all of the sponsors and supporters who helped to raise such a phenomenal amount of money for the charity.

"Dr Nick Crombie, who has been clinical lead for the charity for six years based at RAF Cosford, was the deserving winner of the Clinician of the Year Award. Dr Nick who is also based at the Queen Elizabeth hospital in Birmingham, has led or supported on a number of projects and has always supported the charity at fundraising events, providing presentations on MAAC's clinical performance which has engaged supporters and donors, as well as other air ambulance organisations."

Chris Short, managing director of Concept Resourcing adds: "It was a fantastic evening thoroughly enjoyed by all and we're thrilled to have been part of such an important fundraiser for Midlands Air Ambulance Charity."

To find out more about the specialist recruitment consultancy, Concept Resourcing, please visit: www.conceptresourcing.com

To find out more about how you can help to fund a Midlands Air Ambulance Charity mission, please visit: www.midlandsairambulance.com

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Ambulance family helps paramedic Kath fight life-threatening cancer

Over 100 SWASFT Paramedics recently danced to raise £70K for a potentially life-saving cancer treatment unavailable on the NHS for their friend and colleague, Kathryn Osmond.

Kath was losing her five year battle with metastatic melanoma unless she could pay for Tumour Infiltrating Lymphocyte (TIL) treatment offered privately through Professor Hawkins of the Christie Hospital in Manchester.

The 'Runningman' dance-off was shared through regional media and Ambulance Today and staff fundraised across the region with SWASFT CEO, Ken Wenman, helping to raise thousands through a holiday sacrifice scheme which saw staff line up to sign away a day's holiday for Kath. Two weeks later over £70K was raised.

Kath recently married her partner Sara and by the end of July TILs had begun. Thankfully immunity T cells were found in excised tumours and cultivated in the lab; however scans confirmed changes showing that cancer had spread to her brain. Fortunately, knowing that Kath is a true fighter, her doctors agreed to continue with treatment. After radical chemotherapy to induce neutropenia, the cultivated cells, described as the 'Magic Bullet' were injected back into Kath.

As Ambulance Today goes to press, her friend and fundraiser-in-chief, SWASFT Lead Paramedic, Sasha Johnston, told us: "News on Kath so far is positive, her doctors are pleased with progress, and, fingers-crossed, we're now all hoping for the best."

Kath's positivity, humour, strength and fortitude have been inspirational throughout as demonstrated in her online vlogs which you can visit at her website: **www.runningman4kath.com**

Both during and after treatment Kath and her family will urgently need continued financial aid so if you'd like to make a donation to offer them continued financial support, you can also do this via her website (see above).

SECAmb urges schools and children's groups to sign up to learn life-saving skills

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is urging schools and children's groups to register their interest to take part in an international CPR awareness drive taking place in October.

The Trust is looking for local schools and groups to take part in the Europe-wide initiative, Restart a Heart. As part of Restart a Heart Day on Tuesday 18 October, SECAmb is working with its own staff and volunteers to provide groups with a trainer and all the equipment required to demonstrate CPR for free during the week of 12-18 October.

SECAmb is also keen to hear from any other potential volunteers from across the NHS including hospital clinicians.

To date some 70 people have volunteered to help deliver the training and 38 groups – equating to more than 3000 children will learn CPR.

More than 30,000 people suffer cardiac arrests outside of hospital in the UK every year. If this happens in front of a bystander who starts CPR immediately before the arrival of the ambulance, the patient's chances of survival double.

Today, if someone suffers a cardiac arrest out of hospital in the UK, they sadly have less than a one in ten chance of surviving.

By linking with the Resuscitation Council's European Restart a Heart Day and the British Heart Foundation, SECAmb will provide hundreds of young people with the skills they need to help save a life.

SECAmb's Restart a Heart co-ordinator and Commercial Training Manager Emma Ray said: "We're delighted to be taking part in this initiative as a Trust for the first time. We're focusing our attention on delivering training to schools and young people this year. We were keen to target young people as they are a vital group we need to teach to ensure people gain a life skill and the confidence to act quickly to help someone in cardiac arrest."

Anyone interested in finding out more for their school or group should please contact emma.ray@secamb.nhs.uk or you're their local Community First Responder group

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London Ambulance Service medic's bright idea makes ambulance crews even more accessible to blind patients

Blind and partially sighted patients can now identify ambulance crews in their hour of need thanks to a London Ambulance Service medic.

The Service has recently launched (15th August) a new scheme thanks to an idea by one of the Service's emergency ambulance crew Dean Buttery.

Dean identified the need for the scheme after he came across an elderly blind man who needed help while off duty.

He said: "People were trying to help him, but they were pulling him in different directions and trying to get him to the side of the road. He was swinging his cane about and trying to get people away from him as he felt vulnerable and threatened, and this added to the danger. I walked over and tried to help him, explaining that I worked for the ambulance service, but had no way to prove it.

"When I was a police officer, I had a warrant card with the word 'police' in braille, and I realised the Service had nothing similar. In this situation I could have identified myself to the patient, enabling him to gain my trust."

Dean took action and raised the issue with his colleagues, and the Service's Executive Leadership team embraced the suggestion, leading to a series of workshops and meetings with staff, patient focus groups and the Royal National Institute of Blind People (RNIB).

As a result, the Service has adopted a safer process in which blind and partially sighted patients can verify the identity of ambulance crews through a re-contact call with the emergency operations centre. Our crews will provide patients who question their identity with a unique code, which the patient can then verify over the phone.

Michael Page, RNIB's New Business Manager, said: "RNIB is pleased to be working with the London Ambulance Service to improve accessibility for blind and partially sighted people across a number of areas.

"It's really important that blind and partially sighted people have confidence in the identity of any person who comes to their door, and this new initiative is another tool to help people to check this. We look forward to continuing to work with London Ambulance Service to improve services for people with sight loss."

Praise for EEAST's 'first class' service and ambulance 'angels'

EEAST has received an A* in its latest patient survey results.

"Outstanding", "first class" and "cared for greatly" were some of the comments from respondents to a questionnaire.

Almost 100 people responded to the July patient experience survey with 100% saying they were very satisfied, satisfied, or fairly satisfied with the service they received.

The results also show that 98% of respondents rated the handling of their 999 call as very acceptable or acceptable and 91.6% said the length of time they waited for a response was very acceptable or acceptable. Top marks were also given by patients who said they were treated with privacy and they trusted ambulance staff 100%.

Sandy Brown, Director of Nursing and Clinical Quality for the East of England Ambulance Service NHS Trust (EEAST), said: "These are another set excellent of patient survey results and echo the recent outstanding care rating we received from the Care Quality Commission (CQC).

"We value all feedback from our patients and these fantastic comments are a testament to the hard work and dedication of all of our staff."

The full report is published here http://www.eastamb.nhs.uk/about-us/patient-surveys.htm

Sandy added: "We know how hard our staff and volunteers work every day to make positive contributions to excellent patient care. When you read heartfelt messages from those who have felt that impact, you can't help but stop and think about the difference our teams make in helping people in their hour of need."

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London's Air Ambulance Medical Director Dr Gareth Davies named as one of London's Most Influential People

London's Air Ambulance's Medical Director Dr Gareth Davies has been named as one of London's most influential people by the Evening Standard in its annual Progress 1000 list.

It is wonderful recognition for all that Dr Davies, Medical Director & Trustee of London's Air Ambulance and Consultant in Emergency Medicine, Pre-hospital Care & Emergency Preparedness with Barts Health Trust, has contributed to pre-hospital care throughout London and the rest of the UK.

Dr Davies joined London's Air Ambulance as a registrar in 1993 and has been responsible for the education and training of staff since 1996 when he became Medical Director. He is renowned for the standards he has delivered in pre-hospital medical care and leading on the introduction of innovative procedures which are now copied across the world. These procedures include resuscitative thoracotomy (open-chest surgery), and rapid sequence induction of anaesthesia with intubation. Gareth has been the lead consultant at many of London's major incidents, including the Paddington Rail Disaster and the 7th of July 2005 Bombings.

Speaking after the announcement Dr Davies said;

"It is a great honour to be named as one of the Evening Standard's Progress 1000.

"When I set out to train as a doctor I couldn't have imagined I would be part of London's Air Ambulance for over 20 years. In my time I have witnessed huge advancements in the care that is provided to victims of serious injury in London and the rest of the UK. We are continuously able to save lives of people that previously wouldn't have survived their injuries and this is what I am passionate about.

We have grown so much, but it has really been a team effort by all at the charity, Barts Health, London Ambulance Service and indeed the whole of London. We couldn't do what we do without you."

The Progress 1000, in partnership with Citi, and supported by Berkeley Group, is the Evening Standard's celebration of London's most influential people.

West Sussex fire co-responding pilot set to begin at SECAmb

A potentially life-saving scheme in which West Sussex firefighters attend certain medical emergencies with South East Coast Ambulance Service (SECAmb) is to be piloted in the region.

West Sussex Fire & Rescue Service, (WSFRS), has worked in partnership with SECAmb and will initially respond to immediately life-threatening Red 1 calls.

To date around 40 firefighters, including 12 new wholetime recruits, have successfully completed the Immediate Emergency Care Responder course developed by SECAmb. The trial is expected to commence later this autumn.

The training enables firefighters, whose equipment includes a defibrillator, to provide treatment to patients in the moments before ambulance crews arrive much in the same way as SECAmb's Community First Responders (CFRs). Ambulance clinicians are always assigned to attend a call at the same time but, if available, a co-responder may arrive first.

The trial is part of SECAmb's wider ongoing work of emergency service collaboration across its region.

SECAmb Clinical Quality Manager and co-responding lead Matt England said: "This collaboration is about ensuring our most seriously-ill patients are seen as quickly as possible. When someone is in cardiac arrest, with every minute that passes their chances of survival diminish significantly. We'll always assign an ambulance response to the call at the same time but if firefighters reach the scene of an emergency before ambulance crews, they will be able to begin vital life-saving treatment."

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Shared facilities mean even stronger partnership working between South Western Ambulance Service and Cornwall Fire and Rescue Service

South Western Ambulance Service NHS Foundation Trust (SWASFT), in partnership with Cornwall Fire, Rescue and Community Safety (CFRCS), announces the new facilities at Truro Emergency Services Community Station.

SWASFT will be providing an emergency response from the station and both organisations will share all the facilities.

This collaborative project began in January 2016 and is an exciting opportunity for the two services to work more closely together, providing joint benefits including; shared building costs, better partnership working, better use of shared resources and a more efficient response for the community. This is part of a wider programme of work between blue light organisations to deliver collaborative projects throughout Cornwall.

Steve Small, SWASFT Operations Manager for Cornwall and the Isles of Scilly said: "This community station is the second example of collaborative working between SWASFT and CFRCS Service. After the success of the Tri-Service Station at Hayle, using Truro Fire station for mutual benefit is the most natural next step. The setting of the new station is ideal and being co-located gives both services an opportunity to further build our relationship and gain a better understanding of each other's roles within the community."

Paul Walker Chief Fire Officer for CFRCS Service commented: "I am very pleased to welcome colleagues from SWASFT to the newly refurbished Truro Community Fire Station. Working in partnership,

we have refurbished the building to accommodate individual service requirements, with shared facilities to support everyone to deliver an efficient and professional emergency operational response in Truro and the surrounding area. I would like to personally thank all staff from both services involved in designing and delivering this project and send my best wishes for a successful future working together from our newly refurbished building."

Cornwall Council cabinet member for communities Geoff Brown said: "This is yet another example of the benefits of closer co-operation between blue light services and I am delighted that the changes will enhance community safety in the Truro area."

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O&H launches modular 'four layout options in one'

O&H Vehicle Conversions ('O&H') has chosen the 2016 Emergency Services Show to publicly launch its modular, 'four layout options in one' patient transport vehicle, which is based on the company's innovative 'Flex PTS' engineering and is the first of its kind says O&H.

Flex PTS' common platform converts to seated, stretcher, wheelchair and bariatric layouts, using quick version-to-version change-out to flex with changing PTS fleet demands while keeping operator and maintenance training to a minimum.

O&H is also claiming "blue light leadership" in its field with an at-Show announcement of combined orders from two Ambulance Services for 335 double-crewed, front-line A&E ambulances.

At the Show O&H will be demonstrating its new lower maintenance, lighter weight Paramedic Practitioner Vehicle (PPV), which can now act as a wi-fi hub

hotspot allowing live vehicle patient care data to be sent wirelessly, and high quality video to be streamed from the PPV to its destination hospital.

O&H's front-line A&E, Flex PTS and PPV vehicles have been developed in line with the company's policy of continuous engineering improvement: O&H uses lighter, stronger aerospace-type build materials that increase vehicle durability and lower weight, reducing fuel consumption and cutting CO2 emissions.

O&H's new partnership with Polish specialist vehicle converter Baus AT UK has brought the first box body ambulance offering of its kind to the UK market - on show on Baus stand E65 where O&H representatives will be on hand to answer questions.

To view the Flex PTS and our full range of A&E vehicles visit us at the Emergency Services Show on stands OS70 and G31 on the 21st and 22nd of September 2016

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Cartwright's are Shaw Bet for Future Ambulance Build Success!

The Cartwright Group, now firmly establishing itself as key player in the UK ambulance build sector, has boosted its standing among ambulance customers, with the recent announcement that highly-respected ambulance build expert, Steve Shaw, has come on-board as Director of their Vehicle Conversions Division

The Cartwright Group, a family-owned business, established in 1952, is already recognised as a world-leader in commercial vehicle body and trailer manufacturer, and working from their 38 acre site in Altrincham, Cheshire, they currently provide the UK's largest range of HGV trailers as well as offering a complete service from design, manufacture, finance, rental and fleet maintenance.

In 2010 the Cartwright Group acquired Taurus Bodies, one of the Uk's oldest and best-respected ambulance builders, which had themselves been manufacturing ambulances and carrying out blue light conversions for over 4 decades. Since then they have built up a team of designers engineers and ambulance build specialists drawn from across the UK ambulance build industry and their first modular ambulance, the Taurus, a uniquely aerodynamic design, built for Yorkshire NHS ambulance service, was so successful that they have already expanded the Taurus range to include conversions, rapid response vehicles, control vehicles, special incident vehicles and mountain rescue vehicles.

The recruitment of Steve Shaw, recently MD of Alfred Bekker, and recognized as one of the UK's most respected and well-liked ambulance build experts, sends a strong signal to the UK and international ambulance community that Cartwright's commitment to expansion into the ambulance build sector is a serious and long-term commitment. Many though will know Steve better as the former Commercial Director of O & H – one of the UK's most-familiar ambulance builders.

Steve commented: "As all the fleet people I've worked with over the last couple of decades already know, both in the ambulance manufacturing community and among ambulance

fleet managers, I'm not just passionate about building high-quality ambulances to budget and on-time, I'm also passionate about taking ambulance build innovation forward to meet the changing needs of ambulance crews and their patients. I've been honoured to work with the companies and people I have done in the past, especially at O & H, one of the UK's best-known ambulance builders, recognised over the years for the quality of their build. However, when the Cartwright Group approached me, already having built up a fantastic ambulance team, who also have high-level experience drawn from among leading builders in the sector, and knowing that they already had a versatile set of ambulance offerings as impressive as their Taurus range, the opportunity to lead their ambulance expansion on into the future was just too good to refuse."

Steve added: "When I was then told that as part of Cartwright's commitment to continued expansion into ambulance building they were in the process of making a significant investment into their, now our, new specialist conversions site here in Doncaster, absolutely nothing could have kept me away."

The investment mentioned is a 30,000 sq ft dedicated ambulance build facility which will host Cartwright Conversions' flexible build programme and which has the capacity to produce 1500 vehicles per annum; with its 30 build bays, together with a state-of-the-art design centre and office annex and parts stores, it will be home to Steve and his rapidly expanding team of highly-experienced ambulance engineers.

To find out more about Cartwright Group's Vehicle Conversions and discuss their latest range of ambulance vehicles you can email Steve Shaw at:

steve-shaw@cartwrightconversions.co.uk

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ZOLL Medical introduces two new AEDs in the UK

ZOLL® Medical Corporation, an Asahi Kasei Group Company that manufactures medical devices and related software solutions, announced today that it is expanding its existing product line of automated external defibrillators (AEDs) in the UK with the introduction of the ZOLL AED 3™ and the ZOLL AED 3™ BLS (basic life support). www.zoll.com/uk/aed3

These new AEDs build on ZOLL's legacy of introducing new technology to the AED market to help improve outcomes for cardiac arrest patients. Enhanced Real CPR Help® gives rescuers the power to know when they are providing high-quality chest compressions. ZOLL has also introduced the world's first 5-year universal electrode for both adult and paediatric patients, further improving cost of ownership. Every ZOLL AED 3 comes with

ZOLL AED 3™ BLS

Programme Management Onboard™, which notifies users immediately if the device fails a self-test, or if the battery is due to be replaced, ensuring the device is ready to be used.

The ZOLL AED 3 BLS model is designed specifically for the needs of first responders with the CPR Dashboard™ and the ability to deliver the patient record directly to health care providers.

"We are extremely excited to add two new AEDs to our market-leading portfolio of automated external defibrillators," said A. Ernest Whiton, President of ZOLL's global Resuscitation division. "With the addition of these two new models, our company offers an even more comprehensive line of AEDs to meet the needs of both our public access

ZOLL AED 3™

and BLS customers, including the latest tools to better manage their AEDs' readiness and access to clinical event data."

"This next generation of AEDs extends ZOLL's reputation for defibrillators that offer Real CPR Help, real-time CPR feedback, providing even better support for rescuers," said Richard Knell-Moore, Country Manager of ZOLL Medical UK "We are pleased to make these lifesaving devices available to both lay and professional rescuers in the UK. ZOLL estimates there are at least 1 million deaths globally each year from sudden cardiac arrest.1 In the UK, the annual number of such deaths is approximately 100,000."

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Carnation Designs has been manufacturing industry leading power management and control products for emergency vehicles since 1995. The 'genisys' family of products has consistently been the most chosen system for managing auxiliary electronics on board the UK's front line ambulances since its launch in 2007.

Carnation has long been at the forefront of accident & emergency ambulance technology, offering cost-effective, highly flexible programmable logic controllers, proven to be robust in the most demanding user environments. Now in its twenty-first year serving the emergency services, few companies have an equal understanding of the niche requirements of blue-light applications and the importance of keeping life supporting vehicles on the road.

Designed and manufactured in Britain, Carnation's highly experienced team work closely with converters and end-users to produce systems configured to an infinite variety of role vehicle applications. Much more than providing "just a box", the company prides itself on delivering a comprehensive service, working with their customers from the point of vehicle conception through to bespoke configuration, installation support, first vehicle sign-off, and field backup thereafter.

Having previously exhibited multiple vehicles outside at the Emergency Services Show, Carnation are moving indoors for ESS 2016! At this year's event Carnation will be exhibiting a BMW 2-Series Gran Tourer Air Ambulance Ground Support Unit fitted with the **'genisys Compact'** low-cost 28-output controller.

The Carnation team welcome emergency vehicle operators and converter partners to join them on stand F35 to discuss exciting developments planned for 2016-2017.

For further information visit:
www.carnationdesigns.com
E: info@carnationdesigns.co.uk
T: +44 (0)1924 411211

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Auxilium Systems now available in the USA

We know our system works in the UK ...and now we are offering the same amazing system to the USA.

It can be used as a standalone system within a school, college, business or factory.

Everyone is given a number, a logs their details - then any accidents however minor are logged directly against individual numbers. It eliminates the need for paper and peoples ICE numbers.

It can be used within a private ambulance/hospital - where each user is given a number, and if they call the ambulance they just quote

AUX 23-76-12-78-35

their Auxilium Number and the crew knows all about them. It cuts down on time and hassle as an Auxilium Number is a sequence of ten digit numbers that are easily read over the phone/radio - therefore the "please repeat your name" phrase doesn't occur!

The price is just $1.00 per number per year - with deals available for longer term purchases, and one reader licence for each establishment free for the first year so that you get everything set up and sorted.

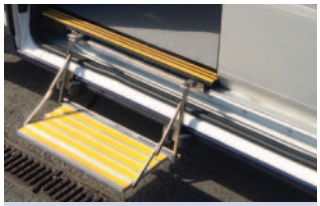
If you want further information please contact us on:

info@auxsys.uk

Slimstep - the complete step system

SG Technical System Ltd [SG], based in East Yorkshire, has established a well-earned reputation for high quality innovative products with excellent reliability. As a direct result of its reliability the company's patented EasyLoad™ ramp is now standard fit across a large proportion of the A&E, PTS and private ambulance sectors. Operators using the EasyLoad ramp have benefited from its exceptional reliability and reported substantial operational cost savings.

SG has now developed, filed a patent on and launched an innovative folding access step, the SlimStep™, bringing the same high level of quality and reliability to the step market. As its name suggests the housing for the SlimStep is very



New SG product: SlimStep

thin. The complete step system is designed to be installed into vehicles with a floor thickness of 18mm (+ 2mm floor covering) to 50mm or more. To install the SlimStep the vehicle converter only cuts the superficial flooring, the vehicle OE floor pan is not cut so its integrity is not compromised.

The stowed SlimStep fits entirely inside the housing, inside the vehicle cabin, so is protected from underbody damage and dirt. However when manually deployed it extends out of the side door and drops down creating a solid step at approximately half the height between road surface and cab floor. Entry and exit to the vehicle is simple in two equal steps. With a safe working load of 250kg, independently tested to 325Kg and in house tested to 380,000 cycles, the SlimStep can accommodate all requirements.

For further information visit:
www.sgtechsys.com
Email: info@sgtechsys.com
Tel: +44 (0) 845 026 8536

PROTECTING AMBULANCE PERSONNEL WITH

BODY WORN CAMERAS

The VideoBadge from Edesix offers protection from threats and abusive behaviour, and has proven to be a valuable asset for facilitating training and operational de-brief. Paired with Edesix's VideoManager software, the VideoBadge captures video and audio footage when required, and stores the data securely for future training purposes, or as court-ready evidence.

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

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sales@edesix.com

quoting "AMB2" or call us on

0131 510 0232

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www.ambulancetoday.co.uk

Woundclot – In Blood We Clot!

See the full Woundclot Hemostatic Gauze range in action with Medtree at ESS 2016 on Stand L57

The characteristics of pre-hospital treatment are that there aren't any and this provides many challenges when dealing with bleeding. WoundClot is a non-pressure application haemostat that is compact, cost-effective, easy-to-apply and is extremely efficient in a wide variety of wounds providing an optimal solution to bleeding control.

WoundClot is available for both first aid and trauma applications providing a range of sizes to treat a wide spectrum of wounds from scrapes and lacerations to severe traumatic arterial and venous bleeding.

WoundClot ABC (Advanced Bleeding Control) is specifically designed for first aid and pre-hospital treatment and is suitable for use by non-trained personnel including First Aid and First Responders. WoundClot ABC is a minor injury treatment kit with a range of sizes including 5 x 5cm, 5cm x 10cm and 10 x 10 cm, allowing the caregiver to manage bleeding on a variety of wounds in an affordable and effective manner.

WoundClot Trauma requires minimal training and is available in larger 8 x 20cm and 8 x 100cm sizes designed for use by Ambulance, Fire, Police and Military to treat severe traumatic injuries.

- Non-compressional application - Enhances and accelerates the natural clotting process - Strong self-adherence - Quick and easy to apply - High absorption capabilities (over 2500% it's own weight) - Can be used on all wounds including non-compressional areas - WoundClot ABC can be used by non-trained personnel (ideal for First Aid and First Responder use) - WoundClot Trauma requires minimal training (ideal for Ambulance, Police, Fire and Military use) - Minimal wastage with a variety of size options available - Can be removed without disruption to the wound site - Works under anti-coagulation treatment.

What happens when WoundClot is used?

When WoundClot is placed on the bleeding site, the products unique gel utilises the hydration forces between the mucosal layer and itself, which results in a strong physical attraction that leads to the adherence of the product to the tissue. The stronger the bleeding pressures in the wound, the stronger the attraction.

For this to happen, the type of gel the product transforms into has been precisely designed with a vast ability to absorb bleeding without breaking down. This ability to absorb and maintain a stable membrane allows for the pooling of active coagulation factors in significant quantities. The membrane flexibility on the molecular gel structure allows a haemodynamic environment in which rapid coagulation cascades are created, given the large amount of coagulation factors present, enhancing and accelerating the natural clotting process.

The coagulation factors attach to the surface tissue and the membrane with the presence of a patented molecular group incorporated into the product. The coagulation process is initiated many times faster and stronger than at the surface of the wound by enhancing the presence of platelets, multiple coagulation factors and amino acids, dramatically reducing the flow of blood from the wound. In turn, this process also increases the adherence of the membrane to the tissue making sure it is stable on the wound site.

Once bleeding has stopped and the coagulation cascade is formed, the capillary and hydration physical forces are reduced, allowing for the easy removal of WoundClot if desired, as one piece without disrupting the clot already formed.

The new and unique Woundclot Hemostatic Gauze range is available exclusively from MedTree in the UK and Ireland.

You can find out more about this device on their website at:
www.medtree.co.uk/woundclot
or by calling them on: 01952 56 56 56 to arrange a free, no obligation demonstration.

Two Reasons to visit Stand M77 at the Emergency Services Show!

DO YOU STRUGGLE TO FIND THE SPOT FOR A RELIABLE SPO2 SIGNAL?

Fingers, ears, nose are all commonly used in an attempt to gain a reliable SpO2 signal. This off license use of sensors designed for measuring from one part of the anatomy, is not effective and can lead to tissue necrosis.

THE ASSURANCER NASAL ALAR SPO2™ SENSOR IS THE SOLUTION

Providing "One and Done" SpO2 monitoring for Emergency Medical Services.

In the world of EMS, speed is everything. Making quick, informed decisions can be the difference in patient outcomes. The Assurance® Nasal Alar SpO2™ Sensor is your "one and done" solution for fast, accurate and dependable SpO2 readings.

- Earlier detection
- Better perfusion
- Dependable monitoring
- Easy access to the alar site
- Immune to ambient light
- Less susceptible to high noise and vibration environments
- Easily repositioned due to non-adhesive attachment

Easy to use and cost effective. Placement of the Assurance® Nasal Alar SpO2™ Sensor is simple. It is readily accessible, which can be important in EMS vehicles. In addition, this single-patient-use sensor maintains its placement on the nasal ala comfortably, without adhesives. As a result, the sensor is easily removed and reapplied, eliminating the waste associated with trying multiple sensors to get a good signal.

Because the sensor's receiver is inside the nose, it is naturally shaded, protecting it from the interferences of ambient light. The Assurance® Nasal Alar SpO2™ Sensor is also less susceptible to dropout caused by the noise and vibrations associated with EMS transportation.

JED[R] (Jaw Elevation Device)

A simple but effective device for efficient, safe management of airways. This is an externally applied, non-invasive device which holds the patient's airway in the proper position for mask ventilation or fibre-optic intubation. It aids with both airway maintenance and in situations when breathing may be

compromised. The JED[R] assists the provider to maintain an open airway "hands free" promoting both patient safety and provider convenience. The JED may be used during any diagnostic or therapeutic procedure requiring analgesics or sedatives for patient comfort.

Contact.
Pentland Medical Ltd
0131 467 5764
mail@pentlandmedical.co.uk
www.pentlandmedical.co.uk

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www.ambulancetoday.co.uk

Specialist Vehicles for Specialist Work

Responsible for a vast network of transport services across the UK, getting the fleet mix right is an essential requirement for any ambulance trust.

Increasingly fleet operators in the ambulance and patient transport sectors are seeking a spectrum of vehicles, to enable them to support

diverse user needs while keeping operating costs down. That's where Allied Fleet can help.

Allied Fleet is fast becoming one of the leading suppliers of flexible, special purpose vehicles for ambulance service providers. Our market-leading wheelchair accessible cars, people carriers and minibuses enable fleet operators to choose the optimum size of ambulance for specific patient transport applications.

Flexibility

Combining wheelchair access stations with seating for able-bodied passengers enables Allied to offer unsurpassed flexibility for different types of work. We offer both a standardised range of tried and tested wheelchair accessible vehicles and a bespoke adaptation service to meet specific end-user needs.

We also provide specialist healthcare features to meet specific operational needs, ranging from oxygen storage points and wipe-clean interiors to removable seating, wheelchairs and secure stretcher stations.

We work with a range of leading vehicle manufacturers to offer a choice of base vehicle too, meaning you can chose the vehicle that best suits your accessibility needs and fleet preferences.

When it comes to accessible transport solutions, trust Allied Fleet to get it right for you.

For more information on our product range call Allied Fleet on 0800 587 9623, visit www.alliedfleet.co.uk or email: fleet@alliedvehicles.co.uk

Jigsaw Medical expands into Basingstoke and displays at the Emergency Services Show

Jigsaw Medical is delighted to announce the opening of a new operational ambulance base in Basingstoke, Hampshire, adding to their already existing bases in Buckingham, Cheshire, Lancashire, Wales, and Yorkshire; as well as their specialised training centre in Chester.

The establishment of a sixth base in Basingstoke has come as a result of increased demand in the area for front-line medical professionals. Basingstoke was a natural choice due to the superb transport links with the surrounding area.

The previous 12 months have been particularly impressive for Jigsaw Medical with multi-million- pound investment, life-saving treatment and unprecedented growth.

Jigsaw Medical have added over 45 brand new fully-kitted ambulances to the already expansive fleet as well as 8 brand new response vehicles that help supplement the ambulances clinically. Several of which will be utilised across the Basingstoke, and Hampshire area.

Founded in 2012 by Chris Percival, Jigsaw Medical has quickly become one of the UK leaders in medical services, offering a range of services for the commercial, media, events sectors across the world and the NHS.

Jigsaw Medical is divided into three entities; our Clinical Services Division, Training Division, and our Specialist Projects Division. We are committed to delivering clinically focused and harmonised solutions to both NHS and private clients across the globe.

Our Clinical Services Division specialises in providing ambulance services, event medical cover, and TV / Film unit medics whilst our Training Division provides first aid training courses and clinical education. Finally, our Special Projects Division provides specific medical training, tactical medicine and medical staff for hostile and remote environments worldwide – making up our three clear divisions.

Operating one of the largest island stands at the event, Jigsaw Medical is delighted to be showcasing at the upcoming 2016 Emergency Services show. The show will give event attendees a chance to see a brand-new fully-kitted Jigsaw Medical ambulance, a highly specialised Jigsaw Special Projects Land Rover Defender, as well as giving the chance for people to chat to CEO Chris Percival and senior members of our Clinical, Operational, and Resourcing departments. There may well also be a few #TeamJigsaw freebies for visitors to our stand too!!

For further information, contact Jigsaw Medical:

Tel: 01829 732615

Email: info@jigsawmedical.com

Web: www.jigsawmedical.com

Multi-purpose emergency/survival blanket

orve+wrap has developed into a multi-purpose emergency/ survival blanket. The core materials and manufacturing process give a very high thermal retention and offer a barrier to the elements.

Each "quilt" offers a thermal property, and causes a convection heat process to raise and maintain

temperature without the necessity of a secondary heat source, making it quite unique in the marketplace. The manufacturing process also allows orve+wrap to be cut to any size without damaging its integrity.

The green reflective "outer" side of the blanket is weather proof so can be used as a makeshift shelter or a barrier to both cold and heat.

orve+wrap was originally designed as a single use, patient specific product for acute emergency situations or for use in operating theatres. However, the blanket is hard wearing and, with reasonable

handling, will offer protection for a prolonged time period.

The features designed into orve+wrap make it quite unique, offering unrivalled weight to thermal efficiency ratio. Its countless benefits in either hot, cold or wet environments means orve+wrap can be used globally.

The individual compress packing of each orve+wrap ensures that not only does every recipient have a product ready for use, but it also aids infection control and logistical efficiencies.

orve+wrap is used by various Ambulance Services, British, Search Rescue organisations and by the NHS to proactively warm patients prior to elective surgery.

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Cartwright to showcase latest products at Emergency Services Show 2016 - PTS Vehicles and New Modular Frontline Rear Door Concept to make debut

Two of the latest products from Cartwright, will be on display at this year's Emergency Fleet Services Show on Stand E29.

Making its debut at the show will be Cartwright's new Modular Frontline Rear Door Concept* featuring an innovative gliding offside rear door which is sequenced with the tail lift operation.

A first for the industry and based on proven bus and coach technology, the rear door is electrically operated and glides outwards to provide a decency screen to the offside of the tail lift when in operation. This feature saves time in the operational use of the rear doors.

The Cartwright Modular Frontline ambulance forms part of our wide range which also includes conversions, rapid response vehicles, control vehicles, special incident vehicles and mountain rescue vehicles

It is a unique combination of innovative design and functionality with aerodynamic features resulting in improved fuel economy and a reduction in carbon footprint.

Also on display will be the company' PTS Vehicles including Cartwright's HDU demonstrator built on a Fiat Ducato.

Cartwright has worked closely with customers to develop a solution that meets both the clinical and aesthetic needs while meeting the strict CEN 1789 European safety standard for the construction of ambulances and achieving NSSTA (National Small Series Type Approval)

The Cartwright Group has over 40 years manufacturing of specialist vehicles. The company had built an enviable reputation in its field and has enjoyed repeat business with many of its customers.

Steve Shaw, Cartwright Conversions Commercial & Operations Director commented: "The combination of Cartwright's technology together with the reputation and experience of Cartwright, will help to create a new generation of ambulances and related blue light products that will offer a new dimension to customers in the healthcare sector

"We are extremely proud of our ambulance range which demonstrate the level of manufacturing expertise we are able to offer. We have a team of professionals who have a wide range of skills and experience that can match any manufacturer in the industry."

To find out more about Cartwright Group's Vehicle Conversions and discuss their latest range of ambulance vehicles you can email Steve Shaw at:
steve-shaw@cartwrightconversions.co.uk

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www.ambulancetoday.co.uk

SP Services launch LifePOINT Plus AEDs

With nearly 60,000 Sudden Cardiac Arrests occurring outside of hospital in the UK every year, making defibrillators more widely available can potentially save more lives each year. When a defibrillator is used within 3-5 minutes of a Sudden Cardiac Arrest, the survival chance rises from 6 to 74% which shows just how vital these machines are.*

In response to this growing awareness of the need for AEDs, SP Services have expanded their AED range to include LifePOINT Plus defibrillators.

The **LifePOINT Plus** AED's have outstanding specifications and are portable, lightweight, reliable and easy to use. With prices starting at just £795 they represent fantastic value for money and are exclusively available through SP Services.

Designed to keep sudden cardiac arrest (SCA) victims alive by directing the user with voice commands, the **LifePOINT Plus** AEDs can be quickly deployed in the event of an SCA, with a simple three-step operation of simply turning the device on, unpacking the pads and attaching them to the patient's chest, followed by defibrillation which is administered semi-automatically. A training model is also available at £295.

With realtime feedback, the rescuer can provide the best CPR resuscitation possible in a SCA situation. The units have a five-year warranty and come in a heavy duty integrated carry case.

Paul Watts, Head of Business Development at SP Services said:

"the **LifePOINT Plus** defibrillators are a great addition to our range and will enable more businesses, schools, sports clubs and the wider community to have access to them. Without the need for training, the rescuer can administer CPR with defibrillation promptly without waiting for several minutes for the emergency services to arrive, potentially saving many lives each year."

To see the full range visit: www.spservices.co.uk

**Source: British Heart Foundation - September 2015*

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.

For further information, contact Edesix
Tel: 0131 510 0232
Email: sales@edesix.com
or visit us at the Emergency Services Show, booth E50.

Short and long term ambulance hire

Had a bump? Need a vehicle quick? Bluelight UK Ltd, based near Manchester have a stock of rental vehicles available for quick turnaround. This is ideal for when you need to take a vehicle off the road for servicing or repair and cannot afford to lose the cover.

Their vehicles range from Peugeot Boxer and Renault Master PTS units, Rapid Response Honda CR-V 4x4 vehicles and Renault Master HDU and Mercedes Sprinter Modular A&E Units, which are available for both short and long term contracts (Subject to availability and status and rental agreement).

They also have a selection of vehicles for sale and can offer the design and build of your new vehicles through their trusted partnerships with converters, enabling you to take maximum advantage of the discounts available on both chassis and build. Finance can also be arranged through their network of funders who also specialise in these types of vehicles.

If you are in the market for either new or used ambulance vehicles, require a short or long term rental vehicle, need spares or repairs, they may be able to help. Your phone call will not be wasted.

For more details log onto www.bluelightuk.co.uk, contact Simon, Julie or Matthew on 01942 888800 or email your enquiry here: sales@bluelightuk.co.uk

Barry's Buddy Benny Boosts Bariquins' Band of Brothers

Bariquins, who produce the 25st (350lb/159kg) training mannequin that can be carried by one person -when it's not assembled- has introduced a new name to their line-up. The original Bariquin, 'Barry', has now been joined by 'Benny' and both will be at Stand P65 at this year's Emergency Services Show at the NEC, UK.

Chris Jarratt, the Managing Director of Bariquins said "We live in a multi-cultural society and obesity is a problem faced by communities globally. Bariquins recognize this and did not want to offer just the single option. Bariquins will continue adding to its 'band of brothers' to reflect this diversity. Female options will become available too."

Supporting this worldwide concern about obesity and its issues, Bariquins has already had interest from abroad, including the U.S. and the Gulf region.

Incorrect handling of a plus-size person may result in musculoskeletal injuries to emergency personnel, healthcare workers or to the individual being rescued or cared for. Musculo-skeletal Disorders (MSDs) cost the NHS £400 million a year, according to the national charity BackCare. Also, the market in medical negligence claims is growing annually. Training with a Bariquins' mannequin can help Governments and organisations who are increasingly under pressure to reduce costs.

'Benny' (foreground) with 'Barry'

Using a Bariquin allows new techniques to be devised, designing out risks. Complicated transfers can be rehearsed before moving the actual person. Practising extrications will result in quicker casualty recovery, reduced times spent dealing with incidents, safer handling skills and less injuries to all parties -with fewer compensation claims and reduced staff sick leave. Revenue can also be earned by providing training to other organisations.

For further information visit: www.bariquins.com
E: enquiries@bariquins.com
T: +44 (0)161 443 4230/33

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High Performing Tactical Footwear

The Alpina HPAM1300, available from Goliath Footwear, has been designed as a lightweight, comfortable safety boot for rapid paramedic response.

As part of a range of specialist multi-role footwear for the emergency services, Goliath Footwear supplies this style from UK stock under an ISO 9001 Quality Assurance process. The boots are packed with comfort and safety features to protect the wearer, designed and developed over the years since Goliath began in 1880. These include a lightweight Aluminium Toe Cap for protection against external impact, such as the dropping of heavy objects, and a flexible Midsole Protection (Tex Protection) to give the whole foot area protection from nails and other sharp objects underfoot. With Reflective Panels on the rear and side profiles, and a hatching leather design the wearer can be made visible in dark environments.

Comfort features include a breathable and washable PU footbed, and thick padding around the rim of the boot to ensure comfortable driving, easy rapid movement, and comfortable kneeling. An important side zip feature with top Velcro

fastening make it easy to don the boots at a moment's notice and to remove them with ease at the end of a long shift.

The lightweight sole unit (PU / Rubber) is manufactured using an injection technique where the sole unit is fused to the uppers for the strongest bond possible. The mid layer is made of soft, cushioning PU to support the foot, and the outer layer is made of Rubber for a dense, more protective material with high grip properties The outsole will resist temperatures underfoot of up to 300°C.

The new footwear designed for Emergency Rescue Personnel is tested to the latest European safety footwear standards EN ISO 20345:2011.

To find out more visit: www.goliath.co.uk or call the sales team on 01274 860380.

Sjb Medical Recruitment: Nationwide Paramedic Vacancies with Industry Leaders

At sjb medical we are the primary recruiters of permanent staff into the independent healthcare and social care sectors in the UK, specialising in recruiting experienced AHPs for nationwide opportunities to train in clinical assessment services.

On behalf of the leading providers of Medical Assessment Services, we offer exciting opportunities for Paramedics to undertake functional health assessment and report writing activities for the Department of Work and Pensions (DWP).

The roles that we offer are predominately clinic based with both part-time and full-time opportunities available. Undertaking this position, you will carry out face to face medical assessment activities, working across a broad range of clinical presentations. No prior assessment experience is necessary as you will be provided with a comprehensive induction programme whilst earning

a full salary, inclusive of e-learning and hands-on training.

This is an exciting and challenging position with excellent prospects for career development within a new specialism. No night, weekend or bank holiday working is required and hours are predictable with an office-based structure ensuring a great work-life balance. A comprehensive benefits package is provided encompassing of protected CPD, HCPC fee reimbursement, re-validation support and private medical insurance.

Functional Health Assessment roles are available in locations nationwide including London, the South East, South West, North West, North East, East of England and Scotland.

If you are interested in finding out more, please contact jobs@sjbmedical.com or call 020 7832 1980 to speak to an experienced healthcare recruitment consultant.

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

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We tailor your insurance needs and offer the following enhanced services

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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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www.strykerems.com

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