

## PREHOSPITAL CARE

# The giraffe: the emergency care practitioner; Fit for purpose? The East Anglian experience

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*Emerg Med J* 2004;21:365–366. doi: 10.1136/emj.2004.014407

This short report describes the background and development of the new emergency care practitioner (ECP) programme run by the East Anglian Ambulance NHS Trust (EAAT) and the Health Schools of the University of East Anglia (UEA). The programme encompasses the emerging national competencies for the ECP. Although the first pilot cohort of 10 paramedics has yet to complete the course at the time of writing, the background and lived experience of developing and providing the programme are discussed. The article also considers a number of the opportunities and threats that may arise with the imminent transfer of the first cohort to an operational role within the NHS.

### BACKGROUND

Throughout the NHS, rapid change, emerging roles, and changing professional and practice boundaries are becoming the norm for practitioners.<sup>1–4</sup> This has had a widespread impact among educationalists who have been called upon, often with short notice, to help design and implement robust courses and programmes to develop cohorts of people to work in new roles and innovative ways. Primary care and emergency services are no exception, with the ECP assuming a key emerging role as the pressures to prevent admission and the service consequences of the GMS contract, among other drivers, become apparent.

The notion of a paramedic practitioner has been floated for a number of years. Initial work in Coventry and Warwickshire involving extended skills within a small group of nurses and paramedics developed this concept further.<sup>5</sup> It is important to emphasise from the outset that while the ECP role has some similarities to both the undefined paramedic practitioner concept and the more established paramedic, nurse practitioner, and emergency nurse practitioner roles it is in reality something quite different and innovative. To quote students in the first cohort of the East Anglia Programme: *“the emergency care practitioner occupies the space between the general practitioner, the nurse and the paramedic.”*

To explore the role of the ECP in a variety of local health economies, a number of schemes were established to undertake training of either one or two cohorts by April 2004. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority was selected as a pilot site for two cohorts and the remit for development was placed with the EAAT.

Undertaking the ECP programme has given EAAT the opportunity to re-define operational roles and challenge traditional models of provision of emergency care. The ECP programme represents an exciting opportunity to bring together paramedics, nurses, and potentially other allied health professionals as learners, and develop core competencies that can be adapted to any given “unscheduled care” situation.

### COURSE DEVELOPMENT

The ECP pilot course has been a challenging and rewarding partnership between EAAT and UEA. The development of a full and complete programme leading to an outcome defined by competencies for a role that was essentially undefined

presented some problems, not least of these was the lack of understanding of roles and competency frameworks between professional groups.

All those involved, especially the project manager and curriculum leads, exploited their networks to gain support both for the theoretical elements and for the clinical placements. Although the programme continues to evolve, an early decision was made for it to be a full time 18 week course with a balance between academic and practical placement based learning (table 1). At this point it is important for us to acknowledge the impact that our first cohort has had on the course development; aside from their flexible attitude and commitment to undertaking a brand new course, they also quickly became accustomed to the principle that they, as adult professional learners, could influence the way in which the course was delivered and its content. At first this was a new and unfamiliar principle particularly for a group with mixed educational backgrounds and for whom most previous development had been “done to them” rather than “with them”. In essence we were crossing the bridge between training and education and at times this was an uncomfortable experience for all involved.

The programme has covered a wide ranging curriculum including patient examination and assessment, minor illness presentations, principles of chronic disease management, and skills such as suturing and catheterisation. In addition mental health was identified as a key area and pharmacology and the use and application of drug therapies have played a significant part in both the theoretical and practical aspects of the programme. Aside from clinical skills and knowledge there were also elements of wider areas such as health promotion, epidemiology, change management, and study skills.

Several key principles underpinned the curriculum:

#### Inter-professional learning and multi-disciplinary, multi-agency involvement

With the changing scope of emergency care it has been a theme of the programme to question some of the professional “silos” that exist. The programme strives to enable the ECPs to think more broadly, across the existing areas of the NHS and make linkages in order to promote the most effective and efficient patient journey. The curriculum has therefore been delivered by a diverse faculty from a range of disciplines.

#### Primary care focus

A clear emphasis on understanding primary care and the opportunities for appropriate management of patients nearer to their homes. This represents a departure from some of the principles of the original ECP—as a person who would work in both the emergency department and prehospital environments.

#### Educational preparation (not training)

Shifting from the traditional basis of training, whereby skills are taught, to education, where principles are learnt and

**Abbreviations:** ECP, emergency care practitioner; UEA, University of East Anglia; EAAT, East Anglian Ambulance NHS Trust

**Table 1** The ECP programme structure (18 weeks is divided in to three blocks of six weeks with assessments at the end of each block)

Weeks 1–6	Weeks 7–12	Weeks 13–18
Six week block; theory weighted with some placements	Six weeks' practice with six study days and action learning sets in practice	Six weeks' practice with six study days and action learning sets in practice
OSCE, and multiple choice	Essay, portfolio	Practice competence, portfolio and essay

developed, was a challenge both for the ECPs and lecturers. However, this has illustrated the shift to practitioner status with people who are able to apply principles and concepts to a variety of different situations and be better prepared to practice in the "swampy lowlands" of broader based practice where there is often no one "right answer".<sup>6</sup>

### Enquiry based and evidence based learning

Development of knowledge and learning by way of research and investigation triggered by the use of scenarios. Learning packages were developed with a simulated or composite patient or family. The key concepts and background data are not "taught" to students, rather the students are supported in the facilitation group to elicit these by questioning, inquiry, and personal/group study.

### Reflective practice

This essential skill for all professionals has been encouraged throughout the programme.

### Theory and practice integration

To develop the skills gained in the theoretical environment exposure to practice is essential. Throughout the programme we have integrated the two elements to ensure that the learning is thorough and well grounded.

### Myth busting

Myth busting was essential, both in terms of challenging the beliefs and actions of the students and the traditional role boundaries and practices that impede effective use of skills and effective and timely access to services. This challenging of received and sometimes ritualised practices also means developing an insight into the issues within the wider NHS and the links between professional groups. It is important that the ECP recognises their own emerging ability to influence the development of this role; which has the potential to be revolutionary within the unscheduled care environment. This will undoubtedly be beset by all the problems of cultural change.<sup>7</sup>

### Student involvement and ownership in the evolution of the role and the structures to support it

Without the student involvement and ownership of the role the programme would not be continuing to evolve and the lessons learnt in this learning environment would not be so openly available for translation into the operational sphere.

### Engagement with and influencing the national debate related to ECP role development

This has been crucial in terms of sharing ideas and influencing concepts in order to aim for best practice for the role nationally.

### OPPORTUNITIES AND THREATS

For the ECP to realise their potential, practitioners and services across the wider healthcare economy need to develop greater awareness of the role and accept changing skills and role boundaries without defensiveness and protectionism.<sup>3,7</sup>

Many "early adopters" are contributing greatly to both the theoretical and clinical components of the curriculum, but it has been difficult to secure quality clinical placements with learning orientated mentors for all students. This was also apparent when briefing faculty; often they did not have a realistic understanding of the skill levels and experiences of the paramedic cohort and needed to be briefed extensively to try and achieve the aims of individual sessions.

Where we stand at the moment is a complex position. We are somewhat clearer about the types of roles that the ECP can carry out, however the operational application of this is still cloudy. We are limited by national constraints, particularly with regard to prescribing. More local limitations regarding clear referral pathways have the potential to restrict the implementation of the role and its full potential, which may be overshadowed by the protectionist attitudes of individuals, departments, and professional groups. This is an often acknowledged but rarely combated negative feature of the NHS.<sup>3,7</sup> Spreading the word and challenging boundaries is a role that, like many individuals before them, these new ECPs will have to undertake locally and nationally. We can be confident however that the development that each of these individuals has undergone will give them a head start both clinically and in terms of the changes in outlook and culture that have been developed throughout the programme.

At this juncture, cultural change and development of an infrastructure to support new clinical decision making and referral pathways is vital to ensure the success of the ECP in enabling appropriate patient journeys and meeting patient needs. Such changes are essential if we are to establish whether the ECP can "occupy the space between the paramedic, the nurse and the doctor" in reality as well as within the scope of this programme.

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Funding: none.

Conflicts of interest: none declared.

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Accepted for publication 2 February 2004

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