South East Coast Ambulance Service NHS
NHS Foundation Trust

Advanced Paramedic Practitioner (Urgent & Emergency Care) Deployment Procedure

Contents

1. Scope.

1.1. South East Coast Ambulance Service NHS Trust (the Trust) has developed a grade of staff to support treatment closer to home for patients with undifferentiated urgent and emergency care needs. These staff are termed Advanced Paramedic Practitioners (Urgent & Emergency Care) and throughout this document they will be referred to as APPs.

1.2. This document provides colleagues with a clear procedure to be followed when considering the deployment of an APP or Student Advanced PP (SAPP).

1.3. From an organisational perspective, APPs work within the Operations Directorate of the Trust.

1.4. APPs are provided with operational first-line management from an Operational Team Leader (OTL).

1.5. Clinical leadership and supervision for APPs is provided by a Practice Development Lead (PDL) within the Medical Directorate.

1.6. APPs meet the level 7 descriptors of the skills for health framework and practice at the level of 'advanced' within the College of Paramedics career framework.

1.7. There are numerous Higher Education Institute (HEI) pathways and programmes which cover the required core curriculum. Staff who have completed an approved HEI pathway with an exit award of at least Diploma level (DipHE), a period of workplace-based assessment (known locally as 'the GP placement') and a professional examination, such as the College of Paramedics Diploma in Primary and Urgent Care, are permitted to use the title Advanced Paramedic Practitioner in Urgent and Emergency Care (APUEC). Since 2016 APPs have been undertaking additional advanced level educational programmes and functions, including Advanced Clinical Practice (ACP) programmes.

1.8. APPs and SAPPs are deployed in a variety of ways in order to meet the needs of the trust, our patients, and adhering to the competencies of the four pillars of advanced practice.

1.9. Health Education England sets out the four pillars of advanced practice in its document "multi-professional framework for advanced clinical practice in England."

1.10. APPs form part of the trust's senior clinical workforce, **working in a variety of ways to support patients, colleagues and the local health economy through:**

- Working within a local Urgent Care Hub (UCH) to provide joint decision making with colleagues and remote patient consultation.
- Working on a single response vehicle (SRV), self-tasking (out of plan) to provide face to face patient assessments.

- Working on a Double Crew Ambulance (DCA) in-plan, to provide face to face patient assessments - this would usually be to provide clinical supervision or peer support to a junior staff member within a clinical setting.

- Provision of clinical and educational supervision of colleagues,

- Utilising OU Support and Governance time.

1.11. SAPPs undergoing a trust-supported urgent and emergency care education pathway are denoted as Student Advanced Paramedic Practitioners (SAPP).

1.12. Other pathways undertaken external to the trust must be mapped via clinical education and a Practice Development Lead (PDL) to ensure parity with the APP job description and academic pathway.

1.13. APPs should be considered for medical or trauma support, including on scene clinical support, triage and multi-casualty or major incidents.

1.14. APPs operate in teams located within Operating Units (OU) across the Trust.

1.15. APPs will have up to 80% of their hours providing clinical care as part of the 'hub' model, Sub-divided into 40% deployed on an SRV and 40% working within the Urgent Care Hub. 20% will be divided between governance and providing clinical support within an OU. This equates to 130 hours for governance and the remaining 260 hours for OU support per annum. This provision is pro-rata for those employed less than 37.5 hours per week.

1.16. It is expected that to work as an APP, all elements of the role must be undertaken, therefore an APP's main role within the Trust must be clinical. Individuals who have undertaken additional 'advanced practice' education but are not working primarily within a clinical role (e.g. an OTL, OM or OUM), will not be eligible to use the title of APP. PDLs will practice as APPs as there is an expectation to maintain a level of advanced practice.

1.17. Bank Enhanced Paramedics may be given ad-hoc OU support time at the discretion of local OU management and PDLs, however will not be denoted APPs.

1.18. Bank staff and those whose main role within the Trust is not clinical, will be titled Enhanced Paramedic (Urgent and Emergency Care).

1.19. OU support and governance time is built into the rota and is not an abstraction. This time can be moved flexibly to support Trust or project needs as outlined in the OU Support Toolkit.

1.20. SAPPs will also have an allowance of OU support time as outlined in the OU Support Toolkit, dependant on their year of study.

1.21. OU support time is protected in times of escalation, however in the event of a Business Continuity Incident, Critical or Major Incident, OU support time may be changed at short notice to SRV, UCH or DCA shifts as required.

1.21.1. **Indicative activities include:**

- Supporting the OU leadership team with clinical support for staff.
- Clinical DIF-2 investigations or complaints.
- Providing CPD sessions for staff.
- Providing clinical supervision within the OU.
- Contributing to clinical audit and quality improvement projects.
- Local frequent caller management support.
- Clinical stakeholder meetings.
- Managing high call volume care settings (e.g. care and nursing homes).
- Providing clinical opinion on adverse incidents.
- Supporting local OU management in local projects.
- Support the provision of Statutory and Mandatory (key skills) training.
- Please refer to Key Performance Indicators and UCH Tool Kit.

2. Procedure.

2.1. Role of Advanced Paramedic Practitioners

2.1.1. All APPs and SAPP must work towards the trusts APP specific KPIs (Appendix A) which will be reviewed for compliance at each appraisal by an OTL.

2.1.2. All APPs and SAPPs must work to their scope of practice, and only undertake clinical interventions where trained, competent, and within their scope of practice for the Trust, as set out in the Scope of Practice and Clinical Standards Policy.

2.1.3. If a SAPP or APP has been trained in, but not competent in a clinical intervention, they may undertake this if they are being supervised by a clinician who is competent. This must not exceed any scope of practice. For example, a SAPP can be mentored in suturing by an APP once they have completed a minor injuries module at university.

2.1.4. It is expected that to work as an APP, all elements of the role must be undertaken – this includes but not limited to OU Support, DCA shifts, SRV shifts, Urgent Care Hub shifts, remote consultations, clinical governance time, utilisation of PGDs, clinical and educational supervision, and peer support.

2.1.5. Bank Enhanced Paramedics are expected to undertake SRV shifts, Urgent Care Hub shifts, remote consultations, clinical and educational supervision, and peer support. OU support can be undertaken on an ad-hoc basis.

2.1.6. DCA shifts may only be undertaken where there is an identified need for peer support or educational supervision only, unless declaration of a BCI or major incident, at the discretion of a Strategic or Tactical commander.

2.1.7. APPs aim to deliver the right care in right place, first time. **They may do this by:**

- Assessing and treating on scene using a range of advanced assessment approaches, including a wide range of medicines, advanced wound care, and risk management strategies.
- Assessing patients, remotely, supported by a remote consultation tool.
- They may also assess and refer or signpost to an appropriate community service, GP or direct to specialty within secondary care as an alternative to Emergency Departments (ED).
- Improving patient safety by supporting clinicians as senior clinical decision maker, either remotely or on scene.
- Undertaking urgent or routine assessments of patients in other settings, where service level agreements exist or are being developed. This may include patient's homes in partnership with GPs and community teams, Urgent Treatment Centres (UTCs), Minor Injury Units (MIUs) or ED.

2.1.8. This helps people to better manage their own health and avoid an unnecessary ambulance conveyance to hospital.

2.1.9. A flexible approach to the daily role of the APP is required to meet the changing need of the Trust and the patients. As an example, during high demand, an APP on an SRV may be requested to relocate to an Urgent Care Hub to undertake remote consultations. This should only be undertaken in consultation with the relevant Tactical Commander and a PDL.

2.2. Urgent Care Hub

2.2.1. Urgent Care Hubs (UCH) are based within local OUs. They work collaboratively to provide a 24-hour provision of service.

2.3. The functions of the UCH include:

- Remote clinical support to colleagues for decision making.
- Remote consultations of patients
- The UCH APP will seek to proactively contact ambulance clinicians on scene to offer specialist support and guidance.

- The UCH APPs should have knowledge of, and access to, information regarding local health services to promote signposting as required. NHS Service Finder (standalone) and the NHS Directory of Services (embedded within consultation support) can be utilised to facilitate this.

- The UCH APP may, when trained, undertake remote patient assessments, utilising the Trust approved support systems, in conjunction with the Computer Aided Dispatch (CAD) system and relevant policies and procedures.

2.3.1. APPs within the UCH may access a variety of resources to support their activities, **including, but not limited to:**

- Electronic Patient Clinical Records (ePCR)
- Shared Care Records
- ECGs
- Clinical Management Plans / Guidelines
- Decision support tools
- NHS Service Finder / Directory of Services

2.3.2. The UCH APP is not available to the Emergency Operations Centre (EOC) for deployment within the SSP (System Status Plan) as they must not book onto a responding resource.

2.3.3. The UCH will have access to CAD where they will receive call back requests via the Emergency Crew Advice Line (ECAL) system, in line with the ECAL Procedure.

2.3.4. All calls must be recorded utilising the Avaya telephony system, as per the ECAL Procedure.

2.3.5. Following discussion with clinicians on scene and where appropriate, the UCH will be able to generate a 2 or 4 hour PP referral incident on the CAD.

2.3.6. PP Referrals are generated via the UCH for crews on scene who feel their patient will benefit from a visit from an APP. This could be, but not limited to, wound care, end of life care or treatment of common conditions requiring pharmacological intervention via a PGD.

2.3.7. The UCH APP should maintain good communication with the operational APP (2.2) and dispatch team to support with appropriate deployments.

2.3.8. Training for relevant systems within the UCH is undertaken by the Integrated Care Training and Development Team. This includes a period of mentorship with a suitably qualified and experienced clinician prior to being able to work autonomously.

2.3.9. All employees must work within Information Governance guidelines to ensure confidentiality and data protection is maintained.

2.3.10. All APPs, and SAPPs from year two, are expected to undertake remote consultations once the clinician has undergone appropriate training and mentoring.

2.3.11. Year one SAPPs may undergo training in CAD and remote consultations should they wish but must not undertake crew requests for on scene support (ECALs) until year two.

2.3.12. SAPPs (once training and mentoring completed) undertaking UCH duties should be supported by an APP. This can be remotely.

2.3.13. APPs should retain familiarity with the CAD system. If the CAD system is not used for a period of six months, access will be deactivated. The individual must either undertake a training refresher or complete full retraining, depending on their circumstances.

2.3.14. If an APP does not undertake a remote clinical within six months, or does not undertake the appropriate system updates, then access will be removed, and the APP will have to undergo re-training by an EOC trainer.

2.4. Operational APP

2.4.1. The operational APP will be a fully qualified APP or a SAPP that has completed their clinical reasoning and physical assessment, minor injury, minor health and pharmacology modules. They will work on a single response vehicle (SRV) and be 'out of plan' from standard EOC deployment, including covering standby points within the system status plan (SSP).

2.4.2. SAPPs not meeting the above educational criteria will work on an SRV, however will be within the SSP and be tasked by EOC as per normal procedures.

2.4.3. The operational APP will proactively use CAD Online to screen incidents within the 'Dispatch List' (i.e. awaiting resource allocation) to identify patients who may benefit from the attendance of an APP. Once identified, the APP can 'self-task' to an incident by contacting their Resource Dispatcher via Airwave. The APP can self-task to any incident of any category where they feel they will provide positive input.

2.4.4. The operational APP can also use CAD Online to monitor the 'Ongoing List' (i.e. incidents with a resource on-scene) to self-task if they feel their additional attendance will support their colleagues to deliver appropriate patient care.

2.4.5. When accessing any incident on CAD Online, the APP must enter clear and detailed 'Call Notes' to explain their rationale for accessing the case and any subsequent decision making following their review – e.g. "Incident reviewed by out-of-plan APP for possible self-taking – appropriate clinical grade assigned and en - route".

2.4.6. The operational APP will be available for allocation to Category 1 incidents, Grade 1 back-up requests and PP Referrals by their Resource Dispatcher in EOC.

2.4.7. If the operational APP is allocated to an incident that is C1 within nature of call (NoC), that subsequently reaches a lower category following triage, it is best practice for the Resource Dispatcher to liaise with the APP to jointly agree whether it is still appropriate for the APP to attend.

2.4.8. For PP Referrals, standard deployment will see the APP only allocated to cases within the OU in which they are working. The APP can attend PP referrals in other OUs, however this should be agreed in advance and should take into consideration maintenance of sufficient APP cover across the Trust.

2.4.9. The operational PP resource will normally be 'tethered' to a suitable location as agreed by local OU leadership team. The will most often be a local ambulance community response post (ACRP) unless otherwise agreed on-shift.

2.4.10. Should a Major Incident be declared, APPs and SAPPs working on an SRV will be dispatched by EOC as per the Major Incident policy, unless otherwise agreed by the Strategic Commander.

2.4.11. As an advanced resource, the operational APP should not be removed from the SRV (e.g. to crew a DCA), unless agreed by the Strategic Commander. APPs are proven to be most effective when self-allocating to suitable patients or working in a UCH. Taking an APP from a dedicated SRV is likely to be detrimental to providing responsive and quality patient care.

2.4.12. There may be times in which it is appropriate to ask an operational APP on an SRV to cover a shortfall in UCH provision. This decision would be taken by a Tactical Commander in discussion with a PDL or Consultant Paramedic.

2.4.13. APPs should seek to keep on-scene times to a minimum. Therefore, if conveyance to hospital is required, appropriate back-up should be requested as soon as possible, with consideration being given to utilising an Urgent Transport Vehicle (UTV) resource where available and suitable.

2.5. Incident tasking strategy for operational APPs

Category	Typical examples	APP tasking
Category 1 (Life-threatening event)	Cardiac arrest Choking Unconscious (agonal breathing) Continuous fitting Not alert after a fall or trauma Allergic Reaction with signs of anaphylaxis	Auto dispatch (CAD) Resource Dispatcher allocation Paramedic backup Self-tasking
Category 2 (Emergency, potentially serious incident)	Stroke Fainting, not alert Cardiac chest pain RTCs, major trauma Major burns Severe sepsis	Self-tasking Paramedic backup

Category 3 (Urgent Problem)	Falls, with injury Fainting, now alert Diabetic problems Isolated limb fractures Abdominal pain Mental health illness	Self-tasking Paramedic backup
Category 4 (Less Urgent Problem)	Diarrhoea Vomiting Non traumatic back pain End of Life Care Falls, without injury	Self-tasking Paramedic backup
PP Referral	Referral following crew attendance: Within 2-hours Within 4-hours	Resource Dispatcher allocation
Conveyances to hospital	The operational APP should not routinely convey patients to hospital in an SRV. UTV vehicles should be utilised with the consideration for a grade 4 backup within a 1 hour timeframe.	

2.6. **Supervision**

2.6.1. As clinical leaders, APPs should undertake clinical and educational supervision of SAPPs and more junior colleagues where required, such as on OU support.

2.6.2. SAPPs require four defined periods of educational supervision to be provided by an APP. This is defined in the 'Student Paramedic Practitioner Roadmap to Practice' document.

2.6.3. Clinical supervision, including peer-to-peer support, should be undertaken by APPs with peers, and more junior colleagues where an issue has been identified by the local OU leadership team.

2.6.4. This may be undertaken on SRV, DCA or OU support time.

2.6.5. Clinical supervision may be able to be undertaken in conjunction with other supporting Heath Care Providers (HCPs) when undertaking clinical placement hours.

2.6.6. APPs should have four to six hours of planned clinical supervision per year, plus ad hoc where needed. This should be with a Practice Development Lead or peer-peer with another APP. This may include structured conversations, group governance session, ride-outs on SRV or DCA or support in the Urgent Care Hubs.

2.6.7. APPs may also undertake ad-hoc peer-peer support on SRV or hub shifts, or on DCA where there is an identified need.

2.6.8. Clinical supervision is formally set out in the OU Support Toolkit.

2.7. Governance

2.7.1. Full time APPs have a governance (SAT) entitlement of 130 hours per year. This is pro rata for employees not on a full-time contract. This time must be built into the rota.

2.7.2. Elective governance time should be a mix of activities that are recordable. The HCPC provide excellent guidance on appropriate CPD activities. Please refer to the Governance Procedure for further guidance.

2.7.3. PDLs will organise set governance days with an educational and supportive agenda, four times a year, which will be taken out of the governance allowance in the rota. Attendance at these sessions is mandatory (with exception of annual leave or sickness).

2.7.4. This entitlement is protected and should not be changed to clinical shifts during escalated operational pressures.

2.7.5. For employees not working a full-time contract, clinical governance and OU support time will be allocated on a pro rata basis (see table below).

2.7.6. Bank Enhanced Paramedics are not entitled to governance time, however, can attend an APP Conference as plain time. This is because bank Enhanced Paramedics are likely to have another clinical employer where governance time would be provided.

2.8. Table for pro rata governance and OU support time:

		SRV	Hub	Governance		OU Support	
Hours per week	% of WTE	Average hours per week	Average hours per week	Approx hours per week	max Governance hours per annum	approx. hours per week	max hours per annum
37.50	1.00	15.0	15.0	2.5	130	5.0	260
34.50	0.92	13.8	13.8	2.3	120	4.6	240
33.75	0.90	13.5	13.5	2.3	117	4.5	235
30.00	0.80	12.0	12.0	2.0	104	4.0	208
26.25	0.70	10.5	10.5	1.8	91	3.5	182
23.00	0.61	9.2	9.2	1.5	80	3.1	160
22.50	0.60	9.0	9.0	1.5	78	3.0	156
18.75	0.50	7.5	7.5	1.3	65	2.5	130
15.00	0.40	6.1	6.1	1.0	50	1.9	100
11.50	0.31	4.7	4.7	0.8	36	1.5	75
11.25	0.30	4.6	4.6	0.8	35	1.5	75
7.50	0.20	3.7	3.7	0.0	7.5	0.0	0
2 shifts per month	0.14	2.6	2.6	0.0	7.5	0.0	0
3.75	0.10	3.8	0.0	0.0	0	0.0	0

1 shift per month	0.07	2.6	0.0	0.0	0	0.0	0

2.8.1. For SAPPs, governance time built into the rota should be converted into clinical shifts or placement shifts, however SAPPs are expected to attend governance days run by PDLs or APPs, as well as a trust organised conference, and this should be reflected as governance days on GRS.

2.9. **OU Support**

2.9.1. This time is built into the rota and is not an abstraction.

2.9.2. Full Details of OU support are included in the OU Support Toolkit.

2.9.3. SAPPs have a significant investment in their development as part of the APP course, both financially and operationally. APPs as soon as they are on the APP rota**, however its utilisation should be as below:**

- **Year 1 SAPP** – OU support time should be converted into clinical shifts (SRV or DCA) to allow consolidation of learning. OU support shifts may also be utilised as part of a SAPPs preceptorship placements to work with a qualified APP. However, if a local project requires a year 1 SAPP, OU support can be utilised for this.

- **Year 2 SAPP** – OU support time is available for local projects; however the focus should still be converting these to clinical shifts. Should a local project require a SAPP (such as but not limited to; Key Skills, vaccination clinics, clinical support for individual staff members) then the SAPP may use OU support time for projects such as these.

- **Year 3 SAPP** – Should be treated as a fully qualified APP in terms of OU support. These shifts should not be converted into clinical shifts but used for local projects and initiatives or work on a Quality Improvement project. If there is a staff member with a need for support from a senior clinician (e.g. identified from a complaint, investigation or appraisal), OU support time can be utilised for clinical supervision shifts.

2.9.4. This entitlement is protected and should not be changed to clinical shifts during escalated operational pressures, however in the event of a Business Continuity Incident, Critical or Major incident, OU support time may be changed at short notice to UCH or clinical (SRV / DCA) shifts.

2.9.5. This time is on a pro-rata basis for those APPs not working full time hours, and their allocation can be seen in 2.7.5.

2.9.6. Bank Enhanced Paramedics are not entitled to OU support time, however if agreed by the local OM/OUM, bank Enhanced Paramedics may be given some ad-hoc OU support time to help facilitate events such as Key Skills or Small Wound Assessment and Management for Paramedics (SWAMP) courses.

2.9.7. OU support time must be booked via the scheduling department at least six weeks ahead, with comments added to denote the nature of the OU support.

2.9.8. OU support time may be moved flexibly to accommodate projects or meetings or other tasks linked with OU support.

2.10. **Bank Enhanced Paramedic**

2.10.1. Paramedics who have undertaken additional education within the field of urgent care (e.g. the previous 'Paramedic Practitioner' pathway), however are not practicing across the 4-pillars of Advanced Clinical Practice, will work within the scope of an Enhanced Paramedic (EP). This includes individuals who work on a bank agreement for the Trust, as they will work strongly within the clinical and leadership pillars, however, will have less opportunity to practice education and research activities (as they will not have regular OU support time).

2.10.2. Bank Enhanced Paramedics should book shifts on an SRV or Urgent Care Hub and undertake clinical consultation calls where trained.

2.10.3. DCA Shifts should not be booked by Bank Enhanced Paramedics unless there is a specific identified need from the local management team.

2.10.4. Bank colleagues are not entitled to OU Support or governance time but may attend an APP Conference paid as plain time. However please see point 2.6.7. above regarding ad-hoc OU Support time.

3. Definitions

3.1. **Urgent Care Hub Model**. - A team of Advanced Paramedics (Urgent & Emergency Care) situated within an OU providing clinical supervision and clinical support to operational clinicians.

3.2. **Urgent Care Hub (UCH). -** An APP or SAPP providing remote clinical supervision from an OU.

3.3. **Advanced Paramedic Practitioner (APP).** - A qualified Advanced Paramedic in Urgent and Emergency Care.

3.4. **Student Advanced Paramedic Practitioner (SAPP).** - A paramedic who is undertaking a recognised Advanced urgent care development educational pathway.

3.5. **Operational APP**. - An APP or SAPP on an SRV, who can self-task to incidents.

3.6. **Computer Aided Dispatch (CAD).** - A system used by the Emergency Operations Centre (EOC) to assist with dispatch decisions.

3.7. **Emergency crew advice line (ECAL)** - a system for allocating and recording clinical call backs.

3.8. **ACRP – Ambulance Community Response Post**. - A community standby point for trust or private ambulance front-line vehicles.

3.9. **Non-Emergency Transport (NET).** - A resource for simple urgent transport to a healthcare facility.

3.10. **Operational Toolkit. -** An operational document setting out the implementation of the Urgent Care Hub Model in an OU.

3.11. **OMC – Operations Manager Clinical** – oversees clinical operations of EOC.

4. Responsibilities

4.1. The Chief Executive is responsible for patient safety.

4.2. The Executive Medical Director is responsible for clinical practice in the Trust.

4.3. The Consultant Paramedic (Urgent and Emergency Care) is responsible for the management of this procedure.

4.4. The Operations Management Team and Practice Development Leads are responsible for the implementation of this procedure.

4.5. The Operations Management Team are responsible for audit and monitoring this procedure.

4.6. All Staff are responsible for adherence to this procedure.

5. Audit and Review (evaluating effectiveness)

5.1. The procedural document will be reviewed at least every three years; or earlier if required due to change in local/national guidance and/or policy; or as a result of an incident that requires a change in practice.

5.2. Ongoing audit against set KPIs as per the Operational Toolkit.

5.3. All policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

5.4. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the

5.5. Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

5.6. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

5.7. All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

6. Associated Trust Documentation

- Advanced Paramedic (Urgent and Emergency Care) Policy
- Clinical Peer Review Procedure
- Clinical Supervision Procedure
- ECAL Procedure
- Clinical Governance (SAT) Procedure
- Frequent Caller Policy and Management Procedure
- Interrupted Care and Delayed Conveyance Procedure
- Scope of Practice and Clinical Standards Policy
- Urgent Care Hub Toolkit
- OU Support Toolkit
- Student PP Road Map

7. References

- National Audit Office Transforming NHS Ambulance Services (2011 & 2017)
- NG94. Emergency and Acute Medical Care in Over 16s, Service Delivery and Organisation.
- QS174. Emergency and Acute Medical Care in Over 16s
- Quality Impact Assessment
- A QIA has been completed and approved.

8. Equality Analysis

8.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

8.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

8.3. Full EIA available on request to the author.

9. Appendix A - APP Key Performance Indicators

Aligned with the four pillars of Advanced Practice.

KPI – Clinical Practice

- Average see and treat rate of 70%
- Average on scene time <60min for see and treat

KPI – Facilitation of Learning

- Development Shifts
- Completion of OU support plan
- Local CPD or SWAMP courses

KPI – Leadership

- Undertake Supervision in line with national framework
- Each APP to have an area of special interest
- Frailty
- Care Homes
- EoLC etc.
- Annual station survey
- Clinical oversight and proactive crew engagement for appropriate pathways consideration, in addition to ECAL response

KPI – Evidence, Research and Development

Consider:

- Quality Improvement Projects
- Completion of governance plan
- Annual Station Survey
- PACCS Audit, 3 per APP per quarter
- ECAL peer review, 3 per APP per quarter
- Journal Club / literature review