What are the lived experiences of Advanced Paramedic Practitioners working in the emerging specialty of Integrated Urgent Care?

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Abstract

The aim of this research was to identify the lived experiences of Advanced Paramedic Practitioners (APPs) working in the emerging specialty of Integrated Urgent Care (IUC). APPs are a professional sub-group of the wider multiprofessional Advanced Clinical Practitioner group as defined by Multiprofessional Framework for Advanced Clinical Practice as defined by Health Education England (2017). The aims of the study were to contribute to:

1) Critically explore the lived experiences of Advanced Paramedic Practitioners.
2) Describe the participants' experience in their own words and to gain insight into the meaning that people describe as their experience.
3) To provide recommendations as to what the developing Advanced Paramedic Practitioner working in Integrated Urgent Care could offer to provide positive multidisciplinary teamwork and service user experience.

The research followed the Interpretivist paradigm, utilising Schutzian Social Phenomenology methodology through unstructured interviews, the data being thus analysed through the perspective of Schutz's 4 realms of Vorwelt, Umwelt, Mitwelt and Folgewelt so as to understand the variance between the experiences of predecessors, the specific experiences of the individual, the observed experiences of others and the intentions for future development.

The were 5 main findings: 1) There has been a breach of the psychological contract between APPs and the ambulances services in the UK. 2) Multiprofessional integration still needs assistance to develop understanding between professions in order to develop a gestalt patient centred service. 3) Employers in the IUC sector need to formalise the managerial authority of advanced practitioners as a separate issue to the concept of leadership. 4) Human Resource Departments need to adopt the multidisciplinary nomenclature of modern practice and step away for the nurse centric perspective. 5) Telephone Triage should evolve as a sub-specialty with greater input from academia so as to achieve a deep philosophical understanding of the subject and in turn support safe, patient centred practice.

Contents

Abbreviations

A&E	Accident and Emergency Department
ACP	Advanced Clinical Practitioner
ANP	Advanced Nurse Practitioner
APP	Advanced Paramedic Practitioner
AHPs	Allied Health Professionals
ASA	Ambulance Service Association
AACE	Association of Ambulance Chief Executives
BERA	British Education Research Association
CQC	Care Quality Commission
CAS	Clinical Assessment Service
CWP	Clinical Workforce Programme
CoP	College of Paramedics
CAD	Computer Aided Despatch
DoH	Department of Health
DfES	Department for Education and Skills
DTAG	Driver Training Advisory Group
EMAS	East Midlands Ambulance Service NHS Trust
ECP	Emergency Care Practitioner
ED	Emergency Department
EoLC	End of Life Care
EBP	Evidence Based Practice
HSE	Health and Safety Executive
HEE	Health Education England
HPW	High Performance Working practices
HE	Higher Education
HRD	Human Resource Development
HRM	Human Resource Management
IUC	Integrated Urgent Care
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
LAS	London Ambulance Service
MIU	Minor Injury Units
NHS	National Health Service
NHSD	National Health Service Digital
NHSE	National Health Service England
NHSS	National Health Service Scotland
NPM	New Public Management
NGO	Non-Governmental Organisations
NP	Nurse Practitioner
NMC	Nursing and Midwifery Council
OfSTED	Office for Standards in Education
OOH	Out of Hours
PP	Paramedic Practitioner
PBP	Performance Based Practice
QCA	Qualification and Curriculum Authority
RCN	Royal College of Nursing
SMT	Senior Management Team
UCC	Urgent Care Centre
UTC	Urgent Treatment Centre
VBP	Values Based Practice

Chapter 1: Introduction

1.1 Introduction

Engaging in any project is best achieved by a period of clear planning and structure development that will not only guide the project but also assist the end user to position the final product in context. Development of an effective, useable piece of research is no different (Denzin & Lincoln 2011:4). Thus, the intention in this first chapter is to layout the structure to come and to give an insight into the motivation of the researcher.

1.2 Personal Reflection

Reflecting on my existence, my driving force has always been to do something useful, I am not particularly interested in accruing financial wealth, I have spent my life trying to use my interests and skills to help other people. My career started in Non-Governmental Organisations (NGO) in the field of Earthquake and Disaster Rescue which gave me a fairly unique grounding for my later roles as a Commissioned Officer in the Royal Air Force Volunteer Reserve (RAFVR), my Paramedic career and my current position as National Head of Clinical Workforce Development for a plc. It is fair to say that I am considered by my colleagues and students to be slightly odd, terrified by social environments, highly focused on my work and with an encyclopaedic memory. The reason for this has only come to light in the last few years with a diagnosis of moderate Asperger's Syndrome, and this explains a great deal. Whilst achieving the highest academic award is a factor to this research, my main aim is to accrue intellectual wealth and share my findings for the benefit of others; I hope this, and later studies will be my legacy.

1.3 My credibility as a researcher

The demonstration of one's credibility is rooted firmly in the path that has already been travelled; one's background and experience in coming to this point in terms of intellectual rigour, professional integrity, and engagement with educational opportunities during the study to support methodological competence.

I have worked in the Paramedic field since the late 1980s in my NGO Rescue role, the RAFVR and since 1997 with the National Health Service (NHS) in England the last 21 years of which has been as a practicing clinician and an educator in both in-house and higher education. During this time, I have seen, participated in, and contributed to some major changes in deployment and practice. So, my fascination with this subject area and desire to contribute to guiding the evolution of the paramedic role and profession, springs from the integrated elements of my professional environment. I was, between November 2004 and June 2013 a Senior Educator and Paramedic Programme Lead in the East Midlands Ambulance Service NHS Trust. In association with this I was a member of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines Development Group and thus a contributor to the 2006, 2011(interim) and 2013 Ambulance Services National Clinical Practice Guidelines. I was a mentor to the East Midlands Immediate Care Scheme (EMICS) the regional volunteer emergency doctors scheme. I have worked as Head of Education and Clinical Services for a private ambulance provider which is an emerging role, as paramedics are no longer purely employed by the NHS or in a solely ambulance role, just as I predicted in my research of 2010. I am also an Expert Witness in Paramedic practice and proficiency to the Courts, an Associate Member of the East Midlands Forensic Pathology Unit, a Fellow of the Higher Education Academy, a Fellow of the Society of Education and Training, an NHS Consultant Paramedic Practitioner, and a Senior Lecturer in Adult Nursing and Paramedic Science.

My desire to study the role of the Advanced Paramedic Practitioner in the emerging specialty of Integrated Urgent Care has inductively developed from my two previous small-scale studies during my service with the East Midlands Ambulance Service NHS Trust (EMAS). In 2010 I studied the barriers to Higher Education (HE) as perceived by in-house competency-based system educated paramedics. This study helped develop local education policy in the transition to paramedic education through HE. Then in 2012, I conducted an impact analysis of Clinical Supervision within EMAS which using a Philips Return on Investment Model (Philips & Philips 2002) demonstrated several elements including value for money in the application of HE in the development of the Paramedic role and in turn its impact on patient care. Through this new research question, I intend to ‘dig’ deeper still into paramedic practice in relation to the role of the Advanced Paramedic Practitioner which has required paramedic education to

develop to the level of a master's degree and a significantly enhanced level of autonomy.

1.4 Research question

Therefore, my research question is:

What are the lived experiences of Advanced Paramedic Practitioners working in the emerging specialty of Integrated Urgent Care?

1.4.1 Concept clarification

As with other professions in both the healthcare and the community, Paramedics have traditionally established and defined roles within the wider scope of the profession. These are generally stated as Clinical Practice, Education, Leadership and Management, and Research (College of Paramedics (CoP) 2014) and Health Education England (HEE) 2017) although as with many professions as they develop, engagement in research is the newest element: "Paramedic" itself, is a young profession in the wider NHS as it only truly appeared as a national qualification standard in 1987, though it should be acknowledged that there were pilot schemes as far back as the mid-1970s (Newton 2011).

"Paramedics are first-contact Allied Health Professionals. This requires them to have the appropriate underpinning knowledge, competencies, and clinical practice experience to provide appropriate assessments and treatment, and to implement appropriate referral, management, or discharge plans for their patients. These plans should be developed through a partnership approach and address patients' specific requirements. Unlike traditional modes of healthcare delivery, this may not require conveyance of patients to hospital but may require the paramedic to utilise alternative care pathways. Paramedics are not isolated from the changes experienced in other healthcare settings and, like other providers, are likely to see an increase in the incidence of acute and chronic illnesses, dementia, mental health issues and end of life care in the patients they attend. The workload of paramedics is predominantly

emergency and urgent undifferentiated healthcare requests, ranging from life threatening to a high proportion of non-life-threatening conditions" (College of Paramedics 2014a)

The role of the Advanced Paramedic Practitioner was expected to be a key element in the provision of the enhanced "mobile urgent treatment services" and prehospital clinical leadership as described in the Keogh Review (Department of Health 2013a: 8), supported in turn by Evans et al. (2013) the College of Paramedics Curriculum (2014a). However, since the HEE (2017) Multi-Professional Framework for Advanced Clinical Practice this has evolved into paramedics bringing their skill set away from their traditional community-based working environment to other clinical settings.

This study looks at the Advanced Paramedic Practitioner in its emerging role as an upper echelon Paramedic in the United Kingdom (UK), that is changing the accepted patterns of deployment as a specific sub-group of the multi-professional Advanced Clinical Practitioner role as specified in the HEE standards of 2017.

"The definition of advanced clinical practice was developed and agreed by all stakeholders is outlined below and some of the terminology has been updated to reflect more current language: Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education, and research, with demonstration of core capabilities and area specific clinical competence. Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families, and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes. This definition therefore requires that health and care professionals working at the level of advanced clinical practice will exercise autonomy and decision making in a context of complexity, uncertainty and varying levels of risk, holding accountability for decisions made". (HEE 2017).

An Advanced Paramedic Practitioner (APP) is defined by the College of Paramedic Career Framework (2014b & 2019) as; an experienced Paramedic Practitioner, educated to MSc and fulfilling a senior role in Education, Research, Management or Clinical Practice. It is not simply a paramedic with dual specialisation. Paramedic services already contribute significantly to the concept of mobile urgent treatment services through the paramedic practitioner grades (formerly known as Emergency Care Practitioners – ECP, (Cooper et al. 2004)) working as solo responders assessing, diagnosing and identifying an appropriate course of action, as discussed by the Department of Health (2005: 49), Woollard (2006) Joint Royal Colleges Ambulance Liaison Committee UK Ambulance Services Clinical Practice Guidelines (JRCALC 2006: 1) and Minney (2007). The intention a decade further on was that the APP would bring yet more skills to the mix and the furtherance of patient care however the expansion of the role has been far greater than simply reinforcing mobile "ambulance-based" functions. This study will focus on the APP who is primarily in Clinical Practice but has moved away from the traditional ambulance-based role to the Integrated Urgent Care Setting as defined by NHS England (NHSE 2017).

1.5 Research aims

The aim of this study will be to:

1. Critically explore the lived experiences of Advanced Paramedic Practitioners.

2. Describe the participants' experience in their own words and to gain insight into the meaning that people describe as their experience.

3. To provide recommendations as to what the developing Advanced Paramedic Practitioner working in Integrated Urgent Care could offer to provide positive multidisciplinary teamwork and service user experience.

1.6 Significance of the research question

This question seeks to identify, what difference will an Advanced Paramedic Practitioner grade make to the established Integrated NHS Urgent and Emergency

Services? How would the post incumbents like to see the role develop and what hurdles for this relatively new grade of staff are there to overcome? How will this new grade of staff be accepted by an already complex integrated healthcare system? As Glendinning et al. 2001 describe, the Health Act (1999) imposes a duty on all NHS organisations to work in partnership, and more than this it is beneficial to enhancing patient safety and quality of care experience (WHO 2010, Morrow et al. 2011 and Francis 2013: 67). But is it achievable despite the law? The Lord Laming report on the Victoria Climbié Inquiry (Home Department 2003) found significant barriers still in place? Francis (2013), 10 years later in the Mid-Staffordshire Enquiry, still found significant failings in Values Based Practice (VBP) and one of these key failings was multidisciplinary working that supports patient centred care. Therefore, it is my assertion, an assertion that I hope to fully support through sound research, that, as described by Fulford et al. (2012), there are still significant issues in generating a non-hierarchical, "round table" decision making environment that is inclusive and rewarding for the Clinician and the Patient and that this emerging new role for the paramedic may only add to the confusion of an already difficult process. Thus, this study aims to help this integration.

1.7 Importance of the research question

The Keogh Review (DoH 2013a) identified the strategic advantage to utilising and developing the NHS Ambulance Service to facilitate mobile urgent care and admission avoidance provision. The Ambulance Service already had basic practitioner grades working towards this ideal (Minney 2007). However, for involvement of Advanced Paramedic Practitioners in patient care to become the norm for all areas, the Ambulance Service still had to make significant changes to their service delivery models. Then, before these changes could become a national standard of service provision the programme was further complicated by the Integrated Urgent Care Service Specification (NHSE 2017) the Multi-professional Framework for Advanced Clinical Practice in England (HEE 2017) and the Independent Prescribing legislation changes of 1st April 2018 authorising paramedics working in advanced practice to become independent prescribers (CoP 2021). These latest advances have vastly increased the scope of career pathways for this professional group. Therefore, it

seems reasonable that this study can add to the fundamental body of knowledge for this emerging role. This work will contribute to:

1 The research-based knowledge of the lived experiences of Advanced Paramedic Practitioners being enhanced.
2 Enhancing the professional standards of paramedic education and paramedics in practice. This will then impact positively on
3 The patient experience of alternative, unscheduled and emergency care functioning within a multidisciplinary team in the local community. This will then enhance
4 Patient safety and patient confidence in adaptive, tailored care planning.
5 Promoting “esprit de corps” within the multidisciplinary NHS structure and the individual clinicians as their confidence in their own autonomous practice develops in a supportive environment.

It is also reasonable to expect that following involvement in the data collection process the APP, given that they are highly educated professionals, will be stimulated into a degree of self-reflection and local development.

1.8 Focus

The world of paramedic practice in the UK has rapidly evolved in the last 20 years and is continuing to develop to meet the needs of the health economy (Newton 2011). This study seeks to support developing APP role and its integration into the existing and complex multidisciplinary NHS healthcare community. The study will reflect the lived experiences of the clinicians in their practice setting. It is not however an examination of their perceived function by other health professionals nor is it an examination of patients’ opinions or satisfaction.

1.9 Framework

In order that the reader understands the defined role and perspectives of an Advanced Paramedic Practitioner it is useful to revisit the College of Paramedics description of the roles and grades of a Paramedic.

"Paramedics are first-contact Allied Health Professionals. This requires them to have the appropriate underpinning knowledge, competencies, and clinical practice experience to provide appropriate assessments and treatment, and to implement appropriate referral, management, or discharge plans for their patients. Unlike traditional modes of healthcare delivery, this may not require conveyance of patients to hospital but may require the paramedic to utilise alternative care pathways. Paramedics are not isolated from the changes experienced in other healthcare settings and, like other providers, are likely to see an increase in the incidence of acute and chronic illnesses, dementia, mental health issues and end of life care (EoLC) in the patients they attend. The workload of paramedics is predominantly emergency and urgent undifferentiated healthcare requests, ranging from life threatening to a high proportion of non-life-threatening conditions" (College of Paramedics 2014a: 11)

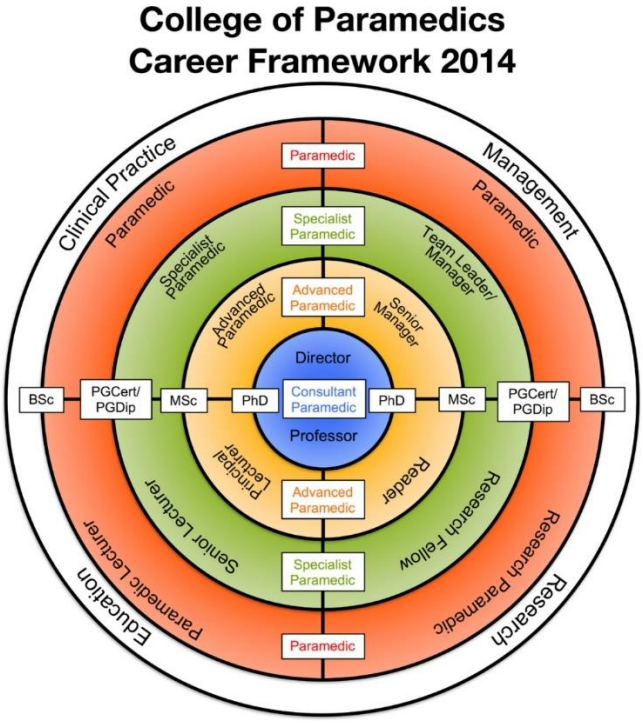


Figure 1

Paramedics further contribute to the concept of urgent care services through the specialist paramedic practitioner grades (formerly known as Emergency Care Practitioners – ECP) such as primary care specialists and critical care specialists, working as solo responders assessing, diagnosing and identifying an appropriate course of action in both emergency response and home visiting services, as discussed by the Department of Health (2005: 49), Wollard (2006) Joint Royal Colleges Ambulance Liaison Committee UK Ambulance Services Clinical Practice Guidelines (JRCALC 2006: 1) and Minney (2007) CoP (2014a), NHSE (2017) and CoP (2021). In 2014 the intention was that the Advanced Paramedic Practitioner would bring yet more skills to the mix and including "clinical leadership and effective on-scene decision making capability" in the furtherance of patient care in an ambulance context (CoP 2014a: 14). However, the scope of practice for the APP accelerated with NHSE (2017) and HEE (2017), just three years into the programme. Further role expansion has been seen due the SARS CoV2/ COVID 19 Pandemic where practitioners function across the spectrum of face-to-face care and remotely through supervisory roles and telemedicine provision through the 111 service (Stokel-Walker 2020, Bashshur 2020, and Mehrotra et al. 2021). It is likely in the research findings that the SARS CoV2 response will be featured in the study if available prior to submission.

At this point, there has been little study of the efficacy of this emerging role from a phenomenological perspective. Indeed, there is little evidence of any kind as to the efficacy of the role or a return on investment. The evolving role is just too new to have been fully examined by many researchers. There are however enough APPs in practice to warrant examination. This study will then impact on development of the role and further deployment as the role expands across the National Health Service. As the multidisciplinary functioning of the NHS is in fact a social structure in a Neo-Weberian model (Goldthorpe 1993 cited in Giddens 2001: 288, Ellis 2010) typified by a hierarchical demonstration of status. It is appropriate to study the lived experiences of the participants from a social perspective and therefore the analysis framework will be structured on the Schutzian Social Phenomenological Model and taking guidance from the phenomenological data analysis described by Kleiman (2004) and Giorgi (2009). Schutz considers that social phenomenology is divided into four realms of reality. Umwelt, the realm of the directly experienced social reality; Mitwelt, the realm

of the indirectly experienced social reality; Folgewelt, the realm of successors; and Vorwelt, the realm of peripheral interest. Of which only Umwelt, one's direct experience and Mitwelt one's experiences of contemporaries can be directly experienced and analysed because the interpretation of peripheral figures, predecessors (Vorwelt) and successors (Folgewelt) is impossible (Emmanuel, 2012). The terms Folgewelt and Vorwelt are retained in analysis of social phenomenology to enable the description of when a line is crossed into an intangible area of belief or desire. For example, a practitioner might hope that the foundations they lay in their current practice and experiences, will aid the role of their eventual successors but the organic nature of societal world and it's changing values my not result in the current intended outcome (Folgewelt). This way it is still possible to acknowledge beliefs of predecessor intentions and desires for future events within common thematic analysis.

1.10 Outline of the study

Chapter two, the literature review, follows this introductory chapter and reviews the literature on role of the paramedic working environment, patient care pathways and central government current vision of further utilisation this staff group within the NHS.

Chapter three describes the study design from a philosophical perspective and the data collection and analysis methods respectively. It also describes the Schutzian model of phenomenology in comparison with alternative theories to demonstrate how the study was narrowed down to decide upon this structure and the application of the interpretive philosophical perspective from an ontological and epistemological perspective.

Chapter four describes the study design and the associated instruments necessary to recruit and protect research subjects.

Chapter five describes the and discusses the findings of the research

Chapter six facilitates a summary of the study, and recommendations in relation to existing theory and future actions.

1.11 Summary of Chapter 1

This first chapter has facilitated an overview of the research question and its relevance as a viable project with the ability to impact positively on several developmentally inductive outcomes. It has established the credibility of the researcher and set foundations upon which the following chapters will greatly expand in terms of methodology and methods, supporting literature and professional application.

Chapter 2: Literature Review

2.1 Introduction

The Paramedic profession in the United Kingdom has evolved from the Municipal, Borough and County Ambulance Services established after the formation of the National Health Service in 1948 (Nuffield Trust 2021). It is essential thus to take some time to consider the wider NHS and its evolution of management and service provision structures as these have an impact on all health care personnel including paramedics.

2.2 Inception of the NHS

Since its inception in 1948 the NHS has come under scrutiny and pressure from successive governments keen to demonstrate to the electorate that taxpayers' money is being spent wisely. As the NHS entered its 4th decade the Conservative Government of 1979 embarked on a number of restructuring exercises to "improve" or demonstrate effective patient care which had direct impact on clinical education and the evolution of clinical specialisms. For example, the White Papers Patients First (Department of Health and Social Services 1979) and The NHS Management Enquiry (Department of Health and Social Services 1983). These were the heralds to the introduction of New Public Management (NPM) as it applies to the NHS.

2.3 New Public Management

NPM was an attempt to demonstrate value for the electorates' money generated in tax, borrowing from examples of successful practices in the private sector and the structure of which is discussed later. (Metcalf and Richards 1987 and Lapsley 2009). NPM itself was an evolution and change in direction from the earlier concept of personnel management. As Mercer et al. describe:

"Personnel management was typically the remit of a separate, specialist, expensive and highly bureaucratic unit within an organisation. It was predominantly concerned with operational procedures and too often offered line managers only belated and unrealistic solutions". Mercer et al (2010: 4)

Personnel management originates from a background of trade union negotiation and liaison e.g. The Whitley Council 1917 – 1982 (National Archives 2021), with a focus

on welfare of the workforce, promoting standards of employment and sexual equality: (Bratton & Gold 2007: 5) whereas Human Resource Management (HRM) and Human Resource Development (HRD) serve as a description for a more strategic method of managing staff within organisations (Middlewood & Lumby 1998: 9 and Chen et al. 2020).

2.4 Human Resource Management

HRM and in turn HRD should infiltrate every element of an organisation with the intention of promoting the individual employee's full potential and ensuring that the collective workforce at every level is committed to the organisational goals so as to achieve the best possible competitive advantage within the organisation's market environment. This requires effective managerial intervention and control at three levels, organisational design, culture and human resource practices and procedures (Bratton & Gold 2007: 4) or as other texts might describe it, team, operational and strategic levels. (Adair 2010: 71).

The difference between HRM and the traditional personnel management perspective is more than just a matter of semantics. Traditional personnel management was based largely on legally negotiated and instituted contracts – "you do this work, for this salary". As Hendry and Pettigrew (1990: 36 cited in Bratton and Gold 2007: 29) state: firstly, HRM is at least in theory integrated into the strategic development of the organisation and second it emphasises the establishment of a psychological contract with the employees to work towards mutually beneficial targets. Thirdly it emphasises the need for education in the workplace and fourthly the motivation of the individual to achieve personal and organisational goals. Mercer et al (2010: 4) consider that there are four key concepts to the establishment of an HRM system: Human capital theory, neo-liberalism, managerialism, and performance management.

2.5 Human Capital Theory

It is often said by managers when developing the strategic direction of an organisation that 'the staff are that organisation's greatest asset'. Certainly, it is people that actually produce goods and services, allocate resources, and monitor quality etc. Perhaps surprisingly for the public sector the education of the workforce is "increasingly seen as a key determinant of economic performance" (Fitzsimons 1999). "Learning interventions can lead to improved performance and business results" as Marsick and

Watkins (2003:141) concur. Therefore, employees are essential to the functioning of the organisation. They are thus Human Capital. Bratton and Gold (2007) credit Schultz (1981) for this term and his definition being:

"Consider all human abilities to be either innate or acquired. Every person is born with a particular set of genes, which determines his innate ability. Attributes of acquired population quality, which are valuable and can be augmented by appropriate investment, will be treated as human capital".

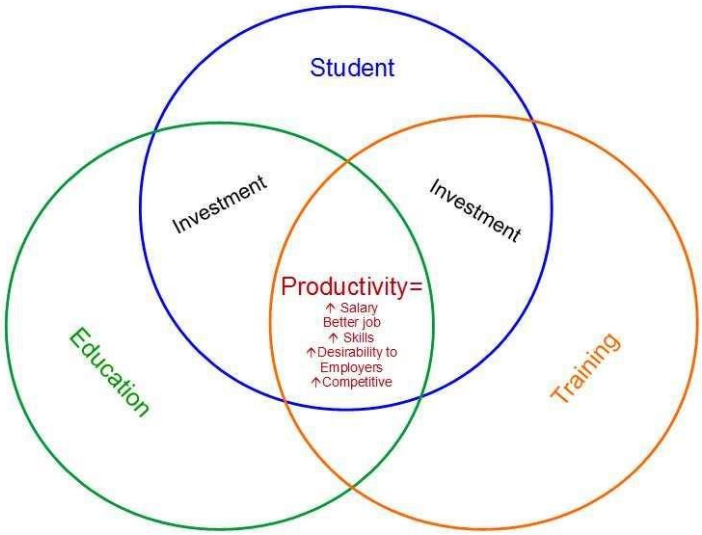


Figure 2

Schultz may be credited with coining the phrase, but the concept has been around far longer. For a blunter description of the potential of human capital we can refer to Karl Marx. In capitalist industry, Marx (cited in Abbott and Wallace 1997: 54) discusses the concept that a labour force sells its skills to the employer and these skills have a defined value identified by the wages paid to the labour force. A labour force educated beyond the immediate needs of the employer and thus paid for only a proportion of their true value creates a surplus value identified as profit. In the public sector surplus value rather than producing direct profit creates organisational flexibility. A concern for the employer is that enhanced education brings greater occupational mobility and thus the possibility of then losing staff to a competitor. However, if employers invest in their human capital the loyalty to the organisation that is generated initiates what (Bratton and Gold 2007; Guest and Conway 2002, Herriot et al 1997, Robinson 2006, Leach

2010 and Tan 2014) describe as a psychological contract and may improve staff retention so that the educational surplus can be channelled towards organisational flexibility and in turn support economic competitiveness. Research by Guest (1992) demonstrates that loyal employees to a point can drive down operational costs.

2.6 Psychological Contracts

"Psychological contracts are an implicit, but largely unwritten contractual understanding between employer and employee concerning their respective role relationship and mutual obligations towards one another that are continually negotiated, test and affirmed within the workplace". (Leach 2010: 331)

Employees with identical legal contracts might have very different perceptions of their psychological contract with their manager. Thus, a manager needs to bear this in mind during a decision-making process and ensure clear communication to reduce the risk of perceptual breaches of psychological contracts despite operating within legal contractual boundaries. (Guest and Conway 2002: 35 cited in Bratton and Gold 2007: 15).

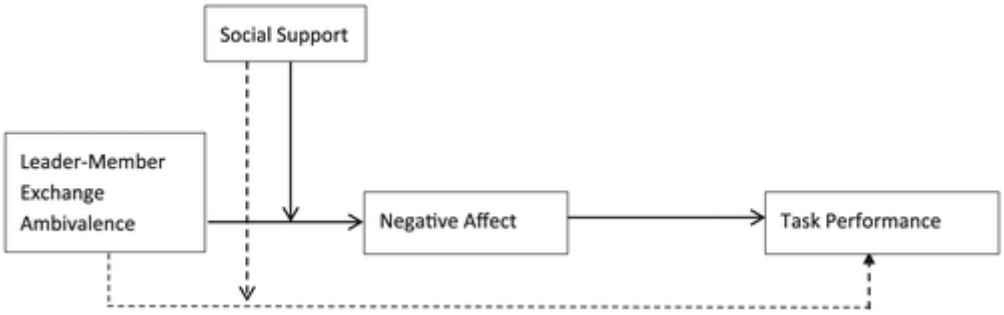
2.7 Leader Member Exchange

Interestingly, the quality of relationships between line managers and their personnel has been analysed by several authors, Dansereau et al. (1975), Graen and Uhl-Bien (1995), Maslyn and Uhl-Bien (2001) in the development of the Leader Member Exchange (LMX) theory.

'LMX theory posits that leaders form dyadic relationships with followers that vary in quality, and that the quality of these relationships has implications for a variety of individual and group outcomes. Central to LMX theory is the notion that leaders differentiate amongst their followers in terms of quality of the dyadic relationships they form. Leaders tend to form high quality relationships with high performing, high ability followers, assigning them more challenging tasks and providing them with high level support. They tend to form low quality relationships with those of low-ability, assigning them more menial work'. Naidoo et al. (2010).

It is this LMX differentiation that may help to explain some variance in reactions to criticism. As Restubog et al. (2010: 423) describe, low LMX employees perceive criticism of their work as a relatively routine process whereas high LMX employees,

who are possibly more used to receiving praise, can react quite adversely and may consider managerial criticism to be a betrayal of trust or of their psychological contract, resulting in a reduction in role performance or organisational citizenship. Ambulance Service clinicians, who like many other healthcare professionals, largely function as autonomous practitioners (HPC 2011) are not directly supervised in their daily duties and thus could be regarded as operating in a moderate to high LMX structure. This in turn may thus serve to explain some potential elements of dissatisfaction with clinical supervision as relevant to the experiences of Advanced Paramedic Practitioners when they move to a more static centre-based mode of practice. As with many theories there is the element of participant perspective and so it is also necessary to consider not only the Leader Member Exchange but also the Leader Follower Relationship. Concentrated organisational structures such a static department may have clearly defined social structures amongst coworkers depending on their level of LMX resulting in aspirations for a higher LMX in terms of a neo-Weberian status or ambivalence to the managerial structure based on the expectation that the first tier and middle management teams have a similar LMX dynamic. LMX quality and the Leader Follower Relationship, particularly in those with a lower exchange status may result in greater ambivalence to managerial directions and leadership goals (Lee et al. 2019) which cyclically reinforce the existing LMX dynamic as a feedback loop. The “wise” leader should thus seek to break the cycle for the benefit of team and organisational development by transforming it into a positive spiral that rather than just repeating itself, learns and moves forward (van Dijk & van Dick 2009, Rose 2018).



Lee et al. (2019: 2)

Figure 3

A similar complicating factor is the achievement of a balance between developmental support and overt managerial control. Line managers are ideally placed to observe the practice of their personnel but as Jones (1996) cautions us, organisations should ensure that clinical supervision policies enable the process to remain as one of support and not stray into a version of 'hierarchical control'. Beyond the professional relationship of an LMX structure and thus potentially in breach of professional standards of conduct, Jenkins et al. (2000) also found that some personnel raised concerns as to confidentiality and uncertainty as to the reliability or trustworthiness of the supervisor.

2.8 Neo-Liberalism

"Neo-liberalism is a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade". (Harvey 2007: 2)

Essentially this theory considers the best economic environment in a capitalist society to be a free and competitive market. This came from the observation of effective management practices in the private sector that brought about the era of NPM in the hopes that privatisation and marketisation would deliver greater effectiveness and efficiency to the public sector. (Kilpatrick and Martinez-Lucio 1995). In the UK in the 1980s and 1990s we saw the privatisation of the utility companies bring them into the private sector and the imposition of the quasi-market on those areas of the public sector that it was not possible to privatise: the NHS, Education and Defence (Bratton and Gold 2007:6; Mercer et al 2010: 6). Though it is argued by Flynn and Williams (1997: 154) and Powell (2003: 726) that quasi markets are not a new invention and have in essence been around for several decades, Powell argues that the quasi-market has been prominent in UK public services since the 1930s rather than as described by others a feature of the Conservative government of the 1980s. Clearly defining a quasi-market is difficult, Powell offers this attempt:

Despite much attention, the precise definition of a 'quasi-market' is not fully clear. Le Grand and Bartlett (1993) explain that they are markets because they replace the monopolistic state providers with competitive independent ones. They are 'quasi' because they differ from conventional markets in one or more of three ways: non-profit

organisations competing for public contracts; consumers purchasing power is either centralised in a single agency or allocated to users in the form of vouchers rather than cash; and in some cases, the consumers represented in the market by agents instead of operating by themselves". (Powell 2003: 726-727)

Harden (1992: 15) "suggests that a quasi-market has three elements: creation of incentives for greater efficiency; the delegation of decision making to lower levels of management and the principle of money following the end users". Whichever description one prefers a market exists and thus there is a need for a management structure that fosters or enables a competitive advantage.

It remains to be seen from the data analysis, but the Neo-Liberalist perspective of the workforce may be beneficial to the emerging role of the Advanced Paramedic Practitioner in that there is the ability to sell ones skills to multiple employers via agency working and self-employment.

2.9 Managerialism

NPM sought to address the traditional view as described by several authors (Pollitt 1993, Clarke, and Newman 1997, Trowler 1998) of the public sector as wasteful of resources and make organisations competitive. This led to development under HRM of packages or bundles of strategically developed interventions called High Performance Working practices (HPW) such as:

- Appropriate selection and recruitment processes
- Comprehensive induction programmes
- Sophisticated and wide coverage training
- Coherent performance management systems
- Flexibility of workforce skills
- Job variety and responsibility
- Team working
- Frequent and comprehensive communication with employees
- Use of quality improvement teams
- Harmonised terms and conditions
- Market-competitive pay
- Use of rewards related to individual and or group performance
- Policies to achieve an appropriate work/ life balance

(Robinson 2006: 61)

Bundles should be organisationally integrated so that they are mutually supportive and reduce inefficient duplication. (Robinson 2006: 34, WHO 2010, NHS 2017, HEE 2017), This essentially defines the intentions of Integrated Care across the NHS and the need for Advanced Practitioners to lead the workforce in its application. Purcell et al. (2003 cited in Robinson 2006: 61) suggest three improvements to organisational performance achieved through HPW: increased workforce skills and abilities; promoting positive attitudes thus increasing motivation; promoting autonomous discretionary behaviour or the right of managers to manage. Patterson et al (1997, West and Borrill et al 2002) demonstrate convincing evidence that HRM is an important factor in determining competitive organisational performance. Detractors argue that the process covertly manipulates the public sector through prescription, inspection, and performativity. (Marginson 1997, Mercer et al 2010).

2.10 Performance management

Teachers and lecturers will observe that assessment is very much an integral part of the teaching and learning process. Unless one can identify what is right or wrong, learnt or yet to be learnt, we cannot plan to address the issues and it is the same for management. Having put in place the HPW bundle appropriate to one's organisation there is a need to be able to monitor compliance and progression, to ensure continual performance improvement and to identify, intervene and solve problems when they occur. Performance management should be all pervasive, operating not as an event but as a continuous cycle. (CIPD 2008). As Perryman (2006) discusses employees become so used to processes of inspection and monitoring that their behaviour and working practices adjust to fit the method of performance management. The concern with this panopticism, as Mercer et al (2010) allude, is the potential for only perfunctory compliance with the process. HRM demonstrates a paradigm shift from a rule-based culture to a performance-based culture (Shim 2001). As with any culture its management and integration are a fine "balancing act" when we lose sight of our motivation the system will eventually fail (Kohn 1999) as was seen in the Mid-Staffordshire Enquiry (Fulford 2012 and Francis 2013) when a hospital trust became overly focused on Performance Based Practice (PBP) ("box-ticking") and Evidence Based Practice (EBP) they forced their staff to lose sight of the equally important

function of Value Based Practice (VBP). Thus, while EBP and in turn audit and are collection a key to strategic development the NHS has since 2013 tried to revitalise the concepts of patient centred values, and this underpins NHSE (2017) and HEE (2017). It ought to be observed that the PBP approach was well intentioned as it sprang from work to improve efficiency in the earlier part of the first decade of the new century as Martin Shalley, President of the British Association of Emergency Medicine in 2004, stated:

'The increasing importance of emergency care to the health service has led to the setting of targets, which have focused clinicians' and managers' minds. This has led to improvements in staff morale and great improvements in the throughput of patients in emergency departments.' Alberti (2004).

2.11 Implementation of Human Resource Management

Implementation of HRM does have its variations which would seem to be often dependant on immediate needs. In the book *New Perspectives on Human Resource Management* (1989) edited by John Storey (cited in Bratton and Gold 2007: 6), there are both 'hard' and 'soft' versions of the HRM model. The hard version focuses on the term 'resource' and adopts the approach of managing personnel as any other resource human or otherwise. The soft approach focuses on the development of the individual and the psychological contracts to achieve competitive advantage. Application of HRM in hard or soft modes bears strong resemblance to McGregor's X and Y theory of management cited in Middlewood and Lumby (1998). Drawing on Maslow's hierarchy of human needs theory McGregor offers an effective if rather, yet necessarily, simplistic theory of management styles. X managers see their average employees as needing to be coerced into working as they are perceived as lazy, lacking direction and responsibility adverse. Y managers see work as natural and that motivated, and mission focused workers are capable of self-directed activity beneficial to the organisation. HRM tries to engage employees and motivate them towards organisational values and objects and leveraging their skills, thus mostly it is Y focused or soft process particularly in its strategic level application. However, at an operational level where the work like it or not has to get done the hard, X focused approach can be manifest.

Today in the NHS we are responding still to a “barrage” of initiatives from Ministers: Working Together - Securing a Quality Workforce for the NHS (Department of Health 1998) The NHS Plan (Department of Health 2000) Improving Working Lives (Department of Health 2004) Our Health Our Care Our Say (Department of Health 2006) Transforming urgent and emergency care services in England: overview report (Keogh 2013a) . As McHugh et al (2007) observe, adapting to these demands has presented managers at an organisational level with a complex series of challenges particularly in relation to human resources. Thus, understanding the underpinning concepts of health service management in the UK and its impact on clinicians, in this case Advanced Paramedic Practitioners, is a key element to the analysis of lived experiences.

2.12 Strategic Management

To gain insight into the development of the national and local policies that have seen the development of the Advanced Paramedic Practitioner and to respond to the data extracted from the primary research it is necessary to consider the factors of strategic management and its operationalisation in the workplace. Therefore, we will continue this early stage of the literature review and the management structures of the NHS with a review of the relevant strategic management theories and practices.

Strategic management is a combination of strategic planning and strategic thinking, although West-Burnham et al. (1995: 62) suggest there is no absolute consensus as to which element is dominant, Mintzberg (1994) as discussed shortly, argues however that there is a clear hierarchy. The amalgamation of the two elements, strategic planning, and strategic thinking will enable the development of a corporate strategy. A corporate strategy as defined by Andrews (1999: 51) “is the pattern of decisions in a company that determines and reveals its objectives, purposes or goals, produces the principal policies and plans for achieving those goals, and defines the range of business the company is to pursue, the kind of economic and human organisation it is or intends to be and the nature of the economic and non-economic contribution it intends to make to its shareholders, employees, customers and communities”.

Strategic Planning is focused on what is already known and understood in relation to organisational performance, it analyses data to facilitate a step-by-step process for the

attainment of goals and for this reason can also be described as strategic programming (Mintzberg 1994 and Schwandt 1997). Whilst strategic planning is necessary to create a guide as to how to proceed because it extrapolates from existing data, it is argued by Mintzberg (1994) that its weakness is a failure to generate creative ideas or facilitate meaningful organisational change. Mintzberg (1994: 110-112) describes this weakness as based on three fallacies; that analysis of past experience can clearly predict the future, which is unknown ; that formalisation through procedures will always accommodate future trend, which denies the organic nature of organisations and can in fact lead to failure by being too rigid; that strategic planners can achieve detachment from the current environment to consider without bias the options available to the organisation. (This should not be confused by practitioners experienced in reflective practice with the immediate experience of reflection in practice and on practice Schon 1983). Thus Mintzberg (1994) is arguing that the core strategy itself cannot be achieved by this group, that whilst planners and strategic programming are necessary because they will enable the strategy to become a 'concrete' and 'make it operational', there is a need for a detached group of Strategic Thinkers or at least an acknowledgement of a change of mindset between the planning and creative thinking elements.

Strategic Thinking differs from the structured process of planning and rational implementation because it needs the opportunity to be creative (Mintzberg 1994: 108) to conceive totally new options for organisational development, and indulge or consider all options, even those that might be somewhat 'less-than-rational' (Preedy, Glatter and Wise 2003: 7). Strategic thinkers will create the energised and stimulating organisational vision and strategic planners will make the vision operational so that a strategy becomes an integrated structure of policies and goals that set a course for the organisation well into the foreseeable future. Therefore Mintzberg (1994) demonstrates his contention that Strategic Thinking is dominant to Strategic Planning.

2.13 Strategic leadership

The strategic vision should be understood and accepted by all members of the organisation as this is a fundamental concept of Human Resource Management (HRM). This requires managerial intervention and control at three levels, organisational design, culture and human resource practices and procedures (Preedy,

Glatter & Wise 2003: 6 and Bratton & Gold 2007: 4) or as other texts might describe it, team, operational and strategic levels. (Adair 2010: 71). A manager, at whatever level, who seeks to lead and contribute to organisational development and particularly in the devolved management structures of HRM (Brewster and Larsen 2000 and Budhwar 2000 cited in Martins 2007), is a person who understands markets relevant to their position and can extract the potential of their human resources to respond to customer needs (Watson & Crossley 2001: 113). However strategic management is a top-down process from the Senior Management Team (SMT) comprised of strategic thinkers and strategic planners who devise the strategic vision and implementation process and thus have the strategic authority (Watson & Crossley 2001). The SMT have the power to shape organisational relationships to respond to the strategy. Power is seen as a multidimensional concept by several authors, for example Handy (1993), Hardy (1996) and Mintzberg (1999) Creed (2011) Lam and Xu (2019). Hardy's model makes a succinct summary considering power in three dimensions. Hardy's first dimension describes the traditionally accepted view of managerial power, that of the ability to make others do what you want. The second dimension is the ability of the SMT to control the organisational politics and therefore limit the agenda for discussion to their strategic vision. The third dimension is the ability to lead cultural change. Though the SMT sets the strategy, it should not be forgotten that it is the middle managers who take the policies and make them function within their departments, who are functionally seen as leading their teams towards the organisational goal (Earley 1998 and Engle et al. 2017). There are however key differences between the perspectives of strategic managers and middle managers described by various authors, Mintzberg (1995), Hanford (1995) and Weindling (1997) Birken et al (2018). It is this focus that demonstrates the difference between strategic management and operational management.

Strategic Management	Operational Management
Longer term	Short term to intermediate
In whole organisation terms	Concerned departmental needs
Reflective	Prompt action
Looking to use fully the whole organisational capabilities	Looking to use accessible resources
Conceptual	Concrete
Creative, breaking new ground	Ongoing, routine
More concerned with effectiveness	More concerned with efficiency
Identifying opportunities	Resolving existing problems
Constantly examining the external environment	Focusing on the internal context
Demonstrating a hands-off approach	Demonstrating a hands-on approach
With a 'helicopter' perspective	With an 'on-the-ground' perspective

Table 1 Middlewood (1998: 8)

A complicating factor to creative strategic thinking in the NHS is that as well as Strategic Leadership there is also Clinical Leadership, both originating from Director Level and both important to our environment. Clinical leadership is a prerequisite for health reforms in the UK. (DoH 1998, Brazier 2005, Stanton 2006, DoH 2007a, DoH 2103a).

'The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served' (Department of Health 2007b: 49).

There is of course nothing wrong with this statement; healthcare should primarily focus on the needs of the users. But control from central government will have a limiting effect on the ability to be creative in devising strategy for health organisations more than perhaps it would affect the private sector. Clinical leadership in attempting to protect the patient also operates from the meta-analytical perspective of evidence-

based practice. Muir Gray (1997) explains that ‘evidence based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best’. Therefore, Clinical leadership, whilst proactive and necessary, adds a further complication to strategic planning in Mintzberg’s (1994) hierarchical description of the strategy development process.

2.14 Weberian Bureaucracy

The combination of NMP, HRM, HRD and the Strategic Management processes might lead one to perceive that this is a relatively new concept but as was stated at the beginning of this section NMP drew on the business practices of the private sector and these can trace their roots back to sociological studies of the 19th century, including Marx as previous discussed in relation to Capitalist theory (Abbott and Wallace 1997: 54) and to Max Weber and his Bureaucratic Theory of 1905 (Cockerham 2015).

Bureaucracy is an organisational structure that is characterised by many rules, standardised processes, procedures and requirements, numbers of desks, meticulous division of labour and responsibility, clear hierarchies, and professional, almost impersonal interactions between employees (Weber 1905 in Cockerham 2015).

Bureaucracy is considered by many to be inevitable and is founded on three elements and characterised by 6 principles as listed below in Table 2.

Foundations	Characteristics
1. Official duties in terms of set regular activities. 2. Imposed rules that demonstrate managerial authority. 3. Rules that establish standard functions.	1. Task specialisation (Specialisation and Division of Labour) 2. Hierarchical layers of authority 3. Formal selection 4. Rules and requirements 5. Impersonal (Impersonality and Personal Indifference) 6. Career orientation

Table 2 (derived from Mulder 2017)

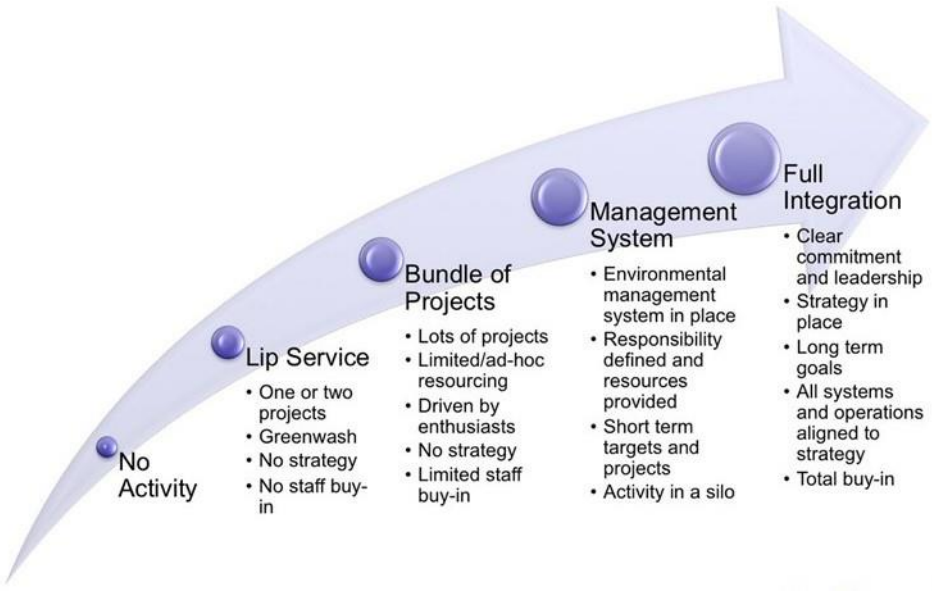
Bureaucracy is rather unfortunately negatively linked in the modern world to perspectives on the civil service and governmental functioning and as a descriptor for unnecessary level of administrative processing. This is a shame because the human mind will always strive for order to make sense of its environment, and this should be accepted as a normal part of our cognitive evolution (Sternberg 1985). Weber's theory sees is as the organic evolution of the human desire for socio-occupational order and structure so as to enable reproduceable results and products that further benefit and enable stakeholders and customers (Weber 1905, Katz, and Khan 1978). Bureaucracy theory underpins other key theories of the business world and in relation to efficacy of the NMP structure of the NHS, Porter's 5 Competitive Forces Model (Porter 1979). Porter's model provides a sound demonstration of the intended functioning and is widely accepted by other authors (Mintzberg, Quinn & Ghoshal 1999: 49, Garratt 2003: 325), as the seminal work for the analysis of an organisation's external strategic position.

2.15 Analysis of the organisation's external business environment

For public sector managers it can be difficult to comprehend the organisation and the services they provide as generating a product but in Porter's model the terms product or service are interchangeable Porter (2004: 5). For the NHS application of such theories can be interpreted by some with an element of trepidation and a perception of such bureaucracy as akin to privatisation of the organisation, through the utilisation

of NHS partnership organisations and the competitive tendering for contracts for a variety of services including Integrated Urgent Care despite over three decades of these New Public Management processes as established in the 1980s. Porter's 5 forces are, 1) Threat of new entrants, 2) Bargaining powers of suppliers, 3) Bargaining powers of buyers, 4) Threat of substitute products and 5) Competitive rivalry (Porter 1979 & 2008).

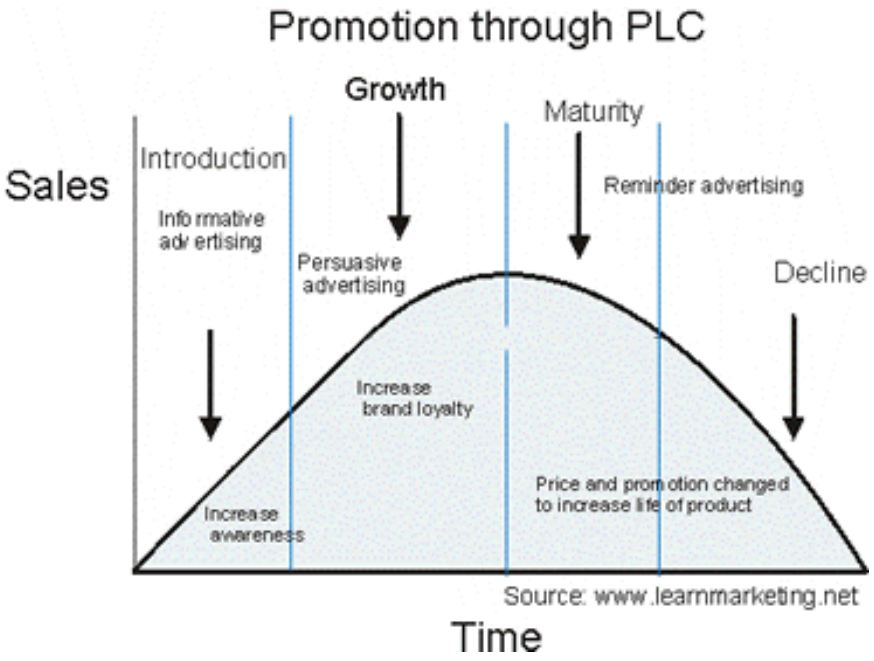
1) Threat of new entrants – New entrants will or should be aware of the market to which they are entering, they bring new enthusiasm for the market, a diversified product, and potentially great resources (Porter 2004: 7). The evolution of Urgent Care as a gestalt, integrate entity is a clear example of a new entrant. Urgent Care departments as separate from Emergency Departments are not a new concept indeed it is clear that the product has now achieved maturity as demonstrated in the *Figure 4* below it is time to break free of the pre-2017 siloed stage and achieve full integration (NHSE 2017).



Terrainfirma (2017)

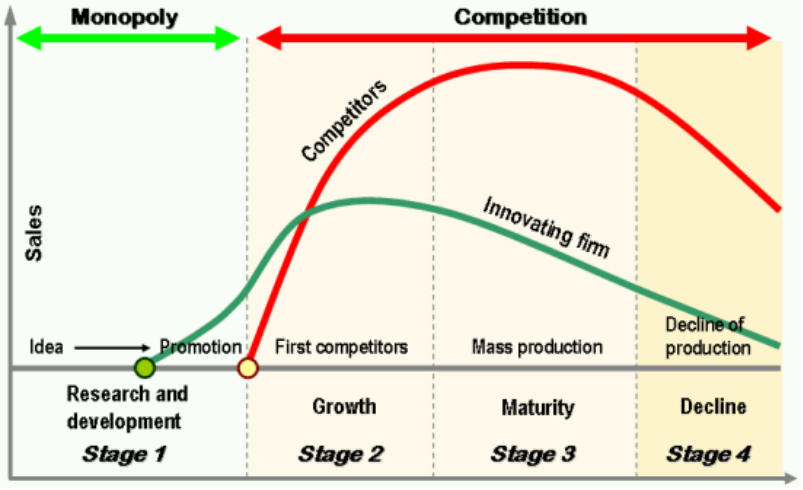
Figure 4

The integrative process creates a new (if perhaps a final in today's incarnation) product life cycle (PLC) to exploit from which the next evolution to better healthcare can grow and preventing decline as demonstrate in *Figures 5 and 6* below.



Learnmarketing.net (2010)

Figure 5



Birou et al. (2008)

Figure 6

However there are barriers to entry that need to be considered that have evolved over time as Porter's work (1979, 2004, 2008) demonstrates, in 1979 Porter considered there to be six barriers, by 2008 this had subdivided to seven. The seven barriers are Supply side economies of scale, Demand side benefits of scale, Customer switching costs, Capital requirements, Incumbency advantages independent of size, Unequal

access to distribution channels and Restrictive government policy (Porter 2008: 81-82).

Supply side economies of scale, force the entrant to compete by either starting immediately with a large-scale operation in order to enjoy the lower costs per unit of established competitors or to accept a cost disadvantage. Achieving a competitive average cost is desirable to develop the product line and gain an established market position (Porter 2004: 242).

Demand side benefits of scale, develops as a network of customers who trust the product. Larger companies with potential for better after sale support are more likely to attract customers when the product is vital to their own processes. The customers' own professional networks then further enhance the company's reputation drawing in more business. It is difficult for a new entrant with an unproven product to break this cycle and their customer base will take time to evolve (Johnson & Scholes 2002: 114).

Customer switching costs, these are those financial and procedural costs that will occur when the buyer has to accommodate the new functionality of the product which in turn impacts upon their provision of products, such as product specification and retraining of existing employees. Provision of support services to facilitate the transition will aid the position of the new entrant (Porter 2004: 227-228).

Capital requirements. Large financial investment in terms of fixed facilities and start-up costs particularly those which are unrecoverable such as initial advertising and research and development can significantly deter the minimally diverse new entrant: Whereas large organisations have the financial resources to diversify and invade new markets with greater ease. (Porter 2008: 81).

Incumbency advantages independent of size, describes the fortuitous position of existing organisations, irrespective of their size, through reputation to access cost and quality advantages, such as access to customers through favourable geographic location or to raw materials that new entrants are unable to compete with, forcing the entrant to attempt to find an alternative perspective from which to enter. This essentially reflects the acquired knowledge and experience of the incumbent and the

learning or experience curve for the new entrant, who needs to learn quickly to establish their market position (Porter 1979: 4, Johnson & Scholes 2002: 156 and Porter 2008: 81).

Unequal access to distribution channels. New entrants must displace existing products not only in the marketplace but with distributors that can ensure an effective supply of their product. Alternatively they need to facilitate their own distribution or find creative ways to change the distribution process in their favour (Porter 2004: 191-210).

Restrictive government policy. The barrier to new entrants is governmental restriction through regulation for the protection of various sections of society such as education standards for allied health professions e.g. standards of proficiency and practice for paramedics (www.hcpc.org). However government policy can be an advantage when seeking to reduce or police monopolies by providing grants and subsidies for those diversifying the sector (Porter 2008: 82 and Johnson & Scholes 2002: 376).

2) Bargaining powers of suppliers – Supplier power is likely to be high when there is a concentration of suppliers approaching a monopoly rather than when there is a diverse or fragmented range of suppliers Porter (2008: 82). Powerful suppliers can raise prices and reduce and organisation's profitability which may not necessarily be recovered by the organisation raising its own prices (Johnson & Scholes 2002: 117). Suppliers can influence switching costs or the desire or ability to switch supplier by ensuring specialist products in their range will only function with their own accessory products and not those of the competition (Porter 1979: 5 and Johnson & Scholes 2002: 118). Or quite simply there is no alternative product, this is often the case with the workforce of a specialist organisation where their own employees are the supplier of their labour. When that workforce is highly skilled and unionised there will be only one available source of skilled potential employees. Thus as Marx cited in Abbott and Wallace (1997: 54) discusses a labour force sells its skills to the employer. Strong unionisation can improve salaries, but this may either increase end product costs and reduce competitive pricing or reduce profit margins if end product pricing cannot increase. Thus it is in the interest of employers who cannot diversify their product to reduce the union influence by proletarianisation or casualisation of the workforce, reducing the

need for extreme specialisation and enabling renegotiation of salaries to increase profit margins (Humphreys & Hoque 2007 and Blanchflower & Bryson 2009).

3) Bargaining powers of buyers. Buyers have a similar influence on an organisation to that of the suppliers in almost a mirror image (Porter 2008: 83). Similarly to suppliers if the concentration of buyers is high, buyer power will be high as the suppliers compete to sell their product in a small market (Porter 2008: 83). However buyers' discrimination between suppliers is increased and their power to choose other sources weakened when the supplier's product is key to the quality of the buyer's product.

4) Threat of substitute products – Johnson & Scholes (2002: 115-116) identify three variances in product substitution; Generic substitution in which products compete for disposable income such as personal computers and televisions etc. Product for product substitution is which sectors converge and service preferences change for example e-mail substituting for the Royal Mail postal service and Substitution of need by a new product rendering the existing product redundant such as the impact of IT reducing organisational dependence on secretarial and printing services; or in education the reduced dependence on libraries due to Athens and classrooms due to virtual learning environments (JISC 2006, BECTA 2009 and Carr 2010). Substitute products limit prices, unless the current products can be improved or significantly differentiated from the substitute, the more attractive the price performance trade off of the substitute, the greater it's hold will be over the industries profit potential (Porter 1979: 7).

5) Competitive rivalry – Competition between organisations of similar size with a similar market share are likely to be aggressive as each tries to protect its market position and profits. Smaller organisations usually survive on the fringes of the environment by responding to niche markets of no interest to their large competitors (Johnson & Scholes 2002: 118) Product life cycle (Johnson & Scholes 2002: 119 & Birou et al. 2008) can dictate the level of aggression in competitive behaviour, when a new product is moving through its development and growth phase, competitors may start to defend their market share but whilst the product is in the growth cycle there is less need to fight for the market share. However once the product achieves maturity the organisations focus will switch to one of defence and a price war is more likely to

occur, particularly if differentiation between products is minimal and switching product is realistic for the buyers. Finally high exit barriers can also prolong rivalry if the failing competitor has for example invested in non-transferable assets or faces high redundancy costs it may be easier to keep fighting than to cease trading (Porter 2004: 21). However merging organisations may help to reduce competition ease market tensions and enable a palatable exit strategy for the weaker competitor.

2.16 Analysis of the organisation's internal environment

In the development of strategy it is not sufficient to simply examine the organisation's external environment, it is also essential to consider the organisational culture, products and the potential for diversification and marketing the organisation to place it in the most competitive location. Although it is my intention to briefly define these elements it is not possible at this time to fully explore each element.

Organisational culture and beyond this industrial, sectoral, and departmental culture is 'a feeling of a pervasive way of life, a set of norms or deep-set beliefs as to how work is organised and carried out' (Handy 1993: 181). There is an explicit link between organisational culture and explanations of strategic management and decision making that makes the analysis of culture essential to the strategy process (Prasad & Prasad 1998 and Johnson 2000)

Diversification is essential for and organisation if it is to continue to generate an income. As was discussed earlier products have a life cycle (Johnson & Scholes 2002: 119 & Birou et al. 2008), in order to remain competitive an organisation needs to periodically review the life cycle of their products to identify those in decline and new products better suited to the evolving market in which they are situated. A useful tool for establishing organisation product direction is the Boston Matrix developed by the Boston Consulting Group (Porter 2004: 361). The matrix defines products as Cash Cows, Dogs, Stars and Wildcats.

Cash cows are mature products with a healthy cash flow that at this time can be used to generate a significant income. NHS Trusts and their partnership organisations of find their Cash Cow in the central governmental funding as cascaded through the

contract tendering process for the provision of high quality yet cost-effective healthcare.

Dogs are possibly cash cows that are now reaching the end of their product life cycle or products that have not been successful, attracting a low market share and modest income and are likely to become cash traps. Thus they need replacing. Dogs within the NHS are mitigated through contract expiration and tendering/ retendering processes that maintain competition to continue the evolution of product life cycles. This indicates that the product life cycle perspective and the associated bureaucracy function to maintain a constant evidence and values-based evolution of services.

Stars are ascendant products in high growth markets that at this time need investment to sustain them, but their strong market position should produce a high financial yield in time. Integrated Urgent Care services would be an example, pertinent to this study of an ascendant product by extolling gestalt healthcare that reduces waste and repetition.

Wildcats (or question marks) are products with a low relative market share in rapidly growing markets that at this time need high investment and their potential success or failure is unclear (Porter 2004: 363). An example of wildcat markets in the NHS would be the evolution of the Mental Health Services function that should integrate with urgent care in the future (NHSE 2021).

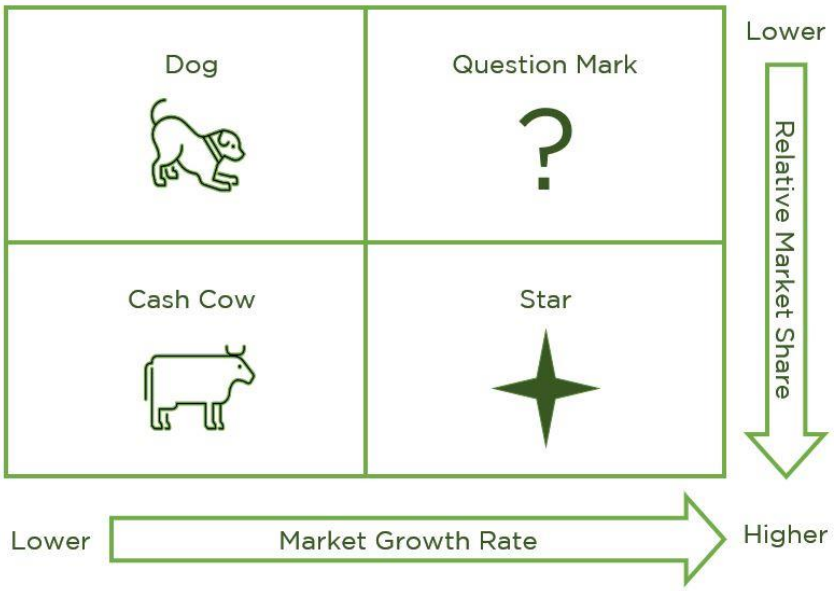


Figure 7

Marketing – this not simply about advertising the business but responding to changing needs and customer demands, it encompasses the issues of quality and community responsiveness and positions the organisation in the most profitable location in the market (Foskett 1998: 49-50), thus in the NHS setting the evolving needs of the local patient groups.

2.17 Dissenters of Bureaucracy.

Whilst the previous discussion provides an argument for bureaucratic structures there are a growing number of dissenters (Hamel and Zanini 2018). Large organisations develop monolithic stagnation in that they are so “anchored” to other similar organisations they unable to move rapidly in response to market forces. Thus whilst they may be fully aware of their progressive product life cycle (Birou et al. 2008) they may find themselves powerless to modify their practices with sufficient alacrity. Highly skilled work forces take time to develop, and position strategically in high bureaucracy environments. Smaller new entrant providers born out of the Neo-Liberalist ideal can in opposition to Porter’s theory provide a responsive alternative.

2.18 The emergence of the Paramedic in the UK

The review thus far has outlined the underpinning processes, theories and structures that control the leadership and managerial function of the NHS in which paramedics function. The next element is to review the history of the emergence of the paramedic in the UK.

Municipal, Borough and County Ambulance Services had functioned successfully in a predominantly transport role since the inception of the NHS in 1948, and by 1966 the Department of Health was ready to see the professionalisation of their services as described in the Millar Report that reviewed both Ambulance Service Training and Equipment standards. The Millar Report made a number of recommendations but foremost the concept that ambulance personnel should be able to provide treatment to the sick and injured in addition to the accepted function of prompt transportation (Millar 1966, Kilner 2004). Despite nearly 55 years since the Millar Report and the many other advances still to be discussed, ambulance personnel are still colloquially known as Ambulance Drivers, a name that still “haunts” the profession amongst our multidisciplinary peers, our politicians and in the press. March 1971, saw the first Paramedics in Europe start working out of Brighton Ambulance Station after six months of ‘extended training’ at the Royal Sussex Hospital (CoP 2021a) under the guidance of Prof. Douglas Chamberlain. From this key point professionalisation of the of the UK ambulance services and the Paramedic profession slowly started to take off, to list all the local projects and development processes would be irrelevant, suffice to say that my 1987 the National Health Service Training Authority (NHSTA) had the first national paramedic syllabus and the full roll out of the paramedic staff grade to the country as a whole. Thus, it is possible see that in comparison to the Nursing and Medical professions the Paramedic profession is still quite young but has developed in “leaps and bounds” to achieve parity with its colleagues in our multi-professional modern NHS. Petter (2012) writing in the Journal of Paramedic Practice provides us with an excellent summary of the pathway to that point. The table below sets out the current structure of frontline NHS Ambulance Service Human Resource Unit and their potential for specialisation.

2.19 Evolution of Paramedic Education

What is relevant to this research and the evolution and lived experiences of Advanced Paramedic Practitioners, are the changes in education format over the years. The original NHSTA (and in later guises of the National Health Service Training Directorate 1991 (NHSTD) and the Institute of Health and Care Development 1996 (IHCD)) process was one of Competency Based Education and Training (CBET) akin to the National Vocational Qualifications structure of the time. CBET represented a process of in-house education encourage by a behaviourist approach to the demonstration of knowledge. The behaviourists' standpoint is that the concept of knowledge developing in the mind is flawed and that what a person knows or feels is purely demonstrated by their actions, this is personal knowledge. The research of one prominent behaviourist Ryle (1973 cited in Hyland 1994: 68) discusses the application of these views in some detail and provided early if simplistic justification to for the CBET movement by "exploding the myth of intellectualist legend" that "the intelligent execution of an operation must embody two processes, one of doing and the other of theorising". CBET took this to extremes producing training packages that seem to deny the need for propositional knowledge by adopting this research and Ryle's earlier behaviourist opinion advocated in his book *The Concept of Mind* (1950) and discussed in Cohen (1983) that knowledge is purely demonstrated by action. The ambulance service in the UK was not the first group of healthcare professionals to encounter this problem. The Nursing profession in the UK had already seen issues with developing the wholly NVQ trained Healthcare Assistants through liberal university education to become nurses as reported by Gould & Carr et al (2004). Therefore, the Nursing profession was already planning its transition to Higher Education (HE) in 1987. The Paramedic profession would not start this process for a further 10 years and only achieving full transition in 2015 (Petter 2012) for profession entrants at the grade of registered paramedic. So just as the other major players in the healthcare sector were transitioning to HE, the ambulance service was stuck with a behaviourist style competency-based education system that rapidly became outdated and undermined the profession in the "eyes" of its peers (Ellis 2010, McCann et al. 2013). It should be noted that a constructivist style of CBET (Abbott 1988, Knowles et al. 2005, Loyens et al. 2007 and Ellis 2010) still exists for the junior grades (non-registered clinicians) in the ambulance services as it does in the rest of the NHS.

2.20 Guidance and control of the Paramedic Profession

Returning now to the key themes of progression of the paramedic to the modern APP. Whilst the delivery of education in the early days of the national paramedic programme could be described as rudimentary due to the limitations of the CBET approach, the intention and content was to establish a strong professional identity. Paramedics have always been guided and controlled in their education by the medical profession (Evans et al. 2013) and this will go some way in later analysis, it is expected, to explain the similarities and the in perspective between doctors and paramedics in their daily practice. Paramedics were initially controlled by the Local Ambulance Paramedic Steering Group (LAPSG or LAP Panel) that was largely made up from the Accident and Emergency Consultants from within the catchment area and overseen by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC 2003). This organisation still exists today but in a more straight forward single entity format which produces and monitors the National Clinical Practice Guidelines (JRCALC 2021). However, with the advent of state registration in 1999 through the Council for Professions Supplementary to Medicine (CPSM 1999) later to become the Health Professions Council (HPC) and thence the Health and Care Professions Council (HCPC 2021). The governance of paramedic education fell, as with all other registered health professions in the UK to a specific College, in this case the British Paramedic Association (College of Paramedics) which was inaugurated at the International Ambulance Exhibition (AMBEX) in 2001 (Whitmore and Furber 2006, CoP 2021a). The College of Paramedics works with the HCPC in its role to manage four primary tasks.

1. Set standards for professionals' education and training and practice.
2. Approve programmes which professionals must complete to register.
3. Keep a register of professionals, meet the standards.
4. Take action if professionals on the Register do not meet the standards.

(HCPC 2021)

2.21 Arrival of the Emergency Care Practitioner

By 2004 the paramedic profession in the UK was making clear strides towards a university educated workforce although full transition was not achieved until 2015 (Petter 2012). One of the first policies to set out the development of this staff group was the Department of Health NHS Modernisation Agency Emergency Care

Practitioner Report “Right Skill, Right Time, Right Place” (DoH 2004) as part of the Clinical Workforce Programme (CWP). This set out the first paramedic specialisation although based on the Ambulance Service Association (ASA) report of 1999, on the future of the NHS ambulance service. At this point the aim of the report was not purely focused of developing the paramedic alone but also nurses and phase one small scale multi-profession pilot schemes for phase one had already started in 2002 (Mason et al. 2004). Thus as ECPs are not all paramedics and this explains to a point why the title of Emergency Care Practitioner (ECP) lingers on in the modern workplace. For paramedics the ECP title would eventually become the Paramedic Practitioner (PP) (AACE 2011) which in turn would lead to the Advanced Paramedic Practitioner (APP) (CoP 2014). The early intentions of a commitment to Integrated Care were already visible and ready to form a foundation for the structure we have thus far in 2021:

“… to challenge the myths that maintain the gaps between health and social care and strived to support new roles that bridge this gap and improve services to users. We are working closely with professional, regulatory and educational bodies to develop new ways of working which improve services for patients and for staff, without compromising safety, and we have made significant progress in addressing regulation and accountability issues” (DoH 2004: 6).

The report intended that the ECP would function across 3 arenas: Acute medicine in the form of the Accident and Emergency Department (A&E) and Minor Injury Units (MIU): Pre-hospital care (Ambulance Response) and: Primary Care (Home visits). This was a positive start let down only by the failure to specify and educational standard for the ECP (Cooper et al. 2004). Within a few years the standard would be set as a bachelor’s degree but in keeping with the transitional state of paramedic education at the time a “mishmash” of courses sprang up, ranging from in-house courses of only a few weeks, following the CBET format (Knowles 2005) to full bachelor’s degrees with honours (Qualification and Curriculum Authority (QCA) 2004). The clear problem for ambulance services was that they knew what they wanted but they did not know how to get there, and this is where the report fell down, there was no “route map” to achieve a credible service. Skill sets were many and varied. ECPs often found themselves swallowed up in the standard ambulance service response resource list held by the control room and either sent to inappropriate patients for their skill set or simply left on

the ambulance station with nothing to do (Mason et al. 2004, National Audit Office 2011, NHSE 2013, Liscott 2016). This saw a sizeable loss of ECPs from the ranks of the ambulance services as these practitioners' sought employment that fitted their new skill set better (National Audit Office 2011). This was a new experience, for the ambulance services and paramedics in the UK, until this point most paramedics had to work solely for the NHS ambulance service itself but now staff were exercising their rights under the neo-liberalism (Harvey 2007) of the NHS NPM system to find employment elsewhere and for the first-time self-employment as agency staff became a real option. This is a major enabling factor for how the APPs that are the focus of this study are found in the Integrated Urgent Care (IUC) workforce.

2.22 The Alberti Report

Associated with the ECP report came the Alberti Report in the same year (2004). Professor Sir George Alberti, the National Director for Emergency Access to the NHS sought to improve the performance and access to emergency care by similarly stimulating a wider scoping of the potentials for interprofessional working. The report proposed four areas for improvement: A&E performance, patient, and carer experience, expanding the workforce and skill mix, and ambulance performance. Relevant specifically to this research were the last two intentions of this report to expand the workforce skill mix and ambulance performance:

"At a local level individual organisations are making decisions about appropriate staffing levels to best meet the needs of the population. While staffing levels in A&E have increased and are increasing, more still needs to be done. Health economies will need to make further investment in the consultant workforce and Emergency Nurse Practitioners in particular to provide a high quality 24 hour, 7 days a week service.
In addition to extra numbers, more GPs are working in A&E, and nurses and allied health professionals (AHPs) are performing expanded roles ensuring that patients get more timely access to specialist care" (Alberti 2004: 11).

Ambulance response availability was seen rather simplistically, and this was perhaps indicative of the institutional underestimation of the service as purely one of transport from the perspective of this report:

"Total time for patients who arrive at A&E by ambulance is counted from 15 minutes after the arrival of the ambulance. This has provided a strong incentive for ambulance services and A&E Departments to work together to speed up the transfer of patients from the care of the ambulance crew to the A&E team. Improved performance against the four-hour target has enabled patients who arrive by ambulance to receive an early assessment in A&E and for the ambulances to be freed up to respond to their next call more quickly" (Alberti 2004: 12).

Unfortunately, history over the last decade has shown that this final part, ambulance performance has rather failed NHS England (2010 to 2020). The causes of this are varied and many are outside the scope of this research. Though at this point it is sufficient to say, the pressures on the ambulance service to provide a timely response indicated by the figures available from NHS England are potentially at odds with a desire to utilise efficiently a wider skill mix of personnel.

2.23 Taking Healthcare to the Patient: Transforming NHS Ambulance Services

Next came a report that is still spoken of in reverent terms within paramedic circles, largely because it was written by a fellow paramedic. Taking Healthcare to the Patient: Transforming NHS Ambulance Services by Peter Bradley, the National Ambulance Advisor and Chief Executive of London Ambulance Service NHS Trust (DoH 2005). This report was inspiring to many and described a state that had been observed for some time, that the focus and intensity of ambulance education was no longer fit for purpose.

The report sets out how ambulance services can be transformed from a service focusing primarily on resuscitation, trauma, and acute care towards becoming the mobile health resource for the whole NHS – taking healthcare to the patient in the community … only 10% of patients ringing 999 have a life-threatening emergency. Many patients have an urgent primary (or social) care need. This includes large numbers of older people who have fallen in their homes (around 10% of incidents attended), some with no injury; patients with social care needs and mental health problems; and patients with a sub-acute onset of symptoms associated with a long-term condition such as diabetes, heart failure and chronic obstructive pulmonary disease (around a further 10% of incidents attended) (DoH 2005: 5 - 8).

The report introduced the divisions of ambulance care of “hear and treat” i.e. starting to manage the patient before the arrival of an ambulance and “see and treat” the care provided by the attending ambulance crew (not necessarily always a paramedic crew).

The expansion of the perspective and catchment of the ambulance service was an admirable intention and further supported the ECP agenda unfortunately it initially stimulated further uncoordinated ECP schemes, as previously discussed (Mason et al. 2004, National Audit Office 2011, NHSE 2013, Liscott 2016), which were in turn a drain on physical response resources and again the services suffering from a lack of physical response capability could not match demand at the time with strategic deployment of its clinicians leading to further disenchantment with the ECP role in the ambulance service (Woollard et al 2010).

Subsequently the British Paramedic Association began to reflect this evolution in its curriculum guidance version 1 (2006), a position that has been maintain since its transition to the College of Paramedics and is still appropriately in the current 5th edition (CoP 2019).

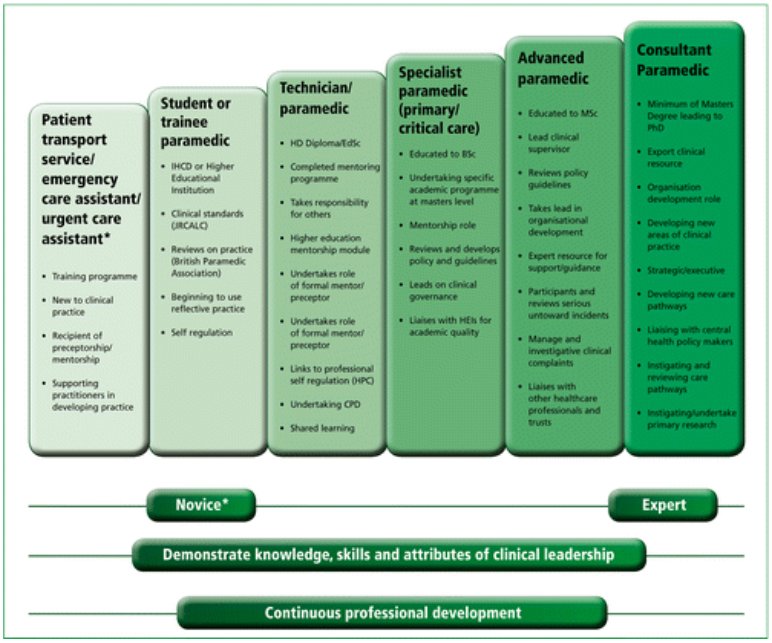


Figure 8

Taking Healthcare to the Patient also initiated the merger of the largely county based ambulance services in the UK to form 12 mainland regional services and the Northern Ireland Ambulances Services with the potential to improve leadership, collaboration and financial saving due to economies of scale through the joint procurement and thus achieving greater business resilience as discussed by many authors prominently including Porter (1979: 4), Johnson & Scholes (2002: 156), Porter (2004: 5), Porter (2008: 81), Elrod and Fortenberry (2017), and Anderson et al. (2021) and continuing a major theme of the New Public Management structure started in the 1980s (DHSC 1979 and 1983 and Metcalf and Richards 1987) discussed earlier.

The return on investment following Bradley's report was analysed in a report by the Association of Ambulance Chief Executives (2011). Essentially this was initiated once the major upheavals of the mergers had settled, and a clear picture was available for analysis. At this point Peter Bradley was the Chairman of the Association of Ambulance Chief Executives, the report was conducted however by the National Audit Office thus relieving the reasonable potential for original author bias (Young 2009). What is always interesting in evaluating such reports is that one does not get to see the raw data, or the research write up that was used to produce the report and as with most governmental reports it does rather focus on the positives rather than on balanced argument as explained by Davis (2021).

Five key areas were reported on positively:

1) Better survival rates for the seriously ill and injured, this section was heavily based on performance measurement as was highly popular in the pre-Francis report era as previously discussed (Fulford 2012 and Francis 2013). Whilst this is an important aspiration and a major function of an ambulance service in 2011, it is less relevant to the aims of this study today in that if integrated urgent care facilities as defined in NHSE (2017) are seeing sizeable numbers of seriously ill and injured patients, then something has gone very wrong with the triage system. In the UK these patients should, enter the hospital system via the Emergency Department. Woollard et al. (2010) would certainly argue that the managing the deployment of the increased variance of paramedic practitioner grades had made the picture nationally fragmented.

2) Resolving the needs of patients who do not need the emergency department; this section is the most relevant to this research as it covers the active participation in the national availability of the ECPs, 95% of which were paramedic practitioners, the forerunners to the further developed advanced paramedic practitioners. By 2011 the national education standard had been set as a BSc, although grandfather rights were held by many practitioners with a CBET education leading to inconsistencies of service delivery in some areas (Woollard 2007, CoP 2014).

"Studies of the effectiveness of these roles have found that they are very successful at finding appropriate care pathways rather than the A&E department, (Mason et al 2006) Cooper et al 2004). These reports show between 50 and 66 per cent of patients not needing or not being taken to an emergency department, compared to the 25-30% not taken to A&E departments by paramedics. Similarly, South East Coast Ambulance Service NHS Foundation Trust's specialist paramedics convey around 58% of their patients to hospital, compared with 70% for other paramedics, with lower rates for more experienced staff … However, it is sometimes difficult to fit the specialist paramedic role into an operational model that is designed to produce rapid responses rather than tailored responses. Some ambulance services have continued to send their specialist paramedics to any 999 calls, rather than focus them on the patients for whom they can make the biggest difference" (Woollard et al 2010) (AACE 2011: 25)

3) Even better patient experience, rather disappointingly this section identifies, in a rather inverse utilitarianist manner, that complaints about the service are generally down across the country rather than an increase in letters of thanks. However this is indicative of the human nature to only take a formal action in response to a negative impact rather than a positive one. (Eysenck 1993, Marketing Charts 2013). If one "digs deeper" into the referenced material Care Quality Commission (CQC 2008 and 2010) reports on their patient surveys the picture is more positive with an encouraging response from patients in relation to having a choice of care options, including treatment at home by a Paramedic Practitioner and it seems a shame the National Audit Office chose to skim over these observations in favour of the graphs and narrative they presented.

4) Higher levels of staff satisfaction: this is a very detailed section but focusing on the key factors that underpin this research there was by 2011 a surge in staff satisfaction following the “doldrums” of the merger processes that was to be expected during cultural change and an organisational paradigm shift (Handy 1993 and 1996, Guest and Conway 2002 and MacLeod and Clarke 2009). In particular, the paramedic group acknowledged the clear national commitment to Higher Education for paramedics and paramedic practitioners which aided their acceptance and integration into the wider NHS. The end to the CBET pathway was set for 2013 marking the full transition to HE, although as Petter (2012) would identify a predicted staff shortage would see this extended to 2015. Deployment issues as discussed by Woolard et al. (2010) would also still feature as a cause of disenchantment in the practitioner groups (AACE 2011: 49).

5) Organisational improvement: This element discussed a multifaceted approach as one might expect that following on from the national mergers of the 31 ambulance Trusts to just 12 there was a streamlining of the service commissioning process and a greater cohesion in health education to the general public for programmes such as the “Think FAST” stroke awareness initiative, with the ambulance services integrating with the hospital strategies similar to the concepts proffered by Hanford (1995) and Mintzberg (1999a). The assertion of integration with the wider NHS hospital system was perhaps a little over confident, if one reflects upon the work identified in the Integrated Urgent Care Specification NHSE (2017) and the Commissioning Framework NHSE (2018). However, as is often said “hindsight is a wonderful thing”, and it was a commendable move in a positive direction.

Commissioners settled upon some simple common currencies; “Call/Hear”; “Hear and Treat”; See and Treat” and “See and Convey” (AACE 2011: 64).

There were also significant moves towards a coordinated telephony, multiservice radio communications and Computer Aided Despatch (CAD) systems associated with a move away from paper notes to electronic patient records (AACE 2011: 67), reducing carbon footprints but more importantly setting the foundations for greater operational and team level integration rather than just strategic integration as differentiated by Adair (2010). This is relevant to the PP and APP role as it was a start to a more

comprehensive level of access to previous notes, treatment, medications, allergies, and alerts rather than depending purely upon the memory or honesty of the patient and thus facilitating the practical processes of advanced practice (AACE 2011: 69). However, nearly a decade later the intention of integrated access to electronic patient records is not as clear cut in practice. Porter et al. (2020) in their mixed methods study of the access to electronic health records in ambulances found as has much of the wider NHS that the concept suffers from connection and software compatibility problems. Due to the neo-liberalist free market intentions of NMP (Harvey 2007), the NHS has in its varying forms been able to purchase through tendering processes at a local level, this means that a wide variety of software packages have appeared on the market and none of them are compatible with their competitors. Due to the merger of the UK ambulances to reduce the number from 31 county services to 12 regional services as initiated by the Bradley report (DoH 2005), there is now a mismatch between hospital organisation and ambulance organisation at local levels. Hospitals will function on a city or county basis and are enabled to purchase whatever computerised patient record system they desire as is the case for General Practitioners in their locally based, patient accessible surgeries (McMillan et al. 2018). The local NHS ambulance service operating on a regional level can then be faced with multiple hospital “dozens” of healthcare facilities all functioning on different software. It should also be noted that regional ambulance services operate with a regional perspective and thus ambulances deploy very largely on the concept who is nearest and not from a catchment area perspective. Therefore, the attending ambulance may not actually come from the local area. Thus, the service has to contract with the most commonly used software as there is no way to predict local compatibility. This in turn affects access to records and the quality of care that practitioners can provide.

2.24 The Francis Report and the Keogh Review 2013

Thus far in this literature review we have discussed the professionalisation of the ambulance service, the governmental structures of management and the early years of the transformation of the service and its personnel to a workforce that offers patients choice in relation to their care and options as to how and where that care is provided. This last section will review the key reports and policies that have created the Integrated Urgent Care environment in which the APPs who are the focus of this research operate.

The “springboard” for the current progression to an overtly patient centred model was the national professional realisation from the Mid-Staffordshire Enquiry (Francis 2013) that we as a national health service had gone too far in the acceptance, performance-based practice (Alberti 2004 and Fulford 2012) in accepting that “good enough” was achieving acceptable patient care and we had lost sight of the vocational element to the health professions (Entwistle 2013). In his enquiry Robert Francis QC identified a litany of complaints and thus initiated several prompt actions, including the establishment of the NHS Leadership Academy which whilst already on the “drawing board” achieved greater impetus and additional motivation to enable VBP and the goal of excellence in care, in addition to EBP and minimum standard achievements of PBP that were already common practice. Following these damning findings of the Francis report on NHS culture and indeed before the final draft was published the Prime Minister of the time David Cameron asked Professor Sir Bruce Keogh the Medical Director of NHS England to conduct an enquiry into those NHS Trusts that were predominantly in “special measures” due to mortality indicators. 14 Trusts were therefore thoroughly reviewed, through a series of planned, unplanned, and Out of Hours (OOH) inspections to establish a robust way forward for the NHS as a whole and reduce the potential for another “Mid-Staffordshire” type event (Royal College of Nursing (RCN) 2013). The review covered 6 key lines of enquiry:

1. Mortality
2. Patient Experience
3. Safety
4. Workforce
5. Clinical and Operational Effectiveness
6. Leadership and Governance.

From these a root cause analysis was achieved identification of a wide variety of causative elements that could then be further “distilled” to the (RCN 2013, Keogh 2013 section 5):

1. Professional and geographic isolation: The Trusts lacked the professional knowledge networks that enabled clear and accessible sharing of clinical

knowledge either by poor interprofessional communication and clinical governance within specialisms (DoH 1998, WHO 2010, Keogh 2013: 28) or by physical distance from other professionals in a position to support continuing professional development of their teams.

2. Failure to act on data that showed cause for concern: Whilst there are any number of instances to which this is applicable, the review saw the introduction of Early Warning Scores as a national concept priority. There were already scoring systems in use at this point but, due to staff shortages across the spectrum of health professions, devolution of authority (Martins 2007) often without clear supervision, (Morrow et al 2011) was common place. Clinically speaking for example roles that were previously the function of a registered health professional are delegated to junior staff, who lack the experience, knowledge, or education to realise when the acquired data is a cause for concern that therefore fail to "flag" the problem promptly to those who have the responsibility to intervene.

3. Absence of a culture of openness and,
4. A lack of willingness to learn from mistakes. Points 3 and 4 are separated as they refer to organisational and individual perspectives but are born of the same anxieties as the organisation is a gestalt entity made of its human capital components (Preedy and Glatter 2003, Brazier 2005 and Bratton and Gold 2007) . This is often due a fear of blame (Eysenck 1993) rather than an opportunity to learn and improve (Khatri et al. 2009, Keogh 2013: 31, Radhakrishna 2015). This will become an important feature in the role of the Advanced Clinical Practitioner (HEE 2017) and the development of this role, to be discussed later.

5. Ineffectual governance and assurance processes (Keogh 2013: 31). Despite the advent of clear leadership and governance standards (DoH 1998) and a stated desire to engage in organisational learning (WHO 2010 and Morrow et al. 2011) It has been a slow process for some organisations and is still a matter of clear facilitated guidance to this day (NHSE 2019).

2.25 The Emergency Care Review

This review subsequently “spurred”: The revision of urgent and emergency care review (Keogh 2013a) which is highly relevant to the evolution of advanced paramedic practice in conjunction with the NHS IUC Blueprint (NHSE 2017) to be discussed next. It was identified that national EDs and GPs together with the NHS Ambulance Services were unable to keep up with exponential annual increases in demand for their services. It is simply not possible to training enough staff to meet the need. Therefore there needed to be changes in the functioning of service provision to cope with demand. Keogh (2013a: 6) identifies 6 work streams to achieve a multifaceted urgent and emergency care structure, these are:

1. Self-care and self-management.
2. Telephone care.
3. Face-to-face care.
4. 999 emergency services.
5. A&E departments; and
6. Emergency admissions to hospital.

Rather than expand upon the subject immediately it is more expedient to move on to the resultant policy the NHS IUC Blueprint, published after four years of work and consultation (NHSE 2017).

2.26 The Integrated Urgent Care Blueprint

At the time of publication by NHSE in 2017 the IUC Blueprint identifies that the NHS facilitated approximately 110M urgent, same day patient contacts annually. 85M contacts were GP appointments and the rest were ED or MIU attendances. There are at this point in 2021, no hard figures available as to the impact of this policy on the situation, the SARS CoV2 pandemic having “muddied” the perspective and the analysis by the NAO on which the new NHS 5 year Forward View is reliant still in abeyance. However, in order to meet the needs of Keogh (2013a) and the increasingly bleak “picture “of pressures upon the NHS (NHSE 2010 – 2020) the plan established a positive way forward in the development of a functionally integrated (i.e. system wide cooperative) service to improve the patient experience and clinical outcomes. Prior to 2017, in preparation for this new system, and as part of its development, a range of

models had been tried and piloted by commissioners to find the most efficacious combinations of the NHS 111 call handling service, GP OOH and Urgent Care or Treatment Centres (UCC/ UTC) as the "grandchildren" of the Hear and Treat and See and Treat initiatives (Bradley 2011). The IUC Blueprint superseded all this previous work by then establishing a national standard of 24/7 care across the country.

The policy established the IUC Clinical Assessment Service (IUC CAS) to improve the provision of care by NHS 111 to deliver a "Consult and Complete" model by increasing the number of calls that were responded to by a clinician and completed without the need for face-to-face consultation where appropriate (NHSE 2017: 1.3). Analysis had shown that more than 50% of calls to the 111 service could be completed in this way. This would be reflected in the Advanced Clinical Practitioner framework as a facet of advanced practice (HEE 2017) as will be discussed in detail later. However, relevant to clinical practice via a telephony system, it was noted in section 5.8.4. (NHSE 2017) that there should be careful consideration and support for the development of telephone consultation skills and the subsequent mental health of the clinicians. This was a wise concept to include because it has been well established by many authors including most notably Whitten and Love (2005), Kruse et al. (2017), Mann et al (2020) and Alkureishi et al. (2021) that the change in patient/ clinician dynamic, the challenges of physical examination or lack thereof, workflows managed by performance-based targets and the pressure to meet these, and overall burnout in the attempt to provide a level of care that the individual clinician considers to be safe and helpful are major factors in staff recruitment, retention and wellbeing.

2.27 Telephone Triage

Patients were and are still encouraged to adopt a "talk before you walk" policy so as to enable triage of the patient to the appropriate care provider, rather than just walking in to the Emergency Department as had become somewhat of a national standard when immediate primary care options were not available, and which was a clear contributing factor to the overloaded A&E system (the Guardian Newspaper 2017). This of course puts telemedicine clinicians in the "thick" of the patient management process, making their health and wellbeing of paramount importance as well as simply being a legal requirement of employers as defined in primary legislation, the Health and Safety at Work Act 1974 (Health and Safety Executive (HSE) 1974).

Another documented source of stress in the telemedicine workforce, and particularly for those working remotely from the geographic location of the patient is the interoperability of patient records, clinical pathway awareness and electronic prescribing (NHSE 2017: section 5.14). The interoperability of services and the ability to provide remote telephone consultations are supposed to be enabled by the integration of electronic patient records and appointment booking. The provider is required to adhere to the ISO 9001 Quality Management Standards, the ISO 27001 Information Security Standards, and the ISO 22301 Business Continuity Standards (section 6.2 of NHSE 2017, International Organisation for Standardisation (2021)) as part of their statutory duties. However, these make little difference to the current presenting picture, as was discussed previously due to the neo-liberalist quasi-markets of the NHS (Harvey 2007) and the ability to tender locally for the provision of electronic patient record and management systems the process is still rather fragmented as described by WHO (2010 a) and more recently by Porter et al. (2020). Phasing out and phasing in electronic patient record systems will be a protracted task, though it is pleasing to see that National Health Service Digital (NHSD 2020) offers some guidance on the resolution of the matter although progression to date quite slow.

The stated vision for the service as per the specification, (NHSE 2017: 2.1) is that the Emergency Department working in close cooperation with the ambulance service is accessed only by patients who genuinely need this care pathway. Anecdotally this clearly is not working although as per discussion of the matter NAO figures are not currently available to judge the success of the Blueprint. All areas of the NHS should function under the HEE (2017) Multiprofessional 4 Pillars of Advanced Practice: clear accountable leadership, education, learning and development, evidence-based practice through research and of course sound clinical practice (NHSE 2017 and NHSS 2018) to deliver high quality health care but this is not necessarily being achieved.

2.28 Home visiting

A particular niche for the APP in the face-to-face consultation realm is the home visiting service for those patients who are unable to make their own way to a facility to receive treatment. In IUC this is a role outside of that of the ambulance service in that they are preserved primarily for 999 emergency calls. APPs in the IUC come with a very skill

set that matches closely the specification of the Blueprint section 5.3.7 (NHSE 2017). By the very nature of their career pathway, APPs are used to providing care in the street or in the home. The specifications call for GPs to be provided with a driver and for the provision of a vehicle that is capable of coping with rural locations and inclement weather. However, APPs benefit this function because they have always been trained for this environment, they are used to working as a "solo responder" and calling for "back-up" as appropriate and in the UK they have all passed the advanced driver qualification as specified by the awarding body relevant to their commencement of service, currently this is the AACE Driver Training Advisory Group (DTAG 2013). This advantage of the APP group was acknowledged in section 5.12.1.3 (NHSE 2017).

2.29 The Multiprofessional Framework for Advanced Clinical Practitioners

The final element of this literature review is to discuss the culmination of years of progression towards the Advanced Clinical Practitioner as defined in the Multiprofessional Framework for Advanced Clinical Practitioners (HEE 2017). To aid the reader of this study, it is useful here to recap the descriptive terminology. The overarching role is that of Advanced Clinical Practitioner (ACP). The ACP professional group is made up of multiple professions as the title of the framework acknowledges. The Advanced Paramedic Practitioner (APP) is the descriptor that identifies that this study is focused on the paramedic professional group and differentiates the APP from other grades of paramedic as defined in CoP (2019).

The purpose of the framework is the provision of a clear structure against which stakeholders can plan their care provision and reset the nomenclature which has, due to the ill-coordinated development of each constituent profession got a little "out of hand" in the last decade or so. As professions have evolved through the processes of Higher Education and devolved authority to practice (Brewster and Larsen 2000 and Budhwar 2000 cited in Martins 2007) in response to shortfalls in the availability of General Practitioners, a range of alternative clinicians have somewhat organically evolved to practice in the urgent care setting. There are now a range of job titles and a lack of clarity about what each is expected or regulated to provide. In spirit of interprofessional working and respect for colleagues, supported by the standards of all the registrant bodies of the professions involved the route qualification titles of

nurse, paramedic, physiotherapist, or pharmacist etc. are largely irrelevant and potentially confusing, when the desired skill set of the practitioners is largely the same.

To briefly explain the matter further. Most professions have now taken a lead from the Royal College of Nursing (RCN) and restructured their grade to mirror the “nurse, nurse practitioner (specialist), advanced nurse practitioner and consultant nurse structure” (RCN 2007) . Paramedics for example in their Curriculum Guidance now operate the “paramedic, paramedic practitioner (specialist), advanced paramedic practitioner and consultant paramedic structure” (CoP 2019). Titles for Paramedic Practitioners such as Emergency Care Practitioner or Community Paramedic have officially been defunct for over a decade (CoP 2014a) but continue as a descriptive shorthand in the sector. The title Emergency Care Practitioners (ECP) also causes further confusion because they are not always paramedics, with nurses also being in the role from the early days of the introduction (Woollard 2007, CoP 2014). Next there is the educational clash between structures that developed a few decades apart; it is possible to have attained an advanced nurse practitioner role with bachelor’s degree (RCN 2007), whereas in the paramedic structure an advanced paramedic practitioner requires a master’s degree (CoP 2014). NHS England and Health Education England now recognise the shared skill sets of advanced practitioners and modern integrated processes of interprofessional learning through the advanced clinical practice awards now available at master’s degree from a number of universities. This is clearly a step away from the root qualification role descriptors of the past, and a welcome simplification.

As the ACP will be leading a team of clinicians and in many services taking over the supervisory role of a doctor onsite, although as per NHSE (2017) there will be remote access to a doctor for clinical supervision and guidance, there is a clear need for a robust and defined education structure against which to assess post holders with “grandfather” rights and for universities to structure their Level 7 (master’s) courses for those aspiring to this type of role (QCA 2004). Whilst clearly there are role similarities in terms of all practitioners in the NHS it is usually the depth of one’s knowledge that is the discerning factor of seniority. However, in progression from the Keogh reviews (2013 and 2013a) and the IUC Blueprint (NHSE 2017) there are 4 Pillars specified so that the individual is able to function both as an individual clinician

and as a manager, a leader, a researcher, and an educator. The 4 Pillars are Clinical Practice, Management and Leadership, Education, and Research.

In Clinical Practice, the ACP must possess the depth of knowledge to manage complex cases within their specialist environment and know when to ask for help form other specialisms to promote VBP (HEE 2017 section 1.2.1, Fulford et al 2012, DoH 2000). They also need the depth of knowledge to have confidence in themselves and to inspire confidence in their staff and patients that their professional judgment is appropriate to the needs of the patient at the time (Moskowitz et al. 1988, Hassmiller and Pulcini 2020 and Isler et al. 2021).

Leadership and management skills are not largely taught on primary degree courses or on practitioner courses. Unless the practitioner has attended a separate management and leadership training course, they are unlikely to have examined the requirements and functions of a manager in any great depth. Whilst administration skills might be easy to acquire the skills of a leader, need reflection and development through formal training (NHS Leadership Academy 2021). These abilities are key to a post-Francis (2013) VBP, patient centred integrated health service.

Education awareness is essential not only to manage one's own educational development but also to contribute the learning experiences of the workforce that one leads. Thereby creating a learning culture, that takes ownership of errors, learns from them, and improves, and avoids the stigma of blame culture (Moskowitz et al. 1988, Eysenck 1993, Marsick and Watkins 2003, Laing et al. 2005, Khatri et al. 2009, Keogh 2013: 31 and Radhakrishna 2015).

Research is also part of the learning culture (Marsick and Watkins 2003, Keogh 2013: 31 and Radhakrishna 2015). The ability to engage in research, to analyse data and extrapolate relevant EBP from the work of others is essential to the high fluid world of healthcare. It is also essential that when faced with a complex problem the ACP is able to engage in research of their own to find and answers and offer alternative, developmental suggestion within their immediate environment and to the wider, international healthcare community for the benefit of everyone.

The creation of a well led, responsive healthcare team will benefit the patients, who are the primary concern but also teams within teams will generate a gestalt entity that will provide a positive working environment and generate an attractive career pathway for the next generation of clinicians, with a clear way forward for organisational development and product life cycles.

2.30 Summary of Chapter 2

In summary, this literature review has considered 4 elements, the professionalisation of the ambulance service, the underpinning structures of the National Health Service business, management and leadership culture, evolution of the ambulance service practitioner grades and the current policy governing the provision of Integrated Urgent Care in which the subject group of APPs for the research operate. This therefore forms a solid structure from which to analyse the data and offer discussion and conclusions.

Chapter 3: Research Philosophy

3.1 Introduction

In order to achieve sound comprehension of the research finding it is necessary to explain the underpinning philosophical perspective, so as to be able understand the impact of the findings and the intention of the conclusions (Hartman 1997). The purpose of this chapter is to explain the selection of the interpretivist paradigm and the Schutzian Social Phenomenological methodology and in turn the reasoned rejection of alternative paradigms.

The identification of the research paradigm and Schutzian social phenomenology was a surprisingly complex period of study, hampered by the thought that one merely needed to read a book or two to grasp the subject area and determine a way forward; this was a fallacy that would hamper the early weeks of this study. Once the magnitude of the study was realised however, it led to a far more thorough understanding of the subject of research beyond masters as a whole and made the final choice of methodology surprisingly straight forward.

3.2 What is Philosophy

Philosophy can be defined as an activity that consists in forming, inventing, and fabricating concepts although this suggests that a concept is purely analytical in nature. A looser description that is relevant to the final intentions of this study would be that a concept is a phenomenon, an event or experience that needs further explanation (Deleuze & Guattari 1994, Smith 2012).

Alternatively, it could be described as:

"the study of problems which are ultimate, abstract and very general. These problems are concerned with the nature of existence, knowledge, morality, reason and human purpose" (Teichman and Evans 1995:1).

“the use of reason in understanding such things as the nature of the real world and existence, the use and limits of knowledge, and the principles of moral judgment” (the Cambridge English Dictionary 2022)

3.3 What is Research?

However, returning to the basics and building a firm foundation for later discussion: What is research? Research as a learning process, as described by Burton and Bartlett (2009: 1) is a formalisation of a key facet of the human condition: the desire for ontological expansion and the greater epistemological awareness. Or in simpler terms, to understand and make sense of how the world exists - Ontology and how we construct our knowledge of it - Epistemology (Benton & Craib 2001: 3). From this formalisation comes the development of methodologies and in turn the instrumentation for data collection guided by our societal values and beliefs (Cohen et al. 2011: 3). Blaxter et al. (2006: 5) explain that “research should be planned, cautious, systematic and a reliable way of finding out and deepening understanding”. As Burton & Bartlett (2009: 2) concur, they stress that “rigour is paramount” and is achieved through processes that are systematic, reliable, and cautious. Research is however more than simply the gathering data, there needs, as discussed by Evans & King (2006: 131), to be an element of analysing and interpreting such that the results have a use and thus value. However, value can be subjective, as all people have their agenda based on their perceived needs both individual and corporate and these will influence communication whatever the medium as discussed by Hargie et al. (1994 Ch.2). In other words, there will always be a bias in our actions and therefore research is also a political tool. Thus in order to achieve validity, reliability and in turn personal credibility researchers must be aware of their bias and seek to minimise it effects (Cohen et al. 2011: 204 and Scott et al. 2017). Despite this concern, bias minimisation is obviously achievable as our society has evolved, at least idealistically, a research orientated culture in which professionals trust researchers to provide the data and analysis on which they will base their decisions (Verma & Mallick 1999, and Burton & Bartlett 2009: 3).

3.4 Evidence Based Practice

The modern research orientated culture is generally referred to as one of Evidence Based Practice (EBP); it is most popular with arguably its earliest users, the Medical

and Allied Health professions (Hargreaves 1996: 3, Cohen et al. 2011: 335) and is often seen within this environment as an indicator of professional maturity (Health Professions Council 2011).

"Evidence based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best" Muir Gray (1997).

“Evidence-based practice provides a framework for the integration of research evidence and patients’ values and preferences into the delivery of health care” (Albarqouni et al 2018)

It is the “mantra” of many Healthcare educators to their students since the Department of Health review of Clinical Governance as part of the modern quality agenda (DH 1998) However EBP is not limited to just healthcare and the sentiment is easily converted to fit whichever profession is currently in focus and particularly education as care of the patient readily converts to care of the student. Generally, teachers will see the advantages to social justice, social improvement, enhanced educational experiences, opportunities and achievement that can be attained through the application of the latest data to their work. Although both the Tooley Report (Tooley & Darby 1998 - OfSTED) and the Hillage Report (Hillage et al. 1998 DfES) raised questions as to the quality and usefulness of research. There has been debate between professionals as to who is best suited to carry out such research and the best paradigm to utilise (Hargreaves 1996, Elliott 2001, Hammersley 2002) it seems to be accepted that EBP is necessary and thus research is essential to this (Burton & Bartlett 2009: 7 and LoBiondo-Wood and Haber 2021). Then finally there is further debate over the application of such evidence and the “grey area” of general consensus that is more applicable to generalised populations rather than clear application to individuals as this quote from a clinical perspective describes:

“we are becoming increasingly uneasy observing that evaluations of the impact of evidence-based practice (EBP) are invariably focused on improving population-level health outcomes rather than at the individual patient level” (McCormack & Elwyn 2018).

It therefore seems reasonable to ensure that research studies, maximise their impact by enabling individual and wider population application in the summarising of results and conclusions.

3.5 Paradigms

A research paradigm is a set of concepts and approaches that define a set of values or beliefs in epistemological terms (Burton & Bartlett 2009: 17). The four major paradigms of social science research, in rough historical order are Positivism, Post-Positivism, Interpretivism and Critical Theory (Murphy 2021 and Bhattacharjee 2021) however before discussing the nature of these it is necessary to summarise some of the assumptions that underpin our perspectives on the social world. Burrell & Morgan (1979 cited in Cohen et al 2011) suggest that these assumptions fall into four categories, ontological, epistemological, human, and methodological.

3.6 Ontology

Ontological assumptions, these are divided into two schools of thought objectivist and subjectivist. The objectivist school considers that social reality is external to individuals and thus imposes itself on their consciousness i.e. that humans respond to an outside stimulus whereas the subjectivist school argues that the world is a product of their consciousness i.e. that human interaction with the world produces a continuous evolving construct (Usher 1996: 9-14, Cohen et al. 2011: 5, Murphy 2021 and Bhattacharjee 2021).

3.7 Epistemology

Epistemological assumptions consider the very construction of knowledge in its fundamental terms. How a person sees the construction of knowledge will affect how they set about testing this knowledge. The schools of thought here are Positivist and Interpretivist (anti-positivist or post positivist). The Positivist school considers knowledge to be hard, objective and tangible that can be tested by pure non-interactive observation. The Interpretivist school sees knowledge as personal, subjective, and unique and will involve the researcher in a process of interaction with their subjects (Usher 1996: 9-14, Kemmis and Taggart 2000 Cohen et al. 2011: 6, Murphy 2021 and Bhattacharjee 2021).

3.8 Human factors

Human factors consider the ways in which people interact with their environment. Here the schools of thought are categorised as Determinist and Voluntarist. The Determinist school sees the humans a responding to their environment as if being controlled by it, mechanically and deterministically. The Voluntarist school portrays humans as creatively constructing their environment as their needs require (Baron 1985, Usher 1996: 9-14, Alexander 2006, Cohen et al. 2011: 6 and Willis and Dalrymple 2015).

3.9 Methodological assumptions.

Methodologies of individual researchers will be founded on how they align with the schools of thought of the first three assumptions. In very general terms, for as will be discussed later, there is a growing concept of mixed method research processes that seek to combine the best of both perspectives, the methodologies can be categorised as Quantitative and Qualitative and are frequently seen as polar opposites (Burton & Bartlett 2009: 17). Quantitative researchers portray the social world as an objective reality that can be studied with an external perspective. Researchers thus tend to be comprised of Objectivists, Positivists and Determinists. Whereas Qualitative researchers portray the social world as being a subjective, personal, and humanly constructed that must be studied from within. Researchers thus tend to be comprised of Subjectivists, Interpretivists and Voluntarists (Cohen et al. 2011: 6,) Murphy 2021 and Bhattacharjee 2021.

3.10 Positivism and Post-Positivism

As has been discussed, Positivism aligns strongly with an epistemology of the social world as being external to the individual, a hard, objective, and tangible entity in which human involvement is mechanical and deterministic and can be tested by pure non-interactive observation and deductive reasoning (Cohen et al. 2011: 5 & 6, Murphy 2021) in which one attempts to prove or disprove a series of hypotheses (Caciopo et al. 2004). Processes of observation of this type have been in use since the Ancient Greeks but it was not until the nineteenth century when people had observed the “early days” of modern natural science (Close 1983: 7) and the societal advantages of improved healthcare and living standards as described by Benton and Craib (2001) that the Positivist paradigm really began. Auguste Comte (1798-1857) is largely credited with the initiation of the paradigm (Turner 2003) and thus the concept that the

approach to the natural sciences could be applied to the study of the social world (Yates 2004 and Evans & King 2006). Positivists believe that the order and structure of social life can be discovered by objective experimentation constructed in the same way as one might construct an experiment in a laboratory. The aim of the positivist is to generate statistical data that through comparative analysis demonstrates behavioural trends, though not everyone agrees that this achieves an effective societal insight as a trend does not necessarily explain as to why it has occurred (Burton & Bartlett 2009: 20).

All paradigms have strengths and weaknesses to consider, Burke-Johnson & Onwuegbuzie (2004: 19) offer this summary of positivism:

Strengths	Weaknesses
Testing and validating already constructed theories about how phenomena occur. Testing hypotheses that are constructed before the data are collected. Can generalise research findings when the data are based on random samples of sufficient size. Can generalise research findings when it has been replicated on many different population and subpopulations Useful for obtaining data that allow quantitative predictions to be made The researcher may construct a situation that eliminates the confounding influence of variables, allowing one to more credibly assess *cause and effect* relationships Data collection using some quantitative methods is relatively quick Provides precise, quantitative, numerical data. Data analysis is relatively less time consuming The research results are relatively independent of the researcher It may have great credibility with people in power It is useful for studying large numbers of people	The researcher's categories that are used may not reflect local understandings. The researcher's theories that are used may not reflect local understandings (a Post-Positivist criticism) The researcher may miss out on phenomena occurring because of the focus on theory or hypothesis testing rather than on theory or hypothesis generation (Confirmation bias) Knowledge produced may be too abstract and general for direct application to specific local situations, contexts, and individuals

Table 3 Burke-Johnson & Onwuegbuzie (2004: 19)

Post-positivism rejects the positivist perspective by asserting that there is a difference between the way in which people think in scientific analysis and the way in which people function is a daily common-sense approach to the hypotheses of their lives (Trochim 2021). Both Positivists and Post-Positivists are realists but in the post-positivist realm the observation is less rigid in that it fallible and theories are capable of evolutionary development. A positivist will see an end point to their study, whereas a post-positivist will never achieve a complete theory because their perspective is on

a “get it right” continuum to evolve towards the perfect answer (Trochim 2021) and perfection in a world of individual and human factors is unattainable (Alexander 2006).

3.10.1 Rejection of the Positivist and Post-Positivist paradigms.

The Positivist and Post-Positivist paradigms direct the researcher towards deductive, empirical collection of data or “calculus of factors” as Baron (1985) would define them, and thus relatively replicable findings that potentially deny the human factors and the variable perspectives of individuality (Baron 1985, Usher 1996: 9-14, Alexander 2006, Cohen et al. 2011: 6 and Willis and Dalrymple 2015). Positivists would compartmentalise the phenomena in an attempt to measure the findings against analytical structures that would deny the organic nature of human experience (Rutty 2010).

3.11 Critical Theory

Critical theory perceives the researcher as proactive in and central to the study and that their findings will be “rooted” in social and historical perspectives (Murphy 2021). In this usage is more than a balanced analysis system but one of criticism and “highlighting” of injustice and subjugation in the social world (Wilkes 1994 and Kincheloe & McLaren, 2000). Kemmis and McTaggart (2000), describe the human experience is characterised by power relations within social and historical contexts.

3.11.1 Rejection of the Critical Theory paradigm.

The critical theory paradigm is overly political for the intentions of this research and may be overly contentious in that the intention is to study a relatively “young” profession in a relatively new and emerging specialisation in the field of healthcare for which there is little previous knowledge against which to critically analyse (Jahn 2021). In a few years’ time when it becomes appropriate to evaluate a return on investment and the status of the professionals in the wider NHS and education systems then this paradigm would be most appealing but at this time it could be accused of looking for faults where there is little data to enable fairness.

3.12 Interpretivism

As has been discussed, Interpretivism epistemologically aligns strongly with a concept of the social world as being personal, subjective, and unique, a product of

consciousness that humans creatively construct as their needs require and will involve the researcher in a process of interaction with their subjects (Cohen et al. 2011 and Murphy 2021). The Interpretive paradigm is largely portrayed as the diametric opposite to the Positivist paradigm (Burton & Bartlett 2009: 19) and a divergence from the Post-Positivist paradigm (Alexander 2006). The primary aim of the interpretive paradigm is to understand the subjective world of human experience and is resistant to the perspective of the researcher as an observer rather it sees the researcher as an actor directly involved in the process. (Cohen et al. 2011: 17, Ponterotto 2005, Freire 1970, Saunders et al. 2012).

Key concepts for Interpretivists are those of action and theory. Firstly actions are more than just behaviours in that behaviour can be seen as operating in conjunction with a past tense stimulus such as societal demands (external stimuli) or thirst (internal stimuli) whereas an action has intention and is thus future oriented as described by Cohen et al. (2011: 17) Actions facilitate communication or interaction between people and are co-dependant on the response (Hargie et al. 1994 Ch2 and Cohen et al. 2011: 18). Secondly, theory to an Interpretivist is emergent from their research as subjects interpret and subsequently interact with their environment as opposed to a Positivist when a theory is a more general concept to be tested by the research (Burton & Bartlett 2009: 22, Cohen et al. 2011: 18 and Delamont 2002: 49). Interpretivist research favours participant processes such as case studies, interviews and focus groups and tend to be small in scale (Burton & Bartlett 2009: 21)

Burke-Johnson & Onwuegbuzie (2004: 19) offer this summary of the strengths and weaknesses of Interpretivist research:

Strengths	Weakness
Data based on the participants own categories of meaning It is useful for studying a limited number of cases in depth It is useful for describing complex phenomena Provides individual case information Can conduct cross-case analysis Provides understanding and description of people's personal experiences of phenomena Can describe, in detail, phenomena as they are situated and embedded in local contexts The researcher identifies contextual and setting factors as they relate to the phenomenon of interest The researcher can study dynamic processes The researcher can use the primarily qualitative data to generate a theory to explain phenomena Can determine how participants interpret constructs Data are usually collected in naturalistic settings Qualitative approaches are responsive to local situations Researchers are responsive to changes that occur during the study Data lends itself to exploring why phenomena occur One can use an important case to demonstrate a phenomenon Determine idiographic causation	Knowledge produced may not generalise to other people or settings. It is difficult to make quantitative predictions It is more difficult to test hypotheses and theories It may have lower credibility with some administrators and commissioners It generally takes more time to collect the data when compared to quantitative research Data analysis is often time consuming The results are more easily influenced by the researcher's personal biases and idiosyncrasies

Table 4 Burke-Johnson & Onwuegbuzie (2004: 20)

Both Interpretivists and Positivists have their theory purists that see any combination of paradigms as impossible as described by Howe (1988). However there has for some time been a growing school of thought as to the effective combination of Interpretivist and Positivists perspectives as Mixed Methods research as described by Burke-Johnson & Onwuegbuzie (2004), Denzin (2008: 322), Denscombe (2010: 137-152) and Cohen et al. (2011: 21) it is a process that mixes and matches processes as the researcher requires. Its suggested strengths and weaknesses are as follows:

Strengths	Weaknesses
Words, pictures, and narrative can be used to add meaning to numbers Numbers can be used to add precision to word, pictures, and narrative Can provide quantitative and qualitative strengths Researcher can generate and test theories Can answer a broader and more complete range of research questions because the researcher is not confined to a single method A researcher can use the strengths of one method to overcome the weaknesses of another Can provide stronger evidence for a conclusion through convergence and corroboration of findings Can add insights and understanding that might be missed when only a single method is used Can increase generalisability	Can be difficult for a single researcher to carry out both qualitative and quantitative research Research has to learn about how to use multiple approaches Purists will not like the mixed approach More expensive More time consuming Some of the details of mixed research remain to be worked out fully by research methodologists

Table 5 Burke-Johnson & Onwuegbuzie (2004: 21)

However, mixed methods would risk a lack of clarity in this analysis of a new and emerging role in healthcare. Thus whilst interesting, mixed-methods research was rejected early in the establishment of an appropriate paradigm.

3.12.1 Justification for the adoption of the Interpretivist paradigm.

The interpretivist paradigm is a humanistic philosophy (Rutty 2010 and Saunders et al. 2012) that is subjective, yet systematic approach to research that enables the lived experiences of the participants to be captured as they perceive them (Kincheloe and McLaren 2000). It will take a broad perspective of the emerging role of the Advanced Paramedic Practitioner specialising in Integrated Urgent Care, providing new knowledge to the profession and in so doing, provide a good foundation for future researchers to draw on as they progress the subject through other paradigms so that we develop a holistic perspective of our profession (Smith et al. 2009, Lewis and Staehler 2010, and Kaufer and Chemero 2015).

3.13 Methodologies

From the Interpretivist paradigm there are essentially four main strategies of research process to consider: Case Studies, Action Research, Ethnography and Phenomenology (Pandey and Pandey 2015).

3.14 Case Studies.

Burton & Bartlett (2009: 61) state that a case study is a strategy whereby the researcher aims to study one particular case in depth. Case studies are popular in the legal profession in that in the UK many of our Laws are developed and evolved from case law which is essentially the in-depth analysis of a single specific situation thus conforming to the above definition. They are also very popular in the Medical and Allied Healthcare professions for very similar reasons, these being that through thorough analysis of cases it is possible to inform the wider professional body and advance patient care and outcomes (Payne et al. 2007). This is therefore one approach to Evidence Based Practice (EBP) as defined earlier in this paper by Muir Gray (1997), McCormack & Elwyn (2018) and LoBiondo-Wood and Haber (2021). Case studies are applicable to any professions where the best evidence is used to inform current practice and therefore they are important in the sphere of education. Methodologically it is important that the study has, as far as possible, defined boundaries so that the researcher can demonstrate the distinction between the case in point and other similar societal events (Denscombe 2010: 56 Pandey and Pandey 2015 and Ponelis 2015). The common boundaries in a case study are temporal parameters, geographical parameters, organisational and institutional characteristics, group characteristics and

function or role dynamics (Cohen et al. 2010: 290 Pandey and Pandey 2015 and Ponelis 2015). However, Yin (2009: 18) states that the boundary between the phenomenon and its context is frequently blurred, as a case study is a study of a situation from a perspective that is embedded in the context and should provide a rich description of events. Case studies have advantages over simple historical studies because of their direct involvement with the subject (Cohen et al 2010: 290 and Pandey and Pandey 2015). The depth of description and thus analysis for a case study is achieved, it is suggested by Burton & Bartlett (2009: 64), by gathering evidence from multiple sources in relation to the subject and whilst interviews are often the main data collection method, questionnaires, historical documents, and photographs etc. all have a place in the process.

Nisbet and Watt (1984 cited in Cohen et al. 2011: 293) suggest the following strengths and weaknesses of case studies.

Strengths	Weaknesses
The results are more easily understood by a wide audience as there is a combination of academic and vernacular language. They are immediately intelligible They catch unique features that might be lost in larger scale research They are strong on reality They provide insights into other similar situations They can be undertaken by a single researcher They embrace and build in unanticipated events and uncontrolled variables	The results may not be generalisable except where other readers/ researchers see the application They are not easily open to cross-checking; hence they may be selective, biased, personal and subjective. They are prone to problems of observer bias, despite attempts made to address reflexivity.

Table 6 Nisbet and Watt (1984 cited in Cohen et al. 2011: 293)

3.14.1 Rejection of the Case Study methodology

The case study approach was a strong contender in the search for the appropriate methodology but as Myers (2009), Yin (2009) and Ponelis (2015) the process is time

consuming, prone to selective bias and may miss the opportunity for generalisability which could enable the foundations for more research across the specialism.

3.15 Action Research.

Du Toit & Wilkinson (2010) supported by Hopkins (1985: 32) and French et al. (2001: 248) in their work with student Occupational Therapists demonstrate that Action Research is a process aimed at identifying the need for and implementing change in one's own sphere of practice. There are a variety of cycles suggested in Cohen et al. (2011 Ch 18) all of which appear to be based on a reflective practice system. However, action research should be more than just simply reflective evaluation of practice, it should be rigorous, in depth and aimed at facilitating change (Burton & Bartlett 2009: 7). Action research can be utilised to overcome apathy and stagnation in a department (Clark et al. 2020). It is accepted that a key indicator of organisational maturity is the ability to evolve and change, yet it is also understood that individual employees often dislike, and resist change as describe by Handy (1999: 201-216 and Cohen et al. 2011: 348) quoting the work of Smulyan (1989: 14) suggest that there is evidence that collaborative working through feelings of ownership and involvement can motivate employees and generate a culture that is more likely to accept change.

3.15.1 Rejection of the Action Research methodology

Action research is frequently used to initiate change within a specific group and has been said, to overcome apathy and stagnation (Avison 1999). However this simply does not fit the diversity of the group to be studied at the time or the presenting picture in the evolution of the APP in Integrated Urgent Care which at the time could be described as ground-breaking and energetic. The desired intention of the research was not to bring about change but to analyse the current state of a change in its early progression.

3.16 Ethnography.

Page (2011: 103) states that "the ethnographic approach is ideal for organisational research and that although contested, ethnography is used in a range of fields as diverse a family research, sports psychology and healthcare and emphasises the priority on gaining an emic perspective". Ethnography finds its roots in anthropological studies and is characterised by rich descriptive accounts of societal groups and

focusing on the micro perspective (Burton & Bartlett 2009: 22). Hitchcock & Hughes (1989: 52-53 cited in Cohen et al. 2011: 221) suggests that there are six elements to ethnography: “the production of descriptive cultural knowledge; the description of activities in relation to a particular cultural context from the point of view of the members of that group themselves; the production of a list of feature constitutive of membership of a group or culture; the description and analysis of patterns of social interaction; the provision as far as possible of insider accounts and the development of theory”. To achieve these Baker (1994: 241-244) states that the researcher can observe, the environment, people, relationships, behaviour, actions, verbalisations, psychological stances, histories and physical objects in order to gain a full picture of the subject.

3.17.1 Rejection of the Ethnographic methodology

Put quite simply, an ethnographic methodology was the early “front-runner” as the selected methodology for this project it has clear capability to develop a rich analysis of the historical and sociocultural development of a group (Giddens 1984 and 2001 and Hammersley 2016). Until that is greater study had taken place on the versatility of Phenomenology, which has a quite similar approach in the process of research.

3.18 Phenomenology

Similar to ethnography in that it is a naturalistic approach to research, Phenomenology (Cohen et al. 2011: 18) “advocates the study of direct experience taken at face value and that sees behaviour as determined by the phenomena of experience rather than by external, objective and physically described reality”. Phenomenology represents the subject’s interpretations of holistic life’s experiences rather than a “calculus of elemental factors” as described by Baron (1985) in his analysis of medical phenomenology methodology and supported by Rodriguez and Smith (2018) and Jamali (2018).

Phenomenology seeks to explain social realities, there are however several identified difficulties for the research to minimise or overcome as defined by Cohen et al. (2011: 245-246). These are briefly: The definition of the situation might be deliberately distorted by the participants or blurred by their own anxieties. The presence of the researcher might prompt a positive or negative manipulation of the situation based on

the participants' perceptions of the researcher's intentions – the Hawthorne effect (Sedgewick and Greenwood 2015). The Halo effect in which existing or given information might cause the unwary researcher to be overly selective in the process of data collection (Nisbett and Wilson 1977 and Nicolau et al. 2020). Over familiarity with the situation or the researcher can lead to tacit elements of detail being overlooked. By focusing of the differences in specific situations it is possible for the research to overemphasise the differences between contexts and situations and fail to acknowledge similarities. Focusing on specific contexts and situations at a micro-level the researcher may lose sight of the wider contexts. Generalisability can be lost if the situations and contexts of the research are too unique and finally if the results are contentious, who owns and therefore controls the release of the data (Kaufer and Chemero 2015).

There is much disagreement concerning the interpretation of phenomenology due perhaps to the term having been used so widely across the world especially as it is well known and accepted that there are many schools of phenomenology involving a number of development phases (Rutty 2010).

The unifying concept of all phenomenological study is the way phenomena appear to the person experiencing them. Aside from this the there are several branches of the philosophy and thus to demonstrate the scope of the subject a selection of the leading theories will be summarised in a general sequence to towards a justification for adoption of Schutzian Phenomenology.

Edmund Husserl (1859 – 1938)

The work of Edmund Husserl is largely seen as the formal commencement of the discipline of Phenomenology and what is frequently known as the German Phase, as it evolved from his studies of descriptive psychology as described by his teacher, the psychiatrist and philosopher Franz Brentano (1838-1917). Although the term was first used by Johann Lambert (1728-1777) as a branch of metaphysics and the philosophy of mind and thence by Immanuel Kant, Johann Fichte and particularly G.E. Hegel in his work of 1807 entitles the Phenomenology of Spirit (Kaufer and Chemero 2015). He developed theories of realist phenomenology and later transcendental phenomenology and through this evolution he established the distinction between

consciousness and the phenomena that is experienced and introduced the methodological concept phenomenological reduction or epoche. (Lewis and Staehler 2010). Epoche, also called bracketing, was first propose by Kant but is most commonly associated with Husserl as an initial process in the aid of phenomenological analysis in suspending judgement about the natural world so as to focus on the experience of the phenomena itself (Smith et al. 2009).

Martin Heidegger (1889-1976)

Martin Heidegger was a student of Husserl and carried forward the philosophy work though he criticised Husserl's later works (Chan et al. 2010 and Denzin and Lincoln 2011). Heidegger in his 1927 work "Being and Time" contests that bracketing is impossible as the observer cannot separate himself from the natural world and thus cannot truly achieve a detached view as Husserl asserts. In so doing Heidegger put ontology the experience of the world before the epistemological perspective. Thus Heidegger is largely credited with the initiation of existential phenomenology, although he himself rejected such a rigid compartmentalisation of his theories (Wheeler 2005).

Maurice Merleau-Ponty (1908-1961)

Maurice Merleau-Ponty was a French philosopher, who was inspired by Kantianism and the concept of gestalt psychology to develop accounts of the nature of perception. In which perception is the foundation of how people experience the world and express their understanding in both passive and active ways whilst in connection with their wider society (Thompson 2007: 313).

"this early proposal emphasises the significance of the perception of one's own body for distinguishing between the "universe of perception" and its intellectual reconstructions, and it gestures toward the "realist philosophers of England and America" (presumably William James and A. N. Whitehead, as presented in Jean Wahl's 1932 Vers le concret) for their insights into the irreducibility of the sensory and the concrete to intellectual relations. While this initial proposal makes no mention of phenomenology, Merleau-Ponty's subsequent 1934 report on the year's research, noting the limitations of approaching the philosophical study of perception through empirical research alone, emphasizes the promise of Husserlian phenomenology for providing a distinctively philosophical framework for the investigation of psychology.

In particular, Merleau-Ponty mentions the distinction between the natural and transcendental attitudes and the intentionality of consciousness as valuable for "revising the very notions of consciousness and sensation" (Stanford 2016).

Jean-Paul Sartre (1905-1980)

If Martin Heidegger rejected the role as a figurehead for essentialism, Jean-Paul Sartre was very happy to assume the mantle and progress the French Phase of Phenomenology. His fundamental aim was to establish an ontological account of what it is to be human, as described in his early publication "Transcendence of Ego" in 1936 (Stanford 2011 and Kaufer and Chemero 2015). Sartre posits that "At first [Man] is nothing. Only afterward will he be something, and he himself will have made what he will be" (Sartre 2007). By this he explains his existential perspective is that all human beings have choices and through choice they have freedom and from this they influence the phenomena they experience.

Alfred Schutz (1899-1959)

Alfred Schutz was an Austrian philosopher and supporter of the Husserlian perspective of phenomenology, who focused on applying it to the social world and in particular the stratified social world of Max Weber (Giddens 2001 and Smith et al. 2009).

"Schutz praised Max Weber's views on value-freedom in social science and the autonomy of science and he commended Weber's methodological individualism and ideal-type methodology. In addition, he applauded Weber's refusal to reduce the social sciences to the natural sciences, while allowing their ideal-typical results to be testable for adequacy. However, Schutz also supplemented Weber, pointing out how interpretation was involved even in selecting an experience out of one's stream of experience and highlighting how the meaning of an action to an actor depended upon the project guiding the extended temporal process of the sub-acts leading to its realization" (Stanford 2018).

As discussed in Chapter 1. Schutz considers that social phenomenology is divided into four realms of reality.

1. Umwelt, the realm of the directly experienced social reality.
2. Mitwelt, the realm of the indirectly experienced social reality.
3. Folgewelt, the realm of successors; and
4. Vorwelt, the realm of peripheral interest.

Of which only Umwelt, one's direct experience and Mitwelt one's experiences of contemporaries can be directly experienced and analysed because the interpretation of peripheral figures, predecessors (Vorwelt) and successors (Folgewelt) is impossible (Emmanuel, 2012). The terms Folgewelt and Vorwelt are retained in analysis of social phenomenology to enable the description of when a line is crossed into an intangible area of belief or desire. For example, a practitioner might hope that the foundations they lay in their current practice and experiences, will aid the role of their eventual successors but the organic nature of societal world and it's changing values my not result in the current intended outcome (Folgewelt). This way it is still possible to acknowledge beliefs of predecessor intentions and desires for future events within common thematic analysis.

3.18.1 Justification for the adoption of Schutzian Social Phenomenology.

As stated in Chapter 1. the multidisciplinary functioning of the NHS is in fact a social structure in a Neo-Weberian model (Goldthorpe 1993 cited in Giddens 2001: 288, Ellis 2010). It is appropriate to study the lived experiences of the participants from a social perspective and therefore the analysis framework was structured on the Schutzian Social Phenomenological Model taking guidance from the phenomenological data analysis described by Kleiman (2004) and Giorgi (2009).

3.19 Methods of data collection and analysis

In this section the following popular data collection methods, Questionnaires and Surveys, Observations Focus Group Interviews, and Interviews, will be briefly discussed in terms of their strengths and weaknesses and then a justification for rejection or adoption will be given as been provide with proceeding theories in this chapter.

3.20 Questionnaires.

Foddy (1993: 1) identifies that “asking questions is widely accepted as a cost efficient (and sometimes the only) way, of gathering information about knowledge, past behaviour and experiences, private actions and motives and beliefs, values and attitudes” as supported in application by White et al. (2006) and Harte & Stewart (2010)

Strengths	Weaknesses
Large amounts of data can be gathered quickly The researcher can compare the responses to particular questions from individuals or between different groups of respondents The data can be expressed statistically, making it possible to compare it with other studies The research may enable overall statements to be made concerning the population.	Questions about complex issues are difficult to compose Respondents may have difficulty categorising their responses The short response may not effectively reflect the depth or complexity of feelings It is the researcher who set the agenda for the questions not the respondent. Questions thus create attitudes when they ask the respondent to comment on subjects that they have not previously considered Comments boxes can create highly subjective responses Respondents may be resistant to admitting a specific behaviour or attitude Questionnaires often have poor return rates or suffer from perfunctory completion where the respondent merely the ticks the same option every time.

Derived from Foddy (1993: 2), Robson (1994: 257) & Burton & Bartlett (2009: 82)

Table 7

3.20.1 Surveys.

The term survey seems to be used interchangeably with the term questionnaire and thus a precise example of the difference is hard to find. For example Mulford et al. (2009) describes a survey that actually goes beyond the textbook definition offered by Cohen et al. (2011: 256) that much like an audit, surveys gather quantitative data, often on a large scale, of conditions at a specific time and are therefore somewhat

retrospective. Interestingly a number of authors seem to completely avoid the discussion of surveys for example Maykut & Morehouse (1994) and Hopkins (2008).

Surveys have many of the same strengths and weakness of questionnaires stated earlier. There are however several key types of survey including telephone surveys, postal surveys, and interview surveys but the main three being longitudinal, cross-sectional and trend studies Cohen et al (2011: 266-288).

Longitudinal studies as the name suggests take several months or even years to complete with the researcher taking surveys at specific intervals. One significant drawback to this is population mortality; this is not necessarily the actual death of a participant but the potential for the constituent members of the study population to drop out or change (Cohen et al. 2011: 266)

Cross-sectional studies take “snap shot” samples from the research population at a specific time, the common example of this is the national census where a representative “cross-section” of the population i.e. different ages, incomes, education, and occupations etc. are sampled at one particular time. It should be acknowledged that longitudinal studies may themselves be repeated cross-sectional studies as well (Cohen et al 2011: 267).

Trend studies examine factors rather than specifically people over time. New samples are drawn each time the survey is used but the factors under examination remain the same (Cohen et al 2011: 267).

3.20.2 Rejection of Questionnaires and Surveys.

For all the weaknesses stated above, questionnaires and surveys are in appropriate for this type of research. They are too unreliable in their formulation in that the question can be misinterpreted by the respondent. Data quality is often subject to perfunctory completion (Cohen et al. 2011) and the asynchronous nature of data collection as remote from the researcher greatly risks the gathering of “rich” descriptive experiences of phenomena.

3.21 Observations

Observations are more than simply watching the subject, they are designed to facilitate a systematic recording process of actions, behaviours, routines, settings and contexts, events, and people (Cohen et al 2011: 456) and as demonstrated in Dihle et al. (2006) in their observational study of post-operative pain management. The observation process must have a structure to guide the observer to watch for specific evolving phenomena, as it is not possible to watching everything and observed fatigue will introduce inaccuracy (Delmont 2002: 130-131)

3.21.1 Rejection of Observations

Observations record the researchers experience of phenomena and even if the subject of the observation is asked later for their interpretation of the experience there is likely to be excessive initial interpretive bias from the original observation record. This is likely to be compounded by the intrusive nature of observations in a clinical setting that due to workload and time constraints may not be subject to discussion until a later date, possibly several days disparity.

3.22 Focus Group Interviews

Focus Group Interviews are portrayed by several authors (Barbour 2005, Yeo 2005, and Cohen et al. 2011: 436) adjunctive to the main chosen methodology of research whether that is one to one interview, questionnaires, observations etc. as a way to either gather multiple perspectives in the planning and research question formation stages of a project of as a way to triangulate established data. The process is one of gestalt opinion generation as the group as a whole discusses the topic supplied by the researcher rather than a simple one to one exchange. There are a number of strengths and weaknesses identified that the researcher should be aware of.

Strengths	Weaknesses
Orientation to a particular field of focus Developing themes, topic for subsequent interviews or questionnaires	Deciding on the number of focus groups for a single topic – one group is insufficient as the researcher does not know if the outcome is unique to the group

Generating hypotheses that derive from the insights and data of the group Generating and evaluating data from different populations Gathering qualitative data Generating data quickly and at low cost Gather data on attitudes, values, and opinions Empowering participants to speak out and use their own words Encouraging groups rather than individuals to voice opinions Encouraging non-literate participants Providing greater coverage of issues than would be possible in a survey Gathering feedback or triangulation from previous studies	Size of the group, too small and intergroup dynamics can be monopolised by individuals, too large and the group is unmanageable How to allow for no attendance. Should extra members be invited to allow for this, But again will the group become too large to manage Ensuring that invited members proportionately represent the required group mix Ensuring that participants have something to say and are prepared to speak Chairing the group to guide discussion but without being too directive is a skill that has to be learned Focus groups are not seen by some as rigorous enough to compete with in depth observational techniques

Derived from Delamont (2002: 3-4) Burton & Bartlett (2009: 93-94) and Cohen et al (2011: 436-437)

Table 8

3.22.1 Interviews.

The interview is a flexible tool for data collection, enabling multi-sensory channels (Hargie 1994) to be used: verbal, non-verbal, non-vocal, spoken and heard as described by Cohen et al (2011: 409). It operates at a greater depth of enquiry than a simple questionnaire because the interviewer can directly interact with the respondent in concordance with theories of interpersonal communication and social skills (Hargie et al 1994) but goes beyond a simple everyday conversation as demonstrated in Pollard (2008) and Dympna (2007). Kitwood (1977) cited in Cohen et al. (2011: 409-410) observes that there are three conceptions to the interaction of an interview: the interview should be a process of pure information transfer in which questions are well formulated and the interviewee responds accurately; the interview will inevitably have bias and steps should be taken to recognise and minimise this and finally the interviewer must keep in mind that this is a social encounter and that all individuals however well controlled, will have their own agenda. Kitwood's third point echoes the earlier theory put forward by Mead (1967 cited in Foddy 1993: 19-20) of symbolic interactionism in which, briefly stated, it is claimed that social actors in any situation are constantly negotiating a shared definition of the situation, taking one another's behaviour and viewpoints into account, and formulating a response.

Strengths	Weaknesses
A research method that is adaptable to different situations and respondents	The interviewer can bias how questions are imparted thus influencing the answer
The interviewer can pick up the non-verbal and non-vocal cues in the conversation	Interviews take a great deal of time and may be difficult to set up. This inevitably restricts the number of possible interviews
The researcher can follow hunches and unexpected responses	Writing down responses during the interview may detract from the discussion but not keeping thorough notes can lead to inaccuracies when the detail is recalled later.
The interviewer can collect detailed data in the respondents' own words	

The completion rate of interviews is considerably higher than the return rate of completed questionnaires	The more unstructured an interview the more variable the data the harder it will be to analyse and identify trends and similarities

Derived from Burton and Bartlett (2009: 94-95) and Cohen et al. (2011: 409-455)

Table 9

3.22.2 Justification for the adoption of Interviews as the mode of data collection.

The desire for a "rich" descriptions of the phenomena as experienced by the research subject makes the interview an ideal format for the acquisition of this level of detail. In particular the unstructured interview can be utilised to set initial guidance and then just let the research subject reflect and talk about their experience of their world. With the interviewer present deep clarification can be sought directly or prompted through encouraging vias (hmm, ah hah etc.) or facial expression and gesturer (Hargie et al. 1994) whilst allowing the subject to provide most of the narrative. Interviews and observations can be time consuming, and observations achieved "in practice" can be disjointed given the situation whereas interviews are achieved "on practice" much in Schon's reflective model (Schon 1983). Therefore, in an interview, distractions can be minimised, and focus can be maintained. Interestingly in the modern post-pandemic world interviews can be achieved remotely via technologies such a "Zoom" or "Microsoft Teams" which enable real-time recording for later transcribing and may improve the flow of the conversation (Archibald et al. 2019). Additionally, unstructured interviews can be utilised to circumvent the issues on group opinion bias that occurs through our now highly connected society from what might be called the Social Media effect (Gilbert 2008, Bachrach et al. 2012, Alan et al. 2016, and Burbach et al. 2020). Social media has opened us all up to the ability to engage in group discussion that is often politically motivated and can place the potential of an emotionally charged "spin" one's perspective of the world. The analysis of phenomena as they appear specifically to the individual can reduce this effect and potential bias. In addition Focus Group Interviews can be maintained as an option to review and triangulate contentious data. Therefore unstructured interviews were chosen as the data collection method.

3.23 Analysis of Data

Quantitative and qualitative data are analysed in different ways (Munn & Drever 2004: 39 and Pandey and Pandey 2015). Dawson (2009: 114-116) discusses that quantitative researchers endeavour to demonstrate statistical data that is stable and consistent and free from bias or errors. Qualitative data can be viewed as sitting on a continuum with high quality reflective type analysis at one end and quantitative type depiction of qualitative data by counting and coding. There are several key types of qualitative analysis:

Thematic analysis is a highly inductive process that describes themes as they appear from the acquired data (Hopkins 2008: 141, Dawson 2009: 119 and Castleberry and Nolen 2018).

Comparative analysis is similar to thematic analysis and may be used on the same project. In this analysis, data from a respondent is compared with that from other respondents to confirm or deny the emergence of new issues or themes (Maykut & Morehouse 1994: 134, Hopkins 2008: 141 and Dawson 2009: 120).

Content analysis occurs when the researcher encodes information as individual respondent's data is analysed so as to categorise responses in conjunction with either a preconceived list of characteristics or more fluidly an evolving set of characteristics. This approach is common in the analysis of open-ended questions (Dawson 2009: 122).

Discourse or conversational analysis examine the intricacies of interpersonal communication, how people speak about a particular subject, what language they use, metaphors or expletives to deduce attitudes and strength of feeling. (Dawson 2009: 123)

3.24 Proposed structure of a Schutzian Data Analysis Tool.

The first intention will be to summarise the global sense of the interview transcript and then to divide the interview transcripts into Schutz's four realm concept, guided by the inference of the transcript: Umwelt, Mitwelt, Folgewelt, Vorwelt (Emmanuel 2012). It is likely that in an unstructured interview there will be elements that cross reference to

more than one realm. The analysis will then consider common themes, their frequency and where these might sit within the realms and also the four domains of Advanced Practice (HEE 2017): Clinical Practice, Research, Management & Leadership and Education. Then from here one can report the finding and then progress on to discuss the implications for the APP. This tool as an extrapolation of Kleiman (2004), Giorgi (2009) Charlick et al. (2016) is expanded upon further in Chapter 4.

3.25 Presentation of Data

When presenting results, one is according to Munn & Drever (2004: 62) trying to achieve two things, “to open your findings up to scrutiny and so validation and to persuade people to a certain point of view”. If one wants people to read the research data then there is potentially a need to engage the reader by making the presentation of data visually intriguing. The use of tables, graphs and charts can assist in this. However the researcher should be selective in what they present as it might be unfair on the reader to try to represent all the data on a single table, graph or chart and it is easy to mystify the reader with complexity and thus diagrammatic representations must be accompanied by an explanatory narrative (Maykut & Morehouse 1994: 157-160 and Munn & Drever 2004: 62-70).

3.26 Ethical considerations

As a society, the judgements and interactions of our daily lives are governed by both ethical and legal considerations. The law sets standards of minimum acceptable behaviour applicable to the wider population, whereas codes of ethics attempt within moral frameworks to establish exemplary standards of behaviour for specific groups to strive for (Herring 2008: 1-10). Ethical codes do not necessarily need to be written down as in the main they are derived from our unique culturally accepted moral values. Ethical judgements as stated by Hope (2004: 2) are made every day by every person in their societal and professional interactions and range from those that are metaphysical to those that are mundanely practical.

The researcher in the field of education in the UK is well advised to adhere to the British Education Research Association (BERA 2018) Guidelines.

"The underpinning aim of the guidelines is to enable educational researchers to weigh up all aspects of the process of conducting educational research within any given context (from student research projects to large-scale funded projects) and to reach an ethically acceptable position in which their actions are considered justifiable and sound. For the vast majority of educational research activity this basic tenet may be non-problematic, but dilemmas will arise for others and these guidelines will provide a basis for deliberation and perhaps resolution or compromise". BERA (2018)

The concept of good ethical practice is one in which the practitioner strives to operate in a manner that is socially and morally justifiable, although it should thus be acknowledged that different cultures have different moral values and thus occasionally ethical conflicts will occur. This is where a code of ethics is useful in that it is negotiated and established within as profession through wide consultation and renegotiation. However unlike a law an ethical guideline will remain in the sphere of "good" advice. The need for an ethical code is however well established and it is unlikely that a textbook on the subject of educational research would ignore the issue as is certainly the case for Bell (2005: 43-60), Hopkins (2008: 201-204), Burton & Bartlett (2009: 29-39), Dawson (2009: 153-158) and Cohen et al (2011: 75-104) all of whom recommend adherence to the BERA (2018) Guidelines. In addition to these guidelines one should also be adherent to the follow standards so as to achieve acceptance with a wider, more international audience:

- Health and Care Professions Council Standards of conduct, performance, and ethics (2020),
- World Medical Association International Code of Medical Ethics (1983)
- World Medical Association Declaration of Helsinki (2014)
- Health Research Authority (2011) (formerly National Research Ethics Service)
- Department of Health Research Governance Framework (2008)

Cohen et al. (2011: 75) observe that the application of ethics is a "balancing act" between the professional scientist's search for truth and the needs of and threats perceived by their subjects'. But to adhere to or work within a code of established

ethics at least creates a foundation on which to build rather than leave the notion to the vagaries of personal opinion.

3.27 Summary of Chapter 3.

In this chapter description, analysis has been offered as to the paradigms and methodologies that are applicable to research in the social sciences. Arguments have been provided thus for and against the option with the final intention being the use of the Interpretivist paradigm and the Schutzian social phenomenology methodology. In the next chapter these will be utilised in the synthesis of the specific methodology to the research project.

Chapter 4: Study Design

4.1 Introduction

The purpose of this chapter is to set out how the research was conducted and explain with reference to previous discussion, the considerations of the research in application of theory to practice. This study collected qualitative primary comparative data through a process of unstructured interviews following a Schutzian Phenomenological structure.

Phenomenology as described in Cohen et al. (2011: 18, Baron 1985 and Teddlie & Tashakkori 2011) “advocates the study of direct experience taken at face value and that sees behaviour as determined by the phenomena of experience rather than by external, objective and physically described reality”. Phenomenology represents the subject’s interpretations of life’s experiences.

4.2 Part 1 of the study

Generation of a cohesive preliminary subject introduction and literature review. This thus generated a series of reasoned areas of enquiry ready for the research phase. In this time, it was also necessary to achieve local ethics approval from the organisations involved. The College of Paramedics agreed to assist in advertising this project and recruiting volunteers to take part (Appendix 1 – Advert, Appendix 2 – Information Sheet and Appendix 3 – Consent Form).

4.3 Part 2 of the study

Conduct unstructured interviews with volunteers recruited in part 1 and from a potential snowballing effect, based on a series of generalised subject areas to stimulate a discussion of the Advanced Paramedic Practitioner role. The advantage to this research of an unstructured interview is that it allows the volunteers more freedom to respond and minimises researcher bias and selective data collection. The interview was very much about introducing a subject area and allowing the interviewee to explain their experience, with the interviewer taking notes and only interjecting to clarify points or to encourage a deeper explanation.

As discussed in Chapter 3 Phenomenology seeks to explain social realities, but there are however several identified difficulties for the researcher to minimise or overcome as defined by Cohen et al. (2011: 245-246 and Kaufer and Chemero 2015):

1. The definition of the situation might be deliberately distorted by the participants or blurred by their own anxieties. By conducting unstructured interviews the interviewer has the opportunity to clarify the intentions of the study and acknowledge anxieties of the research subject as they explain their perception of phenomena, which in turn strengthens the rich data of personal experience.

2. The presence of the researcher might prompt a positive or negative manipulation of the situation based on the participants' perceptions of the researcher's intentions (Costa and McCrae 1992) which is known as the Hawthorne effect (Sedgewick and Greenwood 2015). By using the minimal guidance facilitated by unstructured interviews the researcher's intentions play little role in the explanation of phenomena as described by the research subject.

3. The Halo effect in which existing or given information might cause the unwary researcher to be overly selective in the process of data collection (Nisbett and Wilson 1977 and Nicolau et al. 2020). Data from unstructured interviews in which the research subject provided the vast majority of recorded discussion reduces the selectivity of the research because the subject can say what they really feel. However, it was acknowledged that the interpretation of the acquired data must be true to the own words of the subject and not the terminology of the researcher.

4. Over familiarity with the situation or the researcher can lead to tacit elements of detail being overlooked. As far as possible research subjects that are not known to the researcher were chosen to participate.

5. By focusing of the differences in specific situations it is possible for the research to overemphasise the differences between contexts and situations and fail to acknowledge similarities. Focusing on specific contexts and situations at a micro-level the researcher may lose sight of the wider contexts. This again is

why an unstructured approach were decided upon because to allow the freedom for the research subject to respond with what they think rather than answering a specific question.

6. Generalisability can be lost if the situations and contexts of the research are too unique. The research subjects were drawn from 3 disparate regions of the UK, North East England, the Midlands, and London so that the perspectives in geographically different locations with varying socio-ethnic and socio-economic diversity so that participant perspectives had the opportunity for variation of depth and perspective.

Indicative interview content:

As stated the intention of the study is to conduct unstructured interviews to allow the volunteer to speak freely but there still needs to be a modicum of guidance to the process. These questions have been taken from my initial thoughts and notes as subject headings, each one could be greatly subdivided in a fully structured interview.

Introduction

Consent form completion

Tell me about your role as an Advanced Paramedic Practitioner in relation to:

Section 1 Human Resources and Recruitment
Section 2 Professional Integration
Section 3 Functioning as an Advanced Paramedic Practitioner
Section 4 Innovation and Role Progression
Section 5 Paramedic Profession Potential
Section 6 Career Structure

Thank you

Table 10

4.4 Part 3 of the study

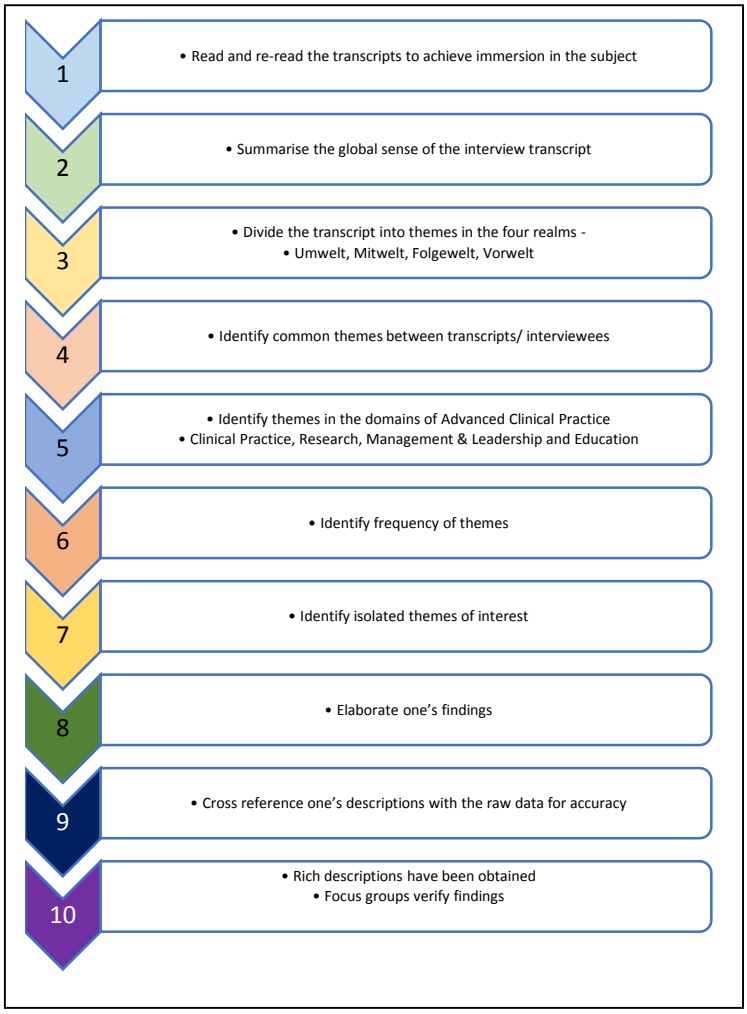
Using the thematically analysed and processed data from part 2, the results were then offered to focus groups with collective volunteers outside of the original interviewees to further bore down to the root cause and trustworthiness of the data and this was documented on a Focus Group Control Sheet (Appendix 7). Essentially these groups were used to prove the rigor of the study and that the findings are regarded as a sufficiently authentic and credible representation of reality. For it has been argued that anonymous studies reduce the credibility (Guba & Lincoln 1989: 245-251 & Dash 2007:871) because anonymity could be used to impart covert researcher bias and potentially damage the validity of the work.

4.4.1 Validity and Reliability

Focus groups specifically assist this study because they can verify the Predictive validity in terms of accuracy and applicability to future performance (Folgewelt). It also confirms the Concurrent validity in terms of the ability to develop thesis, antithesis, and synthesis. Focus Groups rather "nail-bitingly" aid confirmation of Construct validity and Reliability in that the study has been worthwhile and has uniformly and reproducibly measured the subject and finally they confirm the Content validity in that they enable one to ensure there has been thorough coverage of the subject (Gipps 1994 cited in Butterworth 2001, Plummer 2017, and Spiers et al. 2018).

4.4.2 Schutzian Data Analysis Tool

The first intention will be to summarise the global sense of the interview transcript and then to divide the interview transcripts into Schutz's four realm concept, guided by the inference of the transcript: Umwelt, Mitwelt, Folgewelt, Vorwelt (Emmanuel 2012). It is likely that in an unstructured interview there will be elements that cross reference to more than one realm. The analysis will then consider common themes (Appendix 5 and 6), their frequency and where these might site within the realms and also the four domains of Advanced Practice (HEE 2017): Clinical Practice, Research, Management & Leadership and Education. Then from here one can report the findings and then progress on to discuss the implications for the APP.



Taking guidance from the phenomenological data analysis described by Kleiman (2004), Giorgi (2009) Charlick et al. (2016).

Figure 9

4.5 Part 4 of the study

The timings were quite liberal and as expected some timings overlapped and unplanned delays were encountered as would be expected in this type of research. Part 4 however is the writing up phase which is expected to take about 6 months as it will be completed around our occupational concerns.

4.6 Population

Taking the advice of research colleagues, the study intended to recruit 15 to 20 Advanced Paramedic Practitioners to interview in their clinical setting. It was expected that saturation of responses would likely occur between the 12th to 20th interview respondent (Saunders et al. 2018 and Guest et al. 2020) and indeed this occurred at

the 14th interview. Early saturation at the 14th interview was likely as will be discussed in the findings as a result of the social media effect in which in our modern world social media facilitate open discuss across wide national and even international professional groups (Gilbert 2008, Bachrach et al. 2012, Alan et al. 2016, and Burbach et al. 2020).

College of Paramedics definition**:** An Advanced Paramedic Practitioner is defined as, an experienced Paramedic Practitioner, educated to MSc and fulfilling a senior role in Education, Research, Management or Clinical Practice. It is not simply a paramedic with dual specialisation (CoP 2019).

4.6.1 Inclusion and Exclusion Criteria:

Inclusion criteria

The interviewee must be:

A Registered Paramedic with the Health and Care Professions Council.

Employed as an Advanced Paramedic Practitioner working in a clinical setting.

Hold a MSc in a relevant subject area and thus comply with the College of Paramedic definition of an Advanced Paramedic Practitioner. Or have made progress into the second year of an MSc in Advanced Clinical Practice and be employed in a full-time Advanced Practitioner (in Training) post as per the HEE (2017) definition of Advanced Practice.

Exclusion criteria

Practitioners working only in Research, Management or Education

4.7 Ethics

This study will be guided by the following ethical codes and professional standards:

- British Education Research Association Guidelines (2018).
- Health and Care Professions Council Standards of conduct, performance, and ethics (2020)
- World Medical Association International Code of Medical Ethics (1983)
- World Medical Association Declaration of Helsinki (2014)
- Health Research Authority (2011) (formerly National Research Ethics Service)

- Department of Health Research Governance Framework (2008)
- Totally plc. standards of Ethics.

Being cognisant of the position of a researcher, strict and explicit confidentiality and professionalism in relation to engagement with participants during this study was maintained. The ground rules were established through the consent form, information sheet and open clarifying discussion as required as per the example in Appendices 2 and 3. Data collection during interviews and focus groups was not shared with others during the study. Participants were made fully aware of the time involved, data analysis and data protection.

All contact details and copies of consent forms will be held in a participant file identified by a number code only and stored in a locked filing cabinet at the researcher's office. All names and identifying information will be removed from the interview and focus group transcripts. No identifiable information will be used, only pseudonyms. Downloaded data will be stored on a protected server and only accessed by the researcher The researcher is a qualified paramedic of many years' experience and was bound by the HCPC code of conduct, performance, and ethics 2016, of which confidentiality is a key element.

Participants may have found exploration of aspects of their role and the impact of consciousness raising during interviews and focus groups to be challenging and emotionally distressing, although this risk was low. The researcher is an experienced paramedic educator and was thus well equipped to manage such situations.

It is possible that in relation to the study volunteers might discuss or highlight issues of poor practice that need to be addressed immediately. If matters of Fitness to Practice, breaches of the code of conduct or of duty of care were identified it was made clear that these will be reported to the subject's employing authority and as appropriate their registering body. Such matters were identified in the consent form that were discussed and an acknowledgement signed at the beginning of every interview and an information sheet was provided to all interested parties with guidance on where to obtain further support.

Participants were advised that they may withdraw from the study at any time, and this will be respected without the need for explanation. However, collected data may still be included in the study, once a 2-week post collection window has passed because after this the data would have been factored in to the analysis process.

4.8 Summary of Chapter 4

The Keogh Review (DH 2013a) identifies the strategic advantage to utilising and developing the existing NHS Ambulance Service to facilitate mobile urgent care and admission avoidance provision. The Ambulance Service already had basic practitioner grades working towards this ideal (DoH 2005, Minney 2007, Woollard 2009). However, for involvement of Advanced Paramedic Practitioners in patient care to become the norm for all areas, the Ambulance Service still has to make significant changes to their modes of practice and thus we are see significant numbers of Advanced Paramedic Practitioners transitioning to the Integrated Urgent Care specialism (NHSE 2017) which for a variety of reasons it will be useful to analyse and understand.

The study will examine the lived experiences of those clinicians working in the APP role to establish a deep and rich description of their actual function beyond that of simply what role is intended to be.

The findings will be published to support the paramedic profession in the delivery of the best possible patient care as part of a multidisciplinary team.

From these elements, areas for future study will be identified to help put these in progress so that this study is not simply a solo event but continues to develop for the clinical and academic benefit of paramedic profession.

Timeline

ACTIVITY	TIMELINE							
	Part 1		Part 2		Part 3		Part 4	
Preparation, reading, exploration, define and focus study								
Literature searching								
Literature review and synthesis								
Ethical approval								
Prepare/plan fieldwork and data collection								
Data collection								
Data analysis								
Evaluation of data and report writing								
Submission of thesis/dissemination								

Table 11

Chapter five, research findings, and discussion

5.1 Introduction

In this chapter the research findings as a result of a reductive process of thematic analysis (Pearce 2019) are presented with a discussion relevant to each element drawing on the theory discussed in chapter 2 and other sources that may clarify the argument. The findings are derived from the research interview transcripts that can be found in Appendix 4. The research "distilled" through its reductive analysis, five primary themes in the lived experiences of Advanced Paramedic Practitioners working in the emerging specialism of Integrated Urgent Care, these are:

1) Social Group Opinion
2) Expectations of the Ambulance Service
3) Expectations of Integrated Urgent Care
4) The role of the Human Resources Department in Professional Integration
5) Options for Development

Each primary theme also contains a series of sub-themes that further scrutinise the lived experiences of the APP. Within the discussion direct experience (Umwelt), the experience of others (Mitwelt), opportunities for future development (Folgewelt) and the experiences of predecessors (Vorwelt) will be explicitly annotated in these original Schutzian terminology. Direct quotes from the transcripts will be placed in text boxes to make it easier for the reader to discern the discussion from the evidence.

5.2 Social Group Opinion

As was anticipated from studying the effect of modern technology on the evolution of the social environment and thus the effect of research it should be acknowledged from the start that social media has had an impact on the perception of phenomena for the subjects of this research. It has been established by several authors to date that social media has through creating a highly connected society, impacted, augmented, and re-orientated our perception of our social and physical worlds and thus this should be considered when reading modern research projects (Edwards et al. 2013). It was hoped and indeed appears still likely that unstructured interviews can be utilised to circumvent some of the issues of group opinion bias and the social media effect (Gilbert 2008, Bachrach et al. 2012, Alan et al. 2016, and Burbach et al. 2020). The following responses were found during analysis of the interview transcripts.

Umwelt

"I have discussed this with the North division recently. It would be super if the Ambulance Service would take on this functional model so that there was a place for APPs to actually use their skills in the Ambulance Service."

"I am sure you have heard this before, indeed it is all the fora seem to talk about. That we have to leave the Ambulance Service to fully function as an APP, we have to become ACPs in a hospital."

Mitwelt

"As it is, we are all leaving once we get our MSc because we want to work more autonomously and make a difference rather than being just another response resource."

As was expected that saturation of responses would likely occur between 12th to 20th interview respondent (Saunders et al. 2018 and Guest et al. 2020) and indeed this occurred at the 14th interview and content here and in other sections of this chapter have indicated that there is a social clustering of opinion that was potentially limiting or compromising to the purity of the personal experience of phenomena. As has been discussed in the examination the socio-professional relationships in Chapter 2 with

regards to the Leader Member Exchange (Naidoo et al. 2010) and the Leader Follower Relationship (Lee et al. 2019) within a neo-Weberian social structure (Ellis 2010); it seems that everyone enjoys a “good moan”. Although maybe it is better to say cathartic venting; it certainly seems to be good for us to unburden ourselves to others that will understand the situation (Lee et al. 2019). This seems to have become the approach to office humour as we are educated away from the traditional concept of “banter” because this has been identified as a potential source of bullying as described by Palmer (2020) but as Eysenck (1994) alludes and supported by Costa & McCrae (1992), everyone enjoys a good moan, it is part of our human nature to vent our feelings and frustrations. This is certainly a plausible explanation for some of the negativity identified in this research from a workforce that outwardly appears as a staff group to be fairly happy (Manzoni and Barsoux 2009 and Lee et al. 2019: 2). It is still demonstrable from the research that the analysis of individual experiences of phenomena as they occur has still managed to cut through superficial negativity and identify elements of the social media effect to achieve a “rich narrative” for analysis though these elements certainly added additional layers to the reductive analysis process. Focus groups further enabled triangulation of the findings as being authentic, reliable, and valid (Guba and Lincoln 1989: 245-251, Barbour 2005 and Dash 2007:871) and indicated the nuclei of clustered social opinions and thus these were very useful to support interpretation of the transcripts as discussed in the rest of this chapter.

5.3 Expectations of the Ambulance Service

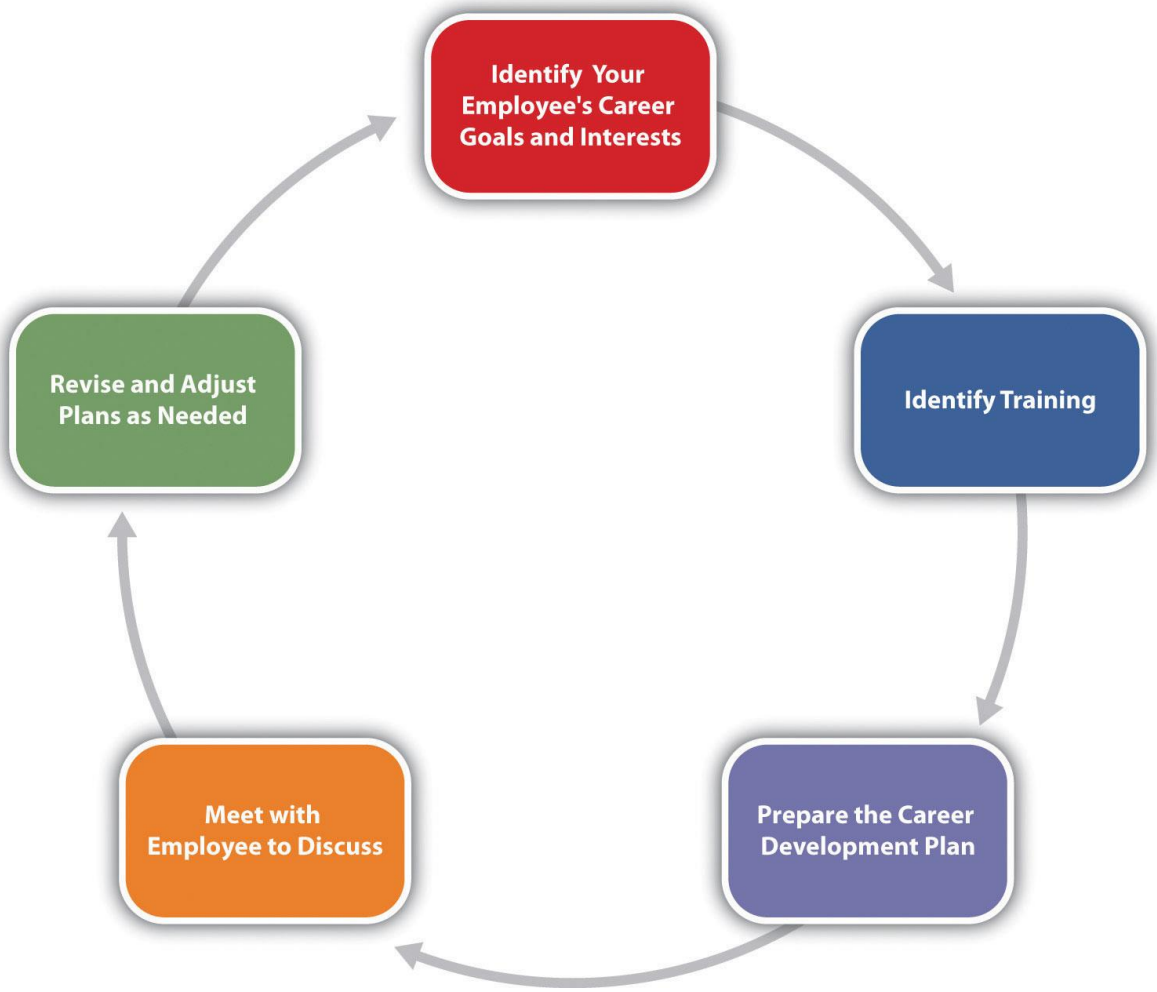
Although an number of interviewees stated that they maintain a Bank Contract with their local ambulance service, there are several specific themes as to why as APPs they left the ambulance service that centre on the concept of psychological contracts, as will be explained.

5.3.1 Breach of the psychological contract

To recap the earlier explanation from Chapter 2: A concern for the employer is that enhanced education brings greater occupational mobility and thus the possibility of then losing staff to a competitor. However, if employers invest in their human capital the loyalty to the organisation that is generated initiates what Bratton and Gold (2007), Guest and Conway (2002), Herriot et al (1997), Robinson (2006), Leach (2010) and Tan (2014) describe as a psychological contract and may improve staff retention so that the educational surplus can be channelled towards organisational flexibility and in turn support economic competitiveness. Research by Guest (1992) demonstrates that loyal employees to a point can drive down operational costs.

"Psychological contracts are an implicit, but largely unwritten contractual understanding between employer and employee concerning their respective role relationship and mutual obligations towards one another that are continually negotiated, test and affirmed within the workplace". (Leach 2010: 331)

Employees with identical legal contracts might have very different perceptions of their psychological contract with their manager. Thus, a manager needs to bear this in mind during a decision-making process and ensure clear communication to reduce the risk of perceptual breaches of psychological contracts despite operating within legal contractual boundaries. (Guest and Conway 2002: 35 cited in Bratton and Gold 2007: 15). Figure 9 below demonstrates the career development cycle that is supported by a sound psychological contract.



Saylor Academy 2020

Figure 10

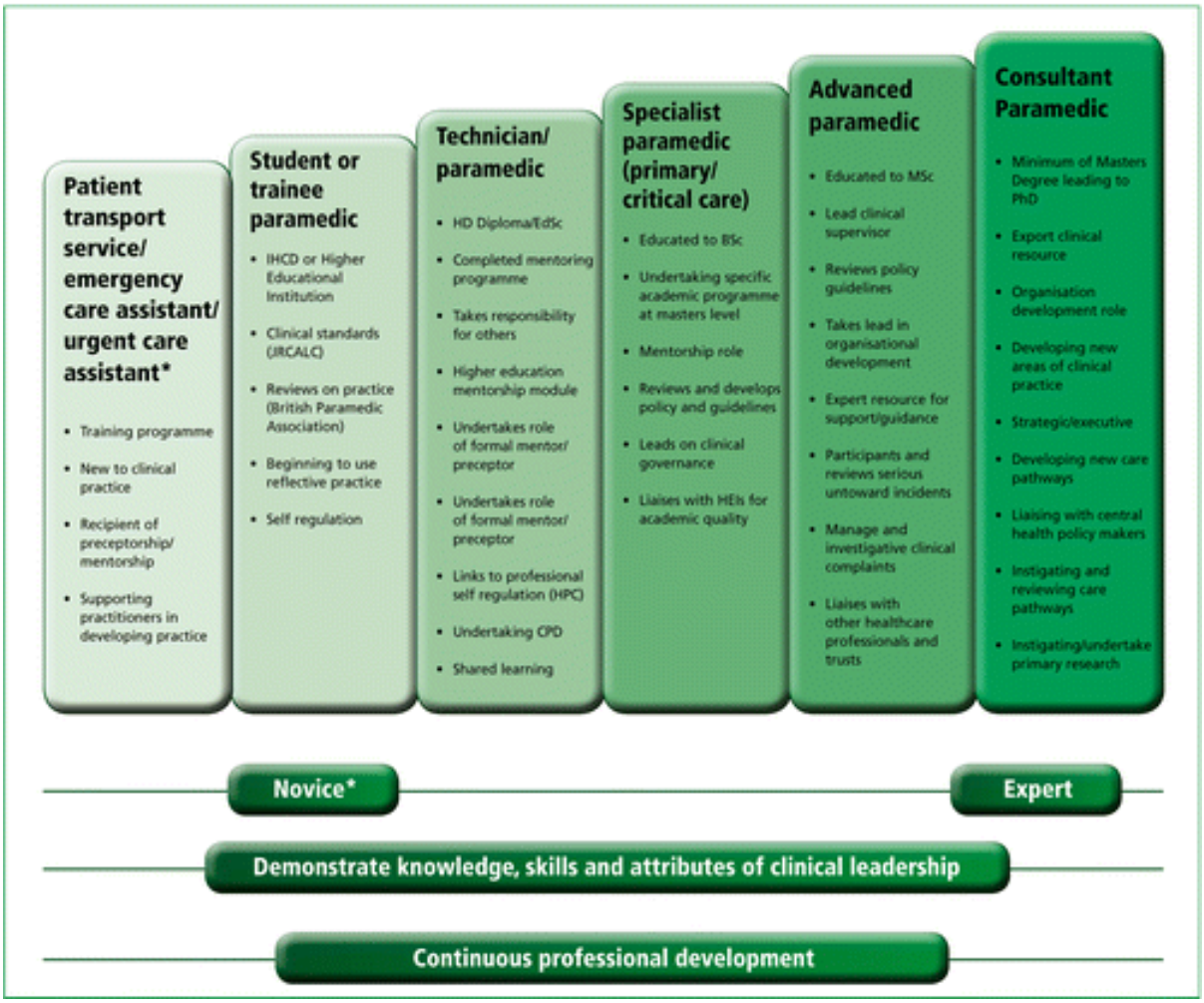
The psychological contract when managed appropriately provides a foundation for career development action plan that can “map out” a mutually beneficial commitment to the organisation.

Umwelt

"We have been under rated as the "ambulance drivers" – I hate that description but how long has it been since we had Paramedics, 40+ years? but certain people still see us as a transport service. The modern University structure is helping use show we are equally capable. I mean I didn't really like the idea of having to attend university and frankly some of the people they turn out as "qualified paramedics" is quite alarming, but we do now at least have the same standard of education."

It seems that despite over 50 years since the Millar report (Millar 1966) there is still friction between the professionalised ambulance service skill set and the public perception of the service. Whilst the experience of this interviewee is interesting, it is a little extreme, though an early "firework display" does grab one's attention. Maybe though it heralds the potential reproletarianisation of the service in current deployment strategies due to the sheer pressures on the ambulance service to respond to demand on its core functions contrary to the post-Millar stance of the past 50 years.

When one examines the Career Structure of the College of Paramedics (2019), one understands that this is the progressive career pathway that one can expect to be applied by the main employer of paramedics in the UK, the NHS Ambulance Service. Of which as we know there are 12 mainland regional services and the Northern Ireland Ambulance Service. This looks excellent on paper but in practice there is a significant variance of application.

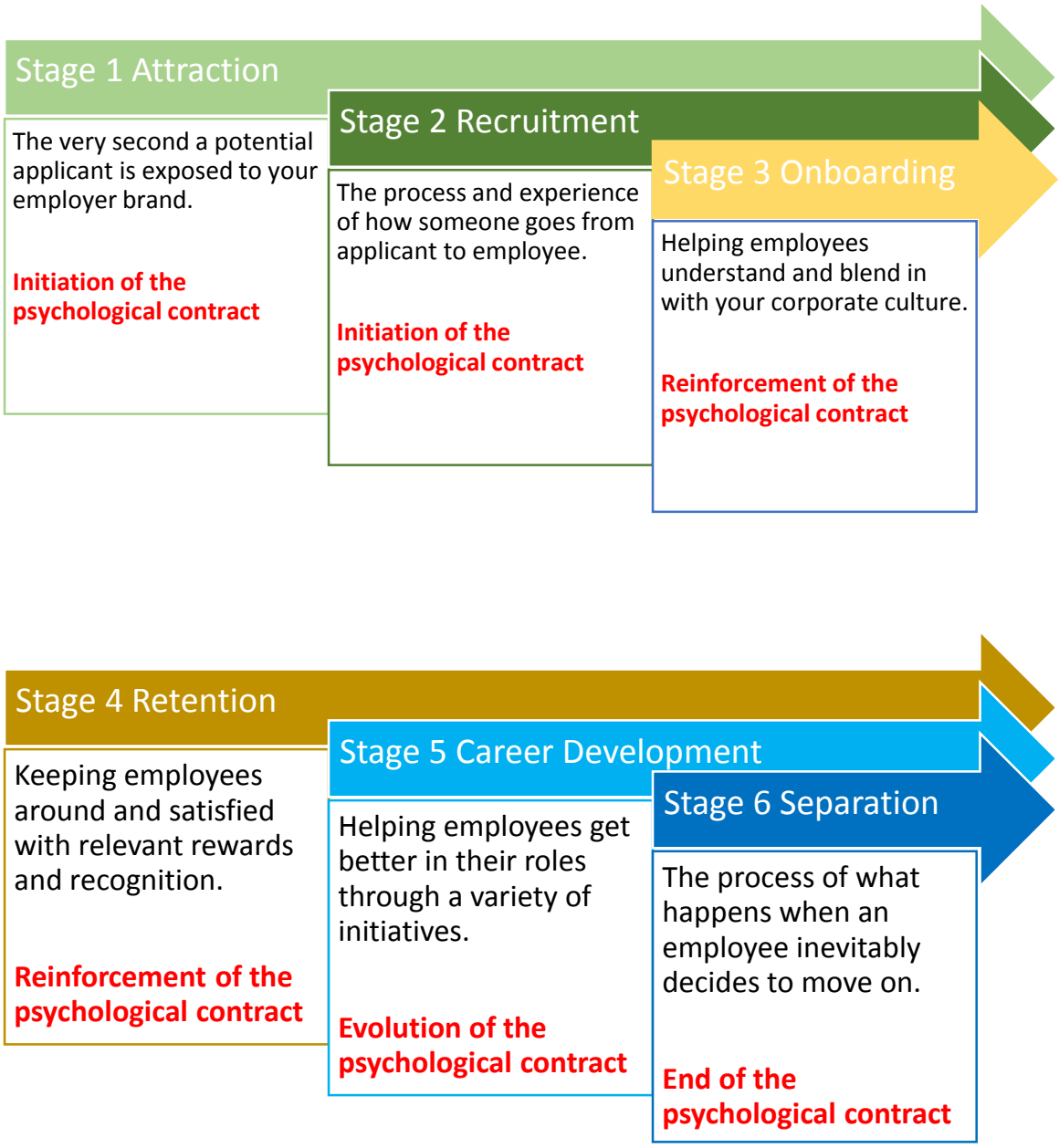


(CoP 2019)

Figure 10

There is evidence that the application of this structure is “patchy” at best, though the London Ambulance Service is acknowledged by several interviewees as providing in their opinion the best practical interpretation of the structure. It is not just a career pathway but a status orientated neo-Weberian social structure (Goldthorpe 1993 cited in Giddens 2001: 288, Ellis 2010) that is attractive to members of the paramedic profession in the UK. It creates a psychological contract (Bratton and Gold 2007; Guest and Conway 2002, Herriot et al 1997, Robinson 2006, Leach 2010 and Tan 2014) with members of the profession that there will be development in clinical skills, leadership and management, research, and education functions. Psychological contracts aim to improve staff retention so that the educational surplus can be channelled towards organisational flexibility and in turn support economic competitiveness. Yet this research has identified evidence that this psychological

contract has been breached (Kilinc and Paksoy 2018 and Collins and Beauregard 2020) for the APP group resulting in an early separation from the organisation and from the Career Life Cycle in its latter half between stages 4 and 5 (Figure 11).



Derived from Personio (2021)

Figure 11

Failure to honour the psychological contract may result in earlier separation from the organisation or ambivalence to the LMX and Leader Follower Relationship (Lee et al 2019) that impacts the opportunity to apply the educational and intellectual surplus of

the staff for the benefit of organisational flexibility and economic competitiveness as described as the desired outcome by Guest and Conway (2002) Herriot et al (1997), Robinson (2006), Leach (2010) and Tan (2014) in the examination of Human Capital Theory. It is as Farnsworth (1982) and Robinson and Rousseau (1994: 245) describe a sign of the times that employees decide it is necessary to take care of themselves which in turn are both examples that this is not a new problem.

Umwelt

"We are getting there but it is a shame that we have to leave the Ambulance Service to achieve it. As with the ECPs over a decade ago if you actually attain your master's, you might get the title of APP, but you will still just be a "glorified" FRV and will not get to use your knowledge and skills. I think we need greater integration so that the Ambulance Service is more part of the hospital as a specialist division of Urgent or Primary Care. So, we are a whole entity, not them and us and so the career progression is clear and rewarding. There is evidence that this works if you look at the London model. I maintain a bank contract, so I stay in touch with the service, but I have less and less to do with that role because IUC Advanced Practice is more stimulating, but I worry that I am losing my paramedic identity."

A "glorified FRV" to briefly explain a FRV is a Fast Response Vehicle, usually this is a car with a solo clinician that responds primarily to life threatening emergencies, often but not always the clinician is a senior grade because they should have the training and experience to cope with whatever they find at the scene, until further help arrives.

Umwelt

"Nothing "flaps" a paramedic. We are the "special forces" of the NHS, every day and from the moment we started our careers we are just "chucked" into situations with little or no warning of what the call is about."

As was discussed in the literature review the expansion of the perspective and catchment of the ambulance service in the report "Taking Healthcare to the Patient"

(DoH 2005) was an admirable intention and further supported the Emergency Care Practitioner (ECP) agenda, unfortunately it initially stimulated uncoordinated ECP schemes, as previously discussed (Mason et al. 2004, National Audit Office 2011, NHSE 2013, Liscott 2016), which were in turn a drain on physical response resources and the services that were already suffering from a lack of physical response capability that could not match demand at the time with strategic deployment of its clinicians leading to further disenchantment with the ECP role (Vorwelt) in the ambulance service (Woollard et al 2010). It would thus appear that the same is true for the APP grade of staff. The NHS as a whole and the ambulance service as the central entity to these lived experiences (of this section of the research summary) is under such pressure that the services simply have to deploy the next available resource to manage the “tsunami” of demand they face every day. This means that PPs and APPs are not always deployed to the types of calls that best fit their skill set and rather than being a specialist clinician that would be better deployed to the calls where admission avoidance could be achieved, they increasingly perceive themselves as inappropriately deployed to just the next emergency call in the queue. This damages the Leader Follower Relationship, leading to LMX ambivalence and through the early separation of employees to new career options it restricts the organisational ability to promote a positive career life cycle and generates a negative development spiral (Manzoni and Barsoux 2009).

Since the advent of the practitioner grades in the in the ambulance service there has been a steady progression of staff exercising their incumbent bargaining power (Porter 1979) and securing alternative employment with other divisions of the NHS and or via staffing agencies in the utilisation of their Neo-Liberalist free market rights (Harvey 2007). Whilst the practitioner is able to access a more fulfilling career, the ambulance service loses a resource they have spent a significant amount of money and time to develop. Replacing a paramedic is an expensive and time-consuming matter. Though as was pointed out in the research:

Mitwelt

"Perhaps the Ambulance Service and the Unis need to recruit paramedics in the volumes that they do for Nursing and Medical cohorts."

Umwelt

"In my case all that hard study I self-funded. My Ambulance Service doesn't provide the training, PPs or APPs themselves fund it but they (the ambulance service) will recognise you as that grade if you get your BSc, PGCert or MSc. You have to pay for it, you have to swap shifts and use your leave to attend the university. The ambulance service gets all the benefits but then still treats you as any other paramedic"

Indeed it would certainly help, to have a strong and steady flow of clinicians from which to recruit but the investment and commissioning in the expansion of paramedic vacancies, equipment and vehicles would need to expand reciprocally. Ambulance services have previously tried to reduce the attrition rate by introducing "education bonds" or "training contracts" which contractually require repayment of course fees or part thereof from staff members who leave before it is considered that they have provided a sufficient return on investment (Philips & Philips 2002) but the legality of this has become something of a "minefield". For example it is easy to establish a loss of return if a staff member leaves the organisation immediately the course has finished but establishing the progression of the return over months and years is difficult to gauge and so costs become troublesome to recover (Advisory, Conciliation and Arbitration Service ACAS 2021). Therefore ambulance services have found it, in some cases, more expedient to invest simply in the recruitment and retention of the basic clinician staff unit of "paramedic" as defined by the CoP (2019) for which there is minimal attrition to other sectors. And this provides a clear indication of mismatch between the career progression envisaged by the CoP and the reality of strategic deployment by the Ambulance Services resulting in a breach of the psychological contract.

Umwelt

"It would be good if we could achieve full career progression in the NHS Ambulance Service rather than having to leave. I hope one day I may be able to go back if they make a role that fits my skills and interests. Maybe we need to be even more integrated and less hospital vs ambulance. I feel we are possibly causing some of the integration issues ourselves by not just being one homogenous NHS."

The ability to return to the service seems to clearly support the London Ambulance Service pilot currently in progress to rotate APPs through Urgent Care Centres for mutually beneficial development that might negate the desire to completely leave the service. At this time and having checked with the London Ambulances Service project lead there is sadly no published data on the project.

Mitwelt

"It seems to be getting better here in London, although I have heard the difficulties discussed at national triumvirate meetings. I think because LAS has actually tried to enable APPs to function as such there is less attrition from the APP group to the wider Integrate Urgent Care. The local HR departments within the Greater London area are used to seeing APPs function as they were intended. The system is not perfect, but we are along way ahead it would seem of other services. The APP role is understood."

"I do not hold with elitism, it is nice to be good at your job, but the CoP career structure is poorly understood by grass roots clinicians, progression is also poorly understood, and it is poorly explained as the elite of the Ambulance Service hold it close to build their own empires. APP still, with the exception of LAS, does not work with the current deployment model."

"As I said London Ambulance Service is streaks ahead of other services and so APPs are understood and respected for their opinions. By deploying us as the concept originally intended, we reduce hospital admissions and facilitate a more patient centred care system. OK, because we are the Ambulance Service a lot of patients still go to hospital, but we are still having an impact. We are even seeing an improvement on the Mental Health agenda with Single Point of Access referrals that circumvent ED."

5.3.2 Misuse of the APP job title

There has for some time (Vorwelt) been evidence of the misuse of the APP job title as it first appeared in the British Paramedic Association curriculum guidance version 1 (2006), where ambulance services have promoted paramedics to these positions, not because of individual attainment of the educational standards aspired to, but due to the pressures of industrial relations and the short-lived positive effects of "ego massage" on the workforce (Gonsalves 2008) and therefore wider perception of the paramedic practitioner grades across the spectrum have become confusing to both

the ambulance service and he wider NHS and again undermines the psychological contract through the perception of a professionalised service.

Umwelt

"I want a consultant opportunity, but they are few and far between. I would love to do a PhD. If only the Ambulance Service as the primary employer for paramedics would use us as the concept of integrated urgent and emergency care sets out it could be great. When I joined the ambulance service I thought it was a job for life with that one employer, but I went as far as I can with them. It galls me that to be an APP I actually have to leave the Ambulance Service. It also galls me that they appoint APPs who have not actually done the MSc and in some cases not even the BSc."

"I had to get out. I couldn't take the enforced overtime, the lack of a breaks, the heavy lifting I'm not getting any younger, or the general abuse by the managers. The patients, I can cope with that but the constant criticism from management of the team as a whole was just toxic. There is nowhere to go with your career, Advanced Paramedic was a nice ego boost, but we were still doing the same job for the same money and conditions."

Mitwelt

"The appointing of APPs who do not hold an MSc has made mockery of the system because no one is sure what each individual is actually capable of."

It is a sad situation for the incumbents of a position that was attained by misguided Human Resource Management as the next example demonstrates.

Umwelt

"I came from the Ambulance Service about nearly 4 years ago. I was an Advanced Paramedic. But in the wider NHS they want more academic qualifications. I was very disappointed at the time and my ego was bruised by having to step down to Paramedic Practitioner, well ECP because despite the change in our structure several years ago from ECP to PP the rest of the NHS still uses the ECP title. They use NP for nurse practitioner but there is an undertone of being second rate as a paramedic ..."

If the ideal is to enable a beneficial psychological contract for both organisational and staff development, then the ambulance service needs to ensure that standards are maintained so that the interpretation of the experience and qualification is uniform. It is interesting, if not disappointing, that the internal education departments in the services have allowed this to happen, because as every educator knows; educators are the custodians of standards, without favour or affection, malice or ill-will, a clear standard is necessary to gauge attainment, confidence, competence, and compliance.

In summary of this concept, it is clear that even if it is not articulated as such in distinct terms, there is a feeling that the psychological contract created on a national scale by the CoP Career Structure (CoP 2019) is being breached by a mismatch between the academic development of the staff, and the realities of the operational pressures facing the ambulance service, which thus impact on their deployment strategies and the utilitarian ideal of at least keeping the staff happy as supported by Gill (2018).

5.3.3 A return to Competency Based Education and Training (CBET)

Staff shortages and the ever-growing demand on the ambulances services has in recent years "spurred" a resurgence (Vorwelt) to the CBET process of developing paramedics that many thought and maybe hoped had been left behind several years ago (Petter 2012). To recap the discussion in Chapter 2. Following the Millar Report (Millar 1966), in March 1971, the United Kingdom saw the first Paramedics in Europe start working out of Brighton Ambulance Station after six months of 'extended training' at the Royal Sussex Hospital (CoP 2021a) under the guidance of Prof. Douglas

Chamberlain. From this key point, professionalisation of the UK ambulance services and the Paramedic profession slowly started to take off, to list all the local projects and development processes would be irrelevant, suffice to say that my 1987 the National Health Service Training Authority (NHSTA) had the first national paramedic syllabus and the full roll out of the paramedic staff grade to the country as a whole. Thus, it is possible see that in comparison to the Nursing and Medical professions the Paramedic profession is still quite young but has developed in “leaps and bounds” to achieve parity with its colleagues in our multi-professional modern NHS. The original NHSTA (and in later guises of the National Health Service Training Directorate 1991 (NHSTD) and the Institute of Health and Care Development 1996 (IHCD)) process was one of Competency Based Education and Training (CBET) akin to the National Vocational Qualifications structure of the time. CBET represented a process of in-house education encouraged by a behaviourist approach to the demonstration of knowledge. The behaviourists’ standpoint is that the concept of knowledge developing in the mind is flawed and that what a person knows or feels is purely demonstrated by their actions, this is personal knowledge. The research of one prominent behaviourist Ryle (1973 cited in Hyland 1994: 68) discusses the application of these views in some detail and provided early if simplistic justification to for the CBET movement by “exploding the myth of intellectualist legend” that “the intelligent execution of an operation must embody two processes, one of doing and the other of theorising”. CBET took this to extremes producing training packages that seem to deny the need for propositional knowledge by adopting this research and Ryle’s earlier behaviourist opinion advocated in his book The Concept of Mind (1950) and discussed in Cohen (1983) that knowledge is purely demonstrated by action. The ambulance service in the UK was not the first group of healthcare professionals to encounter this problem. The Nursing profession in the UK had already seen issues with developing the wholly NVQ trained Healthcare Assistants through liberal university education to become nurses as reported by Gould & Carr et al (2004). Therefore, the Nursing profession was already planning its transition to Higher Education (HE) in 1987 at the time the national paramedic CBET system was in “full bloom”. Later developments of the NHSTD and IHCD education system would seek to include elements of constructivism and spiral curriculum as advocated by Bruner (1961), but this still fell short of a liberal education process. The Paramedic profession would not start its HE transition process for a further 10 years and only achieving full transition in 2015 (Petter 2012) for profession

entrants at the grade of registered paramedic. So just as the other major players in the healthcare sector were transitioning to HE, the ambulance service was stuck with a behaviourist/ constructivist style hybrid of competency-based education system that rapidly became outdated and undermined the profession in the "eyes" of its peers (Ellis 2010, McCann et al. 2013). Believing that we had fully completed our HE transition we now have the return of CBET through the First Response Emergency and Urgent Care courses (FREUC or FREC when referring to the original incarnation of the course).

Mitwelt

"I see the entry point as BSc. The FREC system is just a rehash of the IHCD CBET approach to get "bums on seats" because the ambulance service just cannot meet the demands of the system. Paramedic Practitioner through PGCert. PGDip. APP through MSc. Consultant through PhD. As per the CoP career structure."

Is there however anything wrong with the FREUC approach? The ideal for the paramedic entry point is a bachelor's degree and the course materials identify a "Top Up" course to BSc facilitate by a university will be required at the end of the FREUC system in order to attain professional registration. On review it is most definitely a CBET process with all the limitations that entails. However, as a profession we need to be honest about our own development to this point, many existing paramedics attained their degree from a "Top Up" building on their IHCD in-house award. As Ellis (2010) describes, not everyone enjoyed their schooling, and not everyone achieved success in this environment, but the value or intellect of a human being (Sternberg 1985, 1999, 2003 and 2004) is not solely defined by the educational certificates they have acquired. Teachers must remember that they are successful products of the education system but not everyone enjoyed the process as they did.

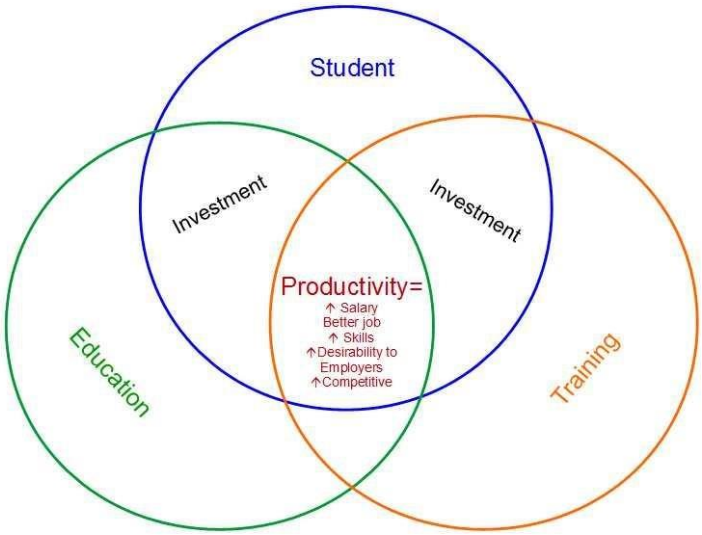


Figure 12

If we truly desire a socially, professionally, and globally mobile culture then we need to enable access to education from multiple entry points (Hursh and Henderson 2011 and Henderson 2020). The people/ the students are central to HRD and deserve a fair chance to achieve their dreams (Middlewood & Lumby 1998: 9, Fitzsimons 1999, Bratton and Gold 2007, Tan 2014 and Chen et al. 2020). However we must be cognisant that there is a risk of creating a neo-Weberian underclass of a potentially less “rounded” clinician who has been “robbed” of their ability to make wider choices as they would have achieved through liberal education and a well-developed and considered understanding of evidence-based practice (Hyland 1994 and Tarrant 2000, Ellis 2010).

Through the FREUC system we may be about to experience a reproletarianisation of the paramedic profession to a Millar or Pre-Millar certificate function (Millar 1966) of a transportation focused entity where the more basic employment unit of Paramedic is more cost effective and sufficient to meet service needs. We may see Paramedics starting in the Ambulance Service but moving to the Integrated Urgent Care Service when they wish to advance through the CoP Career Framework (2019), with an expansion of the home visiting service in an attempt to respond to the intentions of mobile healthcare and patients’ choice for care as discussed by Keogh (2013). Perhaps if the Ambulance Services wish to honour the psychological contract through the CoP Framework and continue to be the primary employer for all paramedic grades

it may be time to consider the option to evolve a 2-Tier segregated service with separate strategic goals and funding streams.

5.4 Expectations of Integrated Urgent Care

There are two clearly identifiable classifications of experiences found in relation to experiences of working in the urgent care department and these as one might have expected; experiences of clinical functioning as an individual and experiences of team functioning as the leader of the team. In relation to the experiences of their transition to working in the Integrated Urgent Care setting it is a mostly positive experience in terms of an individual functioning within the team, but this is not the case for some in the leadership function.

Umwelt

"We are popular with GPs, and I think this is due to two reasons. Firstly Paramedic Education has always been heavily Doctor driven, e.g. the Medical Model of Enquiry as the standard for the early practitioners the "Community Paramedics" remember those days? And the old LAP panels. Secondly we are generalists like the GPs. We have seen every age group from "embryo to death" from day one of our training. You do not know what the next call will be, so we have always studied everything. The doctors like this. There is no refusal to see children or mental health patients or obs and gynae because we have always seen these groups and more. Nothing "flaps" a paramedic… from the moment we started we are just "chucked" into situations with little or no warning of what the call is about, this is where we develop our tolerance of risk."

This comment on experience is accurate in its assertion of the foundations for the delivery of education in the early days of the national paramedic programme (Vorwelt) and comes from an interviewee with over thirty years of ambulance service experience whose career progressed through this process. Early education processes could be described as rudimentary due to the limitations of the CBET approach, though the intention and content was to establish a strong professional identity. Paramedics have

always been guided and controlled in their education by the medical profession (Ellis 2010, Petter 2012 and Evans et al. 2013) and this explains some of the similarities and the shared perspective between doctors and paramedics in their daily practice. Paramedics were initially controlled by the Local Ambulance Paramedic Steering Group (LAPSG or LAP Panel) that was largely made up from the Accident and Emergency Consultants from within the catchment area and overseen by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC 2003). This organisation still exists today but in a more straight forward single entity format which produces and monitors the National Clinical Practice Guidelines (JRCALC 2021). However, with the advent of state registration in 1999 through the Council for Professions Supplementary to Medicine (CPSM 1999) later to become the Health Professions Council (HPC) and thence the Health and Care Professions Council (HCPC 2021) control of the curriculum has become the role of the College of Paramedics that works with the HCPC in its role to manage the paramedic profession (HCPC 2021).

A more expansive discussion of the standards of Paramedic education and the role of the College of Paramedics and the HCPC can be found in Chapter 2. Popularity within the world of the GP for the generalist skill set is also accurate and has been described by Evans (2016) HEE (2018) and Mahtani et al. (2018). As is quoted below, APPs thus usually enjoy a High Leader Member Exchange (Restubog et al. 2010, Naidoo et al. 2010 and Scheuer et al. 2021) within their working environment and enhancing the Leader Follower Relationship (Lee 2019) with the medical profession.

Umwelt

"Once I was recruited everything was fine for a few weeks but then the fact that I see all age groups and the nurses despite having done paediatrics at in their MSc "dug their heels in" and started refusing to see children. This nearly caused a war between the GPs and paramedics on one side and the larger staff group of the nurses on the other. We eventually agreed that the nurses did not have to see children. The problem then occurs that the relationship between the GPs and Paramedics is one of a high LMX whereas the nurses then find themselves experiencing a medium to low LMX due to their identification of an inadequate skill set. I can see why this happens but is just adds to the bad feelings in industrial relations."

Umwelt

"They love the paramedics doing home visiting because let's face it that is what we do, and we see everything rather than "bleating" that we are adult nurses and do not see children."

Mitwelt

"I know a couple of people who have found friction in their teams because paramedics see everything and the GPs are quite vocal about liking this and some of the nurses, rather than stepping up to meet the challenge are just "anti-paramedic." This is very sad because we all have complimentary skills sets that make the whole team an Evidence and Values Base Practice dynamo that furthers the IUC agenda."

"At last week's team meeting paramedics were described as gung-ho in our approach, just because we do not scurry off to ask the duty GP's permission to prescribe or refer. The nurse prescribers are much more timid. This is why paramedics enjoy a high LMX with the supervision GPs, but it impacts on work relations. I think this is because in a hospital the there is always someone to ask. Paramedics at best have a crewmate of the same grade or junior or they are a solo responder on their own. There is no-one to ask. OK, there is supposed to be a support desk at control but the signal in the peaks is lousy. As far as the HCPC and Coroner are concerned it is the paramedic's head on the chopping block and so we toughen up fast and stand our ground. Besides if you have checked BNF and NICE and the local guidelines and it says you can and it is legal, just get on with it. The GPs agreed with me. I mean you can always ask them if you are unsure. In private they will admit that they like the paramedics because we are not, knocking at the door every 5 mins to run something past them or just plain dump another patient on them."

These quotes are potentially inflammatory, but it is a matter that has been heard from several quarters in recent years, and that requires open discussion of the factors that contribute to it. The problem of adult nurses refusing to treat paediatric patients has been addressed and clarified by the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC) via the Code of Conduct which in Section 13 supports nurses with their assertion by stating “work within the limits of your competence” (NMC 2018). Unfortunately in the Integrated Urgent Care setting this argument largely collapses because IUC facilities do not employ “Adult Nurses”, although adult nursing maybe where their careers started, they employ Nurse Practitioners (NP) and since the inception of the nurse practitioner programme in 1996 a nurse practitioner has been educated and thus required under Standard 4 Section 8 of the curriculum to provide a “comprehensive physical assessment of all body systems and facilitate therapeutic care across the life-span …” (RCN 2005) Therefore, it is understandably a “bone of contention” in the IUC setting for nurse practitioners to refuse to see paediatric patients. That said, the quotes are still inflammatory if not qualified with an explanation. The strength of some elements of these quotes are potentially indicative of the narrow vision of the self-righteousness of ego as discussed by Freud (1955 cited in Horowitz 1981). Because it is interesting to note that, as will be discussed later under the subject of Telephone Triage under the wider banner of Telemedicine, there are paramedics who, due to the majority of their work being Face-to-Face consultations, are finding themselves outside of their “comfort zone” and are feeling anxiety about carrying out the Telephone Triage function in the IUC environment and this is compromising their hitherto asserted, cohesive tolerance for risk. In summary this paragraph highlights the need for the key role of the 4 Pillars of Advanced Practice: clear accountable leadership, education, learning and development, evidence-based practice through research and of course sound clinical practice (NHSE 2017 and NHSS 2018) to deliver high quality healthcare. Colleagues who lack confidence or experience in a specific area of practice should be supported and educated to establish the desired level of confidence and competence as Al Gharibi and Arulappan (2020) agree. This requires that all professionals to accept the reality of Continuing Professional Development as a factor of the concept of Life-Long Learning. When it is accepted that we can all learn and improve our skills and knowledge we can begin establishing a learning culture and then beyond a learning culture we need to understand the value of our colleagues and that through mutual respect and

cooperation we build a Community of Practice (Wenger 2000) that truly achieves a gestalt social system for professional benefit and patient centred care. Then from this position, Integrated Urgent Care can build foundations as a clinical specialty in its own right.

5.4.1 Multi-professional integration

When working as the Advanced Practitioner (from any root profession e.g. Paramedic, Nurse, Physiotherapist and Pharmacist etc.) in the department and thus leading the team there have been some multi-professional integration issues that in some respects seem to hinge on clashes between professional perspectives, i.e. the very concept that the IUC programme (NHSE 2017) and the ACP framework (HEE2017) are trying the harness as a positive gestalt entity as a Community of Practice as discussed in the last section.

Umwelt

"You can say all you want about multi-professional working and codes of conduct, but I have none of the freedom my nurse colleagues have in the department."

"It sometimes feels like I am not allowed to do anything without a nurse reviewing it in that they get their instructions and then go and check with a colleague."

"We get micromanaged from a strategic level as if they do not trust use to do our jobs, middle management are more tolerant."

To apply and recap the theory as defined in Chapter 2: Integrated healthcare seeks to utilise the concept of Human Resource Management (HRM) as it developed from the initial managerialism of the early New Public Management (NMP) model. The hope is the development under HRM of packages or bundles of strategically developed interventions called High Performance Working practices (HPW) such as:

- Appropriate selection and recruitment processes
- Comprehensive induction programmes
- Sophisticated and wide coverage training
- Coherent performance management systems
- Flexibility of workforce skills
- Job variety and responsibility
- Team working
- Frequent and comprehensive communication with employees
- Use of quality improvement teams
- Harmonised terms and conditions
- Market-competitive pay
- Use of rewards related to individual and or group performance
- Policies to achieve an appropriate work/ life balance

(Robinson 2006: 61)

Bundles should be organisationally integrated so that they are mutually supportive and reduce inefficient duplication. (Robinson 2006: 34, WHO 2010, NHS 2017, HEE 2017), This essentially defines the intentions of Integrated Care across the NHS and the need for Advanced Practitioners to lead the workforce in its application. Purcell et al. (2003 cited in Robinson 2006: 61) suggest three improvements to organisational performance achieved through HPW: increased workforce skills and abilities; promoting positive attitudes thus increasing motivation; promoting autonomous discretionary behaviour or the right of managers to manage and these are still found to be relevant in contemporary studies in the healthcare arena (Braithwaite et al. 2017, Rosen et al. 2018). Furthermore Patterson et al (1997, West and Borrill et al 2002) with contemporary support from Mannion and Davies (2018) demonstrate convincing evidence that HRM is an important factor in determining competitive organisational performance and quality improvement. Detractors argue that the process covertly manipulates the public sector through prescription, inspection, and performativity. (Marginson 1997, Mercer et al 2010). However, the theory is tried and tested but the operationalisation seems to have encountered some issues, although these are not insurmountable because organisational integration has in itself been thoroughly analysed in the past decades and progression is achievable with an open mind and a willingness make high quality patient centred healthcare the priority (Handy 1993 and

1996, Checkland et al. 2018, Mannion and Davies 2018 and Hamm and Glyn-Jones 2019).

5.4.2 The APP as an Operational Leader and Manager

The next element continues on from multi-professional integration of the IUC experience for the APPs covers the Leadership and Management function of the 4 Pillars of Advanced Practice Model in which there seems to be a degree of “tension” in their application. The first element would appear to be that people have forgotten that these are two separate functions (Lunenburg 2011 and Kotter 2013). Importantly, only one of the APPs in the interview group formally holds a management position and this may be a compromising factor for “non-managers” in staff compliance with their less immediate instructions as was supported through focus group triangulation. Furthermore, there is a difference between Strategic Leadership and Operational Leadership that also needs to be understood because a common error is to only see leadership as a strategic level function (Kotter 2013: 1). As has been previous discussed at length in relation to the Leader Member Exchange (Naidoo et al. 2010, and Ellis 2013) and the Leader Follower Relationship (Lee et al. 2019) leadership is a complimentary function of the management role at all levels of the organisation. It is essential that the future strategic leaders are given the opportunity to develop and hone their leadership skills as at the same time that they develop and hone their skills as managers. It seems that there needs to be an evolution of the organisational policy that clearly established and integrates across all procedures the managerial and leadership status of Advanced Practitioners.

There are two elements to address here that are causing difficulty for the APP in the performance of their team leadership function. Firstly, APPs do not appear to be seen as a manager by the rest of the staff unless the incumbent formally holds a management role and thus it is job title in the organisation that indicates organisational power.

Umwelt

"I do not think that everyone on the team has fully grasped the seniority of the ACP role and that we in many cases provide the supervisory lead. There are still junior personnel that expect me to "scurry off" and check with a doctor. I will, when I need to but part of the function of the ACP is to relieve the doctors of some of this leadership pressure."

"There are those occasions that despite the ACP Model, the nurses feel the need to call the remote medical supervisor to check that my instructions are correct, rather than ask me to support my reasoning. Thankfully, the doctors seem to be aware of this "game" and are supportive, but it keeps happening, particularly from certain specific individuals all of whom are of a nursing background. We do not get this from the Pharmacists, Paramedics or Administration staff. In trying to be charitable, I think they are just used to asking a doctor, but they do not question the decisions of the Nurse ACPs, well not as much to my experience."

It is likely that this is an issue founded the in Weberian Bureaucracy Theory in which the manager "title" invokes a formal standard of mandatory compliance that employees innately accept, that is not exhibited when the seniority of the APP is founded on an academic status. Bureaucracy is considered by many to be inevitable and is founded on 3 elements and characterised by 6 principles.

Foundations	Characteristics
1. Official duties in terms of set regular activities. 2. Imposed rules that demonstrate managerial authority. 3. Rules that establish standard functions.	1. Task specialisation (Specialisation and Division of Labour) 2. Hierarchical layers of authority 3. Formal selection 4. Rules and requirements 5. Impersonal (Impersonality and Personal Indifference) 6. Career orientation

(derived from Mulder 2017)

Table 12

This power as seen by several authors (Handy 1993, Hardy 1996 and Mintzberg 1999 Creed 2011 Lam and Xu 2019) is a multidimensional concept. Hardy's model makes a succinct summary considering power in three dimensions. Hardy's first dimension describes the traditionally accepted view of managerial power, that of the ability to make others do what you want. The second dimension is the ability of the SMT to control the organisational politics and therefore limit the agenda for discussion to their strategic vision. The third dimension is the ability to lead cultural change. Though the SMT sets the strategy, it should not be forgotten that it is the middle managers who take the policies and make them function within their departments, who are functionally seen as leading their teams towards the organisational goal (Earley 1998 and Engle et al. 2017). There are however key differences between the perspectives of strategic managers and middle managers described by various authors, Mintzberg (1995), Hanford (1995) and Weindling (1997) Birken et al (2018). It is this focus that demonstrates the difference between strategic management and operational management and in turn strategic leadership and operational leadership as summarised in the tables below.

Strategic Management	Operational Management
Longer term	Short term to intermediate
In whole organisation terms	Concerned departmental needs
Reflective	Prompt action
Looking to use fully the whole organisational capabilities	Looking to use accessible resources
Conceptual	Concrete
Creative, breaking new ground	Ongoing, routine
More concerned with effectiveness	More concerned with efficiency
Identifying opportunities	Resolving existing problems
Constantly examining the external environment	Focusing on the internal context
Demonstrating a hands-off approach	Demonstrating a hands-on approach
With a ‘helicopter’ perspective	With an ‘on-the-ground’ perspective

Middlewood (1998: 8)

Table 13

Strategic Leadership	Operational Leadership
Define the overall vision and mission of an organisation	Ensuring that organisational processes are effectively carried out on a day-to-day basis
Develop strategies, systems, and structures to achieve the vision and mission	Monitoring performance, Clinical supervision and Addressing constraints
Create both technical and social systems that are effectively integrated, and which address the needs of both customers and employees	Ensuring that employees understand what is to be done and are provided with the authority, knowledge, and skills to do it

(American Society for Quality 2021)

Table 14

Secondly, and strongly linked the previous discussion but also to the wider roles of Human Resource Management (HRM) and Human Resource Development (HRD) is supporting staff through a cultural and operational change (Buonocore 2004, Wenger 2000, and Ellis 2013) towards a cohesive Community of Practice.

Umwelt

"I have had a nurse colleague identify to me at annual appraisal that see does not feel safe when the duty doctor is only on the end of the phone and not physically present in the department, but this may just be a matter of time and commitment from everyone to get used to the new system."

HRM requires intervention and control at three levels, organisational design, culture and human resource practices and procedures (Preedy, Glatter & Wise 2003: 6 and Bratton & Gold 2007: 4) or as other texts might describe it, team, operational and strategic levels. (Adair 2010: 71). A manager, at whatever level, who seeks to lead and contribute to organisational development and particularly in the devolved

management structures of HRM (Brewster and Larsen 2000 and Budhwar 2000 cited in Martins 2007), is a person who understands markets relevant to their position and can extract the potential of their human resources to respond to patient (customer) needs (Watson & Crossley 2001: 113). If staff are lacking confidence due to the absence of historic support structures they have been familiar with, potentially for many years, then this is a clear indication that there is a need as discussed earlier for support and education to establish the desired level of confidence and competence as supported by Lee et al. (2019) and Al Gharibi and Arulappan (2020). The historic LMX dynamic between differing cultures needs to be clearly and openly explained acknowledged for the benefit of the teams so that everyone understands the culture shock when this change: Nurses are frequently used to having senior staff nearby due to the static working environment of a hospital whereas Paramedics are used to minimal direct supervision due to the mobile nature of an ambulance. This is equally applicable to the subordinate staff member and the leader/ manager who will need to work together to establish what HRD interventions are achievable to improve team cohesion, the LMX, the Leader Follower Relationship (Lee et al. 2019) and patient experience (WHO 2010). There will undoubtedly need to be appropriate HRM support from the wider management team so that as per WHO (2010), Keogh (2013 section 5), Morrow et al. (2011) and Radhakrishna (2015), organisational learning and application can also evolve and be cascaded through an inherent learning culture in the evolution of a Community of Practice (Moskowitz et al. 1988, Wenger 2000, Laing et al. 2005, Khatri et al. 2009, Keogh 2013: 31). It is also important to identify that the APPs themselves, also undergo a cultural evolution when they enter the IUC environment as these next statements identify.

Umwelt

"APP functioning is different in the IUC compared to the Ambulance Service. Even in London, where I worked previously, where APPs are given the opportunity to work as the role was intended still perceive their role as treat and discharge at scene or transport and refer on to someone else. In the IUC it is a culture shock that as the APP (ACP) you are taking the majority of patients from assessment to discharge and even when you are referring on to another department, your liaison with the receiving unit is more detailed than simply handing the patient over to ED"

"I found I also needed to change my CPD focus because the role changes your perspective. If, you can keep on top of it the learning is quite fun, but only if you can keep on top of it. This was a struggle in my first few months and people were looking to me as a leader."

"We could however do with picking up some of the more specialist nursing knowledge. I am in awe of the dressings the DNs do. I am trying to arrange my own placement on the DNs service for some CPD."

Perhaps if everyone on the team is honest about their strengths and weaknesses the multi-professionalism can succeed and there will be a truly gestalt service as per the intentions of HEE (2017).

5.5 The role of the Human Resources Department in Multi-Professional Integration

Despite the fact that it is now over 4 years since the publication of the Integrated Urgent Care Blueprint (NHSE 2017) and the Multi-professional framework for Advanced Clinical Practice in England (HEE 2017). It would seem that organisations have focused more on the operationalisation of the patient care processes than the recognition of the multi-professional workforce. The feelings of having entered a purely nurse dominated culture that has no time to acknowledge the equal status of the other advanced practice professions were almost unanimous in the research transcripts.

Umwelt

"HR seem in my opinion unable to cope with the varied nomenclature of the evolving IUC environment. It would be useful to rationalise it, and this of course is what the HEE 2017 ACP standards are trying to do at the advanced level."

The purpose of the Multi-professional framework for Advanced Clinical Practice in England (HEE 2017) is the provision of a clear structure against which stakeholders can plan their care provision and reset the nomenclature which has, due to the ill-coordinated development of each constituent profession got a little "out of hand" in the last decade or so. As professions have evolved through the processes of Higher Education and devolved authority to practice (Brewster and Larsen 2000 and Budhwar 2000 cited in Martins 2007) in response to shortfalls in the availability of General Practitioners, a range of alternative clinicians have somewhat organically evolved to practice in the urgent care setting. There are now a range of job titles and a lack of clarity about what each is expected or regulated to provide. In the spirit of interprofessional working and respect for colleagues, supported by the standards of all the registrant bodies of the professions involved the route qualification titles of nurse, paramedic, physiotherapist, or pharmacist etc. are largely irrelevant and potentially confusing. Most professions have now taken a lead from the Royal College of Nursing (RCN) and restructured their grade to mirror the "nurse, nurse practitioner (specialist), advanced nurse practitioner and consultant nurse structure" (RCN 2007). Paramedics for example in their Curriculum Guidance now operate the "paramedic, paramedic practitioner (specialist), advanced paramedic practitioner and consultant paramedic structure" (CoP 2019). Titles for Paramedic Practitioners such as Emergency Care Practitioner or Community Paramedic have officially been defunct for over a decade (CoP 2014a) but continue as a descriptive "shorthand" in the sector and is thus indicative of a potential lack of interest in paying due respect to colleagues. The title Emergency Care Practitioner (ECP) also causes further confusion because whilst is it used at this time to identify a practitioner whose root profession is a paramedic, they are not always paramedics, with nurses also being in the role from the early days of the introduction (Woollard 2007, CoP 2014). Next, there is the

educational clash between structures that developed a few decades apart; it is possible to have attained an advanced nurse practitioner role with bachelor's degree (RCN 2007), whereas in the paramedic structure an advanced paramedic practitioner requires a master's degree (CoP 2014). NHS England and Health Education England now recognise the shared skill sets of advanced practitioners and modern integrated processes of interprofessional learning through the advanced clinical practice awards now available at master's degree from a number of universities. This is clearly a step away from the root qualification role descriptors of the past, and a welcome simplification. The professions and their registering bodies have worked hard to restructure and indicate parity and equivalency between individual clinicians, but the Human Resource and Recruitment Departments still fail the to modify their standards, to the detriment of the recruitment and ongoing employment experience as these further experiences support:

Umwelt

"Neither HR nor Recruitment had any idea as how to classify an APP. They graded me as an NP and then ANP. When I came to IUC I was at first an NP, then it became ECP despite this being a defunct title and PP would be the correct title and when I completed my master's I became an ANP – well eventually, after they got their head around Masters. I took to wearing a CoP pin badge as openly as I could, so it was clear I was not trying to usurp a protected title and pretend to be a registered nurse. What also really annoys me is that I am still classed as an ANP, there is no ACP contract yet."

"Being referred to as Nurse is annoying. Not that there is anything wrong with nurses, but I have a sense of "esprit de corps", I worked hard to be a paramedic and we have different and complimentary skill sets that should be respected."

"I was recruited to the home visiting service, which is clearly a paramedic type role, but I still had to explain all my qualifications because they did not fit the nursing model person specification that the recruitment team and CCG were using. The recruitment team were clearly not clinicians and did not understand the differences and the clinical managers who recruited me were not educators so they could not interpret the content of my university transcripts and the university from which I got my MSc did not call it MSc ACP but MSc Advanced Clinical Care. This meant that the recruitment team who rigidly followed the person spec. initially rejected my certificates."

As was reviewed in Chapter 2 the difference between HRM and the traditional personnel management perspective is more than just a matter of semantics. Traditional personnel management was based largely on legally negotiated and instituted contracts – “you do this work, for this salary”. HRM led by the Human Resources Department as Hendry and Pettigrew (1990: 36 cited in Bratton and Gold 2007: 29) state: is firstly, at least in theory, integrated into the strategic development of the organisation and second it emphasises the establishment of a psychological contract with the employees to work towards mutually beneficial targets. Thirdly it emphasises the need for education in the workplace and fourthly the motivation of the individual to achieve personal and organisational goals. It is important to employees that they are made to feel welcome and that they have a place and a respected function within the workforce (Saylor Academy 2020). One could say this is a feeling of belonging (Zribi and Souai 2013 and Heffernan and Rochford 2017), which will augment the psychological contract with their employer and enhance their motivation to achieve both their personal and organisational goals when the employee feels that they have a clear place in the team. Failure of the organisation to understand their own workforce will undermine multi-professionalism and negatively impact retention. Then there is this perspective as a final thought for this section.

Folgewelt

“In the future it would be nice to see Paramedic starting their careers with direct entry to a specialty such as Primary Care or IUC and not have to necessarily go in the Ambulance Service. Maybe we do not need separate professional groups, maybe we just need a generic healthcare professional with then a specialisation. Maybe we should all be just nurse or doctor.”

However, examination of this suggestion is beyond the remit of this study but would make a fascinating basis for future studies in the HRM field.

5.6 Options for Development

The discussion in this final section has been reserved for the experiences of Umwelt and Mitwelt that indicate potentials in the future realm of Folgewelt for improvement and development of the IUC role for all advanced practitioners. It is clear that the APP group want to progress positively and as one would expect from a leadership cohort there have been some suggestion as to the beneficial evolution of the role of advanced practice across all root professions. It is indicative of the organic desire for gregarious cohesion common to most human beings.

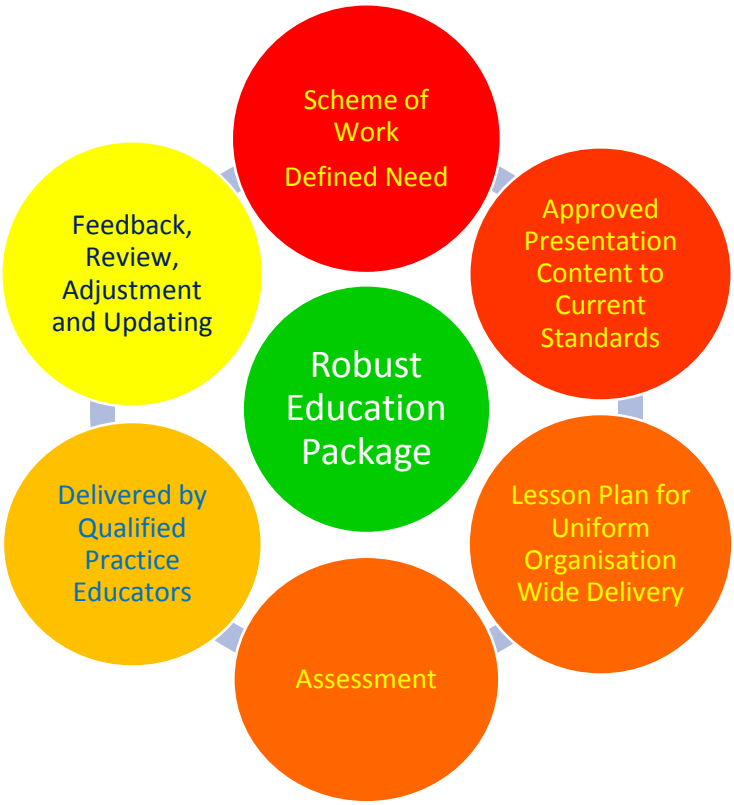
5.6.1 Understanding

Folgewelt

"We accept each other but is this truly interprofessional working – I think we have a long way to go in some areas to be able to say this has been fully achieved. I would like to set up post qualification CPD placements within the whole NHS services structure so when the pressure is off from the requirements of portfolio and assignment completion one can relax and just appreciate one's colleagues. Each year we should have 5 days exchange between departments and services as supernumerary observers to listen to watch and reflect on how we can help each other."

This person has evidently grasped the supportive intentions of the education element of the 4 Pillars of Advanced Clinical Practice. This is the need to bring cohesive progression across the team for mutual benefit of the psychological contract and values-based patient centred practice. As previously discussed in Chapter 2, education awareness is essential not only to manage one's own educational development but also to contribute the learning experiences of the workforce that one leads. Thereby creating a learning culture, that takes ownership of errors, learns from them, and improves, and avoids the stigma of blame culture (Moskowitz et al. 1988, Eysenck 1993, Marsick and Watkins 2003, Laing et al. 2005, Khatri et al. 2009, Keogh 2013: 31 and Radhakrishna 2015) and from a learning culture to an inclusive, nurturing

community of practice (Wenger 2000) as mature clinical specialty. Implementation of such a scheme would need careful planning and is likely to be diluted from the original idea as is common to many educational programmes but it is most definitely an interesting concept. In order to bring such a course to “market” would require several sequential elements, starting with a clear scheme of work to act as part of a business proposal as per the *Spiral of Robust Education* outlined in the figure below.



The Spiral of Robust Education

(Ellis 2021. Totally plc. Urgent Care Division)

Figure 8

5.6.2 Telephone Triage

Lastly in this chapter comes the issue of Telephone Triage, also known more widely as Telemedicine (WHO 2010a) which was always a major element of the IUC Blueprint (NHSE 2017) and again referring to the discussion of theory and policy in Chapter 2: The policy established the IUC Clinical Assessment Service (IUC CAS) to improve the provision of care by NHS 111 to deliver a “Consult and Complete” model by increasing

the number of calls that were responded to by a clinician and completed without the need for face-to-face consultation where appropriate (NHSE 2017: 1.3). Analysis had shown that more than 50% of calls to the 111 service could be completed in this way. This also reflects similar finding some 7 years early as reported by the World Health Organisation in their report on the Telemedicine and its benefits as an international concept (WHO 2010a) as this next quote portrays.

"Telemedicine holds great potential for reducing the variability of diagnoses as well as improving clinical management and delivery of health care services worldwide by enhancing access, quality, efficiency, and cost-effectiveness. In particular, telemedicine can aid communities traditionally underserved – those in remote or rural areas with few health services and staff – because it overcomes distance and time barriers between health-care providers and patients." (WHO 2010a: 11)

This is reflected in the Advanced Clinical Practitioner framework as a facet of advanced practice (HEE 2017). However, relevant to clinical practice via a telephony system, it was noted in section 5.8.4. (NHSE 2017) that there should be careful consideration and support for the development of telephone consultation skills and the subsequent mental health of the clinicians. This was a wise concept to include, as it has been well established by many authors including most notably Whitten and Love (2005), Kruse et al. (2017), Mann et al (2020) and Alkureishi et al. (2021) that the change in patient/ clinician dynamic, the challenges of physical examination or lack thereof, workflows managed by performance-based targets and the pressure to meet these, and overall burnout in the attempt to provide a level of care that the individual clinician considers to be safe and helpful are major factors in staff recruitment, retention and wellbeing. Again the WHO study of 2010 also identified function and sustainability issues:

"Despite its promise, telemedicine applications have achieved varying levels of success. In both industrialized and developing countries, telemedicine has yet to be consistently employed in the health care system to deliver routine services, and few pilot projects have been able to sustain themselves once initial seed funding has ended. Several routinely cited challenges account for the lack of longevity in many

telemedicine endeavours … Legal considerations … Technology … Professional development … data storage." (WHO 2010a: 11)

However, by 2017 the IUC Blueprint (NHSE 2017) was an earnest attempt by the NHS to facilitate a sustainable programme that responds to the modern "Metaverse" environment on the cusp of which the world currently sits (Snider and Molina 2021), that at the time of the WHO report was barely perceptible to the "average" person. The technologies and accepted practices and legal boundaries are now present to make a telemedicine truly viable. Increased impetus was then found from the advent of the SARS CoV2/ COVID 19 Pandemic where practitioners were required to function across the spectrum of face-to-face care and remotely through supervisory roles and telemedicine provision of the 111 service (Stokel-Walker 2020, Bashshur 2020, and Mehrotra et al. 2021). This of course is fantastic, however, there is one major element that is lacking; most senior clinicians are used to predominantly face-to-face patient assessments and there is very little formal education available to aid the development of confidence and competence (Dreyfus & Dreyfus 1986) in the remote assessment role.

Umwelt

"One new system, I need to work on, which has become all the more real since COVID is telephone triage. Honestly, I hate it! I do not feel confident with telephone or video calls, but it is part of my role to at least be able to carry out the Senior Clinician Function. There should a separate specialty and university PGCert rather than a 3-hour online course and then thrown in the deep end! I like to see people, face to face. I do think the telephone consultation system, whilst it has a place in modern healthcare it has gone too far. In my practice, I regularly pick up the pieces of a patient who has an obvious condition if only they were seen face to face but has been repeatedly misdiagnosed over the telephone."

"Plus, telephone call centre work is just boring! And I can only type with 2 fingers!"

"We get forced by our employer to do the phones and then all we get is criticism for not being very good at it. Not, once did we get any training. I have resigned, I am just working my notice."

Patients were and are still encouraged to adopt a "talk before you walk" policy so as to enable triage of the patient to the appropriate care provider, rather than just walking in to the ED as had become somewhat of a national standard when immediate primary care options were not available, and which was a clear contributing factor to the overloaded A&E system (the Guardian Newspaper 2017). This of course puts telemedicine clinicians in the "thick" of the first contact patient management process, making their health and wellbeing of paramount importance as well as simply being a legal requirement of employers as defined in primary legislation, the Health and Safety at Work Act 1974 (Health and Safety Executive (HSE) 1974).

Another documented source of stress in the telemedicine workforce, and particularly for those working remotely from the geographic location of the patient is the interoperability of patient records, clinical pathway awareness and electronic prescribing (NHSE 2017: section 5.14). The interoperability, which was a clear

concern for the WHO in 2010, is despite the advances in technology still an issue. Interoperability of services and the ability to provide remote telephone consultations are supposed to be enabled by the integration of electronic patient records and appointment booking. The provider is required to adhere to the ISO 9001 Quality Management Standards, the ISO 27001 Information Security Standards, and the ISO 22301 Business Continuity Standards (section 6.2 of NHSE 2017, International Organisation for Standardisation (2021)) as part of their statutory duties. However, these make little difference to the current presenting picture, as was discussed previously due to the neo-liberalist quasi-markets of the NHS (Harvey 2007) and the ability to tender locally for the provision of electronic patient record and management systems the process is still rather fragmented as described by Porter et al. (2020). Phasing out and phasing in electronic patient record systems will be a protracted task, though it is pleasing to see that National Health Service Digital (NHSD 2020) offers some guidance on the resolution of the matter although progression to date is quite slow.

Next is a feeling innate to most healthcare professionals, the fear of letting the patient down, of doing less than ones best and then in turn ending up under investigation and potential sanction from the registering body the HCPC is a further stressor on the workforce.

Umwelt

"I hate telephone triage, it bores me to death, plus I cannot touch type, I get eye strain and accommodation issues staring at screens for hours on end. I lose sleep over worrying that I might "short-change" someone over the phone and not achieve my best. I worry I will end up in front the HCPC. We all know colleagues who have found themselves on the wrong side of the HCPC, they don't care, they just leave them "hanging" for months, sometimes years before they process the case."

"We all have strengths and weaknesses to be fair. We make a lot about seeing paediatrics. However, we are just as bad when it comes to refusing to do phones although in this case we were never trained for phones and as paramedics have always done face to face care. Management is very happy to chastise us for not being good at it, despite the fact we were forced to do it without any training at all. It really worries me that I will end up in front the HCPC for an error my boss forced me into. I did not go into this career to treat people to any standard less than my best, and telephone triage is less than my best."

"We are being forced to take on telephone triage. I am OK with it; I touch type and can type and listen, so I have more time to think clearly about what to do for the patient and feel safe in doing so. I know several 2-finger typists who are anxious even depressed about the enforced telephone triage work. I mean we only got a 3-hour (with 2 long coffee breaks included) training session on the NHSD Pathways Senior Clinician Module. They worry about the patients and cannot switch off. There need to be more specialist training on this and very definitely typing skill development or template development to improve the thinking time when we are all pressured to take 6 calls per hour."

It is a significant concern that in a demonstration of a McGregor's X style management (Middlewood and Lumby 1998) as discussed in this document in Chapter 2 Section 2.11, people are being forced into clinical practice with which they are not comfortable and as the second quote identifies every profession has its strengths and weaknesses. The codes of conduct for all health professions in the UK state that one should work within the limits of one's qualification (e.g. the previous discussion of the Adult Nurses (RCN 2005)) but Telemedicine is a "retrofitted" function that was not and is still not covered in the general education of practitioners. Yes, there are short courses e.g. the NHS Pathways Course run by NHSD, but this is still highly algorithm based and provision of the course is "patchy" amongst senior clinicians. As stated previously the key to positive and progressive evolution is rooted in education. Colleagues who lack confidence or experience in a specific area of practice should be supported and educated to establish the desired level of confidence and competence as supported by Al Gharibi and Arulappan (2020). Building on this last discussion point, it has been suggested that not only can local education support the immediate needs of the workforce, including but in no way limited to APPs but that HE and the world of academia could further the depth of understanding of the entire subject.

Folgewelt

"I think 111 should have its own specialty in terms of academic pathway through the BSc and MSc system. All ACPs should be capable of the Senior Clinical Module but some of us could be highly specialised."

"We could do with a formal Telephone Triage module as part of the ACP MSc because while I hate working on telephones, there are some that are good at it. I have been trying to reflect on my frustrations and understand. Perhaps if there was a medical specialty of remote consultations with an academically accredited course supporting it and enabling research into the wider subject, we would improve the system. Right now, it is a disaster. I mean how many 85-year-olds do you know who can comfortably use a smartphone to take a picture of their rash. I'm 46 and I can barely take a selfie."

"As I have just discussed if telephone triage is the future, then the future needs a clear and academically certificated programme looking at not just the skills of the process but the law, ethics, and perceptual psychology of the subject."

If placed in the hands academia there are significant opportunities for the furtherance of Telemedicine in the UK as a clear clinical specialisation that would enable deep examination and research of the subject in its multifaceted phenomena, rather than just its current potentially narrow-perspective presentation. For example from a technological perspective there is Ikram et al. (2020) writing in the Harvard Business Review who provide an insightful set of 4 strategies to enable better utilisation of telemedicine by the elderly population. Or from a social perspective there is Fechina et al. (2022) that examined the contribution of telemedicine to sustainable social development, and this too is well worth reading. The studies are out there but there needs to be more cohesion to expand the subject of telemedicine as an accepted specialist subject area and ensure that the learning is disseminated from the "halls of academia" to the wider health professions in a light and accessible format. A Telemedicine specialist role may then enable the national infrastructure established by the IUC CAS Blueprint to function as intended and in keeping with the WHO (2010a) desire for formal structure. Clinicians and registering bodies such as the GMC, NMC

and HCPC would have a far better understanding of what is safe for both patient and clinician and operationally achievable, which would encourage deeper respect for the field in a multiprofessional environment and further enhance an inclusive community of practice of confident and competent professionals.

5.7 Summary of Chapter 5

This chapter has presented the key themes extrapolated from the interview transcripts of the lived experiences of the APPs in their progression to the emerging specialty of Integrated Urgent Care. Comment has been offered in explanation and clarification of the following themes and their sub-themes:

1) Social Group Opinion
2) Expectations of the Ambulance Service
3) Expectations of Integrated Urgent Care
4) The role of the Human Resources Department in Professional Integration
5) Options for Development

Chapter 6 - Conclusions

6.1 Introduction

In this final chapter we shall return to the research question and summarise the project in its 5 preceding chapters. After which conclusions and recommendation for the evolution of Advanced Paramedic Practice and to some extent the wider Advanced Clinical Practice occupational group shall be offered. This chapter will also identify opportunities for further research, and in doing so acknowledge the limitation of this study of just one facet of the subject area.

The research question was:

What are the lived experiences of Advanced Paramedic Practitioners working in the emerging specialty of Integrated Urgent Care?

6.2 Precis of previous chapters

6.2.1 Chapter 1

Chapter 1 facilitated an overview of the research question and its relevance as a viable project with the ability to impact positively on several developmentally inductive outcomes. It has set foundations upon which the following chapters were based that greatly expand on the terms of methodology and methods, supporting literature and professional application.

As with other professions in both the healthcare and the community, Paramedics have traditionally established and defined roles within the wider scope of the profession. These are generally stated as Clinical Practice, Education, Leadership and Management, and Research (College of Paramedics (CoP) 2014) and Health Education England (HEE) 2017) although as with many professions as they develop, engagement in research is the newest element: “Paramedic” itself, is a young profession in the wider NHS as it only truly appeared as a national qualification standard in 1987, though it should be acknowledged that there were pilot schemes as far back as the mid-1970s (Newton 2011).

The role of the Advanced Paramedic Practitioner was expected to be a key element in the provision of the enhanced “mobile urgent treatment services” and prehospital clinical leadership as described in the Keogh Review (Department of Health 2013a: 8), supported in turn by Evans et al. (2013) the College of Paramedics Curriculum (2014a). However, since the HEE (2017) Multi-Professional Framework for Advanced Clinical Practice this has evolved into paramedics bringing their skill set away from their traditional community-based working environment to other clinical settings. An Advanced Paramedic Practitioner (APP) was defined by the College of Paramedic Career Framework (2014b) as; an experienced Paramedic Practitioner, educated to MSc and fulfilling a senior role in Education, Research, Management or Clinical Practice. It is not simply a paramedic with dual specialisation. In Chapter 2 the reader will find a substantial discussion of the evolution of the paramedic role as it is seen today in the UK. There is particular discussion however throughout the study, commencing with Chapter 1 of the Keogh Review (DoH 2013a) which identified the strategic advantage to utilising and developing the NHS Ambulance Service to facilitate mobile urgent care and admission avoidance provision. The Ambulance Service already had basic practitioner grades working towards this ideal (Minney 2007). However, for involvement of Advanced Paramedic Practitioners in patient care to become the norm for all areas, the Ambulance Service still had and indeed still has to make significant changes to their service delivery strategy. But, before these changes could become a national standard of service provision the programme was further complicated by the Integrated Urgent Care Service Specification (NHSE 2017) the Multi-professional Framework for Advanced Clinical Practice in England (HEE 2017) and the Independent Prescribing legislation changes of 1st April 2018 authorising paramedics working in advanced practice to become independent prescribers (CoP 2021). These latest advances vastly increased the scope of career pathways for this professional group. Therefore, this study aimed add to the fundamental body of knowledge for this emerging role and contribute to:

1 The research-based knowledge of the lived experiences of Advanced Paramedic Practitioners being enhanced.

2 Enhancing the professional standards of paramedic education and paramedics in practice. This will then impact positively on

3 The patient experience of alternative, unscheduled and emergency care functioning within a multidisciplinary team in the local community. This will then enhance

4 Patient safety and patient confidence in adaptive, tailored care planning.

5 Promoting "esprit de corps" within the multidisciplinary NHS structure and the individual clinicians as their confidence in their own autonomous practice develops in a supportive environment.

Thus Chapter 1, gives a clear perspective on the intentions of and hopes for the usefulness of the study.

6.2.2 Chapter 2

This chapter covered the review literature considered the relevant knowledge so far for the profession and it wider relationship with the NHS in 4 elements, the professionalisation of the ambulance service, the underpinning structures of the National Health Service business, management and leadership culture, evolution of the ambulance service practitioner grades and the current policy governing the provision of Integrated Urgent Care in which the subject group of APPs for the research operate. This therefore form a solid structure from which to analyse the data and offer discussion and conclusions.

The inception in 1948 the NHS has always come under scrutiny and pressure from successive governments keen to demonstrate to the electorate that taxpayers' money is being spent wisely. As the NHS entered its 4th decade the Conservative Government of 1979 embarked on a number of restructuring exercises to "improve" or demonstrate effective patient care which had direct impact on clinical education and the evolution of clinical specialisms. For example, the White Papers Patients First (Department of Health and Social Services 1979) and The NHS Management Enquiry (Department of Health and Social Services 1983). These were the heralds to the introduction of New Public Management (NPM) as it applies to the NHS and supports the functioning of both the employing organisations of the service and as would be seen in this research the career mobility of the employees.

The chapter covers several major themes that were echoed in the research findings the first of which was investment in the organisation's human capital. If we refer to Karl Marx as described in the chapter .

In capitalist industry, Marx (cited in Abbott and Wallace 1997: 54) discusses the concept that a labour force sells its skills to the employer and these skills have a defined value identified by the wages paid to the labour force. A labour force educated beyond the immediate needs of the employer and thus paid for only a proportion of their true value creates a surplus value identified as profit. In the public sector surplus value rather than producing direct profit creates organisational flexibility.

Capitalist theory of Human Capital then inductively progresses to a discussion of the psychological contract because a concern for the employer is that enhanced education brings greater occupational mobility and thus the possibility of then losing staff to a competitor and therefore how to generate employee loyalty (Bratton and Gold 2007; Guest and Conway 2002, Herriot et al 1997, Robinson 2006, Leach 2010 and Tan 2014). The text then discusses the psychological contract and how it contributes to staff retention so that the educational surplus can be channelled towards organisational flexibility and in turn support economic competitiveness. Research by Guest (1992) demonstrates that loyal employees to a point can drive down operational costs.

"Psychological contracts are an implicit, but largely unwritten contractual understanding between employer and employee concerning their respective role relationship and mutual obligations towards one another that are continually negotiated, test and affirmed within the workplace". (Leach 2010: 331)

Employees with identical legal contracts might have very different perceptions of their psychological contract with their manager. Thus, a manager needs to bear this in mind during a decision-making process and ensure clear communication to reduce the risk of perceptual breaches of psychological contracts despite operating within legal contractual boundaries. (Guest and Conway 2002: 35 cited in Bratton and Gold 2007: 15).

The psychological contract discussion then moves on to the quality of relationships between line managers and their personnel has been analysed by several authors, Dansereau et al. (1975), Graen and Uhl-Bien (1995), Maslyn and Uhl-Bien (2001) in the development of the Leader Member Exchange (LMX) theory.

"Neo-liberalism is a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade". (Harvey 2007: 2)

Moving on from psychological contracts and staff relations mediated through the Leader Member Exchange, the chapter highlight the impact a loyal and productive workforce can then have on the High-Performance Working practices desired by New Public Management (Pollitt 1993, Clarke, and Newman 1997, Trowler 1998). And then progressed on to discuss the structures of strategic and operation management and leadership and ending that section in a discussion of how Weberian Bureaucracy Theory (Mulder 2017) underpins the modern capitalist management processes and establishes the occupation processes, procedure and the authority of managers that are common place in complex organisations such as the NHS.

Having established the business structures of the NHS of which the ambulance service is a part and in which APPs function there was a discussion of the post Millar Report (Millar 1966) evolution of Paramedic education. As with many occupations the education of ambulance service personnel was a process of in-house education in a Competency Based Education and Training system based heavily on behaviouralist school of education theory (Ryle 1973 cited in Hyland 1994: 68, Ellis 2010, McCann et al. 2013). There is discussion of progression to Higher Education (HE) at the end of the 1990s and leading to almost complete HE for paramedic by 2015 (Petter 2012). The next element was the discussion of the progression of services available via the NHS ambulance services and the career structure of the College of Paramedics (CoP 2006, 2014, 2019) based upon the intended re-evaluation of the paramedic function as described on the "landmark" Bradley report (DoH 2005). Then finally there was an in-depth review of the NHS reports and policies (Keogh 2013, 2013a, NHSE 2017 and

HEE 2017) that define the role of the Advanced Clinical Practitioner of which the Advanced Paramedic Practitioner is a sub group.

6.2.3 Chapter 3 summary

In this chapter description, an analysis was offered as to the paradigms and methodologies that are applicable to research in the social sciences. Arguments were provided thus, for and against the option with the final intention being the use of the Interpretivist paradigm and the Schutzian social phenomenology methodology. In the next chapter these will be utilised in the synthesis of the specific methodology to the research project. In order to achieve sound comprehension of the research finding it was necessary to explain the underpinning philosophical perspective, so as to be able understand the impact of the findings and the intention of the conclusions (Hartman 1997). The purpose of this chapter is to explain the selection of the interpretivist paradigm and the Schutzian Social Phenomenological methodology and in turn the reasoned rejection of alternative paradigms. The chapter defined and gave examples of the application of the terms, Paradigms, Ontology, Epistemology and Human Factors.

Following the introduction and explanation of fundamental terminology there followed a discussion of and argument for and against the rejection of Positivism, Post Positivism and Critical Theory and adoption of the Interpretivist method. From here the chapter moved on to review the methodologies and in keeping with the chapter structure, arguments for rejection of Case studies, Action research, Ethnography, and the adoption of Phenomenology as the methodology were provided. There then followed a brief history of phenomenology as it related the general study of the subject and the selection of Schutzian Social Phenomenology and in turn an explanation of the four Schutzian realms of Vorwelt, Umwelt, Mitwelt and Folgewelt, list here in temporal function order (Emmanuel, 2012). As by this point the reader will expect, a further reductive explanation was offered for the data collection options with arguments for the rejection of Questionnaires, Surveys, Observations, and the eventual adoption of a combined approach of Interviews supported by triangulation for validity and reliability by Focus Groups. The last element discussed in this chapter was a proposed Schutzian analysis tool extrapolated from Kleiman (2004), Giorgi (2009)

Charlick et al. (2016) and supported by a discussion of options for the presentation of data and the key ethical structures and rules the researcher is wise to follow.

6.2.4 Chapter 4

This chapter followed inductively from Chapter 3 in utilisation of the theory already presented to explain the actual process of the research project. As an expansion of the initial research proposal this chapter started with a statement of the phenomenological intentions of the study followed by a 4-part structure explain the progression of the project:

Part 1 reviews the intentions of recruitment of research candidates and links to the appendices in which can be found the advertising, information, and consent form materials.

Part 2 discusses the process of unstructured interviews and offers both acknowledgement of and options to overcome potential difficulties that may occur in the research process, beyond those that would have already been addressed in the information, recruitment, and consent phase of Part 1.

Part 3 explains the process of reductive thematic data analysis.

Part 4 explains the project timeline.

After these elements were discussed the chapter them explains the Population of the research subjects and is explicit in the demonstration of inclusion and exclusion criteria.

The chapter ended with a general review of the research intentions by drawing three elements: Firstly it was useful to revisit the early development of practitioner grades within the paramedic staff group as described in DoH 2005, Minney 2007, Woollard 2009. Secondly there needs to be a brief revisitation of the Keogh Review (DoH 2013a) in the post Francis Review era of Values Based Practice (Francis 2013). Thirdly and finally there was a brief signposting exercise to the policies that set the current environment for Advanced Paramedic Practice; the Integrated Urgent Care Blueprint

(NHSE 2017) and the Multi-professional framework for Advanced Clinical Practice in England (HEE 2017).

The study examined the lived experiences of those clinicians working in the APP role to establish a deep and rich description of their actual function beyond that of simply what role is intended to be.

6.2.5 Chapter 5

This chapter has presented the key themes extrapolated from the interview transcripts of the lived experiences of the APPs in their progression to the emerging specialty of Integrated Urgent Care. Comment has been offered in explanation and clarification of the following themes and their sub-themes:

1) Social Group Opinion
2) Expectations of the Ambulance Service
3) Expectations of Integrated Urgent Care
4) The role of the Human Resources Department in Professional Integration
5) Options for Development

6.3 Strengths and limitations of the research study

Whilst with any humanistic philosophy the interpretivist paradigm in subjective and thus is prone to an individual's strength of opinion because personal opinion will never be exact (Hickman 2015), but it is systematic which enables reflection on and filtering of extremis (Saunders et al. 2012) so that a reliable picture can be established and taken forward to triangulation. Validity and Reliability were attained as far as possible by subjecting the finds from the interview transcripts to focus group discussion and consensus of truth in epistemological terms of propositional knowledge (Gipps 1994 cited in Butterworth 2001, Plummer 2017, Ichikawa 2017, and Spiers et al. 2018). The multidisciplinary functioning of the NHS is in fact a social structure in a Neo-Weberian model (Goldthorpe 1993 cited in Giddens 2001: 288, Ellis 2010). It is appropriate to study the lived experiences of the participants from a social perspective and therefore the analysis framework was structured on the Schutzian Social Phenomenological Model taking guidance. The analysis was detailed and robust, although very time

consuming, as was the transcription of the interview materials, taking over 90 hours of careful listening, pausing, and typing. Dictation transcribing software was tried but it was found to be highly inaccurate in transcribing conversational recordings, though it worked well in early trials of single voice to written word transcription.

6.4 Recommendations

There are some clear areas from the research, that were discussed in Chapter 5 that ought to be considered by the profession and those that control the evolution of the Integrated Urgent Care specialist. Some of the findings as very specific to the Advanced Paramedic Practitioner who has transitioned to the Integrated Urgent Care sector, others are more generalised. These will be brought to wider attention through a number of planned article publications with the intent of supporting and initiating strategic, professional, and academic discussion.

6.4.1 Recommendation 1, the College of Paramedics should work more closely with the ambulances services of the UK to ensure that their ideological concept of a career framework (CoP 2019) is functionally achieved, within the services so that the psychological contract it portrays is upheld. It appears that just as the individual professions of the NHS have become somewhat muddled through the organic expansion of roles so has the Ambulance Service function. It is time for another “Bradley Report”, a review of the structure of the Ambulance Service and what professionals and the wider population want from the service. If there is disassociation between the CoP and the NHS Ambulance Services then perhaps we need to establish a series of independent stratified mobile healthcare services under the overarching Ambulance banner. Yes, this would be a step back to “silo functioning” (Terrainfirma 2017) but it would give “breathing space” to recoordinate the strategic perspective. This would enable greater focused and directed central funding and allow the constituent services to concentrate their resource deployment strategies on narrower scope that will inform the Human Resource/ Recruitment and Retention plan and adherence to psychological contracts and the organisational goal. Also the College of Paramedics needs to expand its perspective of the Paramedic profession so that ambulance service work is only one facet of the employment opportunities available and that perhaps paramedic identity should evolve away from synonymity with the word ambulance.

6.4.2 Recommendation 2, there is evidently a lack of understanding of the skill sets that each profession brings to the gestalt entity of the Integrated Urgent Care centre. There need to be the development of internal education packages that evolve the concept of interprofessional working. See the perspective of other profession through integrated learning in HE is now common place for junior clinicians, but the concepts may have been missed by an older generation and could bring a gentleness to the appreciation of other in the working environment. This would then potentially defuse the ego centric perspective (Freud 1955 cited in Horowitz 1981) and enable values-based multiprofessional development of the organisation (WHO 2010) and the desired High Performance Working practices described in Robinson (2006: 61) of which sophisticated wide coverage training is a part. Clinical specialities need to see beyond the traditional learning culture “mantra” to achieve a deeper and richer evolution of the Community of Practice (Wenger 2000), that will encourage a cohesive team spirit – Esprit de Corps.

6.4.3 Recommendation 3 is that employers need to decide on the bureaucratic authority (Weber 1905) of the advanced practitioner in their daily function, so that the managerial and leadership aspects of the as part of the 4 Pillars of Advanced Practice (HEE 2017) are understood by everyone. In short, advanced practitioners of whatever professional background, are members of the management team with a clear management function and thus authority. This is not a concept of bureaucratic oppression but a necessary policy adjustment to ensure that the status of the Advance Practitioner is clearly supported for both the incumbents of the position and the confidence of their subordinate personnel.

6.4.4 Recommendation 4a Human Resource and Recruitment Departments need to engage with education and clinical colleagues to understand the roles to which they are recruiting so that multiprofessional working has a solid foundation organisational learning. This in turn will ensure the nomenclature of the organisation is welcoming and inclusive of everyone in the professions that make up the Integrated Urgent Care team as per the 6 stages of a Career Lifecycle (Personio 2021).

6.4.4.1 Recommendation 4b This research has clearly shown, as has been discussed at length that the is a breach of the psychological contract between

the CoP and the NHS Ambulance Services. Whilst this is a sad situation for the Ambulance Services, it is a very clear recruitment opportunity for the IUC Sector. It has already been seen that APPs as transitioning to the IUC. If the nomenclature and multiprofessional understanding can be achieved in relation to recruitment, deployment, and retention then there the IUC Sector should embrace the active recruitment of Paramedics. Not just APPs but all Paramedic grades could be welcome in the creation of a clear career structure that will see them stay and grow with the organisation.

6.4.5 Recommendation 5, it is clear that Telephone Triage should be a specialty of its own so that we can reduce the stress factor that affects the wellbeing of the practitioners performing the role. If handed to academia to research and develop a Level 7 academic award and sub-specialisation of the Advanced Clinical Practice group as a whole, greater depth of research, analysis and understanding can impact of the evolution of the role and values-based, patient centred, safe practice. Greater understanding of the role will see both the practitioners and their patients growing in confidence with Telemedicine as formal and effective treatment option and not just a way to “plug the leaks in a sinking ship” as would seem to be the general perception under the current pressures.

6.5 Future research

There were four future studies that became apparent as likely to have an impact on the further understanding of this area of study, and these would be:

- The lived experiences of Advanced Practitioners *[of the other professions]* working in the emerging specialty of Integrated Urgent Care and of course the reciprocal study of the other professions experiences of working with Advanced Practitioners.

Building on perceptions of career opportunities and the psychological contract with their employer in view of the CoP Career Framework.

- The lived experiences of early career paramedics of the opportunities for career development within the ambulance service or in the wider health service?

To establish the value of returning to a CBET education system. It would be useful to examine a number of areas of the FREUC course system.

- What are the lived experiences of First Response Emergency and Urgent Care course student of the opportunities for career development within the ambulance service? And the reciprocal perspective of their colleagues.
- What are the lived experiences of educators and preceptors on the development of CBET qualified clinicians as they progress through higher education?
- What is the patient experience of care provided by CBET Vs Direct Entry Higher Education trained and educated clinicians? Is HE actually better?

Is there a need for multiprofessionalism in the NHS and should we cut through the organically developed myriad of professions so as to have a few main streams such as “Care Providers and Care Directors?” Would this for instance streamline the education systems with a simple generic interprofessional education “root course” and a clearly delineated education and skills progression that would potentially enable clearer recognition of prior learning, thereby clarify the career options for professionals? This is a huge question.

6.6 Summary of Chapter 6

This final summary of this research project brings to a close a fascinating project and one that through publication of the key themes from Chapter 5 with help develop the role of the Advanced Clinical Practitioner and the focal sub-group of this the Advanced Paramedic Practitioner. This chapter has reviewed the introduction to the study intentions, the underpinning history, policies, academic theories, and the research findings. Acknowledging that this study is only on facet of a wider subject, it is hoped that further research, by whomsoever has an interest in evolution of the paramedic

career pathways and to this end, recommendations have been made for the improvement of the lived experiences of Integrated Urgent Care and the potential future research questions.

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Appendix 1

Are you an Advanced Paramedic Practitioner?

A PhD Student needs participants for research on

"The experiences of the Advanced Paramedic Practitioner working in a Clinical Setting"

Volunteers must be:

A Registered Paramedic with the Health and Care Professions Council.

Employed as an Advanced Paramedic Practitioner working in a clinical setting.

Hold a MSc in a relevant subject area and comply with the College of Paramedic definition of an Advanced Paramedic Practitioner.

(An Advanced Paramedic Practitioner is defined by the College of Paramedic Career Framework (2014) as; an experienced Paramedic Practitioner, educated to MSc and fulfilling a senior role in Education, Research, Management or Clinical Practice).

Taking part will require no more than 1 hour of your time for an interview, discussing your experiences as an Advanced Paramedic Practitioner.

For further information, please contact:

Jon Ellis MAEd. MIAS. PGCert NMP. BA (hons). FHEA. FSET. MCPara.

Head of Clinical Workforce Development

Totally Urgent Care Division

Totally plc. Cardinal Square West,

10 Nottingham Road,

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Appendix 2

PARTICIPANT INVITATION and INFORMATION SHEET

Title of Project:

What are the lived experiences of Advanced Paramedic Practitioners working in the emerging specialty of Integrated Urgent Care?

Name of Investigators: Jon Ellis

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask me if there is anything that is not clear or if you would like more information.

Jon Ellis mobile 07716 467 935 email *jon.ellis@vocare.nhs.uk*

Take time to decide whether you wish to take part or not. Thank you for reading this.

What is the study about?

This research is part of my studies for a PhD at Selinus University. I wish to explore the evolving role of the Advanced Paramedic Practitioner.

An Advanced Paramedic Practitioner is defined by the College of Paramedic Career Framework (2014) as; an experienced Paramedic Practitioner, educated to MSc and fulfilling a senior role in Education, Research, Management or Clinical Practice. It is not simply a paramedic with dual specialisation. This study will focus on the Advance Paramedic Practitioner in Clinical Practice.

The role of the Advanced Paramedic Practitioner is a sub-group of the wider Advanced Clinical Practitioner occupational group as per the national framework set by Health Education England in 2017. The role is expected to be a key element in the provision of the enhanced “mobile and static urgent treatment services” and prehospital clinical leadership (Department of Health 2013: 8).

What does taking part in the study involve?

Participants will take part either in Stage 1 or Stage 2 of the study.

Stage 1 involves an audio recorded 1 to 1 interview of about 90 mins to explore your views of the Advanced Paramedic Practitioner role, to take place at a mutually convenient time and place.

In Stage 2 involves taking part in a focus group of 6 to 8 individuals (either in a clinical setting or at an academic facility). Focus groups should last approximately 60 minutes and will be audio recorded.

All collected data will be kept anonymous and the research will be conducted in accordance with the British Education Research Association (BERA 2011) Guidelines.

Why have I been chosen?

You have been chosen because you are an Advanced Paramedic Practitioner.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. I will not inform anyone that you have taken part in the study.

I am interested in taking part, what do I do next?

Contact: Jon Ellis at jon.ellis@vocare.nhs.uk

What if I agree to take part and then change my mind?

If you decide to take part, you are still free to withdraw at any time up to two weeks after the interview or focus group without giving a reason. However, following that time data collected may still be used in the research but will be kept anonymised.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. You will be given an ID code which will be used instead of your name. Any identifiable information you may give will be removed and anonymised. Any direct quotes used will be anonymised however, it may be that something you say may be recognized by others. Procedures for handling, processing, storage, and destruction of study data meet the requirements of the Data Protection Act 1998.

Raw data is normally kept for 5 years after a study has been completed.

You should also be aware that I may be duty bound to pass on information that you provide that reveals harm has occurred to a child or other vulnerable individual.

In focus groups I cannot promise confidentiality as that duty cannot be imposed on all participants in that kind of interview but all data that I collate will be anonymised.

What are the possible disadvantages and risks of taking part?

It is possible that some opinions could be contentious, however, all participants and organisations will be anonymised and therefore there should be no risk to the individual or the organisation in which they work.

Volunteers are of course reminded of their need to behave in accordance with the Health and Care Professions Council standards proficiency, conduct and ethics (2016).

What are the possible benefits of taking part?

There are no direct personal benefits to taking part however, some participants enjoy having the opportunity to reflect on their professions.

What will happen to the results of the research study?

The findings of this study will contribute to my doctoral thesis and will also be used in publications and conference presentations. You will be invited to receive an executive summary of the finding.

Who is organising and funding the research?

This research is part of a self-funded PhD.

Who has reviewed the study?

This study has been reviewed and approved by the Totally plc. Research Ethics Committee. Any concerns or complaints should be directed to this committee.

Thank you for your participation.

Contact for Further Information

Jon Ellis MAEd. MIAS. PGCert NMP. BA (hons). FHEA. FSET. MCPara.

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Return slip to join the study

If you decide to take part in this research study, please keep this information sheet, complete this return slip, and return it to me via mail or email.

Thank you.

Your contact details

Your email

Telephone number

Best time to phone you

Appendix 3

CONSENT FORM

Title of project:

What are the lived experiences of Advanced Paramedic Practitioners working in the emerging specialty of Integrated Urgent Care?

Name of researcher: Jon Ellis

Please initial all boxes if you agree

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time up to two weeks after the interview or focus group without giving a reason. However, following that time data collected may still be used in the research but will be kept anonymised. ☐

I agree to the interview being digitally audio recorded ☐

I understand that data collected during the study may be looked at by a supervisor from Selinus University. I give permission for the supervisor to have access to my data. ☐

I agree that non identifiable quotes may be published in articles or used in conference presentations. ☐

I agree to take part in this study ☐

_____	_____	_____
Print name of participant	Date	Signature
_____	_____	_____
Print name of person taking consent	Date	Signature

Consent form date of issue: January 2021

Consent form version number: 2

Appendix 4

Interview transcripts

These transcripts state only relevant content, “small talk”, vias and softening of some of the “fruitier” expletives paramedics are inclined to use in the vernacular have been excluded to maintain clarity (Hargie et al. 1994).

Realms Annotation			
Vorwelt	**Umwelt**	**Mitwelt**	**Folgewelt**

Interview Id Anonymisation Coding:		
N	=	North Area – Yorkshire, Newcastle, and Sunderland
M	=	Midlands – Staffordshire, Birmingham, and Nottingham
L	=	London and Greater London

Indicative interview content:
As stated, the intention of the study is to conduct unstructured interviews to allow the volunteer to speak freely but there still needs to be a modicum of guidance to the process. These questions have been taken from my initial thoughts and notes as subject headings, each one could be greatly subdivided in a fully structured interview.

Introduction

Consent form completion (Appendix 3)

Tell me about your role as an Advanced Paramedic Practitioner in relation to:

Section 1 Human Resources and Recruitment
Section 2 Professional Integration
Section 3 Functioning as an Advanced Paramedic Practitioner
Section 4 Innovation and Role Progression
Section 5 Paramedic Profession Potential
Section 6 Career Structure

Thank you

Researcher: Jon Ellis

Interviewee N1

Section 1 Human Resources and Recruitment

Acceptance in a heavily nurse lead environment. Like yourself, I am a Consultant Paramedic Practitioner and so A) I am confident enough to stand my ground and B) I have a reputation that protects me from some of the interactive concerns. I enjoy advanced practice and I find it a most satisfying role and it enables me to maintain credibility with my staff and students. A concept I know you and I agree on.

The nomenclature of advanced practice should improve with the HEE 2017 National Standards, but I know several paramedics that find their assimilation into the organisation troublesome. The service is heavily nurse lead and thus the job titles are still nurse orientated which gives problems to colleague because of several points.

A) Use of protected titles, paramedics are not registered nurses. Registered Nurse like paramedic is a protected title. We have paramedics whose contract and name badge say Advanced Nurse Practitioner

B) ANP is not ACP – Job Descriptions need updating to match the HEE 2017.

C) If you haven't studied the 4 Pillars of Advanced Practice, then by the new standards you are not an AP. The old standards are defunct.

D) The NMC offers and accreditation system (until January 2022) to enable ANPs to demonstrate 4 Pillars compliance and have a transferable qualification. All paramedics, OTs, Physios, and Pharmacists have got is internal RPL policies which are great but not always transferable.

E) The Ambulance Service is not blame free however as we both know. They, well some of the services including our local one here, have promoted experienced paramedics to the status within their organisation of Advanced Paramedic Practitioner but this is only based time served and does not reflect 4 Pillars MSc level of education and so they are "bitterly" disappointed when they leave the service only to find they are downgraded to ECP. We need a formal accreditation system like the NMC

Section 2 Professional Integration

I find that my world is very comfortable but again I am a consultant grade and people don't cross me. Ouch! Does that make me seem aggressive, that is not my intention, you know me I'm pink and fluffy?

We are popular with GPs, and I think this is due to two reasons.

A) Paramedic Education has always been heavily Doctor driven, e.g., the Medical Model of Enquiry as the standard for the early practitioners the "Community Paramedics" remember those days? And the old LAP panels

B) We are generalists like the GPs. We have seen every age group from "embryo to death" from day one of our training. You do not know what the next call will be, so we have always studied everything. The doctors like this. There is no refusal to see children or mental health patients or obs and gynae because we have always seen these groups and more. Nothing "flaps" a paramedic. We are the "special forces" of the NHS, every day from the moment we started we are just "chucked" into situations with little or no warning of what the call is about, this is where we develop our tolerance of risk.

C) Nurses will despite their actual NMC code of conduct, and their practitioner education will often, not always but often, take the line of "I'm and Adult Nurse, I don't see children". Thus "dumping" more patients back on the duty GP. Paramedics just get on with it. I have to be honest, this, really annoys me.

I know a couple of people who have found friction in their teams because paramedics see everything and the GPs are quite vocal about liking this and some of the nurses, rather than stepping up to meet the challenge are just "anti-paramedic". This is very sad because we all have complimentary skills sets that make the whole team an Evidence and Values Base Practice dynamo that furthers the IUC agenda.

Section 3 Functioning as an Advanced Paramedic Practitioner

I do not think that everyone on the team has fully grasped the seniority of the ACP role and that we in many cases provide the supervisory lead. There are still junior personnel that expect me to scurry off and check with a doctor. I will, when I need to

but part of the function of the ACP is to relieve the doctors of some of this leadership pressure. Then at other times my presence seems to de-skill some of the junior colleagues who just stop seeing “complex cases” that previously they would have seen without question on the grounds of that is what the ACP is there to deal with and so we end up with me doing all the difficult “stuff”, which is OK, I like problem solving but I dislike laziness in some of my colleagues who use my presence as an excuse to do nothing. I have had a nurse colleague identify to me at annual appraisal that see does not feel safe when the duty doctor is only on the end of the phone and not physically present in the department, but this may just be a matter of time and commitment from everyone to get used to the new system.

Section 4 Innovation and Role Progression

One new system, I need to work on, which has become all the more real since COVID is telephone triage. Honestly, I hate it! I do not feel confident with telephone or video calls, but it is part of my role to at least be able to carry out the Senior Clinician Function. There should a separate specialty and university PGCert rather than a 3-hour online course and then thrown in the deep end! I like to see people, face to face. I do think the telephone consultation system, whilst is has a place in modern healthcare has gone too far. In my practice, I regularly pick up the pieces of a patient who has an obvious condition if only they were seen face to face but has been repeatedly misdiagnosed over the telephone. For example, yesterday – 75 yo Male. 3 weeks of Co-codamol for lumbar back pain with radiculopathy. It was Shingles with neuralgia and 3 weeks late is too late for Acyclovir to be of any help. Poor sod!

Plus, telephone call centre work is just boring! And I can only type with 2 fingers!

Section 5 Paramedic Profession Potential

We are getting there but it is a shame that we have to leave the Ambulance Service to achieve it. As with the ECPs over a decade ago if you actually qualify with a master’s, you might get the title of APP, but you will still just be a “glorified” FRV and will not get to use your knowledge and skills. I think we need greater integration so that the Ambulance Service is more part of the hospital as a specialist division of

Urgent or Primary Care. So, we are a whole entity, not them and us and so the career progression is clear and rewarding. There is evidence that this works if you look at the London model. I maintain a bank contract, so I stay in touch with the service, but I have less and less to do that role because IUC Advanced Practice is more stimulating, but I worry that I am losing my paramedic identity and some of my useful but little used skills. I haven't cannulated in months. Could I actually run an ALS call? We only need BLS. Hmm skill fade.

I know colleagues who report that patients are frequently surprised to find a paramedic in an IUC, but the response is usually positive.

Section 6 Career Structure

I see the entry point as BSc. The FREC system is just a rehash of the IHCD CBET approach to get "bums on seats" because the ambulance service just cannot meet the demands of the system. Paramedic Practitioner through PGCert. PGDip. APP through MSc. Consultant through PhD. As per the CoP career structure but as I have discussed I do not think the APP/ ACP will work in the ambulance service whilst they continue their current deployment model. It may be necessary to see the ACP as per HEE 2017 as a multi-professional role from where we expand our knowledge laterally and return to the ambulance service in managerial, advisor or Consultant roles but Consultant roles are few and far between.

Interviewee N2

Section 1 Human Resources and Recruitment

I came from the Ambulance Service about nearly 4 years ago. I was an Advanced Paramedic in XXAS NHS Trust. But in the wider NHS they want more academic qualifications. I was very disappointed at the time and my ego was bruised by having to step down to Paramedic Practitioner, well ECP because despite the change in our structure several years ago from ECP to PP the rest of the NHS still uses the ECP title. They use NP for nurse practitioner but there is an undertone of being second rate as a paramedic and they seem to want to ignore your background until it serves their purpose. Like a full resus. Or an aggressive patient and then they all want me to do the superman impression.

Getting back onto track … um … I had to get out of XXAS. I couldn't take the enforced overtime, the lack of a break, the heavy lifting I'm not getting any younger, or the general abuse by the managers. The patients, I can cope with that but the constant criticism from management of the team as a whole was just toxic. There is nowhere to go with your career Advanced Paramedic was a nice ego boost, but we were still doing the same job for the same money and conditions. I was annoyed that with my BSc. The same standard then pre 2017 as an ANP I was not considered an advanced practitioner. ACP is changing all that because we all have to have MSc but there are still ANPs with no more skills than me but a title and salary of an Advanced Practitioner. Some of the nurses have done the NMC ACP Accreditation but there is no such thing with the HCPC. – Obviously then you came along Jon, with your RPL policy and I will always be grateful that you leveled the playing field but it is not transferable like the NMC system and so it still feels second rate. I am now on the MSc. ACP Apprenticeship pathway – again thank you Jon. I do now see the difference in standards between PP and APP as per HEE, but there are still old style ANPs who think they are ACPs, but they are not, they would not recognise the 4 pillars if the physically crashed into them. The RPL really helped because they have accredited 3 modules over the 3 years for me.

Section 2 Professional Integration

Locally we have a great team, but I still feel the heavily nurse lead environment, I mean Jon you are the only senior manager who is a paramedic. I feel we are still under rated. HEE 2017 Standards were supposed to change the job names to recognise everyone, but my contract still says ANP. I am not a nurse, and this is 2020 – they have had 3 years. There are those occasions that despite the ACP Model, the nurses feel the need to call the remote medical supervisor to check that my instructions are correct, rather than ask me to support my reasoning. Thankfully the doctors seem to be aware of this game and a supportive, but it keeps happening, particularly from certain specific individuals all of whom are of a nursing background. We do not get this from the Pharmacists, Paramedics or Administration staff. In trying to be charitable, I think they are just used to asking a doctor, but they do not question the decisions of the Nurse ACPs, well not as much to my experience.

Section 3 Functioning as an Advanced Paramedic Practitioner

I am getting there. You got me to the same footing with RPL as an ANP, and I am now on the MSc. I am functioning under supervision, and it is enjoyable to see the bigger picture. Not just one practitioner and one patient but one department, multiple patients, and multiple practitioners to look after and lead – I am doing the Leadership module at the moment.

I spend a fair bit of time explaining to the “next generation” how the perspective changes as the master’s progresses and it really is about a “bigger picture”.

Section 4 Innovation and Role Progression

I am looking forward to seeing how I can develop the integration; my MSc research project is aimed at building a multi-professional toolkit to understand everyone’s professional skill sets and perspectives, because whilst our various codes of conduct require us to respect others there is still a “trench warfare” from some quarters despite the fact we know that interprofessional working is beneficial to the patient and the organisations, budgets, and overall functioning.

There is hesitance in some of our colleagues to go for the MSc because of the research project. Everyone is used to the “literature review” type BSc research, “a la meta-analysis” but actually doing primary research is worrying some. I tell them “When we do the research, we take charge of our EBP”, just look at the evidence-based references on any of the NICE Guidelines or even the JRCALC Guidelines, much of it comes from Nurses and Doctors but there is very little from us.

Section 5 Paramedic Profession Potential

We have been under rated as the “ambulance drivers” – I hate that description but how long has it been since we had Paramedics 40+ years but certain people still see us as a transport service. The modern University structure is helping use show we are equally capable. I mean I didn’t really like the idea of having to attend university and frankly some of the “dross” they turn out as “qualified paramedics” is quite alarming, but we do now at least have the same standard of education. OK, we still have IHCD Paramedics out there. I note the services have started the negative motivation campaign of inhibiting career mobility of the IHCD, NHSTD, NHSTA group by not recruiting them if for instance they want to semi-retire to another part of the country.

Section 6 Career Structure

I can see where the CoP career structure fits, but we are need the ambulance service to stick to it and stop promoting people to just massage their egos and take the heat off industrial relations for a while. I think men are easily swayed by status, our female colleagues all credit to them see through the BS and want improved pay and conditions. Massaging egos is how we get APPs who do not meet the HEE 2017 standards.

Interviewee N3

Section 1 Human Resources and Recruitment

Well as you know, I found myself on a “sticky wicket” with HR when we were looking for APPs in the 111 service. I had been an Advanced Paramedic in XAS when I moved over to 111. At that time 111 did not much care what your qualification were as all the training was provided by NHS Digital and all they were interested in was that I was a registered clinician. The NHSD Pathways training carries no academic credits and I only hold an IHCD award which I now understand as a level 4. I was quite at a loss when the NHSE IUC Blueprint and the HEE ACP standards came out but seemingly through “grandfather rights” I was allowed to continue in my role. Until that is I decided I would like to do the MSc ACP. As you know with the spotlight on me everyone started “back pedaling” on my clinical standing. The job descriptions were massively out of date and highly nurse orientated with no understanding of the paramedic curriculum. I know you have written new ones, but they are still stuck with the board and there are several of us using the RPL system to “hang on to our jobs” let alone enjoy taking an MSc. However, thanks to your work with the X University and your Competency Framework and RPL process, I will be starting an MSc in October, but my word was it a shock and a lot of work just to get to the starting gates.

Section 2 Professional Integration

We were all happily integrated in 111 until the MSc applications and 6 of us found out we were not fully qualified from the integrated service perspective of 2017. I have reported the matter to NHSD, and they confirm that it is a national issue that needs careful thinking about – I know they have already emailed you for help. We had that problem where XXXXX told that poor chap he could have the ACP 111 job and then moved on to his new job, leaving us with a wholly unsuitable chap who had resigned from his primary care post and was looking for a start date.

Section 3 Functioning as an Advanced Paramedic Practitioner

Well, I was functioning as a remote manager but since the qualification’s revelations and the JD review, I am now under supervision more closely myself even though the

RPL was passed by the organisation, but NHSD are not so forgiving even though it was their fault.

Section 4 Innovation and Role Progression

I think 111 should have its own specialty in terms of academic pathway through the BSc and MSc system. All ACPs should be capable of the Senior Clinical Module but some of us could be highly specialised and that was maybe I could have RPL'd more. I think Mental health and Chronic diseases could also be a valuable specialisation particularly in home visiting.

Section 5 Paramedic Profession Potential

There is still a Two-tier system phasing out through retirements but as the last IHCD course was 2015 we have a way to go with IHCD Vs Graduate. Then there is this FREC rubbish, I am sure the people of lovely, but the course lets them down it is rubbish, just rubbish. They just never seem to have the depth of knowledge the old IHCD or NHSTD in my day, Ambulance Technicians had. They can perform skills, but they do not seem to fully grasp why they are doing it.

I know some colleagues in the old IHCD group who cannot transfer to other services because they are only IHCD

Section 6 Career Structure

The career structure is great. If only the Ambulance Service had stuck to the intended academic standards rather than massaging our egos to aid industrial relations. I would have been very happy to do the training, but I do feel bitter about how the Ambulance Service set me up to fail by making me an Advanced Paramedic when I lacked the qualifications to work outside the Ambulance Service and now even those APPs who are MSc qualified, they seem to have to keep telling people so because the waters have been muddied.

Interviewee N4

Section 1 Human Resources and Recruitment

We may say it is a multi-professional system but that is just garbage. I have friends in the team but we are nurse lead and nurse oppressed and the senior managers are all nurses and so they do not want to change or have anyone upset their little empires. We get micromanaged from a strategic level as if they do not trust use to do our jobs, middle management are more tolerant. Just look at the job descriptions you wrote, 18 months later they have still not been actioned. Unless the patient is dying, I am always under the thumb!

Section 2 Professional Integration

Not from my perspective. You can say all you want about multi-professional working and codes of conduct, but I have none of the freedom my nurse colleagues have in the department and I unlike the ANPs with only a BSc, I have an MSc. However, the prescribing award has helped, I just wish the Home Secretary would get a move on and put through the Misuse of Drugs Act amendment so we can prescribe CDs. I do not want to go nuts but not being able to provide an opiate to someone in pain is embarrassing for me and totally unfair on the patient.

Section 3 Functioning as an Advanced Paramedic Practitioner

It sometimes feels like I am not allowed to do anything without a nurse reviewing it in that they get their instructions and then go and check with a colleague. There are only 2 paramedics here and the nurses hate it that I am an ACP with a full MSc. I was hoping when I did my course, I would be able to do what you do, I really like teaching, I am a Practice Educator, but I would have liked more emphasis on teaching. Indeed, the four pillars are not always explicitly taught. The education Pillar is poorly covered by the MSc. Just an assumption that if you are level 7 educated you can just teach – there are some bloody awful teachers in practice and one or two at the Uni.

Section 4 Innovation and Role Progression

I would love to bring in improved clinical supervision as per the policy you brought in but “the nurses” always close ranks and make it impossible to complete. I would go back to the to the Ambulance Service but there is nothing for me to do. APPs are just another response resource; it would just be a waste of all that study. I just want to make a difference.

Section 5 Paramedic Profession Potential

If we can actually get a process of mutual respect going, nationally. I know there will always be personality clashes, but the Integrated concept could be fantastic for the patients then the potential is there. If the Ambulance Service would just use APPs properly and also appoint APPs properly, we could seriously support primary care. The appointing of APPs who do not hold as MSc has made mockery of the system because no one is sure what each individual is actually capable of.

Section 6 Career Structure

Well, we have one, but it is just not being used as intended and it’s all a bloody mess. I know I sound jaded, but I am really fed up right now and I still have 20 years until I can retire.

Interviewee N5

Section 1 Human Resources and Recruitment

The JDs need a serious overhaul. We are still graded as nurses. OK, I get that we are busy, I get that there is a pandemic, and we are massively recruiting to cover the 111 service, but this has been going on for years. We need to reflect multi-professionalism from the moment someone joins the organisation but delaying recruitment every time they recruit someone who is not a nurse, i.e., a physio, a paramedic, a pharmacist while we find out if they hold the relevant qualifications because the nurses that employed them “don’t really know” is embarrassing. There is no place for APPs in the Ambulance Service at present and so if we want to use our K&S, we need to join the IUC or ED. Some places are great, but integration is not really happening as the Health Education England plan would have it, except in London.

Section 2 Professional Integration

We get on famously with the GPs. They love the paramedics doing home visiting because let’s face it that is what we do, and we see everything rather than “bleating” that we are adult nurses and do not see children. If only the Ambulance Service would take on the contract there would be a role for APPs in the Ambulance Service, but response standards and pressures of call volumes mean we are always diverted to 999 calls and just the next one on the stack rather than the one we are best suited to. Perhaps the Ambulance Service and the Unis need to recruit paramedics in the volumes that they do for Nursing cohorts.

Section 3 Functioning as an Advanced Paramedic Practitioner

I love the job; I hate it that my contract says ANP, and my login says nurse – I am not a nurse. The team are super and every day we make a difference to our local community and reduce the number of people taking the 30-mile trip to ED in XXXXXX. Senior management however treat me like an imbecile, and this does not help my confidence, I know I have all the education and experience, but I cannot help the feeling that I might be lacking in some way. They call it the imposter syndrome. In the ambulance service I enjoyed a high degree of autonomy, possibly due to having to

work solo, here in a department with several colleagues also present at the same time I feel like I have to justify myself all the time and it is draining.

Section 4 Innovation and Role Progression

I would like to see the home visiting service increase, we could take the pressure off the GPs and staff it with APPs, DNs, MN, and integrate the Falls response with the Physios and OTs. Again, the Ambulance Service could take this on and collect the funding, but they don't, and we all have to leave in order have job where we use the knowledge, we got from all that hard study. In my case all that hard study I self-funded. My Ambulance Service doesn't provide the training, PPs or APPs themselves fund it but they will recognise you as that grade if you get your BSc, PGCert or MSc. You have to pay for it, you have to swap shifts and use your leave to attend the university. XXAS gets all the benefits but then still treats you as any other paramedic

Section 5 Paramedic Profession Potential

I would love to do a mental health specialisation. I can help and refer all my patients as necessary except for mental health cases when the single point of access phone line pick up, even as an APP I am not allowed to make a referral. I could only make a referral if I were a GP or and MN. Therefore, the poor patient has to be sent to a packed ED to sit and wait to see the 1 MN on duty.

Section 6 Career Structure

I want a consultant opportunity, but they are few and far between. I would love to do a PhD. However yes if only the Ambulance Service as the primary employer for paramedics would use us as the concept of integrated urgent and emergency care sets out it could be great. When I joined the XAS I thought it was a job for life with that one employer, but I went as far as I can with them. It galls me that to be an APP I actually have to leave the Ambulance Service. It also galls me that they appoint APPs who have not actually done the MSc and, in some cases, not even the BSc.

Interviewee N6

Section 1 Human Resources and Recruitment

My process was agonisingly slow. Indeed, I was happy to have this interview with you Jon because you were the only one who got things moving. Well, you and XX who came to you for help. 10 weeks I waited for a started date, but HR could not rationalise an ANP JD against an APP skill set or my MSc. My MSc is advance professional practice in healthcare and not ACP and they couldn't get their heads round it. You got involved and in 3 hours and it was sorted. They say they want paramedics, but they have no idea what a paramedic in comparison to a nurse is.

Section 2 Professional Integration

Aside from the previous discussion everything is going well but I cannot wait for them to change my contract to read APP or ACP rather than nurse. I am not a nurse, and registered nurse as per the JD is a protected title, but I am being forced into using it or giving the impression that I am a registered nurse. We have couple of colleagues who seem to have forgotten the clause in the NMC code of conduct about respecting other professions and consider themselves to be superior despite us all having an MSc. It is not helped by the gushing support the GPs for the APPs that whilst very nice sometimes does not go down very well. Paramedics and GPs, due the old Community Paramedic programme and the old steering committees talk a similar generalist language which makes interaction very comfortable, but I personally would just like everyone to get along.

Section 3 Functioning as an Advanced Paramedic Practitioner

Aside from the last discussion I enjoy the thinking on my feet and leading a team rather than just directing a team. I was an AS training officer and love mentoring the next generation.

Section 4 Innovation and Role Progression

I want to get everyone on your PEd. Course so we can be a centre of excellence for university placements. I would like to work more closely with 111. I enjoy telephone

triage there is still friction that could be overcome with a little more understanding of roles and probably some extended mentored placements on both sides.

Section 5 Paramedic Profession Potential

I think you will have heard this from several others. I did not want to leave the Ambulance Service, but it had to happen if I was going to be able to be a real APP and not just another FRV to beat the response times.

Section 6 Career Structure

I seem to be saying this quite a lot but as per the last discussion it would be good if we could achieve full career progression in the NHS Ambulance Service rather than have to leave. I hope one day I may be able to go back if they make a role that fits my skills and interests. Maybe we need to be even more integrated and less hospital vs ambulance. I feel we are possibly causing some of the integration issues ourselves by not just being one homogenous NHS.

Interviewee M1

Section 1 Human Resources and Recruitment

This doesn't really affect me because I work for myself as my own limited company and so I am my own HR department. However, the APP system has been a firm foundation for the establishment of my own aesthetics business. And before you "roll your eyes" we do a lot of post traumatic injury reconstruction support. The surgeons and the patients like referring to a person who has actual experience of nasty injuries. But yes, I do, do Botox injections and fillers for purely cosmetic applications.

Section 2 Professional Integration

I employ a couple of ANPs, and we all get along swimmingly all girls together. I keep my paramedic skills up my maintaining a bank contract with XXAS. But I am quite isolated in the aesthetics business.

Section 3 Functioning as an Advanced Paramedic Practitioner

I don't really function as an ACP because my MSc is more about demonstrating to clients that I am legitimately qualified and have a significant understanding of the human body.

Section 4 Innovation and Role Progression

I would quite like to see aesthetics link more closely with the NHS because in terms of reconstruction support and in turn the mental well-being of the patients we could very useful, but we are generally viewed as a fringe operation and only in it for the money, which I do not deny is much better than an NHS salary. It would be nice to see aesthetics as an optional module on the MSc.

Section 5 Paramedic Profession Potential

In reconstruction as I have said our understanding of trauma can be very helpful and is popular with the plastic surgeons I know.

Section 6 Career Structure

This does not affect me. I am happy with my bank contract with XXAS so I can still say I am a paramedic, but I would never go back fulltime. I like that I get my meal break, I get to eat healthily, I only have to work a few days per week.

Interviewee M2

Section 1 Human Resources and Recruitment

I was recruited to the home visiting service, which is clearly a paramedic type role, but I still had to explain all my qualifications because they did not fit the nursing model person specification that the recruitment team and CCG were using. The recruitment team were clearly not clinicians and did not understand the differences and the clinical managers who recruited me were not educators so they could not interpret the content of my university transcripts and the university from which I got my MSc did not call it MSc ACP but MSc Advanced Clinical Care. This meant that the recruitment team who rigidly followed the person spec. initially rejected my certificates.

Section 2 Professional Integration

Once I was recruited everything was fine for a few weeks but then the fact that I see all age groups and the nurses despite having done paediatrics at in their MSc “dug their heels in” and started refusing to see children. This nearly caused a war between the GPs and paramedics on one side and the larger staff group of the nurses on the other. We eventually agreed that the nurses did not have to see children. The problem then occurs that the relationship between the GPs and Paramedics is one of a high LMX whereas the nurses then find themselves experiencing a medium to low LMX due to their identification of an inadequate skill set. I can see why this happens but is just adds to the bad feelings in industrial relations.

Section 3 Functioning as an Advanced Paramedic Practitioner

Once the patient call types were ironed out, I have found that I thoroughly enjoy the role of leading care and preventing unnecessary hospital attendances.

Section 4 Innovation and Role Progression

I am working with the local university and Ambulance Service to allow paramedic students to join the home visiting service as part of their placement. However, those plans have been shelved due to the pandemic over fears of clinicians being in close

proximity in the vehicle, despite the fact that GPs have drivers, and the Ambulance Service does not have a problem with crews both siting in the front of vehicles.

Section 5 Paramedic Profession Potential

I have discussed this with the North division recently. It would be super if the Ambulance Service would take on this functional model so that there was a place for APPs to actually use their skills in the Ambulance Service. As it is we are all leaving once we get our MSc because we want to work more autonomously and make a difference rather than being just another response resource.

Section 6 Career Structure

The career structure is very interesting. I don't really see it working until such times as the workload of the Ambulance Service is sufficiently covered and we as APPs can be appropriately deployed. There is a role for PP or specialist paramedics as they are now being called locally, there is space for the Consultant Paramedics but there is nothing for the APP to do to benefit the service and therefore no impetus to study and improve unless you are prepared to leave the service for the IUC or ED.

Interviewee M3

Section 1 Human Resources and Recruitment

They just do not understand the health service. They may work for the health service, but HR and Recruitment do not have a clue how clinicians' function. In the ambulance service they are less clueless but not much less. You would think that there would be a training package for them introducing what people do and what the differences and similarities are between nurses, paramedics mostly but also doctors and physios. One of our recruitment team thought a paramedic was a type of junior doctor. There is this public perception we are superman and can do it all. This doesn't help the ego of those idiots who think they can. The more qualifications you get the more you realise how much you don't know. The JDs are very nurse focused and HR and Recruitment need a wider scoping guide, because they clearly just take the JD to the letter. I know you are studying the APP as a subgroup of ACP, but ACP was supposed to reduce this "crap" with a standardize name for a multidisciplinary workforce.

Section 2 Professional Integration

At last week's team meeting paramedics were described as gung-ho in our approach, just because we do not scurry off to ask the duty GP's permission to prescribe or refer. The nurse prescribers are much more timid. This is why paramedics enjoy a high LMX with the supervision GPs, but it impacts on work relations. I think this is because in a hospital the there is always someone to ask. Paramedics at best have a crewmate of the same grade or junior or they are a solo responder on their own. There is no-one to ask. OK, there is supposed to be a support desk at control but the signal in the peaks is lousy. As far as the HCPC and Coroner are concerned it is the paramedic's head on the chopping block and so we toughen up fast and stand our ground. Besides if you have checked BNF and NICE and the local guidelines and it says you can and it is legal, just get on with it. The GPs agreed with me. I mean you can always ask them if you are unsure. In private they will admit that they like the paramedics because we are not, knocking at the door every 5 mins to run something past them or just plain dump another patient on them. Even when we do ask for help, it is so we can do it not duck-shovel our work so we can get another cuppa.

XX and I turned up last week 2 APPs to find a waiting room full of kids, one poor GP (AD) trying to do them all because both ANPs had taken the “we don’t do kids, we are adult nurses line”. Well, we know that is rubbish they are not just adult nurses, they have done the practitioner course that includes paeds. Then we have all had the update course on paeds, but they still refuse, and the area manager lets them get away with it. Anyway, Jeff and I jumped in – we were there in actuality to do a drugs audit. We jumped in and with the GP we had the back log cleared in 90 mins flat. The ANPs just sat and drank tea.

Section 3 Functioning as an Advanced Paramedic Practitioner

I love it. Aside from the frustrations of JD, I am not a nurse, and the I’m an adult nurse crap. I love it. Leaving the AS was the best move. I get my meal break on time, I finish on time, my salary has gone up, the medical director actually backs us and so you feel safe making a judgement call and I get to use all my skills and knowledge. Every day is a learning day, and the smiles on patient’s faces when you just get on and help them.

The GPs here are super but as we know in all professions, we have the lazy ones. This pandemic has made the telephone appointment situation worse. I spend many hours a week seeing patients who should have had a face-to-face appointment with a GP weeks ago but have been fobbed off and misdiagnosed due to the limitation of the telephone consultation. Yes, I know some need just a phone call but the fallout on the IUC is ridiculous.

Section 4 Innovation and Role Progression

Progress would be to rip out the phone lines at some of the GPs practices, so they actually see some patients. OK, but on a similar idea. We could do with a formal Telephone Triage module as part of the ACP MSc because while I hate working on telephones, there are some that are good at it. I have been trying to reflect on my frustrations and understand. Perhaps if there was a medical specialty of remote consultations with an academically accredited course supporting it and enabling research into the wider subject, we would improve the system. Right now, it is a

disaster. I mean how many 85-year-olds do you know who can comfortably use a smartphone. I'm 46 and I can barely take a selfie.

I hate telephone triage, it bores me to death, plus I cannot touch type, I get eye strain and accommodation issues staring at screens for hours on end. I lose sleep over worrying that I might "short-change" someone over the phone and not achieve my best. I worry I will end up in front the HCPC. We all know colleagues who have found themselves on the wrong side of the HCPC, they don't care, they just leave them "hanging" for months, sometimes years before they process the case. We get forced by our employer to do the phones and then all we get is criticism for not being very good at it. Not, once did we get any training. I have resigned, I am just working my notice.

Section 5 Paramedic Profession Potential

We have a lot to offer. We are for instance as I have discussed confident in our patient care, able to see all patients because we always have and bring an Emergency Medicine perspective to IUC. We are better at Face to Face. We could however do with picking up some of the more specialist nursing knowledge. I am in awe of the dressings the DNs do. I am trying to arrange my own placement on the DNs service for some CPD.

Section 6 Career Structure

It's OK but I think we forget the experience of the "old" IHCD Paramedics and there are still several in this area, they are damn good at what they do but the academic structure of the career pathway leaves them out. I know it is a double-edged sword because some services have tried promoting them within the structure and then they struggle with the more academic colleagues. As, I am sure you have heard from others. There are not enough Consultant Paramedic jobs, which is making the post one of elitism and getting to consultant means you need to leave the service for a while to get APP experience. You can't get it in the service because we are not deployed as they promised due to the call numbers. We are just another rapid response resource and the patients we could really help we, do not get to because we are on another pointless job.

Interviewee M4

Section 1 Human Resources and Recruitment

The interview was very pleasant, but the experience of the recruitment process was unmitigated agony. I was all excited to start my new role but 12 weeks later we were still trying to get an answer as to whether they were going to ratify a new JD or just recruit me as an ANP. So as far as my contract is concerned, I am an ANP.

Section 2 Professional Integration

I think we get along quite well. There were the early battles over who see's children and who doesn't and for a time the paramedic group both PP and APP were as they say about as popular as a "rattlesnake in a lucky dip". However, when you just knuckle down to it and see patients, you just do what you do, and patients get the care they need.

Section 3 Functioning as an Advanced Paramedic Practitioner

I am confident in my position; my team do what I ask of them. I like to think this is because I never ask anyone to do anything I would not do, and I listen to them – sorry "bit of the soldier approach" coming out here. I enjoy seeing the department succeed. We provide a good service and in recognition of this the contract with the CCG has just renewed for another 5 years and so everyone's job is secure. I see myself as a leader rather than a manager. I am on the "shop floor" seeing patients and support the team. Everyone knows I am the boss, but I do not need the rank insignia on my shoulders as I did in the Ambulance Service. OK, analysing that, the Ambulance Service works with more agencies on a daily basis and our own staff and those of the other services cover a county or regional area and so the rank identifiers work because the team may not be as familiar to each other as they might be in one hospital. I do enjoy the horizontal management structures in the hospital setting. I wouldn't change my Ambulance Service experiences though for anything.

Section 4 Innovation and Role Progression

We all have strengths and weaknesses to be fair. We make a lot about seeing Paeds. However, we are just as bad when it comes to refusing to do phones although in this case we were never trained for phones and as paramedics have always done face to face. Management is very happy to chastise us for not being good at it, despite the fact we were forced to do it without any training at all. Despite what Bradley said in 2005 and the change of focus, we still do “Big sick, Little sick” and whilst we can decide face to face this is or is not big sick, over the phone it is hard and safety netting is a cop out. It really worries me that I will end up in front the HCPC for an error my boss forced me into. CNSGP is comforting, but I did not go into this career to treat people to any standard less than my best, and telephone triage is less than my best. We accept each other but is this truly interprofessional working – I think we have a long way to go in some areas to be able to say this has been fully achieved. I would like to set up post qualification CPD placements within the whole NHS services structure so when the pressure is off from the requirements of portfolio and assignment completion one can relax and just appreciate one’s colleagues. Each year we should have 5 days exchange between departments and services as supernumerary observers to listen to watch and reflect on how we can help each other.

Section 5 Paramedic Profession Potential

I am sure you have heard this before, indeed it is all the fora seem to talk about. That we have to leave the Ambulance Service to fully function as an APP, we have to become ACPs in a hospital. But perhaps this smacks of working in silos. If we take my previous thought forward and encourage everyone to see every other profession’s perspective, needs, barriers and the positive. We will build respect and evolve integration so as to maximise integration and as per NPM, HPW, and Porter’s 5 forces make the money go further.

Section 6 Career Structure

It is OK but still quite rigid. Again, it does not link to an integrated concept of healthcare, or it would be more inclusive of other skill sets and experience. It makes the upper levels quite elitist.

Interviewee M5

Section 1 Human Resources and Recruitment

HR seem in my opinion unable to cope with the varied nomenclature of the evolving IUC environment. It would be useful to rationalise it, and this of course is what the HEE 2017 ACP standards are trying to do at the advanced level. Recruitment have difficulty establishing precise skill set and so we get practitioners appearing in the department as APPs and ANPs who do not actually have the right skill set. I hope the competency framework will improve that, but we have had it in place for 2 years and HR are still not using it, and neither have they updated the JDs and Person Specs to fit the associated policy, even though I know there are new JDs sat there waiting to progress the system.

Section 2 Professional Integration

Our centre is well established, we had a bullying culture a few years ago for which we got a bad reputation amongst clinicians who left in droves. We have worked hard to promote interprofessional understand and thus cohesive interprofessional working for the benefit of staff and patients. However, it is my experience that within the organisation other centres are still very cliquey with them and us attitude between the nurses on one side and the smaller staff groups on the other. We have tried to remove the nurse and paramedic elements to our titles and just accept that each profession has its distinct perspectives but also, we are all equal in our patient centred approach. Cliqueness, is quite alien to Paramedic who by the frontline nature of our work just get along with every other paramedic irrespective of which station they come from. We are like a rugby scrum; we just bind on. Cliques were a nasty experience when I left the Ambulance Service for IUC.

Section 3 Functioning as an Advanced Paramedic Practitioner

APP functioning is different in the IUC compared to the Ambulance Service. Even in London, where I worked previously, where APPs are given the opportunity to work as the role was intended still perceive their role as treat and discharge of scene or transport and refer on to someone else. In the IUC it is a culture shock that as the APP

(ACP) you are taking the majority of patients from assessment to discharge and even when you are referring on to another department, your liaison with the receiving unit is more detailed than “dumping them at ED”. I found I also needed to change my CPD focus because the role changes your perspective. If, you can keep on top of it the learning is quite fun, but only if you can keep on top of it. This was a struggle in my first few months and people were looking to me as a leader.

Section 4 Innovation and Role Progression

We are pushing for the local Ambulance Service to follow the London lead and rotate APPs through IUC so we can set up a community of practice or a mutual learning environment.

Section 5 Paramedic Profession Potential

In the future it would be nice to see Paramedic starting their careers with direct entry to a specialty such as Primary Care or IUC and not have to necessarily go in the Ambulance Service. Maybe we do not need separate professional groups, maybe we just need a generic healthcare professional with then a specialisation. Maybe we should all be just nurse or doctor.

Section 6 Career Structure

I do not hold with elitism, it is nice to be good at your job, but the CoP career structure is poorly understood by grass roots clinicians, progression is also poorly understood, and it is poorly explained as the elite of the Ambulance Service hold it close to build their own empires. APP still, with the exception of LAS, does not work with the current deployment model.

Interviewee L1

Section 1 Human Resources and Recruitment

It seems to be getting better here in London, although I have heard the difficulties discussed at national triumvirate meetings. I think because LAS has actually tried to enable APPs to function as such there is less attrition from the APP group to the wider IUC. The local HR departments within the Greater London area are used to seeing APPs function as they were intended. The system is not perfect, but we are along way a head it would seem of other services. The APP role is understood. It is just a shame that in this organisation the ACP JD that you wrote Jon is still stuck with the board after 11 months and so the APPs still get recruited as ANPs.

Section 2 Professional Integration

As I said LAS is streaks ahead of other services and so APPs are understood and respected for their opinions. By deploying us as the concept originally intended, we reduce hospital admissions and facilitate a more patient centred care system. OK, because we are the Ambulance Service a lot of patients still go to hospital, but we are still having an impact. We are even seeing an improvement on the Mental Health agenda with SPA access to referrals that circumvent ED.

Section 3 Functioning as an Advanced Paramedic Practitioner

I did not have to leave the Ambulance Service but for all the positives, I like the expanded exposure to skills and experiences I get from IUC. I hope to go back one day as a Consultant Paramedic. I keep a bank contract. I liked my AS time, but I really enjoy the IUC and ED role. I certainly prescribe more variedly in the IUC which again creates a subliminal CPD because I am always checking the NICE CKS.

Section 4 Innovation and Role Progression

I am working with colleagues in XAS to facilitate a rotation system through IUC to enable colleagues to get a more expansive view of the IUC and their individual potential.

Section 5 Paramedic Profession Potential

The sky's the limit, I am now very interested in the GP/ Doctor apprenticeship route that is about to launch. So, whilst I may want to aim for Consultant Paramedic, I am hoping to be considered for the apprenticeship and I know you are working on facilitating this so please keep me informed.

Section 6 Career Structure

In LAS it is working. We have 4 main universities feeding students and NQPs into us. There is a good feeling of anything is possible and, in the majority, we enjoy the career development with a clear progressive structure.

Interviewee L2

Section 1 Human Resources and Recruitment

When I came over to IUC, it was with a different organisation. They were much smaller than this national organisation and it seemed that they thus had more time to listen to APP needs. There were initially three of us and the HR worked with us to write an APP JD. Then we got bought out and we have to use the wider organisation's HR and Recruitment team. It is like starting again. The new JDs are written but implementation has stalled. We have grandfather rights to our old JD and so local recruitment is still functioning, but I wish the core procedures of the organisations would merge quicker.

Section 2 Professional Integration

Because we were accepted in the smaller organisation more readily, we integrated well. This was also helped by the LAS who were early implementors of the full CoP career structure and actually try to deploy us appropriately to our skills and qualifications. I also hear that there is an IUC rotation system being piloted with us which should help and set standards for everyone else.

Section 3 Functioning as an Advanced Paramedic Practitioner

I preferred the smaller more local organisation. The larger group is unwieldy, and I am considering returning to the Ambulance Service. It is like the national organisation is too slow at everything and too impersonal. Even an organisation as large as the LAS is still relatively local and so it feels like your voice is being heard. For example, we are being forced to take on telephone triage. I am OK with it; I touch type and can type and listen, so I have more time to think clearly about what to do for the patient and feel safe in doing so. I know several 2-finger typists who are anxious even depressed about the enforced telephone triage work. I mean we only got a 3-hour (with 2 long coffee breaks included) training session on the NHSD Pathways Senior Clinician Module. They worry about the patients and cannot switch off. There need to be more specialist training on this and very definitely typing skill development or template development to improve the thinking time when we are all pressured to take 6 calls per hour.

Section 4 Innovation and Role Progression

As I have just discussed if telephone triage is the future, then the future needs a clear and academically certificated programme looking at not just the skills of the process but the law, ethics, and perceptual psychology of the subject.

Section 5 Paramedic Profession Potential

We all have potential. I understand you are purely looking at APPs but to be a bit pink and fluffy right now, inclusive education should be the mantra and every profession should be enabled to achieve its full potential. The NHSE IUC thing of 2017 and the HEE thing, standards are trying to do this. I'm like come on people lets embrace it.

Section 6 Career Structure

In short it works in XAS, it works when there is a local focus but central national management, even if devolved to regional structures is too slow to react.

Interviewee L3

Section 1 Human Resources and Recruitment

Apparently, things are more straight forward down here in the London area. I came down from XXXXXXX and it was dreadful because neither HR nor Recruitment had any idea as how to classify an APP. They graded me as an NP and then ANP. When I came to IUC I was at first an NP, then it became ECP despite this being a defunct title and PP would be the correct title and when I completed my master's I became and ANP – well eventually, after they got their head around Masters. I took to wearing a CoP pin badge as openly as I could, so it was clear I was not trying to usurp a protected title and pretend to be a nurse. What also really annoys me is that I am still classed as an ANP, there is no ACP contract yet. That means I am grade amongst those who have master's but many nurses who have not studied the 4 pillars but simply have a prescribing award because this was a nursing standard of may be 10 years ago. Just having a prescribing award does not make you an Advanced anything. I really dislike it when ambulance crews do not realise, I am a paramedic and treat me like a nurse who doesn't understand the ambulance service practices. We have had some funny well depending on your point of view that is, funny incidents when ambulance crews take the lazy option and try to cut corners and I know what they should do, and I know their boss. My word they quickly sharpen up.

Section 2 Professional Integration

Again, being referred to as Nurse is annoying. Not that there is anything wrong with nurses, but I have a sense of esprit de corps, I worked hard to be a paramedic and we have different and complimentary skill sets that should be respected.

Section 3 Functioning as an Advanced Paramedic Practitioner

Actually, despite all my moaning, here in London we are much better respected. Largely because LAS promotes the concept of APPs and uses them as the CoP curriculum intended. We are immensely busy – yes, I respect the fact that everyone is busy, but it is so busy we do not have time for petty politics, and I have made some

excellent friends in the team I lead. For me prescribing was a bolt on to my MSc and it really makes a difference, I just wish the Home Secretary would get on and amend the Misuse of drugs act o I could prescribe codeine etc.

Section 4 Innovation and Role Progression

I like the fact that LAS are going to rotate their APPs through the IUCs I think it will be of great benefit to enable sharing of knowledge, skills, practice, and reflection.

Section 5 Paramedic Profession Potential

We need to work together to build new career pathways for paramedics. We have proven we have the aptitude we are however still quite linear in our progression.

Option 1 Management

Option 2 Education

Option 3 Clinical Skills as in APP but our focus is still as First Contact Clinicians in Urgent and Emergency work. How about mental health, rehab, conversion to nursing? Nurses have far more options and whilst they are totally nurse focused then the job adverts will continue to read “registered nurse”. I hope the ACP will start to see the healthcare community in a more horizontal perspective with many complimentary facets. Nurse lead environments still do not really understand what a paramedic is, and it is a shame to have to camouflage ourselves under the ACP banner. We should perhaps be able to state our role as ACP (Paramedic), ACP (Nurse), ACP (Physiotherapist) so that everyone knows we are ACPs but that we come with different indoctrinated perspectives, hidden and explicit curricula for better or worse.

Section 6 Career Structure

Yes, it is nice, but it is limiting and largely only benefit the “elite” at this time who in my experience use it to build their own empires – just look and the nursing structure, now there is an aspirational target for us.

Appendix 5

Cross-analysis

Code = Interview Transcript Number and then Section Number.

Subject	Interviewee Number and Section
Expectations of the Ambulance Service	N1S1, N2S1, N2S5, N3S2, N3S6, N4S5, N4S6 N5S2, N5S4, N5S6, N6S6, M3S4, M5S6, L1S1 L1S2, L3S4. L3S1 (other side of integration).
Reasons for leaving Ambulance Service	N1S5, N1S6, N2S1, N2S6, N4S5, N5S1, N5S2, N5S4, N5S6, N6S5, N6S6, M2S5, M2S6 L1S3, L2S3
Expectations of Integrated Urgent Care	N1S2, N1S3, N2S1, N2S2, N2S5, N3S2, N4S1, N4S2, N4S3, N5S1, N5S5, N6S1, M2S1, M3S1, M4S3, M4S4, M5S2, M5S3, L2S1, L2S6.
Options for Development	N2S4, M2S4, M4S4, M4S5, L1S2, L1S5,
Specific Concepts: Integration/ Social Stratification N1S1, N2S2, N6S1 Understanding M4S4 Telephone Triage N1S4, N3S1, N3S4, M3S4, M4S4, L2S3, L2S4 Turf Wars N2S4, M2S2, M2S3,	
Working with GPs	N1S2, N2S2, N5S2, N5S4, N6S2, M2S2, M3S2, M3S3
Alternative working	M1S1
Loss of professional identity	M1S1, M1S6
HR, HE and Professional Integration	N1S1, N1S3, N2S1, N2S2, N2S4, N2S5, N3S1, N3S2, N3S3, N3S5, N3S6, N4S1, N4S3, N4S4, N5S1, N5S3, N5S5, N6S1, N6S2, M1S1, M2S1, M3S1, M3S5, M4S1, M4S3, M5S1, M5S5, L1S1, L1S2, L2S1, L2S2, L3S1, L3S2, L3S3,
Social Group Opinion	M2S5, M4S5

Appendix 6

Social Reality Analysis of the themes

Vorwelt	Umwelt	Mitwelt	Folgewelt
the realm of peripheral interest or of the past.	the realm of the directly experienced social reality	the realm of the indirectly experienced social reality	the realm of successors
	Nomenclature – modern standards poorly understood	Nomenclature – modern standards poorly understood	
Nurse dominated sector	Nurse dominated sector	Nurse dominated sector	
ANP does not cover the 4 Pillars of Adv. Practice	ANP does not cover the 4 Pillars of Adv. Practice	ANP does not cover the 4 Pillars of Adv. Practice	
	Misuse of protected titles	Misuse of protected titles	
	IUC Blueprint	IUC Blueprint	
	Competency Framework	Competency Framework	Competency Framework
	Professionalism and Multi-professionalism.	Professionalism and Multi-professionalism.	Professionalism and Multi-professionalism.
Conflicting Education systems. CBET Vs Liberal Education.	Conflicting Education systems. CBET Vs Liberal Education.	Conflicting Education systems. CBET Vs Liberal Education.	Conflicting Education systems. CBET Vs Liberal Education.
NMC accreditation to 4 Pillars but only RPL local policy for paramedics	NMC accreditation to 4 Pillars but only RPL local policy for paramedics	NMC accreditation to 4 Pillars but only RPL local policy for paramedics	NMC accreditation to 4 Pillars but only RPL local policy for paramedics
Interprofessional working (ellis13)	Interprofessional working	Interprofessional working	Interprofessional working
	Professionalism and Multi-professionalism.	Professionalism and Multi-professionalism.	Professionalism and Multi-professionalism.

	Spiral Curriculae	Spiral Curriculae	Spiral Curriculae
Inappropriate promotion to APP within the Ambulance Service	Inappropriate promotion to APP within the Ambulance Service	Inappropriate promotion to APP within the Ambulance Service	
Ambulance Deployment Model doesn't really fit the APP/ ACP IUC role. Misuse of the Career Structure Ambulance Service driving forces – response times vs clinical outcomes.	Ambulance Deployment Model doesn't really fit the APP/ ACP IUC role. Misuse of the Career Structure Ambulance Service driving forces – response times vs clinical outcomes.	Ambulance Deployment Model doesn't really fit the APP/ ACP IUC role. Misuse of the Career Structure Ambulance Service driving forces – response times vs clinical outcomes.	
Service culture and public expectation of transportation to hospital. (PM John Major – Patient's Charter 1992)	Service culture and public expectation of transportation to hospital. (PM John Major – Patient's Charter 1992)	Service culture and public expectation of transportation to hospital. (PM John Major – Patient's Charter 1992)	
	Leadership & Management structures Porter's 5 Forces	Leadership & Management structures Porter's 5 Forces	Leadership & Management structures Porter's 5 Forces
	Service and Culture merger	Service and Culture merger	Service and Culture merger
	MSc ACP Apprenticeship pathways	MSc ACP Apprenticeship pathways	
	Paramedics as generalists	Paramedics as generalists	
Benefit of medical control of paramedic education	Benefit of medical control of paramedic education	Benefit of medical control of paramedic education	

	Anti-paramedic response	Anti-paramedic response	
	Misdiagnosis from Telephone Consultations	Misdiagnosis from Telephone Consultations	
	NHSD Senior Clinician Module for Pathways.	NHSD Senior Clinician Module for Pathways.	
	Not the job we signed up for (Telephones)	Not the job we signed up for (Telephones)	
			PGCert Telephone Triage
	Alternative roles, Career mobility	Alternative roles, Career mobility	Alternative roles, Career mobility

Themes extrapolated to the 4 Pillars of Advanced Clinical Practice.

Pillar 1 Clinical Practice	Pillar 2 Leadership & Management	Pillar 3 Education	Pillar 4 Research
Nomenclature – modern standards poorly understood	Nomenclature – modern standards poorly understood	Nomenclature – modern standards poorly understood	Nurse dominated sector
Nurse dominated sector	Nurse dominated sector	Nurse dominated sector	Spiral Curriculae
ANP does not cover the 4 Pillars of Adv. Practice	Misuse of protected titles	ANP does not cover the 4 Pillars of Adv. Practice	IUC Blueprint
Competency Framework	ANP does not cover the 4 Pillars of Adv. Practice	Competency Framework	Professionalism and Multi-professionalism.
Spiral Curriculae	Competency Framework	Conflicting Education systems. CBET Vs Liberal Education.	Interprofessional working

IUC Blueprint	NMC accreditation to 4 Pillars but only RPL local policy for paramedics	Spiral Curriculae	PGCert Telephone Triage
Professionalism and Multi-professionalism.	Inappropriate promotion to APP within the Ambulance Service	IUC Blueprint	Misdiagnosis from Telephone Consultations
Interprofessional working	Conflicting Education systems. CBET Vs Liberal Education.	Professionalism and Multi-professionalism.	Alternative roles, Career mobility
Complimentary skill sets	Spiral Curriculae	Interprofessional working	
Paramedics as generalists	IUC Blueprint	PGCert Telephone Triage	
Benefit of medical control of paramedic education	Professionalism and Multi-professionalism.	Misdiagnosis from Telephone Consultations	
NHSD Senior Clinician Module for Pathways.	Interprofessional working	Alternative roles, Career mobility	
Misdiagnosis from Telephone Consultations	Anti-paramedic response	MSc ACP Apprenticeship pathways	
Not the job we signed up for (Telephones)	NHSD Senior Clinician Module for Pathways.		
Alternative roles, Career mobility	Misdiagnosis from Telephone Consultations		
Service culture and public expectation of transportation to hospital. (PM John Major – Patient's Charter 1992)	Not the job we signed up for (Telephones)		
Service and Culture merger	Ambulance Deployment Model doesn't really fit the APP/ ACP IUC role. Misuse of the Career Structure Ambulance Service driving forces – response		

	times vs clinical outcomes.		
	Alternative roles, Career mobility		
	Service culture and public expectation of transportation to hospital. (PM John Major – Patient's Charter 1992)		
	MSc ACP Apprenticeship pathways		
	Leadership & Management structures Porter's 5 Forces		
	Service and Culture merger		

Appendix 7

Focus Group Control Sheet		
Date	Start Time	Location
No. of Participants	Finish Time	Chaired by:

	Timing	**Title**
Topic 1		
Aims		
Topic 2		
Aims		
Topic 3		
Aims		
Topic 4		
Aims		
Topic 5		
Aims		

Previous Knowledge Assumed: *(e.g. Qualified Clinical Advisors)*

Materials and Equipment Required:
Register, Room booking confirmed, Refreshments, Handouts, Pens, Paper etc. *(Adjust as applicable to your needs)*

Differentiation:
The approach to this supervision should be one of support for all levels of participant. Participants should be invited to discuss in private any concerns they have over diversity and differentiation. Common concerns will likely be Dyslexia, Dyspraxia, and Dyscalculia for which further Hidden Disability support is available. Hidden Curriculum issues (that is previous discrimination on the grounds of impairment, age, sex, race, social class etc.) for some this might also affect confidence in the classroom setting.

Ground Rules:
Confidentiality – what is said stays in the room unless agreed otherwise. Confidentiality – No patient identifiable information.
Professional behaviour.
Professional and polite language.
Active but respectful participation.
Allow everyone to have input.
Non-judgemental – professionals can admit their mistakes but should not feel persecuted for them.

Register

Confidentiality will be maintained during all forms of Clinical Supervision however the supervisee should note information will be shared with line managers as part of Induction, Personal Development Reviews, Appraisals or Development Plans. Furthermore, there is a professional expectation that the Supervisor would disclose information that may be related to patient harm or any situation in which the supervisor's regulatory body (HCPC, NMC, GMC etc.) mandates disclosure. **By signing this document in the sections immediately below both the Supervisor and Supervisee acknowledge the content of this statement.**

Number	Name	Signature	Department	Time	
				Arrived	Departed
1					
2					
3					
4					
5					
6					
	Supervisor Name	Supervisor Signature			

Topic 1					
Interaction Monitoring					**Notes on interaction:**
Participating Yes / No	Number		Statements to the general group		Number	
	1				1	
	2				2	
	3				3	
	4				4	
	5				5	
	6				6	
			Statements to the chair			
Actions and Comment						
General notes						
Managerial Actions *(Normative)*						
Learning Actions *(Formative)*						
Supportive Actions *(Restorative)*						
Group has agreed to feedback actions as appropriate Yes / No						
Date of feedback						
To whom was feedback given?						
By what medium was the feedback given? *(e.g. email, F2F, Minuted Meeting)*						
Responses feedback to group Yes / No						

Thanks

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