Education and Training Committee – 10 March 2010

Review of the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts

Executive summary and recommendations

Introduction
This paper invites the Committee to approve the document 'Review of the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts for publication'.

The Committee is asked to note that approval for publication would be subject to changes as a result of the publication process which includes legal scrutiny by HPC's solicitor.

Decision
The Committee is asked to discuss the review report and approve it subject to changes arising from the publication process.

Background information
- "HPC Approval of IHCD Paramedic Programmes", Approvals Committee, 5 September 2006
- "Pre-registration education and training for Paramedics", Education and Training Committee, June 2007, enclosure 11
- "Pre-registration education and training for Paramedics", Education and Training Committee, March 2008, enclosure 14
- Education and Training Committee - Review of the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts – 22 September 2009, enclosure 10

Resource implications
Employee time in relation to the production of this document was not accounted for in the Education Department work plan 2009-2010, but provisions have been made for the 2010-2011 work plan.

Financial implications
The costs associated with production and dissemination of the publication have been accounted for the Education Department budget 2010-2011.

Appendices
Appendix 1 - Review of the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts

Date of paper
26 February 2010

Review of the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts

(Publication code: XXXX)

Contents

Section one: Introduction

About us (the Health Professions Council)

We are the Health Professions Council (HPC) and we were set up to protect the public. To do this, we keep a register of professionals who meet our standards for their training, professional skills, behaviour and health.

Professionals on our Register are called 'registrants'. We currently regulate 14 health professions.

- Arts therapists
- Biomedical scientists
- Chiropodists / podiatrists
- Clinical scientists
- Dietitians
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists / orthotists
- Radiographers
- Speech and language therapists

We may regulate other professions in the future. For an up-to-date list of the professions we regulate, please visit our website at www.hpc-uk.org

Our Register is available on our website for anyone to search, so that they can check the registration of their professional.

Our main functions

To protect the public, we:

- set standards for registrants' education and training, professional skills, conduct, performance, ethics and health;
- keep a register of professionals who meet those standards;
- approve programmes which professionals must complete to register with us; and
- take action when professionals on our Register do not meet our standards.

The Health Professions Order 2001 ("the Order") says that we must set our standards to protect the public, and that we must set standards which are necessary for safe and effective practice. This is why our standards are set at a 'threshold' level (a minimum level of safe and effective practice).

Brief overview of the approval process
We visit all the programmes we approve to make sure that:

- the education programme meets or continues to meet our standards of education and training (SETs);

- those who complete the programme are able to meet or continue to meet our standards of proficiency (SOPs) for their part of the Register; and

- all programmes and education providers are assessed fairly and consistently.

When we carry out an approval visit, we are represented by what we refer to as the HPC Panel. The HPC Panel is normally made up of two visitors, at least one of whom is from the same part of the Register as the profession with which the programme is concerned and an education executive. The education executive's role is to support both the visitors and the education provider. Throughout the visit, we will ask questions of staff, students, senior managers and placement providers. We relate all our discussions back to our standards. At the end of the approval visit, the visitors will make a judgement about whether, or to what extent, the programme meets or continues to meet our standards. Their recommended outcome will be sent to our Education and Training Committee (ETC) which makes the final decision.

About this document
This report details the work conducted to review the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts.

The review focused on the series of approval visits undertaken by the Education Department to UK ambulance trusts. In particular the review focused on the following areas:

- how the HPC made the decision to undertake a programme of visits to UK ambulance NHS trusts;
- how the work the HPC performed to undertake the visit programme was formulated;
- the impact of the implementation of the approval visit on the ambulance trusts and the HPC; and
- the outcomes of the approval visits and the implications for the future of paramedic education from a regulatory perspective.

The review draws on:
- qualitative review of Department records of the amended approval process used to conduct the programme of visits and a structured interview with the lead Education Officer for the project;
- quantitative data drawn from operational records held by the Education Department to describe some of the key features of the implementation of the approval process; and
- quantitative and qualitative review of the reports produced after each visit.

Section two: Why and how the review was conducted

The history leading to the programme of visits
At the meeting held in February 2004, the Education and Training Committee decided to conduct approval visits to all approved programmes of study which had not been subject to a visit following the publication of the Quality Assurance Agency's Subject Benchmark Statement for each profession.

This led to a period of activity for the Education Department in which programmes that had not received a visit following publication of the Subject Benchmark Statement were contacted and visits arranged. The publication date for the Benchmark Statement for paramedic programmes is 2004.

In the case of the paramedic profession many of the approved programmes were delivered by UK ambulance trusts and followed the IHCD (part of Edexcel) rules for delivery and assessment of the programme. It was anticipated at the time that a visit was required to approve the IHCD model of training programme rather than visits to specific sites of delivery.

Information available at that time indicated that the IHCD model of programme was due to be phased out as the profession made the transition to higher education. Additionally, the UK ambulance trusts were also subject to restructuring in July 2006 with the majority of trusts being merged.

The uncertainty surrounding the longevity of the programmes alongside the significant resource impact of 34 visits being added to the schedule led to the decision being made that the UK ambulance trusts had first to be entered into the annual monitoring audit process before visits would be undertaken. The annual monitoring process would then be used to prioritise visits as appropriate in the visit schedule for the following academic year.

In the 2005/2006 cycle of annual monitoring all UK ambulance trusts submitted an audit which was assessed by visitors. Of the 34 ambulance trusts, only three resulted in a recommendation that an approval visit was required to, if necessary, place conditions on continued approval. A paper was brought to the Committee on 5 September 2006 to report the outcomes of annual monitoring for the UK ambulance trusts. In this paper it was stated that the distinctiveness of the arrangements for delivery and assessment of the programmes at each ambulance trust warranted site specific visits.

Owing to the continuing uncertainty related to the longevity of the IHCD model of paramedic training and the recent merger of 34 trusts into 15, the Committee directed the Education Department to contact all the ambulance trusts to determine if there was an intention to continue to run a programme of this type. If an ambulance trust had an intention to continue to run the programme, the Education Department was directed to organise a visit as appropriate in light of that information.

At this time it was anticipated that following the site specific visits, a visit would take place to IHCD to deal with generic matters across all delivery sites and related to the IHCD programme structure.

On 12 June 2007 another paper was brought to the Committee to report on the findings from the exercise to contact the UK ambulance trusts. It was stated in this paper that though there was a clear intention to move paramedic training into higher education, the duration of time required for the transition required that IHCD programmes continue to run until at least 2008. The Committee decided that all ambulance trusts were to be subject to an approval visit unless written confirmation was provided that the programme would cease to enrol students beyond 1 September 2008.

Preparation for the programme of visits

It was recognised that the IHCD model of education and training was significantly different from the majority of approved programmes that are based in higher education. However, it was also recognised that the standards of education and training (SETs) and the approval process were appropriate to ensure that those who complete programmes delivered at ambulance trusts have demonstrated an ability to meet the standards of proficiency.

As a result, the Education Department commenced work to review and amend the approval operational process to be appropriate for ambulance trusts. This work commenced with a meeting with a group of HPC paramedic visitors with experience of conducting visits. At this meeting each standard was discussed to determine what types of appropriate evidence for the SETs an ambulance trust may be able to provide and any particular themes that may emerge as a result of implementing the approval process. This information was then used to undertake a series of activities to prepare for the visits. These activities included:

- tailoring correspondence to visitors and education providers to use appropriate terminology;
- producing an agenda suitable for an ambulance trust;
- producing a tailored visitors' report;
- training Education Officers and Education Administrators to attend this type of visit or deal with queries respectively; and
- communicating the standards and amended process to the ambulance trusts.

An additional consideration was made with regard to the visiting panel. It was decided that the visiting panel would, when possible, be made up of two paramedic visitors and, to provide support, a third visitor from another profession who had experience in the education setting and of attending HPC approval visits.

The process of scheduling visits into the 2007/2008 academic year proved challenging in some cases owing to specific extenuating circumstances related to individual trusts or, in one case, failure to submit documentation that was then followed by submission of extenuating circumstances. The first visit took place on 11 March 2008 and the last visit took place on 20 January 2009.

Outcomes from the programme of visits
All the visitors' reports have been produced and approved by an Education and Training Panel and the majority of the programmes were granted continued approval. There were three programmes that had there approval withdrawn as the final outcome and one programme is to have a decision made on the final outcome at the next meeting of the Education and Training Committee in March 2010. The recommendation being made to committee in this instance is to withdraw approval also.

As there was sufficient data to start describing trends from the visits, focus was then turned to the outcomes as documented in the reports, Departmental records and feedback from the Ambulance Trusts involved with this process. All the reports can be found online in the Education and Training Panel papers and, once a final outcome has been reached, on the Education Department webpage (www.hpc-uk.org/education). Appendix A summarises the outcomes reached in the case of each of the 15 UK ambulance trusts. Please note that South Central Ambulance Service Ambulance Service NHS Trust indicated that there was no intention to continue delivering the programme beyond 1 September 2008 and therefore no visit was required meaning that only 14 ambulance trusts are displayed in the graphs that follow in this report.

The evidence base
The evidence used to review the programme of visits to pre-registration education and training delivered by UK ambulance NHS trusts was gathered from visitor reports produced from the 14 visits undertaken, the experience of a key member of the Education Department responsible for planning and overseeing the implementation of the approval process, and from feedback sought from the 14 ambulance trusts who were subject to an approval visit.

Visitor's reports
Visitor's reports are produced after an approval visit has been conducted to a programme. This report details the visitors' recommendation about whether a programme can receive open-ended approval or re-approval of this status. Their recommendations are based upon whether a programme meets all of the SETs. Visitors' can make one of three recommendations:

1. To approve/reapprove the programme
2. To approve/reapprove the programme subject to conditions being met
3. To not approve/withdraw approval from a programme

When conditions are applied to a programme, these are detailed in the visitors' report and always relate to a particular SET and always contain reasons for applying it. Conditions are then met via the submission of further documentation from the education provider to the visitors'. The visitor's must be satisfied the documentation submitted in response to the conditions demonstrates how the programme meets the SETs. Education providers are afforded two opportunities to meet conditions prior to a final visitor recommendation being made to the ETC.

Experiences of the Executive
Interviews were conducted with the Education Officer overseeing the planning and implementation of the approval process. The aim of the series of interviews was to record their experience of adapting the traditional approval process to undertake visits to the ambulance trust programmes. The interview covered the methods used to conduct the pre-visit, visit and post-visit stages of the process in-depth.

Ambulance Trust Feedback
A feedback form was distributed to all Ambulance Trusts involved in the approval process in December 2009. The form was designed to gather each trust's experiences of the approval process. The form extracted information on a range of pre-visit, visit and post-visit issues and each trust's views on how these they were managed. Issues explored further included:

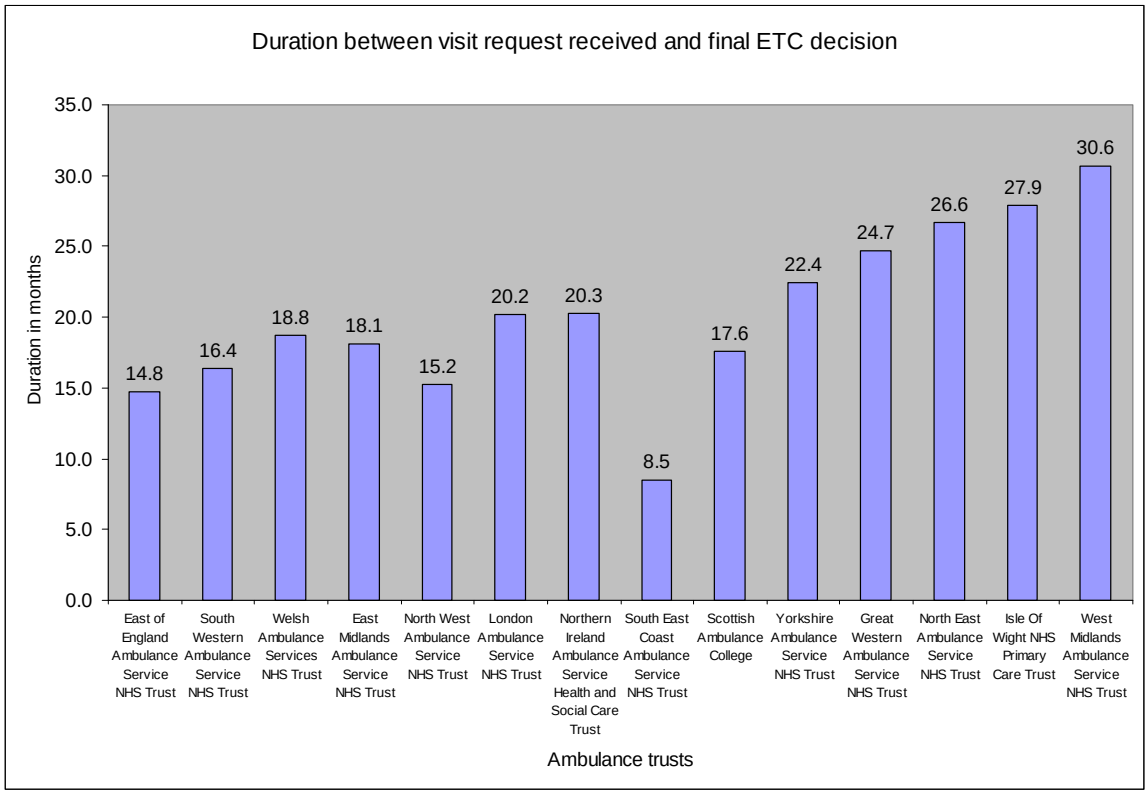
- the appropriateness of publications and communications to inform the trusts of the purpose and requirements to met for the visit;
- the appropriateness of the suggested agenda and the groups of people to be met at the visit;
- the documentation required prior to visit;
- the role and remit of the HPC and the visiting panel at the visit; and
- the appropriateness of the report and its usefulness in clarifying the requirements for conditions to be met.

It should be noted that six ambulance trusts responded to this feedback request. Of these, five trusts have received reconfirmation of open-ended approval and one trust has had approval withdrawn from the programme. This represents a 40% response rate to the feedback request from the sample. The sample represents ambulance trusts and programmes which received differing final outcomes from their engagement with the approvals process. A copy of the feedback form can be found at Appendix B.

Section three: Analysis

The resource impact for the HPC

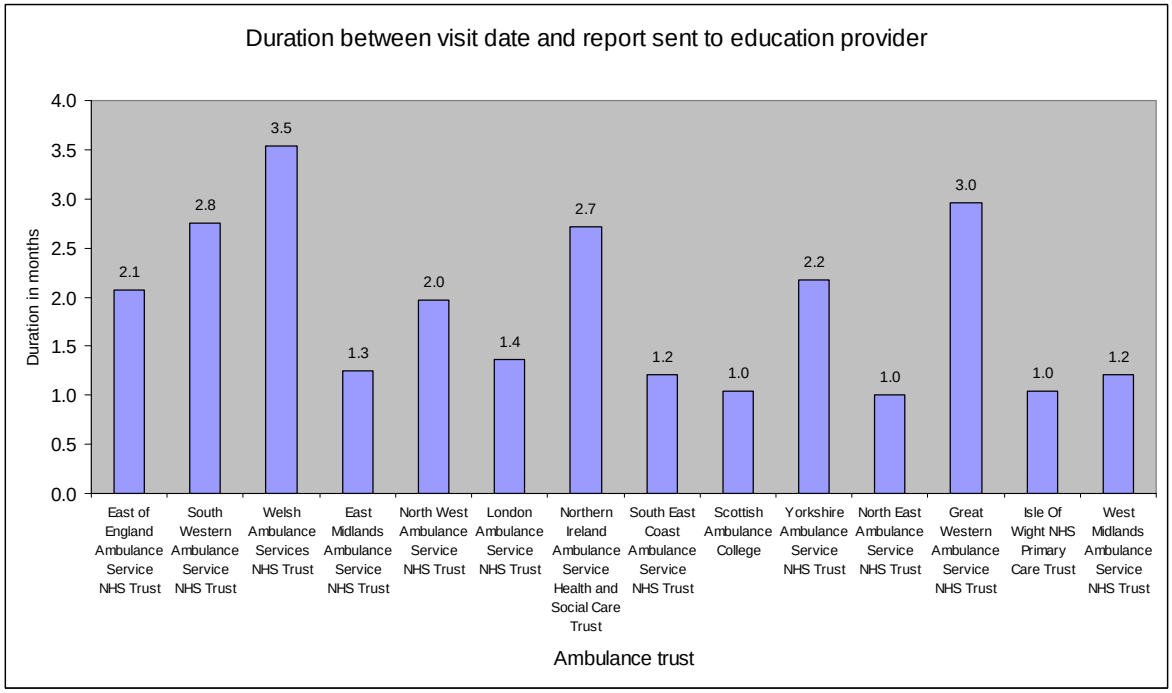
From an operational perspective, the work undertaken to visit each of the programmes was significant. The duration of the approval process was extended owing to the increased resource requirements related to the different stages in the approval process. The graphs below illustrate some of the durations of stages of the approval process.



The graph above illustrates the durations for the full approval process to reach completion from the date on which a visit request was received. It is apparent that duration of the implementation of the process is significantly longer than is the case with visits to other types of programme of study. This is representative of the complexity of each of the approval event and the associated impact on the time spent working on these visits. In some cases the process has taken in excess of two and a half years from the date the visit request was received. This extended duration can be attributed to a variety of reasons, including:

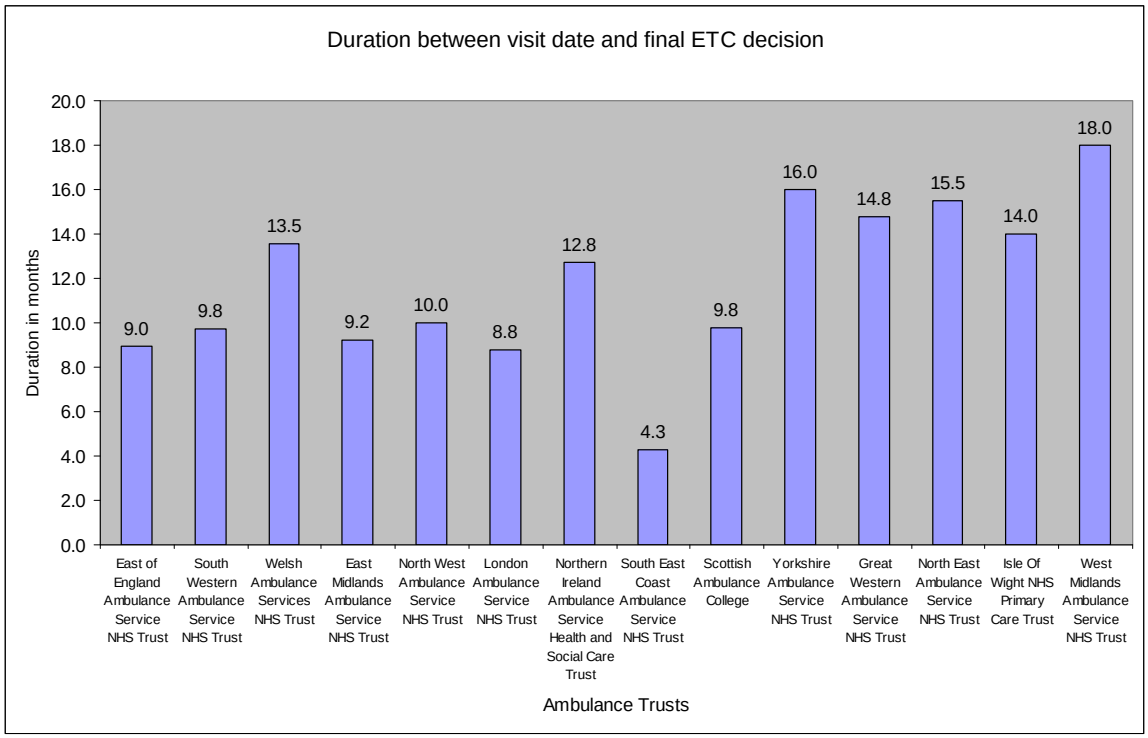
- education providers suggesting the latest possible dates for their visit to be undertaken to maximise the time to present documentation;
- extenuating circumstances leading to rescheduled visits;
- documentation deadlines being missed leading to cancelled visits;
- the durations taken to produce reports; or
- the time required for education providers to meet conditions.

These atypical resource demands resulted in the extended duration of the approval process. For example the following graph shows the duration taken to produce visitors' reports after each of the visits.



All the reports took one month or more to produce and in some cases more than three months. These durations are in stark contrast to the durations taken to produce reports in previous Department annual reports in which 94% of reports are submitted to education providers within 28 days of the visit date. These extended durations can be attributed to the individual complexity of some of the cases and the numbers of conditions required. For some of the earlier reports, there was also the requirement to seek legal advice on specific wording which led to increased time spent on drafting reports.

Another resource intensive period in the implementation of the approval process can be seen in the post visit stage. The graph overleaf shows the durations of the post visit stage from the visit date through to the date the ETC made the final decision for each programme.



Previous annual reports have indicated that the post visit process is completed in the majority of cases (57%) within four months of the visit date. Only 11% of cases were reported in the 2007 annual report to have required more than six months in order to meet conditions placed on approval or continued approval. In all but one case, the post visit process for the ambulance trusts exceeded six months. The one case in which the post visit process was resolved in less than six months was a result of a decision of the Education and Training Committee to withdraw approval without the education provider submitting a response to the conditions.

The post visit process in some cases was impacted by the duration it took to produce reports, but in the majority of cases was a result of the time the ambulance trusts required to respond to the conditions placed on continued approval. In some cases, the education providers submitted observations on the visitors' report to contest issues of accuracy in the report but also to request extended deadlines or split deadlines for meeting conditions. Extended or split deadlines were granted by the Education and Training Panel in cases where specific conditions could not be met within the normal time frame owing to extenuating circumstances, such as a particular trust waiting for publication of curriculum information by IHCD.

Feedback from ambulance trust's

Although the resource impact to the HPC was considerable, the impact to the ambulance trusts in applying the approval process was also significant. Information regarding the ambulance trust's satisfaction with the duration of the approval process was sought in the feedback exercise and the results are detailed in the table below.

Table 1

Question 12	Responses			
Did you find the time taken to complete the process satisfactory (from submission date of visit request form to receipt of official outcome of the approval process)?	**Yes**	4	**No**	2

Of the six ambulance trusts to respond, four found the time taken to be satisfactory. The two trusts, unsatisfied with the time taken, both received reconfirmation of approval. Both cited the feedback from visitors' as the part of the process with which they were most dissatisfied. Given the trend emerging above related to the time taken to produce reports, it is inevitable that some negative feedback would be received in this area. However the responses to this question indicate that the feedback was not wholly negative. This may be attributed to the increased speed of production of reports as the Education Department and visitors became more used to managing the complexities of these visits alongside better management of the expectations of the education providers.

Recommendations from visitors regarding responses to condition on approval also took longer than usual. It is pertinent at this point to highlight the complex issues that arose during approval visit and the post visit process which affected the duration of the decision making process for visitors. Visitors required extended durations to consider documentation submitted and in most cases exceeded the traditional timeframes set for this part of the process.

Further feedback was sought regarding the timeliness of communications across the three stages of the approval process –pre-visit, visit and post-visit. Table 2 below details the responses from the trusts to these questions:

Table 2

Approval stages – Communication and information	Responses			
Did you find communication and information was delivered in a timely manner throughout the approval process? (Pre-visit)	**Yes**	6	**No**	0
Did you find communication and information was delivered in a timely manner throughout the approval process? (Visit)	**Yes**	5	**No**	1
Did you find communication and information was delivered in a timely manner throughout the approval process? (Post-visit)	**Yes**	4	**No**	2

All six trusts appear to state that in the main communication and information was delivered in a timely manner. However it is apparent that there is a reduction in satisfaction as the approval process moved towards completion.

Five of the respondent trusts agreed information and communication was delivered in the timely manner at the visit itself. One ambulance trust disagreed and indicated communication and information was not delivered in a timely

manner at this stage of the process. One issue in particular was seen as contributing to this view. The respondent cited the lack of collaboration the HPC panel had with the rest of the approval visit panel members and used a comparison to another HPC approval event the respondent had observed.

This programme received a reconfirmation of approval as the final outcome for this visit. However this particular trust was one of the first programmes to be visited by the HPC. In light of this information, the response regarding the perceptions of the visiting panel is expected and brings to light to a pertinent point. This was an existing process being applied to an education provider outside the traditional higher education environment. This presented complex challenges for the HPC and the ambulance trust. Both the visiting panels and the education provider often had to work hard to communicate effectively in relation to standards and processes common in higher education by more rarefied in the ambulance trusts.

The resource impact into the planning, communication and implementation of the approval process sought to ensure a fair and equitable process was applied. It is obviously, however, a factor that the lessons learnt from this early visit were fed into future visits and is reflected in the responses of the other five ambulance trusts.

Regarding the post visit stage, four trusts found communication and information was delivered in a timely manner. Two trusts indicated they did not find this to be the case. These respondents cited the duration to receive the visitors' report and the feedback from the visitors' regarding the ambulance trusts responses to conditions exceeded the timeframes communicated through publications and at the visit. These extended durations and the reasons for them have been highlighted in earlier sections of this review. Yet this feedback further acknowledges the effects this had on the ambulance trusts themselves. The final outcomes for the programmes delivered by these two trusts were that of reconfirmed approval. Though the time taken may have exceeded operational norms it is possible to view this additional time as being necessary to manage the complexities of the visits. In particular, the time taken to produce reports allowed each visiting panel to give definitive information and provided clear messages to each trust regarding their programmes.

Pre-visit stage

To further explore the application of the approval process in more detail, ambulance trusts also responded to more detailed aspects of the pre-visit, visit and post-visit stages of the approval process. Table 3 below details the responses received from ambulance trusts regarding aspects of the pre-visit process.

Table 3

Pre-visit stage questions	**Responses**			
Q1. Did you find our publication the 'Approval process - supplementary information for education providers' useful to prepare for your visit?	**Yes**	5	**No**	1
Q2. Did you feel well informed regarding the HPC's purpose for conducting an approval visit?	**Yes**	5	**No**	1
Q3. Did you feel well informed during the organisation of the visit?	**Yes**	5	**No**	1

Q4. Did you feel the suggested agenda for the visit was easy to accommodate and negotiate?	**Yes**	6	**No**	0
Q5. Was it clear what groups/people the HPC needed to meet with as part of the suggested agenda?	**Yes**	5	**No**	1
Q6. Was it clear what documentation we needed from you once a visit date had been suggested?	**Yes**	4	**No**	2

Feedback was sought regarding the usefulness of the 'Approval process - supplementary information' publication in preparation for visits. The majority of respondents found this publication to be useful. One trust however did not and in particular found the information contained difficult to understand as this was a new process from the perspective of the trust. This feedback highlights one of the main challenges the HPC faced in preparing for these visits. Traditionally, the approval process has been applied to programmes within higher education (though it is designed to work across education settings). A shared understanding of terminology between the HPC and higher education institutions along with reliance upon existing policies and processes assists the smooth implementation of the approval process.

Many of these advantages were not present when working with ambulance trust programmes. The particular ambulance trust in question had approval of the programme withdrawn in this instance. Due to the sample size and the response rate within the sample, no credible correlation can be made between the usefulness of the publication and the predicted outcome of a visit. However the data does suggest that successful engagement with the supplementary information document may be a factor in achieving a successful visit outcome.

Respondents were also asked whether they felt well informed of the HPC's purpose for conducting an approval visit. Five trusts felt they were well informed. One trust did not feel well informed of the purpose for the visit. In particular they did not understand why the HPC were visiting individual ambulance trusts instead of IHCD itself. This particular feedback highlights another challenge which was anticipated by HPC in the preparation for these visits. Although this feedback was from one trust, the experience was that this was a widely held view. The evidence within this report supports the view that all the programmes were based on the IHCD curriculum, but delivered in unique ways. This was the viewpoint held by HPCs Education and Training Committee in deciding to visit individual sites of delivery.

Respondents also advised if they felt well informed during the organisation of the visit. The majority of respondents did indeed feel well informed. Broadly across all the visits the data here suggests the significant resources employed by the Education Department to communicate key messages were expended successfully. In particular, in spite of the extended durations afforded to ambulance trusts to provide documentation and negotiate agendas, the key messages regarding the organisation of the visit were communicated. This view is supported when referring back to Table 2 which clearly demonstrates all respondents were satisfied with the pre-visit stage of the process. Furthermore, this data supports the view that the approval process can be flexibly applied to other models of education outside of higher education.

One trust disagreed and felt uniformed at the visit itself. The communication of information by the HPC panel at the visit was an issue raised by the respondent and forms an emergent theme specific to that visit.

The respondents were also asked two questions concerning the agenda. In response to the first question all ambulance trusts were satisfied with the agenda and the fact this was negotiable and could accommodate other stakeholder requirements. The agenda was tailored to these visits. Significant resource was applied to ensure the meetings were appropriate and could be incorporated within the structure of each trust. Terminology was also used which was reflective of the professional titles used within the programmes. The data suggests these efforts were successful in achieving their purpose.

The second question sought feedback on the understanding respondents had regarding the groups the HPC were required to meet at the visit. In this case, five of the trusts felt they understood the people the HPC needed to meet with. Confusion arose with one trust regarding this issue. In this particular case, the ambulance trust had representatives fulfilling multiple roles within the programme. Therefore their presence was duplicated at different meetings at the visit. This particular trend is not unusual when reviewing visits to other education programmes across different professions. It is often the case that members of the programme team are also present at meetings with senior team members. Yet, the challenges which caused the most confusion centred on the roles and titles used within ambulance trusts and how these differed to those in higher education settings. In such cases and due to the nature of the visits, further clarification of these roles was sought out at the visit itself.

The submission of documentation is a key milestone in the pre-visit approval process. Respondents were asked if they were clear about the documentation the HPC required once a visit date had been confirmed. Four of the trusts indicated they were clear about these requirements. Interestingly, although clear, one trust did note the HPC did not account for some additional mapping documentation which was supplied by the ambulance trust. This documentation related to how the programme meets the requirements for other external stakeholders. The HPC visitors are appointed to assess how the programme meets the SETs and will consider evidence relating specifically to these. This feedback highlights the clarity of the regulatory role of the HPC and that of other external bodies (QAA, professional bodies, funding bodies) was not communicated clearly to this trust. As this was a new process applied to ambulance trusts, it can be expected this understanding will increase as the education provider continues to engage with HPC processes.

The remaining two respondents were not clear of the documentation requirements. One trust indicated that as this was the first visit they were subject to, they were unprepared for the specific documentation requirements. Particular reference was made to the approval process being traditionally applied to stakeholders within higher education which are better placed to interact with the documentary requirements. The final outcome for this programme was to have approval withdrawn. The challenges highlighted by this particular trust regarding documentation were identified by the HPC as challenges common to all sites of delivery and was accounted for in the preparatory adaptations to the approval process terminology (apparently successfully in most cases).

The second trust dissatisfied in this area cited the requirements outlined in the approval - supplementary publication could be interpreted in different ways. The challenge raised in this instance is one which was also clear to the HPC at the beginning of the review of ambulance trust programmes. This is also a challenge as the organisation continues to function as a multi-professional regulator with the approval of programmes leading to registration outside the higher-education environment. This publication and all other publications are designed to communicate with a range of stakeholders. Therefore, information contained within is generic and open to interpretation depending on the audience. As mentioned previously, significant resource was expended in this review of paramedic programmes to ensure issues of terminology and process were clarified. These two trusts highlighted similar challenges in submitting appropriate documentation to the HPC. Interestingly, the final outcome for this trust was to have ongoing approval confirmed for their programme. This suggests the final outcome of the process for trusts does not clearly correlate to the challenges faced by each trust in meeting our documentary requirements. Again this supports the view each trust was unique in its delivery of paramedic programmes and the application of the approvals process is robust and adaptable to different models of education.

The Visit stage

Feedback was also gathered on the trust's experience of the approval visit itself, the results of which are included in Table 4 below.

Table 4

Visit stage questions	**Responses**			
Q7 At the visit was the role and remit of the HPC made clear?	**Yes**	5	**No**	1
Q8. At the visit was the role of the visitors and the HPC executive made clear?	**Yes**	6	**No**	0
Q9. During the approval process were the post visit procedures made clear to you?	**Yes**	6	**No**	0

In particular, views were sought on whether the role and remit of the HPC was made clear to those present at the visit. The Education Executive present at any approval visit is required to inform the approval panel (representatives of the education provider, external stakeholders and the HPC) of the HPC's role and remit. This is usually communicated at the beginning of an approval visit. As part of this communication, the specific role of the Executive and the visitors is also clarified. Feedback was also sought on whether this information was also made clear to the panel at the visit. Five of the respondent trusts agreed the role and remit of the HPC was made clear. All six trusts agreed the role and remit of the executive and visitors' was also made clear. One trust disagreed there was a clear communication of the role and remit of the HPC. In particular, the respondent indicated the HPC panel did not engage in collaborative discussion with the rest of the members of the joint panel. This is a consistent area of feedback from a particular education provider and has been discussed earlier in this review.

Another important area at the visit is the communication of the post-visit procedures to the education provider. Feedback was sought on whether these procedures were made clear to the ambulance trusts. Due to the complexity and

number of conditions, feedback to the panel was limited to information about operational timeframes for the post-visit stage. One trust commented that although the post-visit timeframes were communicated, they were not adhered to (28 day turnaround for report and visitor feedback). In practice it was these post-visit procedures and the traditional timeframes which proved most challenging to the HPC, visitors and the ambulance trust. These challenges are detailed further in the report and provide learning points about the application of the post-visit process to an education provider outside of higher education.

The Post-visit stage

Table 5 below details the results of specific feedback to questions focused on the post-visit stage of the approval process.

Table 5

Post-visit stage questions	**Responses**			
Q10. Was the function and format of the visitors' report clear and easy to understand?	**Yes**	5	**No**	1
Q11. Did you understand exactly what was required of you in order to address the conditions set as outlined in the visitors' report?	**Yes**	4	**No**	2

In particular, information from the trusts was sought regarding the clarity of the visitor reports. Additionally, feedback was also gathered regarding whether the trusts understood exactly what was required of them to address the conditions set in the visitor reports. Five out of the six trusts agreed the reports were clear and easy to understand. One trust disagreed and cited the practice of listing each standard of proficiency (SOPs) not met as the reason for this view. The final outcome for this particular programme was to have approval withdrawn.

The listing of particular SOPs not met for conditions relating to SET 4, is not a standard practice and is applied where it is deemed useful to do so for the education provider to address the condition. For the purposes of visits to ambulance trust programmes, individual SOPs were listed in 12 of the 14 reports. In the two cases where the SOPs were not listed, the programmes received over 20 conditions each and of those at least 3 conditions were related to the curriculum. In both cases the final outcome was to approve the programme. However seven other programmes also received approval with SOPs listed.

Once received, four of the trusts understood what was required of them in order to address the conditions set for the programme. One comment cited the need to contact the Education Department for further clarification. Two trusts did not understand the requirements to meet conditions. One of the respondents did state they required further clarification to gain a full understanding of the conditions set. This was an expected trend given this was the first HPC visitors' report each trust received as a result of an approval visit. Education executives were required to provide additional support to trusts to clarify the conditions set. This increased support was above that normally required to other programmes. However, the extended duration required to produce the reports provided three trusts with reports that they could clearly understand. Further support through phone and email contact with the HPC clarified requirements for two other trusts. These measures, although not normal to the post-visit stage, were necessary for these purposes. Interestingly, these five trusts all had ongoing approval

confirmed by the ETC. The remaining trust referenced the list of SOPs not met in the visitors' report for not understanding the requirements set out by the conditions.

Education provider feedback conclusions

The feedback acknowledges this was a challenging process for the ambulance trusts to understand and engage with as they were not familiar with such a process being applied to their programmes. With this reflection in mind, the majority were satisfied with the approach adopted by the HPC in relation to these programmes. The difficult issues emerging as concurrent themes from each trust's experiences included:

- gaining a clear understanding of why visits were taking place;
- gaining a clear understanding of how the approval process was applied and the potential outcomes;
- the terminology used by the HPC throughout publications, correspondence and visitors reports;
- the groups of people who were to be present at the visit itself; and,
- the time taken to receive visitor feedback on the trust's responses to conditions

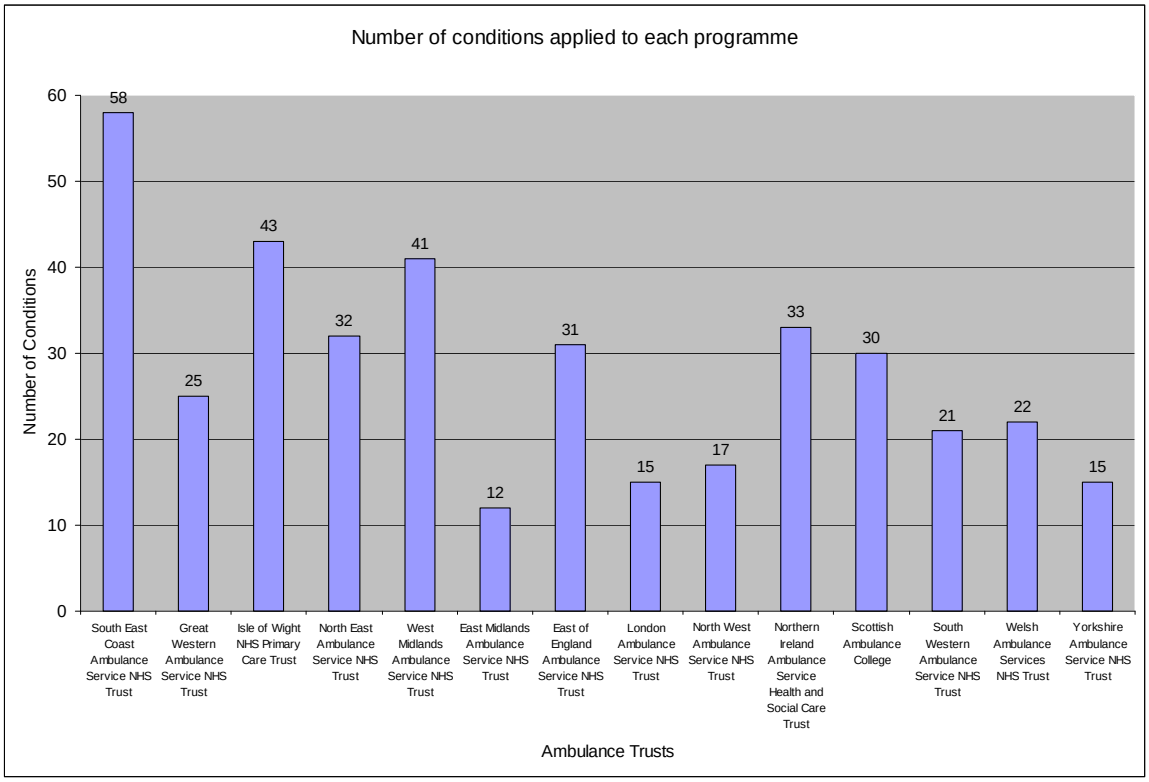
These common issues were addressed with each trust as and when they were required to by the Executive. The requirement for additional assistance required to assist the trusts through this process directly affected the length of time taken to complete the process. However the view widely held by the trusts who did respond to the consultation was that in light of these challenges the HPC Executives and visitors were contactable, approachable and well informed.

Wider considerations regarding the methodology used to review pre-registration education and training delivered by UK ambulance NHS trusts needs to be made. Firstly, the evidence highlighted in the feedback exercise supports the view the adaptations applied to the approvals process were effective to some extent in assisting ambulance trusts in engaging with HPC. The pre-visit, visit and post-visit stages, traditionally applied to higher education programmes, were successfully applied to a different model of education. The particular challenges to education providers and the resource burden to the Executive have been acknowledge in this report. These provide valuable areas for consideration when undertaking comparable work in the future.

Furthermore, the trends in the feedback indicate no direct correlation between the process adopted and the predicted final outcome for programmes. Although similar challenges were faced across the trusts, the outcomes for each individual trust varied, even within the feedback respondents.

Standards of education and training

As mentioned previously, one of the increased demands on Education Department employee and visitor time was spent in producing reports. This was particularly attributed to an unusually high number of conditions placed on continued approval. The graph below illustrates the numbers of conditions applied to each programme.



There is considerable variation between the numbers of conditions applied across the programmes. In some cases the number of conditions is significantly higher than commonly found in cases of visits to programmes that already have approval. In contrast, a number of the programmes have less than 20 conditions applied to ongoing approval, which is relatively typical of a programme visited for the first time by the HPC following the publication of the QAA Benchmark Statement. The variance between the number of conditions supports the view that the individual ambulance trusts implemented the IHCD model of paramedic education in distinctive ways and therefore a delivery site visit was required.

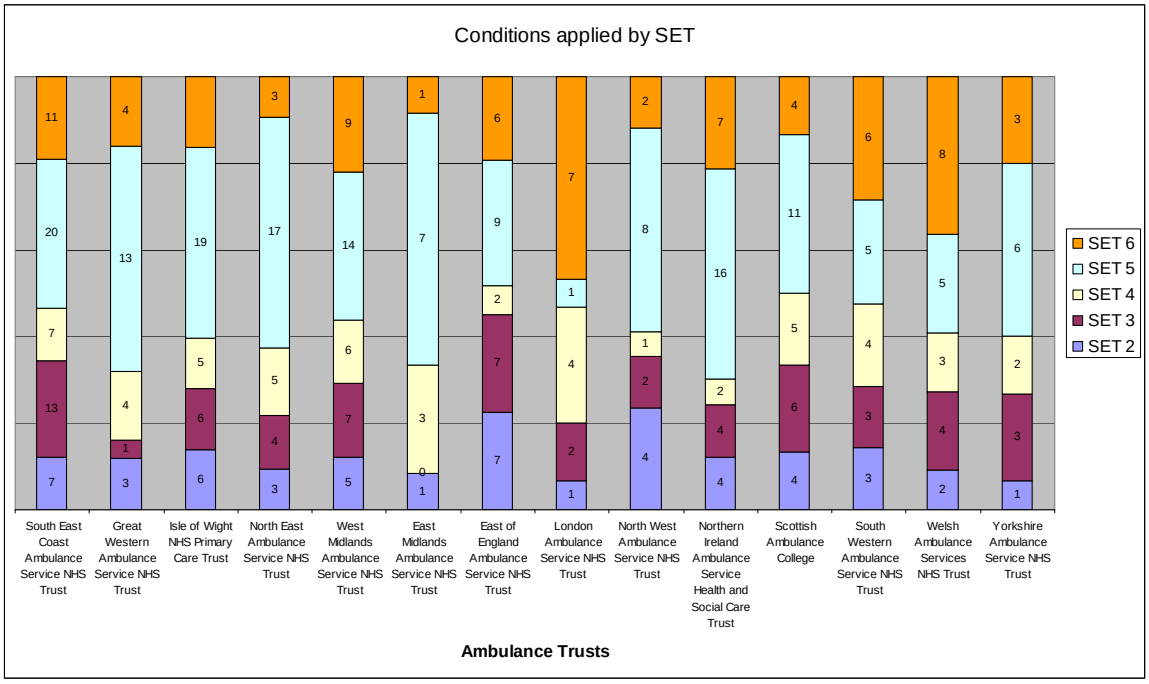
Notably, in the case of the programme which received the highest number of conditions (over 50), an eventual decision for withdrawal of approval was reached by the Education and Training Committee. Of the two programmes which received more than 40 conditions, one has had approval withdrawn and the other has its' decision on approval pending to be considered at the Education and Training Committee meeting to which this paper is also being submitted. The recommendation to committee in this instance will be to withdraw approval also.

These three programmes, although all likely to have approval withdrawn took varying times from 8.5 – 30.6 months to complete the approval process. Therefore, the high number of conditions applied did not necessarily relate to the length of the approval process. These programmes tended to have extenuating

circumstances related to key programme team members as the main cause for the extended duration. Many programmes had more than 30 conditions, but less than 40. Programmes within this range of conditions reached a final outcome within a wide variance of time from 14.8 – 20.6 months taken to complete the approval process. A selection of programmes had more than 10 conditions, but less than 30. These programmes took between 15.2 – 24.7 months to reach a final outcome and complete the approval process. Again this supports the view that the number of conditions does not necessarily relate to a predictable extended duration for the approval process. However, these do further highlight the complexities of each ambulance trust and programme visited and further supports the decision to visit each site separately.

One consequence of the number of conditions applied to each programme was that it made it challenging to provide useful informal feedback at the end of the approval visit and in many cases it was decided that it would be inappropriate to list the conditions that were being placed on continued approval. This made the production of the visitors' report more crucial for the ambulance trusts as it was the first opportunity to determine the full nature of the outcome related to the approval visit and begin the work of responding to conditions.

The graphs which follow below provide more detail on the nature of the conditions that were applied to the ongoing approval of the programmes.



The graph above illustrates which areas of the SETs were subject to conditions at each of the ambulance trusts. Again, there is significant variance between each programme in terms of application of conditions to a particular type of standard. For example, in relation to SET three (management and resource standards), one programme received no conditions whilst other programmes received up to 13 conditions.

Generally, a trend emerges that the most significant proportion of conditions applied to each programme fell under SET five (practice placement standards). This is relatively typical of all programmes of study subject to approval visits and

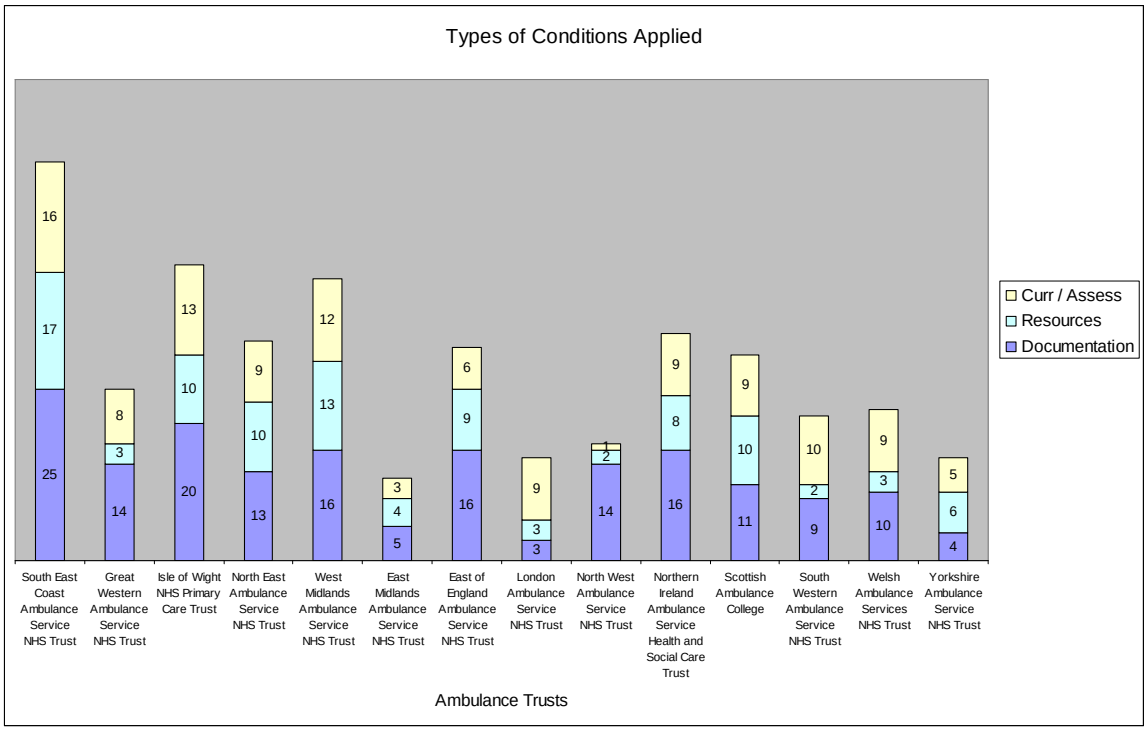
is a recorded trend in previous annual reports. Some programmes stand out as exceptions to this, such as the one delivered by the London Ambulance Service NHS Trust, which received just one condition related to the practice placements and proportionally received more conditions related to assessment standards.

Commonly, the range and duration of placement experience was an area for further development in the programmes. Each ambulance trust has responded individually to the conditions, but IHCD have also recently amended the rules that dictate how training is delivered to increase the required range and duration of placement education.

For one programme that has reached a final decision for withdrawal of approval it is possible to see that there were a significant number of conditions applied to all areas of the standards. However, for two other programmes and the final programme due for a final decision on withdrawal, SET 5 conditions were also the highest, however there were no clear trends of significant conditions across all other SETs.

The graph on the following page provides an illustration of the nature of the conditions applied. The conditions have been broken into three categories:

- **Resource based** – requires changes to resource allocation for the programme for the standard to be met;
- **Documentary based** – there is evidence to show that the standard is met, but documentation requires updating to reflect this evidence; and
- **Curriculum or Assessment based** – requires review of the curriculum or assessment procedures to ensure the standard is met.



As is common to many approval visits, a trend emerges which shows that visitors have received verbal confirmation or demonstration that a standard is met, but did not receive documentary evidence to support this. In 11 out of the 14 cases,

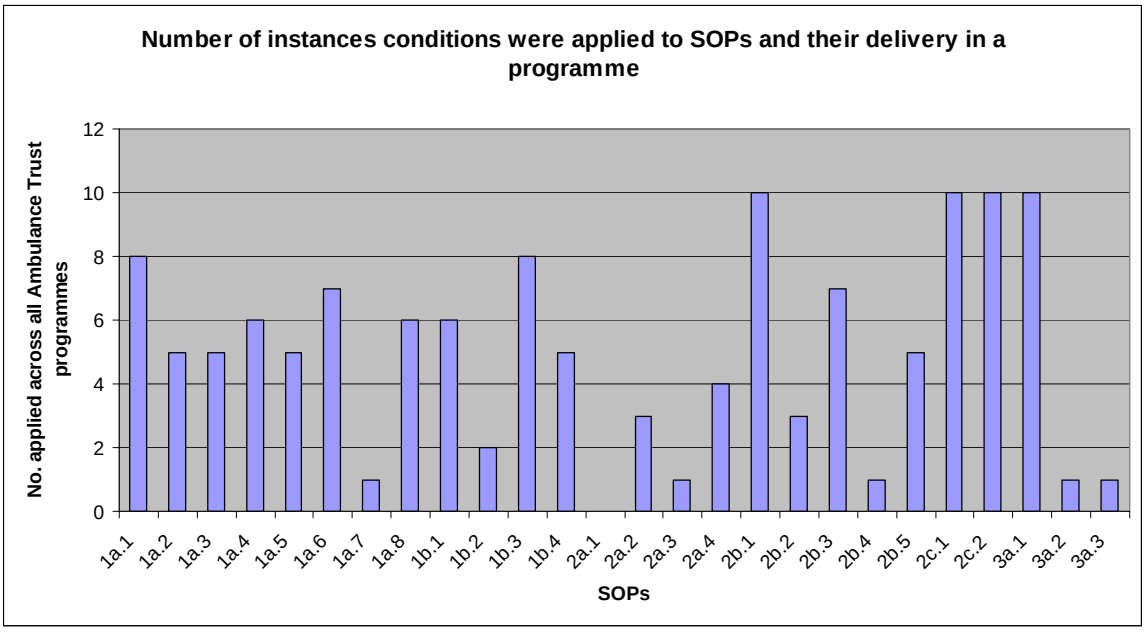
this type of condition is the most common. This type of condition is indicative that in terms of student experience or attainment of the standards of proficiency the standard is in effect met, but not adequately documented.

Resource based conditions appear in relatively high proportion in the three programmes which have reached a final outcome of withdrawal of approval and in the one programme due for consideration at the March 2010 Education and Training Committee. In this case, the recommendation is to also to withdraw approval. However, programmes which received a similar proportion of conditions related to resources have received outcomes for continued approval.

Curriculum or assessment based conditions also appear in relatively high proportion across all programmes (excluding East Midlands Ambulance Service NHS Trust and North West Ambulance Service NHS Trust). This is statistically significant in contrast to previously published annual reports which indicated the emergence of a potential trend that curriculum based conditions were relatively infrequent. Across the reports there is a general trend of a condition being put in place to document that significant numbers of standards of proficiency have not been adequately mapped against learning outcomes for the programme.

Standards of proficiency

The graph below reports the number of times conditions were applied which required education providers to better articulate particular standards of proficiency (SOPs) in programmes. The distribution of conditions related to individual SOPs illustrates variance across the ambulance trusts.



In relation to this variance, there is no standard of proficiency common to all the 14 programmes which required greater articulation. There are, however, four standards which were outlined in conditions placed on 10 of the 14 programmes that were visited. The highest occurrence of SOPs occurs at 2b.1, 2c.1, 2c.2 & 3a.1. It is important to note that this analysis does not take into account the individual sub-standards under each SOP heading. At this stage it is suggestive, but not conclusive, that these may have been common areas not articulated in the IHCD curriculum guidance for this type of education and training.

Further analysis (documented later in this review) was undertaken under each of the SOP headings to ascertain whether these instances are related to specific sub-standards within the SOPs or whether a significant variance of sub-standards within these can be found. It may be the case that only one sub-standard under a SOP heading may have required greater articulation in the programme documentation.

The standards of proficiency which required conditions in 50% or more of the visited programmes are:

SOP heading number	SOP wording
1a.1	be able to practice within the legal and ethical boundaries of their profession
1a.6	be able to practise as an autonomous professional, exercising their own professional judgement
1b.3	be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relatives and carers
2b.1	be able to use research, reasoning and problem-solving skills to determine appropriate actions
2b.3	to be able to formulate specific and appropriate management plans including the setting of timescales
2c.1	be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly
2c.2	be able to audit, reflect on and review practice
3a.1	know and understand the key concepts of the bodies of knowledge which are relevant to their profession specific practice

In the majority of cases in the above SOPs it is apparent that they fall into a category of professional skills rather than technical competencies.

Each ambulance trust has responded individually to the conditions, but IHCD have also recently amended the rules that dictate how training is delivered to include the addition of Module J which is entitled “Professional Paramedic Practice” and includes explicit delivery of learning outcomes related to professional skills rather than technical competencies. Some ambulance trusts have made the decision in responding to the conditions to incorporate the IHCD Module J, whilst others have taken a different approach by either including a trust designed module J or amending the programme in other ways. Again, this reflects the significant variance between the individual programmes.

The tables below provide further analysis of the SOPs which were most commonly identified across the visitor reports. Each table is grouped according to the three overarching areas of practice as articulated in the HPC Standards of proficiency for paramedics. Each table is then further defined according to the sub-areas of practice applicable. For the purposes of further analysis, each sub-standard SOP was allocated a specific number in order to identify each easily. A copy of this numbering system can be found at Appendix C.

Expectations of a health professional

- *1a - Professional autonomy and accountability*

1a.1 Sub Level		1a.6 Sub Level		1b.3 Sub Level	
1.a.1.i	**4**	1a.6.i	**5**	1b.3 i	**6**
1.a.1ii	**6**	1a.6.ii	**6**	1b.3 ii	**8**
1.a.1 iii	**5**	1a.6.iii	**5**	1b.3 iii	**8**
1.a.1 iv	**6**	1a.6.iv	**6**	1b.3 iv	**8**
1.a.1 v	**2**	1a.6.v	**6**	1b.3.v	**7**
				1b.3 vi	**7**
				1b.3 vii	**7**
				1b.3. viii	**7**

SOP 1a.1 was referenced in eight visitor reports. All sub-standards were referenced in at least two visitor reports, three sub-standards were at least five times, but no sub-standard was referenced in all eight reports. The distribution of data illustrates SOP 1a.1 and the majority of its sub-levels were referenced in a high proportion of visitor reports. This SOP is a professional skill which is generically applied to all health professions regulated by the HPC. The data suggests the evidence of the delivery of this SOP varied across the programmes visited and in a majority of cases was not evident. Factors influencing this could potentially relate to the design and delivery of the individual programme and also the articulation of these professional skills within the IHCD curriculum, however these are not conclusive only suggestive.

SOP 1a.6 was referenced in seven of the visitor reports. No sub-standard was referenced in all seven reports. However three sub-standards were referenced in six reports and the remaining two sub-standards were referenced in five reports. Similarly to SOP 1a.1, the distribution of data within SOP 1a.6 and the majority of its' sub-levels, also generic to all health professions, were referenced in half the visitors' reports. Although half the programmes did not provide evidence of how this SOP is delivered, obviously the other half did. This suggests there was a variance in design and delivery of programmes across each trust.

SOP 1b.3 was referenced in eight of the 14 visitor reports. All sub-standards were referenced in at least six reports. Three sub-standards were referenced in all eight reports. The professional skills articulated in these sub-standards are generic across all health professions except SOP 1b.3.viii which is specific to the paramedic profession. The distribution of data highlights this SOP in its entirety as common to a high proportion of visitor reports. This suggests this area of practice was not clearly articulated in the programme documentation of a high proportion of programmes. Common factors influencing this trend could possibly be attributed to these professional skills not being clearly articulated in the IHCD curriculum guidance in the first instance; however this is suggestive and not conclusive. As mentioned previously, clearly the design and delivery of each programme varied significantly which may have also affected the delivery of this SOP.

The skills required for the application of practice

- *2b – Formulation and delivery of plans and strategies for meeting health and social care needs*
- *2c – Critical evaluation of the impact of, or response to, the registrant's actions*

2b.1 Sub Level		2b.3 Sub Level		2c.1 Sub Level		2c.2 Sub Level	
2b.1.i	**10**	2b.3 i	**7**	2c.1.i	**9**	2c.2.i	**10**
2b.1.ii	**9**	2b.3 ii	**7**	2c.1.ii	**6**	2c.2.ii	**9**
2b.1.iii	**10**			2c.1.iii	**8**	2c.2.iii	**9**
2b.1.iv	**8**			2c.1.iv	**5**	2c.2.iv	**9**
2b.1.v	**10**					2c.2.v	**10**
						2c.2.vi	**8**

SOP 2b.1 was referenced in 10 of the 14 visitor reports resulting from approval visits to ambulance trusts. This SOP and its' sub-standards are generic to all health professions regulated by the HPC. Three of the sub-standards of this SOP were not met in all ten reports. The remaining two standards were referenced in at least 8 of the reports. The significant distribution across all the sub-standards suggests one of two likely causes for their absence from these trust programmes.

Firstly, the IHCD curriculum upon which these programmes were based, did not clearly articulate the proficiencies encompassed by this SOP. Or secondly, these ambulance trusts did not clearly articulate how this SOP is delivered from the programme documentation submitted. Further analysis of these trends is not possible with the data set provided for this report. The absence of evidence relating to SOP 2b.1 in its entirety from 10 of the 14 programmes visited does however suggest each trust was responsible for the design and delivery of their programme and not dependent on meeting external stakeholder requirements.

SOP 2b.3 was referenced in half of the reports. Interestingly, one sub-standard is generic to all health professions and the other is specific to the paramedic profession. Both sub-standards were also referenced across all these reports. Again the data illustrates this SOP was applied in its' entirety to half the programmes. Although not conclusive, the absence of this SOP can be related to the area of practice not being clearly articulated in either the IHCD curriculum guidance or the programme documentation, or possibly a combination of both. It is important to note half the programmes met this standard in its entirety and therefore this highlights the unique nature of these programmes across different ambulance trusts.

SOP 2c.1 was referenced in 10 out of the 14 visitor reports. This SOP and all its sub-standards are generic across all regulated professions with the HPC. Of the four sub-standards, no one sub-standard was referenced in all 10 reports. The variance of the data within this SOP highlights the unique design of each programme delivered at different sites and further supports the decision to visit each. However sub-standard 2c.1.i was referenced nine times and 2c.1.iii was referenced eight times. This is a significant trend within the data set.

These sub-standards relate to the gathering of information, including qualitative and quantitative data to help evaluate the response of service users to care, and the need to monitor and evaluate the quality of practice and contribute to generation of data for the quality assurance and improvement of programmes. These sub-standards both relate to professional skills of gathering of evidence to influence practice. The data suggests the curriculum design specifically addressing this SOP and its sub-standards varied depending on the individual trust. The data does not suggest the curriculum was deficient in delivering these sub-standards, but merely the programme documentation did not evidence how SOP 2c.1 was delivered.

SOP 2c.2 was referenced in 10 out of the 14 visitor reports. This SOP and all its sub-standards are also generic across all regulated professions with the HPC. Two of the sub-standards were not met in all ten reports and the remaining four standards were referenced in at least 8 of the reports. The presence of each sub-standard throughout all or most of the 10 reports is statistically significant to the data set. In particular, similarly to the trends identified in SOP 2b.1, the data suggests the IHCD curriculum upon which these programmes were based, did not clearly articulate the proficiencies encompassed by this SOP. Or alternatively these ambulance trusts did not clearly articulate how this SOP is delivered from the programme documentation submitted.

Knowledge, understanding and skills

- *3a – know and understand the key concepts of the bodies of knowledge which are relevant to their profession-specific practice.*

3a.1 Sub Level		3a.1.viii Sub Level		3a.1.ix Sub Level	
3a.1.i	**0**	3a.1.viii.a	**9**	3a.1.ix.a	**3**
3a.1.ii	**7**	3a.1.viii.b	**9**	3a.1.ix.b	**2**
3a.1.iii	**2**	3a.1.viii.c	**8**	3a.1.ix.c	**4**
3a.1.iv	**3**			3a.1.ix.d	**8**
3a.1.v	**1**			3a.1.ix.e	**7**
3a.1.vi	**4**				
3a.1.vii	**1**				
3a.1.viii	**9**				
3a.1.ix	**8**				
3a.1.x	**2**				

SOP 3a.1 was also referenced in 10 out of the 14 visitor reports. Nine out of the ten sub-standards were referenced in the reports. Of these nine, no one sub-standard was referenced in all 10 reports. However sub-standard 3a.1.viiii was referenced nine times and 3a.1.ix was referenced eight times and there presence can be considered significant to the data set. Both these sub-standards are standards of proficiency which are specific to the paramedic profession. These SOPs require registrants to have an understanding of aspects of behavioural and clinical science. These sub-standards have further sub-levels which are explored further on in this report. This will clarify which areas within this SOP, if any, were common to all the visitor reports.

It is pertinent to raise two relevant points at this juncture regarding this SOP. Firstly this SOP relates to technical competencies a registrant must possess.

This deviates from the analysis already discussed which has identified the common presence of SOPs relating to professional skills. These competencies are also specific to the paramedic profession which again differs according to the common trends outlined previously in this report. This suggests further analysis and conclusions cannot simply focus on multi-professional skills common to all health professions. Rather particular focus needs to be given to the profession specific skills and competencies and how these were addressed and delivered at individual trust sites. This added complexity further highlights each trust's approach to delivering the IHCD curriculum differed and the documentation produced varied accordingly.

SOP 3a.1.viiii relates to the understanding of various aspects of behavioural science. Of the three sub-standards related to this SOP two were applied across all nine visitor reports and the remaining standard was applied to eight. The significant presence of all the sub-level standards to at least 80% of programmes which applied SOP 3a.1.viii highlights a common trend.

The data does suggest the psychological and social aspects underpinning the knowledge, understanding and skills delivered on programmes were not articulated clearly. This can possibly be contributed to each trust's approach to delivering their programmes. In particular, the common trend highlighted for this SOP must be balanced to consider three programmes did actually evidence the delivery of this SOP. Although a significant proportion did not evidence the delivery of SOP 3a.1.viii, the variance within the small data set further highlights the unique nature of each programme. Furthermore, the data may suggest the IHCD curriculum did not clearly articulate this standard in the first instance. Therefore this may have compounded the effect this may have had in each trusts' delivery of paramedic programmes.

SOP 3a.1.ix concerns the understanding of various aspects of clinical science. Of the five sub-standards related to this SOP two sub-standards were referenced at least seven times with SOP 3a.1.ix.d referenced eight times. There is a variance of distribution of all the sub-levels. This highlights the complexity of delivery within this SOP across different programmes, and can be more broadly applied to signify the unique nature of each programme. However, unlike the previous sub-standard analysis, conclusions should focus on the significant trends within this particular data set. In particular, the SOPs relating to:

- the principles of evaluation and research methodologies which enable the integration of theoretical perspectives and research evidence into the design and implementation of effective paramedic practice, and
- the theories supporting problem solving and clinical reasoning,

were common to at least 70% of the reports referencing SOP 3a.1.ix. The significance of these two SOPs may indicate these technical competencies were not clearly articulated in the programme documentation of a significant proportion of ambulance trusts or that the IHCD curriculum did not clearly articulate these standards of proficiency in the first instance. The variance found across all the sub-standards relating to this SOP strongly suggests the deliver of this SOP and the sub-levels was dependant on factors concerning the site of delivery.

Conclusions on SOPs data

Further analysis conducted into the most common SOPs contained within the visitors' reports highlight many issues. Firstly, the data continues to suggest the IHCD curriculum guidance upon which these programmes where traditionally based may have not articulated common standards of proficiency. However the variance of SOPs applied to programmes at the first, second and where applicable the third sub-levels indicates each trust delivered their programmes in their own way. The factors influencing the common trends and also the variance within each SOP could be further explored. In particular a gap analysis could be conducted within the IHCD curriculum to ascertain if any elements relating to the professional skills and technical competencies identified in the visitors reports could be attributed to the curriculum itself. However, this research is outside the scope and purpose of this report. The SOPs data definitively suggests the model of education adopted within each ambulance trust differed significantly. Therefore, the decision to view each site and programme unique and visit accordingly is confirmed and to some extent negates the value of the reviewing the IHCD curriculum document against the SOPs directly.

Although the variance of SOPs within each visitors report is evident, there are common trends which have been explored further. Of note is the clear evidence these SOPs related predominantly to professional skills, however some elements of technical competencies were also present. Further analysis has highlighted all the professional skills common to the visitor reports are generic professional skills applicable to registrants of all health professions regulated by the HPC. This suggests these aspects of practice, which may be founded within the education programmes of other health professions, is continuing to be developed and embedded within some models of paramedic education. This is certainly not conclusive given the size of the data set, however worth noting as the HPC continues to engage with paramedic education in the coming years.

The data also highlighted common technical competencies which related to SOPs referenced in a high proportion of visitor reports. The competencies were profession specific and related to the understanding of aspects of behavioural and clinical science. Factors affecting the absence of these SOPs in the programmes delivered by ambulance trusts cannot be explored further within this data set.

It is important to note at this stage that the data above does not correlate directly to whether or not individuals who have completed one of these programmes have attained the standards of proficiency, just that the programme documentation did not clearly indicate how learning outcomes were linked to standards of proficiency.

IHCD as a curriculum setting body

Much of the data above and the range of responses to conditions also demonstrates that the IHCD curriculum has been an important element of the programmes that have been visited, but that each ambulance trust has made a different decision about how closely to follow IHCD guidance in the process of meeting conditions placed on continued approval. This reflects the status of the IHCD curriculum in these programmes as being similar to that of other curriculum guidance documents for the professions subject to regulation by HPC. Curriculum guidance documents form an important part of an education provider's reference tools in the development and implementation of an approved programme of study. However, as the standards of education and training and standards of proficiency are the threshold standards required for approval of a programme, curriculum guidance documents are not critical to the decision making process to grant approval to a programme. This means that education providers must be cognisant of the curriculum guidance available to a profession, but that each education provider must make an individual decision about the most appropriate way to meet HPC standards.

In the case of the programmes delivered at ambulance trusts, this approach to the IHCD curriculum has led to the significant variance between programmes growing in scale in the process of meeting conditions placed on continued approval.

In the cases of programmes that have received a final outcome of continued approval it is difficult to state that they are only comprised of elements from the IHCD curriculum. In many cases, the programmes incorporate elements derived from:

- the IHCD curriculum;
- the College of Paramedics curriculum guidance document;
- ambulance trust specific initiatives; or
- procedures from higher education partner institutions.

In effect this has meant that whilst many of the programmes still contain with the programme title "IHCD paramedic award", it is challenging to define these programmes as being solely IHCD models of education and training.

Section four: Conclusions

It is clear from the data and analysis in this report that the implementation of the programme of visits resulted in a disproportionate resource burden on the Education Department. This resource burden appears to have been the result of:

- the differences between the type of education and training delivered by ambulance trusts and higher education programmes, which was anticipated; and
- the individual complexity of implementing the approval process at particular trusts, which was difficult to anticipate.

These burdens were acknowledged and confirmed by the ambulance trusts as part of feedback sought from each delivery site on the implementation of the approval process. Furthermore, the feedback clearly demonstrated satisfaction from those trusts which responded with the process which was adopted in light of these burdens. The reflections received from the ambulance trusts confirm the additional resource burden undertaken by the Education Department to implement the approval process was necessary, and contributed to the successful implementation of the approval process. The data and analysis support the view the approval process is robust and flexible and can be applied to programmes which exist outside of the higher-education model. There are areas for further development, relating particularly to the communication activities at the post-visit stage, which have been highlighted in this report and will prove useful to future undertakings of a similar nature.

The final outcomes from each approval visit indicate that there is significant variance between each site of delivery and this supports the decision to visit each site. Trends have emerged in relation to the conditions applied to continued approval, but from the data it is difficult to determine their statistical relevance. Trends have also emerged in relation to the SOPs applied to the programmes. This data suggests there is also significant variance in the how programmes evidence the SOPs. Common themes also emerged regarding professional skills and technical competencies consistently applied and whether these where generic to all professions or specific to paramedics. These issues broadly highlight the trends specific to paramedic education and the importance of continually assessing the site of delivery of paramedic programmes.

For programmes which have reached a final outcome of continued approval, all conditions have been met. The responses to conditions varied in approach across the ambulance trusts and further distinguish the programmes delivered by ambulance trusts from one another. The distinctiveness of each programme reflects that IHCD acts as a curriculum setting body rather than as an education provider. Accordingly, in conducting visits to each site of delivery, this has effectively reviewed all the ambulance trusts and no specific visit is required to review the IHCD as a curriculum authority.

Section five: Our continued work in this area

Following on from reviewing a draft version of this review report, the Education and Training Committee in March 2009 made the decision to conduct a tailored annual monitoring review of all ambulance trust programmes granted open-ended approval. This review would draw on the routine evidence base for monitoring of all approved programmes, but also require trusts to comment on three areas which emerged from the review data. These three areas are:

- the progress of implementing and embedding professional skills into the delivery of their programme;
- the progress of implementing the range of appropriate placements; and
- the availability resources and confirmation of the ongoing provisions.

A key piece of information to take into account when considering the future of the IHCD model of education and training is the planned migration into the National Qualification Framework. Current information is suggestive that Edexcel are currently working on this and plan to have the work completed in or following 2011.

Given the Education and Training Committee's continued focus on the ambulance trusts and the still changing field of a key curriculum setting body, the HPC will continue to publicise, this document, the outcomes related to the annual monitoring exercise and the future plans related to the IHCD curriculum.

Appendix A – Summary table of outcomes for each visit

Current Trust name	Programme Name	Modes of study	Status
East Midlands Ambulance Service NHS Trust	IHCD Paramedic Award	FT and PT	Reconfirmed approval
East of England Ambulance Service NHS Trust	Certificate of Higher Education in Emergency Medical Care (incorporating the IHCD paramedic award)	PT	Reconfirmed approval
Great Western Ambulance Service NHS Trust	IHCD Paramedic Award	FT	Closed
Isle Of Wight NHS Primary Care Trust	IHCD Paramedic Award	FT	Approval withdrawn
London Ambulance Service NHS Trust	IHCD Paramedic Award	Block Release	Reconfirmed approval
North East Ambulance Service NHS Trust	IHCD Paramedic Programme	FT	Approval withdrawn
North West Ambulance Service NHS Trust	IHCD Paramedic Award	Block Release	Reconfirmed approval
Northern Ireland Ambulance Service Health and Social Care Trust	Paramedic-in-training	FT	Reconfirmed approval
Scottish Ambulance College	IHCD Paramedic Award	FT	Reconfirmed approval
South Central Ambulance Service NHS Trust	IHCD Paramedic Award	PT	Closed
South East Coast Ambulance Service NHS Trust	Early Registration Programme (IHCD Modules)	FT	Approval withdrawn
South Western Ambulance Service NHS Trust	IHCD Paramedic Award	FT	Reconfirmed approval
Welsh Ambulance Services NHS Trust	IHCD Paramedic Award	FT	Reconfirmed approval
West Midlands Ambulance Service NHS Trust	IHCD Paramedic	FT	Pending*
Yorkshire Ambulance Service NHS Trust	IHCD Paramedic Award	FT and PT	Reconfirmed approval

* To be considered at ETC on 11 March 2010

Appendix B – Feedback form

Ambulance Trust Feedback Form

Education Provider:
Name:
Position:

The Education department undertook approval visits to paramedic pre-registration education and training programmes delivered by NHS Trusts ambulance trusts in the 2007/2008 academic year. This questionnaire is designed to gather your feedback on the approval process adopted for these visits. Your thoughts, experiences and feedback on the process will be used to report to our Education and Training Committee in March 2010. The report produced will not reference specific names or bodies, just trends found across the data gathered from this form. Also your responses will have no affect on the outcome of the approval process conducted for your programme.

Approval Process: Pre-visit, Visit and Post-Visit

Pre-Visit

Q1 - Did you find our publication the 'Approval process - supplementary information for education providers' useful to prepare for your visit?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q2 - Did you feel well informed regarding the HPC's purpose for conducting an approval visit?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q3 - Did you feel well informed during the organisation of the visit?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q4 - Did you feel the suggested agenda for the visit was easy to accommodate and negotiate?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q5 - Was it clear what groups/people the HPC needed to meet with as part of the suggested agenda?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q6 - Was it clear what documentation we needed from you once a visit date had been suggested?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Visit

Q7 - At the visit was the role and remit of the HPC made clear?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q8 - At the visit was the role of the visitors and the HPC executive made clear?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Post –Visit

Q9 - During the approval process were the post visit procedures made clear to you?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q10 - Was the function and format of the visitors' report clear and easy to understand?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q11 - Did you understand exactly what was required of you in order to address the conditions set as outlined in the visitors' report?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Q12- Did you find the time taken to complete the process satisfactory (from submission date of visit request form to receipt of official outcome of the approval process)?

Yes ☐ No ☐

If no, please use the box below to provide further comments:

Overall

Q13 - Did you find communication and information was delivered in a timely manner throughout the approval process?

Pre-Visit	Yes	☐	No	☐
Visit	Yes	☐	No	☐
Post-Visit	Yes	☐	No	☐

If no, please use the box below to provide further comments:

Q14 - Do you have any further comments regarding the approval process?

Thank you for completing this form.

Please return electronic forms to us at education@hpc-uk.org

Alternatively if you would like to complete the form by hand please send completed forms to:

Education Department
Health Professions Council
Park House
184 Kennington Park Road
London
SE11 4BU

Please send all completed forms back to us by **22 January 2009.**

Appendix C – SOPs numbering

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
Expectations of a health professional		The skills required for the application of practice		Knowledge, understanding and skills	
1a Professional autonomy and accountability	1a	**2a Identification and assessment of health and social care needs. Registrant clinical scientists must**	2a	**3a Knowledge, understanding and skills**	3a
1a.1be able to practise within the legal and ethical boundaries of their profession	1a.1	2a.1 be able to gather appropriate information	2a.1	**3a.1 know and understand the key concepts of the bodies of knowledge which are relevant to their profession-specific practice**	3a.1
Understand the need to act in the best interests of service users at all times	1.a.1.i	**2a.2 be able to select and use appropriate assessment techniques**	2a.2	understand the structure and function of the human body, relevant to their practice, together with a knowledge of health, disease, disorder and dysfunction	3a.1.i

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
understand what is required of them by the Health Professions Council	1.a.1ii	be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment	2a.2.i	be aware of the principles and applications of scientific enquiry, including the evaluation of treatment efficacy and the research process	3a.1.ii
understand the need to respect, and so far as possible uphold, the rights, dignity, values and autonomy of every service user including their role in the diagnostic and therapeutic process and in maintaining health and wellbeing	1.a.1 iii	be able to conduct a thorough and detailed physical examination of the patient using observation, palpation, auscultation and other assessment skills to inform clinical reasoning and to guide the formualtion of a diagnosis across all age ranges, including calling for specialist help where available	2.a.2.ii	recognise the role of other professions in health and social care	3a.1.iii

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
be aware of current UK legislation applicable to work of their profession	1.a.1 iv	be able to use observation to gather information about the functional abilities of patients	2.a.2.iii	understand the theoretical basis of, and the variety of approaches to, assessment and intervention	3a.1.iv
be able to practise in accordance with current legislation governing the use of prescription-only medicines by paramedics	1.a.1 v	understand the need to consider the assessment of both the health and social care needs of patients and carers	2.a.2.iv	know human anatomy and physiology, sufficient to understand the nature and effects of injury or illness, and to conduct assessment and onservation in order to establish patient management strategies	3a.1.v
1a.2 be able to practise in a non-discriminatory manner	1a.2	**2a.3 be able to undertake or arrange investigations as appropriate**	2a.3	understand the following aspects of biological science:	3a.1.vi

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
1a.3 understand the importance of and be able to maintain confidentiality	1a.3	**2a.4 be able to analyse and critically evaluate the information collected**	2a.4	human anatomy and physiology, especially the dynamic relationships of human structure and function and the musculoskeletal, cardiovascular, cardiorespiratory, digestive and nervous systems	3a.1.vi.a
1a.4 understand the importance of and be able to obtain informed consent	1a.4	**2b Formulation and delivery of plans and strategies for meeting health and social care needs.**	2b	how the application of paramedic practice may cause physiological and behavioural change	3a.1.vi.b
1a. 5 be able to exercise a professional duty of care	1a.5	**2b.1 be able to use research, reasoning and problem solving skills to determine appropriate actions**	2b.1	human growth and development across the lifespan	3a.1.vi.c
1a. 6 be able to practise as an autonomous professional, exercising their own professional judgement	1a.6	recognise the value of research to the critical evaluation of practice	2b.1.i	the main sequential stages of normal development, including cognitive, emotional and social measures of maturation through human lifespan	3a.1.vi.d

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem	1a.6.i	be able to engage in evidence-based practice, evaluate practice systematically, and participate in audit procedures	2b.1.ii	normal and altered anatomy and physiology throughout the human lifespan	3a.1.vi.e
be able to initiate resolution of problems and be able to exercise personal initiative	1a.6.ii	be aware of a range of research methodologies	2b.1.iii	relevant physiological parameters and how to interpret changes from the norm	3a.1.vi.f
know the limits of their practice and when to seek advice or refer to another professional	1a.6.iii	be able to demonstrate a logical and systematic approach to problem solving	2b.1.iv	disease and trauma processes and how to apply this knowledge to the planning of the patient's pre-hospital care	3a.1.vi.g
recognise that they are personally responsible for and must be able to justify their decisions	1a.6.iv	be able to evaluate research and other evidence to inform their own practice	2b.1.v	the factors influencing individual variations in human function	3a.1.vi.h

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
be able to use a range of integrated skills and self-awareness to manage clinical challenges effectively in unfamiliar circumstances or situations	1a.6.v	**2b.2 be able to draw on appropriate knowledge and skills in order to make professional judgements**	2b.2	understand the following aspects of physical science	3a.1.vii
1a.7 recognise the need for effective self-management of workload and be able to practise accordingly	1a.7	be able to change their practice as needed to take account of new developments	2b.2 i	principles and theories of physics, biomechanics, electronics and ergonomics that can be applied to paramedic	3a.1.vii.a
1a.8 understand the obligation to maintain fitness to practise	1a.8	be able to demonstrate a level of skill in the use of information technology appropriate to their practice	2b.2 ii	the means by which the physical sciences can inform the understanding and analysis of information used to determine a diagnosis	3a.1.vii.b
understand the need to practise safely and effectively within their scope of practice	1a.8.i	**2b.3 be able to formulate specific and appropriate management plans including the setting of timescales**	2b.3	the principles and application of measurement techniques based on biomechanics or electrophysiology	3a.1.vii.c

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
understand the need to maintain high standards of personal conduct	1a.8.ii	understand the requirement to adapt practice to meet the needs of different groups distinguished by, for example, physical, psychological, environmental, cultural or socio-economic factors	2b.3 i	understand the following aspects of behavioural science	3a.1.viii
understand the importance of maintaining their own health	1a.8.iii	understand the need to demonstrate sensitivity to the factors which shape lifestyle that may impact on the individual's health and affect the interaction between the patient and paramedic	2b.3 ii	psychological and socail factors that influence an individual in health and illness	3a.1.viii.a

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
understand both the need to keep skills and knowledge up to date and the importance of career-long learning	1a.8.iv	**2b.4 be able to conduct appropriate diagnostic or monitoring procedures, treatment, therapy or other actions safely and skilfully**	2b.4	how psychology and sociology can inform an understanding of physical and mental health, illness and health care in the context of paramedic practice and the incorporation of this knowledge into paramedic practice	3a.1.viii.b
be able to maintain a high standard of professional effectiveness by adopting strategies for physical and pschological slef-care, critical self-awareness, and by being able to maintain a safe working environment	1a.8.v	understand the need to maintain the safety of both service users, and those involved in their care	2b.4.i	how aspects of psychology and sociology are fundamental to the role of the paramedic in developing and maintaining effective relationships	3a.1.viii.c
1b.1be able to work, where appropriate, in partnership with other professionals, support staff, service users, and their relatives and carers	1b.1	ensure service users are positioned (and if necessary immobilised) for safe and effective interventions	2b.4.ii	understand the following aspects of clinical science	3a.1.ix

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team	1b.1.i	know the indications and contra-indications of using specific paramedic techniques, including their modifications	2.b.4.iii	pathological changes and related clinical features of conditions commonly encoutered by paramedics	3a.1.ix.a
understand the need to engage service users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals	1b.1.ii	be able to modify and adapt practice to emergency situations	2.b.4.iv	the changes that can result from paramedic practice, including physiological, pharmacological, behavioural and functional	3a.1.ix.b
be able to make appropriate referrals	1b.1.iii	**2b.5 be able to maintain records appropriately**	2b.5	the theorectical basis of assessment and treatment and the scientific evaluation of effectiveness	3a.1.ix.c

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
understand the range and limitations of operational relationships between paramedics and other healthcare professionals	1b.1.iv	be able to keep accurate, legible records and recognise the need to handle these records and all other clinical information in accordance with applicable legislation, protocols and guidelines	2b.5.i	principles of evaluation and research methodologies which enable the integration of theoretical perspectives and research evidence into the design and implementation of effective paramedic practice	3a.1.ix.d
recognise the principles and practices of other healthcare professionals and healthcare systems and how they interact with the role of a paramedic	1b.1.v	understand the need to use only accepted terminology in making records	2b.5.ii	the theories supporting problem solving and clinical reasoning	3a.1.ix.e
1b.2 be able to contribute effectively to work undertaken as part of a multi-disciplinary team	1b.2	**2c Critical evaluation of the impact of, or response to, the registrant's actions.**	2c	understand relevant pharmocology, including pharmacodynamics and pharmacokinetics	3a.1.x

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
1b.3 be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, service users, their relatives and carers	1b.3	**2c.1 be able to monitor and review the ongoing effectiveness of planned activity and modify it accordingly**	2c.1	**3a.2 know how professional principles are expressed and translated into action through a number of different approaches to practice, and how to select or modify approaches to meet the needs of an individual, groups or communities**	3a.2
be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5	1b.3 i	be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care	2c.1.i	know how to select or modify approaches to meet the needs of patients, their relatives and carers, when presented in emergency situations	3a.2 i

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
understand how communications skills affect the assessment of service users and how the means of communication should be modified to address and take account of factors such as age, physical ability and learning ability	1b.3 ii	be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user	2c.1.ii	know the theory and principles of paramedic practice	3a.2 ii
be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others	1b.3 iii	recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes	2c.1.iii	**3a.3 understand the need to establish and maintain a safe practice environment**	3a.3

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
be aware of characteristics and consequences of non-verbal communication and how this can be affected by culture, age, ethnicity, gender, religious beliefs and socio-economic status	1b.3 iv	be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately	2c.1.iv	be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these	3a.3 i
understand the need to provide service users (or people acting on their behalf) with the information necessary to enable them to make informed decisions	1b.3.v	be able to make judgements on the effectiveness of procedures	2c.1.v	be able to work safely, including being able to select appropriate hazard control and risk management, reduction or elimination techniques in a safe manner in accordance with health and safety legislation	3a.3 ii

Standard of Proficiency	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**	**Standard of Proficiency**
understand the need to use an appropriate interpreter to assist patients whose first language is not English, wherever possible	1b.3 vi	be able to use quality control and quality assurance techniques, including restorative action	2c.1.vi	be able to select appropriate personal protective equipment and use it correctly	3a.3 iii
recognise that relationships with service users should be based on mutual respect and trust, and be able to maintain high standards of care even in situations of personal incompatibility	1b.3 vii	**2c.2 be able to audit, reflect on and review practice**	2c.2	be able to establish safe environments for practice, which minimise risks to service users, those treating them, and others, including the use of hazard control and particularly infection control	3a.3 iv
be able to identify anxiety and stress in patients, carers and others and recognise the potential impact upon communication	1b.3. viii	understand the principles of quality control and quality assurance	2c.2.i	understand and be able to apply appropriate moving and handling techniques	3a.3 v
1b. 4 understand the need for effective communication throughout the care of the service user	1b.4	be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures	2c.2.ii	understand the nature and purpose of sterile fields and the paramedic's role and responsibility for maintaining them	3a.3 vi

Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency	Standard of Proficiency
recognise the need to use interpersonal skills to encourage the active participation of service users	1b.4.i	be able to maintain an effective audit trail and work towards continual improvement	2c.2.iii		
		participate in quality assurance programmes, where appropriate	2c.2.iv		
		understand the value of reflection on practice and the need to record the outcome of such reflection	2c.2.v		
		recognise the value of case conferences and other methods of review	2c.2.vi		