I remember going to a job, it was a 6-year-old, he was 9 days post tonsillectomy, and was filling bowls of blood up by the minute. His parents greeted me with the words 'please don't let our son die, our daughter has already died'. I had a lot of work to do, he was very poorly, but the information from the parents really impacts you as a clinician. Thankfully we managed to get him into surgery just in time.

Unfortunately, we weren't able to do the same for two other children involved in a fatal RTC, as a result the road has been changed and the speed limit has reduced; but I will always remember them as I drive past. These are the not so good days.

Thankfully there are better days, I've delivered babies in the back of an ambulance and at the side of the road; you name it we've probably been there, beaches, brothels, Mansions, woods, council estates, I've been to football matches, it's a great job!

But actually, the reason I am here today is to talk to you about the other side of my job, it's those patients who don't know where to turn to in the middle of the night when the surgery is shut, or the chemist is closed, or they simply can't get through to their surgery.

Patients like 80-year-old Margaret, who has COPD and probably calls us every other month, she's well overdue a COPD and medication review, but getting in touch with the GP surgery can feel like too much hard work.

It's patients like 78-year-old Agatha who has been given a palliative diagnosis, but not all the information she needs to manage her condition moving forwards; she and her family feel confused by the information and process, and when she starts displaying some symptoms at 3am they call the ambulance. This is fine, but there are much better community services available to support her.

We are called out to patients like 36-year-old Dave who has a tracheostomy which develops a minor blockage, although his carers should have been taught how to manage effectively in the community.

With more training, support and community resources, there is a real opportunity to manage these patients in a different way. This is when I realised, that if I knew more, in terms of signposting and clinical capability then I could do more for my patients and thus started my journey in Advanced Clinical Practice.

What does this mean? It is a Generic Masters that any Allied Health Professional (AHP) or Nurse can complete, so an OT, pharmacist, physio, paramedic etc can undertake and it provides the same base level of education, which is underpinned by the pillars of Advanced Practice, Research, Education, Leadership and Clinical Excellence. Now this is a toolkit, for professions to develop these skills and excel in their own area of practice.

What did this mean for me? I decided that I needed go to Primary Care, to understand how they made their decisions and managed their patients to benefit from the supervision, mentorship and risk stratification that they adopt in this setting. So, in 2017 I moved into Primary Care. I quickly realised that my strengths lay in the community, not the surgery! It is a whole different skill set, managing to get a patient to leave your room after a consultation, especially when your running behind; I had been so used to leaving the patients home on my own terms previously. I remember seeing an ingrown toenail and thinking 'What do I do with that, it's not hanging off!'. So there was a steep learning curve.

Playing to the skill set of a paramedic, I was able to manage the bulk of the home visiting for our frail, elderly population, considering the holistic picture. I was able to create a network of contacts from duty social workers, OTs, District Nurses, Enhanced Care teams and we were able to navigate community-based systems to support the patient to stay well and safely at home and avoid admission to hospital. This was partly because I knew what their admission journey might look like, potentially a 6hr wait for an ambulance, an 18hr wait outside the ED on the ambulance, a 2 day stay in the ED department, with a further few weeks on a ward in the hospital; with a potential stint in the community hospital before being discharged home. By this time patients have often deconditioned so much they feel a shell of their former selves after going through that experience. But if we could avoid admission altogether, and manage the patient at home, surely this has to be the gold standard we strive for.

Then I started picking up the care home and nursing home ward rounds. This was a caseload of around 410 patients, who I could check on weekly and this was such a great way to learn about complexity, frailty, chronic conditions, palliative and terminal care. Again, my learning grew exponentially.

This was great from a prevention and admission avoidance perspective, actually engaging with patients, carers, staff, families on a weekly basis and helping them navigate the local healthcare system the complexities and the journey of their loved ones or for the patients themselves or their staff. This was so different from my experience on the ambulance turning up at 3am, which managed the urgent and emergency exacerbations of a lot of these conditions. Actively being involved in the planning and prevention felt that I was effectively preventing my colleagues from having to turn up at 3am to these patients where fewer options are available to manage successfully in the community where the unfortunate default all too often is ED.

Patients felt educated, empowered and supported to have these community-based strategies. They could take ownership of their health and understand the trajectory

of their conditions and make a plan for the future. It was an element of my job I thoroughly enjoyed and still do weekly.

Something else was also happening during this time. I noticed that not a week went by when there was some form that I could not complete or a policy I would be excluded from due to being a HCPC registered paramedic, not your typical Nurse or GP who traditionally worked in Primary Care. I inadvertently became what I have coined an 'accidental leader', I went on a journey to link in with policy holders and form creators to advise them that we are here as a Profession, we can prescribe, we can do x, y & z and your policies/ forms/ documents need to reflect that. This engaged my 'Leadership Pillar' of advanced practice, but also actively helped changed the system, not just for me but for my profession the wider AHP professions but also those coming after me. It was definitely a case of being at the 'right place, right time'. But I felt a lot of really important changes were made not just for paramedics but also for Primary Care during that time.

So, when an opportunity for clinical leadership came up in my previous organisation, I thought I would give it a go and take the learning that I had gained from Primary Care back into the ambulance service. I was so enthusiastic; I was full of ideas and sprouting out to anyone who would listen the importance of advanced practice on our organisational development. Thankfully I was knocking on an open door with our director of paramedicine, which had been one of the attractions in returning, they completely understood the importance of Advanced Paramedics on how we deliver future healthcare to our population, and 10 months after coming back as the Health board Clinical Lead Link with BCU, the Professional Development Lead for Advanced Practice role was created, which as you've probably guessed I was successful in obtaining. This now meant I had a national portfolio of developing advanced practice across the organisation, the phrase "be careful what you wish for" springs to mind!

I came into post at the point that there was an evaluation of a PACESETTER project going on right here in North Wales, they had also come to the conclusion that training advanced paramedics to understand how primary care functions was the place for them to be and a rotational model was developed where they worked operationally on an ambulance rapid response car, in the control room supporting crews and patients and in Primary Care. The evaluation can be found at www.apppacesetter.co.uk and is a great source of information if you're interested in the world of advanced paramedics in primary care.

What this evaluation showed us, is that when staff train and work locally, they understand what community pathways are available for those patients and we can help navigate patients' admission avoidance routes and wrap the care around the patient, particularly in the 24hr space when resources and services are really limited.

So, it is a really important learning journey, understanding primary care and having access to the system and infrastructure as it helps us manage the same patient group better in the unscheduled, urgent context we often find ourselves in on the ambulance.

So, this is my plea to you, if you are part of a health board or primary care sector and want to learn more, please get in touch. We are growing our MSc student and qualified advanced practice numbers to over 100, with more potential students starting September 23, and now have rotational models across every Health Board in Wales. But we are looking for more strategic collaboration to grow and develop this further. Currently we have Joint Monitoring Groups with BCU and HD and we are keen to develop strategic links across all Health Boards in Wales.

If you are interested in thinking about how rotational Advanced Paramedics could work in your areas, in terms of rural recruitment, training capacity, future care provision, now is the time and this is the place, so please reach out for more information.

Thank you so much for listening.