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MOUNTAIN MEDICINE
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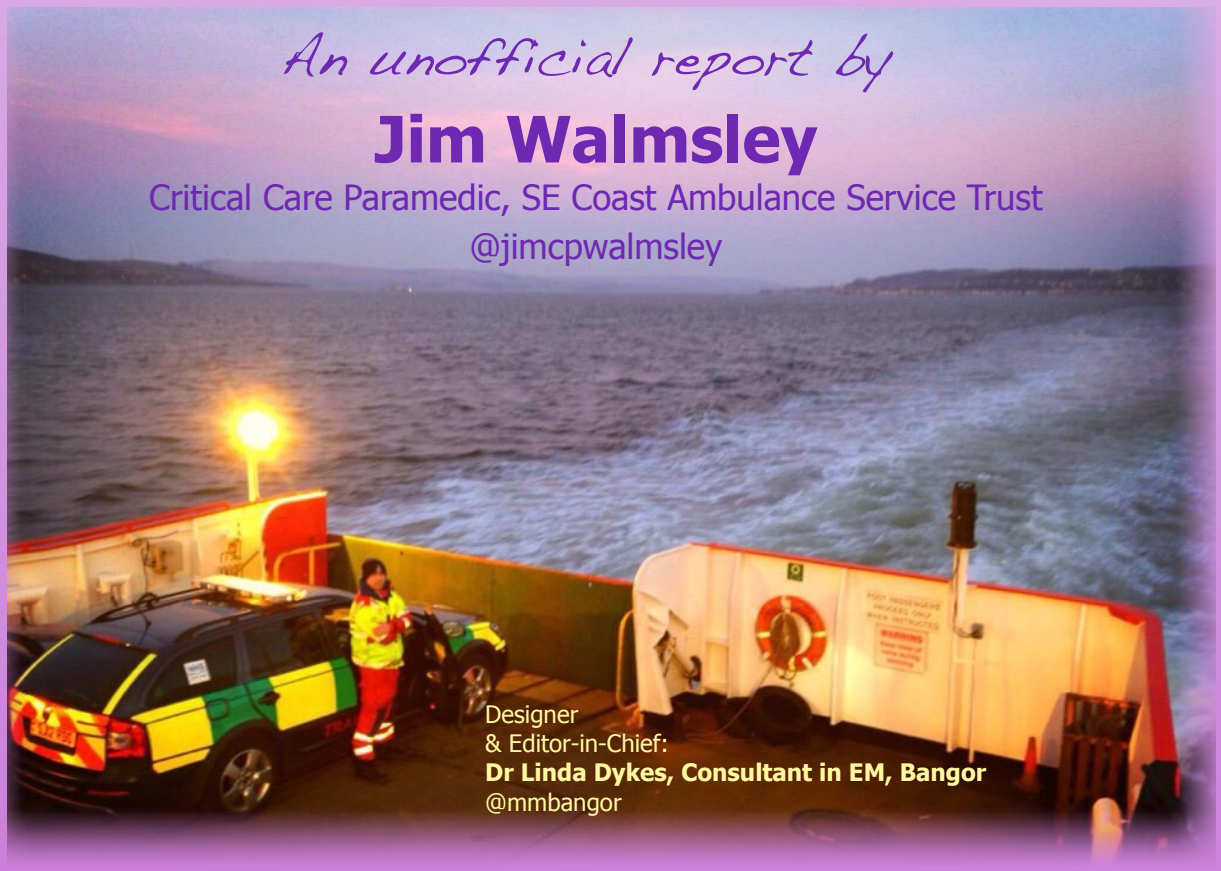
#FOAMEd

Highlights from

RETRIEVAL 2015

UK's National Prehospital & Critical Care Transfer Conference

Day Two



An unofficial report by

Jim Walmsley
Critical Care Paramedic, SE Coast Ambulance Service Trust
@jimcpwalmsley

Designer
& Editor-in-Chief:
Dr Linda Dykes, Consultant in EM, Bangor
@mmbangor

Introduction: Day Two

RETRIEVAL 2015

Ever heard your colleagues talking about fantastic conferences they've been to, and wished you could have gone too? So have we!

These unofficial conference reports originated from Bangor ED, where we encourage our staff to make notes at conferences and to share them on their return. From there it has been a short step to deciding we'd like to share our notes with others: you can find the full collection at www.scribd.com/BangorED.

For this report - Retrieval 2015 - our own Clinical Fellow Dr Niki Boyer (Day One, which was published back in July) is now joined by Jim Walmsley from South East Coast Ambulance Service who was the sole reporter for Day Two.

We must make an important disclaimer. Whilst our reporters make their notes as accurate as possible, this whole publication is based upon *notes made during the lectures* with all the attendant distractions and possibility of mis-recording the words of individual speakers.

Whilst we have cross-checked data were possible, and sometimes include links to studies mentioned during lectures, we can accept no responsibility for any errors or omissions we have made (or that the speakers made and we may have inadvertently propagated).

You should never change your clinical practice based solely on a report like this, but, we hope it will provide you with a springboard for learning. And if you do spot a mistake, please let us know - contact details are on the last page!

Linda
(Designer & Editor-in-Chief of the Bangor ED Conference Reports)

Jim & Niki (Reporters)

Reflection for your CPD

Some of the topics we report here are ripe for your CPD folder. We've flagged up those that are particularly juicy with these snazzy green boxes, and included links to relevant papers, abstracts and websites.

Running a conference? Want a report like this?

Talk to us... depending on how it fits with our study leave quota, Team Bangor ED may be able to attend your EM/EMS/PHEM/Critical Care event & produce a report for you.

Unless we were planning to attend anyway in funded Study Leave, we'd need to have our costs covered, but even these *unofficial* conference reports get 1000-3000 hits: imagine what a bespoke *official* report could do to spread your message further.

Please contact Linda.Dykes@wales.nhs.uk to discuss.

Have you seen the Day One report?

Over 1500 downloads so far!

Click here or visit www.scribd.com/BangorED

Day Two: Contents

RETRIEVAL 2015

All Day Two reporting by Jim Walmsley @jimcpwalmsley
Critical Care Paramedic & Practice Lead, SE England Ambulance Trust

Please help us support Tusk Trust!

We created this report because we’re passionate about FOAMed, and wanted to share what we’d learned. If you enjoy it and find it useful, could you consider making a donation to the Tusk Trust? This wonderful charity is dedicated to protecting rhino and elephant populations endangered by the greed for rhino horn and ivory - but also education and supporting communities in Africa.

If readers of previous Retrieval reports had given just £1/$1 each, we would have raised over $4000 (they didn’t, by the way, you stingy lot!)
Please visit our Just Giving page by clicking HERE to donate

Developing the MedSTAR CCP role in Aeromedical Retrieval - Ben Stanton

As Ben launched Day Two of Retrieval 2015 with a fascinating journey into how MedSTAR came to serve the emergency medical retrieval needs of South Australia, we heard how 2008 – 2009 saw a "changing of the guard", bringing with it an opportunity to redesign, and "think outside the box" as the South Australia Ambulance Service (SAAS) sought to centralise its retrieval services.

As a result, MedSTAR developed a new Critical Care Practitioner role, better able to support multiple service delivery models, and more adept at providing care to the critically ill and injured throughout the SA Health care region and beyond.

So why a CCP role for MedSTAR? Ben went on to explain, that for them, the CCP role has very much allowed them to evolve and enhance for some of the following reasons including:

- An ability to provide a single non-physician response to suitable retrieval missions.
- An enhanced CCP/ Doctor partnership capability.
- A CCP led clinical response/ support for complex cases where physician cover is not necessary, further allowing financial benefits.
- Providing a training and mentoring role for paramedics, retrieval nurses, and medical registrars.
- Pathways better able to provide treatment options, rather than prescriptive instructions.
- A programme of clinical accreditation, skills assurance & maintenance.
- Role modelling built on: Leadership, education, mentoring.
- Clinical procedural skills that can be practiced independently, under consult, or in emergency.

The challenges ahead include:

- Establishing a practitioner role tool kit.
- Skills assurance & maintenance, appropriate case load & tasking, as well as supervision.
- Acceptance of role.
- Standardisation of capability (Paramedic, RN).

What they said on Twitter...

And in case you'd forgotten how large Australia is, you can fit all of Europe (and more) in it. - @drsgrier

In 2008 @MedStar_SA started: on day it launched they did 10 retrievals. Now do 2500 missions per annum - @drsgrier

Royal Adelaide Hospital = closest Major Trauma Service to patients in Northern Territory eg Darwin - 2500kms away- @drbillgriggs

Ben Stanton - '08 centralisation/coordination of retrieval in S.Aus. Seems where we are all going - @Drtmr

CCP saves clinical resources, provides specialist retrieval, creates a career pathway for nurses & potentially saves money - @NikiLBoyer

In UK 'paramedic' is a registered profession and protected title - 'Practitioner' isn't - @johnboy237

Implementing the CCP role initially found challenges with getting a case load and maintaining skills - @ross71521

CCP development : essential for the 'top' to drive down as opposed to the bottom driving up - @Curlytoes12

Barrier to drugs is legislation at present - barrier to CCP RSI is cultural - @johnboy237

Aviation Safety Management Systems - Captain Stuart Pike

As a dual-role commercial airline pilot & a SAR helicopter pilot, Stuart shared some of the characteristics of aviation safety management, that touched on history, as well as lessons learnt the hard way.

Highlights of Stuart's talk included:

- Don't be afraid of reporting.
- *Use* your DATIX system – encourage *everyone* to file reports & engage.
- Reporting systems feed back into an audit trail that can then pick up on trends and common problems.
- Aviation Safety Management Systems have evolved their focus over the decades:
  - 1950s: technical factors.
  - 1970s: human factors.
  - 2000s: organisational factors.
- Evangelise the concept of testing using simulation: training enhances the process of 'stress inoculation'.
- Use checklists to offload 'lower cognitive skills' or for when tasks are too complex (see green box).

CPD activity

How aviation checklists came into being...

This article on aviation checklists - why they were introduced, how to use them correctly, and how they can be abused - is from 2010. Please note we could not get the link to work on a Mac running Safari, but it works on Firefox (not tested in MS Explorer)

Checklists when something is "too complex for any one man's memory - @NikiLBoyer

Aviation safety - Checklists are written in blood - @neilahughes

Originally flight data monitoring was for accident investigation. Now it's proactive. - @Medibrat

"Stress inoculation for training." Good human factors learning - @nickpheath

A proactive approach of helping prevent accidents rather than adopting a blame culture will seriously help us all out - @cawley_owen

Commercial aviation - culture of reporting means trends can be spotted and feedback given - lessons for NHS - @neilahughes

Lessons from aviation: report in order to promote safety! Requires feedback = encourage staff! - @Curlytoes12

If you report something and are criticised or get no feedback, would you report something next time? - @neilahughes

What's your safety system? - @NoS_EMPhysician

"I"m fine, I just need..." - Dr Mark Dunn

The #retrieval15 Twitter feed exploded after this talk - a candid and honest talk about personal experiences of mental health problems, and the wider lessons for other medical staff. Mark reduced the lecture theatre to silence.

As arguably one of the highlights to the Retrieval 2015 conference, Mark quite literally took us on a very personal journey through how being a high functioning clinician can lead to stress and mental health issues coming from quite literally the middle of nowhere:

- "How the hell did this happen to me?"
- "I have a stable personality – I'm a high performing clinician."
- "I didn't see it coming."
- "I've had previous Mental Health training."
- "…and my work performance didn't suffered."

What is a trigger: how much exposure to difficult jobs does it take? How do we maintain the high standards we set ourselves, when much of what we find and do, can be out of our control?

For Mark, this crunch point came at a most unexpected point (watching a film at the cinema with family by his side) and on reflection felt the trigger it could be traced back to one particular patient (a patient conscious, with 100% burns, and in agony).

Using examples such as Schwartz's theory that autonomy and freedom of choice are what lead to well being, it seems we often find ourselves in a paradox: a 'paradox of choice' whereby we are not able to choose our own professional experiences, goals, patient outcomes (or even our own expectations) resulting in an in-balance in happiness.

Mark explained his belief that, by setting ourselves up for goal achievement, we inadvertently set ourselves up for success or failure – and we often don't realise that our choice of standards can affect the level of satisfaction we experience from the decisions we make.

As professionals in the pursuit for excellence, does outcome bias hard wire us to being blind to the reality?

CPD activity

Medical professionals are at high risk of PTSD and mental health problems. At any one time, it's likely that someone we work with is struggling... sometimes we miss it completely, at other times we may shirk away from asking, accepting the problem is "hidden in pain sight".

Watch out for unexpected changes - check out this video!

For more about Schwartz's theory of subjective well-being, try page 27 of this e-book pdf.

Higher functioning groups tend to hide stress/mental illness more - @drsgrier

20% of us are likely to have mental illness during our career - @jamestooley

@EMRSscotland consultant Mark Dunn with candid talk on stress & mental health in healthcare - @Curlytoes12

Overcoming mental illness takes a lot of time, a lot of support - @Medibrat

Audience stunned by MD talking about his personal experience of serious mental illness - things we still usually keep hidden - @neilahughes

Once you get well, the question becomes "how the hell did that happen to ME?" truth: it can happen to any one of us - @Medibrat

touching and candid story of suffering with mental illness as a high performing clinician #nooneisimmune - @DrJimBlackburn

I know Mark is not the only one in this room to experience this. I wonder how many others? - @drbillgriggs

Outstanding presentation from Mark, leading a frank and honest discussion about MH in medical staff. - @JoelSymonds999

"I"m fine, I just need..." - Dr Mark Dunn

As Mark left us all feeling touched and asking the question could this happen to me, take home messages from his talk included:

- Triggers can be varied – often there is a slow filling up of the 'bucket', until that final trigger.
- Paradox of choice – with expectation comes disappointment (outcomes cannot be controlled).
- Mental health illness can affect each and everyone one of us – be aware for yourself and of others.
- Offer meaningful cues to those around you: "I'm fine... I just need…"
- Be prepared: have a code(s) set up for those around you – a way of knowing the balloon is up.
- Offer a 'buddy' system(s) – be prepared for when it may happen, rehearse.
- There is no perfect. Aim for excellence, learn to accept good enough.
- Cognitive psychology: "when change is slow, you don't notice the changes."
- YOU are not immune.

CPD activity

The BMA has a very useful resource section for doctors struggling with mental health challenges on their website (accessible to non-member) and there is a BMA Counselling Service.

The Doctors Support Network offers both peer support & assistance liaising with agencies such as the GMC.

Finally, please do remember it is a GMC requirement that all doctors are registered with a GP... for many junior doctors moving house regularly, this is often forgotten, but it isn't much use if your GP is hundreds of miles away.

"Your work doesn't suffer in mental illness until you're really, really far down the line" - Mark Dunn - @cawley_Owen

We are at very high risk of PTSD prehospital - some systems such as TRIM can help you through this - @ketaminh

Confirmation bias: when everything you search for confirms the outcome you desire. Horrible cycle in MH progression - @Medibrat

We experience all kinds of bias trying to prove to ourselves we are not ill - @neilahughes

We are like-minded individuals working in a high stress environment - @Medibrat

I have never experience so rowdy a crowd be silenced in to such awe [at retrieval2015] - @DrHillyHazel

We live in a society of incredible expectations - disappointment leads to unhappiness - @neilahughes

Audience encouraged to support, stay in contact with and look after your peers, your juniors, your colleagues and friends - @drsgrier

Dr Mark Dunn giving a stunning+brutally accurate talk on MH, stress, & his journey - @ParamedicWeekly

Near silence in lecture theatre. I suspect Mark has hit a lot of chords with many people. Sounds terribly familiar to some - @drsgrier

Have you seen the #Retrieval2015 Day One report?

Over 1500 downloads!
Click here or visit www.scribd.com/BangorED where you'll find many other conference reports (including Retrieval 2014 with over 3000 downloads!)

Come & work with the team who make these reports!

"...then he lost it!" - Jeff Proctor

Sub-titled "ACCP experiences of Consultant's bandwidth overload", Critical Care Paramedic Jeff Proctor of Scotland's Emergency Medical Retrieval Service (EMRS) shared some of his lessons learned from situations when his physician crew-mates have experienced cognitive overload .

A practical talk from someone who's walked the walk as well as talked the talk: we bring you here the key learning points.

Jeff opened his talk by explaining how, every so often, cognitive overload and (and does) lead to a complete breakdown of functionality.

Troublemakers that contribute to "maxing out"

- Distractions
- Environment
- Fatigue
- Interruptions
- Choices

Striking a balance between being under- or over-aroused is often the ticket to performing effectively. Having cognitive capacity & executive functioning of the brain is what provides the ability to process information and make decisions. Understanding the psychology of cognitive overload (see box, left) helps to devise practical strategies to overcome it:

- Prepare for the worst - expect the best
- Facilitate a detailed team brief at the start of every shift
- When you arrive on scene, introduce yourselves, assign tasks, and exude confidence.
- Do the basics, well
- Speak up when needed: "Everyone needs to stop - look at me..."
- Ensure you give good handovers: rehearse when with your colleagues if necessary
- Make time for training, skills & drills
- Have a standardised approach
- Use action cards & checklists

CPD activity

The psychology of cognitive overload

Performance vs. Arousal: the Yerkes Dodson curve (the one that makes you realise your brain function is remarkably similar to the Starling curve about myocardial functioning!) is described in this fantastic EMCrit blog post.

Learn from others

Embrace other models of excellence: F1 "Pit stop" teams turn strategy into success by training regularly as a team. Read more here.

Jeff's unique CALM DOON check-list

- **C**alming influences
- **A**llocate tasks
- **L**isten
- **M**ental Model

- **D**on't worry! if you don't know, the CCP does!
- **O**ff patient
- **O**nward steps: what's next?
- **N**ever be afraid to take a step back

Arousal increases performance, until the tipping point - then it doesn't @neilahughes

Our critically ill patients require high performance teams in pre-hospital / retrieval to deliver care @drsgrier

@jamestooley and don't google 'arousal' when preparing talk #retrieval2015 @johnboy237

ACCP Jeff Proctor: retrieval teams are comparable to formula 1...highly functioning, safe & reliable! @EMRSscotland

Detailed team briefing. Introduce team. Assign tasks. Basics done well. Speak up. Good pt handovers. See the big picture. @Medibrat

Top 5 things to overload you - distractions, environment, fatigue, interruptions and too many choices @neilahughes

Maximising bandwidth in prehosp medicine - the Scottish model #HumanFactors #CalmDoon #retrieval2015 @Gasdoc2857

I really wish many of my surgical colleagues had been around for this morning's #HumanFactors session #SoMuchToLearn @Gasdoc2857

Non-invasive haemodynamic monitoring in prehospital care: is ECHO all you need? - Professor Tim Harris

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Tim Harris - surely one of the cleverest brains in the UK EM/PHEM world (if not the planet) - loves Echo - "it's the best bit of my practice".

During this talk, Tim launched into the benefits of ultrasound-guided shock assessment and resuscitation, losing no time in explaining his firm belief that echo guides the diagnostic decisions used in resuscitation situations... and that, in the future, it will become integral to all of our clinical practices.

Highlights included:

What is the cause of shock?

- Hypovolaemia: small "kissing" chambers & small IVC as well as normal/ hyperdynamic LV.
- Distributive: sepsis – hyperdynamic LV function & variable IVC.
- Myocardial: poor LV function & dilated chambers.
- Obstructive:
  - PE – RV?LV ('D' sign), RV hypokinesis.
  - Tamponade – RV collapses during diastole.

- USS guided resuscitation: optimises fluid management & use of catecholamines, assesses LV function.
- Cardiac Tamponade: rare but ultrasound identification of a tamponade will completely change your management.
- Cardiac
  - LV function: hyperdynamic, normal, depressed/ severely depressed or absent LV & RV?
  - RV function: if thin & wall <5mm + deviated septum = acute PE stopping outflow from RV.
  - RV function: if big & wall >8mm = a *chronic* change: it takes months to grow.
- Sepsis: Hyperdynamic Left Ventricular Function = a 33% sensitivity but 94% specificity in sepsis.
- Measuring IVC – size & collapsibility with respiration – a quick 'end of the bed' assessment (i.e. a guide to intra-vascular volume).

Take-home messages:

- ECHO is key to diagnosis as well as management.
- USS is diagnostic tool in defining the aetiology of shock.
- USS guides resuscitation.
- Is simple to apply in a PHC context (with good outcome data, similar to ED results).
- If time is available (i.e. in hospital), it can also be useful in gaining ejection fractions & filling pressures.

Useful piece of kit - or another cumulative factor in cognitive overload? #retrieval2015 @jamestooley

Echo is useful in cardiac arrest - "completely change the way you fix your patients" @cawley_owen

Tim Harris - the heart is dancing around in fluid. So happy it is about to arrest! #tamponade #echo @DRTMR

USS shows a non-collapsible IVC that doesn't change with inspiration, so not fluid responsive & doesn't need more fluid resus @ross71521

"Echo is one of the most useful tools in determining resuscitation in prehospital care" @cawley_owen

Prof Tim Harris - excellent! Ultrasound in Pre-hosp. Pragmatic approach, another tool in the box, #convert #retrieval2015 @drpaddymorgan

Equipment innovation - Dr Malcolm Russell MBE

Giving a hugely inspirational talk based on his experience of innovating and inventing on emergency medical equipment, Malcolm took us through a wish-list fuelled utopia, free of constraints. With typical under statement, we were treated to a master class that included some of the following highlights:

- Nurture the geek – invest in the team – you can do more with the team than alone.
- When looking to improve the toolkit, look for:
  - capability gaps (they might be staring you in the face)
  - improvise, innovate, and invent.
- Make stuff: clear the desk, clear your mind, play… think like a child
- Don't be constrained by cost, risk, or feasibility.
- Start by: "walking backwards into the future - it's only when you have a view of the past that you get a sense of direction for the future".
- Use the 'If Carlsberg did…' principle.
- There is no ego in innovation.

"It's not just about the kit – innovation is *all around you...*"

Who needs ideas?

Malcolm briefly outlined some of the aspects of our equipment that has not changed (and so might pose easy solutions.... or they may not!):

- weight of kit.
- the spaghetti factor of cables, leads, etc.
- monitoring that often translates to mean very little.
- monitoring equipment that's unreliable.
- gloves that tear.
- tape and scissors still hanging off flight suits.

But imagine these looked from the past...

There are changes arriving into emergency medical practice that, a few decades ago, we probably would have said were crazy to contemplate:

- 24-hour HEMS flying.
- communications that work.
- navigation systems that work.
- a distinct HEMS/ retrieval community.
-
- blood products pre-hospital.
- REBOA & ECMO at scene
- Infection control & modern kit packaging.

Gazing into the future...

Malcolm ended his talk with a little blue-sky gazing into the future:

- individual kit smaller and lighter (carry less or do more?).
- imaging, diagnostics and monitoring: better and more meaningful.
- better situational awareness.
- patient-tailored monitoring and treatment.

"It is not the straining for great things that is most effective; it is the doing the little things, the common duties, a little better and better..."

Elizabeth Stuart Phelps
(1844-1911) American Writer

Equipment innovation - Dr Malcolm Russell MBE

"If you do what you always did, you will get what your always got..."

One 20 minute talk and I want to go make stuff!! Innovation at its best #retrieval2015 @C_HAWKINS999

Inspired to innovate by @Malcolm_999? 3D printing of splints/airways/drugs in the helicopter?? @Retrieval2015

Drones to assess the scene of an RTC – can you see the benefits? #retrieval2015 @jamestooley

There is no ego in innovation #retrieval2015 @johnboy237

Booking now
Click HERE to visit the Retrieval 2016 website!

Retrieval Research - Dr Hans Morten Lossius

Hans' talk followed a lively, heckling-positive debate about video laryngoscopy versus direct laryngoscopy - and he opened by confessing he'd never before altered a lecture immediately prior to presenting, but this time he did.. "Helicopters sure are sexy... but they don't intubate... even with video laryngoscopes"!

Talking about the point of care revolution, Hans explained how ultrasound, bedside blood testing, and even ECMO, were all clear examples of how equipment has become smaller and more portable - a factor that has led to a portable CT scanner being introduced and made viable through the Norwegian Air Ambulance Service, with pre-hospital diagnosis of stroke a real possibility plus early head and neck CT scanning capabilities (& you don't need a Jumbulance to transport it - they weigh as little as 100kg!

Don't worry about chewing off more than you can chew – your mouth is probably a whole lot bigger than you Think. #retrieval2015 @Medibrat

Adapt the system to the patient! Future of prehospital care #retrieval2015 @Curlytoes12

Norwegian service at advanced stages of putting a CT scanner in an EC-145. Got weight down from 400 to around 100kg @neilahughes

SP99 Memorial Lecture:

Hanging out in Norway & lessons for specialist retrieval in Scotland- Dr Mike Donald @Mike_Donald1

Bringing the Retrieval conference to an end, Mike reflected on the tragic events that occurred on the evening of 30th November, 2013 when a police helicopter crashed into the Clutha pub, Glasgow. As part of a commitment to honouring those victims involved and to the crew of police helicopter SP99, EMRS chose to create the SP99 Memorial Lecture. Set up as a travel fellowship; the award specifically seeks to support EMRS staff the opportunity to observe fellow medical retrieval services around the world.

What started out as a simple mission to arrive and visit Norway's national PHEM service, ended up becoming a journey of epic proportions. After delays on arrival, stop-offs and a stark lesson in 'moose' avoidance tactics (failure of which result all too often in fatal road traffic collisions in Norway), Mike was treated to "a little know how as to why Norway have become pioneers of PHEM for over 40 years".

Instead of being seen as a bit on the side on top of the day job (as is often the case in the UK), Norwegian physicians are funded and supported by the government to lead on pre-hospital care, as part of a long term commitment to their own base specialities. Essential to their success, and with an ability to blend specific skill sets, pilots, paramedic/ rescuers and doctors often find themselves "mixing and matching" the functionality they provide, to further meet the unique needs an incident may pass to hand. For the Norwegians, it all becomes a question of how integration, harmony, and training regularly as a team helps to underpin and enhance the safety, efficiency, and decision making needed for mission undertake.

Mike ended with the following thoughts:

- What gains could the UK make if it were to merge the new SAR budget, with various regional HEMS budgets?
- What could a combined UK HEMS/ SAR/ Retrieval service achieve?

Last session of this fantastic conference, the colossus that is @Mike_Donald1 delivering the SP99 memorial Lecture, remembering @polscotair @Retrieval2015

SP99 memorial lecture in honour of the loss of the police heli in Glasgow being given by @Mike_Donald1 on his trip to Norway #retrieval2015 @johnboy237

@Mike_Donald1 on the dangers of moose-strikes in Norway – almost always fatal #retrieval2015 @neilahughes

Do we need winch capabilities in UK HEMS ? I think not..But anyone think otherwise ? #retrieval2015 @jamestooley

Said before: Recognise and cherish those days when your're truly inspired. Remarkable people. One family. Thanks @Retrieval2015. Bye @Malcolm_999

CEM 2014 Conference

Didn't make it to the (now-Royal!) College of Emergency Medicine conference in September 2014? Catch up with a Bangor ED conference report! (Day One was the biggest ever - we had reporters out all over the place!)

- Day One
- Day Two & Three

Booking now
Click HERE to visit the Retrieval 2016 website!

PROGRAMME – DAY 1 27th APRIL 2016

08.30 – 09.30	**Registration & Refreshments**	
09.30 –09.35	**(Auditorium) Welcome**	Jon McCormack
09.35 –09.50	**Introduction**	Paul Gray *Chief Executive NHS Scotland*
09.50 – 10.20	**Keynote - Simulation in pre-hospital care**	Gareth Grier *Consultant in Emergency Medicine & Prehospital Care, London's Air Ambulance*
10.20 – 10.30	**Plenary**	
10.30 – 11.00	**Coffee (Arcoona) - Poster & Trade Stand Viewing**	
11.00 – 12.00	**Service Development**	Chair: Alistair Kennedy
	Developing a retrieval service for Wales	Dindi Gill *Consultant in Emergency Medicine & EMRTS Wales*
	Developing the Scottish national cardiac arrest strategy	Gareth Clegg *Senior Clinical Lecturer & Consultant in Emergency Medicine, Edinburgh*
	Challenging aspects of retrieval service development – The Adult Retrieval Victoria Experience	Marcus Kennedy *Director, Adult Retrieval, Victoria, Australia*
12.00 – 12.15	**Plenary**	
12.15 – 13.15	**Lunch (Waterhouse) – Poster & Trade Stand Viewing (Arcoona)**	
13.15 – 13.45	**Keynote - Retrieval medicine in South Africa**	Heike Geduld *Consultant in Emergency Medicine, Cape Town, South Africa*
13.45 – 14.00	**Plenary**	
14.00 – 15.20	**Neonatal & Paediatric Retrieval**	Chair: James Tooley
	Neonatal airway management outside the NNU	Patricia Weir *Paediatric Anaesthetist, Bristol Children's Hospital*
	Paediatric drowning & post-ROSC management	Paddy Morgan *Consultant in Anaesthesia & Prehospital care, EMRTS Cymru*
	Post-FEAST: Paediatric fluid resuscitation	Damian Roland *Consultant in Paediatric Emergency Medicine, Leicester Hospitals*
	Pre-hospital Neonatal retrieval	John Glen Consultant Anaesthesia/ICU & EMRTS Cymru
15.20 – 15.35	**Plenary**	
15.35 – 16.05	**Coffee (Arcoona) - Poster & Trade Stand Viewing**	
16.05 – 17.25	**Interactive retrieval simulation** Embrace, specialist transport for critically ill infants & children, Yorkshire & the Humber & the Emergency Medical Retrieval Service	**Chair: Gareth Grier & Hazel Talbot**
	CLOSE OF DAY ONE	
18.00	**Conference Run (Meet at Retrieval 2016 registration desk)**	
19.30 for 20.00	**Conference Dinner - Waterhouse**	

RETRIEVAL 2016

27TH & 28TH APRIL 2016
BEARDMORE HOTEL & CONFERENCE CENTRE, GLASGOW
(soon to be Golden Jubilee Conference Hotel)
www.thebeardmore.com

PROGRAMME – DAY 2 28th APRIL 2016

08.30 – 09.00	**Coffee (Arcoona) - Poster & Trade Stand Viewing**	
09.00 – 09.05	**Introduction** (Auditorium)	Stuart Daly
09.05 – 09.35	**Keynote - Inspiration is not what you are looking for**	Ross Fisher *Consultant Paediatric Surgeon, Sheffield Children's Hospital*
09.35 – 09.45	**Plenary**	
09.45 – 10.45	**Search & rescue medicine**	Chair: Pete Davis
	The interface between medicine and SAR - the UK perspective	Linda Dykes *Consultant in Emergency Medicine, Bangor, North Wales*
	Education & training for emergency medicine in Alpine rescue	Oli Resiten *Specialist Anaesthetist & Flight Physician, Air Zermatt, Switzerland*
	Technical challenges in Alpine rescue - from the Alps to the Himalaya	Robi Andenmatten *Pilot & UIAGM/IFMGA Mountain Guide, Air Zermatt, Switzerland*
10.45 – 11.00	**Plenary**	
11.00 – 11.30	**Coffee (Arcoona) - Poster & Trade Stand Viewing**	
11.30 – 13.00	**Free Papers**	Chair: Alasdair Corfield & Marcus Kennedy
13.00 – 14.00	**Lunch (Waterhouse) – Coffee, Poster & Trade Stand Viewing (Arcoona)**	
13.20 – 14.00	**Lightning Poster session**	
14.00 – 14.20	**Debate – Critical care practitioners will replace doctors in PHARM**	Chair: Jimmi Ronaldson
	For	John Pritchard *Lead paramedic, Scotland's Charity Air Ambulance*
	Against	John Ferris *Consultant in Emergency, Prehospital & Retrieval Medicine, Aberdeen*
14.20 – 15.20	**Innovation**	Chair: Mike Donald
	WILDCAT - Improving cardiac arrest survival in rural Scotland	Colville Laird *Director of Education, BASICS Scotland*
	Improving RSI quality with on scene filming	Tim Parke *Consultant in Emergency & Retrieval Medicine, EMRS Scotland*
	Helipad to Ipad – Developing the optimal retrieval electronic record	Paul Campbell *Consultant Anaesthesia, Clinical eHealth Lead for GG&C, GJNH & SG*
15.20 - 15.35	**Plenary**	
15.35 – 16.05	**Coffee (Arcoona)**	
16.05 – 16.30	**SP99 Memorial Lecture** Finland HEMS – A Technological Nirvana	Introduction: Stephen Hearns Richard Burnett *Consultant ICM, Anaesthesia and Retrieval, EMRS Scotland*
16.30 – 16.40	**Closing Address**	Anne Harkness *Director of Acute Services, South Glasgow/QEUH*

RETRIEVAL 2016

27TH & 28TH APRIL 2016
BEARDMORE HOTEL & CONFERENCE CENTRE, GLASGOW
(soon to be Golden Jubilee Conference Hotel)
www.thebeardmore.com

The last page...

We would like to thank the many people who reported this conference on Twitter - some of their contributions are included in this report. Do please follow them on Twitter - you will find them by their @Twitterusername!!

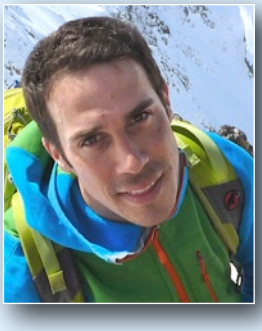
Running a conference? Want a report like this?

Talk to us... depending on how it fits with our study leave quota, we may be able to attend your EM/EMS/PHEM/Critical Care event & produce a report for you.

Unless we were planning to attend anyway in funded Study Leave, we'd need to have our costs covered, but even these *unofficial* conference reports get 1000-3000 hits, so imagine what a bespoke *official* report could do to spread your message further.

Please contact Linda.Dykes@wales.nhs.uk to discuss.

Day Two was brought to you by...



Jim Walmsley
(@jimcpwalmsley)

Having previously spent many years dedicated to chasing dreams, adventures and a life spent living for the outdoor experience, the last eleven years have seen Jim swapping of one challenging environment to that of quite another.

Since starting a career with the Yorkshire Ambulance Service in 2004, the last two years saw Jim take up the opportunity to undertake postgraduate study as part of a bursary-supported initiative at Sheffield University (ScHARR).

Subsequently joining the South East Coast Ambulance Service in 2013, Jim has been working within the role of Critical Care Paramedic (CCP), and he recently took up opportunities as a CCP Practice Lead driving the coordination of the 'Critical Care Desk', an initiative to get CCPs working in the control room.

Dr Linda Dykes
(@mmbangor)

Linda came up with the idea of reports like this, and compiles, edits, & designs the Bangor ED Conference reports.

Linda graduated from Newcastle Medical School in 1996. Trained in both EM & General Practice, she has been a Consultant in Bangor ED since 2005 and also works with the Welsh Ambulance Service at the Health Board/EMS interface two sessions a week, bringing her a small step closer to her ideal portfolio career combining EM plus EMS/primary care interface, and teaching.

Her research interest is Mountain Medicine (she maintains a database of all mountain casualties from Snowdonia brought to her hospital) & she particularly enjoys teaching medical students & paramedics.

THE END

Please tell us what you thought of this report: we are always trying to improve our conference reports and we also need to know if we have any corrections to make!

Please send any feedback/suggestions to Linda.Dykes@wales.nhs.uk or via Twitter to @mmbangor.

Please feel free to share this document widely, in the spirit of #FOAMEd, but it may not be used for commercial purposes without our express consent. Many thanks to the organisers of Retrieval 2015/6 for permission to use the conference logo, and for allowing us to feature the 2016 programme & flyer.

PS - Please, please make a donation to Tusk Trust!