Northern Ireland Ambulance Service
Health and Social Care Trust

Public Trust Board Meeting
Thursday 4 April 2019, 10:00am, NIAS Headquarters, Site 30, Knockbracken Healthcare Park, Belfast, BT8 8SG

		Click on links to navigate:
1.0	**Welcome and Introductions**	
2.0	**Apologies**	
3.0	**Minutes of the meeting of the Trust Board held 6 February 2019** *(for approval & signature)*	**TB 04/04/2019/01**
4.0	**Matters Arising**	
5.0	**Chair's Business**	
6.0	**Chief Executive's Business**	
7.0	**Clinical Response Model Report and Final Proposal** ***(Mr B McNeill) – for approval***	**TB 04/04/2019/02**
8.0	**HSC Bullying and Harrassment Policy** ***(Ms R O'Hara) – for approval***	**TB 04/04/2019/03**
9.0	**NIAS Property Assessment Management Plan 2018/19 - 2023/24** ***(Mr B McNeill) – for approval***	**TB 04/04/2019/04**
10.0	**The Ambulance Service Charity** ***(Ms Sue Noyes)***	
11.0	**Directors Highlight Reports at December 2018** *(by exception only)*	
	Human Resources	**TB 04/04/2019/05**
	Medical	**TB 04/04/2019/06**
	Operations	**TB 04/04/2019/07**
	Finance	**TB 04/04/2019/08**

12.0 **Assurance Committee Minutes 14 November 2018 – *for noting*** **TB 04/04/2019/09**

13.0 **Audit Committee Minutes - *for noting*** **TB 04/04/2019/10**

14.0 **Forum for Questions**

15.0 **Any Other Business**

The Next Trust Board meeting will be held on Tuesday, 7 May 2019 at NIAS Headquarters.

Standing Orders

This section is designed to provide information extracted from Standing Orders pertinent to the smooth running of the public Board meeting. The full Standing Orders are available for consideration at any time through the Chief Executive's Office or from the website. The excerpts below represent key items relevant to assist with the management of the Public Meeting.

Admission of Public and the Press

3.17 ***Admission and Exclusion on Grounds of Confidentiality of business to be transacted***

The public and representatives of the press may attend meetings of the Board, but shall be required to withdraw upon a resolution of the Trust Board as follows:

'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 23(2) of the Local Government Act (NI) 1972'

3.18 ***Observers at Board meetings***

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these Terms and Conditions as it deems fit.

PROCEDURE RELATING TO SUBMISSION OF QUESTIONS FROM THE PUBLIC AT NIAS TRUST BOARD MEETINGS

Questions may be put to the Board which relate to items on the Agenda.

Every effort will be made to address the question and provide a response during the meeting at the appropriate point on the Agenda.

If it is not possible to provide a response during the meeting a written response will be provided within seven days.

Questions must be put to the Board in written form and must be passed to the Senior Secretary before the item on the Agenda entitled "Forum for Questions".

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

Thursday 4 April 2019 at 10.00am, at Ambulance Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast

TB/04/04/2019/01

Return to Agenda

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of Trust Board – Public Meeting

Thursday, 7 February 2019, Boardroom, NIAS Headquarters, Site 30 Knockbracken Healthcare Park, Belfast, BT8 8SG

Present:

Mrs N Lappin	Chair
Mr T Haslett	Non-Executive Director
Mr A Cardwell	Non-Executive Director
Mr D Ashford	Non-Executive Director
Dr J Livingstone	Non-Executive Director
Mr M Bloomfield	Chief Executive
Mrs S McCue	Director of Finance & ICT
Ms R O'Hara	Director of HR & Corporate Services
Mr B McNeill	Director of Operations
Dr N Ruddell	Medical Director

In Attendance:

Miss H Coard	Senior Secretary
Miss L Pollock	Senior Secretary

1.0 Welcome and Introductions:

The Chair welcomed everyone to the February Trust board meeting. The board was confirmed as quorate.

2.0 Apologies:

There were no apologies received.

3.0 Minutes of the meeting of the Trust Board held 6 December 2018

The minutes were approved on the proposal of Dr Livingstone and seconded by Mr Haslett.

4.0 Matters Arising:

There were no matters arsing

5.0 Chair's Business

The Chair outlined her activities and meetings attended since the last Trust Board meeting as follows:

- The Chair and Mr Haslett had spoken to the RQIA as part of their review of progress made in relation to IPC, in particular about board assurance. It was welcomed that this had led to the lifting of Improvement Notices. The Chair recognised the huge amount of work by many staff in the organisation and thanked everyone who contributed to the progress made as recognised by RQIA.
- Ms Lorraine Gardner participated in a conference call with Ambulance Services across the UK in relation to maternity uniforms from which the feedback was very positive. NIAS will also present at the next HRD forum on the provision of uniforms for female staff in general.
- The Chair and Chief Executive attended the Mid-Year Accountability Review meeting with the Permanent Secretary which had been very positive. There had been a useful discussion about the challenges and opportunities that are available to NIAS.
- The CRM consultation finished on 18 January 2019 and the Chair thanked everyone who contributed to this.
- The Chair advised the Board that she has spoken with Ms Sue Noyes, Chair of The Ambulance Staff Charity (TASC) and discussed various services offered by the charity for families in need of support. Sue has been invited to present to Trust Board in April 2019.
- The Trust Board Workshop to review governance and Board effectiveness had been very productive and the Chair thanked everyone for attending. The Chair will work with the Chief Executive and Directors to review the outcomes of the workshop and take the necessary steps for going forward.

6.0 Chief Executive's Business

The Chief Executive outlined his activities and meetings attended since the last Trust Board as follows:

- Winter Pressures – the Chief Executive recognised it has been a challenging period for staff in recent months and expressed his appreciation for their commitment in challenging circumstances. He highlighted the significant planning for winter as previously presented by Mr McNeill, and reported that this had contributed to a more controlled position that in recent years.
- The Chief Executive referred to a specific challenge in relation to hospital turnaround times and advised of an initiative to put Hospital Receivers in the larger Emergency Departments to improve the timeliness of handovers from Ambulance crews. The Department has allocated an additional £500k to NIAS for this purpose. While it is difficult to directly link any specific factor to improved turnaround times, it was noted that overall the position has improved since last winter – in particular very long waits have reduced.

- IPC – Following the unannounced inspections by RQIA at the end of November 2018, formal notification has been received confirming that the remaining Improvement Notices have been lifted. The RQIA did however identify one area where further improvement is required in relation to staff training and an Improvement Notice with a review date at the end of March 2019 has been issued. Consideration is being given to requesting an extension to June 2019. The Chief Executive said that although he believes a corner has been turned, the IPC issue should not be considered as fixed, and it will be important to maintain focus going forward.
- Paramedic Foundation Degree Programme – The Chief Executive confirmed that 48 paramedic students commenced the programme on 7 January 2019 based the training school in NIAS HQ and at the Magee Campus, University Ulster. EMT and ACS training courses are also on-going to provide backfill for these posts. CEO has written to the Permanent Secretary to request funding for a second cohort of Paramedic Training to commence later this year.
- The Permanent Secretary visited NIAS in January as part of a series of visits to meet with front line staff across the HSC to see what transformation meant for them. He met with staff in the emergency control room and clinical support desk as well as paramedic students. He also received an update on a number of transformation projects. The visit has been very positive and demonstrated how NIAS can contribute to the transformation agenda.
- Chief Executive informed Trust Board that the DOH Accountability meeting had been positive with no issues of concern raised. The three key points of discussion were:
    - The proposed new Clinical Response Model.
    - The long-standing pay banding issue.
    - Paramedic Education

7.0 Allocation of Emergency Vehicles Policy and Procedures (for approval)

Mr McNeill presented an overview of the draft Policy on Allocation of Emergency Vehicles and Procedures for approval by the Trust Board. Mr McNeill explained that the Policy provides guidance on the allocation of marked cars and when these can be used when staff are not on duty. The guidelines specifically addresses the issues highlighted by HRMC.

The Chair thanked Mr McNeill for the work involved in reviewing the arrangements and bringing forward the policy for consideration by the Board.

Following a detailed discussion, the Board approved the policy on the proposal of Dr Livingstone and seconded by Mr Cardwell.

8.0 Clinical Response Model Consultation Update

The Chair welcomed Mr Jarlath Kearney to the meeting and invited him to present an update on the Clinical Response Model Consultation

Mr Kearney presented an overview of the consultation process, responses received and emerging themes. Ms O'Hara thanked Mr Kearney and his team for their work.

Mr McNeill outlined the next steps in relation to the development of the CRM Programme.

The Chief Executive advised that he had written to the Department for approval to start the preparation work for the implementation process, subject to the approval of the proposals by the Trust Board and Department. He has since received a response from the Department confirming they are content for preparation work to commence.

9.0 Health and Safety Policy Statement

Ms O' Hara advised the Board that the Health and Safety Policy Statement is a legal requirement which the Health and Safety Committee in partnership with Trade Unions have developed for approval by the Trust Board.

Following discussion, the Trust Board approved the Policy on the proposal of Dr Livingstone and seconded by Mr Cardwell.

10.0 EU Exit Plan (Verbal Update)

Dr Ruddell updated Trust Board on the EU Exit Plan. A number of meetings have been attended by NIAS to explore potential issues and risks in the event of a "No Deal Brexit". The DoH are establishing a reporting structure for regular updates from all the Trusts immediately prior to and following the EU Exit.

11.0 Directors Highlight Reports at December 2018 (by exception only)

11.1 Medical Directorate:

Dr Ruddell provided an update to the Trust Board. The following highlights were noted.

- RQIA will be reviewing the reporting of Serious Adverse Incidents across HSC.
- NIAS Corporate Risk Register was presented for information.

11.2 Director of Operations:

Mr McNeill provided an update to the Trust Board. The following highlights were noted:

- CAT A performance had deteriorated further over the winter period. However Mr McNeill acknowledged the efforts by the CSD Team, Control Team, Resource Management Centre and all staff who worked over the holiday period.

- The sluice replacement programme will be completed in 12 stations this year. The remaining 9 will be rolled out from April 2019. The reason for the delay was due to additional costs being identified and some of the stations required major works on site.

11.3 Director of Finance & ICT:

Mrs McCue, Director of Finance & ICT, provided an update to the Trust Board. The following highlights were noted

- The end of December financial position shows an overspend of £7k. The Trust is predicting break even position by the end of March.
- AFC – Agenda for Change is expected to be fully funded by the Department by the financial Year End.
- Capital Expenditure – Allocation of £5.9 million of which £3 million is allocated each year to vehicles.
- IT – actions are ongoing to address cybersecurity.

11.4 Director of HR &CS:

Ms O'Hara, Director of HR & Corporate Services, had no significant highlights to report.

12.0 Application of Trust Seal

The NIAS Trust Seal has been applied once on 17th December 2018 in relation to the renewal of Derriaghy station.

13.0 Forum for Questions

There were no questions.

14.0 Any Other Business

The Chair proposed for the minutes of the Audit Committee to be brought to Trust Board each time for approval.

The minutes were approved on the proposal of Mr Cardwell and seconded by Mr D.Ashford.

15.0 Date of Next Meeting

The next meeting of the Trust Board will be held on Thursday 4 April 2019, NIAS Headquarters, Belfast.

TB/04/04/2019/02

Return to Agenda

Northern Ireland Ambulance Service Health and Social Care Trust

Clinical Response Proposal
Annex to Consultation & EQIA
For noting by NIAS Trust Board
4 April 2019

Northern Ireland Ambulance Service Health and Social Care Trust

CRM Consultation Responses – Next Steps

Key

A	Significant Comment requires response
A	Implementation Stage
A	Key point for inclusion in final document
A	For Noting

No.	Respondent	Comment	Theme	NIAS Response
1	**Age NI**	**Generally we support the introduction of this model.** **CRM should not result in a reduction or delays to ambulance services that older people currently rely on for non-emergency patient care and transportation including specialized health transportation.**	**Service Delivery** **Service delivery**	**Noted** **The proposed changes do not extend to the non-emergency Patient Care Service of the NIAS. There are no plans to reduce this service**
		The plan to increase hours of cover and match supply with demand is welcomed. It will be important to understand fully what impact the projected demands are likely to have and for this to be accounted for in any new CRM.	**Service Delivery**	**The increase in hours of cover have been model using specialist information modelling tools. This modelling has generated a capacity plan which identifies by hour of day 24/7 the optimum levels of cover to achieve the standards and indicators proposed in the consultation document.**
		We ask that NIAS consider how best to **manage conditions that affect older people and are likely to present challenges, in particular, dementia and frailty. Consideration for such conditions should be incorporated into all stages within the CRM proposed, from staff training, through to call handling and treatment. Failure to recognise such conditions at an early stage poses significant risks. We welcome the proposal for an enhanced call but have concerns.**	**Clinical Care**	**NIAS are in the process of expanding its Paramedic Clinical Support Desk (CSD) within the Emergency Ambulance Call Centre (EAC) to provide a 24/7 service. This service will support the Call takers and Dispatchers within the Centre to better manage any calls that will require specialists support such as clinical advice and support, access to specialist services. NIAS will review and where necessary improve its management of older people particularly those with dementia and frailty throughout the whole call cycle, i.e. from point of contact to closing the call after the patients' needs have been fully met.**
		Age NI welcomes the proposal for continuous monitoring in the implementation and roll out of any new CRM. To ensure evidence based potential adverse impacts are identified, we suggest that NIAS should consult further with	Equality	It is the intention of NIAs to continue the engagement and consultative process throughout the projects required to implement the various elements of the model.

Key

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		stakeholders prior to and during any implementation of the new CRM. Data available via other sources should also be examined, for example 10,000 voices data.		Data from 10,000 voices was considered during the data collection phase of the EQIA. Opinions gathered from the survey are used to continuously inform learning and development within NIAS. Presenting analysis of the S75 characteristics of 10,000 voices respondents risked identifying individuals due to the small sample size.
		We ask NIAS to consider how someone taking an emergency call could effectively establish if someone who might appear to have had a relatively minor incident but also lives with frailty could be best prioritised.	**Call take / prioritisation**	**Under the new proposals Emergency Call takers will initially apply the use of the Pre Triage Sieve (PTS) and Nature of Call (NOC) protocols to identify if the call is immediately life threatening... They will then move into using the Advanced Medical Priority Dispatch protocols to ensure that the call has been properly coded and to provide on line advice to the caller should this be required. Call takers will stay on line until help arrives on scene if necessary. The Call takers can refer the call to the specialist Paramedic Support Desk for further management. NIAS are in the process of expanding its Clinical Support Desk (CSD) within the Emergency Ambulance Call Centre (EAC) to provide a 24/7 service. This service will support the Call takers and Dispatchers within the Centre to better manage complex calls or calls that may require specialist skills or support services, eg management of conditions that affect older people.**
		Education and learning development plans should include training on conditions that affect older people such as dementia and clinical frailty.	**Training and Education**	**The Care and management of Older People is included in both the Associate Ambulance Practitioner (AAP) training programme for Emergency Medical Technicians and the Foundation Degree programmes for Paramedics. Both programmes include specific set of learning objectives in relation to Dementia.**

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		We have concerns that older people's falls may be wrongly categorised as "low priority" in the new system.	**Call prioritisation**	**NIAS will endeavour to ensure that calls for older people who have fallen will be prioritised and manage appropriately.** **Where the patient is found to have an injury and / or illness that requires assessing, an ambulance is dispatched. NIAS paramedics are equipped to complete a comprehensive assessment of patients who have fallen including diagnostics such as ECGs; blood pressure; blood glucose; oxygen saturations and temperature.** **Where an injury / illness is found that requires further assessment, the patient is either transported to an Emergency Department or referred to teams such as Acute / Enhanced Care at Home.** **Where the patient is found to be well with no injury / illness, the paramedic will refer the patient to a falls team who will make contact with the patients within 2 working days of the referral. Where it is apparent during the initial 999 call that the patient has no immediately life threatening problems, they will be transferred to the Clinical Support Desk (CSD) for further assessment / triage by an experienced paramedic. The CSD paramedics have completed additional training and use a tool called Manchester Triage to assist with their decision making. Following assessment, the paramedic has a number of options including:** **• Dispatch a non-emergency ambulance** **• Advise family / friends to transport the patient to an Emergency Department / GP** **• Make a falls referral** **Where safe to do so, the CSD paramedic will talk the patient through methods of getting up off the floor.**

CRM Consultation Responses – Next Steps

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				Where family / friends are on scene, the CSD paramedic will provide advice on how to lift the patient from the floor. They will provide with advice as long as it is clinically appropriate and regardless of the weather conditions. **Where the CSD paramedic establishes the need for an ambulance response and that the patient is vulnerable due to environmental concerns, they have the option of "upgrading" the call. CSD paramedics also review calls that are waiting on an ambulance response. This means that where a patient has fallen and requires an ambulance but one is not yet available, they will be able to receive advice from the CSD paramedic via phone**
		Age NI welcomes the proposal to consult further. We strongly recommend that older people, particularly those with experience of service use should be included in consultations as the process unfolds. We would welcome the opportunity to support the NIAS with this through our Consultative Forum. You can find out more about the role of the Consultative Forum on the Age NI website www.ageni.org	Equality	Ongoing consultation and additional equality impact screenings/assessments will be conducted as appropriate going forward.
2	**Alliance Party**	**The new model is strongly to be supported (with some minor additional confirmatory detail required)**	**Service Delivery** **Communications**	**Noted** **Noted**

CRM Consultation Responses – Next Steps

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		There is a significant communications risk contained within it which needs to be managed.		
		The document fronts up with a proposal to reduce the "highest level of response" from 30% to 7% and states confidently that this frees up resources for more adequate response overall. There is little reason to doubt this upon reflection and assessment of the evidence base, but it is instinctively counter-intuitive and thus comes with a significant PR/communications risk	**Engagement**	**Noted**
		There is a case for a meeting with the Ambulance Trust to discuss whether politicians can assist in mitigating this communications risk.	**Engagement**	**NIAS intends to establish a stakeholder forum with a continuous and meaningful engagement function in relation to CRM and its various projects**
3	**Antrim and Newtownabbey Council**	**The Council welcomes any change which will enhance the efficiency and positive outcomes of the Service. However, we recognise the need for positive communication and public reassurance.**	**Communications**	**Noted**
		The council at this time does not identify any specific adverse impact, however recognises that any change of working practices may have unforeseen outcomes. The Council however takes comfort from the depth of research and the successful implementation of this model in other ambulance response services.	Equality	Ongoing consultation and additional equality impact screenings/assessments will be conducted as appropriate going forward

CRM Consultation Responses – Next Steps

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		The Council would welcome evidence of effectiveness at an early stage in the implementation of the new Clinical Response Model.	**Monitoring / standards and indicators**	**Noted**
4	**BMA Northern Ireland General Practitioners Committee (NIGPC) Domestic Negotiations Team.**	**NIGPC also commented that "referral to GP" could be added to the suite of options available and we could help develop confidence within practices that this was acceptable and appropriate. This suggestion was well received by NIAS**	**Call take / prioritisation**	**NIAS would welcome the opportunity to engage with BMA and commissioners to review the management of GP urgent calls and explore the potential for "referral to GP" to be included as a "treat and refer option". NIAS would also be very keen to engage with NIGPC to develop sharing NIAS Directory of Services with GPs. NIAS would welcome having access to a wider range of respite services "that would avoid unnecessary hospital admissions".**
		In a number of instances, it will be beneficial to the patient to be referred to their GP for future treatment. It could also prevent an additional and unnecessary trip to hospital for both the patient and NIAS. It is important however that should this course of action be taken the language used is chosen sensitively, patients should not be told their GP will definitely call to see them, especially within a time frame defined by the NIAS.	**Service delivery**	**NIAS would welcome the opportunity to engage with BMA and Commissioners to review the management of GP urgent calls and explore the potential for "referral to GP" to be included as a "treat and refer option".**
		NIGPC would welcome the opportunity to work with NIAS on a referral to GPs process and developing a method through which GPs can access the NIAS directory of services. This could result in less calls to NIAS as GPs	**PARTNERSHIP & ENGAGEMENT**	**NIAS would be keen to engage with NIGPC to include "Referral to GP in its directory of Appropriate Care Pathways". In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**

CRM Consultation Responses – Next Steps

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		would not need to call NIAS to for referral to these.		
		Finally, on this point, our members highlighted that the option of admission to a wider network of respite care services should be considered rather than hospital admission as the norm.	**Call take / prioritisation**	**Noted**
		BMA Northern Ireland members have reported feeling that if they call an ambulance for a patient they are with a response can take longer as there is a doctor present. The patient's condition should be the only issue dictating the response time not the presence of a doctor.	**Call take / prioritisation**	**NIAS would welcome the opportunity to engage with NIGPC to discuss the dispatch protocols that will be used in managing HCPC calls.**
		NIGPC members raised an issue with calls not being accepted when they come from nursing home staff. We welcome the reassurance given by Michael Bloomfield that this should not be the case and would encourage greater communication of this with NIAS staff.	**Service delivery**	**NIAS will continue to engage with Nursing Homes in improving its response to calls made from Nursing Homes as appropriate.**
		Without dedicated funding we question whether significant transformation, such as that laid out in the consultation can be achieved.	**Funding**	**NIAS acknowledge that full funding to support a transformation programme will be required to achieve the Response and Clinical Quality indicators that have been proposed.**
		We would strongly encourage the development of a timeline to allow progress and changes to be clearly tracked. Alongside this a comprehensive communication strategy should be developed.	**Communications**	**Noted**

CRM Consultation Responses – Next Steps

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		A public education campaign on appropriate use of the ambulance service may be something NIAS may wish to consider.	**Communications**	**NIAS welcome this proposal and will give it due consideration**
5	**British Red Cross**	**There should be a meaningful investment in community based frequent attender support programmes to in part mitigate impacts of the proposals and to invest more broadly in preventative approaches**	**Communications**	**NIAS are keen to support any preventative initiatives and would welcome investment in this regard. NIAS have experienced a reduction in demand from engaging with users who make frequent demand on the service, though a Pilot programme.**
		For NIAS to hold face to face community engagement sessions as well as through key interest groups to effectively communicate changes to groups and individuals most likely to be affected by the changes and to support the development of new pathways and initiatives to better support people in a community setting.	**Engagement**	**Ongoing consultation, engagement and additional equality impact screenings/assessments will be conducted as appropriate in relation to the Clinical Response Model and its various projects. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to CRM.**
		We recommend that RQIA regulate the provision of non-statutory providers	**Policy**	**Noted**
6	**College of Paramedics**	**While fully supporting the intention of the proposals, we have paid special attention to sections 1.5i and 7, which refer to staff. It is our firm opinion that the successful implementation of the CRM will be highly dependent on the configuration and preparation of the paramedic workforce in the Northern Ireland Ambulance Service (NIAS}.**	**Training and Education**	**NIAS agree with the COP comment in relation to the essential contribution that the Paramedic workforce will make to the successful implementation of the CRM. NIAS have and will continue to use the COP guidance in education, training and development pathways for Paramedics. We are grateful for the continued support and offer of assistance from COP.**
		This large low-acuity patient group represents one of the main challenges in	**Training and Education**	**NIAS acknowledge the importance of preparing its Paramedic workforce to safely and effectively manage**

CRM Consultation Responses – Next Steps

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		preparing the paramedic workforce to safely and effectively manage the associated risks.		**low acuity patients. This will be a significant challenge for Paramedics on Frontline duties and the Paramedics servicing the Clinical Support Desk.**
		We would be willing to provide any advice and/or guidance that might assist the NIAS as it undertakes preparations for the implementation of the CRM. The College of Paramedics applauds the steps that are being taken to reform the service model for the NIAS	**Training and Education**	**NIAS welcome the offer support from the College of Paramedics**
7	**COPNI**	**COPNI would support appropriate funding being made available for the new clinical response model.**	**Policy**	**NIAS acknowledge that full funding to support a transformation programme will be required to achieve the Response and Clinical Quality indicators that have been proposed.**
		A clear timeline including start and end dates along with key milestones is important COPNI would wish to see such independent evaluation built in to the planning process for the NIAS model.	**Engagement**	**NIAS plan to develop an implementation plan and associated timeline following the consultation exercise. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		Community paramedics - COPNI would welcome the expansion of this project.	**Training and Education**	**NIAS are currently working in collaboration with CAAWT in a Community Paramedics programme in Western Division (Castlederg). NIAS would be keen to work with local communities and expand on this project in other Rural areas.**
		NIAS need to be aware of patients living with dementia and how their specific needs could be met by NIAS. The number of people living with dementia will continue to increase and it	**Monitoring process / audit / EQIA**	**The care and management of Older People is included in both the Associate Ambulance Practitioner (AAP) training programme for Emergency Medical Technicians and The Foundation Degree programme for Paramedics.**

CRM Consultation Responses – Next Steps

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		is important that NIAS staff are trained and informed about the condition.		**Both programmes include specific set of learning objectives in relation to Dementia.** **NIAS are committed to meet the diverse needs of social groups through best endeavours on a practical and policy basis, balanced against other organisational factors. We will keep this under review in the context of our equality and disability duties**
8	**DUP**	We consider it essential the response model in place would be up-to-date and evidence-based. Resources must be targeted where they can have the greatest impact and enhance outcomes. The deployment of ambulances should be on the basis of clinical need. We trust that a new model can lead to improvements in the time within which patients with conditions such as stroke and heart attack can receive definitive care.		**The national ambulance response standards (which NIAS propose to adopt) were introduced in July 2017 and are designed to ensure that the most suitable high-quality response is delivered to every patient in an appropriate clinical timeframe. The introduction of these new standards, which were rigorously tested on some ten million 999 calls, recognises that many of the patients the ambulance service traditionally tried to reach in eight minutes did not actually derive a clinical benefit from a response in that timeframe. The new system allows the ambulance service to concentrate on providing an even faster response to those patients who are truly life-threatened, whilst also reducing the transport delays for all other categories of patients'.**
		We consider it essential that the road ambulance response is fully integrated with the helicopter emergency medical service in Northern Ireland.		NIAS has overall responsibility for clinical standards and clinical governance working within the structures of the Medical Directorate. The service is managed on a day to day basis by the HEMS Operational Lead supported by the HEMS Clinical Lead with a team of 6 paramedics and a sessional rota of 15 Doctors.

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				The team of doctors have specialities in Emergency Medicine, Anaesthetics and Intensivists. The Trust is responsible for the tasking of the aircraft and has established a fully functioning air desk at the Emergency Ambulance Control centre. The air desk is operated by a HEMS paramedic at all times and all organisational tasking is integrated as appropriate.
		We encourage the pursuit of collaborative opportunities with healthcare colleagues		**NIAS welcome the opportunity to work in collaboration with Health & Social Care professionals to improve quality of care for all patients. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		We support the early introduction of a comprehensive electronic health and care record, with mobile access		**NIAS are investing in updated technology through its REACH (Regional Electronic Ambulance Communications Hub) project. NIAS is introducing WiFi communications hubs across all its vehicles effectively creating secure Vehicle Area Networks (VANs) as the central communications hub with internet connectivity and the ability to send, transmit and access data relating to calls and patients in the mobile environment. In addition to this there will be investment in - Control technology, Fleet Mobile data system, and electronic patient report systems. These investments in technology will provide a flexible and robust platform to support NIAS' transformation and modernisation focusing on the provision of safe, high quality patient-focused care.**

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9	**ECNI**	The Commission welcomes that NIAS has conducted an EQIA on this proposed new clinical response model, and that it follows the Commission's recommended seve-step EQIA process It may be useful for NIAS to have some more focused consultation/engagement with key staff at emergency departments, regarding the likely impact of the new model	Equality Equality	**Noted** **Actioned during consultation, and will be built upon through establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		Outline any changes or mitigating measures that NIAS has put in place or plans to put in place to further promote equality of opportunity within the scope of the new model	Equality	**Ongoing consultation and additional equality impact screenings/assessments will be conducted as appropriate going forward.**
		You outlined a number of measures that NIAS has put in place, or plans to put in place, which aim to promote equality of opportunity… The provision of this service will help to reduce the communication barriers for those whose first language is not English and help to ensure that clients have improved access to emergency services. These would be considered mitigating measures/measures which will help to promote equality of opportunity for minority ethnic groups, in terms of access to NIAS's emergency services. NIAS could include reference to these as mitigating measures in its final EQIA report	Equality	**Noted and actioned**
		NIAS should outline future monitoring arrangements in relation to the proposed model in its final EQIA report.	Equality	**NIAS welcome the comprehensive feedback provided by the Equality Commissioning in its response. We appreciated the assessment, advice and guidance given**

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				in relation to conducting this consultation. NIAS is committed to continuous monitoring and evaluation around impacts, in a way that takes fully into account relevant and updated data, for example following the revised modelling exercise. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.
10	**Fermanagh & Omagh Council**	A more appropriate response model should be introduced in Northern Ireland – one which fully considers: Rural and urban residents - noting key challenges for each area Community Based First Responders and their roles (as well as the need for improved communication and cooperation with these individuals, who provide such an invaluable service). The ageing population and future population projections (likely to lead to an increase in the demand for NIAS services).	Rurality	NIAS is very conscious of its obligations in providing cover in areas with significant rural populations and ambulance staff work very hard to ensure that the quality of service received by people living in these areas is of the highest calibre, even though it is accepted that at times, patients in these areas will not always receive a response as quickly as they would if they lived in an urban area. NIAS is committed to reaching all categories of patients as quickly as possible and in line with agreed ambulance response standards – but must also do so in a way that makes efficient and effective use of the service's limited resources. NIAS is committed to ongoing collaboration and co-operation with rural stakeholders including local government and will be engaging with partners to best implement CRM as the program develops. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects. This is a not a new issue, and ambulance services have been working hard to find new ways to improve the quality of care provided

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				to patients in rural areas for many years. Aside from increases in the number of staff allocated to rural areas, other initiatives currently in place and to be considered for further development include:• the use of strategically-placed standby points where ambulances are stationed until they are needed. • Community Paramedics working locally in the most rural areas who are able to respond to life-threatening emergencies. • Co-responder partnership arrangements with police and fire and rescue colleagues –• Initiatives supported through our Community Resuscitation Programme such as the training of school children in Basis Life Support, the introduction of more defibrillators into rural communities and the mapping of defibrillators so people know how to find their nearest one quickly. It is also important to remember that while response times are critically important in some cases, they are not the only measure of the service provided by NIAS ambulance services. In most cases, the health outcome for rural patients is as good as for those in urban areas. The national ambulance response standards which NIAS propose to adopt are designed to ensure that the most suitable high-quality response is delivered to every patient in an appropriate clinical timeframe. The introduction of these new standards, which were rigorously tested on some ten million 999 calls, recognises that many of the patients the ambulance service traditionally tried to reach in eight minutes did not actually derive a clinical benefit from a response in that timeframe. The new system allows the ambulance service to concentrate on providing an even faster response to those patients who

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				are truly life-threatened, whilst also reducing the transport delays for all other categories of patients'.
		• Number of individuals who live alone – particularly those aged 65 years and over (approximately 4,676 individuals at present, which is only likely to increase).	Equality	One person households, particularly with regard to older people was considered in the EQIA and concluded "For older people being alone is a likely indicator that they will use emergency and non-emergency ambulance services more than adults who live with other adults"
		Currently the Cat A8 NI target - 72.5% and 67.5% Western LCG. This indicates a substantial difference for rural areas and should be addressed as part of any future NIAS response model. It is unacceptable for residents in the Western Areas of Northern Ireland to receive a lesser service or response time.	**Monitoring / standards and indicators**	**The current CAT A8 performance standards will be replaced by the proposed standards presented in table 3 9.5 page 30 of the Consultation Document, September 2018. These standards will provide a much improved and more equitable service for the population of NI.**
		NIAS should utilise the lessons learnt in these areas to assist in the creation of an appropriate and effective response model for all of Northern Ireland.	**Policy**	**NIAS has reviewed the Ambulance Response models in England Scotland and Wales, ref. 4.6. Of the Consultation Document, September 2018. NIAS is proposing to adopt the model that has been implemented in NHS England, which was designed following the comprehensive Ambulance Response Programme (commenced 2015). This programme is the most comprehensive study about ambulance services completed anywhere in the worlds and 14 million calls have ben proceed through the programme with no reported adverse incidents. NIAS will continues to monitor all three National Services during the implementation phase and will adopt best practice as appropriate. NIAS does engage with all three services**

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				independently and through the Associate of Ambulance Service Chief Executives, AACE.
		It is essential that any new Model is thoroughly tested before being rolled out. It would be beneficial for any new model to be introduced on a pilot basis and reviewed after 12 months as was the implementation model for the Clinical Response Model in Wales.	**Policy Transformation**	**NIAS will give this proposal due consideration. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		NIAS should ensure that when introducing the Clinical Response Model the wider range of efficiency led reforms are also complemented and reviewed on an on-going basis. The response model should complement: • • A review of systems processes and structures within Emergency Ambulance Control. • • The ongoing implementation of appropriate care pathways - where patients are assisted to get more appropriate health services in non-emergency circumstances. • • The community resuscitation and defibrillator strategy. • • Partnership working with local HSCTs (as outlined later within this response document).	**Consultation Proposal**	**The consultation document specifically focuses on the Clinical Response Model. NIAS recognise that there is need for a transformation programme for the Trust that will support the full implementation of CRM including the areas identified in this comment from Fermanagh and Omagh Council.**

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		A review of systems processes and structures within Emergency Ambulance Control.	**Service delivery**	**NIAS are engaged in an Emergency Ambulance Control improvement programme, this includes recruiting additional staff, review of structures and processes, procurement of new systems.**
		The ongoing implementation of appropriate care pathways - where patients are assisted to get more appropriate health services in non-emergency circumstances.	**Service delivery**	**NIAS plan to develop additional Appropriate Care pathways and increase the hours of its clinical support desk to support the introduction of all pathways**
		The community resuscitation and defibrillator strategy.	**Service delivery**	**NIAS are fully committed to the DOH Community Resuscitation strategy**
		The Council remains concerned that the impacts on rural residents are not sufficiently considered as part of the new Clinical Response Model. Within the Consultation Documents, NIAS included the following image – showing various incidents where ambulance appliances where dispatched (in the 2017/2018 reporting period). The green areas indicate instances where appliances reached the incident within 8 minutes, whilst red areas indicate instances when this target was not met. Within the District, as across Northern Ireland, there are substantial areas of 'red highlighted areas'.	**Rurality**	The map referenced in the comment shows exact locations of each call (that received a physical response to the scene of the incident) in relation to a standard 8 minute drive time from ambulance stations. Approximately 68% of category A calls that had a response to the scene of the incident occurred within these drivetime areas. **Actual response times to these incidents have not been included in this analysis and it should be remembered that resources are not always deployed from ambulance stations**. NIAS acknowledge that there are remote rural areas outside the drivetime areas; there are also locations in urban areas outside of the drivetime radius. **Ongoing monitoring and modelling will assess the impact on performance in rural areas throughout the implementation of the CRM.**
		NIAS and HSCT Partnership Working - The Council would also urge NIAS to undertake some partnership working with the local Health and Social Care Trusts. Local	**Service delivery**	**NIAS will give this comment due consideration. NIAS current 999 response protocol is that all patients are transported to the closest appropriate Emergency Department.**

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		communities have genuine concerns for local hospitals (South West Acute Hospital and Omagh Hospital and Primary Care Complex) and the services offered in them. It would be mutually beneficial for the NIAS and (in this instance) WHSCT to ensure that Ambulance Services are transporting patients (particularly those in emergency situations) to the closest hospital. This would ensure that Ambulance services are not transporting patients on longer unnecessary journeys, as well as freeing up ambulance services/personnel more quickly. It is important that the NIAS in their 'early recognition' of life threatening conditions is supported by local HSCTs offering the appropriate treatment, in the closest available hospitals. Recognition, treatment and hospital care should always work in a complementary way.		
		Training on new systems/processes are vital and the pre-triage questions the Council would urge NIAS to focus some resources on basic Logistics Training as well as on the geography of Northern Ireland. This would help to ensure that services from the 'best placed' ambulance station would be utilised to respond to calls.	**Service delivery**	**NIAS will provide extensive training to its Dispatchers. NIAS are investing in updated technology through its REACH (Regional Electronic Ambulance Communications Hub) project. NIAS is introducing WiFi communications hubs across all its vehicles effectively creating secure Vehicle Area Networks (VANs) as the central communications hub with internet connectivity and the ability to send, transmit and access data relating to calls and patients in the mobile environment. In addition to this there will be investment in - Control technology, Fleet Mobile data system, and electronic**

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				patient report systems. These investments in technology will provide a flexible and robust platform to support NIAS' transformation and modernisation focusing on the provision of safe, high quality patient-focused care.
		The importance of improving the training arrangements it is essential that speed of response is not disregarded entirely. In emergency situations (e.g. cardiac arrest within the required timeframe. This should also be addressed as a matter of urgency when introducing any new Response Model.	**Service delivery**	**Noted**
		It is vital that rural communities (such as those within the Fermanagh and Omagh District) are not forgotten about. NIAS must liaise with local HSCTs to ensure transportation of patients in the most effective way.	**Policy**	**Noted. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		We welcome that part of the proposed new CRM will include the introduction of new Ambulance Quality Indicators (AQIs) to record and measure the quality of patient care. We welcome also the potential for this proposed new CRM to have a wider benefit for the NHS in NI.	**Monitoring / standards and indicators**	**Noted**
11	**The Green Party**	**The Green Party NI supports the NIAS goal of working collaboratively with its staff to develop and deliver improvement and modernisation, and in ensuring clinical staff**	**Service Delivery**	**Noted**

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		receive the highest standards of education, learning and development to perform effectively and safely, supported by advancements in technology, medical equipment, clinical practice and clinical audit.		
		The Green Party NI broadly welcomes the NIAS proposed new CRM for ambulance provision, we welcome its potential to reduce pressure on A&E departments by enabling NIAS paramedics and ambulance crews to do more for patients in need of urgent and emergency care without needing to transport them to hospital.	**Service delivery**	**Noted**
12	**Individual Stakeholder - CC**	**I believe with some additional training being provided to ACA staff that this model will be more effective and will positively impact on the patient experience.**	**Training and Education**	**In order to ensure that we can provide the right resource first time, work will be undertaken to review scope of practice and skillsets across all grades of staff and how they will be deployed, through collaborative working arrangements within the Trust, , and appropriately resourced actions will be taken to meet identified needs.**
		· The provision of Blue Light D2 response training to ACA staff.		
		· Training in the use of Pain Relief such as Entonox etc.		
		· Training in Patient immobilisation/Fracture immobilisation.		
		· Further "Assisting the Paramedic" training.		

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	Individual Stakeholder - RR	**Consideration be given to widening the remit of ACA personnel, providing some additional training and making some minor alterations to P.C.S. vehicles, these additions in my opinion would be an asset to the organisation as a whole.** **Issues I feel should be addressed are as follows:-** **Familiarising personnel with equipment used by A & E tier** **Training on the administration of Entonox** **Further training on the identification of Fractures**	**Training and Education**	**In order to ensure that we can provide the right resource first time, work will be undertaken to review scope of practice and skillsets across all grades of staff and how they will be deployed, through collaborative working arrangements within the Trust, . , and appropriately resourced actions will be taken to meet identified needs.**
		With regard to modification of vehicles I feel it would be appropriate to fit equipment which would be used to safely accommodate the carriage of A & E equipment … allowing R.R.V. paramedics to confidently use the vehicle as a method of transport. **The fitting of blue lights to vehicle grills and adjusting the rear red lights to alternate would I feel be an advantage and would in my estimation be cost effective.**		

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13	**Individual Stakeholder – AC**	**The Proposal - Model is not workable in current format.**		
		Given the halo ability to manage patients and release news.		
14	**Individual Stakeholder - AM**	**I am concerned that you may have overlooked a significant risk to older people from your proposals. Your consultation identifies falls as 5.6% of your Cat A. incidents but doesn't mention the larger group of elderly fallers in other categories. A search of local newspaper reports will throw up a small but very concerning number of stories about extended delays in response to old people who had fallen outdoors and were exposed to environmental risks.**	**Call prioritisation/ clinical care**	**Falls continue to be one of the main reasons people call 999 with approx. 30,000 calls per year. NIAS accept the need to ensure that Older People who have fallen should be managed and cared for appropriately. NIAS will continue to develop improved models of response which meet the needs of this patient group.** The consultation concentrated on patients in Cat A as they will comprise the patient group most likely to be impacted by the change in categorisation included within the proposal. Additional data analysis of service users in the other categories has been made available within this report.
		Services' responses to these reports always began with an apology and usually went on to say that their staff were busy with higher priority emergencies. Some of these old people later died. All of them suffered pain and other sequelae. Your 40 minute transport standard for Category 2 is, understandably, a 90th percentile. However, such patients all too frequently end up in the tail of the frequency distribution and that tail can be very long.	**Response time**	**NIAS do recognise that elderly fallers are known to be at risk and that our reputation suffers should we leave people on ground and exposed to environmental risks. We are highly attuned to the challenges raised. It is imperative that NIAS secure the additional resources requested in order to ensure that serious or adverse incidents o not occur.**

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		If this initial clinical assessment identifies a high risk of physical harm, the patient should be re-prioritised accordingly. If the risks are of a lower level and the response is likely to be delayed beyond the 90th percentile, the patient should be reassessed and their priority reviewed, periodically, by a clinician.	**Clinical Care/ Patient safety** **mitigation column**	**In relation to Older People who have fallen and are found to have an injury and / or illness that requires assessing, an ambulance is dispatched. NIAS paramedics are equipped to complete a comprehensive assessment of patients who have fallen including diagnostics such as ECGs; blood pressure; blood glucose; oxygen saturations and temperature. Where an injury / illness is found that requires further assessment, the patient is either transported to an Emergency Department or referred to teams such as Acute / Enhanced Care at Home.** **Where the patient is found to be well with no injury / illness, the paramedic will refer the patient to a falls team who will make contact with the patients within 2 working days of the referral. Where it is apparent during the initial 999 call that the patient has no immediately life threatening problems, they will be transferred to the Clinical Support Desk (CSD) for further assessment / triage by an experienced paramedic. The CSD paramedics have completed additional training and use a tool called Manchester Triage to assist with their decision making. Following assessment, the paramedic has a number of options including:** **• Dispatch a non-emergency ambulance** **• Advise family / friends to transport the patient to an Emergency Department / GP** **• Make a falls referral** **Where safe to do so, the CSD paramedic will talk the patient through methods of getting up off the floor. Where family / friends are on scene, the CSD paramedic will provide advice on how to lift the patient from the**

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				floor. They will provide with advice as long as it is clinically appropriate and regardless of the weather conditions. **Where the CSD paramedic establishes the need for an ambulance response and that the patient is vulnerable due to environmental concerns, they have the option of "upgrading" the call. CSD paramedics also review calls that are waiting on an ambulance response. This means that where a patient has fallen and requires an ambulance but one is not yet available, they will be able to receive advice from the CSD paramedic via phone.**
		I assume that the AQIs referred to in the consultation document are based on those that were introduced in England in 2011. I support this strongly because outcomes and best practice inputs need to be measured and reported upon both internally and externally.	**Monitoring / standards and indicators**	**The quality indicators are based on those accepted and currently used in the Ambulance Services in NHS England.**
		However, I would advise NIAS and its commissioners and performance managers to consider the purpose of these indicators explicitly. They should be INDICATORS and not STANDARDS. In other words, the objective should be continuous improvement rather than compliance. It is inevitable that there will be some drift from the former to the latter, so it would be wise to have a	**Monitoring / standards and indicators**	**Accepted. NIAS intend to develop a continuous Clinical quality improvement programme adopting best practice from the Ambulance Response Programme NHS England where appropriate.**

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		formal acceptance of this principle by all parties so that the necessary corrections can be made.		
15	**Individual Stakeholder – B O'H**	In the section, **Care of Dependants, 10.46**, the statement made **"The wide ranging of definition for people who have care of dependant responsibility makes it difficult to accurately quantify."** .....the HSC have legislative guidance (Carers and Direct Payments Act (Northern Ireland) 2002) on who is a carer and what the law means by the term carer. Then you have seemingly conflicting statements based on 10-year-old stats: Page 53, section 10.48. Over 63% of unpaid carers are in the 35-64 age groups. Census 2011 data shows that a high proportion of carers have a long term illness or disability: c. 9.6% of people who provide some unpaid care also reported having a long term health problem or disability that impacts day to day activity a lot. It would be expected that older carers would be more likely to require emergency and unplanned care.	Equality	Consideration of data and impacts in this category was under Section 75 consideration of having due regard to promoting equality of opportunity between "persons with dependents and persons without". The definition of Carer under the legislation mentioned does not encompass all persons who have the S75 protected characteristic. As NIAS has no such direct data on service users, various data sources regarding the population as a whole were considered with particular consideration of multiple identities that may make persons with dependents more likely to require pre-hospital emergency care. NIAS acknowledges that there are gaps in the S75 data relating directly to patients. Data is gathered for the

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		NIAS do not collect information on patient's carer status so this cannot be confirmed based on service user data. (why not?) If they don't collect the carer data in the first place and can't identify who is a carer after providing a service , how can they state "**There is therefore no adverse impact".** Also stating that, "Over 63% of unpaid carers are in the 35-64 age groups." Means nothing in the context of the rest of the paragraph. This group are likely to be the most mobile of carers. The other 37% are more likely to have significant travel issues.		purposes of assessing and meeting the patient's clinical need. The emergency or urgent, and often, brief duration of contact between NIAS and an individual service user precludes gathering data specifically for the purposes of equality monitoring. GDPR considerations prevent NIAS from using patient information to contact them for equality monitoring or to directly seek their opinions on the patient experience. NIAS is currently undergoing transformation in other areas that includes electronic patient records and there is an ambition that this will link to medical records for identified patients that will aid the clinicians in their response to incidents. This may provide additional data, such as carer's status (as defined under the Carer's and Direct Payments Act) but will still be a limited resource as to the S75 characteristics of NIAS service users.
16	**MacMillan**	**Growing and increasingly complex demands, and the impact of an ageing population, can be managed in a sustainable way. As such, we welcome plans to develop a new Clinical Response Model for NIAS.**	**Service delivery and risk to older people**	**Noted**
		By way of example, Macmillan and the South West Ambulance Service in England have developed an innovative partnership to improve end of life care for patients. Examples of effective partnership working like these demonstrate how services can be improved if they are to meet the needs of a growing number of people being diagnosed and living with cancer. We would value the	**Service Delivery model**	**NIAS welcome the opportunity to work in collaboration with McMillan to improve Palliative and End of Life care for the people who call an ambulance.**

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		opportunity to engage with NIAS on the potential for innovation and collaboration in the future.		
17	**Marie Curie**	**We believe that further integration of Marie Curie's Rapid Response Service into NIAS's new CRM could help to address these issues. We are proposing that an additional protocol be included in the enhanced Call Taking Process – whereby, when a Category 2, 3 and 4 call is received and the patient is identified as having a terminal illness/being at the end of life.**	**Policy / Transformation**	**NIAS welcome the opportunity to work with Marie Curie in reviewing the call take process and ensure that these processes clearly identify those patients with terminal illness, and that their needs are prioritised appropriately.**
	`	**We strongly support NIAS's proposal to create a series of standards and indicators to measure the effectiveness and safety of the new Clinical Response Model. That carers understand how the new system will work and, crucially, the benefits and rationale behind it.**	**PARTNERSHIP & ENGAGEMENT**	**In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
	Mid and East Antrim Borough Council	**M&EA Council approves of the implementation of the proposed new clinical response model** **Council has been made aware of media attention to the subject matter of this consultation. A widely held belief appears to be that a specific manner of answering**	**Service Delivery** **Communications**	Noted NIAS will be developing a full communications plan in relation to CRM programme and its various projects, and this response will be taken into account.

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		dispatcher questions could hinder your ability to ascertain an ambulance when an individual dials 999. Council feels it would be beneficial for NIAS to address this matter publically to dissolve any public confusion which could result in a negative reaction to the proposed change in clinical response model.		
		Whilst the consultation document outlines that NIAS propose to adopt the clinical response model of NHS England which is based on the most comprehensive research in the world, Council is wary of the impact that implementing a major change in emergency services provision could have on the public. **Council feels it would be desirable to see further evidence-based research as to the success of the NHS England clinical response model being implemented to highlight any challenges they faced and how they overcame them.**		**NIAS has reviewed the Ambulance Response models in England Scotland and Wales, ref. 4.6. of the Consultation Document, September 2018. NIAS is proposing to adopt the model that has been implemented in NHS England, which was designed following the comprehensive Ambulance Response Programme (commenced 2015). This programme is the most comprehensive study about ambulance services completed anywhere in the worlds and 14 million calls have ben proceed through the programme with no reported adverse incidents. NIAS will continues to monitor all three National Services during the implementation phase and will adopt best practice as appropriate. NIAS does engage with all three services independently and through the Associate of Ambulance Service Chief Executives, AACE.**
		The consultation document mentions several times that a call's category can be adjusted to the appropriate level throughout the call as the dispatch call handler better establishes which category the incident belongs to and therefore establishing which emergency response vehicle is most appropriate to send to the scene, if any.	**Call prioritisation**	If for example a call is downgraded from a Category 1 Life threatening call to a Priority 2 call category the expected response time will change from a mean 8 min response time to a mean 18 minute response time.

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		Council would appreciate clarification on what affect is caused on the response time if a category is de-escalated during the call.		
		Council seek assurance from NIAS that the implementation of the proposed new clinical response model is planned and managed appropriately to ensure no impact on our citizens. We also urge a review of the new model at the earliest opportunity and any revisions made to ensure smooth delivery.		**Ongoing monitoring and modelling will assess the impact on performance throughout the implementation of the CRM. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
	Mid Ulster District Council	**The council is broadly supportive of the proposal, its rationale and objectives. Mid Ulster district has experienced some of the lowest performance in relation to ambulance response times, which have steadily increased since 2012. Mid Ulster residents are also doubly penalised as the travel time to a hospital with major injury capabilities is over eight minutes longer that the NI average.** **This new Response Model, if appropriately resourced and implemented, has the potential to help address this issue**	Policy	Noted
		Health services and facilities which interface with NIAS must be required to ensure their processes are aligned to integrate effectively with this proposal and play their part in supporting its delivery.	**Partnership and engagement**	Noted

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		Furthermore, alleviating the pressure on A&E departments will also require significant investment in other areas		
		Increasing the capital, fleet and staffing capacity at NIAS is critical to the proposal; the council believes a unique opportunity exists for the locating of a new station at the Desertcreat site. Any new development at Desertcreat must not be detrimental to NIAS estate and services operating from the current sites.	**Funding and Development**	Noted
		Ideal location to 'pilot' the roll out of the new model and requests that NIAS considers working with council's community planning model to support this.	**Service Delivery Model**	NIAS will give this request due consideration during the implementation phase in line with the Councils community planning model.
		The council calls upon the Department of Health to make it a priority to ensure that the budget required by NIAS to take forward this new proposal is made available and ensure rural populations have the same safe and equitable access to this service as their urban counterparts.	**Service delivery/ rurality**	Noted
		• **population grew by 18.7% between 2001 and 2013 against the regional average of 8.3%, making Mid Ulster the fastest growing of the 11 council areas, this trend is projected to continue with population climbing to 165,000 by 2030.**		

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		• **By 2037 83% will be aged 65+ (NI average 68%)** • **Mid Ulster travel time to a hospital with major injury treatment capabilities is over 8 minutes longer than the NI average.**		
		The proposed new model will only deliver the requisite results and achieve maximum impact if it is adequately resourced and implemented. Its development should be taken forward as part of a wider strategic framework using a joined up and fully integrated approach to service planning and delivery, not just across the health sector but also from the Department of Infrastructure and the Economy.	**Funding and Development**	Noted
		The community have a part to play in supporting initiatives such as community resuscitation, community first responders and the defibrillator strategy, these initiatives must not, in any way, be seen as offering alternatives to, or replacements for providing rural communities with the full level of service to which they are entitled.	**Rurality**	NIAS would identify these initiatives as complimentary systems to support core services in Rural Communities
		The NIAS estate in Mid Ulster is currently in poor condition; significant funding will be required to refurbish buildings, and increase fleet and staffing to support the delivery of the new model. The Council welcomes that rural/urban impacts will be taken into	**Capital Development**	NIAS will engage with the council in relation to the implementation of its Hub and Spoke model.

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		account in designing new NIAs Estate Strategy and in relation to ambulance stations, the council understands that a 'hub and spoke' model is being considered; again given the predominantly rural demography of this area, local deployment points must not only retained but also upgraded and enhanced.		
		In addition the council also calls on NIAS to now give serious consideration to developing a 'hub' at Desertcreat, adjacent to the NIFRS Learning & Development Centre – this offers a unique central location for the service which would have scope for a large scale development. This could provide for a full time facility with a comprehensive range of services including fleet management, repair and re-stocking services, thereby freeing up paramedics to focus on their critical work. **Any new development at Desertcreat, however, must not be detrimental to the NIAS estate and services operating from the current South Tyrone Hospital and Magherafelt sites.**	**Capital Development**	NIAS will engage with the Council in relation to the implementation of its Hub and Spoke model, which will include the feasibility of accessing Desecrate as a potential Hub
		Council believes the NIAS location to 'pilot' the roll out of a new model and request NIAS considers working with council's community planning.	**Service Delivery**	NIAS welcome the opportunity to engage with the Council in enhancing provision of Ambulance Services with the area.

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		This could also include the design of other complementary systems of care, e.g. community paramedics, CFR programmes.		
		Council also believes that NIAS and NIFRS need to develop closer working relationships resulting from the number of callouts to both services.	**Engagement and Partnership.**	NIAS will continue to work in collaboration with NIFRS in this regard.
		The council also strongly welcomes the proposal to increase staffing by one third to reach 333. **A major concern … is the potential projected 'gap' in the availability of qualified staff when the current paramedic qualification will no longer be accepted in 2020+ and a new one then introduced, which trainees will graduate with in 2023.** **Identifying solutions for bridging this gap must be addressed**	**Staffing**	NIAS with be working with the DOH in developing workforce and Education plans to secure the required WTEs required to deliver the service to the required standards and indicators.
		This new model places an even greater requirement on the ability of the call taker to make a critical decision in the very early stages of the call to triage the category 1s from the other three. It is imperative that staff in this position are provided with the quality of training and support to identify calls meriting a category 1 response; an error for a patient located in an urban area may be quickly redressed by deploying	**Call prioritisation**	NIAS Call Takers will undertake comprehensive training in preparation for delivery of the CRM.

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		resources from nearby, this option is rarely available in a rurally isolated location.		
		Rural Proofing **The council also requests that a rural proofing and rural needs assessments must be conducted, in accordance with the statutory framework, to inform the planning process for the model, ensuring it is designed to deliver an equitable service to both urban and rural populations.**	**Rurality**	The consultation document included an integrated EQIA and rural needs assessment which considered limited impacts of the proposal. As the proposal moves into implementation NIAS are committed to ongoing consultation and additional equality impact screenings and assessments and rural needs assessments as required during this process.
		The Council understands that once this consultation is completed and the findings sent to the Department, the Business Case will then be undertaken. Given the current and increasing demand-capacity gap highlighted by NIAS in their proposal, and the worsening situation in relation to performance targets, it is imperative that the request for funding this new model is expedited as a matter of priority.	**Funding**	**Noted**
		Key to measuring the new model's effectiveness will be the achievement of performance within the set limits. The key change proposed of an 8min response to ILT calls, regionally is acceptable, if achieved. While the council welcomes this as regional target, once operational we will require to see performance broken down across each	**Service Delivery**	**NIAS will consider this request in the design of its information reporting suite.**

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		of the LGDs to review the difference in achievement of targets in rural areas. The introduction of a new target of a 15 minute response time for 9/10 calls will also be critical for rural areas, if delivered will be significantly better than the current performances. However as above this must be kept under review and will require close monitoring to ensure the current urban-rural disparities do not recur.		
		The Council take s this opportunity to extend an invitation to NIAS and other health partners to work with them as part of the Community Planning process to identify and take forward the most appropriate solutions for the delivery of the NIAS service across Mid Ulster, ensuring its citizens have access to an equitable level of service which has not been the case to date.	**Partnership and engagement**	NIAS welcome the opportunity to engage with the Council in enhancing provision of Ambulance Services with the area.
	Northern Ireland Local Government Association	The need for communication to the public about why change is required, what changes are happening, what level of service they can now expect, and how their actions can play a part in contributing to service improvement. There is a particular need for communication to those who may perceive themselves to be 'losing out' as a result of the changed model, for example those		**NIAS will be developing a full communication plan in relation to CRM. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**

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		with long term chronic illness, living in more deprived urban areas. Support for change and assistance in communication should be sought from partners in the public and voluntary/community sectors, and the local media.		
		As a statutory partner in the council-led community partnerships, NIAS should use these and other networks to ensure that widespread understanding of the changes is developed. NILGA is aware that there have already been local government led projects between councils, blue light services and other partners (e.g. the NI Housing Executive) to work better collaboratively to improve services locally. This early partnership working should be built upon and the new clinical response model should form part of a wider suite of public sector service improvement, collaboration and efficiency stemming from Community Plans and Partnerships, and Policing and Community safety Partnerships.		**NIAS will be developing a full communication plan in relation to CRM. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects**
		It will be essential to ensure that adequate and well-resourced training is provided and a training programme maintained, across Northern Ireland. This may form part of or be additional to the 'community resuscitation and defibrillator		**Initiatives currently in place and to be considered for further development include** **• the use of strategically-placed standby points where ambulances are stationed until they are needed;** **• Community paramedics working locally in the most**

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		strategy' to which paragraph 3.11 of the consultation document refers.		**rural areas who are able to respond to life-threatening emergencies.** **• Co-responder partnership arrangements with police and fire and rescue colleagues –** **• Other initiatives we support through our Community Resus Programme are the training of school children in Basis Life Support, the introduction of more defibrillators into rural communities and the mapping of defibrillators so people know how to find their nearest one quickly.**
19	**Royal College of Midwives**	**Engagement with Maternity Services is essential in relation to the additional questions asked as part of the triage software (AMPDS). To ensure the safe and effective use of the system, Midwives would require clarity as to the nature and number of additional questions to be asked and whether they are concise or extensive in nature. It is essential that any additional questions do not add any delay to the dispatch of ambulance support and that cognisance is given to the opinion of the attending midwife. Ongoing mandatory training for FMUs and for Home Birth situations depends on clarity around the processes required when summoning help to an emergency. This training could be**	**Clinical**	**NIAS welcome the opportunity to engage with Representatives from RCM to discuss the use of AMPDS in the management of Maternity calls. NIAS would also welcome the involvement of RCM in the education and training programmes for NIAS Staff.**

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		enhanced by a multi-professional approach with the NIAS.		
		We note that in paragraph 5.21 that the intention is to develop 'Ambulance Quality Indicators' which evidence quality of patient care. It will be essential that these are developed using a 'co-production' approach, consulting with Maternity Services, Midwives and the women who access services, particularly those who access the services of FMUs or intend to birth at home.	**Clinical**	**Maternity cases will be identified through the Nature of Call protocol as a Category 1 response. NIAS will be adopting Clinical Quality Indicators for STEMI, Stroke in the first instance. NIAS welcome the opportunity to develop additional Clinical Quality Indicators using the co-production model in association with Maternity Service providers.**
		It is important that definitions of 'serious maternity complications' are shared and discussed with the providers of maternity services to ensure that they are appropriately applied. It would be the view of the RCM that the person best placed to identify the seriousness of the complication would be the midwife attending to the women and requesting ambulance assistance. It would be an expectation that all 'serious maternity complications' would be placed in category 1 with an aimed response time of the 8-19 minutes outlined	**Clinical**	**NIAS welcome the opportunity to engage with Representatives from RCM to agree a common understanding of "serious maternity complications" NIAS can confirm that serious maternity complications will be categorised as category 1.**
20	**Royal College of Occupational Therapists**	In 4, 'Providing the Best Patient Care', we are pleased to see there is a proposal to introduce a set of Ambulance Quality Indicators which will evidence the quality of patient care across a range of clinical indicators and that work has	**Partnership and engagement**	**NIAS welcome the opportunity to work in partnership with Occupational Therapy Services in design of services that best meets user needs and reduces attendance at Hospital.**

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		begun on Clinical Performance Indicators and Care Bundles in preparation for this. In 5.22 it mentions that Paramedics will determine if the patient needs to attend hospital or can be referred to community-based services which can best meet their needs through use of Appropriate Care pathways and /or transport to alternative destinations. The Royal College would like to see more details in this proposed model of how NIAS can expand on this and work with in partnership with occupational therapy services. In our recent policy document, Reducing the Pressure on Hospitals: A report on the value of occupational therapy in Northern Ireland 1(RCOT 2016), we have shown the benefits occupational therapists can provide to reduce pressure on hospitals, and ensure patients who do not need to be admitted to hospital are not admitted to hospital.		
		This recent policy document, Reducing the Pressure on Hospitals: A report on the value of occupational therapy in Northern Ireland 1(RCOT 2016), highlights a number of recommendations which would complement the work of NIAS in ensuring patient receives the right treatment at the right time. These recommendations include:	**Partnership and engagement**	**NIAS welcome the opportunity to work in partnership with Occupational Therapy Services in design of services that best meets user needs and reduces attendance at Hospital.** **Work is ongoing with commissioners to obtain funding to undertake a feasibility study of co response NIAS and OT's to falls. Both NIAS and The Royal College are keen that this partnership work taken is forward. . In addition, NIAS is establishing a stakeholder forum that will have a**

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		1. To prevent falls-related admissions, there must be increased partnership working between occupational therapy services and ambulance services when responding to falls. 2. All hospital at home schemes, rapid response and acute and emergency care services must have occupational therapists embedded within the multidisciplinary teams, and this includes 'Home Treatment' teams for mental health. 3. To achieve optimum patient flow and fast-paced assessments, commissioners must include occupational therapy in funding for out of hours services. 4. All multidisciplinary admission and discharge teams across the hospital environment must include occupational therapists, with therapy-led discharge planning for people with complex health care needs. 5. To ensure timely and successful discharge, commissioners and providers must support the development of therapy-led services.		**continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		There appears to be more of a consideration and analysis of Category A calls. While this Category is extremely important we believe that the overall analysis should have contained equal information on other Categories, if this is to be an overall new approach and clinical response model for NIAS.	**Equality**	The consultation concentrated on patients in Cat A as they will comprise the patient group most likely to be impacted by the change in categorisation included within the proposal. Additional data analysis of service users in the other categories has been made available within this report.

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		As we have shown through the our case study examples of working together, there is an opportunity to ensure that any potential adverse impacts in relation to the proposals could be minimised by including an occupational therapist within the NIAS teams. We have also shown how the deployment of an occupational therapist within an Ambulance Service can reduce the need for patients to attend hospital, reduce pressure on hospitals, and save the health service significant funds. The Royal College of Occupational Therapists would welcome the opportunity to further explore how we can work in partnership with the NIAS.	**Partnership and Engagement**	**NIAS will Review the case studies provided of Occupational Therapists and Ambulance Services working together. NIAS agree that there is a great deal more that can be done, not only to support people in their communities but also that a co-ordinated approach and partnership working across services is needed more than ever.**
		The Royal College of Occupational Therapists welcome the detailed research on the impact these proposals will have on service users based on Section 75 groupings and rurality. We note the predicted rise in the older population aged over-60, with a 12.5% increase in the next five years, and the impact this will have upon the service provided by NIAS. We also note that this increase will lead to an increase in clinical demands on emergency and non-emergency service provision. As noted within the consultation document, the failure to introduce the new Clinical Response Model will have the greatest impact on this section of the community. Within our policy document, Living, not Existing: Putting prevention at the heart of	**EQIA**	**Noted**

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		care for older people in Northern Ireland, we make three recommendations for change 7(RCOT 2017): 1. The RCOT recommends that more occupational therapists are based within primary care to prevent or delay the need for care and support. 2. The RCOT recommends that occupational therapists are deployed to develop person and community-centred approaches to ensure older people live independently for as long as possible in their communities. 3. The RCOT recommends that partnership agreements are formally developed across local housing, health and social care sectors to ensure all older people irrespective of social, economic or housing circumstance, have access to occupational therapy. These recommendations and those contained within this policy document will further contribute to a wider framework approach from NIAS. This would also better promote equality of opportunity in respect of these proposals for those over-60.		
		5.26 refers to 'medical professionals', the Royal College of Occupational Therapists would ask that this is changed to health and social care professionals.	**Change request**	**Noted and actioned**

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21	**Royal College of Psychiatrists**	**Further consultation should be held with groups representing those with disabilities – especially those with chronic mental health illness needs and those with communication needs. We are happy to meet you**	**Training**	**NIAS would welcome the opportunity to engage with the Royal College of Psychiatrists and other representative groups to discuss how NIAS can best meet the needs of all of our service users. We are particularly interested in supporting the needs of mental health patients through having professional expertise embedded in our Clinical Support Desk Team.** NIAs met with representatives of the British Deaf Association and held a public forum with their membership to discuss the CRM but accessibility issues to emergency healthcare in general. NIAS have a number of measures in place to assist those with communications needs, including the emergency SMS system and telephone interpretation services and are mindful of seeking ways to improve accessibility in the wider transformation projects that are ongoing and in staff development. **In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		In relation to paragraph 10 entitled 'Full Equality Impact Assessment', we would highlight that disability can affect all ages. Furthermore, particular attention must be paid to the needs of those with serious mental illness and those with a learning disability, all of whom may qualify as	**Equality**	The EQIA has been updated to better reflect the diversity of disabilities. Age and disability was given particular consideration in the context of S75 multiple identities due to the high proportion of older service users.

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		having a disability under the Disability Discrimination Act 1995 and some of whom may have communication difficulties.		
		Good communication skills on making calls to the Service are assumed throughout the document. The needs of these Patient cohorts must be taken into account when formulating training programmes for staff and in developing appropriate policies and protocols for the Clinical Response Model. in particular regarding the former	**EQIA Engagement**	**Call takers will receive comprehensive training on all aspects of the new clinical response model.**
		Proposed New Categories do not include any acknowledgement of mental health emergencies. This can often be a situation which requires an urgent response, as the Patient may have the potential to cause harm to him/herself or others or both, could be violent or could abscond. Typically this will be following his/her detention for assessment and thereafter he/she may/will frequently require to be conveyed to hospital by ambulance. There is no reference to the Regional Inter Agency protocol under Article 130 of the Mental Health (NI) Order 1986. These are glaring gaps in the document and we are happy to meet with you to discuss further. Elaboration as to how mental health emergencies for detention etc. fit into the Proposed New Categories would therefore be essential.	**Service Delivery**	**NIAS would welcome the opportunity to engage with the Royal College of Psychiatrists and other representative groups to discuss how NIAS can best meet the needs of all of our service users. We are particularly interested in supporting the needs of mental health patients through having professional expertise embedded in our Clinical Support Desk Team.** **NIAS will commit to addressing the issue of addressing how Mental Health Emergencies will be categorised and managed through the proposed CRM model with particular emphasis on Article 130 of the Mental (NI) Order 1986 and the Regional Inter Agency Protocol.**

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		We would draw attention to the figures given in paragraph 10.35, which appear inaccurate and need clarification.	Equality	**Noted and actioned**
22	**Royal College of General Practitioners NI**	**Current research highlights a higher incidence of Category C calls from Northern and Belfast Trust regions. RCGPNI supports further exploration into these statistics and offers to work with NIAS to assess the reasons for this. Current statistics suggest a higher rate of category C calls from urban areas. The use of paramedic practitioners to efficiently perform home visits could help to support limited GP resources and, by using their unique skills, ensure unnecessary hospital admissions are avoided.**	EQIA	**Noted**
		Improving communication between NIAS staff and GP staff should also be prioritised. RCGPNI is currently leading a piece of work with other medical Royal Colleges in Northern Ireland to improve communications and professional behaviours at the primary/secondary care interfaces that exist across the HSC. Regardless of our role, we are all part of the one health system and should consider ourselves colleagues who work as part of the one team. As in other areas when a referral or request is sent through, the receiver does not always have all of the information they need or would like to make decisions and do the best job that	**Engagement**	**NIAS welcome the opportunity to work in collaboration with RCGPNI and other Medical Royal Colleges in NI, in improving communications, sharing of information and access to professional support, with a view to jointly improving services, safely and efficiently.**

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		they can in taking the request forward. Direct access with team members who requested NIAS assistance, enabling appropriate access to patient records and ensuring handover of all necessary paperwork and information are all areas that need further explanation, so solutions can be found and implemented. RCGPNI is happy to support this work where we can. Improving relationships between various professions, as well as addressing local communications barriers, should help us all to work better and more efficiently together.		
23	**Sinn Fein**	Can the NIAS list what meetings it has had throughout the consultation process with regards to the new CRM involving stakeholders.	**Equality**	NIAS engaged in a wide range of formal and informal meetings with stakeholders and individual staff members and service users. An outline of the Trust's approach to the consultation is outlined in this document.
		Sinn Féin have some concerns with the EQIA. In the section, Care of Dependants, 10.46, it states "The wide ranging of definitions for people who have care of dependant responsibility makes it difficult to accurately quantify." However the HSC have legislative guidance, Carers and Direct Payments Act (NI) 2002, defining who is a carer and what the law means by the term carer. Based on this it should be possible to quantify the number carers for consideration within the EQIA. This needs to be addressed.	**Equality**	Consideration of data and impacts in this category was under Section 75 consideration of having due regard to promoting equality of opportunity between "persons with dependents and persons without". The definition of Carer under the legislation mentioned does not encompass all persons who have the S75 protected characteristic. NIAS acknowledges that there are gaps in the S75 data relating directly to patients. Data is gathered for the purposes of assessing and meeting the patient's clinical need and the emergency or urgent and often brief duration of contact between NIAS and an individual service user

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				precludes gathering data specifically for the purposes of equality monitoring. GDPR considerations prevent NIAS from using patient information to contact them for equality monitoring or to directly seek their opinions on the patient experience. NIAS is currently undergoing transformation in other areas that includes electronic patient records and there is an ambition that this will link to medical records for identified patients that will aid the clinicians in their response to incidents. This may provide additional data, such as carer's status (as defined under the Carer's and Direct Payments Act) but will still be a limited resource as to the S75 characteristics of NIAS service users.
		Within the HSCB Audit of Inequalities 'Emerging Themes', under the Disability theme it identifies access to emergency services for deaf people as inequality. Although there was an understanding around the emergency SMS service being available for access to the PSNI, a similar level of knowledge that the service can be used to access NIAS was limited.	**Equality**	NIAs met with representatives of the British Deaf Association and held a public forum with their membership to discuss the CRM and accessibility issues to emergency healthcare in general. NIAS have a number of measures in place to assist those with communications difficulties, including the emergency SMS system and telephone interpretation services and are mindful of seeking ways to improve accessibility in the wider transformation projects that are ongoing and in staff development. It is impossible to quantify the use of the emergency SMS service. Any calls are recorded as being received from another agency as the Emergency SMS service alerts to PSNI Belfast Regional Control.

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		Sinn Féin would have concerns around the layout of the full Equality Impact Assessment. Although it gives some detail under each section 75 category, it is not clear as to which category the responses from identified impact and mitigation required actually relates to.	**Equality**	Each of the 9 categories was assessed appropriately and was detailed as a single response. The final EQIA takes into account additional data, issues and considerations raised during the consultation process, and has been revised accordingly.
		The absence of a substantial investment in ambulance services would significantly undermine a new CRM in terms of providing better health outcomes and instead would be seen as a cost saving measure. Sinn Féin would be deeply concerned by any attempts to introduce a new CRM in the absence of the necessary investment.	**Funding**	**NIAS acknowledge that full funding to support a transformation programme will be required to achieve the Response and Clinical Quality indicators that have been propose**
		Furthermore, with regard to the provision of ambulance services in rural areas, what is the evidence base for suggesting that the introduction of a new CRM would improve response times for life-critical emergency calls in rural areas compared to current response times? Can the ambulance service give assurances that this improvement in response times in rural areas will materialise?	**Performance in Rural Areas**	**NIAS is very conscious of its obligations in providing cover in areas with significant rural populations and ambulance staff work very hard to ensure that the quality of service received by people living in these areas is of the highest calibre, even though it is accepted that at times, patients in these areas will not always receive a response as quickly as they would if they lived in an urban area. NIAS is committed to reaching all categories of patients as quickly as possible and in line with agreed ambulance response standards – but must also so in a way that makes efficient use of the service's limited resources. NIAS is committed to ongoing collaboration and co-operation with rural stakeholders including local government and will be engaging with partners to best implement CRM as the program develops. There are two things that NIAS believe will contribute to an improved**

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				response times in Rural Areas. 1. The Reduction in the demand for the number of calls requiring an 8 minute response form 30% of 999 calls to 7%. 2. The operational deployment modelling completed to support this proposal identifies an uplift of 4,478 additional Emergency Ambulance hours per week across NI and 179 Intermediate Care Ambulance hours. This uplift in cover will contribute to improved response times in all areas. Aside from increases in the number of staff allocated to rural areas, other initiatives currently in place and to be considered for further development include **• the use of strategically-placed standby points where ambulances are stationed until they are needed;** **• Community paramedics working locally in the most rural areas who are able to respond to life-threatening emergencies.** **• Co-responder partnership arrangements with police and fire and rescue colleagues –** **• Other initiatives we support through our Community Resus Programme are the training of school children in Basis Life Support, the introduction of more defibrillators into rural communities and the mapping of defibrillators so people know how to find their nearest one quickly.**
			Performance in Rural Areas	**While response times are critically important in some cases, they are not the only measure of the service provided by NIAS ambulance services. In most cases, the health outcome for rural patients is as good as for those in urban areas. The national ambulance response standards which NIAS propose to adopt were introduced**

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				in July 2017 are designed to ensure that the most suitable high-quality response is delivered to every patient in an appropriate clinical timeframe. The new system allows the ambulance service to concentrate on providing an even faster response to those patients who are truly life-threatened, whilst also reducing the transport delays for all other categories of patients. NIAS has already secured additional funding from their commissioners and are currently in the process of training and deploying additional staff. Over time these initiatives will continue to allow further improvements in response times to be made. In order to address this particular issue raised in regard to improving performance in Rural areas Rural areas NIAS will undertake to refresh the operational modelling undertaken in 2017.
		Notwithstanding some improvement during the consultation process greater efforts need to be made with regards to co-design/co-production.	**Engagement**	**Comment accepted**
		Sinn Féin are clear that any new CRM requires significant investment in NIAS workforce, fleet and infrastructure as stated above.	**Funding**	**The uplift in the size of the workforce and the review of rosters to better match levels of cover with demand for service, will require investment in Fleet, Equipment, Estate and support services.**
		Measuring outcomes of a new model will be vital and it is important a regional mean target covering the 6 counties does not hide gaps in response times between areas, such as urban versus rural.	**New Standards and Indicators**	**Noted**

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		NIAS must provide sound evidence that improvements to the service with the introduction of a new CRM would improve response times to life threatening emergency calls in rural areas		**Noted**
		Sinn Féin would encourage NIAS to continue to engage with the ambulance service in the south of Ireland	**Engagement**	**NIAS do work in collaboration with National Ambulance Service in Southern Ireland. NAS are in the process of preparing to introduce a new response model in Southern Ireland. This will further enhance collaborative working and contingency support arrangements. . In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		Sinn Féin are clear that any new CRM requires significant investment in NIAS workforce, fleet and infrastructure as stated above.	**Funding**	**Following the introduction of the new standards ambulance trusts have been working hard to reduce the numbers of fast response units and increase the numbers of ambulances. In many instances trust have also secured additional funding from their commissioners and are currently in the process of training and deploying additional staff. Over time these initiatives will continue to allow further improvements in response times to be made.**
24	**Stroke Association**	**NIAS changes should align with recent changes to stroke services in HSCNI**	**PARTNERSHIP & ENGAGEMENT**	**NIAS are fully engaged with the "reconfiguration of Stroke Services " project led by the DOH**
25	**UUP**	**I would give a guarded support to the adoption of the new proposed critical**	**Call Prioritisation**	**Please Review section 4.5 page 15**

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No.	Respondent	Comment	Theme	NIAS Response
		response model. Specifically I would support the creation of the new category 1 enabling early identification and despatch of an ambulance to immediately life threatening conditions. I would however seek clarity as to whether new categories 1 and 2 will replace the old category A, category 3 replace B and category 4 replace C so that comparisons with the previous outcomes could continue.		
		I would also be concerned at this stage about the proposed removal of almost half of the single paramedic rapid response cars. These cars have been essential in responding to incidents when ambulances may not have been available, so again I would suggest that no such reduction takes place until the NIAS are in possession of the proposed new ambulance vehicles	**Service Delivery**	**Reduction of RRV,s is the most optimum configuration of vehicles required to deliver the service based on a comprehensive modelling of future need.**
		The rural community, which makes up a third of the population in Northern Ireland experiences longer response times and care must be taken that the changes proposed will actually improve response times and patient outcomes.	**Performance in Rural Areas**	**NIAS is very conscious of its obligations in providing cover in areas with significant rural populations and ambulance staff work very hard to ensure that the quality of service received by people living in these areas is of the highest calibre, even though it is accepted that at times, patients in these areas will not always receive a response as quickly as they would if they lived in an urban area. NIAS is committed to reaching all categories of patients as quickly as possible and in line with agreed ambulance response standards – but must also so in a way that makes efficient use of the service's limited resources. NIAS is committed to ongoing collaboration**

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				and co-operation with rural stakeholders including local government and will be engaging with partners to best implement CRM as the program develops. **This is a not a new issue, and ambulance services have been working hard to find new ways to improve the quality of care provide to patients in rural areas for many years. Aside from increases in the number of staff allocated to rural areas, other initiatives currently in place and to be considered for further development include** **• the use of strategically-placed standby points where ambulances are stationed until they are needed;** **• Community paramedics working locally in the most rural areas who are able to respond to life-threatening emergencies.** **• Co-responder partnership arrangements with police and fire and rescue colleagues –** **• Other initiatives we support through our Community Resus Programme are the training of school children in Basis Life Support, the introduction of more defibrillators into rural communities and the mapping of defibrillators so people know how to find their nearest one quickly.** **It is also important to remember that while response times are critically important in some cases, they are not the only measure of the service provided by NIAS ambulance services. In most cases, the health outcome for rural patients is as good as for those in urban areas. The national ambulance response standards which NIAS propose to adopt were introduced in July 2017 are designed to ensure that the most suitable high-quality**

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				response is delivered to every patient in an appropriate clinical timeframe. The introduction of these new standards, which were rigorously tested on some ten million 999 calls, recognises that many of the patients the ambulance service traditionally tried to reach in eight minutes did not actually derive a clinical benefit from a response in that timeframe. The new system allows the ambulance service to concentrate on providing an even faster response to those patients who are truly life-threatened, whilst also reducing the transport delays for all other categories of patients. **Following the introduction of the new standards ambulance trusts have been working hard to reduce the numbers of fast response units and increase the numbers of ambulances. In many instances trust have also secured additional funding from their commissioners and are currently in the process of training and deploying additional staff. Over time these initiatives will continue to allow further improvements in response times to be made.**
		With Northern Ireland being a more rural area than much of England I would like to have known how the outcomes delivered will be monitored to confirm that the improvements indicated are actually delivered upon locally. The rural community, which makes up a third of the population in Northern Ireland experiences longer response times and care must be taken that the changes proposed will		One of the key considerations about measuring potential impacts is that the relevant data can only be indicative. Substantive real-time data of the actual impact of the proposed new Clinical Response Model will only be available after it becomes activated. At that point, AMPDS codes will be allocated to the new categories and dispatch protocols under the design of new proposed model. The number and proportion of calls within each category could then be analysed, and that data could be modelled for response times and clinical outcomes. This recognition of data gaps

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		actually improve response times and patient outcomes.		helps explain why NIAS intends to do a further focused consultation on the results of this document and ensure a continuous monitoring process
		1. I am aware that at peak periods it is not unusual for ambulances and staff to endure significant handover delays at several hospitals across Northern Ireland. If a new clinical response model is to be introduced and delivered I believe addressing this particular problem would first need to be of utmost importance. Whilst I appreciate that this would more be a task for the hospital and HSCT, I do believe the NIAS would have an important contribution to make.	**Service Delivery model**	**The PHA are leading a review of delays in Ambulance Turnaround times at ED. Representatives from HSCT, HSCB, and NIAS will participate in the review.**
		Technology is ever evolving and especially so in healthcare. Yet I note that the only real reference it received in the entire consultation document was at the start and that was within one of the key themes of the NIAS when it stated that clinical staff will be equipped to carry out their role supported by advancements in technology. Whilst that is all very appropriate I wold have preferred a much greater emphasis placed on the use of modern technology to treat patients at the scene.	**Technology**	**NIAS are investing in updated technology through its REACH (Regional Electronic Ambulance Communications Hub) project. NIAS is introducing WiFi communications hubs across all its vehicles effectively creating secure Vehicle Area Networks (VANs) as the central communications hub with internet connectivity and the ability to send, transmit and access data relating to calls and patients in the mobile environment. In addition to this there will be investment in - Control technology, Fleet Mobile data system, and electronic patient report systems. These investments in technology will provide a flexible and robust platform to support NIAS' transformation and modernisation focusing on the provision of safe, high quality patient-focused care.**

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				NIAS is addressing this issue through core business procuring new technologies e.g. electronic patient reporting and upgrading existing technologies e.g. Emergency Control systems and Fleet mobile data system.
		One of the questions I would have liked to have seen addressed in this consultation was whether the adoption of new medical technologies and innovation could result in reducing conveyance rates to hospitals. In addition I am still unsure entirely as to whether the current ambulance fleet maximises – or even due to the age of some vehicles is able to – the use of modern technology.	**Technology**	**NIAS has a five year fleet replacement programme and all vehicles are technology capable**
		1. Unfortunately I could see little emphasis on collaborative action within the new proposed model, or how indeed the NIAS hopes to build on existing relationships. I am familiar with the pilot scheme in Lurgan where NIFRS crews were notified of cardiac/respiratory arrest and chest pain related calls. That was the sort of cross-cutting and joined-up work that can deliver real and meaningful results on the ground. Similarly, I believe real value, synergies and excellence could be achieved with shared training opportunities – something that had unfortunately fallen away from the final Desertcreat proposals.	**Joint working**	**NIAS is engaged with NIFRS on a range of joint working projects involving, training, capital projects for shared facilities and response and deployment plans. . In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**

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		Whilst I have already welcomed the commitment of new staff, and expressed concern about funding, I would also have liked to have seen a greater emphasis placed on ongoing staff support. Ambulance staff perform one of the most difficult of all public services and they are often witness to some very traumatic scenes. That is why it is so important that they receive the correct level of support and ongoing care themselves. One specific measure that I would like to see rolled out across Northern Ireland is critical incident debriefing.	**Engagement**	A number of workstreams to better support staff are being taken forward through the Health and Wellbeing Partnership with Unison. One strand of this work is the ongoing pilot of the Peer Support programme to support colleagues experiencing high levels of stress or exposure to traumatic events which commenced in October 2018 NIAS have appointed a Health and Wellbeing Manager due to take up post in April 2019.
		I would ask you to consider introducing any changes gradually so that confidence can be obtained that improvements of response times and outcome results from the changes in both urban and rural environments.	**EQIA Engagement**	**Ongoing monitoring and modelling will assess the impact on performance in rural areas throughout the implementation of the CRM.**
26	**Unite**	**Our concern is that this saves lives for the sickest but reduces the service to others. Our concern is that this exercise will improve the statistics of urgent responses at the cost of "other" sick people**	**Standards**	**The consultation document proposes the new standards and indicators for each category of call. The modelling completed by the service has identified the level of resourcing required to meet these standards and indicators**
		We do not believe that adequate consideration has been given to the "Scottish Model". Demographically we have a lot of similarities with Scotland including the range of Health issues and urban and rural geography	**Service Delivery Model**	**NIAS did Review the Clinical Response Models in England Scotland and Wales. NIAS elected to adopt the NHS England model based on the evidence and research available which supports that it is clinically safe.**

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		It is not possible to provide supporting evidence against something that is a proposal. What we do have is concerns that no additional measures will be put in place to address the turnaround times that currently exist and which are	**Service Delivery**	**A work stream lead by the PHA is currently ongoing in relation to this issue.**
27	**Unison**	**We expect that any intended process to implement a revised Clinical Response Model, subject to the outcome of this consultation process, will be discussed and agreed at the Partnership Forum well in advance of such a process beginning.**	**Engagement**	**NIAS will fulfil its statutoy obligations and follow due process in the development, implementation and monitoring in partnership post implementation of the of the CRM. Updates on CRM will be a standard JCNC item. . In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		However we would seek assurances from the NIAS as to applicability of this study to Northern Ireland given the differences that exist between Northern Ireland and England in terms of geography, the spread of our population, our regional, single ambulance Trust, our road infrastructure (particularly poor in the West of Northern Ireland) and the location of our services.	**Service delivery**	**This issue has been addressed through the Service Delivery modelling exercise completed by ORH.**
		We would request clarity as to whether the NIAS has conducted any exercise to map or measure the impacts of adopting this revised model to Northern Ireland which considers the above factors. In this regard, we note that the introduction of a new ambulance	**Service delivery**	**NIAS have reviewed the methodology employed by Scotland England and Wales in the development and introduction of their Ambulance response model. NIAS can confirm that NIAS have taken account of factors such as demography, road networks, location of services in the modelling exercise completed by ORH**

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		response system within the Scottish Ambulance Service was subject to a pilot phase, which followed after a clinically evidenced review process which examined nearly half a million calls over a 12 month period. The pilot phase was then monitored by the Scottish Chief Medical Officer.		and shared with Unison. This foundation work supports the CRM proposal
		Particular concern and confusion may exist in relation to cases of stroke. The public health campaign in relation to stroke is clear that time is of the essence when dealing with cases of stroke, with the FAST campaign designed to ensure that where a person is suspected of having a stroke, medical assistance is sought as quickly as possible. However, NIAS suggests that for a patient with suspected stroke, the aim will be to get the patient to a specifically identified centre of care within a specific time from the onset of their symptoms. They state that when the ARP model was trialled in England, stroke patients arrived at the specialist centre quicker, despite the initial ambulance response taking longer, as the right response was sent first time, rather than the fastest response which may be inappropriate (e.g. a single paramedic rather than a vehicle to convey the patient).	Stroke Services	The new model should lead to improvements in the time patients with conditions such as Stroke reach definitive care in specialist units. For example, for a patient with a suspected stroke the aim of the response will be to deliver them directly to a specifically identified centre of care i.e. a hospital with hyper acute stroke services, in as short a time as possible, thereby increasing the chances of receiving treatment aimed at reversing the effects of a stroke and increasing the likelihood of a better recovery In England, during the trials on a similar model, it was found that stroke patients were arriving in specialist centres sooner than under previous arrangements despite the initial ambulance response taking longer to arrive.
		Whilst UNISON would be supportive of approaches which result in faster appropriate treatment for stroke patients, we	Stroke Services	NIAS will take the opportunity to highlight the importance of the Ambulance Service being able to meet

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		would reiterate the concerns expressed above around the applicability of such findings in Northern Ireland. We would also highlight that significant uncertainty exists as to the future configuration of stroke services across acute hospital sites in Northern Ireland which may have a significant negative impact on the time it takes to transport some patients to receive the treatment		**any proposed travel time standards through the future consultation of Reconfiguration of Stroke Services.**
		· UNISON would seek further information and consultation with NIAS in relation to the training and support programmes that will be offered to staff in implementing the enhanced call taking process. Limited reference to this issue is made within the consultation document.	**Training**	**Call takers will receive comprehensive training on all aspects of the new clinical response model.**
		In particular, we require further clarification from NIAS as to what clinical input will be provided at the call-handling stage in order to ensure that the pre-triage sieve process both genuinely identifies the sickest patients, and those patients who do not require an immediate category 1 response.	**Training**	**Call takers will receive comprehensive training on all aspects of the new clinical response model.**
		However as we have highlighted above, NIAS must be very clear with the public in relation to those specific incidents, such as a suspected stroke, which had previously been considered as requiring a Category A response, but which will no longer be within Category 1 in the revised model	**Engagement**	**The new model should lead to improvements in the time patients with conditions such as Stroke reach definitive care in specialist units. For example, for a patient with a suspected stroke the aim of the response will be to get to the patient. For example, for a patient with a suspected stroke the aim of the response will be to deliver them directly to a specifically identified centre of**

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				care i.e. a hospital with hyper acute stroke services, in as short a time as possible, thereby increasing the chances of receiving treatment aimed at reversing the effects of a stroke and increasing the likelihood of a better recovery In England, during the trials on a similar model, it was found that stroke patients were arriving in specialist centres sooner than under previous arrangements despite the initial ambulance response taking longer to arrive.
		For this reason and the reasons outlined below, UNISON recommends that the introduction of any new Clinical Response Model be undertaken on a phased and independently monitored basis.	**Policy**	**NIAS note the concerns raised by Unison in this regard. The implementation of the full CRM Programme will be on a phased approach based of funding streams and the capacity to secure Paramedics though the Foundation Degree Programme.**
		We would welcome clarity from the NIAS in relation to the level of investment that will be made in the NIAS in order to enable these changes to be made and the timescale over which this investment will be made. UNISON is not willing to support a revised CRM unless it is supported by adequate, recurrent funding	**Funding**	**An implementation plan including full costing of the programme of change will commence following closure of the consultation.**
		Staff within the NIAS work under extreme pressure and would welcome additional staffing, but are concerned by the prospect of new models being imposed without the additional staff being in place to implement them.	**Health and Wellbeing**	**NIAS are committed to working to securing the staffing levels required to achieve the Standards prosed in the consultation. NIAS believe that there is the potential to realise immediate benefits for staff through introduction of the new categories in relation to better compliance with Rest Periods and a reduction in late finishes. NIAS are committed to continue working in partnership with Unison in improving the health and wellbeing of our Staff.**

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		UNISON would also make clear that any attempts to increase hours of cover through outsourcing, the use of agency staffing or privatisation will be strongly opposed.	**Policy**	**NIAS note the concerns raised by Unison in this regard.**
		For these reasons, we would recommend that the NIAS commits to a phased implementation of the revised CRM, with a revised model only becoming fully operational once additional staff are all recruited and trained appropriately, and once the new vehicles required to implement the revised model have been procured and are in service. This process should be fully transparent, with progress being independently assessed at regular intervals, with full UNISON involvement and input. Such an approach would be fully in line with the commitment to co-production across the HSC system, aimed at empowering groups including staff to design the system in which they work. This would also be in line with the graduated response that was undertaken to implementing the Ambulance Response Programme in England and the pilot phase that was undertaken for the introduction of a new model in Scotland, which we	**Engagement**	**NIAS note the concerns raised by Unison in this regard. In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		UNISON wishes to see this commitment on the part of NIAS translated into further engagement with us and the commencement of formal negotiations on all matters affecting the terms and conditions of our	**EQIA Engagement**	NIAS will fulfil its statuary obligations and follow due process in the development, implementation and monitoring in partnership post implementation of the CRM. Updates on CRM will be a standard JCNC item and NIAS will be engaging with Unison local Representatives. **In addition,**

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		members in respect of these proposals. As we outline below, we are concerned at this stage that no assessment appears to have been conducted of the equality impacts such proposals would have on staff, in compliance with section 75 of the Northern Ireland Act 1998.		**NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		NIAS must therefore immediately revise the EQIA which is currently being consulted upon to include an assessment of the impact of these proposals on all staff. This revised EQIA should include proposed measures to mitigate any differential adverse impacts that may be identified, as well as any alternative policy proposals which may better promote equality of opportunity. This should then be subject to full consultation in line with the requirements of the NIAS Equality Scheme with trade unions and the workforce.	**EQIA Engagement**	In terms of the impact of the proposal on staff there has been limited opportunity as yet to fully assess what the new model will mean in practice for staff and which staff will be most affected. Ongoing consultation and additional equality impact screenings/assessments will be conducted as appropriate during all aspects of the CRM programme, particularly with regard to potential RRV paramedic redeployment. NIAS will fulfil its statuary obligations and follow due process in the development, implementation and monitoring in partnership post implementation of the CRM. Updates on CRM will be a standard JCNC item and NIAS will be engaging with Unison local Representatives. **In addition, NIAS is establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects.**
		Given the concerns highlighted within this submission UNISON would welcome a clear commitment on the part of the NIAS to further engage with us and other relevant stakeholders and to commence formal negotiations on all matters affecting the terms and conditions of our members in respect of these proposals. We request	**EQIA Engagement**	**NIAS will comply with all statutory obligations in this regard.**

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		further information from NIAS as to how it intends to analyse responses to the consultation process.		
		We anticipate a detailed response to our comments which demonstrates that they have been given proper consideration. We believe that direct engagement is the most valuable form of engagement in relation to these proposals.	**Engagement**	**NIAS concur with Unison in the benefits to be realised through direct engagement and welcome the opportunity to further engage with Unison in relation to the issues raised in this consultation.**

Northern Ireland Ambulance Service Health and Social Care Trust

NIAS Clinical Response Model
Summary Proposal Document
March 2019

Contents

1. BACKGROUND TO PROPOSED CHANGES

Why are changes needed?

1.1 Consistent with the position across the rest of the UK and elsewhere, demand for ambulance services in Northern Ireland continues to grow and change. This has increased significantly in recent years, taking into account factors like an older population, more comprehensive and effective evidence-bases, and improved medical technology.

1.2 NIAS has recently completed a demand forecast exercise by combining historic demand rates per head of population with projections taken from the Northern Ireland Statistics and Research Agency. Over the next 5 years emergency demand is predicted to increase by 3.1% per year, although this varies by Local Government District.

1.3 Given the changing nature of clinical demand and the health service over the past 40 years, NIAS believes it is now timely, necessary and appropriate to consult on introducing changes to how we direct our capacity in the most clinically appropriate way to best meet the needs of the patients we serve.

1.4 At present NIAS aims to reach Category A emergency calls – i.e. those designated as absolute emergencies – within a target time of 8 minutes. Times based targets, introduced in 1974, were identified as being key for people in cardiac arrest or likely to go into cardiac arrest when ambulance services and public health were very different. Time based standards have been used as a key performance measure for ambulance services both nationally and internationally, despite lack of evidence that they actually lead to good clinical care. Time based ambulance response standards have been effective in driving improvements and maintaining response times to the most critical and injured patients.

1.5 However efforts to meet these standards in the face of rising demand have led to a range of operational behaviours that may be inefficient, with the potential to distort the system away from a central focus on patient care and clinical outcomes.

1.6 Studies have shown that there is no significant supporting clinical evidence that response times lead to improved outcomes for other patient groups. The current NIAS operating model results in the rapid dispatch of multiple resources to a large number of patients whose clinical condition may not warrant that level of response. Currently NIAS categorises circa 30% of patients as requiring an 8-minute response when emergent evidence demonstrates that fewer than 7% of patients require a response this quickly. In the context of ever rising demand this operating model is not sustainable.

1.7 In addition, the current model puts disproportionate focus on reaching patients quickly rather than sending the most appropriate resource for the patient's needs or measuring the quality of care given by ambulance personnel. In practical terms this means that when a 999 call is answered the nearest available resource, either a conveying A&E vehicle or single responding

Paramedic in a car, is often dispatched regardless of the patient's actual clinical need.

1.8 As demand for Ambulance services continues to grow, NIAS proposes to direct ambulance resources more accurately and appropriately to the smaller number of very acute emergency calls to ensure these are responded to more quickly and effectively, with a larger number of less acute calls waiting a bit longer for a more appropriate response.

1.9 It is worth reiterating that cardiac arrest is the only primary emergency medical condition for which immediate response times are the key indicator of successful clinical outcomes. In short, evidence shows that every second is critical to the survival of a cardiac arrest patient, in a way that no other condition routinely experiences. Cardiac arrest is by far the most time-critical emergency condition when it comes to the clinical rates of survival. The quicker that cardiac arrests get clinical assistance, the more likely a person is to survive. None of the available evidence has demonstrated any positive relationship between shorter response times and decrease in mortality across all emergency patients or those with life threatening conditions other than out of hospital cardiac arrest ([1]).

1.10 People who contact NIAS need help for increasingly complex and diverse health problems. As a service we have been developing a range of responses – for example, enhanced telephone assessment, appropriate care pathways, as well as providing emergency and non-emergency transport. This means that there is a pressing need to improve the process of matching the right response to clinical need at the time someone calls for help but this process is constrained by the need to meet very challenging response time targets for a larger proportion of patients than actually require it.

1.11 NIAS is proposing that the new Clinical Response Model will be part of a wider framework of ongoing efficiency led reforms, including, review of systems process and structure within our Emergency Ambulance Control, the ongoing implementation of appropriate care pathways where patients are assisted to get more appropriate health services for non-emergency conditions and a community resuscitation and defibrillator strategy across Northern Ireland (including local community first responders).

1.12 NIAS wishes to consider this proposal for a new Clinical Response Model in the context of a recognised requirement for a significant uplift in the size of our frontline staff, increase in fleet and a new estates strategy. While substantial investment in staff recruitment and an estates strategy are separate policy proposals in their own right, NIAS believes they are linked and integral to the modernisation of the service and the successful implementation of the new Clinical Response Model.

1.13 Given the development of the role of Paramedics and other ambulance personnel in the pre-hospital environment, the current operating model is

[1] Turner J etal. Ambulance Response Programme, Evaluation of Dispatch on Disposition, June 2016 v4

limiting the delivery of best care to patients and is not making best use of resources or clinical skills.

1.14 The NIAS proposal for a new Clinical Response Model on the way that we will respond to calls from Northern Ireland's entire population will revolve around:

- Identify the Sickest, Quickest
- Get to the Sickest, Quickest
- Send the Right Resource, First Time
- Provide the Best Patient Care

2. CHANGE IN HOW WE CATEGORISE OUR CALLS

How will the new clinical response model work?

2.1 In order to make our proposed changes work, it is imperative that we review how calls made to our Emergency Control Centre are categorised.

2.2 Ambulances are dispatched in response to 999 emergency calls based on the clinical need of the patient. The calls are prioritised according to the seriousness of the patient's condition: Category A - Potentially Immediately life-threatening; Category B - Serious but not immediately life-threatening; Category C - Non-life threatening/serious.

2.3 NIAS, like many ambulance services in the UK and internationally, uses the prioritisation system AMPDS (Advanced Medical Priority Dispatch System). This is a clinical model that accounts for a variety of risk factors in presentation of illness, pain and injury.

2.4 The protocols and the risk factors relating to gender and other personal characteristics are based on research and are updated based on new evidence via the International Academies of Emergency Dispatch. These protocols determine the priority of the 999 calls and the category/code to which they will be allocated.

Table 1 presents an overview of the call category and the types of call that fall into each category.

Current Call Categories

Call Type	Category / Code
999 Potentially immediately life threatening	Category A (Purple/ Red)
999 Serious but not life threatening	Category B (Amber)
999 Neither life threatening or serious	Category C (Green)
Healthcare Professional Calls (HCP)(GPs who 'book' an ambulance after seeing a patient and deciding they need to be admitted to hospital within a set time frame)	HCP Calls
Routine	Routine

Table 1: Current call categorisation

2.5 Under the proposed new clinical response model we plan to reconfigure the categories by reducing the number from five to four, and by adopting the code sets which determine the composition of these four categories from the NHS England Ambulance Response Programme (ARP).

2.6 The NHS England Ambulance Response Programme (commenced 2015) is the most comprehensive study about ambulance services completed anywhere in the world. There has been some 14 million 999 calls processed through the programme with no reported adverse incidents, and it has been independently evaluated on a continual basis by Sheffield University School of Health and Related Research (ScHARR). NIAS propose adopting the call categories that were used in this programme and that have now been implemented in all NHS England Services. (Table 2)

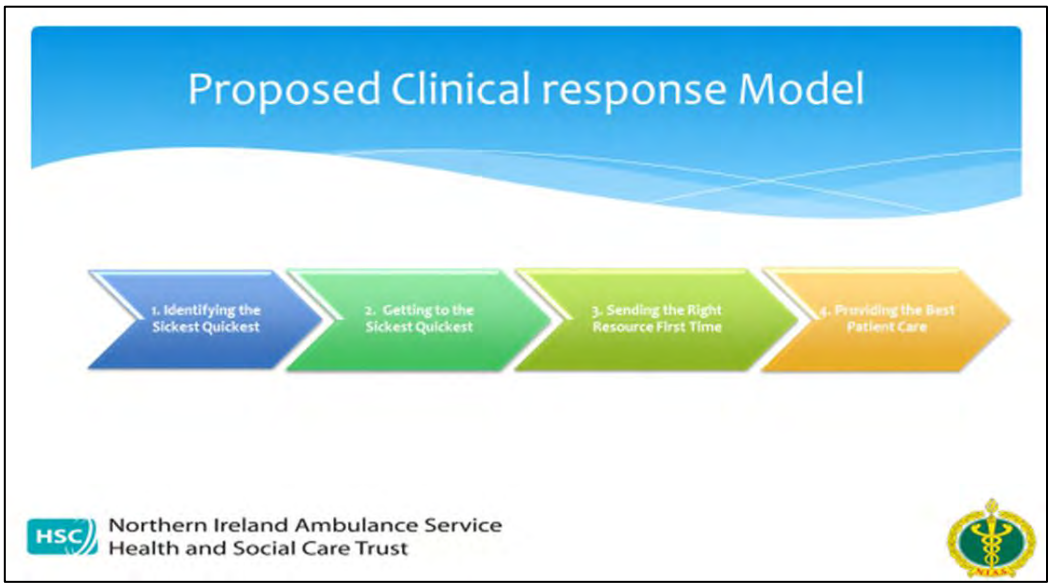
Proposed New Categories

Call type	Category / code
999 Immediately life threatening	Category 1
999 Emergency – potentially serious incidents	Category 2
Urgent Problem	Category 3
Less urgent problem	Category 4

Table 2: Proposed new Categories

2.7 The new categorisation of calls results in closer to 7% of our 999 patients being in potential or actual Immediately Life Threatening conditions rather than the 30% of our 999 patients we currently identify as such. This results in a reduction in the proportion of incidents requiring an 8-minute response from around 30% to around 7%, which will in turn release resources to improve our overall response to ALL our patients. The new model has four elements to it as presented in the schematic above. This section will explore what we propose in each element, how we will do it, and what the impact of the change will be.

3. PROPOSED CLINICAL RESPONSE MODEL



1. IDENTIFYING THE SICKEST QUICKEST

3.1 We propose to introduce an ***enhanced call taking process*** based on the Pre-Triage Sieve (PTS) and Nature of Call (NOC). When receiving 999 calls Ambulance Control staff will utilise these processes prior to opening the full triage software (AMPDS) to identify at the earliest opportunity those patients with an Immediately Life Threatening (ILT) condition i.e. Category 1 Patients.

How will we do that?

3.2 On receipt of a 999 call, we will first ask the caller "is the patient breathing and conscious?" If the answer is 'not breathing' or 'not conscious but with noisy breathing', we will immediately dispatch the nearest ambulance resource. This is known as the Pre-Triage Sieve (PTS). The ARP study has proven that by asking this question the Ambulance Call Taker can quickly identify most Category 1 patients.

3.3 After the PTS, process ambulance control will further establish other conditions known to be linked closely with Immediately Life Threatening conditions. Examples of these conditions include patients who are fitting, patients with serious maternity complications, patients involved in drowning or water incidents and patients involved in very serious road traffic collisions. This process is known as the Nature of Call. It further identifies serious conditions also grouped into Category 1 and we will immediately dispatch the nearest ambulance resource.

3.4 Ambulance control will then continue to establish further details about the patient utilising the full triage software (AMPDS). This will identify any remaining conditions that must be responded to as a Category 1 and triage the rest of the calls as Category 2, 3 and 4. The Call takers can refer the call to the Paramedic Support Desk for further management. This desk will

support the Call Takers and Dispatchers within the Centre to better manage complex calls or calls that may require specialist skills or support services. It is envisaged that this should have a beneficial impact on medical conditions affecting frail and/or older people.

3.5 This enhanced call taking process will triage approximately 7% of our 999 patients as Category 1 compared to the 30% of our 999 patients currently put into that group.

What does this mean?

3.6 Evidence from England and Wales shows that PTS and NOC successfully identifies 75% of Category 1 patients facilitating the dispatch of a resource earlier than would previously have been the case. Modelling indicates that if NIAS operate PTS and NOC processes then the average time to activate an ambulance resource to Category 1 ILT patients will reduce by up to 41 seconds.

2. GETTING TO THE SICKEST QUICKEST

3.7 We propose to target our resources to Category 1 patients and provide the ***fastest possible response*** to these Category 1 patients with Immediately Life Threatening conditions.

How Will We Do That?

3.8 Category 1 calls, which include Cardiac Arrest, are patients in the most need of rapid response and clinical interventions in order to improve their chance of survival. These incidents will receive a paramedic-led response using a variety of resources where appropriate. It is often the case that these patients require to be managed by a team of responders. Ambulance resources will be drawn from, and may include, Paramedic Rapid Response or Paramedic led A&E Ambulance response. Support may be drawn from Co-Responders, Community First Responders, Intermediate Care Vehicles and Patient Care Service. NIAS will use the closest appropriate resource and back it up as required for this group of critical patients.

What Does This Mean?

3.9 Earlier activation of ambulance resources to Category 1 incidents has the potential to realise significant benefits for patients. Research evidence shows that for each one minute reduction in response time cardiac arrest survival increases by 24%. So, a 33 second reduction could potentially increase survival by 13% and a 41 second reduction could increase survival by 16%.[2]

3.10 Trials in England using this approach have resulted in a reduction in the rates of Multiple Ambulance Responses (MAR). In England this is measured as Resources per Incident (RPI). The aim in Category 1 calls is to send enough resources to provide best clinical care / outcome. The aim in all other calls is to send the one right response to the incident i.e. achieve an RPI of 1. This

[2] O'Keefe C, Nicholl J, Turner J, Goodacre S. Role of ambulance response times in the survival of patients with out-of-hospital cardiac arrest. http://dx.doi.org/10.1136/emj.2009.086363

maintains the response to the most seriously ill patients, improves the response to other patients, and reduces long conveyance delays.

3. SENDING THE RIGHT RESOURCE, FIRST TIME

3.11 We propose to match appropriate ambulance resources to the needs of the patient. Category 1 calls are the most critical and demand a response based on the level of clinical intervention required. Calls in Categories 2, 3 and 4, whilst still urgent in nature do not require a similar response as Category 1.

3.12 NIAS currently sends higher levels of response to approximately 30% of emergency calls received. By utilising the enhanced Call Taking Process the critical calls will be more accurately identified as 7% of emergency calls. They will receive the highest level of response.

How will we do that?

3.13 The enhanced Call Taking Process identifies the sickest category of patients and it also triages all patients into the appropriate clinical category. NIAS can then match the resource to the patient based on their clinical triage.

3.14 The reduction in the percentage of calls classified in the highest category (30% to 7%) means that we would not be over responding to the 23% who would now be clinically triaged into the other call categories. This frees up resources to respond effectively to Category 1 calls and to respond more appropriately to the other categories.

3.15 Not every patient needs to be taken to hospital. Not every patient needs immediate paramedic intervention. Ensuring that an ambulance is appropriately dispatched for a patient who needs to be taken to hospital – and not a paramedic in a car – will mean many of the patients whose condition is KNOWN to require specific clinical destinations will reach that definitive place of care quicker than they do at present.

What does this mean?

3.16 The new model should lead to improvements in the time patients with conditions such as stroke reach definitive care in specialist units. For example, for a patient with a suspected stroke, the aim of the response will be to deliver them directly to a specifically identified centre of care, i.e. a hospital with hyper acute stroke services, in as short a time as possible, thereby increasing the chances of receiving treatment aimed at reversing the effects of a stroke and increasing the likelihood of a better recovery. In England, during the trials on a similar model, it was found that stroke patients were arriving in specialist centres sooner than under previous arrangements despite the initial ambulance response taking longer to arrive.

NIAS will take the opportunity to highlight the importance of the Ambulance Service being able to meet any proposed travel time standards through the future consultation of Reconfiguration of Stroke Services.

In England during the ARP trials it was found that stroke patients were arriving in specialist centres sooner than under previous arrangements despite the initial ambulance response taking longer to arrive. This was a direct impact of sending the right conveying resource first time rather than a faster solo response (such as RRV paramedic) that was not appropriate to the patient's needs and would still require ambulance transport to hospital.

3.17 For a diabetic patient, unconscious due to low blood sugar, we may send a Paramedic Rapid Response Vehicle as these patients are often assessed and treated at scene without the need of being transported to the Emergency Department. In this way we will preserve conveying resources for those patients who need transportation.

3.18 Currently we send the nearest available ambulance resource when an emergency call is received and we have a resource to send. In the new model we will take a little additional time to ensure we know more about the patient's complaint / condition before sending the most appropriate resource. To take account of this it is proposed that future Ambulance Response Performance measures will be changed to take account of this new approach in line with the other Ambulance Services in the UK.

4. PROVIDING THE BEST PATIENT CARE

We propose that for those patients who require an ambulance response we will continue to aim to provide the best, most appropriate patient care.

How will we do this?

3.19 The change programmes in the rest of the UK have not found any new evidence to offer a definitive position about appropriate time based standards. In fact, it remains the case that the only condition that has ever been shown to benefit from an 8-minute response is cardiac arrest, which occurs in less than 1 in 100 ambulance calls. We are therefore continuing to make cardiac arrest and threatened cardiac arrest an absolute clinical priority in terms of speed of response and patient outcome. For other problems, we will take an approach that matches the patient's needs and distributes resources more appropriately across all patients who contact the ambulance service.

3.20 We propose to introduce a set of Ambulance Quality Indicators (AQIs) which will evidence the quality of our patient care across a range of clinical indicators. While speed of response is still an important consideration, and especially so for those patients in Category 1, it is vital that the clinical quality of the care we give is appropriate and effective for the patient. We have already begun some work to introduce Clinical Performance Indicators and Care Bundles in our service in preparation for this.

3.21 The quality of our care will be monitored for all categories of call. The best care for the patient is not always to attend the Emergency Department. Our Paramedics will determine whether the patient needs to attend hospital or can be referred to community-based services which can best meet their needs

through use of Appropriate Care Pathways and/or transport to alternative destinations.

3.22 Care Bundles are sequences of caring activities that are recognised and prioritised for specific medical conditions e.g. stroke and diabetes. Appropriate care Pathways and/or alternative destinations are programmes that allow NIAS to direct patients to specialised services more suited to their condition. This provides a better more focused service to the patient and saves unnecessary and inappropriate attendance at Emergency Departments.

3.23 Other patients, who call the ambulance service, may not require an ambulance attendance at all. In those cases we will provide effective clinical telephone advice, where their condition or complaint can be managed through telephone advice or referral to an appropriate service without the need for the attendance of an ambulance. Provision of clinical telephone advice is a benefit of our newly established Paramedic-led Clinical Response Desk within the control environment

What does this mean?

3.24 NIAS will use a range of standards, measures and indicators to offer assurance that the new Clinical Response Model is operating effectively, safely and in the best interests of patients.

3.25 Clinical quality indicators will be developed to measure our performance across the range of services provided and this will be done in conjunction with medical professionals across the HSC.

4. HOW ARE WE PLANNING TO MAKE THE CHANGE?

Increase in hours of cover, matching supply with demand, and increase in frontline staffing levels.

4.1 *We plan to increase the total hours of Ambulance cover.* We have modelled the impact of adopting the new clinical response model and taking account of predicted demand trends up to 2021/22. This modelling identifies the need to increase the number of ambulances by the order of 50%, which will require an uplift of approximately 300 frontline staff. With this emphasis of increasing patient transport capacity there will be less reliance on single paramedic rapid response cars which will be reduced by approximately 45.6%.

4.2 It is important to be clear that this does not represent a cut in service provision. Where we reduce hours of cover provided by RRV, under this model, we will supplement those with additional A&E ambulance hours of cover and ensure that the nett result will be an overall increase in provision of ambulance cover.

4.3 In order to ensure that predictive modelling is appropriate and accurate for the development and planning of the overall CRM programme needs, and in order to take into account responses to the consultation (for example, those that focused on the impact in rural areas or the impact on staff Canges), NIAS will now be conducting a further modelling exercise.

5. HOW WILL WE MONITOR PERFORMANCE AND EQUALITY IMPACTS?

5.1 NIAS is committed to monitoring the impact of these proposals as they are implemented. We plan to introduce new standards and indicators to ensure efficiency, safety, equity and quality in how we provide our service.

5.2 We will use a range of standards, measures and indicators against this code set to offer assurance that the new CRM is operating effectively, safely and in the best interests of patients. The current and only standard / performance target for NIAS is; "72.5% of Cat A calls (potentially immediately life threatening) to be responded to within 8 minutes; 67.5% in each Local Commissioning Group area; with 95% of Cat A calls receiving a conveying resource within 21 minutes".

5.3 Table 3 presents the proposed new standards NIAS will be expected to achieve. NIAS will achieve an average 8 minute response to Immediately Life Threatening calls, regionally.

5.4 A key change will be reporting on a mean response time of 8 min, mean is representative of all ambulance responses, and provides an incentive to reduce long waits. We plan to introduce a 90th centile (9 out of 10) in 15 mins, we feel is more readily understood by the public, and drives an improved response to more patients.

5.5 Overall we feel that these new indicators will be more easily understood and will provide a much improved and more equitable service for the population of NI.

5.6 As already indicated, NIAS will also be keeping the CRM programme and its various related projects under continuous equality monitoring and evaluation, including conducting equality screening/impact assessment as appropriate in line with s.75 obligations, the collection and identification of more focused data as appropriate to enable ongoing monitoring, and the creation of a new stakeholder forum that will have a continuous and meaningful engagement function with the CRM programme/projects, not least in order to contribute to equality considerations.

Category	Statistic	Clock Stop	Target Time (minutes : seconds)
1 Life threatening	Mean	Response	08:00
		Transport	19:00
	90th centile	Response	15:00
		Transport	30:00
2 Emergency – potentially serious	Mean	Response	18:00
	90th centile	Transport	40:00
3 Urgent problem	90th centile	Conveying Response	120:00
4 (999 calls) Less urgent problem	90th centile	Conveying Response	180:00

Table 3: Proposed new standards

5.7 In undertaking monitoring following implementation of the proposals, NIAS will give full consideration to the Equality Commission for Northern Ireland Section 75 Monitoring Guidance and devise related measures to ensure that ongoing impacts are regularly assessed against specific categories.

6. WHAT WILL THIS MEAN FOR STAFF?

6.1 The previous sections have explained what the proposed changes mean for those who access our services. It is important that we also consider what they would mean for our staff.

6.2 As indicated, delivery of the model would require significant investment in the service and a related substantial increase in our frontline staffing figures. We consider this to be a very positive development for our workforce, who work very hard in a very challenging climate given current pressures.

6.3 The likely reduction of RRV hours would mean a re-profiling of RRV Paramedic shift patterns and would be managed largely through vacancy controls. It is possible that there could be an element of redeployment of Paramedic posts. If this were to be the case it would be managed through established processes in consultation with trade union colleagues. There is no potential for job losses associated with this proposal.

6.4 The Trust will give full consideration to any staff training needs associated with the proposed changes, should they be implemented and reflect this in Education, Learning and Development Plan. Work will be undertaken to review scope of practice and skillsets across all grades of staff through collaborative working arrangements within the Trust, and appropriately resourced actions will be taken to meet identified needs.

6.5 Impact on staff can only be fully assessed as detailed project proposals are devised and as accurate data becomes available in relation to the detail of those proposals. This is why a revised modelling exercise is important. In addition to constructive engagement through existing mechanisms with staff side, NIAS is also committed to the continuous monitoring and evaluation of all potential equality impacts upon staff, including equality screening/assessment as appropriate in line with the Trust's s.75 equality duties. NIAS is also committed to creating a standing forum of stakeholders that will meet regularly (including staff side) and that will have an ongoing and meaningful engagement function in relation to the overall CRM programme and its various implementation projects, in order to build upon the positive engagement process evidenced during the consultation.

7. CONCLUSION

The adoption of this new clinical operating model is expected to realise a range of benefits for patients including:

- Reducing the proportion of patients receiving the highest level of response from circa 30% to a more appropriate 7%. This will allow resources to be focussed on improving the response to those patients who genuinely require an Immediately Life Threatening response.

- Identifying Category 1 patients earlier than is currently the case and allocating a resource between 33-41 seconds more quickly than at present using PTS and NOC. This should lead to improved response times for the only group of patients for whom there is evidence that response times make a difference to outcome and creates the potential to improve cardiac survival by 13%-16%.

- Improving efficiency by reducing the deployment of multiple resources to incidents where the patient's condition does not warrant that level of response. Further improvements to efficiency are gained through the reduction of incidents where resources are repeatedly mobilised then stood down. This will release resources to improve the response to the most seriously ill patients and the response to lower acuity patients (although in Northern Ireland delays on lower acuity incidents is less of problem than elsewhere in the UK).

- More effective targeting of the right resource, first time to meet the patient's needs which should, for example, lead to improvements in the time patients with conditions such as Stroke and Heart Attack reach definitive care in specialist units.

- Creating the opportunity to manage more patients appropriately through telephone advice or treatment at the scene without the need for transportation to hospital. This improves efficiency both for the ambulance service and hospital emergency departments and delivers the right outcome for patients in the right setting.

- Producing greater system resilience and stability through the introduction of a

clinical operating model that works under less stress and hence is better able to absorb peaks in demand.

- Including a more comprehensive range of standards, measures and indicators to provide greater transparency about whole-system ambulance performance in language that is understandable to the public.

- Enhancing the engagement and involvement of stakeholders with the organisational improvement of NIAS in the future, through the creation of a stakeholder forum and the related commitment to ongoing assessment of potential impacts.

Northern Ireland Ambulance Service Health and Social Care Trust

Clinical Response Proposal
EQIA and Consultation Response
March 2019

Northern Ireland Ambulance Service Health and Social Care Trust

Contents

1. INTRODUCTION

1.1 The Northern Ireland Ambulance Service HSC Trust (NIAS) was established by the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995 as amended by the Health and Social Services Trusts (Establishment) (Amendment) Order (Northern Ireland) 2008 and Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

1.2 NIAS responds to the needs of a population in Northern Ireland in excess of 1.8 million people in the pre-hospital environment. We provide ambulance care, treatment and transportation services to the people of Northern Ireland twenty four hours per day, seven days per week, and three hundred and sixty five days per year. The Trust has an annual budget of around £70 million and approximately 1,270 staff. The Trust handles over 220,000 emergency calls from 36 stations, using 116 emergency ambulances, 43 paramedic-led Rapid Response Vehicles (RRV), on a continuous 24/7 basis throughout the year.

1.3 The principal ambulance services we provide are:

- Emergency response to patients with sudden illness and injury;
- Non-emergency patient care and transportation;
- Specialised health transport services; and,
- Co-ordination of planning for major events and response to mass casualty incidents and disasters.

1.4 NIAS Vision, Values, Key Themes

Our Vision is:

To provide excellent quality of care, experience and outcomes for the patients we serve.

This vision is underpinned by our core values that will help us to deliver the highest levels of care and services.

Our Core Values are:

- Compassion
- Respect
- Integrity
- Learning & Improvement

1.5 Key Themes

NIAS has identified six key themes from which our Corporate Objectives and annual priorities are developed, to ensure consistency between strategy and delivery.

i. **Motivated & Engaged Workforce:** the Trust will explore how we can fully achieve this for staff, at all levels. We will find opportunities for staff involvement and engagement in developing and modernising how we deliver our services. We will collaboratively develop and deliver modernisation and improvement, and encourage staff to have a greater understanding of their impact on service delivery and outcomes for patients. We will enable staff to be part of learning activities that are adapted and appropriate for them.

ii. **Right Resources to Patients Quickly:** the Trust will develop sustainable, innovative workforce and systems solutions building on the recommendations of the NIAS Demand & Capacity Review, 2017. We will aim to have the right number of staff with the right skills to ensure our quality of service meets agreed standards in terms of time and clinical quality. We will develop highly skilled staff equipped to deliver safe patient care with a focus on the delivery of clinical excellence and appropriate pathways. Through this we will ensure we deploy the right resources, skills and response that is appropriate to clinical need.

iii. **Improving Experience & Outcomes for Patients:** The Trust will ensure that we listen to and learn from patients and others in the planning and delivery of services. We will promote meaningful engagement and involvement in service developments. We will use a range of standards, measures and indicators to

offer assurance that our service is operating effectively, safely and in the best interest of patients.

iv. **Clinical Excellence at Our Heart:** we will ensure the best outcomes for our patients through working to the highest standards of care and developing, leading and sharing best clinical practice. We will ensure clinicians receive the highest standards of education, learning and development to perform effectively and safely. Clinical staff will be equipped to carry out their role supported by advancements in technology, medical equipment, clinical practice and clinical audit. NIAS will develop and implement clinical supervision for regulated professionals. We will involve our staff and others to identify and develop best models of clinical practice and appropriate systems and processes for measuring outcomes.

v. **Recognised for Innovation:** the Trust will continue to work collaboratively on innovations and transformations that deliver on our priorities. We will position NIAS as an integral part of the whole HSC system and influence and shape services to ensure improvements to the patient experience and outcome. We will develop and embed a quality improvement methodology within the Trust and celebrate related successes. NIAS has a vital role to play in the delivery of urgent and emergency care, providing a range of clinical responses to patients in their homes and community settings and can potentially integrate seamlessly across the spectrum of providers in health and social care. We can increasingly shift the balance of care away from hospitals, reduce demand on emergency departments and take the pressure off general practice. There are real benefits to be gained for patients by investing in NIAS services to improve the future sustainability and performance of the health system overall. NIAS will identify the impact of those changes in an open and evidenced manner using clear, validated and timely data is essential.

vi. **Effective, Ethical, Collective Leadership:** the Trust will develop an Organisational Development Framework and annual delivery plan that will provide a focus on promoting the right culture and supporting behaviours to drive

improvements and transformations. We will ensure there are leadership development opportunities to develop the skills and confidence of our leaders to support the Trust priorities, as outlined in the Corporate Plan.

2. PURPOSE AND CONDUCT OF THE CONSULTATION

2.1 NIAS has experienced significant growth in demand for emergency 999 response calls over recent years. The service is undergoing significant reform and improvement. It has developed from being entirely transport-focused to having a greater emphasis on provision of clinical care in an out of hospital context. Many of these reforms are designed to implement best practice NHS changes, while taking account of specific aspects of implementation in Northern Ireland.

2.2 As part of this wider transformation agenda, we are proposing to introduce a revised Clinical Response Model (CRM), similar to those introduced in recent years elsewhere in the UK. This would be designed to provide a more clinically appropriate ambulance response than the current model, which was introduced over forty years ago, by better targeting the right resources (clinical skills and vehicle type) to the right patients. This proposal would represent a significant change in the way that NIAS provides its services.

2.3 The purpose of the consultation process was to engage in a conversation with key stakeholders that would fully consider all of the perspectives and potential impacts of this proposal to introduce a new Clinical Response Model (CRM) for NIAS. NIAS completed a pre-consultation engagement that included discussions with political representatives, Trade Unions and our workforce. The pre-consultees were positive in relation to the proposals. There were some areas requiring clarification and these were addressed.

2.4 The detailed consultation proposals, including draft EQIA, were launched on September 27, 2018. The consultation period was originally intended to close on December 21, 2018. Consultation was promoted by a range of actions, including: direct email contacts with over 450 stakeholders; the offer and uptake of individual meetings; attendance at Local Commissioning Group meetings; interaction with the Patient Client Council; and, the use of mainstream and social media.

A specially commissioned animation promoting the key messages in the proposals was viewed across all NIAS social media platforms 10,589 times during the consultation period. Promotion of the CRM consultation had a reach of 40,613 on Facebook and 33,278 impressions on Twitter. The CRM consultation was downloaded 1,667 times from the NIAS website. NIAS adopted an approach of considering real-time feedback from stakeholders in order to enhance the consultation process. For example, this included improving the approach to informing the public about the ongoing consultation through more detailed social media. It also included publishing an easy-read version on request, although this took longer than anticipated to be published and this delay forms an important learning outcome for the Trust.

The easy-read version was downloaded 281 times. As a consequence of that delay, and as part of the Trust's broader effort to maximise the consultation process in response to stakeholder feedback, NIAS extended the consultation deadline until January 18, 2019. In total, NIAS received 45 written consultation responses from stakeholders, including replies using the consultation format and responses through direct contact (as well as individual service user responses), over the sixteen weeks of the consultation.

In advance of the finalisation of this document, NIAS offered a further opportunity for informal engagement to stakeholders who responded directly to NIAS during the consultation. As part of the consultation's assurance framework, NIAS senior management had continuous oversight of the consultation throughout its duration and Trust Board was kept apprised of key updates as appropriate during this process.

2.5 This document is organised on the following format. It includes the final policy proposals for the CRM changes. It publishes a final Equality Impact Assessment (EQIA) that looks at the potential impact of the proposed changes in line with the Trust's responsibilities under Section 75 of the Northern Ireland Act 1998. It also summarises the views of stakeholders who responded to the

CRM consultation, including the NIAS responses to those issues that are directly relevant to the development of CRM. These stakeholder views have been conscientiously considered and taken into account in formulating the final documents, both in a general and a specific fashion. While wider issues related to the role of NIAS in the health sector have been taken into account, these have not been directly addressed in this document if they are not directly correlative with the CRM proposals. Other specific issues raised by stakeholders that do not impact upon the CRM proposals will dealt with in ongoing interaction with stakeholders. For this reason the summary of consultation responses does not does not capture a response for each individual submission.

2.6 Section 75 requires NIAS, as a public authority, in carrying out its work, to have due regard to the need to promote equality of opportunity:

- Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- Between men and women generally;
- Between persons with a disability and persons without;
- Between persons with dependants and persons without.

In addition Section 75 (2) requires NIAS to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

2.7 An Equality Impact Assessment (EQIA) is an in-depth study of a policy or decision to assess the extent of the impact of the policy on equality of opportunity for the nine equality categories identified by Section 75, listed above.

2.8 An EQIA has now been finalised by NIAS to assess the impact of proposed changes in line with 'Practical Guidance on Equality Impact Assessment' produced by the Equality Commission for Northern Ireland, this document will:

- Define the aims of the policy to release efficiency savings and target CSR investment through the reconfiguration of frontline services.
- Consider available data and research.
- Assess the impacts of the proposals on Section 75 groups.
- Consider measures which might mitigate any adverse impacts and alternative policies which might better achieve the promotion of equality of opportunity.

We will also explain how we intend to consult on the proposals and how we will publish the results and monitor for adverse impact in the future.

2.9 As a consequence of the consultation NIAS has revised its original equality impact assessment in relation to identifying a potential impact on some Section 75 groupings, and related considerations and mitigating measures have been outlined. These will now be included as part of the continuous future monitoring and evaluation of CRM in its development and implementation. Relevant available data and detailed impact assessment is included in Section 10. The consideration of this information in terms of equality and rural impacts is set out in the summary table at Section 10.

3. BACKGROUND TO PROPOSED CHANGES

Why are changes needed?

3.1 Consistent with the position across the rest of the UK and elsewhere, demand for ambulance services in Northern Ireland continues to grow and change. This has increased significantly in recent years, taking into account factors like an older population, more comprehensive and effective evidence-bases, and improved medical technology.

3.2 NIAS has recently completed a demand forecast exercise by combining historic demand rates per head of population with projections taken from the Northern Ireland Statistics and Research Agency. Over the next 5 years emergency demand is predicted to increase by 3.1% per year, although this varies by Local Government District.

3.3 Given the changing nature of clinical demand and the health service over the past 40 years, NIAS believes it is now timely, necessary and appropriate to consult on introducing changes to how we direct our capacity in the most clinically appropriate way to best meet the needs of the patients we serve.

3.4 At present NIAS aims to reach Category A emergency calls – i.e. those designated as absolute emergencies – within a target time of 8 minutes. Times based targets, introduced in 1974, were identified as being key for people in cardiac arrest or likely to go into cardiac arrest when ambulance services and public health were very different. Time based standards have been used as a key performance measure for ambulance services both nationally and internationally, despite lack of evidence that they actually lead to good clinical care. Time based ambulance response standards have been effective in driving improvements and maintaining response times to the most critical and injured patients.

3.5 However efforts to meet these standards in the face of rising demand have led to a range of operational behaviours that may be inefficient, with the

potential to distort the system away from a central focus on patient care and clinical outcomes.

3.6 Studies have shown that there is no significant supporting clinical evidence that response times lead to improved outcomes for other patient groups. The current NIAS operating model results in the rapid dispatch of multiple resources to a large number of patients whose clinical condition may not warrant that level of response. Currently NIAS categorises circa 30% of patients as requiring an 8-minute response when emergent evidence demonstrates that fewer than 7% of patients require a response this quickly. In the context of ever rising demand this operating model is not sustainable.

3.7 In addition, the current model puts disproportionate focus on reaching patients quickly rather than sending the most appropriate resource for the patient's needs or measuring the quality of care given by ambulance personnel. In practical terms this means that when a 999 call is answered the nearest available resource, either a conveying A&E vehicle or single responding Paramedic in a car, is often dispatched regardless of the patient's actual clinical need.

3.8 As demand for Ambulance services continues to grow, NIAS proposes to direct ambulance resources more accurately and appropriately to the smaller number of very acute emergency calls to ensure these are responded to more quickly and effectively, with a larger number of less acute calls waiting a bit longer for a more appropriate response.

3.9 It is worth reiterating that cardiac arrest is the only primary emergency medical condition for which immediate response times are the key indicator of successful clinical outcomes. In short, evidence shows that every second is critical to the survival of a cardiac arrest patient, in a way that no other condition routinely experiences. Cardiac arrest is by far the most time-critical

emergency condition when it comes to the clinical rates of survival. The quicker that cardiac arrests get clinical assistance, the more likely a person is to survive. None of the available evidence has demonstrated any positive relationship between shorter response times and decrease in mortality across all emergency patients or those with life threatening conditions other than out of hospital cardiac arrest ([1]).

3.10 People who contact NIAS need help for increasingly complex and diverse health problems. As a service we have been developing a range of responses – for example, enhanced telephone assessment, appropriate care pathways, as well as providing emergency and non-emergency transport. This means that there is a pressing need to improve the process of matching the right response to clinical need at the time someone calls for help but this process is constrained by the need to meet very challenging response time targets for a larger proportion of patients than actually require it.

3.11 NIAS is proposing that the new Clinical Response Model will be part of a wider framework of ongoing efficiency led reforms, including, review of systems process and structure within our Emergency Ambulance Control, the ongoing implementation of appropriate care pathways where patients are assisted to get more appropriate health services for non-emergency conditions and a community resuscitation and defibrillator strategy across Northern Ireland (including local community first responders).

3.12 NIAS wishes to consider this proposal for a new Clinical Response Model in the context of a recognised requirement for a significant uplift in the size of our frontline staff, increase in fleet and a new estates strategy. While substantial investment in staff recruitment and an estates strategy are separate policy proposals in their own right, NIAS believes they are linked and integral to the modernisation of the service and the successful implementation of the new Clinical Response Model.

[1] Turner J etal. Ambulance Response Programme, Evaluation of Dispatch on Disposition, June 2016 v4

3.13 Given the development of the role of Paramedics and other ambulance personnel in the pre-hospital environment, the current operating model is limiting the delivery of best care to patients and is not making best use of resources or clinical skills.

3.14 The NIAS proposal for a new Clinical Response Model on the way that we will respond to calls from Northern Ireland's entire population will revolve around:

- Identify the Sickest, Quickest
- Get to the Sickest, Quickest
- Send the Right Resource, First Time
- Provide the Best Patient Care

4. CHANGE IN HOW WE CATEGORISE OUR CALLS

How will the new clinical response model work?

4.1 In order to make our proposed changes work, it is imperative that we review how calls made to our Emergency Control Centre are categorised.

4.2 Ambulances are dispatched in response to 999 emergency calls based on the clinical need of the patient. The calls are prioritised according to the seriousness of the patient's condition: Category A - Potentially Immediately life-threatening; Category B - Serious but not immediately life-threatening; Category C - Non-life threatening/serious.

4.3 NIAS, like many ambulance services in the UK and internationally, uses the prioritisation system AMPDS (Advanced Medical Priority Dispatch System). This is a clinical model that accounts for a variety of risk factors in presentation of illness, pain and injury.

4.4 The protocols and the risk factors relating to gender and other personal characteristics are based on research and are updated based on new evidence via the International Academies of Emergency Dispatch. These protocols determine the priority of the 999 calls and the category/code to which they will be allocated.

Table 1 presents an overview of the call category and the types of call that fall into each category.

Current Call Categories

Call Type	Category / Code
999 Potentially immediately life threatening	Category A (Purple/ Red)
999 Serious but not life threatening	Category B (Amber)
999 Neither life threatening or serious	Category C (Green)
Healthcare Professional Calls (HCP)(GPs who 'book' an ambulance after seeing a patient and deciding they need to be admitted to hospital within a set time frame)	HCP Calls
Routine	Routine

Table 1: Current call categorisation

4.5 Under the proposed new clinical response model we plan to reconfigure the categories by reducing the number from five to four, and by adopting the code sets which determine the composition of these four categories from the NHS England Ambulance Response Programme (ARP).

4.6 The NHS England Ambulance Response Programme (commenced 2015) is the most comprehensive study about ambulance services completed anywhere in the world. There has been some 14 million 999 calls processed through the programme with no reported adverse incidents, and it has been independently evaluated on a continual basis by Sheffield University School of Health and Related Research (ScHARR). NIAS propose adopting the call categories that were used in this programme and that have now been implemented in all NHS England Services. (Table 2)

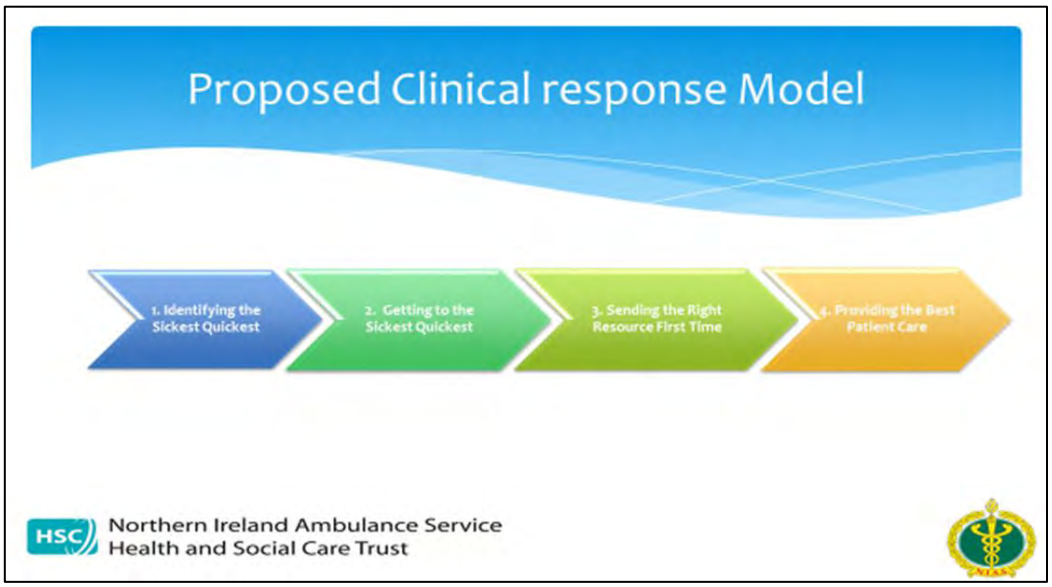
Proposed New Categories

Call type	Category / code
999 Immediately life threatening	Category 1
999 Emergency – potentially serious incidents	Category 2
Urgent Problem	Category 3
Less urgent problem	Category 4

Table 2: Proposed new Categories

4.7 The new categorisation of calls results in closer to 7% of our 999 patients being in potential or actual Immediately Life Threatening conditions rather than the 30% of our 999 patients we currently identify as such. This results in a reduction in the proportion of incidents requiring an 8-minute response from around 30% to around 7%, which will in turn release resources to improve our overall response to ALL our patients. The new model has four elements to it as presented in the schematic above. This section will explore what we propose in each element, how we will do it, and what the impact of the change will be.

5. PROPOSED CLINICAL RESPONSE MODEL



1. IDENTIFYING THE SICKEST QUICKEST

5.1 We propose to introduce an ***enhanced call taking process*** based on the Pre-Triage Sieve (PTS) and Nature of Call (NOC). When receiving 999 calls Ambulance Control staff will utilise these processes prior to opening the full triage software (AMPDS) to identify at the earliest opportunity those patients with an Immediately Life Threatening (ILT) condition i.e. Category 1 Patients.

How will we do that?

5.2 On receipt of a 999 call, we will first ask the caller "is the patient breathing and conscious?" If the answer is 'not breathing' or 'not conscious but with noisy breathing', we will immediately dispatch the nearest ambulance resource. This is known as the Pre-Triage Sieve (PTS). The ARP study has proven that by asking this question the Ambulance Call Taker can quickly identify most Category 1 patients.

5.3 After the PTS, process ambulance control will further establish other conditions known to be linked closely with Immediately Life Threatening

conditions. Examples of these conditions include patients who are fitting, patients with serious maternity complications, patients involved in drowning or water incidents and patients involved in very serious road traffic collisions. This process is known as the Nature of Call. It further identifies serious conditions also grouped into Category 1 and we will immediately dispatch the nearest ambulance resource.

5.4 Ambulance control will then continue to establish further details about the patient utilising the full triage software (AMPDS). This will identify any remaining conditions that must be responded to as a Category 1 and triage the rest of the calls as Category 2, 3 and 4. The Call takers can refer the call to the Paramedic Support Desk for further management. This desk will support the Call Takers and Dispatchers within the Centre to better manage complex calls or calls that may require specialist skills or support services. It is envisaged that this should have a beneficial impact on medical conditions affecting frail and/or older people.

5.5 This enhanced call taking process will triage approximately 7% of our 999 patients as Category 1 compared to the 30% of our 999 patients currently put into that group.

What does this mean?

5.6 Evidence from England and Wales shows that PTS and NOC successfully identifies 75% of Category 1 patients facilitating the dispatch of a resource earlier than would previously have been the case. Modelling indicates that if NIAS operate PTS and NOC processes then the average time to activate an ambulance resource to Category 1 ILT patients will reduce by up to 41 seconds.

2. GETTING TO THE SICKEST QUICKEST

5.7 We propose to target our resources to Category 1 patients and provide the ***fastest possible response*** to these Category 1 patients with Immediately Life Threatening conditions.

How Will We Do That?

5.8 Category 1 calls, which include Cardiac Arrest, are patients in the most need of rapid response and clinical interventions in order to improve their chance of survival. These incidents will receive a paramedic-led response using a variety of resources where appropriate. It is often the case that these patients require to be managed by a team of responders. Ambulance resources will be drawn from, and may include, Paramedic Rapid Response or Paramedic led A&E Ambulance response. Support may be drawn from Co-Responders, Community First Responders, Intermediate Care Vehicles and Patient Care Service. NIAS will use the closest appropriate resource and back it up as required for this group of critical patients.

What Does This Mean?

5.9 Earlier activation of ambulance resources to Category 1 incidents has the potential to realise significant benefits for patients. Research evidence shows that for each one minute reduction in response time cardiac arrest survival increases by 24%. So, a 33 second reduction could potentially increase survival by 13% and a 41 second reduction could increase survival by 16%.[2]

5.10 Trials in England using this approach have resulted in a reduction in the rates of Multiple Ambulance Responses (MAR). In England this is measured as Resources per Incident (RPI). The aim in Category 1 calls is to send enough resources to provide best clinical care / outcome. The aim in all other calls is

[2] O'Keefe C, Nicholl J, Turner J, Goodacre S. Role of ambulance response times in the survival of patients with out-of-hospital cardiac arrest. http://dx.doi.org/10.1136/emj.2009.086363

to send the one right response to the incident i.e. achieve an RPI of 1. This maintains the response to the most seriously ill patients, improves the response to other patients, and reduces long conveyance delays.

3. SENDING THE RIGHT RESOURCE, FIRST TIME

5.11 We propose to match appropriate ambulance resources to the needs of the patient. Category 1 calls are the most critical and demand a response based on the level of clinical intervention required. Calls in Categories 2, 3 and 4, whilst still urgent in nature do not require a similar response as Category 1.

5.12 NIAS currently sends higher levels of response to approximately 30% of emergency calls received. By utilising the enhanced Call Taking Process the critical calls will be more accurately identified as 7% of emergency calls. They will receive the highest level of response.

How will we do that?

5.13 The enhanced Call Taking Process identifies the sickest category of patients and it also triages all patients into the appropriate clinical category. NIAS can then match the resource to the patient based on their clinical triage.

5.14 The reduction in the percentage of calls classified in the highest category (30% to 7%) means that we would not be over responding to the 23% who would now be clinically triaged into the other call categories. This frees up resources to respond effectively to Category 1 calls and to respond more appropriately to the other categories.

5.15 Not every patient needs to be taken to hospital. Not every patient needs immediate paramedic intervention. Ensuring that an ambulance is appropriately dispatched for a patient who needs to be taken to hospital – and not a paramedic in a car – will mean many of the patients whose condition is KNOWN to require specific clinical destinations will reach that definitive place

of care quicker than they do at present.

What does this mean?

5.16 The new model should lead to improvements in the time patients with conditions such as stroke reach definitive care in specialist units. For example, for a patient with a suspected stroke, the aim of the response will be to deliver them directly to a specifically identified centre of care, i.e. a hospital with hyper acute stroke services, in as short a time as possible, thereby increasing the chances of receiving treatment aimed at reversing the effects of a stroke and increasing the likelihood of a better recovery. In England, during the trials on a similar model, it was found that stroke patients were arriving in specialist centres sooner than under previous arrangements despite the initial ambulance response taking longer to arrive.

NIAS will take the opportunity to highlight the importance of the Ambulance Service being able to meet any proposed travel time standards through the future consultation of Reconfiguration of Stroke Services.

5.17 In England during the ARP trials it was found that stroke patients were arriving in specialist centres sooner than under previous arrangements despite the initial ambulance response taking longer to arrive. This was a direct impact of sending the right conveying resource first time rather than a faster solo response (such as RRV paramedic) that was not appropriate to the patient's needs and would still require ambulance transport to hospital.

5.18 For a diabetic patient, unconscious due to low blood sugar, we may send a Paramedic Rapid Response Vehicle as these patients are often assessed and treated at scene without the need of being transported to the Emergency Department. In this way we will preserve conveying resources for those patients who need transportation.

5.19 Currently we send the nearest available ambulance resource when an

emergency call is received and we have a resource to send. In the new model we will take a little additional time to ensure we know more about the patient's complaint / condition before sending the most appropriate resource. To take account of this it is proposed that future Ambulance Response Performance measures will be changed to take account of this new approach in line with the other Ambulance Services in the UK.

4. PROVIDING THE BEST PATIENT CARE

We propose that for those patients who require an ambulance response we will continue to aim to provide the best, most appropriate patient care.

How will we do this?

5.20 The change programmes in the rest of the UK have not found any new evidence to offer a definitive position about appropriate time based standards. In fact, it remains the case that the only condition that has ever been shown to benefit from an 8-minute response is cardiac arrest, which occurs in less than 1 in 100 ambulance calls. We are therefore continuing to make cardiac arrest and threatened cardiac arrest an absolute clinical priority in terms of speed of response and patient outcome. For other problems, we will take an approach that matches the patient's needs and distributes resources more appropriately across all patients who contact the ambulance service.

5.21 We propose to introduce a set of Ambulance Quality Indicators (AQIs) which will evidence the quality of our patient care across a range of clinical indicators. While speed of response is still an important consideration, and especially so for those patients in Category 1, it is vital that the clinical quality of the care we give is appropriate and effective for the patient. We have already begun some work to introduce Clinical Performance Indicators and Care Bundles in our service in preparation for this.

5.22 The quality of our care will be monitored for all categories of call. The best care for the patient is not always to attend the Emergency Department. Our

Paramedics will determine whether the patient needs to attend hospital or can be referred to community-based services which can best meet their needs through use of Appropriate Care Pathways and/or transport to alternative destinations.

5.23 Care Bundles are sequences of caring activities that are recognised and prioritised for specific medical conditions e.g. stroke and diabetes. Appropriate care Pathways and/or alternative destinations are programmes that allow NIAS to direct patients to specialised services more suited to their condition. This provides a better more focused service to the patient and saves unnecessary and inappropriate attendance at Emergency Departments.

5.24 Other patients, who call the ambulance service, may not require an ambulance attendance at all. In those cases we will provide effective clinical telephone advice, where their condition or complaint can be managed through telephone advice or referral to an appropriate service without the need for the attendance of an ambulance. Provision of clinical telephone advice is a benefit of our newly established Paramedic-led Clinical Response Desk within the control environment

What does this mean?

5.25 NIAS will use a range of standards, measures and indicators to offer assurance that the new Clinical Response Model is operating effectively, safely and in the best interests of patients.

5.26 Clinical quality indicators will be developed to measure our performance across the range of services provided and this will be done in conjunction with medical professionals across the HSC.

6. HOW ARE WE PLANNING TO MAKE THE CHANGE?

Increase in hours of cover, matching supply with demand, and increase in frontline staffing levels.

6.1 *We plan to increase the total hours of Ambulance cover.* We have modelled the impact of adopting the new clinical response model and taking account of predicted demand trends up to 2021/22. This modelling identifies the need to increase the number of ambulances by the order of 50%, which will require an uplift of approximately 300 frontline staff. With this emphasis of increasing patient transport capacity there will be less reliance on single paramedic rapid response cars which will be reduced by approximately 45.6%.

6.2 It is important to be clear that this does not represent a cut in service provision. Where we reduce hours of cover provided by RRV, under this model, we will supplement those with additional A&E ambulance hours of cover and ensure that the nett result will be an overall increase in provision of ambulance cover.

6.3 *In order to ensure that predictive modelling is appropriate and accurate for the development and planning of the overall CRM programme needs, and in order to take into account responses to the consultation (for example, those that focused on the impact in rural areas or the impact on staff changes), NIAS will now be conducting a further modelling exercise.*

7. WHAT WILL THIS MEAN FOR STAFF?

7.1 The previous sections have explained what the proposed changes mean for those who access our services. It is important that we also consider what they would mean for our staff.

7.2 As indicated, delivery of the model would require significant investment in the service and a related substantial increase in our frontline staffing figures. We consider this to be a very positive development for our workforce, who work very hard in a very challenging climate given current pressures.

7.3 The likely reduction of RRV hours would mean a re-profiling of RRV Paramedic shift patterns and would be managed largely through vacancy controls. It is possible that there could be an element of redeployment of Paramedic posts. If this were to be the case it would be managed through established processes in consultation with trade union colleagues. There is no potential for job losses associated with this proposal.

7.4 The Trust will give full consideration to any staff training needs associated with the proposed changes, should they be implemented and reflect this in Education, Learning and Development Plan. Work will be undertaken to review scope of practice and skillsets across all grades of staff through collaborative working arrangements within the Trust, and appropriately resourced actions will be taken to meet identified needs.

7.5 Impact on staff can only be fully assessed as detailed project proposals are devised and as accurate data becomes available in relation to the detail of those proposals. This is why a revised modelling exercise is important. In addition to constructive engagement through existing mechanisms with staff side, NIAS is also committed to the continuous monitoring and evaluation of all potential equality impacts upon staff, including equality screening/assessment as appropriate in line with the Trust's s.75 equality duties. NIAS is also committed to creating a standing forum of stakeholders that will meet regularly (including staff side) and that will have an ongoing and

meaningful engagement function in relation to the overall CRM programme and its various implementation projects, in order to build upon the positive engagement process evidenced during the consultation.

8. WHAT WILL THIS MEAN FOR SERVICE USERS?

SUMMARY – SECTION 75 EQUALITY IMPACT ASSESSMENT, INCLUDING RURALITY

SUMMARY - Section 75 Impact Assessment		
Data Summary	Impact Identified	Mitigation if Required
GENDER Women are in a slight majority of the population and live longer than men. Ambulance use increases with age-related medical conditions. Men are less likely to attend a GP, or to leave it too late, leading to greater likelihood of attending A&E. Indicative figures for 2017/18 suggest that men account for a greater number of cardiac arrests.	The only personal criterion affecting the introduction of CRM is an individual's clinical need. CRM is designed to improve emergency ambulance provision, based on more effective response to clinical need – specifically cardiac arrests. The CRM proposals are being introduced alongside wider organisational improvements, to increase options such as appropriate care pathways for chronic conditions which do not require an immediate emergency ambulance response.	The CRM proposals are being introduced alongside wider organisational improvements. Any wider organisational improvements will seek to further positively impact on the service provision to all citizens in Northern Ireland, for example, through a new NIAS estates strategy. NIAS is also committed to establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects, including the equality impacts. Further equality screening/impact assessment will be undertaken as appropriate, including continuous review and evaluation of all impacts. NIAS will review its processes and procedures to ensure appropriate care and management of this group of patients.
POLITICAL OPINION The geo-political spread of Northern Ireland's population based on political opinion is evidenced through Council, Assembly and Parliamentary		

electoral results. While NIAS services are changing, political opinion and its dispersal in Northern Ireland is not a factor in determining either the clinical need patients or ambulance provision to them. Political opinion has no bearing on the introduction and implementation of CRM		
COMMUNITY BACKGROUND/RELIGION According to the 2011 Census, the Protestant proportion of Northern Ireland's population is currently greater at older age groups. Demographic trends suggest the Catholic proportion of older age groups will be greater in time. Since age is a likely predictor of increased ambulance use and medical conditions, the introduction of CRM is likely to benefit all communities in Northern Ireland because it is based on clinical need		
AGE Older age groups are increasing and people are living longer. Older age groups (55 and above) have a higher proportional use of ambulance services, a higher level of cardiac arrests, and higher levels of chronic ailments and disabilities. The CRM proposals will positively impact on this grouping because clinical need will be addressed more appropriately and effectively.	From the consultation feedback, some concerns have been raised in relation to a potential adverse impact for older people who have fallen.	NIAS will review its processes and procedures to ensure appropriate care and management of this group of patients In relation to older people who have fallen and are found to have an injury and / or illness that requires assessing, an ambulance is dispatched and a comprehensive assessment will be completed including

		diagnostics such as ECGs; blood pressure; blood glucose; oxygen saturations and temperature. Where an injury / illness is found that requires further assessment, the patient is either transported to an Emergency Department or referred to teams such as Acute / Enhanced Care at Home. Where the patient is found to be well with no injury / illness, the paramedic will refer the patient to a falls team who will make contact with the patients within 2 working days of the referral. Where it is apparent during the initial 999 call that the patient has no immediately life threatening problems, they will be transferred to the Clinical Support Desk (CSD) for further assessment / triage by an experienced paramedic. The CSD paramedics have completed additional training and use a tool called Manchester Triage to assist with their decision making. Following assessment, the paramedic has a number of options including: • Dispatch a non-emergency ambulance • Advise family / friends to transport the patient to an Emergency Department / GP • Make a falls referral Where safe to do so, the CSD paramedic will talk the patient through methods of getting up off the floor. Where family / friends are on scene, the CSD paramedic

		will provide advice on how to lift the patient from the floor. They will provide with advice as long as it is clinically appropriate and regardless of the weather conditions. Where the CSD paramedic establishes the need for an ambulance response and that the patient is vulnerable due to environmental concerns, they have the option of "upgrading" the call. CSD paramedics also review calls that are waiting on an ambulance response. This means that where a patient has fallen and requires an ambulance but one is not yet available, they will be able to receive advice from the CSD paramedic via phone. NIAS will also consider the need for additional services/mechanisms as appropriate and practicable to address rural needs issues arising during the development and implementation of CRM, including the potential requirements of Rural Needs Assessments as appropriate, in the context of greater data and detail,
ETHNICITY Northern Ireland is becoming more diverse. According to the 2011 Census, around 11% of the population was not born here. Key issues for ethnic minorities in engaging with the health service relate to communications and		

understanding. CRM will ensure that the clinical needs of patients are addressed more appropriately and effectively. Issues such as telephone translation services within health are provided through regional arrangements, and CRM will have no bearing on these.		
SEXUAL ORIENTATION Research shows that LGBT people can be more vulnerable to certain conditions, such as vulnerability to suicide or self-harm. CRM is designed to appropriately and effectively address clinical need, and the sexual orientation of any person is not a factor in the provision of ambulance services.		
MARITAL STATUS There is limited data to suggest any impacts would arise in relation the martial status of citizens. While older people living alone in rural areas may arguably require ambulance assistance more than those living with partners or family (for example, in terms of transport), CRM will ensure that clinical need is the basis for more appropriate and effective ambulance service provision.		
DEPENDENT STATUS		

The role of carers and/or parents/guardians is one that should be improved by CRM based on clinical need, particularly when carers themselves may also have a condition or disability.		
DISABILITY Disability, chronic conditions or long-term illness are increasingly more likely to affect older age groups. CRM should create positive improvements and impacts for those with disabilities, particularly when implemented with new Appropriate Care Pathways across the health sector in Northern Ireland.		
RURALITY 67% of the population resides in urban or mixed urban/rural locations, with 33% residing in rural locations. Indicative figures for 2017/18 suggest that slightly higher disproportion of cardiac arrests may take place in urban areas than happen in rural areas. While the proposed new CRM may see urban residents in deprived areas with more chronic conditions waiting a bit longer for more appropriate clinical responses, CRM should see service-deprived rural areas getting a positive impact through better responses to life-critical emergency calls.	From the consultation feedback, some concerns have been raised in relation to a potential adverse impact in relation to response times for Rural communities	

9. HOW WILL WE MONITOR PERFORMANCE AND EQUALITY IMPACTS?

9.1 NIAS is committed to monitoring the impact of these proposals as they are implemented. We plan to introduce new standards and indicators to ensure efficiency, safety, equity and quality in how we provide our service. Detailed proposals for monitoring performance and equality impacts will be developed and brought forward by the CRM Programme Team and considered through engagement with the stakeholder forum.

9.2 We will use a range of standards, measures and indicators against this code set to offer assurance that the new CRM is operating effectively, safely and in the best interests of patients. The current and only standard / performance target for NIAS is; “72.5% of Cat A calls (potentially immediately life threatening) to be responded to within 8 minutes; 67.5% in each Local Commissioning Group area; with 95% of Cat A calls receiving a conveying resource within 21 minutes”.

9.3 Table 3 presents the proposed new standards NIAS will be expected to achieve. NIAS will achieve an average 8 minute response to Immediately Life Threatening calls, regionally.

9.4 A key change will be reporting on a mean response time of 8 min, mean is representative of all ambulance responses, and provides an incentive to reduce long waits. We plan to introduce a 90th centile (9 out of 10) in 15 mins, we feel is more readily understood by the public, and drives an improved response to more patients.

9.5 Overall we feel that these new indicators will be more easily understood and will provide a much improved and more equitable service for the population of NI.

9.6 As already indicated, NIAS will also be keeping the CRM programme and its various related projects under continuous equality monitoring and evaluation, including conducting equality screening/impact assessment as appropriate in line with s.75 obligations, the collection and identification of more focused

data as appropriate to enable ongoing monitoring, and the creation of a new stakeholder forum that will have a continuous and meaningful engagement function with the CRM programme/projects, not least in order to contribute to equality considerations.

PROPOSED NEW STANDARDS

Change in how we will measure our service performance .

Category	Statistic	Clock Stop	Target Time (minutes : seconds)
1 Life threatening	Mean	Response	08:00
		Transport	19:00
	90th centile	Response	15:00
		Transport	30:00
2 Emergency – potentially serious	Mean	Response	18:00
	90th centile	Transport	40:00
3 Urgent problem	90th centile	Conveying Response	120:00
4 (999 calls) Less urgent problem	90th centile	Conveying Response	180:00

Table 3: Proposed new standards

9.7 In undertaking monitoring following implementation of the proposals, NIAS will give full consideration to the Equality Commission for Northern Ireland Section 75 Monitoring Guidance and devise related measures to ensure that ongoing impacts are regularly assessed against specific categories.

10. FULL EQUALITY IMPACT ASSESSMENT

SUMMARY OF IMPACTS - Section 75 Equality Impact Assessment, including Rurality

Data Summary	Impact Identified	Mitigation if required
GENDER Women are in a slight majority of the population and live longer than men. Ambulance use increases with age-related medical conditions. Men are less likely to attend a GP, or to leave it too late, leading to greater likelihood of attending A&E. Indicative figures for 2017/18 suggest that men account for a greater number of cardiac arrests. **POLITICAL OPINION** The geo-political spread of Northern Ireland's population based on political opinion is evidenced through Council, Assembly and Parliamentary electoral results. While NIAS services are changing, political opinion and its dispersal in Northern Ireland is not a factor in determining either the clinical need patients or ambulance provision to them. Political opinion has no bearing on the introduction and implementation of CRM. **COMMUNITY BACKGROUND/RELIGION** According to the 2011 Census, the Protestant proportion of Northern Ireland's	The only personal criterion affecting the introduction of CRM is an individual's clinical need. CRM is designed to improve emergency ambulance provision, based on more effective response to clinical need – specifically cardiac arrests. The CRM proposals are being introduced alongside wider organisational improvements, to increase options such as appropriate care pathways for chronic conditions which do not require an immediate emergency ambulance response.	The CRM proposals are being introduced alongside wider organisational improvements. Any wider organisational improvements will seek to further positively impact on the service provision to all citizens in Northern Ireland, for example, through a new NIAS estates strategy. NIAS is also committed to establishing a stakeholder forum that will have a continuous and meaningful engagement function in relation to the CRM programme and its various projects, including the equality impacts. Further equality screening/impact assessment will be undertaken as appropriate, including continuous

population is currently greater at older age groups. Demographic trends suggest the Catholic proportion of older age groups will be greater in time. Since age is a likely predictor of increased ambulance use and medical conditions, the introduction of CRM is likely to benefit all communities in Northern Ireland because it is based on clinical need. **ETHNICITY** Northern Ireland is becoming more diverse. According to the 2011 Census, around 11% of the population was not born here. Key issues for ethnic minorities in engaging with the health service relate to communications and understanding. CRM will ensure that the clinical needs of patients are addressed more appropriately and effectively. Issues such as telephone translation services within health are provided through regional arrangements, and CRM will have no bearing on these. **SEXUAL ORIENTATION** Research shows that LGBT people can be more vulnerable to certain conditions, such as vulnerability to suicide or self-harm. CRM is designed to appropriately and effectively address clinical need, and the sexual orientation of any person is not a factor in the provision of ambulance services. MARITAL STATUS There is limited data to suggest any impacts would arise in relation the martial status of citizens. While older people living alone in rural areas may arguably require ambulance assistance more than those living with partners or family (for example,		review and evaluation of all impacts.

in terms of transport), CRM will ensure that clinical need is the basis for more appropriate and effective ambulance service provision. **DEPENDENT STATUS** The role of carers and/or parents/guardians is one that should be improved by CRM based on clinical need, particularly when carers themselves may also have a condition or disability. **DISABILITY** Disability, chronic conditions or long-term illness are increasingly more likely to affect older age groups. CRM should create positive improvements and impacts for those with disabilities, particularly when implemented with new Appropriate Care Pathways across the health sector in Northern Ireland.		

AGE

Data Summary
Older age groups are increasing and people are living longer. Older age groups (55 and above) have a higher proportional use of ambulance services, a higher level of cardiac arrests, and higher levels of chronic ailments and disabilities. The CRM proposals will positively impact on this grouping because clinical need will be addressed more appropriately and effectively.
Impact Identified
From the consultation feedback, some concerns have been raised in relation to a potential adverse impact for older people who have fallen.
Mitigation if Required
NIAS will review its processes and procedures to ensure appropriate care and management of this group of patients. In relation to older people who have fallen and are found to have an injury and / or illness that require assessing, an ambulance is dispatched and a comprehensive assessment will be completed including diagnostics such as ECGs; blood pressure; blood glucose; oxygen saturations and temperature. Where an injury / illness are found that requires further assessment, the patient is either transported to an Emergency Department or referred to teams such as Acute / Enhanced Care at Home. Where the patient is found to be well with no injury / illness, the paramedic will refer the patient to a falls team who will make contact with the patients within 2 working days of the referral. Where it is apparent during the initial 999 call that the patient has no immediately life threatening problems, they will be transferred to the Clinical Support Desk (CSD) for further assessment / triage by an experienced paramedic. The CSD paramedics have completed additional training and use a tool called Manchester Triage to assist with their decision making. Following assessment, the paramedic has a number of options including: • Dispatch a non-emergency ambulance • Advise family / friends to transport the patient to an Emergency Department / GP • Make a falls referral Where safe to do so, the CSD paramedic will talk the patient through methods of getting up off the floor. Where family / friends are on scene, the CSD paramedic will provide advice on how to lift the patient from the floor. They will provide with advice as long as it is clinically appropriate and regardless of the weather conditions. Where the CSD paramedic establishes the need for an ambulance response and that the patient is vulnerable due to environmental concerns, they have the option of “upgrading” the call. CSD paramedics also review calls that are waiting on an ambulance response. This means that where a patient has fallen and requires an ambulance but one is not yet available, they will be able to receive advice from the CSD paramedic via phone.

RURALITY

Data Summary
67% of the population resides in urban or mixed urban/rural locations, with 33% residing in rural locations. Indicative figures for 2017/18 suggest that slightly higher disproportion of cardiac arrests may take place in urban areas than happen in rural areas. While the proposed new CRM may see urban residents in deprived areas with more chronic conditions waiting a bit longer for more appropriate clinical responses, CRM should see service-deprived rural areas getting a positive impact through better responses to life-critical emergency calls.
Impact Identified
From the consultation feedback, some concerns have been raised in relation to a potential adverse impact in relation to response times for Rural communities
Mitigation if Required
The CRM programme will improve response times in Rural Areas through: 1. The Reduction in the demand for the number of calls requiring an 8 minute response from 30% of 999calls to 7%. 2. An uplift of 4,478 additional Emergency Ambulance hours per week across NI and an additional 179 Intermediate Care Ambulance hours. This uplift in cover will contribute to improved response times in all areas. Other improvement initiatives include: • the use of strategically-placed standby points • Community paramedics in rural areas • Co-responder partnership arrangements with police and fire and rescue colleagues • Community Resuscitation Programmes - training of school children in Basis Life Support, the introduction of more defibrillators into rural communities and the mapping of defibrillators so people know how to find their nearest one quickly NIAS will also consider the need for additional services/mechanisms as appropriate and practicable to address rural needs issues arising during the development and implementation of CRM, including the potential requirements of Rural Needs Assessments as appropriate, in the context of greater data and detail,

HOW DID WE CONDUCT OUR EQIA, AND WHAT INFORMATION DID WE CONSIDER?

10.1 The detailed consultation proposals, including draft EQIA, were launched on September 27, 2018. The consultation period was originally intended to close on December 21, 2018. Consultation was promoted by a range of actions, including direct email contacts with over 450 stakeholders, the offer and uptake of individual meetings, attendance at Local Commissioning Group meetings, interaction with the Patient Client Council, and the use of mainstream and social media.

A specially commissioned animation promoting the key messages in the proposals was viewed across all NIAS social media platforms 10,589 times during the consultation period. Promotion of the CRM consultation had a reach of 40,613 on Facebook and 33,278 impressions on Twitter. The CRM consultation was downloaded 1,667 times from the NIAS website. NIAS adopted an approach of considering real-time feedback from stakeholders in order to enhance the consultation process. For example, this included improving the approach to informing the public about the ongoing consultation through more detailed social media. It also included publishing an easy-read version on request, although this took longer than anticipated to be published and this delay forms an important learning outcome for the Trust. The easy-read version was downloaded 281 times.

As a consequence of that delay, and as part of the Trust's broader effort to maximise the consultation process in response to stakeholder feedback, NIAS extended the consultation deadline until January 18, 2019.

In total, NIAS received 45 written consultation responses from stakeholders, including replies using the consultation format and responses through direct contact (as well as individual service user responses), over the sixteen weeks of the consultation. In advance of the finalisation of this document, NIAS offered a further opportunity for informal engagement to stakeholders who responded directly to NIAS during the consultation. NIAS also met with the Equality Commission during the consultation period. As part of the

consultation's assurance framework, NIAS senior management had continuous oversight of the consultation throughout its duration and Trust Board was kept apprised of key updates as appropriate during this process.

10.2 Anonymised data about service users and incidents for the period 2017/2018 was analysed to show trends in the characteristics of those who have used the service[3]. However, as the pool of potential service users is comprised of the entire population it was necessary to consider their needs and how this proposal could impact different groups.

10.3 Equitable healthcare has been defined as: "*care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location and socio-economic status".* (Szczepura, 2005)

Geographic Analysis

10.4 In the period FY17/18, 220,090 emergency calls were made to NIAS, of which 201,508 received a response to the scene of the incident. The equivalent of just over 10% of the population required a response to the scene of an incident in the period.

[3] A Data Protection Impact Assessment was undertaken prior to preparing this report in line with GDPR and NIAS policy.

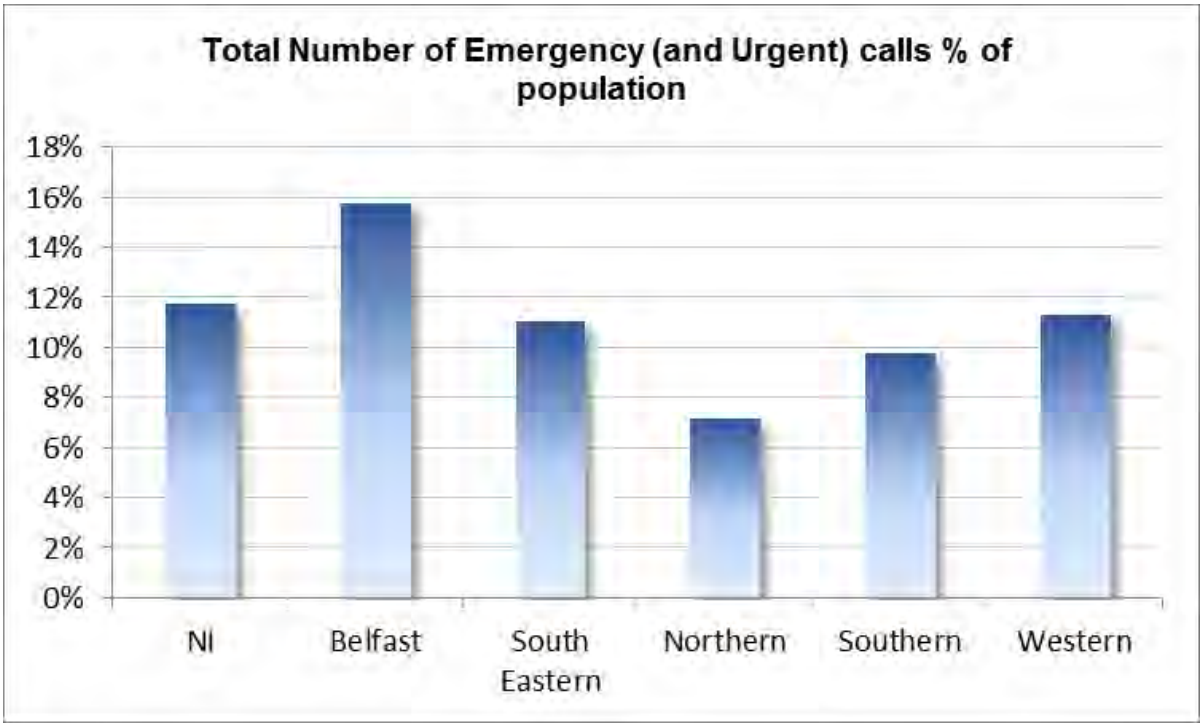


Figure 1 - Emergency and Urgent calls as % of resident population by NI HSC Trust

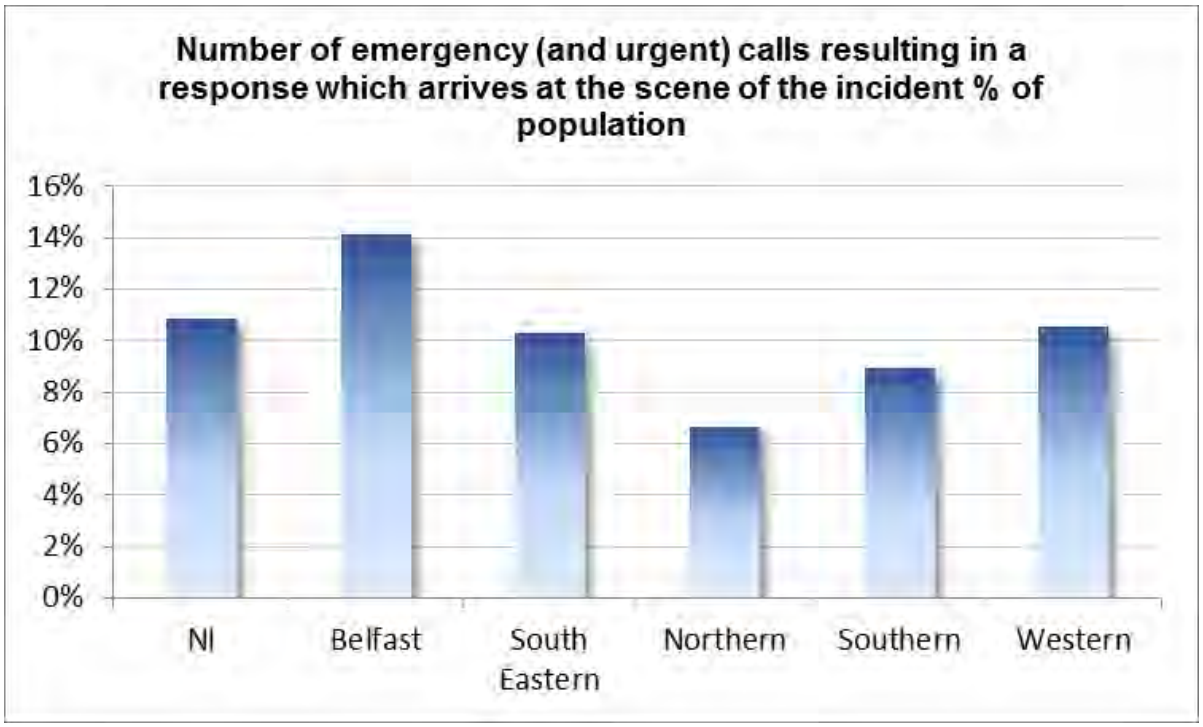


Figure 2 - Emergency and urgent calls resulting in a response to the scene of the incident as a percentage of the resident population by NI HSC Trust

10.5 Demand as a proportion of the population is highest in Belfast Local Commissioning Group (LCG) at 15.8% and lowest in Northern LCG (7.2%) with the regional average being 11.8%. It is unclear why there is such variation in demand, but the higher rate in Belfast is likely due to the transient population of those who work, study and/or socialise in Belfast LCG but do not reside there. In addition, the population of the Greater Belfast area, as designated in the Belfast Metropolitan Area Plan (encompassing the areas of Belfast, Lisburn, Carrick, Castlereagh, Newtownabbey and North Down) is approximately 670,000, around 37% of Northern Ireland's population. Census figures from 2011 put the commuting population into Belfast Local Government District (LGD), who normally reside in other LGD areas, at just over 92,000. LGDs do not align directly to Health and Social Care Trusts (HSCT), so these figures are simply an indication of increased population that may account for the higher demand. Tables 3 and 4 below show how factoring this population increase brings each trust closer to the regional figures.

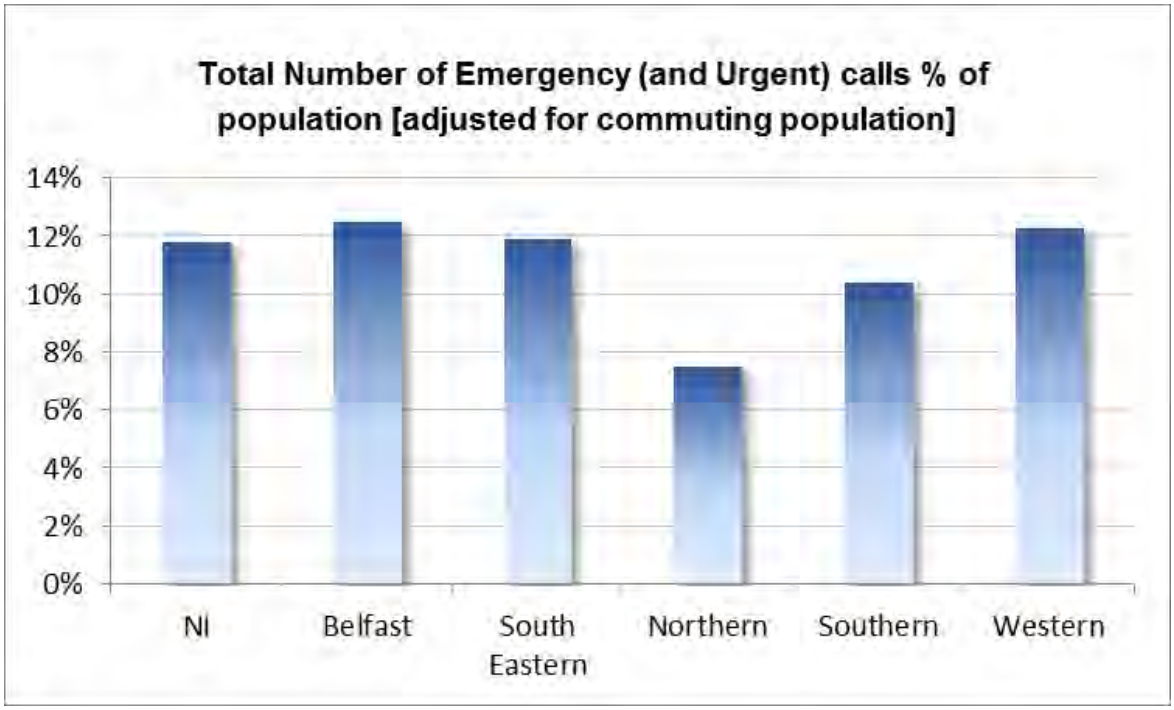


Figure 3 - Emergency and urgent calls as percentage of population adjusted for commuting figures

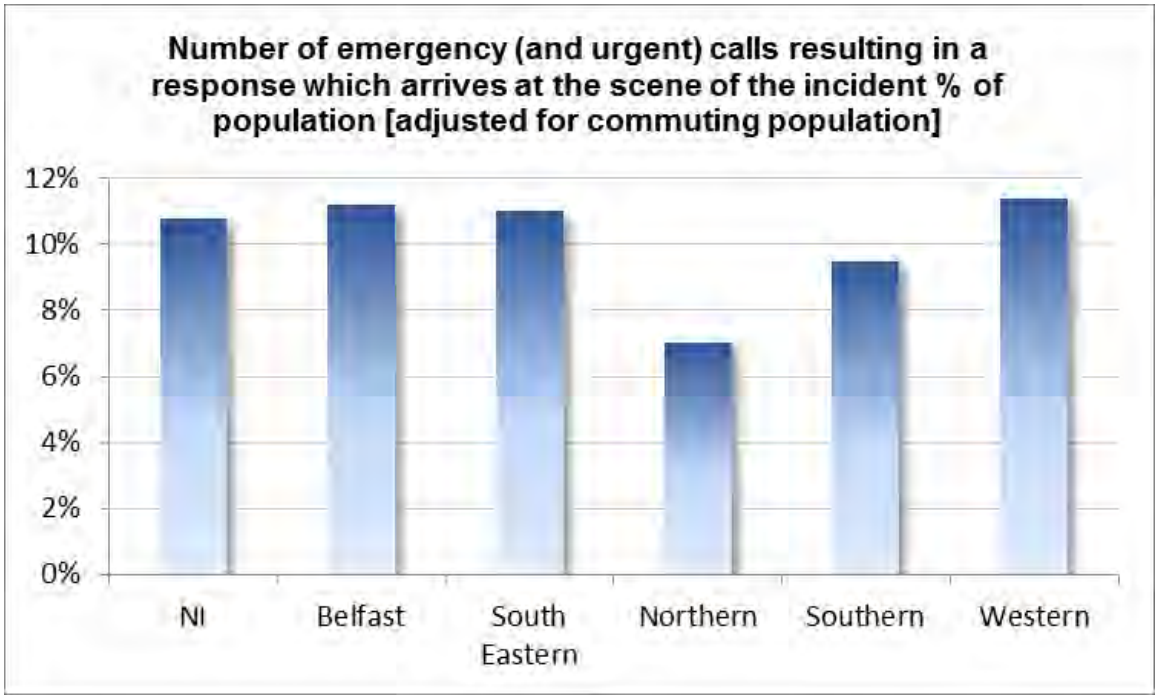


Figure 4 - Emergency and urgent calls resulting in a response to the scene of the incident as a percentage of the population adjusted for commuting figures

10.6 Of the 220,090 emergency calls, c. 29% are categorised as Category A, potentially Immediately Life Threatening (ILT) calls in Northern Ireland. This proportion remains fairly constant across all regions despite the differences in demand. This indicates that the current triage method for identifying patients whose Chief Complaint/Symptom group falls within the highest priority category is consistent.

10.7 The table below shows the classifications all of Emergency and Urgent calls for 2017/2018.

	A	B	C	Cat C HCP
Apr, 2017	28.6%	44.7%	8.0%	18.7%
May, 2017	27.7%	44.9%	8.0%	19.3%
Jun, 2017	28.4%	44.0%	8.4%	19.3%
Jul, 2017	27.5%	45.9%	8.7%	18.0%
Aug, 2017	27.9%	45.9%	8.3%	17.8%
Sep, 2017	27.9%	45.4%	8.5%	18.2%
Oct, 2017	29.4%	44.4%	7.4%	18.7%
Nov, 2017	28.0%	45.2%	7.6%	19.1%
Dec, 2017	30.0%	45.3%	6.9%	17.8%
Jan, 2018	30.4%	44.1%	6.1%	19.3%
Feb, 2018	29.2%	45.7%	6.4%	18.7%
Mar, 2018	29.7%	45.3%	7.0%	18.0%
Total for year 17/18	**28.8%**	**45.1%**	**7.6%**	**18.6%**

Table 1: Categories of all Emergency and Urgent calls in each category, 2017/2018

10.8 The number of calls NIAS categorises as the highest priority (A) is very high. Under the current model we are not effectively identifying the sickest patients who most require a speedy response.

10.9 There is a slight increase in winter months in Cat A calls, but the percentage of calls being allocated into the 4 categories remains quite consistent.

10.10 There is little variation between coding of calls as Cat A between different HSCTs. It is noted that Belfast and Northern HSCT have a higher percentage of Health Care Professional Cat. C calls compared to the other 3 Trusts. Healthcare professional calls can originate from hospitals, nursing and residential homes and GPs, including Out of Hours GPs.

	A	B	C	Cat C HCP
Belfast HSCT	28.9%	43.3%	7.2%	20.6%
Northern HSCT	27.4%	44.4%	6.9%	21.2%
South Eastern HSCT	28.9%	45.0%	8.3%	17.9%
Southern HSCT	29.4%	46.7%	8.0%	15.9%
Western HSCT	29.8%	47.5%	7.9%	14.7%

Table 2: Proportion of Emergency and Urgent calls in each category by HSCT, 2017/2018

10.11 It is unclear why this disparity exists. Further research would be required to understand this. There are a number of possible factors influencing the data that would need to be considered:

- high volume of hospital transfers in Belfast;
- Northern HSCT has the largest population of people in nursing places in nursing and residential homes;
- GPs in Northern have the highest number of registered patients;
- Downgrading and escalation of calls from HCP

GP out-of-hours usage associated with Northern Trust

10.12 Cat C HCP calls comprise c.19% of all emergency and urgent calls.

	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Age Not Specified	Total
Cat C HCP Calls	453	1382	2137	4586	8646	23383	290	**40877**
% of Cat C HCP calls by age group	1.10%	3.40%	5.20%	11.20%	21.20%	57.20%	0.70%	
Cat C HCP Calls per 1000 population in each age group	1	4	6	13	36	198	N/A	

Table 3: Cat C HCP calls 2017/2018 by age

10.13 One of the key considerations about measuring potential impacts is that the relevant data can only be indicative. Substantive real-time data of the actual impact of the proposed new Clinical Response Model will only be available after it becomes activated. At that point, Advanced Medical Priority Dispatch System (AMPDS) codes will be allocated to the new categories and dispatch protocols under the design of new proposed model.

The number and proportion of calls within each category could then be analysed, and that data could be modelled for response times and clinical outcomes. This recognition of data gaps helps explain why NIAS intends to do further focused engagement on the CRM programme, including ensuring a continuous engagement and monitoring process.

	A	B	C	Cat C HCP
URBAN	28.6%	44.9%	7.6%	18.9%
RURAL	29.0%	45.0%	7.7%	18.3%

Table 4: Emergency and Urgent call categories by rural:urban 2017/2018

10.14 There are generally no differences in call allocation between urban and rural locations in general[4].

10.15 67% of the population resides in urban or mixed urban/rural locations, with 33% residing in rural locations. The charts below show the population distribution by gender and 15 year age groups in urban and rural areas.

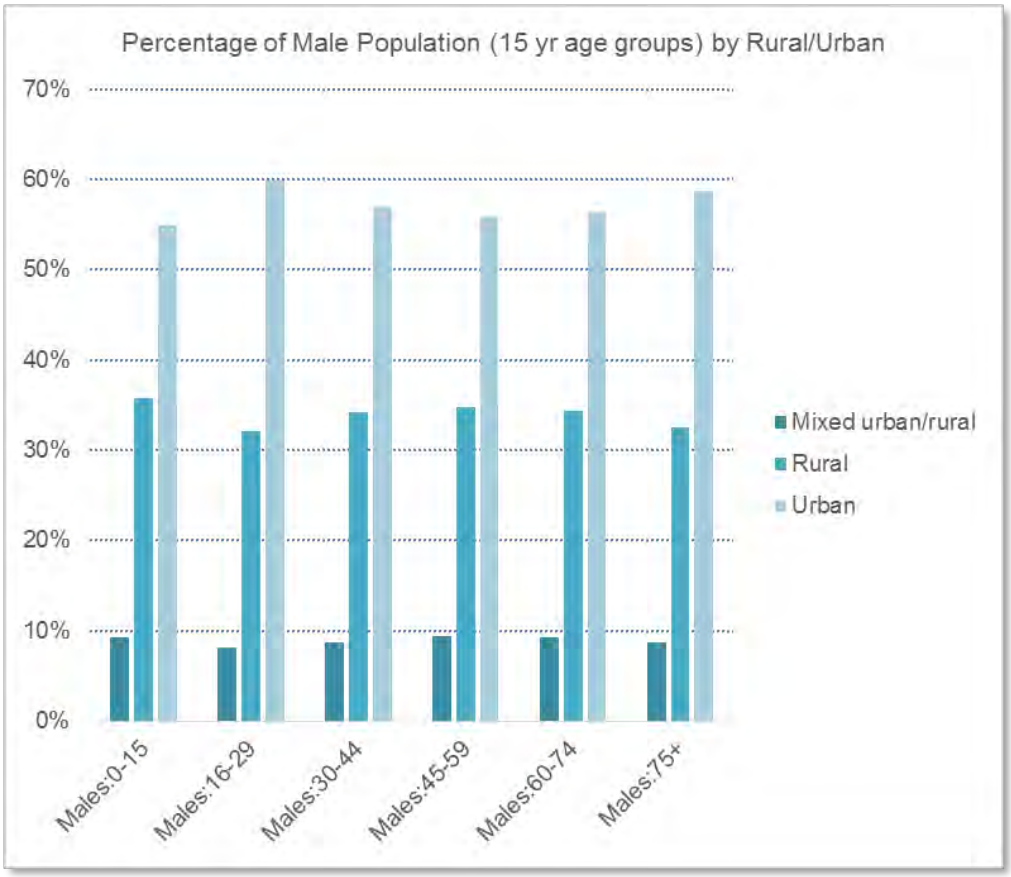


Figure 5: Distribution of male population by age groups and rural:urban (Census 2011)

[4] It should be noted that a small number of calls, 1960, were not included in this table as the geographical origin of the call could not be ascertained.

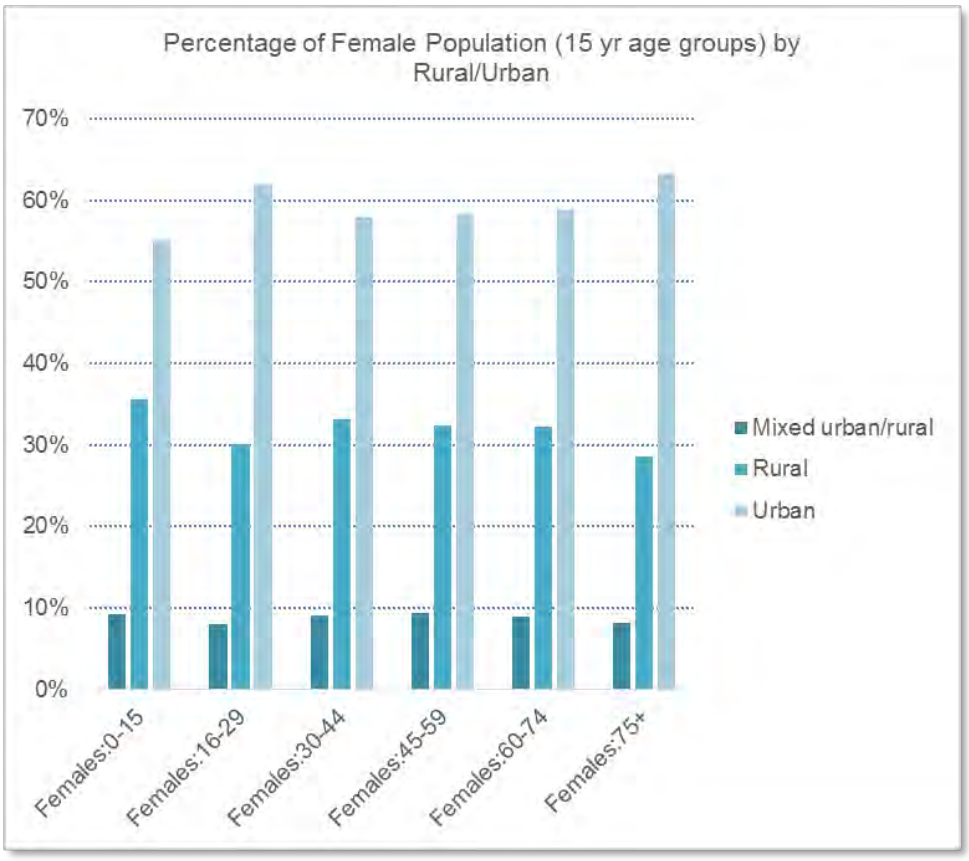


Figure 6: Distribution of female population by age groups and rural:urban (Census 2011)

10.16 All emergency and urgent calls and calls with a response to the scene of the incident are shown below by location in terms or urban or rural.

	Emergency and Urgent Calls		Calls with a Response to Scene		Usually resident Population	
RURAL	53885	24.7%	50674	25.1%	602918	33.3%
URBAN	164245	75.3%	150834	74.9%	1207945	66.7%

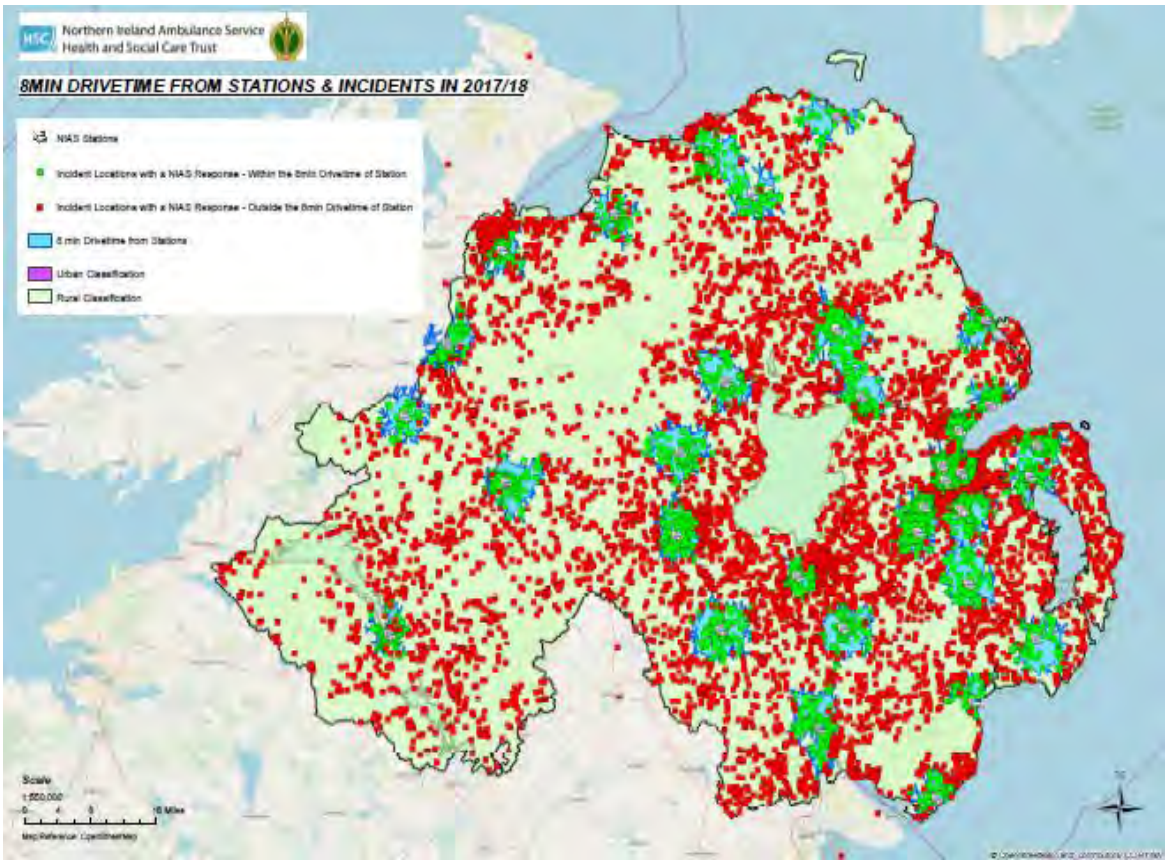
Table 5: all emergency and urgent calls by rural:urban (NIAS 2017/2018)

10.17 The overall demand in relation to the usually resident population is lower in rural areas. This is likely due to a number of factors including: increased 'commuting' populations into urban locations for work, studying and socialising; location of GP practices and hospitals; higher traffic volumes in and around urban centres.

	Cat A Calls		Cat A Calls with a Response to Scene		Usually resident Population	
RURAL	15612	25.0%	14835	25.3%	602918	33.3%
URBAN	46914	75.0%	43820	74.7%	1207945	66.7%

Table 6: Category A calls by rural:urban

10.18 Exact locations of each call with a response to the scene of the incident are shown on the map below in relation to a standard 8 minute drive time from ambulance stations. Approximately 68% of category A calls that had a response to the scene of the incident occurred within these drivetime areas. Actual response times to these incidents have not been included in this analysis and it should be remembered that resources are not always deployed from ambulance stations.



Map 1: Location of all Emergency and Urgent calls that received a response 2017/2018 overlaid on rural:urban and showing 8min drivetime from stations.

As can be seen, there are remote rural areas outside the drivetime areas; there are also locations in urban areas outside of the drivetime radius.

10.19 Discussion of the potential impact of CRM on the geographical location of incidents could also be informed by reviewing the location of those incidents that would meet the criteria for new Category 1 calls; and related clinical outcomes. Once again, however, this additional data could potentially be modelled and considered in the context of ongoing engagement throughout the implementation phases of the programme.

10.20 The Multiple Deprivation Measure Indices 2017 statistics issued by the Northern Ireland Statistical Research Agency (NISRA) demonstrate a persistently high correlation between levels of ill-health within localities of high socio-economic deprivation. These localities are predominantly worst off within more densely populated urban areas that fall within the existing drive-time radius. Levels of equitable access to public services are lower in more rural areas. While the proposed new Clinical Response Model may have an impact on urban residents in deprived areas waiting a bit longer for a more appropriate response to emergency calls associated with chronic long-term conditions, the more appropriate deployment of ambulance resources should have a beneficial impact in responding better to life-critical emergency calls within service-deprived rural areas.

10.21 The NI Health Inequalities Annual Report 2018 found that fire and ambulance response times continued to remain higher in rural areas. The notable change in Rural-NI gaps was the decrease of the gap in ambulance response from 84% in 2013 to 52% in 2017.

Population and Service User Analysis

10.22 Data has been gleaned from Census 2011 and other open sources about the characteristics of the usually resident population of the area served by NIAS. Analysis of the resident population has been conducted considering the Section 75 characteristics in isolation. However, making generalisations on health status (that could be associated with increased use of NIAS HSCT services) based on a single characteristic and that does not account for other factors incorrectly assumes homogeneity among people who share a particular characteristic. While each of the nine categories is given due

regard, multiple identities and other factors influencing health inequalities are also considered.

10.23 High use of emergency ambulance services by a particular group does not equate to their being a potential adverse impact from the clinical response model, but does provide an awareness of vulnerable groups that use NIAS and consideration can be given to ensure equitable access and treatment.

10.24 Healthcare services, including ambulance services are shared cross-border, so the potential population of service users does extend beyond the population of Northern Ireland. However, the number of emergency responses NIAS provides to assist the National Ambulance Service is low in comparison to overall demand. (101 calls in 2016; 67 in 2017).

10.25 In addition, NIAS has a memorandum of understanding with the Scottish Ambulance Service providing mutual assistance between emergency control rooms. Coding for calls from Scotland is conducted in exactly the same manner as with local calls.

Gender Identity

10.26 Historically there have been gender gaps between life expectancy, healthy life expectancy and disability-free life expectancy. However, the most recent Department of Health, Health Inequalities Annual Report (Bell et al. 2018) shows the gender gap has declined in recent years in all three categories with both males and females in Northern Ireland having similar expectation of healthy and disability-free life. The report shows that the differential factor in these categories is deprivation, where persons in the most deprived areas are more likely to have lower life expectancy, lower healthy life expectancy and lower disability-free life expectancy.

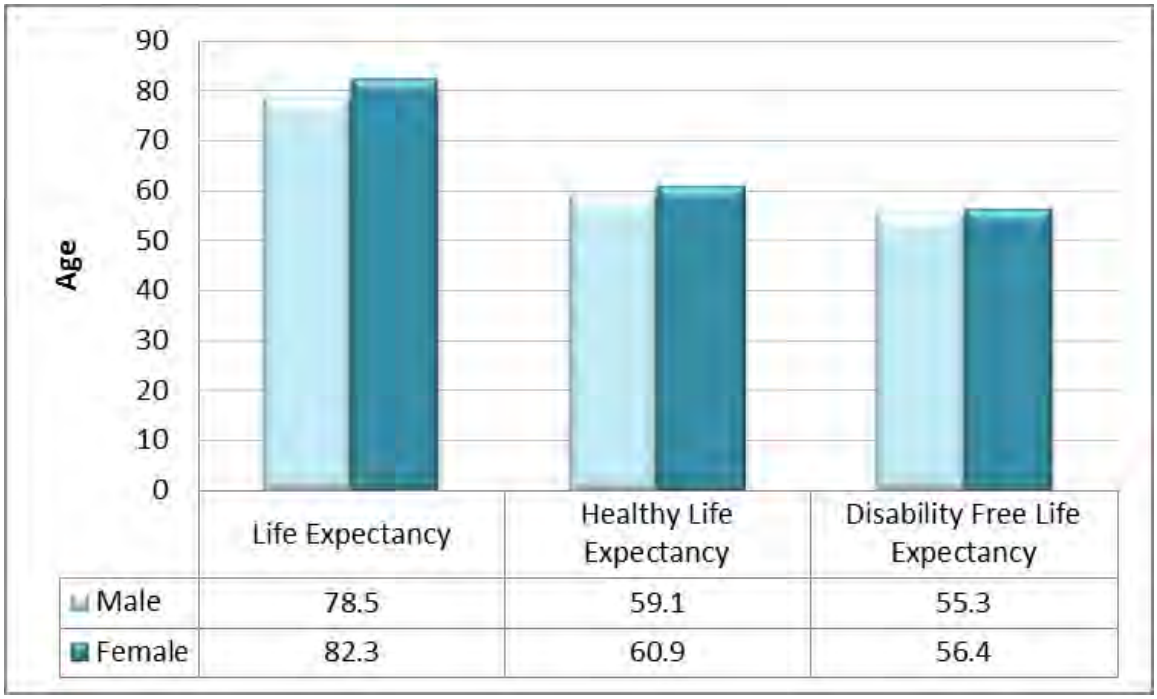


Figure 7 Average age by gender for life expectancy, healthy life expectancy and disability-free life expectancy in NI in 2014-2016 (source HSCIMS report).

10.27 It should be noted that while the gender gap has diminished in all three categories, only life expectancy has improved for both genders. Since 2010-2012, healthy life expectancy for women has decreased by 1.1% while for men it has increased by 1%, so outcomes for women have slightly worsened, while for men there has been a slight improvement. Disability-free life expectancy has reduced for both genders since 2010-2012, from 60.4 years for men and 61.2 years for women, an 8.6% and 7.8% decrease respectively.

10.28 An analysis of the census 2011 data on those who report having a long-term illness or disability that has a limiting effect on their daily activities shows some significant gender differences in the older population.

	Male			Female		
Age group	Total	Limiting long-term illness or disability	No limiting long term illness or disability	Total	Limiting long-term illness or disability	No limiting long term illness or disability
Under 16	194,392	12,694	181,698	184,931	7,330	177,601
16-29	176,584	13,274	163,310	175,149	11,663	163,486
30-44	182,900	22,795	160,105	191,047	25,571	165,476
45-59	172,629	41,613	131,016	175,221	46,172	129,049
60-74	115,256	50,797	64,459	124,634	56,261	68,373
75 and older	45,562	31,390	14,172	72,558	55,086	17,472
All Age groups	887,323	172,563	714,760	923,450	202,083	721,457

Table 7 People reporting having a limiting long-term illness or disability by age and gender

10.29 Long-term physical or mental ill health and/or disability can be a predictor of a person's need for emergency or unplanned care. This may involve a higher incidence of usage of ambulance services. This is borne out in many studies examining characteristics of those who use emergency services, both pre-hospital and A&E attendances.

10.30 Across all age groups and genders, 20% of the population reported a long-term health problem or disability that limits their daily activities to some degree. This varies dramatically with age, rising to 73% of the population aged over 75. For the population under the age of 60 there is no significant gender difference in the proportion of people reporting. However, in the over 60 population, women are 20% more likely than men to have long-term ill-health or disability that limits daily activities to some degree.

10.31 It is difficult to assess risk by gender in relation to trauma or injury, as the mechanisms by which trauma or injury are sustained are wide-ranging. Injury as a result of road traffic collisions is one of the few mechanisms that have reliable figures available.

10.32 PSNI figures on fatalities and injuries in RTCs in 2017-2018 show that men accounted for 80% of fatalities and 65% of serious injuries. Records of slight

injuries as a result of RTC are roughly 50:50 between male and female. Looking at previous years this has been a consistent trend. Other mechanisms of trauma are difficult to quantify in relation to risk differentials based on gender. Some studies (Grazier 2008) conclude that men are more likely than women to be in occupations that carry a higher risk of injury. Not all injuries will result in a call for an ambulance or even attendance at A&E.

10.33 Some medical conditions are particular to one or other gender, or may present symptomatically different between men and women. As outlined earlier NIAS, like many ambulance services in the UK and internationally, uses the prioritisation system AMPDS. This is a clinical model that accounts for a variety of risk factors in presentation of illness, pain and injury. The protocols and the risk factors relating to gender and other personal characteristics are based on research and are updated based on new evidence via the International Academies of Emergency Dispatch.

10.34 A number of studies examining individual characteristics that may predict use of emergency care, whether by attendance at A&E or by use of ambulances, did not find gender to be a significant factor. (Lowthian, Cameron et al, 2011; Victor et al, 1999; Lowthian, Jolley et al, 2011; Rucke et al 1997). One study by Squire (2010) did not even examine gender differences, while Clarke's 1999 study found that males were higher users of ambulance and emergency services than females. McConnel and Wilson's 1998 study found the opposite, with women slightly more likely to use emergency services and transport but less likely to need them for life-threatening conditions.

10.35 Data on the use of prehospital emergency care by trans and gender non-conforming people is lacking. The number of trans and gender non-conforming people in the population is unknown. Researchers often rely on prevalence of people presenting to GPs with a gender identity issue, e.g. to explore transition or to seek treatment for mental health issues such as depression that gender dysphoria can contribute to, as a way of estimating the number of trans people in a population. In a study undertaken on behalf of GIRES, it is estimated that up to 20 in 100,000 people (equates to c. 360 people in NI population) have a degree of gender variance (Reed 2009).

There is significant stress associated with being gender variant that can result in mental ill-health, with 34% of transgender adults reporting at least one suicide attempt in a survey for the Cabinet Office. A report by the Institute of Conflict Research also found that some trans people have faced inappropriate and discriminatory behaviour from healthcare professionals in Northern Ireland. Issues of particular note were use of inappropriate pronouns and using old names in front of others.

Service Users

10.36 The tables below show the male/female gender of service users by category of call and category of call with a response to the scene of the incident.

10.37 A small number of calls (3.9% of all emergency and urgent calls to EAC) were excluded from the analysis where gender had not been recorded.

All Ages					
Calls to NIAS EAC	Female	Female (% of calls)	Male	Male (% of calls)	Total
All Emergency & Urgent Calls	106655	50.4%	104947	49.6%	211602.00
Cat A	28866	48.1%	31168	51.9%	60034.00
Cat B	47138	50.1%	46997	49.9%	94135.00
Cat C	8243	49.7%	8349	50.3%	16592.00
Cat C HCP	22408	54.9%	18433	45.1%	40841.00
Under 60					
Calls to NIAS EAC	Female	Female (% of calls)	Male	Male (% of calls)	Total
All Emergency & Urgent Calls	42722	46.9%	48448	53.1%	91170.00
Cat A	13186	46.2%	15352	53.8%	28538.00
Cat B	21662	47.0%	24472	53.0%	46134.00
Cat C	3659	46.1%	4285	53.9%	7944.00
Cat C HCP	4215	49.3%	4339	50.7%	8554.00
Over 60					
Calls to NIAS EAC	Female	Female (% of calls)	Male	Male (% of calls)	Total
All Emergency & Urgent Calls	61419	53.9%	52439	46.1%	113858
Cat A	15214	50.7%	14775	49.3%	29989
Cat B	23735	54.4%	19925	45.6%	43660
Cat C	4394	53.6%	3798	46.4%	8192
Cat C HCP	18076	56.5%	13941	43.5%	32017

Table 8: Volume of emergency and Urgent calls by code allocated and gender (where gender was recorded) 2017/2018

All Ages					
Calls with Response to the incident	Female	Female (% of incidents)	Male	Male (% of incidents)	Total
All Emergency & Urgent Calls	100616	50.8%	97638	49.2%	198254.00
Cat A	28053	48.3%	29984	51.7%	58037.00
Cat B	44870	50.5%	43988	49.5%	88858.00
Cat C	6696	50.6%	6529	49.4%	13225.00
Cat C HCP	20997	55.1%	17137	44.9%	38134.00
Under 60					
Calls with Response to the incident	Female	Female (% of incidents)	Male	Male (% of incidents)	Total
All Emergency & Urgent Calls	39234	47.2%	43803	52.8%	83037.00
Cat A	12633	46.5%	14523	53.5%	27156.00
Cat B	20068	47.4%	22309	52.6%	42377.00
Cat C	2750	47.0%	3098	53.0%	5848.00
Cat C HCP	3783	49.4%	3873	50.6%	7656.00
Over 60					
Calls with Response to the incident	Female	Female (% of incidents)	Male	Male (% of incidents)	Total
All Emergency & Urgent Calls	59161	54.1%	50292	45.9%	109453
Cat A	14995	50.8%	14516	49.2%	29511
Cat B	23256	54.5%	19439	45.5%	42695
Cat C	3798	54.2%	3210	45.8%	7008
Cat C HCP	17112	56.6%	13127	43.4%	30239

Table 9: Emergency and Urgent calls with a response to the scene of an incident by code allocated and gender (where gender was recorded) 2017/18

10.38 All calls, across all ages show an even distribution between the genders in line with the NI population. Males have a slightly higher use of NIAS emergency services than females under 60, women use the services slightly more in the over 60 group, but both are in a proportion consistent with the population in these age groups. (Men make up 45% of the over 60 population). The exception to this is that calls from males over 60 show a disproportionately higher rate of Cat A codes but not to a statistically significant level.

Sexual Orientation

10.39 The sexual orientation of service users is not routinely gathered and the 2011 Census did not gather data on sexual orientation. A report commissioned by the Office of the First Minister and Deputy First Minister suggested that: “it is feasible to operate on the assumption that a certain proportion of the

population (up to 10%) is LGBT (lesbian, gay, bisexual, and transgender), and to formulate policies accordingly." An estimated 10% of the NI population is 181,086.

10.40 Research shows that LGB&/T people are particularly vulnerable to developing mental health problems due to societal and familial stressors. This community can be more likely to self-harm, feel suicidal, experience depression, misuse alcohol/drugs, suffer from anxiety or develop problems with food.

10.41 The Rainbow Project's 2013 report, "Through our Minds", found that 12.6% of their respondents had attended hospital after deliberately self-harming. This is disproportionately high compared with the 0.5% of the population as a whole. The report also demonstrated that the LGBT community are much more vulnerable to suicide attempts, with almost a quarter of respondents having attempted suicide compared to the general population of 5%.

Marital Status

HSCT	All usual residents: Aged 16+ years	Single (never married or never registered a same-sex civil partnership): Aged 16+ years	Single (never married or never registered a same-sex civil partnership): Aged 16+ years %	Married or in a registered same-sex civil partnership: Aged 16+ years	Married or in a registered same-sex civil partnership: Aged 16+ years %	Separated (but still legally married or still legally in a same-sex civil partnership): Aged 16+ years	Separated (but still legally married or still legally in a same-sex civil partnership): Aged 16+ years %	Divorced or formerly in a same-sex civil partnership which is now legally dissolved: Aged 16+ years	Divorced or formerly in a same-sex civil partnership which is now legally dissolved: Aged 16+ years %	Widowed or surviving partner from a same-sex civil partnership: Aged 16+ years	Widowed or surviving partner from a same-sex civil partnership: Aged 16+ years %
Belfast	283079	123572	43.7%	106796	37.7%	14029	5.0%	17296	6.1%	21386	7.6%
Northern	366872	122083	33.3%	187157	51.0%	13220	3.6%	19742	5.4%	24670	6.7%
South Eastern	275606	87369	31.7%	142590	51.7%	10185	3.7%	16577	6.0%	18885	6.9%
Southern	276654	96812	35.0%	138987	50.2%	9799	3.5%	13396	4.8%	17660	6.4%
Western	229329	87557	38.2%	106544	46.5%	9678	4.2%	11063	4.8%	14487	6.3%
Northern Ireland	1431540	517393	36.1%	682074	47.6%	56911	4.0%	78074	5.5%	97088	6.8%

Table 10: Marital Status of population (over 16 yrs) by Health & Social Care Trust (NISRA Census 2011)

Age group	Total	Single (never married or never registered a same-sex civil partnership)	Married or In a registered same-sex civil partnership	Separated (but still legally married or still legally in a same-sex civil partnership)	Divorced or formerly in a same-sex civil partnership which is now legally dissolved	Widowed or surviving partner from a same-sex civil partnership
Population						
16-29 yrs	351733	315985	32149	2425	840	334
30-44 yrs	373947	123624	209086	21524	17990	1723
45-59 yrs	347850	45456	230943	23138	39570	8743
60-74 yrs	239890	19778	162753	8496	17257	31606
75 and older	118120	12550	47143	1328	2417	54682
Males						
16-29 yrs	176584	163276	12241	623	322	122
30-44 yrs	182900	67529	100747	7345	6830	449
45-59 yrs	172629	26676	116804	9906	16869	2374
60-74 yrs	115256	10938	84426	4214	7858	7820
75 and older	45562	4657	27893	730	960	11322
Females						
16-29 yrs	175149	152709	19908	1802	518	212
30-44 yrs	191047	56095	108339	14179	11160	1274
45-59 yrs	175221	18780	114139	13232	22701	6369
60-74 yrs	124634	8840	78327	4282	9399	23786
75 and older	72558	7893	19250	598	1457	43360

Table 11: Marital status of population by 15yr age group (NISRA Census 2011)

HSCT	Number of Adults living alone (vs living with other adults)	One person household: Person aged 65+ years
Belfast	80221	18213
Northern	73959	19904
South Eastern	58064	15394
Southern	54109	13634
Western	50325	10956
Northern Ireland	316678	78101

Table 12: Number of adults living alone by HCST (NISRA Census 2011)

10.42 Marital or domestic status as a factor to predict use of emergency ambulance services and emergency care is not fully explored in the academic literature. Rucker found that adult patients who lived alone or were lone parents were no more likely than adults who lived with other adults to use emergency ambulance services. (Rucker et al.1997).

10.43 Sun (2003) found that single and divorced people and single parents were more likely to be high users of emergency departments (>4

attendances/annum). However this study had very narrow criteria for inclusion of participants and did not consider mode of transport to the ED. Clark (1999) also states that single people are more likely to place demand on emergency ambulance services.

10.44 Several studies that correlated increased patient age with increased use of ambulance services and emergency care postulate that living alone may contribute to this increased use. (Lowthian,2011; Downing, 2005)

10.45 There are no obvious health inequalities between being married or not. For older people being alone is a likely indicator that they will use emergency and non-emergency ambulance services more than adults who live with other adults. Marital status alone does not provide a direct correlation of one person households, e.g. 1672 married people over the age of 60 live in communal establishments and their partner may continue to reside in the family home in a one person household.

Care of Dependants

10.46 People with responsibility for care of dependants includes parents/guardians of children and people who, without payment, provide help and support to someone who may not be able to manage without this help because of long-term physical or mental ill-health/disability, or problems related to old age. This also includes young carers.

10.47 The wide ranging of definition for people who have care of dependant responsibility makes it difficult to accurately quantify. The legalistic definition of a carer as defined by the Carer and Direct Payments Act (Northern Ireland) 2002 does not fully cover all persons who may fall under the S75 characteristic of having care responsibilities for dependents and with whom NIAS may interact in providing emergency clinical responses. The remit of this EQIA is wider than the Act's definition of a carer.

10.48 Individuals may have multiple caring responsibilities. It would be inaccurate to combine the figures for care of a child or children with unpaid care as people could be in both datasets.

10.49 There is significant disparity between the number of people who claim Carers Allowance (72, 730 in 2017) and people who self-identify as unpaid carers under the census definition (213,980).

HSCT	All usual residents	Persons providing unpaid care	% of Population
Belfast	348204	42913	12.3%
Northern	463297	53507	11.5%
South Eastern	346911	44460	12.8%
Southern	358034	40607	11.3%
Western	294417	32493	11.0%
Northern Ireland	1810863	213980	11.8%

Table 13: Persons reporting providing unpaid care (NISRA Census 2011)

10.50 The table below shows the number of parents by gender in the population as a whole and by HSC Trusts.

HSCT	Population	All parents of dependent children	All parents as a percentage of the population	Males	% of male parents	Females	% of female parents
Belfast	348204	67,093	19.3%	25614	38.2%	41479	61.8%
Northern	463297	104,133	22.5%	45,260	43.5%	58873	56.5%
South Eastern	346911	78,008	22.5%	33639	43.1%	44369	56.9%
Southern	358034	84,844	23.7%	37,298	44.0%	47546	56.0%
Western	294417	66,773	22.7%	27903	41.8%	38870	58.2%
Northern Ireland	1810863	400,851	22.1%	169,714	42.3%	231,137	57.7%

Table 14: Parents[5] of dependent children in Census 2011

10.51 The majority of unpaid carers (c. 63%) are in the 35-65 age groups. A significant proportion of carers are older people. (c.23%).

10.52 Census 2011 data shows that a high proportion of carers have a long term illness or disability: c. 9.6% of people who provide some unpaid care also reported having a long term health problem or disability that impacts day to day activity a lot. The proportion of carers with disability increases with age. It would be expected that older carers would be more likely to require emergency and unplanned care.

[5] includes lone parents; both parents in a marriage/civil partnership/ co-habiting; and, grandparents with care of grandchildren where no intervening generation is resident

10.53 NIAS do not collect information on patient's carer status so this cannot be confirmed based on service user data.

10.54 There is limited evidence (Sun et al. 2003) that single parents are more likely to be frequent users of emergency and unplanned care, including ambulance services.

10.55 There is nothing to indicate that being a carer will directly impact on use of emergency and pre-hospital services. However, people who have care of dependents may be reluctant to avail of treatment without safeguards in place for their dependent(s). The NIAS safeguarding policy aims to address this in individual cases and this will continue under the new model.

Age

10.56 Age is one of the most reliable predictors of use of emergency or unscheduled healthcare. In his 1999 study in Queensland, Clarke found that one-third of emergency ambulance resources were used by older people (age over 65 years), while they accounted for use of two-thirds of non-emergency ambulance resources. This is reflected in recent figures for non-emergency ambulance journeys with NIAS. Based on NISRA's population projections, persons over the age of 55 in 2017 made up 27.4% of the population, therefore 27.4% of people used almost 79% of non-emergency ambulance resources.

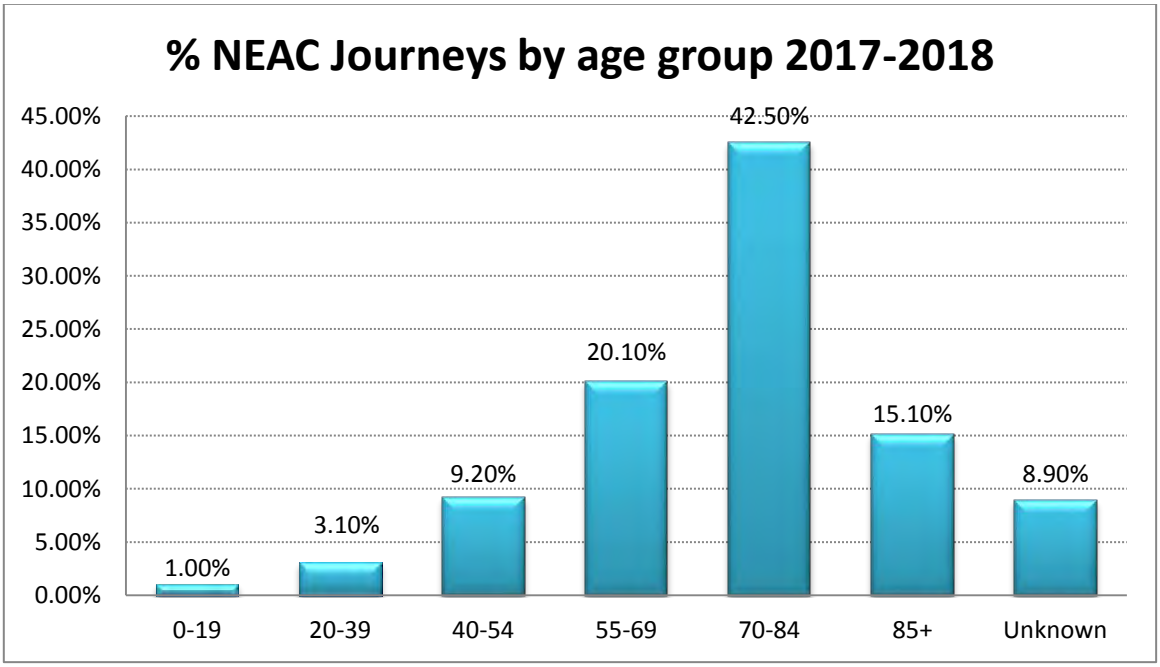


Figure 8: Percentage of Non-emergency Ambulance Journeys by age group, 2017-2018

10.57 Other studies in the UK, Australia and USA also found that older age is a predictor of emergency healthcare, both ambulance use and attendance at A&E. (Rucker 1997, McConnell 1998, Squire, 2010, Lowthian 2011). With these studies in mind it could be expected that as the population ages, demand on NIAS will also increase.

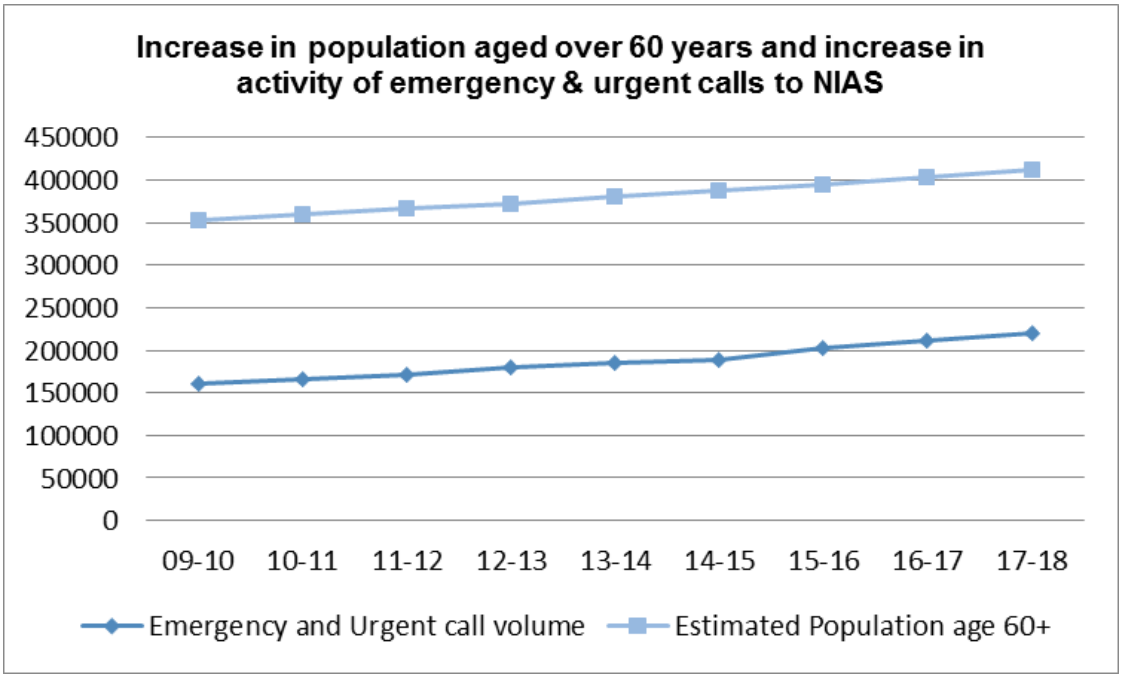


Figure 9: Increase in population aged over 60 years and increase in activity of emergency and urgent calls to NIAS.

10.58 In 5 years it is predicted that the older population (over 60 years) will have increased by 12.5% in comparison to an overall population increase of just 2.12%. Figure 7 shows the estimated population demographics by age bracket between 2011 and 2028. With the increase in this section of the population it is likely that demand for emergency and unplanned care will continue to increase. In this context, it is also likely that a failure by NIAS to develop the proposal for a new Clinical Response Model more appropriately to the emergency needs of Northern Ireland's projected population will lead to lower performance and clinical outcomes.

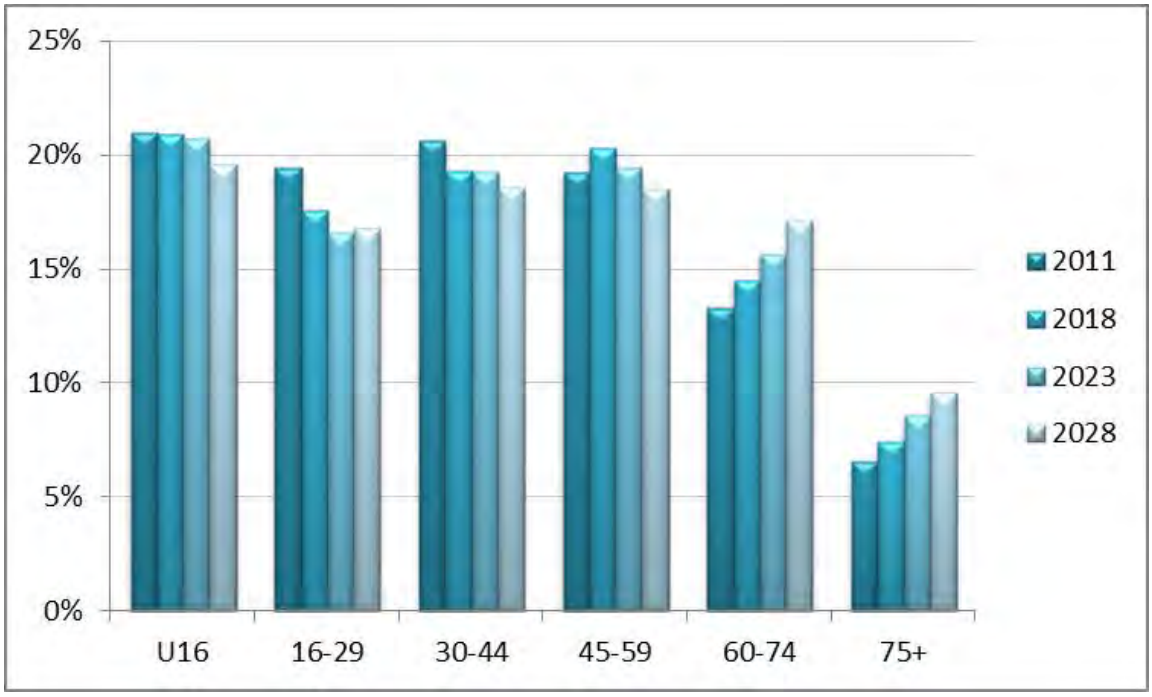


Figure 10: Estimated proportion of population by age bracket over time (NIRSA population projections)

10.59 Downing's 2005 study of 14 A&E departments in the West Midlands over a period of three years specifically looked at differences between patients aged between 0-64 and patients over 65 years. It supports the increased use of ambulances for older patients as 64.7% of the older group arrived by ambulance compared to just 19.9% of the younger group. The study also compared the nature of diagnoses in the two groups. The largest category in both age groups was injury (33.1% of over 65s; 59.9% of 0-64); Cardiac, cerebrovascular, respiratory conditions and infectious disease were all much more common in the older patient group than the younger group. As with gender, AMPDS factors in the patient's age in relation to symptoms to assist in establishing the chief complaint and to reach the coding for the incident. Age will also be taken into account for infants and children who may require specific paediatric procedures.

10.60 While emergency admissions do not directly correlate with pre-hospital care and ambulance use, a 2010 Kings Fund study found that children under 5 and older people are at higher risk of emergency admissions than others. Care should be taken with this data set as the admissions described are for one

Primary Care Trust and are not presented as a proportion of the population in each age range.

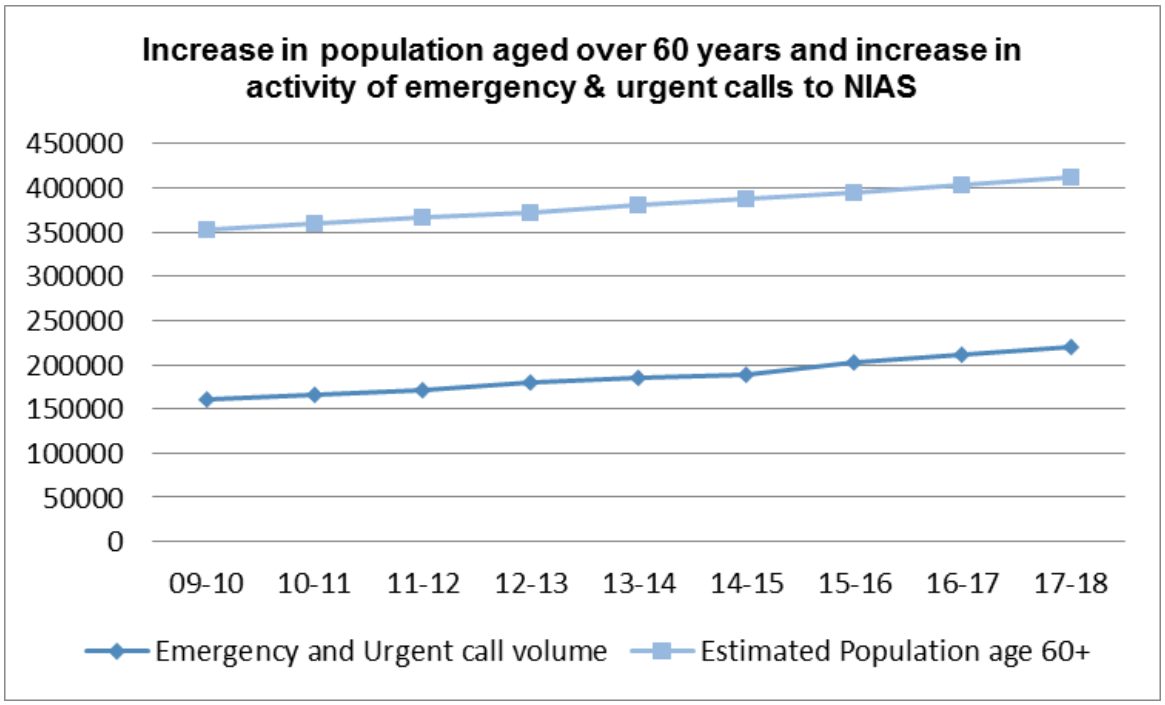


Figure 11: Increase in population aged over 60 years and increase in activity of emergency and urgent calls to NIAS.

10.61 In 5 years it is predicted that the older population (over 60 years) will have increased by 12.5% in comparison to an overall population increase of just 2.12%. Figure 7 shows the estimated population demographics by age bracket between 2011 and 2028. With the increase in this section of the population it is likely that demand for emergency and unplanned care will continue to increase. In this context, it is also likely that a failure by NIAS to develop the proposal for a new Clinical Response Model more appropriately to the emergency needs of Northern Ireland's projected population will lead to lower performance and clinical outcomes.

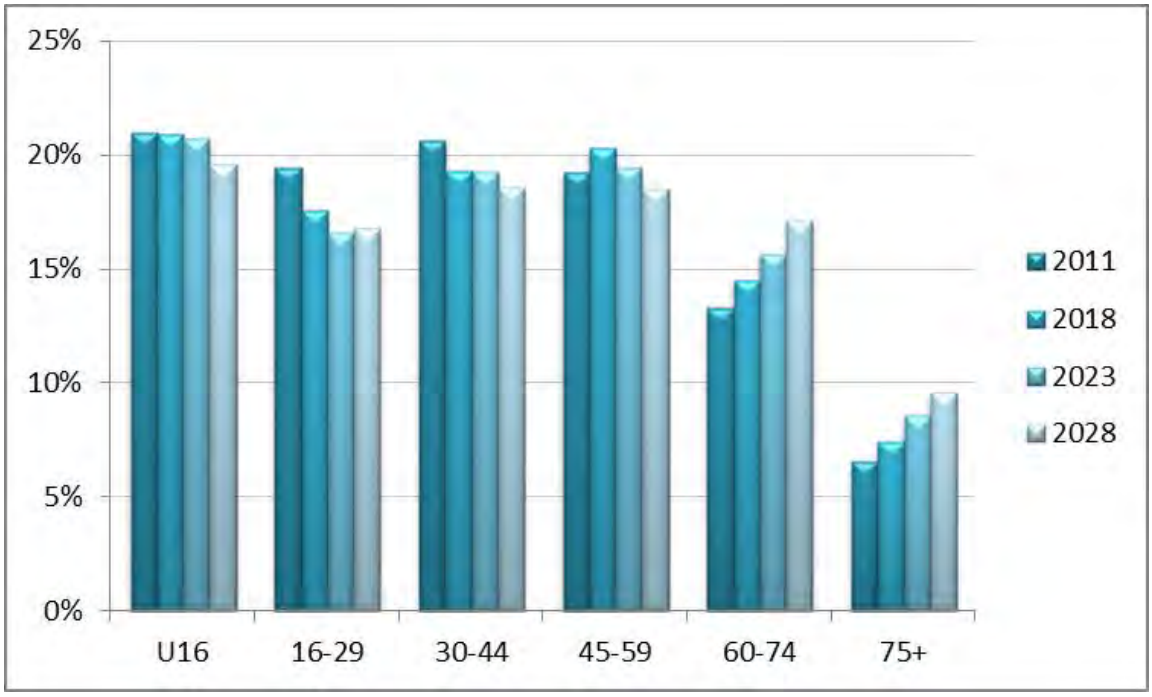


Figure 12: Estimated proportion of population by age bracket over time (NIRSA population projections)

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Primary Care Trust and are not presented as a proportion of the population in each age range.

Service Users

10.64 56% of emergency and urgent calls to NIAS are currently for patients aged 60 or over.[6] This is slightly lower than the academic research would suggest but correlates to only 20% of the population.

HCST	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Total
Belfast HSCT	2082	7660	7258	8612	9535	16864	52011
Northern HSCT	2397	5139	5099	7622	9844	19294	49395
South Eastern HSCT	1769	3940	3904	5355	7792	15097	37857
Southern HSCT	1901	3691	4027	5715	6844	12311	34489
Western HSCT	1674	3749	4245	5453	6550	9808	31479
Total	**9823**	**24179**	**24533**	**32757**	**40565**	**73374**	**205231**

Table 15: Number of emergency and urgent calls by age group and HSCT (2017/21018)

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	4.00%	14.73%	13.95%	16.56%	18.33%	32.42%
Northern HSCT	4.85%	10.40%	10.32%	15.43%	19.93%	39.06%
South Eastern HSCT	4.67%	10.41%	10.31%	14.15%	20.58%	39.88%
Southern HSCT	5.51%	10.70%	11.68%	16.57%	19.84%	35.70%
Western HSCT	5.32%	11.91%	13.49%	17.32%	20.81%	31.16%
Northern Ireland	**4.79%**	**11.78%**	**11.95%**	**15.96%**	**19.77%**	**35.75%**

Table 16: percentage of emergency and urgent calls by age group and HSCT (2017/2018)

10.65 The age of people who received a Cat A response in 2017/2018 shows a slightly different profile to the overall volume of emergency and urgent calls. There is a slightly higher incidence in the age group 30-59 years, but people aged over 60 still account for 52% of these calls.

[6] This is based on 205231 calls where age is recorded. Some calls where age is recorded are based on estimates of the patient's age and may not be accurate.

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Grand Total
Belfast HSCT	627	2232	2219	2728	2740	3643	14189
Northern HSCT	756	1219	1408	2355	3067	4218	13023
South Eastern HSCT	626	1031	1209	1800	2404	3616	10686
Southern HSCT	561	915	1165	1917	2182	3042	9782
Western HSCT	551	951	1135	1764	2141	2478	9020
Northern Ireland	**3121**	**6348**	**7136**	**10564**	**12534**	**16997**	**56700**

Table 17: Category A calls with a response to the scene of an incident by age (2017/2018)

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	4.42%	15.73%	15.64%	19.23%	19.31%	25.67%
Northern HSCT	5.81%	9.36%	10.81%	18.08%	23.55%	32.39%
South Eastern HSCT	5.86%	9.65%	11.31%	16.84%	22.50%	33.84%
Southern HSCT	5.74%	9.35%	11.91%	19.60%	22.31%	31.10%
Western HSCT	6.11%	10.54%	12.58%	19.56%	23.74%	27.47%
Northern Ireland	**5.50%**	**11.20%**	**12.59%**	**18.63%**	**22.11%**	**29.98%**

Table 18: percentage of Category A calls with a response to the scene of an incident by age (2017/2018)

Disability

10.66 In the 2011 Census, just over one in five (21%) of the population said that they had a long-term health problem or disability that limited their day-to-day activities, 3% of whom were born with a disability, affecting almost 37% of households. This was a slight increase in the proportion of people who said they had a disability in the 2001 Census (20%). Strabane and Belfast (both 24%) had the highest proportions of residents with a long-term health problem or disability.

10.67 Not everyone who has a disability or long term health problem will have reported that they have any limitations in daily activity and will not be included in the 21%. They still may have specific needs that could be impacted by the service NIAS provides.

Trust	All usual residents	Long-term health problem or disability: Day-to-day activities limited a lot	% of population	Long-term health problem or disability: Day-to-day activities limited a little	%	Long-term health problem or disability that limits daily activities a lot or a little	%
Belfast HSCT	348204	48585	14.0%	31637	9.1%	80222	23.0%
Northern HSCT	463297	50066	10.8%	40961	8.8%	91027	19.6%
South Eastern HSCT	346911	37602	10.8%	31142	9.0%	68744	19.8%
Southern HSCT	358034	40991	11.4%	29323	8.2%	70314	19.6%
Western HSCT	294417	37988	12.9%	26351	9.0%	64339	21.9%
Northern Ireland	1810863	215232	11.9%	159414	8.8%	374646	20.7%

Table 19: Persons reporting a long-term health problem or disability that limits daily activity (NISRA Census 2011)

10.68 Disability comprises a range of conditions and illnesses: physical, mental and intellectual. Different disabilities will present different challenges to individuals around accessibility to healthcare services and as a predictor of use of emergency or unscheduled healthcare.

10.69 The proposed new model is reliant on telephone communication between callers and EMDs to allow for accurate coding for prioritisation and dispatch.

10.70 However, NIAS has a number of measures in place to assist those with communication needs, including the emergency SMS system. AMPDS includes a variety of options that influences the coding of a call if there are difficulties in communication.

10.71 NIAS is mindful of seeking ways to improve accessibility through transformation projects, through staff training and development, and continuous and meaningful engagement with stakeholders

10.72 As mentioned in the section on age above, age is one of the most reliable predictors of use of emergency or unscheduled healthcare, including ambulance services.

10.73 Disability or long-term illness may also be a predictor of a person's need for emergency or unplanned care but there is currently limited evidence to interrogate this hypothesis. Data on every patient's level of disability is not routinely held in relation for the purposes of impact assessment, NIAS will consider whether this data should be routinely gathered to improve services, in the context of the new Electronic Patient Report Form.

Multiple Identities

10.74 Whilst the incidence of disability among service users is not recorded, there is a link between people in older age groups and increased likelihood of limiting disability or long-term illness.

10.75 Among both men and women, the rate of disability increases with age. Women on average live longer than men, therefore disability tends to be more common among women. The rate of prevalence of disability is particularly high for women aged 75 and above (62%). The prevalence of disability amongst adults varies significantly with age, ranging from a low of 5% amongst young adults aged 16-25 to 60% amongst those aged 75 and above. In those aged 85 and above, the prevalence of disability increases to almost 67%.

Age group	Population	Limiting long-term illness or disability	No limiting long term illness or disability
Under 16	379,323	20,024	359,299
16-29	351,733	24,937	326,796
30-44	373,947	48,366	325,581
45-59	347,850	87,785	260,065
60-74	239,890	107,058	132,832
75 and older	118,120	86,476	31,644
All Age Groups	1,81,0863	374,646	1436,221

Table 20: People reporting having a limiting long-term illness or disability by age

Ethnicity

10.76 Northern Ireland is becoming an increasingly diverse population. The number of the resident population born outside of the region increased by 2%, from 9% to 11% between the 2001 Census and the 2011 Census.

10.77 The number of people identifying as belonging to a minority ethnic group has more than doubled since 2001 and at Census 2011 made up just under 2% of the population.

10.78 As with other Section 75 characteristics, it must be remembered that ethnicity does not provide a homogenous description of an individual's identity and

needs. Consideration of some of the common barriers to access healthcare and parity of care can assist in identifying potential impacts of the proposal.

10.79 The Race Equality Foundation's 2015 report on ethnicity and prehospital healthcare concluded that 3 related barriers exist at patient, provider and service level: cultural competency; language and communication; and, limited understanding of the healthcare system. Furthermore some ethnic minority groups experience higher risk and incidence of a number of illnesses that could be reflected in the use of pre-hospital emergency care.

Language

10.80 In terms of the Clinical Response Model and coding for prioritisation of dispatch and nature of dispatch, language is likely to be the most impactful of these 3 barriers. NIAS have a contract for telephone interpretation. Connecting the caller to an appropriate interpreter can introduce delay in the EMD understanding the circumstances of the call and assessing the clinical need and providing an appropriate response.

Year	Median by month
14/15	16
15/16	19
16/17	25
17/18	29
18/19 (to date)	31

Table 21 – average use of telephone interpretation service by month (NIAS data)

10.81 The number of languages requiring interpretation has increased each year, further reflecting the changing population. Polish, Lithuanian and Romanian have consistently been among the most frequent languages interpreted, with a need for Arabic interpreters becoming more frequent in the past two years. The telephone interpreter contract is a regional contract through the Department of Finance that covers the various government departments and bodies and includes a requirement for interpreters to be aware that they may be required to interpret emergency calls and to have some familiarity with medical terminology. This is to minimise the risk of misunderstanding of symptoms that could result in an inappropriate code/response.

10.82 As it may take time to connect an appropriate interpreter into an ongoing call, AMPDS incorporates codes for the EMD not understanding the caller's language and other communication difficulties. These codes indicate that the EMD does not have the full picture of the patient(s)' needs. Where a call cannot accurately be coded due to difficulty understanding the caller's language and connecting with an appropriate interpreter, there is a "Caller's language not understood" code that will trigger an immediate Category B response under the current model. The response can be adjusted as the call continues and the EMD elicits additional information, either through connection of an interpreter or bystander intervention. If no additional information can be obtained there is risk of an inappropriate response to the patient. This has potential to lead to preventable morbidity and mortality as described by Richardson et al.

10.83 Language barriers also exist when frontline clinical staff are on scene with a patient. NIAS provides a multilingual emergency phrase book to assist patients in communicating their medical needs to personnel on scene. If transporting to hospital or referring to an alternative care pathway the clinician can give advance notice of the need for an interpreter. NIAS is considering additional possible measures to reasonably improve the communicative capacity of staff in dealing with those facing language barriers, including those who need to use sign language.

Limited Understanding of the Healthcare System

10.84 The Health and Personal Social Services Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015 ensures that emergency care, including ambulance pre-hospital care is not chargeable under any circumstances. However, registering for primary care with a GP is subject to conditions of normal residency and impacts on non-emergency health care entitlement. Data held by NISRA shows 9245 non-UK nationals registered with GPs in NI.

10.85 This can lead to a small group of vulnerable people relying on emergency services. Either those who do not meet the requirements for free healthcare provision under the regulations and cannot afford the associated costs of

urgent and elective care; or, those who are unaware of the regulations and that they have entitlement. Studies that demonstrate socio-economic factors impacting access to healthcare, particularly for ethnic minority and immigrant populations, indicate an associated delay in seeking treatment. This could lead to patients from ethnic minorities presenting with higher acuity symptoms when calling 999. However, Szczepura (2005) makes it clear that ethnic differences in accessing healthcare cannot be reduced to purely socio-economic factors.

Health Outcomes

10.86 There are ethnic variations in a prevalence of a number of diseases, including higher rates of type 2 diabetes and coronary heart disease in people of South Asian heritage, for example. Race could potentially provide clinical indicators in the AMPDS process in a similar manner to age and gender. As the triage process is conducted by phone with no accurate knowledge of a patient's race this would be difficult to take into account and it would not be recommended that EMD's make assumptions based on language or name. In the emergency environment it would not be appropriate to question callers on the patient's ethnic identity, particularly 2nd or 3rd party callers. A caller may provide information about a pre-existing health condition. The impact of the pre-existing condition on emergent symptoms would either be taken into account through the AMPDS protocols or notified on dispatch to ensure the responding crew are aware of the wider medical picture and could account for it in clinical decision-making on scene. Some of these pre-existing conditions may be race specific, e.g. sickle cell anaemia.

Religious Belief/Community Background

HSCT	Catholic	Catholic %	Protestant and Other Christian	Protestant and Other Christian %	Other religions	Other religions %	None	None %
Belfast	151452	43.5%	164525	47.2%	5667	1.6%	26560	7.6%
Northern	155691	33.6%	276015	59.6%	3790	0.8%	27801	6.0%
South Eastern	107991	31.1%	207432	59.8%	3151	0.9%	28337	8.2%
Southern	202952	56.7%	140163	39.1%	2344	0.7%	12575	3.5%
Western	199299	67.7%	87582	29.7%	1640	0.6%	5896	2.0%
Northern Ireland	**817385**	**45.1%**	**875717**	**48.4%**	**16592**	**0.9%**	**101169**	**5.6%**

Table 22: Religion or Religion Brought up in by HSCT (NISRA Census 2011)

10.87 There is some regional variation in the composition of the population. The highest proportion of people from a Protestant background, are in the Northern and South Eastern HSC Trusts at 60%. In the Western HSC Trust, 68% of the population are from a Catholic background. Belfast and South Eastern HSC Trusts have the highest proportion of people from other religions or none at 9%. Some 149 religions are practised in Northern Ireland.

10.88 There is no evidence to indicate that there are health inequalities between people of the 2 predominant community backgrounds simply because of their religion or religious upbringing.

10.89 Analysis of the 20% Most Deprived Super Output Areas (NISRA, Multiple measures of deprivation) shows that 57% of these are predominantly populated by people from a Catholic background, 23% have a mixed population and 20% have a population predominantly from a Protestant background. Deprivation has been shown to produce health inequalities that could correlate to greater demand for ambulance services.

Political Opinion

	Nationalist	Unionist	Alliance	Others
Source ARK NI (2017 Westminster Election Results)	41.2%	46.6%	7.9%	4.2%
Source Lucid Talk (March 2018 telephone poll)	41%	46.2%	8%	4.8%

Table 23: Political Opinion held in Northern Ireland based on two sources.

10.90 Analysing the political opinion of the population as a whole is difficult due to lack of complete data sources. The question is not asked as part of the census questionnaire. The data available only allows analysis at Northern Ireland level and cannot be broken down by HSC Trusts or smaller statistical geographies.

10.91 Furthermore, both data sources have flaws. The results of the 2017 Westminster election is based on 65.4% voter turnout, it cannot be assumed that the political opinion of the remainder of the electorate would hold to similar proportions.

10.92 The Lucid Talk polling data is based on a small yet representative NI population sample (N=2079) responding to the question of party for first preference vote if an election were to be held tomorrow. It is reasonably consistent with the analysis of the most recent Westminster elections.

10.93 Both data sets exclude the views of younger people (no one under 18 at the time of the data collection was considered).

10.94 There is no evidence to indicate that political opinion impacts on health inequalities.

NIAS Staff Profile

Gender	Emergency Ambulance Control	Ambulance Operational
Male	48.9%	76.0%
Female	51.1%	24.0%

Community Background	Emergency Ambulance Control	Ambulance Operational
Protestant / Perceived Protestant	46.6%	52.6%
Roman Catholic / Perceived Roman Catholic	40.9%	40.9%
Neither / Perceived Neither	4.5%	4.0%
(blank)	8.0%	2.5%

Political Opinion	Emergency Ambulance Control	Ambulance Operational
Broadly Nationalist	12.5%	10.2%
Broadly Unionist	9.1%	11.9%
I do not wish to answer	35.2%	28.3%
Other	18.2%	16.2%
(blank)	25.0%	33.4%

Age Range	Emergency Ambulance Control	Ambulance Operational
20-29	13.6%	6.2%
30-39	27.3%	17.7%
40-49	30.7%	44.3%
50-59	25.0%	27.2%
60-69	3.4%	4.6%

Marital Status Key	Emergency Ambulance Control	Ambulance Operational
Mar/CP	43.2%	55.9%
Single	46.6%	40.7%
Other	10.2%	3.3%

Disability Status	Emergency Ambulance Control	Ambulance Operational
Yes	4.5%	2.3%
No	85.2%	80.2%
(blank)	10.2%	17.4%

Ethnicity	Emergency Ambulance Control	Ambulance Operational
Filipino		0.1%
Mixed Ethnic Group	1.1%	0.4%
Other		0.1%
White	88.6%	83.7%
(blank)	10.2%	15.6%

Sexual Orientation - Towards	Emergency Ambulance Control	Ambulance Operational
I do not wish to answer	3.4%	4.0%
Opposite sex	67.0%	60.6%
Same sex	4.5%	1.9%
(blank)	25.0%	33.4%

Caring Responsibilities	Emergency Ambulance Control	Ambulance Operational
Yes*	31.8%	37.3%
No	31.8%	24.7%
(blank)	36.4%	38.0%

* Caring for a Child/Children / Dependant / Older Person / Person with a Disability

Table 24: NIAS staff composition by S75 categories (June 2018)

10.95 Impact on staff can only be fully assessed as detailed project proposals are devised and as accurate data becomes available in relation to the detail of those proposals. This is why a revised modelling exercise is important. In addition to constructive engagement through existing mechanisms with staff

side and detailed communication with those potentially affected, NIAS is also committed to the continuous monitoring and evaluation of all potential equality impacts upon staff, including equality screening/assessment as appropriate in line with the Trust's s.75 equality duties. NIAS is also committed to creating a standing forum of stakeholders that will meet regularly (including staff side) and that will have an ongoing and meaningful engagement function in relation to the overall CRM programme and its various implementation projects, in order to build upon the positive engagement process evidenced during the consultation.

Chief Complaints/Symptoms analysis

Datasets used:

- Cat A Emergency and Urgent calls 2017/2018
- Cat A with response to scene of incident 2017/2018
- The Data Protection Impact Assessment for the EQIA covers this appendix.

10.96 The purpose of this analysis is not to suggest that codes be retained in the highest priority category based on frequency of allocation. Rather it is intended to ensure that clinical decision-makers have an awareness of the characteristics of patients in these coding groups. If required the analysis can be extended to the individual dispatch codes rather than the Chief Complaint/Symptom group.

Most Frequent Chief Complaints/Symptoms

10.97 In 2017/2018 63,319 emergency and urgent calls were given a Cat A coding, 28.8% of all emergency and urgent calls. A response was provided to 58,655 Category A incidents, 29.1% of responses, in the same period.

10.98 Six chief complaints accounted for c. three quarters of all incidents given a coding in Category A under the current system. Non-traumatic chest pain is the most frequent, closely followed by breathing problems. Healthcare Professional (HCP) Admissions account for the 3rd most frequent, likely due to emergency transfers between hospitals to access specialists services.

10.99 Combined, these most frequent symptoms comprise 21% of all emergency and urgent call volume and 22.5% of emergency and urgent calls with a response to the scene.

Chief Complaint/Symptoms	Cat A Calls	% of Cat A Calls	Cat A Calls with response	% of Cat A calls with response
CHEST PAIN (Non-Traumatic)	12248	19.34%	12084	20.60%
BREATHING PROBLEMS	10383	16.40%	10247	17.47%
HCP ADMISSION	8579	13.55%	8458	14.42%
UNCONSCIOUS / FAINTING (Near)	7425	11.73%	7041	12.00%
CONVULSIONS / FITTING	4455	7.04%	4295	7.32%
FALLS	3484	5.50%	3279	5.59%
Total	46574	73.55%	45404	77.41%

Table 25: Most frequent chief complaints/symptoms 2017/2018

Most Frequent Chief Complaints/Symptoms – Gender

10.100 Gender is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the gender of the patient recorded. The same Chief Complaint/Symptoms groups have the same highest incidence as with the patient population as a whole.

10.101 The chart below shows all the chief complaint/symptom groups allocated by gender. Complaints that had an incidence of less than 0.1% of the total calls for each gender were grouped together[7].

[7] A chief complaint/symptom not listed specifically for one gender does not mean that there was no incidence, it only indicates that the incidence was less than 1% of all incidents for the gender. The only chief complaints that were gender specific were a small number relating to Pregnancy, childbirth and miscarriage and one incident relating to an eye injury.

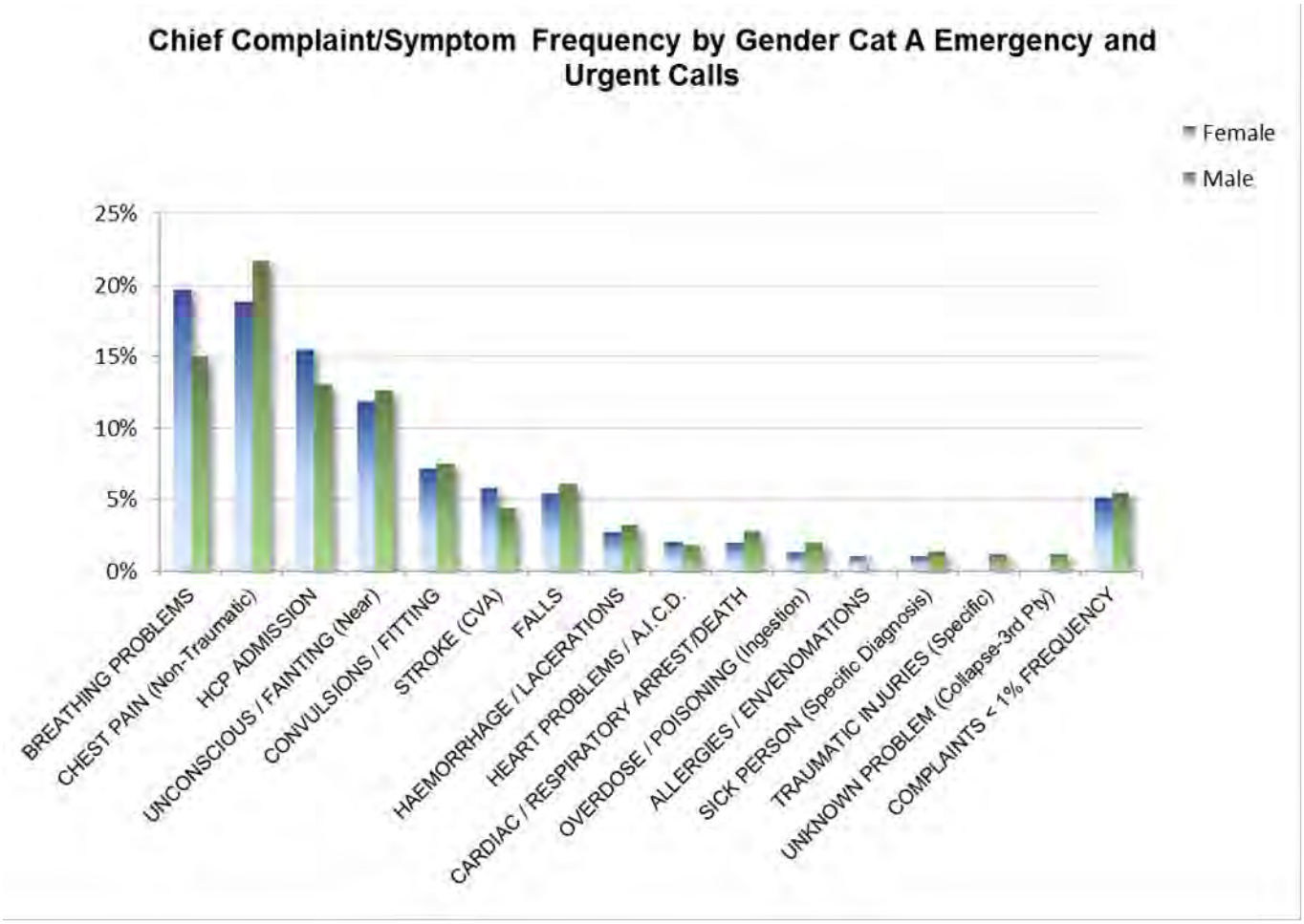


Figure 13: Frequency of Chief Complaint Group by gender. Emergency and Urgent Calls 2017/2018

10.102 As with all Cat A calls, the same 6 groups show the highest frequency for each gender. 79% of all Cat A calls for female patients and 76% of all Cat A calls for male patients. The most frequent complaint group for male patients is non-traumatic chest pain, followed by breathing problems. The order is slightly different for female patients with Breathing Problems being highest frequency and non-traumatic chest pain second. The order of frequency remains the same for both genders in the other 4 groups. Men are almost 20% more likely than women to present with non-traumatic chest pain (OR 1.19). Women are c. 40% more likely to present with Breathing Problems than men (OR 1.39).

	Cat A Calls where gender is recorded (n=60034)						Cat A calls with response where gender is recorded (n=58037)					
Complaint/Symptoms	Female	% Female	Male	% Male	Total	% Total	Female	% Female	Male	% Male	Total	% Total
CHEST PAIN (Non-Traumatic)	5454	18.9%	6780	21.8%	12234	20.4%	5379	19.2%	6692	22.3%	12071	20.8%
BREATHING PROBLEMS	5695	19.7%	4678	15.0%	10373	17.3%	5631	20.1%	4607	15.4%	10238	17.6%
HCP ADMISSION	4480	15.5%	4084	13.1%	8564	14.3%	4426	15.8%	4019	13.4%	8445	14.6%
UNCONSCIOUS / FAINTING (Near)	3429	11.9%	3944	12.7%	7373	12.3%	3285	11.7%	3706	12.4%	6991	12.0%
CONVULSIONS / FITTING	2084	7.2%	2360	7.6%	4444	7.4%	2010	7.2%	2274	7.6%	4284	7.4%
FALLS	1561	5.4%	1913	6.1%	3474	5.8%	1487	5.3%	1783	5.9%	3270	5.6%
TOTAL	**22703**	**78.6%**	**23759**	**76.2%**	**46462**	**77.4%**	**22218**	**79.2%**	**23081**	**77.0%**	**45299**	**78.1%**

Table 26: Most frequent chief complaints/symptoms by gender 2017/2018

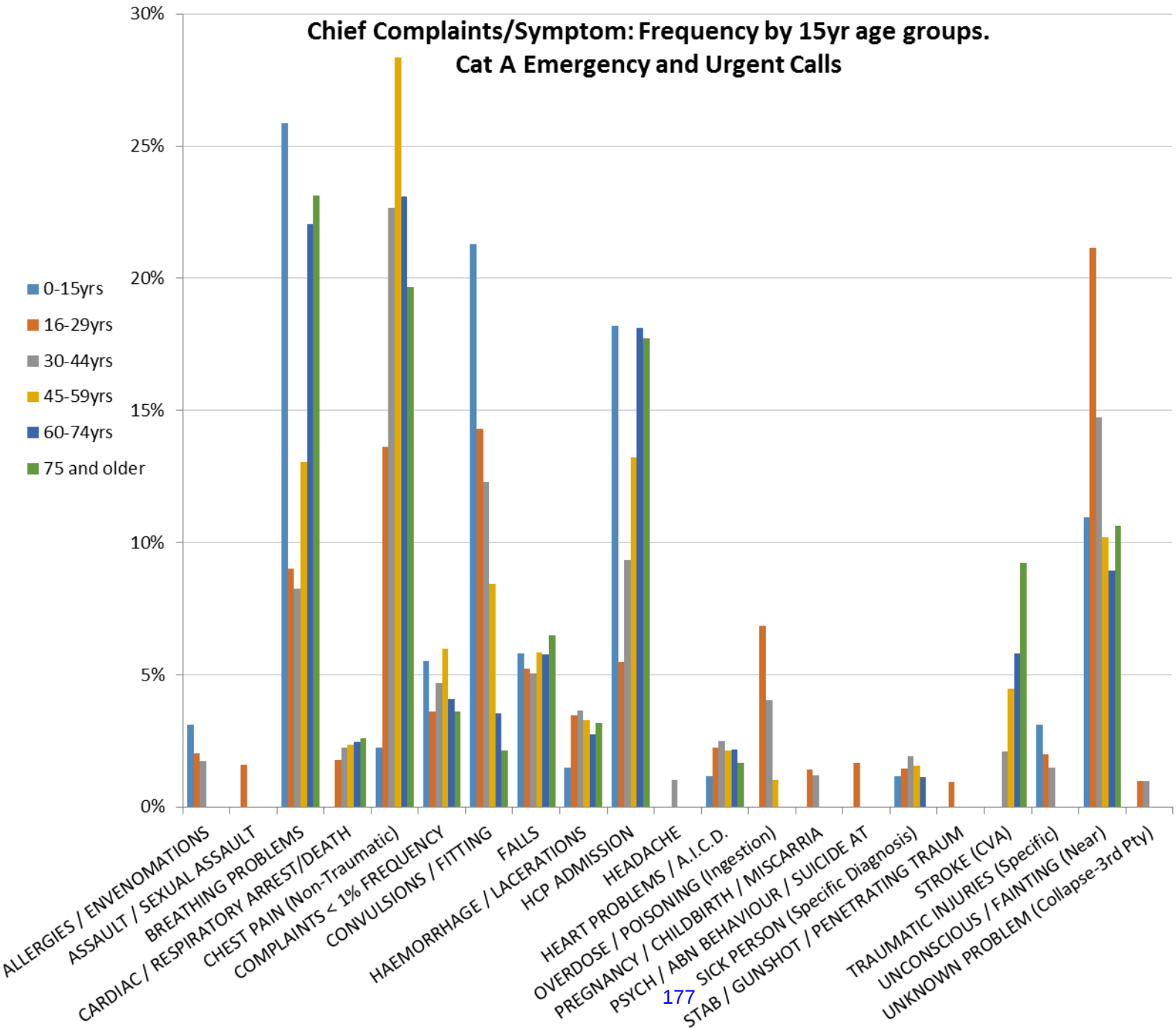
Most Frequent Chief Complaints/Symptoms – Age Group

10.103 Age is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the age of the patient recorded. It should also be noted that 2nd and 3rd party callers may provide an estimate of age to EMDs if the exact age of the patient isn't known, although this may be corrected on the Patient Record Form (PRF) on attendance at the scene of the incident.

10.104 The chart on page 81 shows all the chief complaint/symptom groups allocated by 15 year age groups. Complaints that had an incidence of less than 0.1% of the total calls for each gender were grouped together.[8]

10.105 Chest pain, breathing problems, HCP Admission and Unconsciousness/Fainting are the most frequent chief complaint groups in calls and incidents where age is known. Frequency of each of these varies greatly across different age groups. Table 27 shows the most frequent of chief complaints in each age group.

[8] A chief complaint/symptom not listed specifically for one age group does not mean that there was no incidence, it only indicates that the incidence was less than 1% of all incidents for that age group.


Chief Complaints/Symptom: Frequency by 15yr age groups.
Cat A Emergency and Urgent Calls
30%
25%
20%
15%
10%
5%
0%
0-15yrs
16-29yrs
30-44yrs
45-59yrs
60-74yrs
75 and older
ALLERGIES / ENVENOMATIONS
ASSAULT / SEXUAL ASSAULT
BREATHING PROBLEMS
CARDIAC / RESPIRATORY ARREST/DEATH
CHEST PAIN (Non-Traumatic)
COMPLAINTS < 1% FREQUENCY
CONVULSIONS / FITTING
FALLS
HAEMORRHAGE / LACERATIONS
HCP ADMISSION
HEADACHE
HEART PROBLEMS / A.I.C.D.
OVERDOSE / POISONING (Ingestion)
PREGNANCY / CHILDBIRTH / MISCARRIA
PSYCH / ABN BEHAVIOUR / SUICIDE AT
SICK PERSON (Specific Diagnosis)
STAB / GUNSHOT / PENETRATING TRAUM
STROKE (CVA)
TRAUMATIC INJURIES (Specific)
UNCONSCIOUS / FAINTING (Near)
UNKNOWN PROBLEM (Collapse-3rd Pty)

Chief Complaint/Symptom	Cat A Calls: age recorded (n=58574)		Cat A Calls with response: age recorded (n=56700)	
0-15 years				
BREATHING PROBLEMS	25.8%	838	26.1%	815
CONVULSIONS / FITTING	21.3%	690	21.7%	677
HCP ADMISSION	18.2%	590	18.6%	580
UNCONSCIOUS / FAINTING (Near)	11.0%	355	10.9%	341
TOTAL 0-15 YEARS	100.0%	3242	100.0%	3121
16-29 years				
UNCONSCIOUS / FAINTING (Near)	21.1%	1456	21.1%	905
CONVULSIONS / FITTING	14.3%	985	14.7%	935
CHEST PAIN (Non-Traumatic)	13.6%	938	14.3%	1340
TOTAL 16-29 YEARS	100.0%	6890	100.0%	6348
30-44 years				
CHEST PAIN (Non-Traumatic)	22.7%	1695	23.3%	1663
UNCONSCIOUS / FAINTING (Near)	14.7%	1101	14.2%	1016
CONVULSIONS / FITTING	12.3%	918	12.4%	882
TOTAL 30-44 YEARS	100.0%	7476	100.0%	7136
45-59 years				
CHEST PAIN (Non-Traumatic)	28.3%	3104	28.9%	3050
HCP ADMISSION	13.2%	1448	13.5%	1423
BREATHING PROBLEMS	13.1%	1431	13.3%	1409
UNCONSCIOUS / FAINTING (Near)	10.2%	1119	10.0%	1060
TOTAL 45-59 YEARS	100.0%	10953	100.0%	10564
60-74 years				
CHEST PAIN (Non-Traumatic)	23.1%	2952	23.3%	2924
BREATHING PROBLEMS	22.1%	2820	22.3%	2790
HCP ADMISSION	18.1%	2316	18.3%	2292
TOTAL 60-74 YEARS	100.0%	12783	100.0%	12534
75 and older				
BREATHING PROBLEMS	23.1%	3982	23.3%	3961
CHEST PAIN (Non-Traumatic)	19.7%	3387	19.9%	3375
HCP ADMISSION	17.7%	3052	17.8%	3021
UNCONSCIOUS / FAINTING (Near)	10.6%	1831	10.6%	1797
TOTAL 75 AND OLDER	100.0%	17230	100.0%	16997
ALL AGES				
CHEST PAIN (Non-Traumatic)	20.7%	12149	21.1%	11988
BREATHING PROBLEMS	17.6%	10310	17.9%	10174
HCP ADMISSION	14.5%	8483	14.8%	8369
UNCONSCIOUS / FAINTING (Near)	12.0%	7004	11.8%	6661
TOTAL ALL AGES	100%	58754	100.0%	56700

Table 27: Most frequent (incidence >10%) chief complaints/symptoms by age group 2017/2018

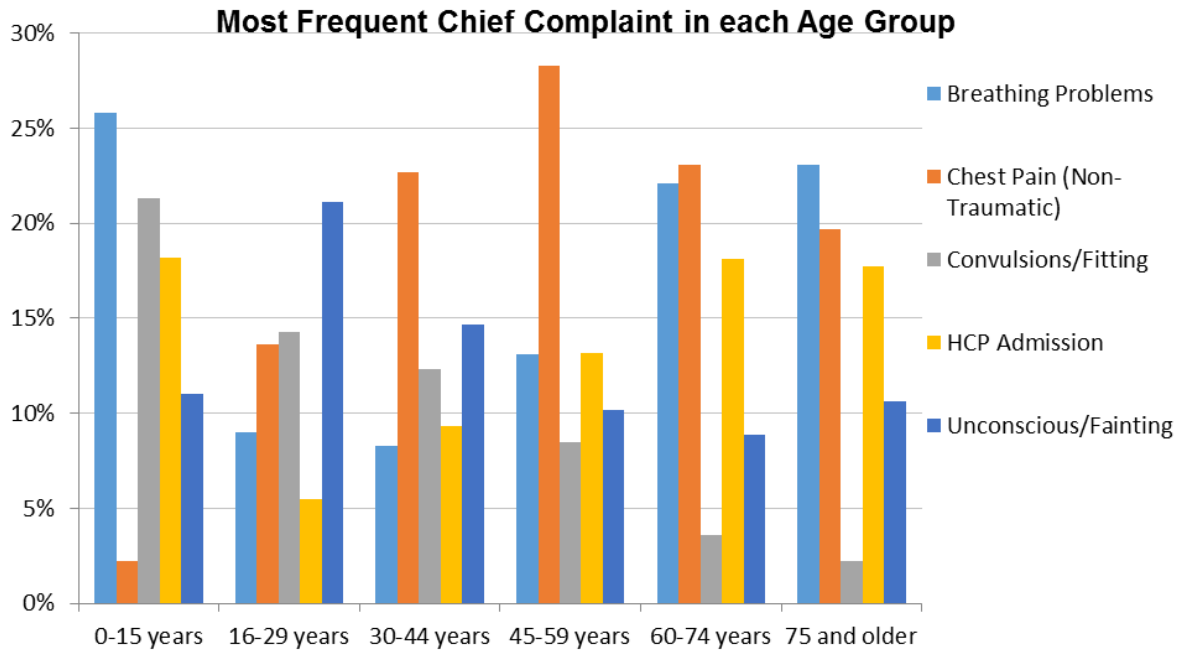


Figure 15: Most frequent Chief Complaints in each age group (Cat A Emergency and Urgent Calls 2017/2018)

10.106 The very young and the very old show the highest incidences of breathing problems and HCP admissions.

10.107 Chest pain shows highest incidence in 30-59 year olds and has very low incidence in under-16s.

10.108 Convulsions/Fitting has high incidence in under-30s, gradually reducing in the older age groups.

10.109 Unconsciousness/Fainting shows a spike in incidence in the 16-29 age group but remains consistently between 8% and 14% in the other age groups.

10.110 Included in the original consultation and draft EQIA were figures relating to age groups of services users in 2017/18 (reshown below). Data was presented with regard to all calls and Category A calls with response to the scene of the incident. The focus was on these calls as these would be subject to re-prioritisation under the proposed model.

10.111 In response to comments from respondents to the consultation NIAS hereunder presents additional data on other call categories.

10.112 Until despatch codes are realigned from the current categories to the new categories it will not be possible to model any changes in age and gender profiles of services users across the new categories.

10.113 56% of emergency and urgent calls to NIAS are currently for patients aged 60 or over.[9] This is slightly lower than the academic research would suggest but correlates to only 20% of the population.

All Calls

HCST	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Total
Belfast HSCT	2082	7660	7258	8612	9535	16864	52011
Northern HSCT	2397	5139	5099	7622	9844	19294	49395
South Eastern HSCT	1769	3940	3904	5355	7792	15097	37857
Southern HSCT	1901	3691	4027	5715	6844	12311	34489
Western HSCT	1674	3749	4245	5453	6550	9808	31479
Total	**9823**	**24179**	**24533**	**32757**	**40565**	**73374**	**205231**

Table 28: Number of emergency and urgent calls by age group and HSCT (2017/2018)

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	4.00%	14.73%	13.95%	16.56%	18.33%	32.42%
Northern HSCT	4.85%	10.40%	10.32%	15.43%	19.93%	39.06%
South Eastern HSCT	4.67%	10.41%	10.31%	14.15%	20.58%	39.88%
Southern HSCT	5.51%	10.70%	11.68%	16.57%	19.84%	35.70%
Western HSCT	5.32%	11.91%	13.49%	17.32%	20.81%	31.16%
Northern Ireland	**4.79%**	**11.78%**	**11.95%**	**15.96%**	**19.77%**	**35.75%**

Table 29: percentage of emergency and urgent calls by age group and HSCT (2017/2018)

Category A

10.114 The age of people who received a Cat A response in 2017/2018 shows a slightly different profile to the overall volume of emergency and urgent calls. There is a slightly higher incidence in the age group 30-59 years, but people aged over 60 still account for 52% of these calls.

[9] This is based on 205231 calls where age is recorded. Some calls where age is recorded are based on estimates of the patient's age and may not be accurate.

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Grand Total
Belfast HSCT	627	2232	2219	2728	2740	3643	14189
Northern HSCT	756	1219	1408	2355	3067	4218	13023
South Eastern HSCT	626	1031	1209	1800	2404	3616	10686
Southern HSCT	561	915	1165	1917	2182	3042	9782
Western HSCT	551	951	1135	1764	2141	2478	9020
Northern Ireland	**3121**	**6348**	**7136**	**10564**	**12534**	**16997**	**56700**

Table 30: Category A calls with a response to the scene of an incident by age (2017/2018)

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	4.42%	15.73%	15.64%	19.23%	19.31%	25.67%
Northern HSCT	5.81%	9.36%	10.81%	18.08%	23.55%	32.39%
South Eastern HSCT	5.86%	9.65%	11.31%	16.84%	22.50%	33.84%
Southern HSCT	5.74%	9.35%	11.91%	19.60%	22.31%	31.10%
Western HSCT	6.11%	10.54%	12.58%	19.56%	23.74%	27.47%
Northern Ireland	**5.50%**	**11.20%**	**12.59%**	**18.63%**	**22.11%**	**29.98%**

Table 31: percentage of Category A calls with a response to the scene of an incident by age (2017/2018)

Category B

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Total
Belfast HSCT	1009	3497	3171	3347	3431	5725	20180
Northern HSCT	1192	2688	2531	3350	3691	6834	20286
South Eastern HSCT	858	2004	1852	2217	3053	5689	15673
Southern HSCT	997	1979	1959	2457	2757	4818	14967
Western HSCT	828	1956	2175	2392	2716	4019	14086
Northern Ireland	**4884**	**12124**	**11688**	**13763**	**15648**	**27085**	**85192**

Table 32: Category B calls with a response to the scene of an incident by age and HSCT (NIAS 2017/2018)

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	5.00%	17.33%	15.71%	16.59%	17.00%	28.37%
Northern HSCT	5.88%	13.25%	12.48%	16.51%	18.19%	33.69%
South Eastern HSCT	5.47%	12.79%	11.82%	14.15%	19.48%	36.30%
Southern HSCT	6.66%	13.22%	13.09%	16.42%	18.42%	32.19%
Western HSCT	5.88%	13.89%	15.44%	16.98%	19.28%	28.53%
Northern Ireland	**5.73%**	**14.23%**	**13.72%**	**16.16%**	**18.37%**	**31.79%**

Table 33: percentage of Category B calls with a response to the scene of an incident by age and HSCT (NIAS 2017/2018)

Category C

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Total
Belfast HSCT	125	418	412	481	508	941	2885
Northern HSCT	162	342	336	431	520	1033	2824
South Eastern HSCT	118	243	240	327	565	1054	2547
Southern HSCT	138	256	321	396	436	812	2359
Western HSCT	131	263	328	385	448	697	2252
Northern Ireland	**674**	**1522**	**1637**	**2020**	**2477**	**4537**	**12867**

Table 34: Category C calls with a response to the scene of an incident by age and HSCT (NIAS 2017/2018**)**

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	4.33%	14.49%	14.28%	16.67%	17.61%	32.62%
Northern HSCT	5.74%	12.11%	11.90%	15.26%	18.41%	36.58%
South Eastern HSCT	4.63%	9.54%	9.42%	12.84%	22.18%	41.38%
Southern HSCT	5.85%	10.85%	13.61%	16.79%	18.48%	34.42%
Western HSCT	5.82%	11.68%	14.56%	17.10%	19.89%	30.95%
Northern Ireland	**5.24%**	**11.83%**	**12.72%**	**15.70%**	**19.25%**	**35.26%**

Table 35: percentage of Category C calls with a response to the scene of an incident by age and HSCT (NIAS 2017/2018)

Category C HCP

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older	Total
Belfast HSCT	98	373	584	1293	2298	5752	10398
Northern HSCT	116	250	417	1009	2217	6621	10630
South Eastern HSCT	29	164	263	632	1378	4177	6643
Southern HSCT	89	150	275	612	1164	3238	5528
Western HSCT	59	252	354	641	1032	2373	4711
Northern Ireland	**391**	**1189**	**1893**	**4187**	**8089**	**22161**	**37910**

Table 36: Category C HCP calls with a response to the scene of an incident by age and HSCT (NIAS 2017/2018)

HSCT	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
Belfast HSCT	0.94%	3.59%	5.62%	12.44%	22.10%	55.32%
Northern HSCT	1.09%	2.35%	3.92%	9.49%	20.86%	62.29%
South Eastern HSCT	0.44%	2.47%	3.96%	9.51%	20.74%	62.88%
Southern HSCT	1.61%	2.71%	4.97%	11.07%	21.06%	58.57%
Western HSCT	1.25%	5.35%	7.51%	13.61%	21.91%	50.37%
Nothern Ireland	**1.03%**	**3.14%**	**4.99%**	**11.04%**	**21.34%**	**58.46%**

Table 37: percentage of Category C HCP calls with a response to the scene of an incident by age and HSCT (NIAS 2017/2018)

10.115 As with overall demand, the majority of calls in each category are in response to patients aged over 60. This is most stark in the Cat C HCP category in comparison to the all calls data with 79.8% of the patients receiving a response in this category being over 60.

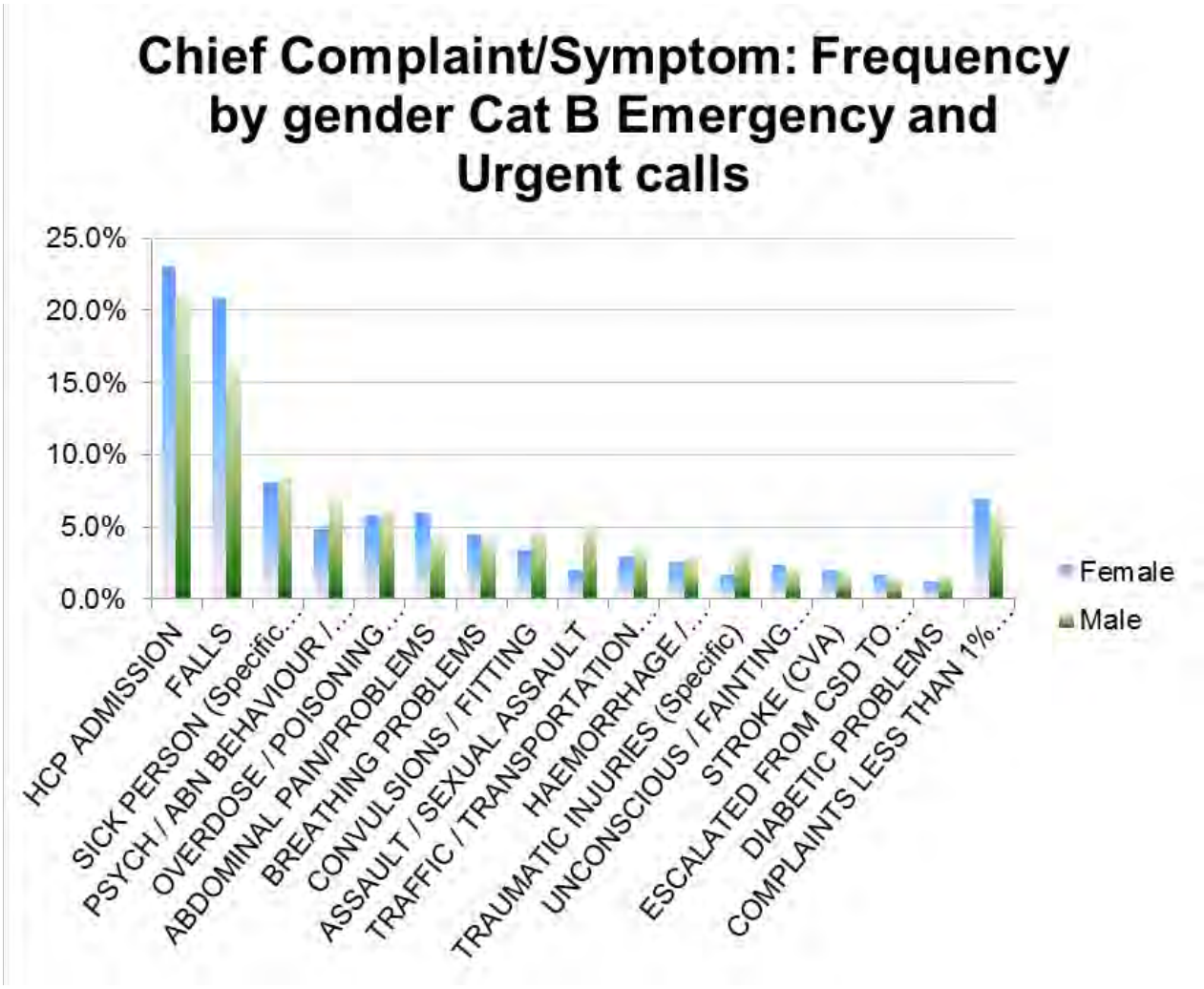


Figure 16: Frequency of Chief Complaint Group by gender. Cat B calls NIAS 2017/2018

10.116 The same three chief complaints have the highest incidence for both genders with approximately 50:50 distribution between male and female patients in each chief complaint.

	Cat B calls where gender is recorded (n=94,135)						Cat B calls with response where gender is recorded (n=88,858)					
Complaint/Symptoms	Female	% Female	Male	% Male	Total	% Total	Female	% Female	Male	% Male	Total	% Total
HCP ADMISSION	10845	23.0%	9882	21.0%	20727	22.0%	10739	23.9%	9788	22.3%	20527	23.1%
FALLS	9842	20.9%	7619	16.2%	17461	18.5%	9521	21.2%	7184	16.3%	16705	18.8%
SICK PERSON (Specific Diagnosis)	3794	8.0%	3970	8.4%	7764	8.2%	3583	8.0%	3711	8.4%	7294	8.2%
ABDOMINAL PAIN/PROBLEMS	2834	6.0%	2071	4.4%	4905	5.2%	2723	6.1%	1975	4.5%	4698	5.3%
OVERDOSE / POISONING (Ingestion)	2711	5.8%	2850	6.1%	5561	5.9%	2412	5.4%	2530	5.8%	4942	5.6%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	2295	4.9%	3315	7.1%	5610	6.0%	2002	4.5%	2865	6.5%	4867	5.5%
Total for 6 most frequent complaints/symptoms	32321	68.6%	29707	63.2%	62028	65.9%	30980	69.0%	28053	63.8%	59033	66.4%

Table 38: Category B most frequent chief complaints/symptoms by gender NIAS 2017/2018

Category B - Most Frequent Chief Complaints/Symptoms– Age Group

10.117 Age is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the age of the patient recorded. It should also be noted that 2nd and 3rd party callers may provide an estimate of age to EMDs if the exact age of the patient isn't known, although this may be corrected on the Patient Record Form (PRF) on attendance at the scene of the incident.

10.118 The graph on the following page shows all the Cat B chief complaint/symptom groups allocated by 15 year age groups. Complaints that had an incidence of less than 1% of the total calls for each age group were grouped together. Table 40 shows the top four chief complaints/symptoms by each age group.

Chief Complaints/Symptoms analysis

10.119 Incidence of Chief Complaints by age in Category A calls has been analysed earlier in this document. Further to examining the potential impact of CRM, particularly on older people, additional analysis has been conducted with regard to chief complaints/symptoms in the other categories and with particular reference to older people.

Datasets used:

- Cat B, Cat C & Cat C HCP Emergency and Urgent calls 2017/2018
- Cat B, Cat C & Cat C HCP with response to scene of incident 2017/2018

Most Frequent Chief Complaints/Symptoms – Category B

10.120 In 2017/2018, 99,206 emergency and urgent calls were given a Cat B coding, 49% of all emergency and urgent calls. A response was provided to 91,376 Category B incidents, 45% of responses, in the same period.

10.121 Six chief complaints accounted for over 60% of all incidents given a Category B response code under the current system. Healthcare Professional (HCP) Admissions comprised the most frequent incident type in Cat B, followed by falls and sick person (specific diagnosis).

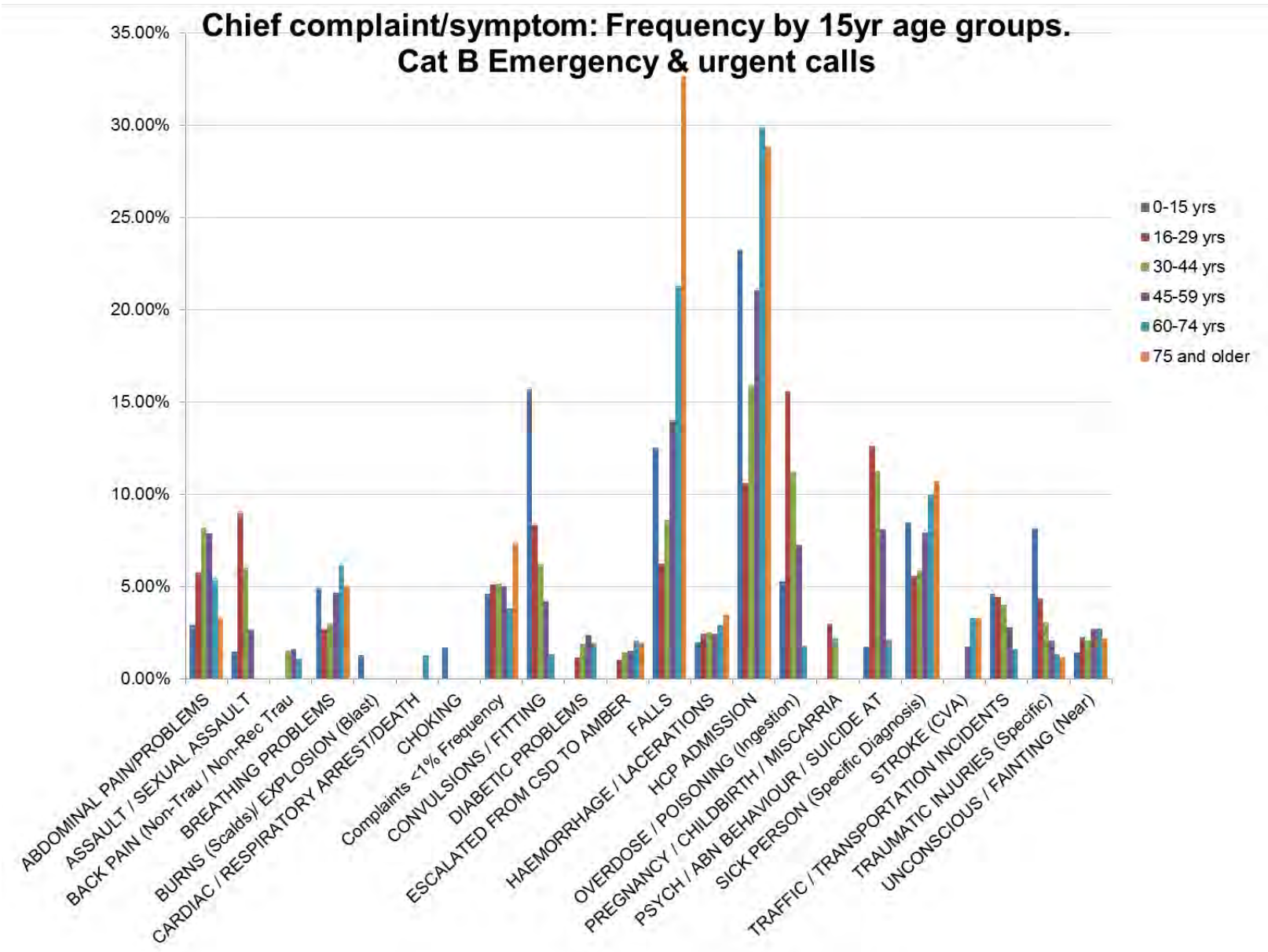
CHIEF COMPLAINT/SYMPTOM	Cat B Calls	% of Cat B calls	Cat B calls with response	% of Cat B Calls with response
HCP ADMISSION	20764	20.9%	20563	22.5%
FALLS	17521	17.7%	16762	18.3%
SICK PERSON (Specific Diagnosis)	7787	7.8%	7316	8.0%
OVERDOSE / POISONING (Ingestion)	5614	5.7%	4987	5.5%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	5628	5.7%	4884	5.3%
ABDOMINAL PAIN/PROBLEMS	4909	4.9%	4702	5.1%
TOTAL	62223	62.7%	59214	64.8%

Table 39: Most frequent chief complaints/symptoms assigned as Category B, NIAS 2017/2018

10.122 Gender is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the gender of the patient recorded. The same Chief Complaint/Symptoms groups have the same highest incidence as with the Cat B patient population as a whole.

10.123 The chart below shows all the chief complaint/symptom groups allocated by gender. Complaints that had an incidence of less than 1% of the total calls for each gender were grouped together[10].

[10] A chief complaint/symptom not listed specifically for one gender does not mean that there was no incidence, it only indicates that the incidence was less than 1% of all incidents for the gender. The only chief complaints that were gender specific were a small number relating to Pregnancy, childbirth and miscarriage and one incident relating to electrocution.


Chief complaint/symptom: Frequency by 15yr age groups.
Cat B Emergency & urgent calls
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
0-15 yrs
16-29 yrs
30-44 yrs
45-59 yrs
60-74 yrs
75 and older
ABDOMINAL PAIN/PROBLEMS
ASSAULT / SEXUAL ASSAULT
BACK PAIN (Non-Trau / Non-Rec Trau
BREATHING PROBLEMS
BURNS (Scalds)/ EXPLOSION (Blast)
CARDIAC / RESPIRATORY ARREST/DEATH
CHOKING
Complaints <1% Frequency
CONVULSIONS / FITTING
DIABETIC PROBLEMS
ESCALATED FROM CSD TO AMBER
FALLS
HAEMORRHAGE / LACERATIONS
HCP ADMISSION
OVERDOSE / POISONING (Ingestion)
PREGNANCY / CHILDBIRTH / MISCARRIA
PSYCH / ABN BEHAVIOUR / SUICIDE AT
SICK PERSON (Specific Diagnosis)
STROKE (CVA)
TRAFFIC / TRANSPORTATION INCIDENTS
TRAUMATIC INJURIES (Specific)
UNCONSCIOUS / FAINTING (Near)

Chief Complaint/Symptom	Cat B calls: age recorded (n=89922)		Cat B calls with response: age recorded (n=85192)	
0-15 yrs				
HCP ADMISSION	1207	23.27%	1190	24.37%
CONVULSIONS / FITTING	815	15.71%	774	15.85%
FALLS	649	12.51%	610	12.49%
SICK PERSON (Specific Diagnosis)	439	8.46%	407	8.33%
TOTAL 0-15 yrs	5187	100.00%	4884	100.00%
16-29 yrs				
OVERDOSE / POISONING (Ingestion)	2130	15.57%	1871	15.43%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	1723	12.60%	1464	12.08%
HCP ADMISSION	1452	10.61%	1425	11.75%
ASSAULT / SEXUAL ASSAULT	1225	8.96%	962	7.93%
TOTAL 16-29 yrs	13679	100.00%	12124	100.00%
30-44 yrs				
HCP ADMISSION	2018	15.88%	1986	16.99%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	1431	11.26%	1250	10.69%
OVERDOSE / POISONING (Ingestion)	1422	11.19%	1273	10.89%
FALLS	1093	8.60%	997	8.53%
TOTAL 30-44 yrs	12705	100.00%	11688	100.00%
45-59 yrs				
HCP ADMISSION	3087	21.07%	3040	22.09%
FALLS	2056	14.03%	1889	13.73%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	1188	8.11%	1055	7.67%
SICK PERSON (Specific Diagnosis)	1161	7.92%	1078	7.83%
TOTAL 45-59 yrs	14653	100.00%	13763	100.00%
60-74 yrs				
HCP ADMISSION	4820	29.88%	4784	30.57%
FALLS	3437	21.30%	3312	21.17%
SICK PERSON (Specific Diagnosis)	1612	9.99%	1540	9.84%
BREATHING PROBLEMS	990	6.14%	970	6.20%
TOTAL 60-74 yrs	16133	100.00%	15648	100.00%
75 and older				
FALLS	9006	32.67%	8844	32.65%
HCP ADMISSION	7956	28.86%	7918	29.23%
SICK PERSON (Specific Diagnosis)	2947	10.69%	2878	10.63%
BREATHING PROBLEMS	1378	5.00%	1349	4.98%
TOTAL 75 AND OLDER	27565	100.00%	27085	100.00%
ALL AGES				
HCP ADMISSION	20540	22.84%	20343	23.88%
FALLS	17094	19.01%	16393	19.24%
SICK PERSON (Specific Diagnosis)	7665	8.52%	7213	8.47%
OVERDOSE / POISONING (Ingestion)	5237	5.82%	4670	5.48%
TOTAL ALL AGES	89922	100.00%	85192	100.00%

Table 40: most frequent chief/complaints/symptoms in each age group in Category B emergency and urgent calls 2017/18

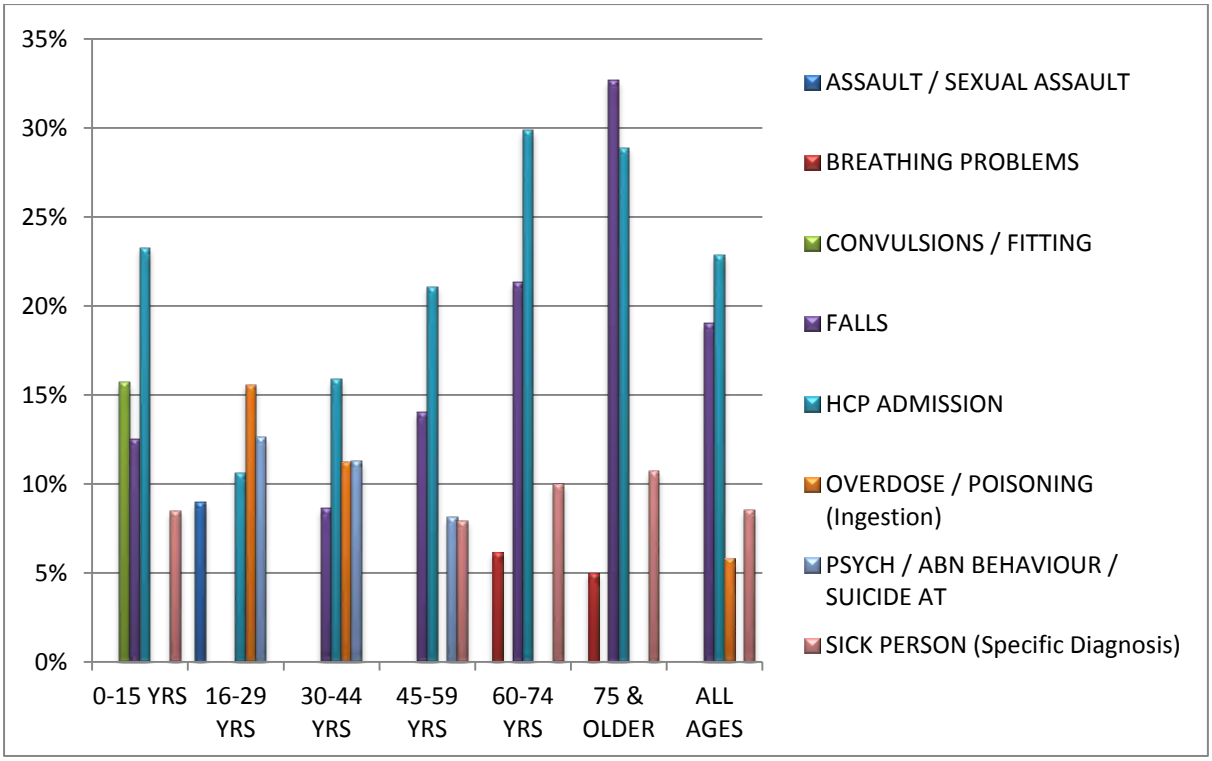


Figure 18: most frequent chief/complaints/symptoms in each age group in Category B emergency and urgent calls 2017/18

10.124 Across all age groups in Category B, HCP Admissions and Falls are the most frequent incidence of chief complaint/symptoms. Together they constitute c.42% of all category B calls and 43% of all category B calls with a response.

10.125 The only age group that does not feature Falls in the top 4 most frequent chief complaints/symptoms is the 16-29 year olds. Except for the youngest patients, the frequency of Falls and HCP Admission increases as age group increases.

10.126 There are fewer conditions with very high rates of frequency within category B than Category A. It would be expected, under the new model for the volume of calls in Category 2 to be much higher than Category B in the new model.

Most Frequent Chief Complaints/Symptoms – Category C

10.127 In 2017/2018, 16,688 emergency and urgent calls were given a Cat C coding, 7.6% of all emergency and urgent calls. A response was provided to 13,608 Category C incidents, 6.6% of calls with response, in the same period. Category C has the lowest volume of calls allocated.

10.128 Two chief complaints/symptoms accounted for almost 60% of all incidents given a Category C code: Sick Person (specific diagnosis) and Falls. All other

chief complaints/symptoms are between 0.01% and c. 6% prevalence within Cat C.

Chief Complaint/Symptom	All Cat C Emergency & Urgent Calls		Car C Emergency & Urgent Calls with response	
SICK PERSON (Specific Diagnosis)	6078	36.42%	4655	34.98%
FALLS	3751	22.48%	3406	25.59%
UNCONSCIOUS / FAINTING (Near)	1043	6.25%	724	5.44%
TRAUMATIC INJURIES (Specific)	1029	6.17%	788	5.92%
BACK PAIN (Non-Trau / Non-Rec Trau	904	5.42%	733	5.51%
ABDOMINAL PAIN/PROBLEMS	808	4.84%	625	4.70%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	791	4.74%	618	4.64%
	14404	**86.3%**	**11549**	**86.8%**

Table 41: Most frequent chief complaints/symptoms assigned as Category C, NIAS 2017/2018

10.129 Gender is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the gender of the patient recorded. The same Chief Complaint/Symptoms groups have the same highest incidence as with the Cat C patient population as a whole.

10.130 The chart below shows all the chief complaint/symptom groups allocated by gender. Complaints that had an incidence of less than 1% of the total calls for each gender were grouped together.

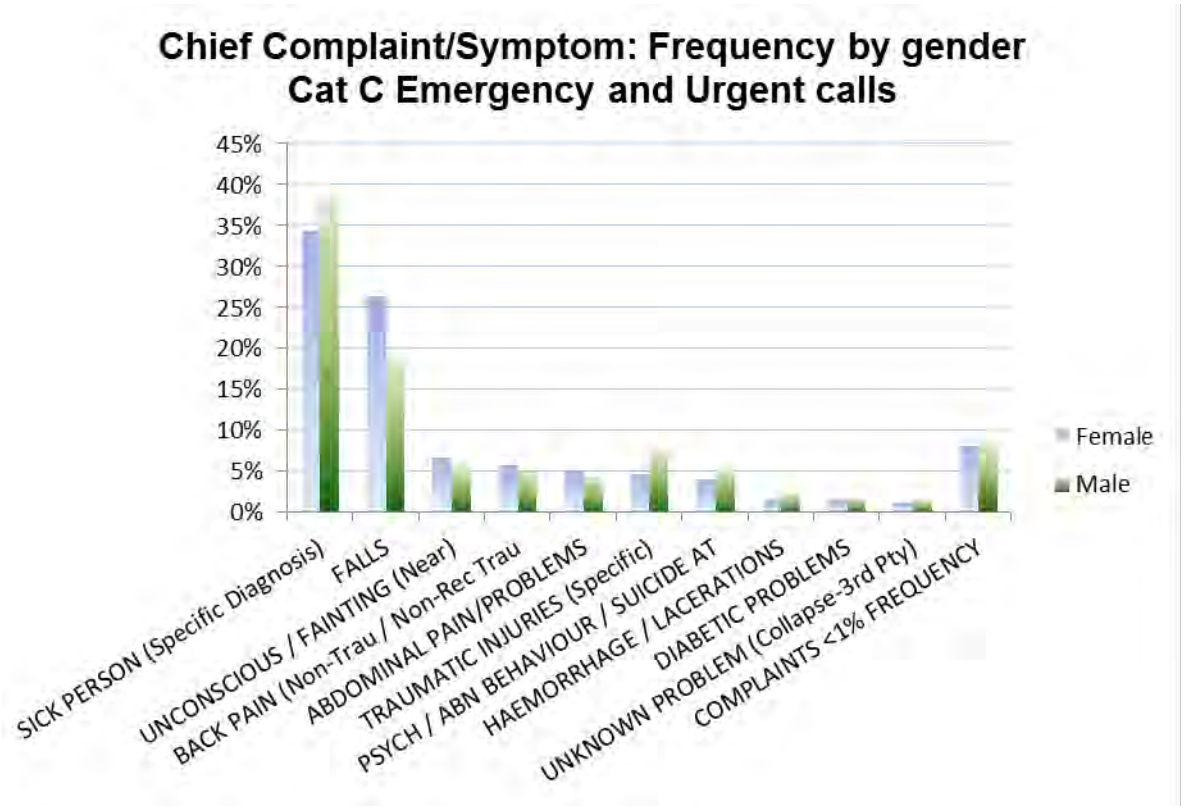


Figure 19: Frequency of Chief Complaint Group by gender. Cat C calls NIAS 2017/2018

10.131 The same three chief complaints have the highest incidence for both genders

	Cat C calls where gender is recorded (n=16,592)						Cat C calls with response where gender is recorded (n=13,225)					
Complaint/Symptoms	**Female**	**% Female**	**Male**	**% Male**	**Total**	**% Total**	**Female**	**% Female**	**Male**	**% Male**	**Total**	**% Total**
SICK PERSON (Specific Diagnosis)	2834	34.4%	3212	38.5%	6046	36.4%	2156	32.2%	2472	37.9%	4628	35.0%
FALLS	2176	26.4%	1569	18.8%	3745	22.6%	1999	29.9%	1401	21.5%	3400	25.7%
UNCONSCIOUS / FAINTING (Near)	551	6.7%	491	5.9%	1042	6.3%	378	5.6%	345	5.3%	723	5.5%
TRAUMATIC INJURIES (Specific)	386	4.7%	642	7.7%	1028	6.2%	315	4.7%	473	7.2%	788	6.0%
BACK PAIN (Non-Trau / Non-Rec Trau	482	5.8%	420	5.0%	902	5.4%	407	6.1%	324	5.0%	731	5.5%
ABDOMINAL PAIN/PROBLEMS	433	5.3%	374	4.5%	807	4.9%	345	5.2%	279	4.3%	624	4.7%
Total for 6 most frequent complaints/symptoms	**6862**	**83.2%**	**6708**	**80.3%**	**13570**	**81.8%**	**5600**	**83.6%**	**5294**	**81.1%**	**10894**	**82.4%**

Table 42: Category C most frequent chief complaints/symptoms by gender NIAS 2017/2018

Category C - Most Frequent Chief Complaints/Symptoms– Age Group

10.132 Age is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the age of the patient recorded. It should also be noted that 2nd and 3rd party callers may provide an estimate of age to EMDs if the exact age of the patient isn't known, although this may be corrected on the Patient Record Form (PRF) on attendance at the scene of the incident.

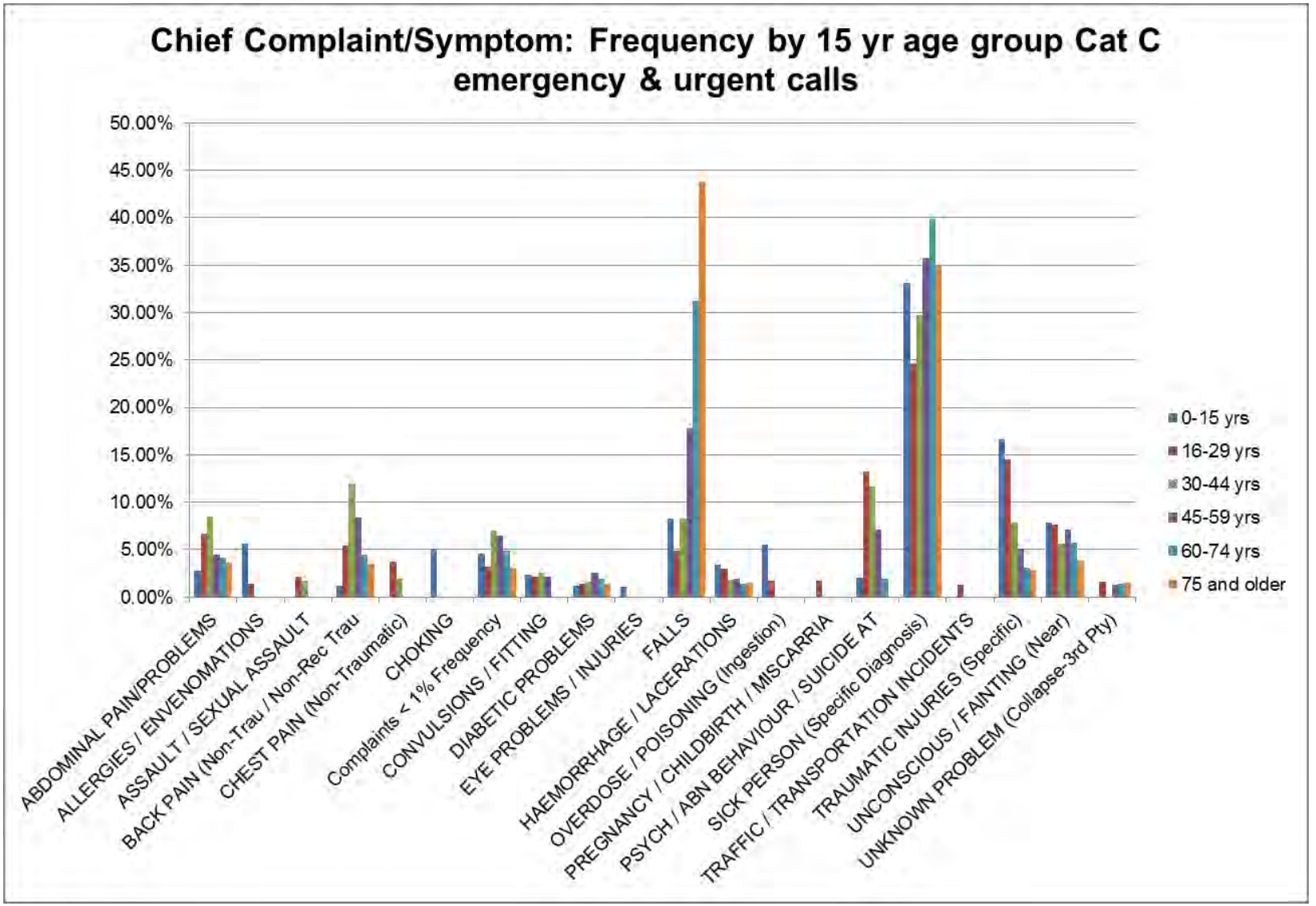
10.133 The graph on the following page shows all the Cat C chief complaint/symptom groups allocated by 15 year age groups. Complaints that had an incidence of less than 1% of the total calls for each age group were grouped together. Table 16 shows the top four chief complaints/symptoms by each age group.

10.134 Across all age groups "Sick Person (specific diagnosis)" is the most frequent Category C call.

10.135 Across all age groups in category C, Sick Person and Falls are the most prevalent, comprising 67.5% of the volume of calls responded to in this category.

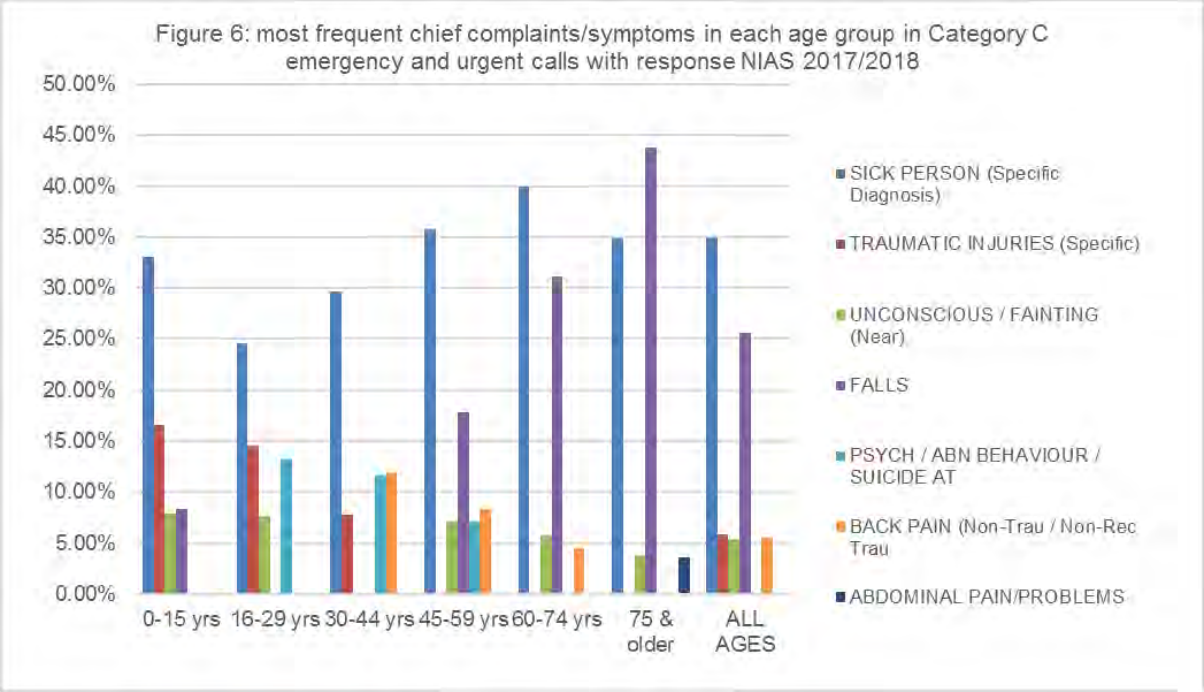
10.136 In one age group (45-59 yrs) the most frequent chief complaints/symptoms changes between all calls and calls with a response to the scene of the incident. Unconsciousness and Back Pain are the 3rd and 4th most frequent cause respectively in all calls graded Cat C. However, Back pain is 3rd most frequent in this age group for calls with response and unconsciousness is equalled by psychiatric calls as 4th most frequent.

10.137 This is reflected in the figures for all age groups. There is a differential in chief complaints/symptoms in Cat C between all calls and calls with a response to the scene. Understanding this would require detailed analysis of each individual call to explore why more calls in one chief complaint/symptom required a lower proportion of response to scene.


Chief Complaint/Symptom: Frequency by 15 yr age group Cat C emergency & urgent calls
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
ABDOMINAL PAIN/PROBLEMS
ALLERGIES / ENVENOMATIONS
ASSAULT / SEXUAL ASSAULT
BACK PAIN (Non-Trau / Non-Rec Trau
CHEST PAIN (Non-Traumatic)
CHOKING
Complaints < 1% Frequency
CONVULSIONS / FITTING
DIABETIC PROBLEMS
EYE PROBLEMS / INJURIES
FALLS
HAEMORRHAGE / LACERATIONS
OVERDOSE / POISONING (Ingestion)
PREGNANCY / CHILDBIRTH / MISCARRIA
PSYCH / ABN BEHAVIOUR / SUICIDE AT
SICK PERSON (Specific Diagnosis)
TRAFFIC / TRANSPORTATION INCIDENTS
TRAUMATIC INJURIES (Specific)
UNCONSCIOUS / FAINTING (Near)
UNKNOWN PROBLEM (Collapse-3rd Pty)
0-15 yrs
16-29 yrs
30-44 yrs
45-59 yrs
60-74 yrs
75 and older

Chief Complaint/Symptom	Cat C calls: Age recorded (n=16148)		Cat C calls with response: age recorded (n=12867)	
0-15 yrs				
SICK PERSON (Specific Diagnosis)	323	34.33%	223	33.09%
TRAUMATIC INJURIES (Specific)	147	15.62%	112	16.62%
UNCONSCIOUS / FAINTING (Near)	75	7.97%	53	7.86%
FALLS	74	7.86%	56	8.31%
TOTAL 0-15 yrs	941	100.00%	674	100.00%
16-29 yrs				
SICK PERSON (Specific Diagnosis)	575	25.81%	375	24.64%
TRAUMATIC INJURIES (Specific)	309	13.87%	221	14.52%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	262	11.76%	201	13.21%
UNCONSCIOUS / FAINTING (Near)	200	8.98%	116	7.62%
TOTAL 16-29 yrs	2228	100.00%	1522	100.00%
30-44 yrs				
SICK PERSON (Specific Diagnosis)	693	31.29%	486	29.69%
BACK PAIN (Non-Trau / Non-Rec Trau	256	11.56%	196	11.97%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	227	10.25%	190	11.61%
TRAUMATIC INJURIES (Specific)	177	7.99%	128	7.82%
TOTAL 30-44 yrs	2215	100.00%	1637	100.00%
45-59 yrs				
SICK PERSON (Specific Diagnosis)	959	37.39%	723	35.79%
FALLS	413	16.10%	360	17.82%
UNCONSCIOUS / FAINTING (Near)	208	8.11%	143	7.08%
BACK PAIN (Non-Trau / Non-Rec Trau	199	7.76%	169	8.37%
PSYCH / ABN BEHAVIOUR / SUICIDE AT	181	7.06%	143	7.08%
TOTAL 45-59 yrs	2565	100.00%	2020	100.00%
60-74 yrs				
SICK PERSON (Specific Diagnosis)	1256	41.82%	989	39.93%
FALLS	850	28.31%	772	31.17%
UNCONSCIOUS / FAINTING (Near)	192	6.39%	142	5.73%
BACK PAIN (Non-Trau / Non-Rec Trau	131	4.36%	111	4.48%
TOTAL 60-74 yrs	3003	100.00%	2477	100.00%
75 and older				
FALLS	2108	40.57%	1988	43.82%
SICK PERSON (Specific Diagnosis)	1940	37.34%	1584	34.91%
UNCONSCIOUS / FAINTING (Near)	225	4.33%	175	3.86%
ABDOMINAL PAIN/PROBLEMS	191	3.68%	162	3.57%
TOTAL 75 and older	5196	100.00%	4537	100.00%
ALL AGES				
SICK PERSON (Specific Diagnosis)	6078	36.42%	4655	34.98%
FALLS	3751	22.48%	3406	25.59%
UNCONSCIOUS / FAINTING (Near)	1043	6.25%	724	5.44%
TRAUMATIC INJURIES (Specific)	1029	6.17%	788	5.92%
BACK PAIN (Non-Trau / Non-Rec Trau	904	5.42%	733	5.51%
TOTAL	16688	100.00%	13308	100.00%

Table 43: most frequent chief/complaints/symptoms in each age group in Category C emergency and urgent calls 2017/18



Most Frequent Chief Complaints/Symptoms – Category C HCP

10.138 Category C HCP calls are urgent calls requested from a healthcare professional for a patient in their care. Most of these calls involve the HCP 'booking' an ambulance after seeing a patient and deciding they need to be admitted to hospital within a set time frame or a patient needing an inter-hospital transfer.

10.139 In 2017/2018, 40,877 emergency and urgent calls were given a Cat C HCP coding, 18.6% of all emergency and urgent calls. A response was provided to 38,169 Category C incidents, 18.9% of calls with response, in the same period.

10.140 As would be expected, one chief complaint/symptom accounted for over 94% of all incidents given a Category C HCP code: HCP Admission. All other chief complaints/symptoms are between 0.01% and c. 3% prevalence within Cat C HCP and do not provide a statistically significant sample for additional analysis.

CHIEF COMPLAINT/SYMPTOM	Cat C HCP Calls	% of Cat C HCP Calls	Cat C HCP calls with response	% of Cat C HCP calls with response
HCP ADMISSION	38587	94.40%	36090	94.55%

Table 44: Most frequent chief complaint/symptom assigned as Category C HCP, NIAS 2017/2018

10.141 Gender is not always recorded on the patient record. The data considered in this section excludes incidents that do not have the gender of the patient recorded.

10.142 55% of HCP Admissions are for female patients. This slight shift away from the general population gender ratio is explained by the age profile of patients in this category. The proportion of females rises in older age groups and the majority of HCP Admissions are for older patients as will be shown in the following section.

CAT C HCP Chief complaint/symptom	0-15 yrs	16-29 yrs	30-44 yrs	45-59 yrs	60-74 yrs	75 and older
HCP ADMISSION	375	1112	1741	3908	7609	21102
	1.05%	3.10%	4.86%	10.90%	21.23%	58.87%
All CAT C HCP Calls	391	1189	1893	4187	8089	22161
	1.03%	3.14%	4.99%	11.04%	21.34%	58.46%

Table 45: Cat C HCP by age group. NIAS 2017/2018

10.143 Patients over 60 years old account for c. 80% of all patients in Cat C HCP. Understanding which groups will be affected by the re-categorisation inherent in the Clinical Response Model will only be clear from monitoring the changes as the model is implemented. The new categories do not align directly with the current categories and the more comprehensive range of standards measures and indicators will not map against the previous time based target for Category A.

10.144 NIAS commits to ongoing monitoring of the new model and continued engagement with stakeholders to address and mitigate any adverse impacts that may be revealed in this process.

11. WHAT WILL THE IMPACT BE ON SERVICE USERS BASED ON SECTION 75 GROUPINGS AND RURALITY?

11.1 The introduction of CRM across Northern Ireland will have a region-wide impact on the population, and on the delivery of NIAS services. However, Section 75 of the NI Act 1998 requires NIAS to consider the impact on specified sectors, and between those sectors. Two factors are important in considering the S.75 impacts of the CRM proposals.

11.2 First, NIAS patients and service users throughout Northern Ireland have multiple identities in terms of the nine Section 75 categories. This means that the impact assessment needs to consider the impacts ***within*** categories, as well as the overlap ***between*** categories, such as a combination of age and gender in relation to patient demographics. The impact assessment below should therefore be read in its totality, since each section is interrelated.

11.3 Second, the regional nature of the new CRM proposals means that the urban/rural placement of NIAS resources, and population spread, also has to be considered in relation to the Section 75 impacts. This is particularly important given that rural areas are consistently more likely to have less access to public services, including transport. Again, the assessment of rural/urban impacts should be read in the context of the wider considerations.

11.4 Detailed datasets and information have been gathered and analysed to inform the specific assessment of impacts, in accordance with statutory and policy obligations.

Section 75 categories

Gender

11.5 According to the Census 2011 in Northern Ireland, women are a larger proportion of the population than men, at 51% versus 49% respectively. Figures for 2014-16 in Northern Ireland show that women have a higher level of life expectancy at 82.3 years to 78.5 years for men. At a general level, one might assume that women are therefore quantitatively more likely to experience the types of ill-health that arrive in older populations.

11.6 However, men and women are prone to different illness at different ages, and there is different prevalence of health behaviours. Evidence suggests that men are less likely to attend a GP or leave it too late, the impact being that men are more likely to attend A&E.

11.7 All emergency and urgent calls show an even distribution between genders in line with the NI population, across all ages. Men under-60 have a slightly higher use of NIAS emergency vehicles that women under-60, but both findings are largely in line with population proportions. Given the limited data on trans- and gender non-conforming people it is not possible to extrapolate any significant impact.

11.8 A core element of CRM is the focus upon 'sickest/quickest', with cardiac failure having been identified as the condition most likely to be effectively treated within eight minutes.

11.9 Given that in 2017/18, indicative figures suggest that men in Northern Ireland may account for proportionately more cardiac arrests, the focused application of NIAS resources towards this particular condition will be more likely to positively impact upon men.

11.10 However, the likely positive impact upon men's emergency survival rates does not necessarily denote a negative impact for women's health conditions. This is because the types of conditions that will fall within non-life threatening emergency responses are more likely to have underlying chronic factors which will be more effectively addressed through better use of Alternative Care Pathways.

Political Opinion

11.11 Political opinion is not a factor in determining the social or geographical spread of health conditions or emergency ambulance use.

11.12 However, some political opinions may be more likely to correlate with areas that are affected by specific, ingrained patterns of ill-health or medical emergency.

11.13 For example, in urban areas of high deprivation which largely have confined political opinions, the risk of death by suicide is over three times greater than that experienced in the least deprived areas of Northern Ireland which are more likely to be politically diverse areas.

11.14 Given CRM's enhanced focus on improving responses to life-threatening emergency calls, it is likely that the impact of CRM would be positive in all such

circumstances. There is no differential impact arising from CRM proposals due to the political opinion of citizens living in more deprived areas.

11.15 At a macro level, across the whole of Northern Ireland, the spread of political opinion is broadly identifiable by elected political representativeness at Council, Assembly and Parliamentary level.

11.16 The highest level of connected urban conurbations in Northern Ireland, is the Belfast Metropolitan Area (BMA) with around 670,000 citizens, over one third of Northern Ireland's population.

11.17 The city of Belfast has a population of around 280,000 people, in which political parties with unionist/loyalist political opinions have a marginal minority of the elected councillors versus others. However the surrounding council areas that contribute to the rest of BMA, namely Antrim and Newtownabbey, Ards and North Down, and Lisburn and Castlereagh Council, have a majority of elected councillors affiliated with unionist political opinions.

11.18 Parliamentary constituencies west of the Bann, which are more rural with lesser connectivity, are more likely to be represented by nationalist elected representatives, while those constituencies east of the Bann, which are relatively more urban with better connectivity, are more likely to be represented by unionist elected representatives.

11.19 In the circumstances, while there may be an impact on the ***types*** of emergency ambulance response provisions – for example in rural areas – none of these differentials under CRM would be determined directly or indirectly by the factor of political opinion; and all changes are intended to have an overall beneficial impact for all sections of society based on more effectively addressing clinical need. Emergency ambulance provision and resources will be improved across all of Northern Ireland, as will the provision of additional benefits through Appropriate Care Pathways and community first responder teams.

Community Background/Religion

11.20 Similar considerations apply to assessing impacts based on the community background or religion of NIAS service users. The community background/religion of those who access emergency ambulance services is not a determinant factor for medical condition or service provision. Likewise there is no evidence that any major differentials of medical conditions arise due to

community background or religion. Once again, factors such as residence in rural versus urban localities, or high deprivation versus low deprivation areas, are likely to be more reliable indicators of patterns of ill-health and ambulance use.

11.21 Notwithstanding that, according to Census 2011 the Protestant proportion of Northern Ireland's population in older age groups outweighs the Catholic proportion (which is larger in younger age groups).

11.22 Since the older population has significantly greater use of emergency ambulance services, it is possible to predict that there will be a short to mid-term positive impact for the existing older predominantly Protestant population, while there will be a mid to long-term positive impact for the future older predominantly Catholic population. Over time, CRM will therefore have a positive impact on both main communities.

11.23 These positive impacts are indirect, and there are no adverse impacts for either of Northern Ireland's main communities since the CRM model is based on clinical need and community background/religion is not a factor in medical conditions or emergency ambulance provisions.

Age

11.24 Age is one of the most reliable predictors of whether a person will use emergency and unscheduled healthcare. Based on NISRA's population data, persons over the age of 55 in 2017 made up 27.4% of the population. According to NIAS figures for 2017-18, the over-55 age group used over 80% of all non-emergency ambulance journeys. It is estimated that 56% of emergency and urgent calls to NIAS are for patients aged over 60, and that 52% of CAT A responses for people over 60. These figures again indicate the correlation between greater use of ambulance services and membership of older age groups.

11.25 It is predicted that the older population over-60 will have increased by 12.5% in the next five years. It is therefore likely that the clinical demands will increase on emergency and non-emergency ambulance provision. It is also likely that the failure by NIAS to develop the proposal for a new CRM more appropriately to the clinical needs of Northern Ireland's projected population will, in turn, lead to lower performance and worse clinical outcomes. In this circumstance, it is assessed that the greatest adverse impact for patients based on their age group *would*

come from a failure to reform the existing response model and a failure to progress the CRM proposals. The new CRM proposals are therefore assessed as having a positive impact based on age.

Ethnicity

11.26 Northern Ireland is becoming an increasingly diverse population. According to the Census 2011, the proportion of the population born outside of the region was 11%. There are parts of Northern Ireland where relatively large ethnic minority communities locate based on employment and social factors, for example in the Mid-Ulster area and in districts of Belfast. It is assessed that there will be no adverse impact from CRM based on the locality of ethnic minorities in Northern Ireland.

11.27 However the Race Equality Foundation (2015) has reported that three related barriers exist in relation to healthcare at the levels of patient, provider and service. These barriers are cultural competency, language and communications, and limited understanding of the healthcare system. In addition, some ethnic minority groups may be affected by a higher risk and incidence of illnesses reflected in their use of pre-hospital care. Once again, however, given that CRM is designed to improve NIAS services to the entire population based on clinical need, there is no adverse impact assessed on the specific factor on ethnicity. Cross-sectional factors, such as locality, are taken into account throughout this assessment.

11.28 It is likely that communication and language, and understanding of the NIAS role, will remain factors for ethnic minorities to engage with emergency ambulance services. In this regard, NIAS currently provides interpreting services for patients under a regional HSC contract. While the connection with an appropriate interpreters may introduce a short delay in assessing the clinical needs of the caller, these circumstances cannot be altered by the introduction of CRM, and it is assessed that there is therefore no adverse impact based on ethnicity.

Sexual Orientation

11.29 The sexual orientation of NIAS service users is not routinely gathered, nor was such data compiled under the 2011 Census. However, a report

commissioned by the Northern Ireland Executive has previously suggested that it is feasible to assess that "a certain proportion of the population (up to 10%) is LGBT (lesbian, gay, bisexual and transgender), and to formulate policies accordingly". Research shows that LGBT people are more vulnerable to developing mental health issues, particularly due to external stressors; they can therefore be more proportionately likely to self-harm, suicidal ideation, experiencing depression, and other anxiety-related conditions. The rainbow Project's 2013 report 'Through our minds', reported that 12.6% of respondents had attended hospital after deliberately self-harming.

11.30 In these circumstances, it is likely that the introduction of CRM will have a neutral or positive impact, since the premise of the new model is based on clinical need. The additional consideration is when this section 75 category is considered with others, such as age, disability or gender. However, once again, improved models for attending clinical need is the basis of CRM, and the impact should therefore be positive.

Marital Status

11.31 There is limited data to consider any impact from the CRM based solely on marital status, and it is more appropriately considered as a composite factor in relation other section 75 categories. For example, it could be surmised that older people living alone may be more likely to access emergency ambulance services than those living with other adults, since the latter would likely have greater support networks. But these are individual cases, rather than an indicative social grouping. On the basis that CRM is intended to address all citizens based on clinical need, there is no obvious adverse impact arising from the marital status of any person.

Dependent Status

11.32 The likely impact upon those with dependents – ie. carers and/or parents/guardians – can best be assessed through the consideration of other section 75 factors, such as the caring context of age and disability. For example, data from the 2011 Census also shows that almost 10% of people who provide some unpaid care reported having a long-term health problem or disability that can impact on day-to-day activity. The role of carers and/or parents/guardians in

looking after dependents is one that should be enhanced by the more appropriately resourced and targeted provision of ambulance services under CRM. There is therefore no adverse impact.

Disability

11.33 In the 2011 Census, 21% of the population said that they had a long-term health problem or disability that limited their day-to-day activities (3% of whom were born with a disability), affecting 37% of households. Belfast and Strabane showed the highest proportions of people with long-term health problems or disabilities. It should be noted that not everyone who has a disability or long-term health problem will have reported limitations in their daily activity and may therefore be underreported.

11.34 Disability or long-term illness is more likely to affect older age groups for both gender. For example, over 60% of women aged 75 and over are affected. When additional factors such as access to services and rurality are taken into account, there is a strong argument in favour of reforming the NIAS emergency response model to ensure that it is driven by clinical need. In these circumstances, there should be no adverse impact for service users based on age; and those older patients with chronic health problems. Rather CRM should create positive improvements and impacts, particularly when implemented in conjunction with new Appropriate Care Pathways across the health sector.

Rural Impact

11.35 Once again, considerations about the rural impact of the new CRM proposals need to take into account the context of other impacts. For example, rural impacts may be perceived as greater for some large ethnic minority communities, such as those which are based in the Mid-Ulster region.

11.36 A critical consideration in assessing the rural/urban impact is the ratio of cardiac arrests. Indicative NIAS figures for 2017/18 suggest that around two-thirds of cardiac arrests took place in urban areas of Northern Ireland, as opposed to rural areas.

11.37 The new Clinical Response Model is intended to substantially increase the proportion of such emergency calls being answered quicker. While precise modelling will only be able to take place in practice, and while guarantees cannot

be given in relation to every single incident, there is likely to be a substantial improvement in appropriate and effective ambulance response in rural areas.

11.38 For example, while Rapid Response Vehicles will decrease in terms of hours of service, there will be a net gain under the new CRM model in relation to emergency ambulance cover in rural areas. In addition, the rural/urban impacts will be taken into account in designing the new NIAS Estates Strategy, and in rolling out the Community First Responder programme and community defibrillators.

11.39 A persistently high correlation exists between patterned levels of chronic ill-health and urban areas of high deprivation. These localities are predominantly within more densely populated areas that fall under the current drive-time radius. Patients with chronic conditions may have need for more frequent ambulance use, but – due to better planning and resourcing - it is assessed that the ambulance service provided for these patients will not be adversely impacted by the new CRM.

11.40 While response times are critically important in some cases, they are not the only measure of the service provided by NIAS ambulance services. In most cases, the impact on health outcomes for rural patients is as good as for those in urban areas. The national ambulance response standards which NIAS propose to adopt are designed to ensure that the most suitable high-quality response is delivered to every patient in an appropriate clinical timeframe. The new system allows the ambulance service to concentrate on providing an even faster response to those patients who are truly life-threatened, whilst also reducing the transport delays for all other categories of patients. Over time these initiatives will continue to allow further improvements in response times to be made. In order to address this particular issue raised in regard to improving performance in Rural Areas NIAS plan to refresh the operational modelling undertaken in 2017.

WHAT MITIGATING MESURES ARE HAVE BEEN CONSIDERED TO ADDRESS ANY ADVERSE IMPACTS?

11.41 This EQIA has identified that there are no adverse impacts based on Section 75 grouping or rurality, and since the CRM proposals are part of a wider package of organisational transformation they are intended to have positive impacts for all of Northern Ireland's population based on the primary criterion of clinical need.

This EQIA concludes that the only obvious adverse impact would arise from failing to introduce the CRM proposals and continuing with the status quo emergency response model in circumstances that are rapidly and evidently changing.

MONITORING AND REVIEW

11.42 In undertaking monitoring following implementation of the proposals, NIAS will give full consideration to the Equality Commission for Northern Ireland Section 75 Monitoring Guidance and devise related measures to ensure that ongoing impacts are regularly assessed against specific categories. As a consequence of the original consultation NIAS revised its draft EQIA in relation to identifying a potential impact on some Section 75 groupings, and related considerations and mitigating measures have been outlined. These will now be included as part of the continuous future monitoring and evaluation of CRM in its development and implementation. This demonstrates the proactive and continuous commitment of NIAS to examining and reviewing potential impacts, and the Trust is committed to delivering this ethos through the CRM programme and its various projects. In addition to constructive engagement through existing mechanisms with staff side and detailed communication with those potentially affected, NIAS is also committed to the continuous monitoring and evaluation of all potential equality impacts upon all stakeholders, including equality screening/ assessment as appropriate in line with the Trust's s.75 equality duties. NIAS is also committed to creating a standing forum of stakeholders that will meet regularly, and that will have an ongoing and meaningful engagement function in relation to the overall CRM programme and its various implementation projects, in order to build upon the positive engagement process evidenced during the consultation.

12. CONCLUSION

The adoption of this new clinical operating model is expected to realise a range of benefits for patients including:

- Reducing the proportion of patients receiving the highest level of response from circa 30% to a more appropriate 7%. This will allow resources to be focussed on improving the response to those patients who genuinely require an Immediately Life Threatening response.

- Identifying Category 1 patients earlier than is currently the case and allocating a resource between 33-41 seconds more quickly than at present using PTS and NOC. This should lead to improved response times for the only group of patients for whom there is evidence that response times make a difference to outcome and creates the potential to improve cardiac survival by 13%-16%.

- Improving efficiency by reducing the deployment of multiple resources to incidents where the patient's condition does not warrant that level of response. Further improvements to efficiency are gained through the reduction of incidents where resources are repeatedly mobilised then stood down. This will release resources to improve the response to the most seriously ill patients and the response to lower acuity patients (although in Northern Ireland delays on lower acuity incidents is less of problem than elsewhere in the UK).

- More effective targeting of the right resource, first time to meet the patient's needs which should, for example, lead to improvements in the time patients with conditions such as Stroke and Heart Attack reach definitive care in specialist units.

- Creating the opportunity to manage more patients appropriately through telephone advice or treatment at the scene without the need for transportation to hospital. This improves efficiency both for the ambulance service and hospital emergency departments and delivers the right outcome for patients in the right setting.

- Producing greater system resilience and stability through the introduction of a clinical operating model that works under less stress and hence is better able to absorb peaks in demand.

- Including a more comprehensive range of standards, measures and indicators to provide greater transparency about whole-system ambulance performance in language that is understandable to the public.

- Enhancing the engagement and involvement of stakeholders with the organisational improvement of NIAS in the future, through the creation of a stakeholder forum and the related commitment to ongoing assessment of potential impacts.

13. CONSULTATION RESPONSES

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TB/04/04/2019/03

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING 4 APRIL 2019

PRESENTATION OF PAPER

Title:	Conflict, Bullying and Harassment in the Workplace Policy & Procedure
Purpose:	To provide all staff, particularly managers, with clear guidance on how to handle conflict, bullying and harassment in accordance with best practice and relevant employment legislation; To outline to all staff their rights and their collective responsibility to create and maintain a safe, harmonious, positive and enabling working environment for all; To provide a mechanism to facilitate prompt resolution of issues that may arise; To prevent bullying of all staff members, including agency workers; To prevent harassment of all staff members, including agency workers;
Content:	
Recommendation:	For noting.
Previous Forum:	Policy & associated procedure have been developed & consulted upon within HSCNI via Regional JNF
Date of SEMT Approval:	
Prepared and Presented by:	

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

Conflict, Bullying and Harassment in the Workplace

January 2019

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1. Our Commitment

The Northern Ireland Ambulance Service Health and Social Care Trust (NIAS) is an equal opportunities employer. As such, we will comply with the spirit and letter of the law, including equality legislation. We strive to create and promote a harmonious working environment, where all staff feel safe at work and are treated with respect and dignity, regardless of their age, disability status, marital or civil partnership status, political opinion, race, religious belief, sex (including gender reassignment), sexual orientation, with dependants or without dependants.

Poor working relationships, unresolved conflict, bullying and harassment can have a detrimental effect on personal wellbeing, as well as the wider working environment. Evidence shows that effective team working, supported by good communication and responsive line management, impacts positively on patient and client care. Issues which affect the ability of staff to work well together will be taken seriously and addressed promptly. Bullying and harassment in the workplace is unacceptable and will not be tolerated or condoned under any circumstances.

We will help to create the sort of organisation that people want to be a part of and feel proud to work in by fostering a climate of dignity and respect amongst staff at all levels, and in demonstrating our commitment to deal with conflict, bullying and harassment effectively and promptly.

2. Purpose and Aims

The purpose and aims of this policy and associated procedure are:

- To provide all staff, particularly managers, with clear guidance on how to handle conflict, bullying and harassment in accordance with best practice and relevant employment legislation;

- To outline to all staff their rights and their collective responsibility to create and maintain a safe, harmonious, positive and enabling working environment for all;
- To provide a mechanism to facilitate prompt resolution of issues that may arise;
- To prevent bullying of all staff members, including agency workers;
- To prevent harassment of all staff members, including agency workers;

3. Scope

3.1 This policy applies where there is general interpersonal conflict within the workplace or when a member of staff believes they have been subject to bullying or harassment, as defined in this policy. Where group conflict exists, the same principles laid down in this policy will apply. All staff have a responsibility to comply with this policy. We expect our staff to both receive and show courtesy and respect to and from colleagues, patients, service users and anyone else with whom they come into contact in the course of their work. There is a particular obligation on managers to ensure the effective application of this policy, and to work to cultivate and maintain a safe and positive working environment within their teams.

3.2 This policy also applies to events which could reasonably be regarded as an extension of the workplace, such as Christmas parties and conferences, the use of social media or any other situation which is an extension of the working environment. This policy should be read in conjunction with any related social media policy.

3.3 This policy should be read in conjunction with any relevant codes of conduct, and Maintaining High Professional Standards (applicable to medical and dental staff only).

3.4 It is expected that staff members will raise concerns of conflict, bullying or harassment in a timely manner and as close as possible to the alleged issue(s) or event(s). This should not normally be later than four months after the alleged issue(s) or event(s), other than in exceptional circumstances.

3.5 This policy must not be interpreted, or applied in such a way as to detract from the legitimate right and obligation of those in management roles to manage their staff in accordance with other Human Resources (HR) and Trust organisational policies. Constructive and fair criticism of behaviour or performance is not bullying or harassment. Management has a right to identify and address unacceptable standards of behaviour or performance and must do so in a fair, respectful and measured way and in accordance with this policy. Failure to do this in a fair and respectful way may be considered and addressed under this policy and any other relevant HR policy.

3.6 This policy is not applicable where a member of staff believes they are being bullied or harassed by a member of staff from another organisation or a patient, client or member of the public. In such instances, staff should first seek advice from their line manager and HR and/or their trade union as appropriate, in order to progress their concern and receive the right support. Where a concern of bullying or harassment is raised by a member of staff from another organisation or a patient, client or member of the public against a staff member, this policy may be applied, and in all cases advice must be sought from HR.

3.7 If a concern is raised by a staff member against an agency worker, the line manager should refer the concern to the employment agency from whom they were recruited. The agency should have their own policies and procedures for dealing with concerns about their employees. The line

manager will liaise with the employment agency to ensure there is an effective resolution of the concern.

This policy will apply where a concern is raised by an agency worker against a member of staff. The line manager, in conjunction with HR, will work with the employment agency, using this policy, towards an effective resolution of the issues.

4. Definitions and Legal Context

4.1 What is general conflict?

4.1.1 General interpersonal conflict can take many forms, for example: colleagues who simply do not work well together as a result of different styles of working, someone changing their behaviour causing an unpleasant atmosphere, differing opinions and perceptions, personality clashes, or an overspill of personal issues outside of work. Most of us will experience an issue or level of conflict with someone at work at some point in our careers. However, these issues have the greatest chance of resolution if addressed locally and quickly through dialogue and all staff are encouraged to 'test their perception' (see page 16) before labelling their experience or attempting to pre-determine the pathway for resolution.

4.2 What is bullying?

4.2.1 Bullying occurs 'where one person or persons engage(s) in unwanted conduct in relation to another person which has the purpose or effect of violating that person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person. The conduct shall be regarded as having this effect only if, having regard to

all the circumstances and in particular the alleged victim's perception, it should be reasonably considered as having that effect.'[1]

4.2.2 Unlike harassment, bullying need not be related to any of the protected characteristics outlined in Section 4.3.1. Examples of bullying at work may include:

- Subjecting an individual to humiliation or ridicule;
- Inappropriate shouting or use of abusive language;
- Spreading malicious rumours or telling untruths;
- Constantly undermining effort, competence or confidence;
- Deliberately withholding information to affect a staff members' performance or reputation;
- Persistent adverse criticism in public or in private;
- Isolation or exclusion at work or from work related events;
- Intimidating body language or physical behaviour;
- Changing of work responsibilities unreasonably or without justification.

This is not an exhaustive list, and all cases will be considered individually.

4.3 What is harassment?

4.3.1 Harassment bears very broad similarities to bullying and the behaviour described in Section 4.2.2. However, the crucial difference is that harassment is based on, motivated by or related to one of the equality

[1] 'Harassment and Bullying in the Workplace' – A joint publication by the Equality Commission for Northern Ireland and the Labour Relations Agency.

grounds laid down in anti-discrimination legislation, and summarised in the table below. Harassment can also constitute a civil or criminal offence.

Legislation	Protected Equality Groups
Sex Discrimination (NI) Order 1998 as amended	Gender Gender identity and expression Marital or civil partnership status Pregnancy or maternity Carers
Fair Employment and Treatment (NI) Order 1998 as amended	Community background Religious and philosophical beliefs Political opinion Trade union membership
Employment Equality (Age) Regulations Northern Ireland 2006 as amended	A particular age or range of ages
Disability Discrimination Act 1995 as amended	Disability (Disability is defined as a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities)
Employment Equality (Sexual Orientation) Regulations Northern Ireland 2003 as amended	Sexual orientation (Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes)
Race Relations (NI) Order 2007 as amended	Race Colour Nationality Ethnic or national origin Irish Travellers

4.3.2 Harassment can be a single serious incident or an ongoing campaign. Conduct shall be regarded as harassment only if, having regard to all the circumstances and in particular the alleged victim's perception, it should be reasonably considered as having that effect. Where it is not mutually acceptable behaviour, this may constitute harassment. Harassment on the grounds of, or related to, a

protected characteristic is unlawful discrimination and may constitute a criminal offence.

4.3.3 It is not necessary that a person possesses a particular characteristic themselves, as outlined in the table at 4.3.1, to be a victim of harassment. It can be as a result of their association with a person who falls into one of these categories, or a mistaken belief that they possess one of these characteristics.

4.3.4 Harassment can take many forms, as per the table below. This is not an exhaustive list of examples of behaviour that may amount to harassment, or indeed bullying, if it does not relate to one of the equality grounds listed in 4.3.1.

- **Physical conduct**, ranging from touching to assault or making obscene gestures;
- **Verbal and written harassment** through jokes, racist, sexist, sectarian, homophobic or transphobic comments, comments about a person's disability, offensive language, gossip and slander, sectarian songs, mobile ring tones, threats, use of social media, letters and emails;
- **Visual displays** of posters, screensavers, downloaded images, graffiti, flags, bunting or emblems or any other offensive material;
- **Isolating** a person, including exclusion from social events;
- **Overloading** a person with unreasonable work activities;
- **Forcing** a person to offer sexual favours or to take part in religious or political activities;
- **Intrusion** by pestering, spying or following.

4.3.5 Causing or contributing to conflict, bullying and harassment is unacceptable behaviour which will not be permitted, accepted or condoned. Notwithstanding the legal implications of engaging in such behaviour, bullying and harassment are contrary to the standards of conduct that we expect of our staff and have the potential to impact on patient and client care. Such behaviours are

detrimental to a productive, harmonious working environment, as well as the confidence, morale and performance of those affected by it, including anyone who witnesses or knows about the unwanted behaviour.

4.3.6 If you are experiencing conflict at work, but remain unsure as to whether it is general interpersonal conflict or bullying or harassment, you can seek advice from a trusted colleague, trade union representative or HR, so that the most appropriate course of action is taken to deal with your concerns quickly and effectively. If you believe your concern may constitute harassment as defined in this policy, you should report this to the appropriate manager immediately, to enable prompt resolution and ensure any relevant statutory time limits, such as those of the Employment Tribunals, can be adhered to.

4.3.7 If behaviour is found to be in breach of this policy, it may result in disciplinary action, up to and including dismissal.

5. The Rights and Responsibilities of All HSC Staff

5.1 As HSCNI staff, we have the right to work in an environment that is free from unresolved conflict, bullying and harassment, where all staff feel safe, and are treated with respect and courtesy. HSCNI fully recognises your right to complain about harassment or bullying and as such all concerns will be dealt with seriously, promptly and confidentially. In matters relating to interpersonal conflict, it is expected that all staff participate in efforts to resolve their issues locally and promptly and without the need for formal investigation.

5.2 NIAS's internal procedures do not negate the right of an aggrieved staff member to also pursue complaints through an Industrial Tribunal, the Fair Employment Tribunal or through the courts. If you wish, you can obtain advice from your trade union representative, the Equality Commission and the Labour Relations Agency. There are strict time limits for making complaints to a tribunal, and complainants normally will be expected to have raised their concerns under the relevant HSCNI procedure first, though it is not necessary for the matter to have been brought to a conclusion.

5.3 Line Managers and HR will ensure that any staff member who raises a concern under this policy, or who gives evidence or information in connection with such cases will not be victimised, i.e. they will not be discriminated against, harassed or bullied in retaliation for their actions. Victimisation is also discrimination contrary to equality laws and this policy, and will be treated as misconduct which may warrant disciplinary action, up to and including dismissal.

5.4 It is **not acceptable** for staff to fail to report or deal with serious bullying or harassment. This may be viewed as condoning this behaviour and action may be taken as appropriate.

6. The Role of HSC Staff

All staff have a responsibility to familiarise themselves with this policy, and to ensure that their behaviour complies with what is expected. Staff must recognise that they have a vital role to play in the creation, promotion and maintenance of a good and harmonious working environment, where the dignity of all is respected.

6.1 Staff are expected to participate in any relevant training to support this policy and to adhere to all relevant procedures including professional codes of conduct where applicable.

6.2 If you raise a concern, you are required to participate in any process that is invoked as a result to resolve the issue. This includes, for example, facilitated meetings and investigation, where this has been deemed necessary. You will also be expected to give due consideration to mediation, where appropriate. Failure to participate in attempts to resolve the issue that you have raised may result in the matter being deemed closed.

6.3 If a concern is raised about you, you will be required to participate in any facilitated meetings or investigations, where appropriate, as well as giving due consideration to mediation, if applicable. Failure to meaningfully participate in attempts to resolve the issue may result in management taking action.

6.4 Where group conflict exists, staff should work with management to agree an appropriate way forward to progress the matter on behalf of the group.

6.5 Staff must not allow situations of misunderstanding to develop into conflict situations. Instead, staff should be proactive in dealing with issues as they arise, so long as they feel confident enough to do so. Where staff lack confidence, they should seek advice from a trusted colleague, trade union representative, manager or HR.

6.6 Any staff member who is aware of or witnesses any instances of conflict, bullying or harassment should support their colleagues and alert a manager or supervisor to enable its swift and effective resolution. Where the behaviour in question is that of a manager, the staff member should either report it to the manager's line manager or seek advice from HR or a trade union representative.

7. The Role of Managers

7.1 Line managers have a specific responsibility in the prevention and resolution of conflict, bullying and harassment. They are responsible for creating a safe, harmonious and enabling working environment, setting a good example for other staff members to follow, intervening when conflict arises and ensuring that their teams are aware of their obligations and relevant policies.

7.2 Managers should ensure they are fully aware of their responsibilities under the relevant policies, and are alert to potential issues of conflict, bullying and harassment; and that they intervene and take appropriate action quickly when issues of conflict, bullying or harassment occur.

7.3 Managers have a responsibility to be responsive and supportive to any member of staff who raises an issue of conflict or makes an allegation of bullying or harassment. They must provide clear advice on the procedure, maintain strict confidentiality throughout the process and actively seek to bring matters to a timely conclusion. They should also seek to prevent a reoccurrence of the same problem, either whilst the concern is being resolved or after it has been dealt with.

7.4 Managers must also take particular care to ensure their behaviour sets an example and must be mindful of their interactions with their team, particularly during sensitive but necessary conversations, for example during appraisals, performance reviews or attendance management meetings.

8. The Role of Trade Unions

8.1 Trade union representatives can help support and guide a member towards the most appropriate course of action in a situation of conflict, bullying or harassment. It is best to involve your trade union representative at the earliest possible stage so they can help you to test your perception and advise appropriately. Trade union representatives can also provide valuable support, advice and representation in relation to bullying and harassment and formal processes as detailed within this procedure.

8.2 Trade union representatives also have a role in supporting and educating members on their rights and responsibilities under this policy.

9. The Role of Human Resources

9.1 HR has a key role to play in the resolution of conflict, bullying and harassment in the workplace. HR is firstly responsible for raising awareness of this policy and procedure, and ensuring that managers are confident and competent to deal with conflict locally and at an early stage.

9.2 It is expected that cases of general interpersonal conflict will be addressed locally by line managers. HR is available for advice and guidance and can assist managers and staff members to test their perceptions and

triage an issue as appropriate. HR may participate in or facilitate a meeting to progress resolution.

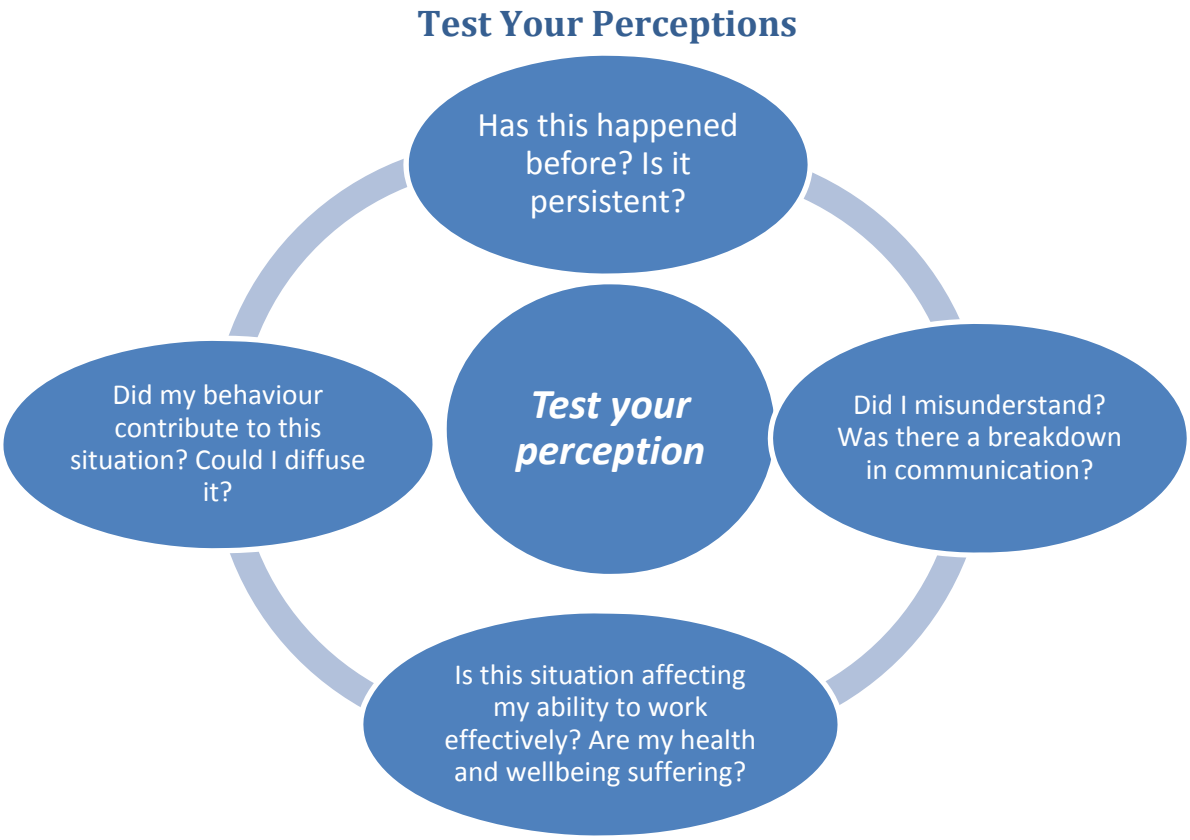
9.3 HR will work with management, the complainant and their trade union representative, if applicable, to identify the most appropriate process for handling the concern.

9.4 Where it is agreed that a formal procedure is necessary to consider bullying or harassment, HR will support the parties concerned by providing advice and guidance on process and policy application, signposting to sources of support for staff, liaising with legal representatives where necessary and case-managing the process in accordance with best practice and employment legislation. HR, in conjunction with the relevant line manager, has a responsibility to progress the formal procedure and bring such matters to a timely conclusion.

9.5 HR will also monitor trends in turnover, sickness absence rates and take particular note of the working lives of rotational staff in order to surface any underlying workplace issues.

1. Procedure

This procedure outlines the steps that should be followed where an employee raises a concern about conflict, bullying or harassment. Before using this policy, you should always test your perceptions. In other words, you should explain your version of events to a trusted colleague, manager or trade union representative. The aim of doing this is to gain greater clarity and perspective on the incident or behaviours and prevent rash decision making. The diagram below outlines some key questions to help you do this.



1.1 If at the end of your test you feel you are being bullied or harassed, then report this **immediately** to either your line manager, or their manager, if the concern relates to your own manager. You can also seek support from your trade union representative or HR.

1.2 In terms of conflict, staff should bear in mind their personal responsibility to promote good relations and attempt to resolve conflict where there are instances of staff members not working well together, so long as they feel confident enough to do so. For example, approaching the other individual at an early stage, and making it clear that their behaviour is unwelcome and should stop. It is advisable to keep a written record of any attempts to stop the unwelcome behaviour.

2. Self-Resolution

2.1 If you simply want the behaviour to stop and where the incident was not very serious, then the informal procedure is likely the most appropriate approach to effect swift, confidential resolution to an issue. If you feel confident and able to do so, you should try and resolve conflict yourself, by approaching the person concerned, outlining the event or incident that you are referring to, describing how you felt and explain why you would not wish it to happen again and what steps you will take if it does reoccur. You can do this with the support of a colleague or a trade union representative if you wish.

Informal Procedure

2.2 Where this fails, or where you do not feel able to approach the person, you should discuss the matter with your line manager as soon as is reasonably possible. Should the concern be against the line manager, it should be brought to their line manager who will take it forward.

2.3 The manager dealing with the concern should act promptly, maintaining strict confidentiality at all times. The manager will:

- **Listen** to what has happened, drawing the person's attention to informal resolution through dialogue and using the 'test your perception' model where appropriate.

- **Meet[2].** with the complainant, and also meet with the person against whom the concern has been made to make them aware. Both parties should be informed that the other person involved is also having an individual meeting. The manager should listen out for recurring and common themes which could be used to direct dialogue when parties are brought together. The manager should remind the parties of their obligation to resolve matters locally and promptly.

- **Meet with the parties together** this should be a future-focused meeting, with common themes being drawn out and discussed. The meeting should ideally end with an agreement to draw a line under the matter or, where appropriate, with the completion of an action-plan detailing how the parties propose to work well together in future. The manager should make a note of any outcomes or action plans and follow up on these within a suitable time period. Again, it is not usually necessary for parties to be accompanied at these meetings.

- **Monitor the situation** and be alert to any deterioration of the situation or any patterns of behaviour emerging. Equally, staff should make genuine efforts to embed what was agreed at the meeting and to work well together.

2.4 Once this series of meetings are over, the matter will be considered closed. Only where there are new issues or where the situation deteriorates will the matter be reopened. If this occurs, HR together with the appropriate manager, will triage the issue, making a decision on the way forward by reviewing information and circumstances of the case. It

[2] It is not usually necessary for HR or trade union colleagues to attend these meetings, but that does not preclude their attendance if necessary.

may be the case that formal mediation is required. Where the issue remains one of interpersonal conflict, there is no automatic right to move to a formal process. Where there is evidence that one or other of the parties has failed to comply with the previous agreement, consideration should be given to the appropriateness of other policies and procedures, including the Disciplinary Procedure, in relation to conduct.

3. Mediation

3.1 In cases where informal resolution has not been successful, you will be expected to consider mediation. Whilst it is not mandatory that you participate, you will be expected to give it due consideration.

3.2 Mediation is not about placing blame or making judgments. It is designed to help parties gain clarity around the claim of conflict or bullying, and help everyone assess their individual needs, goals and expectations.

3.3 Trained mediators will facilitate open and honest communication, in a safe and impartial environment in order to foster better relations, and ultimately help the parties come to an agreement as to how they will work together in future. This will be written and signed by all concerned. The manager concerned will not be privy to the details of what was said or agreed. They will only know if the mediation was successful or not, unless the parties to the mediation agree for particular information to be shared.

3.4 Where mediation is agreed, you will take part in the mediation process within 4 weeks (or as soon as is reasonably practicable in view of leave arrangements) of the mediation having been agreed.

3.5 Where it is a matter of general interpersonal conflict, mediation will be the last stage of the process. If you refuse to participate in mediation or where mediation fails, the manager reserves the right to take action as necessary to ensure that a harmonious and safe working environment is achieved. Action may include:

- Moving either or both parties;
- Changing working patterns of either or both;
- Disciplinary action where behaviour warrants it.

Senior management and HR will make the final decision on any redeployment, ensuring this is in line with the relevant terms and conditions, and will not put the employee at a substantive detriment.

4. Formal Procedure

4.1 Concerns should be raised as soon as possible (and not later than 4 months) following an alleged act of bullying or harassment and, where possible, should be set out in writing to the appropriate manager or HR, making it clear which protected characteristic the alleged harassment relates to, if appropriate. Concerns may be raised by a staff member, or someone on their behalf such as a colleague or a trade union representative and should be discussed with HR immediately.

a. If the incident(s) reported is so serious that it is deemed by HR and the manager inappropriate to use the informal method, the issue will be addressed through the formal procedure. It is accepted that in making this determination discussion will have taken place with the affected staff member(s) and/or their trade union representative where appropriate to ensure understanding. Acknowledgement of the concern in writing and where available details of the next steps should be provided to

the staff member within 3 working days of receipt by HR. In relation to concerns raised about Medical or Dental staff, consideration must also be given to procedures and timescales laid out within Maintaining High Professional Standards and advice sought on how to proceed.

b. In some instances, there may be clear evidence of misconduct that is so serious that it may be appropriate to move straight to disciplinary proceedings. Where there is concern that conduct may constitute a criminal offence, advice should be sought immediately from HR.

c. Whilst this is a more formal process, the possibility of mutual resolution in instances of bullying or harassment through mediation at any stage of the process may be considered with the agreement of HR, management, the employee and their trade union representative, if applicable. This will be considered in the context of the case and the seriousness of the incident which gave rise to the concern.

Step One: Appointment of the investigating officer/ team and clarifying the process

- On receipt of a concern and having discussed the matter with HR and the complainant, an investigating officer or team will be appointed without undue delay.
- The team will be required to establish the facts and decide how the matter should be progressed. The investigating officer/team should be clear at the outset about how information will be used and shared throughout the

investigation and where necessary HR should provide guidance on this.

- It is anticipated that most investigations should be completed within a period of 8-12 weeks. The investigating officer/team should draw up an action plan at the outset of proceedings, outlining how the investigation will be conducted. This action plan will be flexible, as relevant parties may need to be interviewed on more than one occasion. It is the responsibility of the investigating officer/team to update the parties on the status of the investigation and provide an explanation for any delays. In any case, the investigating officer/team must provide an update to all relevant parties at the six week mark.
- At this stage, a senior manager will need to decide whether it is necessary to keep the complainant and alleged bully or harasser separated until the issue is resolved. The decision of who is moved to facilitate this will be reasonable and proportionate, considered on a case by case basis, and in consideration of service needs. In most cases, this decision will be made by a senior manager within the relevant department.
- Should a move be deemed necessary, this will be at a post of the same substantive grade for the duration of the investigation. Should there only be a post available at a lower grade, the staff member will retain the pay and benefits of their substantive grade for the duration of the investigation.
- Both parties should be advised of the process and expectations in going forward.
- A decision to suspend the alleged bully/harasser from work on normal pay as a precaution, either at the outset or at any

stage in the process, should only be taken in conjunction with HR.

- Decisions to refer the alleged bully/harasser to a relevant professional body, eg NMC, GMC, DBS, NISCC, HCPC and also to the Police Service of Northern Ireland (PSNI) should be taken in conjunction with HR. The employer is also required, under the Protection of Children and Vulnerable Adults (NI) Order 2003, to make a referral to the Department of Health if a person working in a child care or vulnerable adults position has been dismissed, would have been dismissed, or considered for dismissal had he/she not resigned, or has been suspended, or transferred from a child care or vulnerable adult position.[3]
- At regular intervals, the manager and HR should remind all staff about the support and counselling services that can be accessed at any stage in the process.

Step Two: Initial meeting with complainant

- The investigating officer/team will interview the complainant to clarify and formally record the nature of the concern and ensure it is being handled under the correct procedure. The complainant has the right to be accompanied by a work colleague or trade union representative at this stage.
- The investigating officer/team will advise the complainant that the issue is being dealt with strictly confidentially, but that the details of the concern will be shared with the alleged bully or harasser. They will be advised that the outcome of the investigation will be confirmed in writing.

[3] For medical and dental staff, MHPS will also apply.

- The complainant will receive a written note of the meeting to ensure it is an accurate record of what was discussed.

Step Three: Informing the alleged bully or harasser

- The investigating officer/team will meet with the alleged bully/harasser who will be given an opportunity to answer the concern. This meeting should be scheduled within the action plan to take place as soon as is reasonably practicable after the initial meeting with the complainant. They have the right to be accompanied to this meeting by a work colleague or trade union representative. They will also be informed that they should not contact the alleged victim and that the outcome of the investigation will be communicated.
- Where a written complaint has been received, the alleged bully or harasser has a right to see it, but should be made aware that it may be redacted.
- The alleged bully/harasser will receive a written note of the meeting to ensure it is an accurate record of what was discussed.

Step Four: Meeting with other parties/witnesses as part of the investigation

- The investigating team will also meet with those who they have deemed important in helping to establish facts, and/or have been cited as a direct witness.
- In recognising the importance of candour all staff are required to co-operate to enable an investigation to be carried out effectively and promptly.
- Witnesses are not normally represented but can be accompanied by a trade union representative or colleague not involved in the

matter. This is for support only. Witnesses must be reminded about the importance of confidentiality.

- All parties will receive a written note of their meeting, which they agree to be an accurate account of what was discussed.
- The complainant, the alleged bully/harasser and witnesses should all be advised that whilst the investigation process is confidential, records of evidence may be requested, for example, by subject access request and may by law require to be furnished, subject to any appropriate redaction. In addition, records of evidence obtained during the investigation may be discoverable documents and may require to be disclosed where relevant to any subsequent legal proceedings.

Step Five: Reporting the facts

- The investigating officer/team will prepare a report outlining the facts, indicating their findings and whether a case of bullying or harassment is substantiated. They may also make recommendations.
- This will be considered by the relevant manager in collaboration with HR to determine the outcome and whether any further action should be taken. [4]
- Staff should be aware that there are a number of potential outcomes that an investigation may produce. Although this list is **not exhaustive**, examples include:
    - No further action required
    - No further action required at this time, but the situation is to be monitored and kept under review
    - Mediation where both parties agree to take part

[4] Medical and Dental staff should be aware that further action may be taken under MHPS.

- Invocation of Capability Procedure where there is no evidence of intent to cause harm
- Redeployment of staff where there is an irretrievable breakdown in relationships (any decision to move a member of staff will be reasonable and proportionate, and taken in conjunction by senior management and HR, on a case by case basis, with regard to service need)
- Invocation of the Disciplinary Procedure

Step Six: Communicating the decision and right of appeal

- Once a final report of findings and recommendations has been produced, the complainant and alleged harasser/bully will be informed of the outcome of the investigation in writing, and a meeting will also be held to discuss.
- Potential decisions may include invocation of the formal Disciplinary Procedure without the need for another investigation, mediation if parties agree, or a finding of no evidence to support the concern.
- An investigation into bullying and or harassment under this procedure will afford the complainant a right of appeal against the findings. This should be made in writing to the Director of HR **within 10 working days** of being notified.
- The complainant must set out the specific grounds of their appeal, beyond their dissatisfaction with the outcome, focusing on factual inaccuracies and/or omissions and this will be considered by a final stage appeal panel. The panel will consider the case presented by the complainant. An investigating officer will be in attendance to provide information to the panel.
- In respect of the alleged bully/harasser, the right of appeal is only afforded through the disciplinary procedure at a formal hearing.

Review

The operation of this policy will be monitored and reviewed regularly (every 3 years) to ensure its relevance and effectiveness.

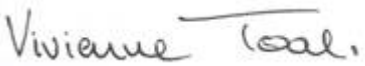
Signed on behalf of Trade Union Side:

Anne Speed

Date:

8th February 2019

Signed on behalf of Employer:



TB/04/04/2019/04

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service

Property Asset Management Plan

2018/19 – 2023/24

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

1: EXECUTIVE SUMMARY

This Property Asset Management Plan (PAMP) sets out what the Northern Ireland Ambulance Service Trust intends to do in the future to ensure property assets supports the Trust's corporate priorities, strategic objectives in line with the Trust's Corporate plan and the Executives Asset Management Strategy to make best use of Trusts financial resources and deliver value for money.

Effective asset management is essential to meeting the Trust's priorities and improvement aims with asset rationalisation a key means of reducing costs and improving efficiency. Strategic use of land and property assets is a prerequisite for the achievement of key corporate priorities in relation to providing a high quality health service with a patient and client focus.

NIAS provides accident and emergency services across Northern Ireland and therefore its Estate allows a distribution of our fleet and staff resources to stations and deployment points, located across Northern Ireland, identified to match the emergency and non-emergency call distribution and density. This creates a network of response points to minimise the response time to emergency calls. Stations are a base for staff, vehicles, local stores and training, while the deployment points provide a safe location for staff to wait for the next call when tactically deployed to provide geographical cover.

The current network has been developed over the years to meet increasing demand and challenging response targets. It is unlikely that a major shift in these locations will be required as the population distribution does not change significantly from year to year.

Key Statistics:

51 leased properties	£393k revenue costs per annum	£1.6m backlog maintenance liability (Excluding Environmental)
13 freehold properties	£175k capital costs per annum	Freehold Estate 9020 m2
Leasehold Estate 10850 m2	66% of buildings are less than 50 years old	5% of the Estate meets Statutory Standards
25% of properties are adequately used for space	20% of the Estate is in an acceptable overall condition	4 leased buildings are not in a satisfactory overall condition

The new Ambulance Station in Enniskillen went operational on the 5th December 2017.

The Trusts intends to undertake complete condition and specialist surveys to ensure these key performance indicators are accurate and to inform the estate strategy which is in development.

It is important that this plan is viewed as a live document that is continually updated and utilised as an effective property management tool to help inform and drive continuous change and improvement for the Trust.

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

2. ORGANISATION OVERVIEW

The Northern Ireland Ambulance Service (NIAS) was established in 1995. The functions of NIAS are "to provide goods and services for the purposes of health and social care and, in particular, to provide and manage ambulance and associated services; and such other services as can reasonably be carried out in conjunction with the provision and management of ambulance and associated services." NIAS operates a single Northern Ireland wide Ambulance Trust with operational areas reflecting those covered by the other five Health and Social Care (HSC) Trusts.

NIAS responds to the needs of a population in Northern Ireland in excess of 1.8 million people in the pre-hospital environment. NIAS provide ambulance care, treatment and transport services to the people of Northern Ireland 24 hours a day, seven days per week and 365 days per year.

The Ambulance Service delivers care to patients at the scene of any incident or accident for the emergency response and also provides care and transport for scheduled and un-scheduled patient journeys including outpatients, hospital admissions, discharges and inter-hospital transfers.

NIAS is operational across an area of approximately 5,450 square miles, serviced by a fleet of over 300 vehicles. Over 1,100 staff are directly employed across 64 Sites including: 36 ambulance stations, 24 deployment points, an Emergency Ambulance Control Centre, a Regional Training Centre, a HART (Hazardous Area Response Team) facility and Headquarters. Many of these properties will provide minimal office space but all are multifunctional. There are 13 properties owned by NIAS; 12 are on Commercial Lease arrangements of various lengths and 39 are shared with other Health Trusts or NIFRS.

The main focus of NIAS is on operational capability and the functions of the estate as, either a station, where staff are based, or a deployment point, where staff are assigned during their duty. Support functions such as Emergency and Non-emergency Controls, Training, Fleet, Stores and Resource Management are distributed through the estate as required.

The NIAS Corporate Plan is available on the NIAS Website

Key Estate risks on the Trusts risk register

"If the Trust does not make suitable arrangements to adequately maintain and improve the overall condition of its estate, this may result in breaches of statutory duty and put staff at risk. There is the potential for closures of sites."

New Estate Strategy is in Draft – highlights of proposal:

NIAS is facing operational pressures due in part to call volumes

This growth is predicted to continue and has been used as a basis of an independent Demand Capacity Review (DCR). The DCR report makes certain recommendations to meet the Category A response target of 72% of Calls receiving a conveying resource within 8 minutes including (a) an increase in Paramedic and Emergency Technicians (some 333 additional staff) (b) with increase in A&E Vehicles (at the peak operational requirement an additional 37 vehicles in order to meet all targets .

NIAS proposes a New HUB and Spoke model would replace the traditional NIAS frontline operational model in favour of a series of 9 large HUBs , 9 Large Reporting Stations (2 of which exist at Ballymena and Enniskillen) and 42 Small Stations / Tactical Deployment Points (with Welfare Facilities). The Increase in Tactical Deployment Points is facilitated (in part) by changing the use of an existing site from A&E station to Deployment Point

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

3. EXISTING PROPERTY ASSETS – WHERE WE ARE NOW

(Refer to appendices A – H for supporting information)

The Trust has 51 leased properties, 50 of which are service delivery and 1 of which is a store, and 13 freehold properties which are used for service delivery. The Trust has no vacant or underused leased or freehold property.

Summary of NIAS Estate Condition:

Overall Condition – As at 31st March 2018, 20% of NIAS Estate is categorised as Green (Acceptable). .

Physical Condition – As at 31st March 2018, 82% of NIAS Estate is categorised as A or B (Acceptable).

Space Utilisation – As at 31st March 2018, 25% of NIAS Estate is categorised as 3 (Adequately used).

Statutory Standard – As at 31st March 2018, 5% of NIAS Estate is categorised as A or B (Satisfactory).

Functional Suitability – As at 31st March 2018, 46% of NIAS Estate is categorised as A or B (Satisfactory)

Age Profile – As at 31st March 2018, 66% of NIAS estate is less than 50 years old.

Backlog maintenance liability breakdown:

Backlog Element	Backlog £ '000
Building	966
Engineering	450
Statutory	42
Fire	15
DDA	101
Total	1,574

N.B. Environment Backlog of £450,000 has been omitted from the report

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

4. FUTURE DEMAND FOR PROPERTY ASSETS – WHERE WE WANT TO BE

The Trust has no underused or vacant freehold estate.

The sustained lack of investment in the replacement of the Trust's infrastructure means that General Capital must be directed to in an effort to maintain properties. The result is deteriorating facilities which are less than fit for purpose and an ever increasing backlog maintenance.

Current backlog maintenance is £1,574k (Excluding Environment £450k) however ongoing work to assess the maintenance and works to ensure NIAS is compliant with all extant law is expected to bring about a significant increase. NIAS Head of Estates has estimated the spend required to become compliant as approximately £2,500. A business case seeking approval will be submitted to the Department in Q1 2019/20

New Estate Strategy is in Draft – highlights of proposal :

NIAS is facing operational pressures due in part to call volumes as set out in the Appendix1 KA34 2017/18

This growth is predicted to continue and has been used as a basis of an independent Demand Capacity Review (DCR). The DCR report makes certain recommendations to meet the Category A response target of 72% of Calls receiving a conveying resource within 8 minutes including (a) an increase in Paramedic and Emergency Technicians (some 333 additional staff) (b) with increase in A&E Vehicles (at the peak operational requirement an additional 37 vehicles in order to meet all targets .

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Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

NIAS Priorities to take forward In 2019/20

NIAS has not identified Surplus Land or Buildings, or any reduction in underperforming assets

	System Improvement	Surplus Land & Buildings	Reduction in underperforming Assets
PRIORITY 1			Commence Compliance Statutory Standard Refurbishment Works across 64 NIAS sites
PRIORITY 2			Complete Clinical and Domestic sluice Upgrade across 21 sites
PRIORITY 3			Commence Implementation phase of Estate Strategy focused on Compliance, Performance and Rationalisation of NIAS Estate
PRIORITY 4			Complete Asset condition Surveys for all NIAS sites
PRIORITY 5	Manage 3i Database and Procure Mobile estates critical audit and condition assessment tool		

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

5. DELIVERY OF STRATEGIC PROPERTY ASSET MANAGEMENT OBJECTIVES – HOW WILL WE GET THERE?

This Property Asset management Plan outlines how NIAS estate will be transformed to fulfil requirements as determined by overarching Strategies including the HSC Commissioning plan 2016/17, The New NIAS Clinical response Model, Demand Capacity Review and related NIAS Operational Strategies, Objectives and Initiatives and to meet National and Local Response Targets.

The Estate Re-Configuration, AS DISCUSSED IN THE Estate Strategy, is a radical transformation of the current estate model based on a hub and spoke model with Hubs , Large Stations and Deployment Points

The proposed timescale for this plan is 10 years plus; however a significant portion is targeted to commence within the lifetime of this PAM

The finished model will consist of 5 Divisional HQ (in line with the number of HSC trusts) and approximately 10 HUBS located to serve the larger population Centres and surrounds and the remainder covered by Deployment points.

The Primary objective of the Re-configuration is to facilitate support Responses times to Category A, B, C and Urgent Calls

The Secondary objective is to improve the Estate Statutory Standard, The Overall Condition, The Functional Suitability, The Physical Condition, and Space Utilisation and reduce the overall estate age profile thereby providing improved facilities for staff

The timed action plan for the next year sets the foundation for the change by reviewing estate in light of the Demand/Capacity review.

NIAS plans to monitor and report on delivery of the actions and targets identified in this AMP progress against the timed action plan will be monitored through the quarterly meetings of the Facilities and Support Group chaired by the Director of Operations. Estate Performance KPIs will be developed and presented to this group. Activities of this group form part of the Director of Operation's reports to Assurance Committee and Trust Board. The Facilities and Support Group will flag up any estate risks to be added to the Corporate and Local risk registers.

The key successes relating to NIAS PAM Plan in the past year are as follows
Divisional HQ and Ambulance station in Ballymena was completed in May 2016 and the Ambulance station in Enniskillen completed in November 2018 Enniskillen Ambulance Station has received a number of design awards

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

The Trust follows the Department of Health guidance relating to property, to effectively manage critical lease dates and will review critical lease dates in terms of continued need and value for money. This includes complying with policy contained in Finance Circular HSC (F)-2013-34-Addendum–Guidance on the completion of business cases relating to accommodation projects.

The Trust follows department guidance relating to property to effectively manage critical lease dates and will review critical lease dates in terms of continued need and value for money. This includes complying with policy contained in Finance Circular HSC (F)-2013-34Addendum–Guidance on the completion of business cases relating to accommodation projects.

6. PROPERTY ASSET MANAGEMENT CAPABILITY

NIAS is assisted by Land and Property Services (LPS) when negotiating leases, renewals or at break points. They also assist with identifying sites and advice on the current market. LPS and Central Procurement Directorate, Construction Division Health Projects (CPD CDHP) provide the professional expertise to ensure NIAS complies with good practice and achieves best value for estates issues.

The services provided by CPD CDHP of the Department of Finance and Personnel are as follows:-

- Procurement of Supplies & Services
- Information about public procurement in Northern Ireland - Procurement Activity Reports
- Construction Related Services
- Programme & Project Management Advice & Support
- Information about current Collaborative Arrangements (Pan Government Contracts and Framework Agreements)

Legal services are provided by Directorate of Legal Services in relation to land transactions, acquisition and disposal and leases and they act on NIAS behalf in conjunction with LPS to ensure NIAS receive best value from all property matters.

There are a number of processes, personnel and systems in place to ensure NIAS deliver on value for money with regard to our property assets, both freehold and leasehold, as follows. The Assistant Director of Operations (Fleet and Estate) has specific responsibility over these assets. The new building projects in Ballymena and Enniskillen are monitored by a Project Manager and a Project Board. The Facilities and Support Group have Estates issues on its Terms of Reference. This Group reports to the Assurance Committee who in turn report to the Board. This PAM Plan contributes to the organisations management and monitoring of Estates issues across NIAS. It is an integral element that complements NIAS Corporate Plan.

There is a NIAS Assets Register which is maintained by the Finance Department. The value of assets are regularly reviewed and reported to the Audit Committee and to the Board. Finance also keep a watching brief on Estates accounts and report any exceptions that arise. The accounts are subject to regular inspection as part of the audit programme.

On 13/11/2018 NIAS engaged an additional Estates Officer (Temporary) to practically deliver the sluice programme thereby freeing up an existing estate officer to concentrate on Business Cases, Post Project Evaluations and Compliance. This Estates Officer will leave in February 2019 , during the Sluice Programme. Existing NIAS Project Manager to take over responsibility for Programme Delivery

7. PERFORMANCE MONITORING

NIAS Facilities and Support Group monitors and reviews estates issues, as a standard agenda item, and this group reports to the Assurance Committee who are in turn responsible to the Trust Board. Any variance in the usage of the estate will be scrutinised at all these levels based on Estates data.

NIAS has systems and procedures in place to manage estates including 3i Estates Manager, Estates Terrier and Risk manager.

NIAS is compliant with departmental directives in relation to recording NIAS Estates data and associated costs on 3i.

The 3i system is geared towards storing estates information but provides limited dynamic management output. Due to the deficiencies of the 3i system , NIAS has developed a large number of spreadsheets as an overview of Planned Preventative Maintenance, Minor works, Remedial Works and Reactive Repairs. It is NIAS intention to procure a Critical Audit Tool on which to manage all aspects of estates risk management and asset condition appraisals. A more detailed analysis of the 3i issues has been made available to the Department.

The Northern Ireland Ambulance Service (NIAS) Board and Senior Executive Management team are committed to the objectives of the Executive approved Asset Management Strategy and support the NIAS Property Asset Management Plan. It links to NIAS Corporate Plan, the Trust Delivery Plan and the Annual Business Plan.

NIAS does now have a dedicated Estates Department, managed by The Head of Estates along with 3 WTE staff (All Estates team members including the Head of Estates are agency staff on short term contract basis).

The Facilities and Support Group (F&S Group) has responsibility for monitoring and progressing estates issues, policies and procedures. The F&S Group reports to the Assurance Committee who are responsible to the Trust Board.

An Administrative Officer divides their time between uniform administration, equipment administration and maintaining 3i estates software and data.

Northern Ireland Ambulance Service
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8. ACHIEVEMENTS IN THE PREVIOUS FINANCIAL YEAR

KPI	Key Performance Indicator	2015/16 Baseline Performance	2017/18 Performance	Percentage Point Improvement from 2015/16
Physical Condition	Percentage of estate by floor area categorised as A or B for Physical Condition of estate appraisals	82	**82**	0
Functional Suitability	Percentage of estate by floor area categorised as A or B for Functional Suitability of estate appraisals	46	**46**	0
Statutory Standards	Percentage of estate by floor area categorised as A or B for Statutory Standards of estate appraisals	61	**5**	-56
Space Utilisation	Percentage of estate by floor area categorised as 3 adequately used for Space Utilisation of estate appraisals	25	**25**	0
Overall Condition	Percentage of estate by floor area categorised as Green for Overall Condition of estate appraisals	27	**20**	-7
Age Profile	Percentage of estate by floor area less than 50 years old	66	**66**	0

The significant change since last year is in the Statutory Standards Compliance Score which has reduced from 61% to 5%

Clinical non-compliance with statutory standards relates to Infection Prevention Control (IPC), as stipulated by RQIA, and the fundamental requirement to have separate clinical and domestic sluices at all service delivery locations where NIAS cleans vehicles.

The NIAS IPC lead and Head of Estates have conducted a series of station tours and inspections to assess works required to address IPC Estates matters as well as to develop satisfactory domestic cleaning regimes.

The NIAS critical audit tool (Auditonline) also facilitates station based reporting of estates IPC issues via the creation of management plans which are assigned to the NIAS head of estates.

NIAS prioritises remedial work required to address compliance issues, subject to approval of funding e.g. the Sluice Programme seeks to improve domestic and clinical sluice facilities at 21 sites and is estimated to cost £627k

NIAS has instructed a series of compliance surveys, audits and reports to estimate the scope of the estates Statutory Standards non-compliance e.g. the NIAS Health and Safety (H&S) Officer has conducted H&S audits on the majority of NIAS stations and has found non-compliance at all sites. NIAS awaits further survey reports on Asbestos, Legionella and Fire Risk (PAS79)

During the year 7 leases were renewed, in conjunction with LPS, and savings of £6k were achieved

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

2: ASSET TEMPLATE SUMMARY :

BREAKDOWN OF PROPERTIES BY USE AND TENURE **TEMPLATE (A)**

ORGANISATION NAME:	**Northern Ireland Ambulance Service Health and Social Care Trust**	**DATE:**	**28th August 2018**

Use ***(If description not included below, add to list)***	**No. of Freehold Properties**	**No. of Leasehold Properties**	**TOTAL**
Office	0	0	0
Stores	0	1	1
Service Delivery	13	50	63
Vacant	0	0	0
TOTALS:	13	51	64

NIAS commenced the re negotiation, in conjunction with LPS, of a number of Ambulance Station / Deployment Point leases in 2017/18, namely:

Coleraine
Newcastle
Kennedy Way
Derriaghy
Lisnaskea
Irvinestown
Carrickfergus

At date of writing all but Carrickfergus have been completed; NIAS awaits the outcome of the rental negotiation between Land and Property Services and Mid and East Antrim Borough Council.

Savings have been achieved, most notably at Derriaghy where a saving of £6k per annum was negotiated by LPS.

Northern Ireland Ambulance Service
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BREAKDOWN OF OFFICE ACCOMMODATION **TEMPLATE (B)**

ORGANISATION NAME:	**Northern Ireland Ambulance Service Health and Social Care Trust**	**Date:**	**28th August 2018**

Name of Property & Full Postal Address	Freehold? Yes/No	Leasehold? Yes/No	Meets BMO Criteria? Yes/No	Falls Under DAO Requirements? Yes/No
NIL RETURN				
TOTALS:	0	0	0	0

NIAS does not have Freehold or Leasehold Office accommodation that meets BMO / DAO criteria as recently clarified by the Department

Northern Ireland Ambulance Service
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TEMPLATE (C)

COMMERCIALLY LEASED PROPERTY REGISTER

ORGANISATION NAME: Northern Ireland Ambulance Service Health and Social Care Trust

NAME OF PROPERTY & FULL POSTAL ADDRESS	USE
Ballynahinch	Service Delivery
Bangor Seafront	Service Delivery
Bridge End	Service Delivery
Carrickfergus	Service Delivery
Coleraine	Service Delivery
Derriaghy	Service Delivery
Irvinestown	Service Delivery
Kennedy Way	Stores / PCS
Limavady	Service Delivery
Lisnaskea	Service Delivery
Newcastle	Service Delivery
TOTAL:	**11**

NIAS occupies 11 Commercially leased premises for a variety of purposes :

7 Ambulance Station

3 Deployment Point

1 Store / PCS

In terms of Overall Condition:

0 categorised as D or DX

4 Categorised as C or CX

7 as A or B

There are currently no underused leasehold properties in NIAS estate (See Template K) The 20117/18 Target was based on NIAS having no underused leasehold properties. NIAS will monitor and review any underused estate as it arises. NIAS Facilities and Support Group monitors and reviews estates issues, as a standard agenda item, and this group reports to the Assurance Committee who are in turn responsible to the Trust Board. Any variance in the usage of the estate will be scrutinised at all these levels based on Estates data.

Northern Ireland Ambulance Service
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LIST OF FREEHOLD PROPERTIES **TEMPLATE: (D)**

ORGANISATION NAME:	**Northern Ireland Ambulance Service Health and Social Care Trust**
DATE:	**28th August 2018**

NAME OF PROPERTY & FULL POSTAL ADDRESS	USE	STATUS
Altnagelvin	Ambulance Station	to be retained (whole)
Antrim	Ambulance Station	to be retained (whole)
Ardoyne	Ambulance Station	to be retained (whole)
Newtownards	Ambulance Station	to be retained (whole)
Ballymena	Ambulance Station	to be retained (whole)
Cookstown	Ambulance Station	to be retained (whole)
Dungannon	Ambulance Station	to be retained (whole)
Kilkeel	Ambulance Station	to be retained (whole)
Knockbracken Site 5 Office,	Service Delivery	to be retained (whole)
Knockbracken HQ Office	Service Delivery	to be retained (whole)
Newry	Ambulance Station	to be retained (whole)
Omagh	Ambulance Station	to be retained (whole)
Strabane	Ambulance Station	to be retained (whole)
	13	

NIAS owns 13 Freehold properties; all of which are classified as either Ambulance Station or Service Delivery buildings

In terms of Overall Condition:

0 categorised as D or DX

11 Categorised as C or CX

2 as A or B

There are currently no underused freehold properties in NIAS estate (See Template J) The 2017/18 Target was based on NIAS having no underused freehold properties. NIAS will monitor and review any underused estate as it arises

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

PERFORMANCE IMPROVEMENT IN KEY PERFORMANCE INDICATORS AGAINST 2015/16 BASELINE (HSC TRUSTS & NIFRS ONLY) **TEMPLATE (K)**

ORGANISATION NAME:	**Northern Ireland Ambulance Service Health and Social Care Trust**	**DATE:**	**28th August 2018**

KPI	Key Performance Indicator	2015/16 Baseline Performance	2017/18 Performance	Percentage Point Improvement from 2015/16
Physical Condition	Percentage of estate by floor area categorised as A or B for Physical Condition of estate appraisals	82	**82**	0
Functional Suitability	Percentage of estate by floor area categorised as A or B for Functional Suitability of estate appraisals	46	**46**	0
Statutory Standards	Percentage of estate by floor area categorised as A or B for Statutory Standards of estate appraisals	61	**5**	-56
Space Utilisation	Percentage of estate by floor area categorised as 3 adequately used for Space Utilisation of estate appraisals	25	**25**	0
Overall Condition	Percentage of estate by floor area categorised as Green for Overall Condition of estate appraisals	27	**20**	-7
Age Profile	Percentage of estate by floor area less than 50 years old	66	**66**	0

Northern Ireland Ambulance Service
Property Asset Management Plan 2018/19 – 2023/24

PROGRESS AGAINST TIMED ACTION PLAN 2017/18

TEMPLATE (L)

	DETAIL TIMED ACTION	STATUS	JUSTIFICATION OF STATUS
1	Manage 3i Database ; Review Lease info, energy costs, maintenance costs	Not Delivered	Lease and Cost information has been delivered and an assurance has been received from CPD that the 3i database is being managed however NIAS has not updated 3i with critical audit information in relation to H&S and Fire Risk and is awaiting results of Asset Condition Surveys , Legionella and asbestos Surveys. Intention is to update 3i on receipt / completion of surveys
2	Increase Estate Team ; Proposal for Estate Structure	Not Delivered	1 Staff Member on Secondment to NHSCT; A.D. Director of Fleet & Estates in new role; All Estates Team members on Temporary or Agency Contracts
3	Estate Condition ; Complete Enniskillen, Omagh/Strabane projects	Not Delivered	Defects and Latent Defects still not fully resolved at Enniskillen and Ballymena ; Omagh Modular Transfer and Strabane overdue, NIAS taking legal advice from DLS to close case in 2018/19
4	Appoint Design Team ; Tender and award Contract	Not Delivered	Design team appointed in 2018/19 ; CPD advised NIAS that a business case is needed for fees , in order to engage Design Team
5	Estate Surveys ; Tender for Condition and specialist surveys	Not Delivered	Capacity within Estates Team
6	FM Contract ; Award Contract	Delivered	Contract Awarded in May 2017
7	Replacement Station, Belfast ; Identify site	Not Delivered	Capacity within Estates Team , Dependent on NIAS Estates Strategy , LPS cannot be engaged until Strategy Published
8	Review Current Estate ; Review Demand/Capacity report implications for estate	Not Delivered	Capacity within Estates Team , Dependent on NIAS Estates Strategy
9	Improve Cost Information ; Identify costs for stations.	Not Delivered	Capacity within Estates Team
10	Replacement Station, Belfast ; Identify site (2)	Not Delivered	Capacity within Estates Team , Dependent on NIAS Estates Strategy , LPS cannot be engaged until Strategy Published
11	Replacement Station, Conlig ; Renew Planning Permission	Not Delivered	Capacity within Estates Team , Dependent on NIAS Estates Strategy , LPS cannot be engaged until Strategy Published
12	Replacement Station, Craigavon ; Liaise with Southern Trust	Not Delivered	Informal Agreement to transfer site agreed in 2018/19

Northern Ireland Ambulance Service
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TIMED ACTION PLAN TO DELIVER BENEFITS - 2018/19 **TEMPLATE (J)**

ORGANISATION NAME: Northern Ireland Ambulance Service Health and Social Care Trust **DATE:** 28th August 2018

	PROPERTY ASSET MANAGEMENT RELATED OBJECTIVE	ACTIONS	DATE ACTION TO BE COMPLETED	CURRENT POSITION	RAG RATING
1	Technical Capability of Estate Team	Proposal for Estate Structure	Q4 2018/19	GAP Analysis complete , Skill Sets identified , Proposal in Draft to NIAS Director of Operations and SEMT	Amber
2	Complete Ballymena , Enniskillen, Omagh/Strabane projects	Instruct Directorate of Legal Services (DLS) to litigate for costs in relation to unresolved defects and latent defects	Q4 2018/19	NIAS Engaged with DLS ; NIAS Project Manager preparing outline case	Amber
3	Appoint Design Team	Write Business Case for Design Team Fees in respect of Craigavon Project	Q3 2018/19	Scope of Services in Draft	Amber
4	Estate Surveys	Complete Condition and specialist surveys to inform estate strategy	Q4 2018/19	Asbestos, Legionella, Fire Risk Assessments underway. NIAS Head of Estates agreeing scope of Survey with FM contract Provider	Red
5	Replacement Station, Craigavon	Complete Site Transfer from SHSCT to NIAS	Q3 2018/19	NIAS in process to agree final site footprint, agreement expected in Q3 2018/19 subject to AEMB approval and LPS engagement	Amber
6	Planning Permission for Replacement station at Craigavon	Full Planning Approval Certified	Q4 2018/19	Cant commence application until (5) achieved)	Red
7	NIAS Estate Strategy Consultation	NIAS Estate Strategy Consultation with all Relevant Stakeholders	Q4 2018/19	Draft Document presented to SEMT	Amber
8	Review Current Estate	Formal Independent Review Demand/Capacity report implications for Estate Tender Specification Complete	Q4 2018/19	Not started	Red
9	Improve Cost Information	Identify costs for stations.	Q3 2018/19	NIAS Head of Estates has access to BOXI Reports	Green
10	Replacement Station, Belfast	Engage LPS to search for a site for a new large station in Belfast	Q4 2018/19	Precise Location dependent on (6) and (7)	Red

Northern Ireland Ambulance Service
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1 On 13/11/2018 NIAS engaged an additional Estates Officer (Temporary) to practically deliver the sluice programme thereby freeing up an existing estate officer to concentrate on Business Cases, Post Project Evaluations and Compliance

2 NIAS Continues to work with CPD to reduce the list of Latent Defects before an evaluation of the position to Directorate of Legal Services. The Last Enniskillen / Ballymena Project board is scheduled for February 2019

3 NIAS in discussion with CPD to draft a scope of services for the Design Team in order for a fee estimate to be issued to advise a NIAS business case

4 Compliance Estate surveys in progress, Estimated to complete in Q4 2018/19

5 Project Manager for Craigavon Project in negotiation with SHSCT on exact size and placement of site

6 Planning Permission Dependent on Site having been transferred to NIAS

7 Draft NIAS Estate Strategy to be presented to NIAS SEMT in December 2018

8 Design team to be instructed to undertake Review of NIAS Estate Needs, to inform final estate strategy

9 NIAS considering use of BOXI reports

10 NIAS to meet with LPS in Q4 2018/19

Benefits of Completion of Timed Action Plan 2018/19

Reduction in non-compliant estate

David McKelvey

Head of Estates
Rev 2 28/01/2019

TB/04/04/2019/05

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

HUMAN RESOURCES AND CORPORATE SERVICES DIRECTORATE

Director of Human Resources and Corporate Services

(As at 28 February 2019)

Section 1: **Human Resources & Corporate Services**

HRCS KPI: **Shaping & Developing Future Workforce (Workforce Information, Recruitment, Job Evaluation)**

JOB EVALUATION - PARAMEDICS, RRV PARAMEDICS AND EMTS

Further to the report to Trust Board in December 2015, NIAS has received Partnership correspondence from the Regional Quality Assurance (RQA) team advising that the RQA team had reached a conclusion "that the current banding levels ie: EMT (Band 4); Paramedic (Band 5) and RRV Paramedic (Band 5) remain unchanged". This outcome requires to be validated by the RQA team through the production of a Job Evaluation report which remains outstanding from the RQA team. All affected staff were advised of the conclusion of the RQA team in December 2015 and will be formally notified of the outcome of their job evaluation process following completion of the Job Evaluation Report. Thereafter in line with due process they will have the right to request a review of the outcome. From December 2015, the Trust has engaged with Regional Leads and the Department of Health colleagues to endeavour to bring this process to a conclusion through due process, however the position has not moved forward in this regard. The Trust continues to meet with the Department of Health Workforce Policy Directorate to attempt to conclude this process.

WORKFORCE INFORMATION

Monthly Corporate Workforce Information is published monthly in arrears; consequently the table below reflects the NIAS workforce position as at **31 January 2019**. This information is taken from HRPTS.

JANUARY 2019	TRUST TOTAL	CX / BOARD	FINANCE / ICT	HRCS	MEDICAL	OPERATIONS
FUNDED (WTE) RECURRENT / (TEMPORARY FUNDING)	1,330.28 (46.00)	7.00 (0.00)	31.63 (4.00)	26.15 (11.00)	68.00 (15.00)	1,197.50 (16.00)
STAFF IN FUNDED POSTS (WTE) PERM STAFF / (TEMP STAFF)	1,279.78 (17.52)	1.00 *(6.00)	22.78 (2.00)	24.06 (0.80)	61.80 (2.00)	1,170.14 (6.72)
OVERALL VACANCY LEVELS (WTE)	**-78.98**	**0.00**	**-10.85**	**-12.29**	**-19.20**	**-36.64**

NB: *The above figures do not include individuals who support ELD clinical programmes as required, nor individuals employed on Bank Contracts.*

On the basis of the information above @ **31 January 2019**, the Trust has an overall vacancy level of **78.98** WTE posts.

*Non-Executives employed on a Fixed Term Contract.

Section 1: **Human Resources & Corporate Services**

HRCS KPI: **Shaping & Developing Future Workforce (Workforce Information, Recruitment, Job Evaluation)**

RECRUITMENT ACTIVITY

The following table provides a breakdown of frontline vacancies as at **31 January 2019** and provides related details on current recruitment activity, in line with operational directives.

Post	Funded Est (WTE)	Staff-in-Post (WTE)	Vacancy (WTE)	Bank Staff	Recruitment Activity	Current Trainees (WTE)	Date Next Training Cohort Due to Commence	Further Planned Training Cohorts
Station Supervisor	31.00	15.82	-15.18	0	No recruitment activity planned, due to issues, relating to the Station Supervisor model, which currently remain ongoing.	N/A	N/A	N/A
Paramedic + Trainee Para	320.40	352.24	31.84	34	Opened ended qualified Paramedic recruitment campaign ongoing and scope expanded to allow Final Yr Paramedic Students to apply. Fd in Paramedic Science commenced during January 2019.	47	TBC	TBC
RRV Paramedic	85.20	67.20	-18.00	0	No recruitment activity planned.	0	N/A	N/A
EMT + Trainee EMT	301.40	269.15	-32.25	6	Current active waiting list for Trainee EMT's. Further internal recruitment for Trainee EMTs planned to commence in February 2019. Open ended recruitment for Qualified EMTs ongoing.	44	2 courses of 48 Students in total due to commence in May-19 and in Jun-19.	2 courses of 48 Students in total planned to commence Oct-19.
ACA (inc. PCS Sup.) + Trainee ACA	263.50	270.23	6.73	2	External recruitment for Trainee ACA's planned to commence in February 2019.	20	1 course of 24 Students planned to commence Jul-19.	1 course of 24 Students planned to commence Oct-19.

Section 1: **Human Resources & Corporate Services**

HRCS KPI: **Supporting Staff To Achieve High Quality Performance (Attendance Management)**

CORPORATE ABSENCE REPORT (@ 28 FEBRUARY 2019)

The Trust's sickness absence target for the current Reporting Year (2018/19), as advised by the Department of Health, is to show a 5% improvement on the 2017/18 absence levels, ie a reduction from 10.50% to 9.97%. Monthly absence continued to fall during January and February, however the Trust continues to remain off track to achieve its absence target.

2018/19 Monthly Sickness Absence including Comparators to Previous Reporting Year (2017/18)												
MONTH	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
NIAS ABSENCE TARGET (2018/19)	**REDUCE SICKNESS ABSENCE RATES BY 5% ON 2017/18 PERFORMANCE TO 9.97%**											
NIAS cumulative % hrs lost (17/18)	**8.18%**	**7.98%**	**8.11%**	**8.40%**	**9.00%**	**9.36%**	**9.60%**	**9.67%**	**10.14%**	**10.50%**	**10.57%**	***10.50%*[4]**
NIAS monthly % hrs lost (17/18)	**8.18%**	**7.82%**	**8.36%**	**9.30%**	**11.24%**	**11.25%**	**11.05%**	**10.13%**	**14.05%**	**13.55%**	**11.38%**	**10.83%**
NIAS cumulative % hrs lost (18/19)	**9.73%**	**9.88%**	**10.92%**	**11.33%**	**11.36%**	**11.52%**	**11.44%**	**11.25%**	**11.35%**	**11.39%**	**11.41%**	
NIAS monthly % hrs lost (18/19)	**9.73%**	**10.02%**	**13.09%**	**12.57%**	**11.50%**	**12.32%**	**11.05%**	**9.98%**	**12.09%**	**11.78%**	**11.57%**	
Monthly % hrs lost (S/T)	2.65%	2.12%	3.41%	2.66%	2.49%	2.61%	2.81%	2.86%	3.38%	3.64%	2.67%	
Monthly % hrs lost (L/T)	7.08%	7.89%	9.66%	9.91%	9.01%	9.69%	8.24%	7.12%	8.72%	8.14%	8.90%	
Av. days lost (7.5 hrs) per Employee per Mth	1.97	2.24	2.54	2.68	2.55	2.38	2.47	2.13	2.32	2.62	2.41	
Av.NIAS cumulative costs (£'000)	£354	£360	£458	£441	£408	£412	£410	£405	£410	£416	£421	
NIAS CUMULATIVE % HRS LOST:	**(2017/18) 10.59%**				**(2018/19 @ 28 February 2019) 11.41%**					**NOT ON TARGET**		

NB:(1) The Figures exclude Bank Staff and the Non-Executive Team; (2) The information is reported from HRPTS and, in line with HSC regional reporting, is in % hours lost; (3) In respect of average days lost it should be noted that, whilst the majority of NIAS staff are shift workers (approx 88%), who mostly work 12 hour shifts, the HRPTS calculation automatically divides working days over a standard 5-day week (Monday – Friday, based on a 7.5 hr day). (4) 10.5% represents the final cumulative total for NIAS, as per the Regional HRPTS re-run absence figures, (as re-run in May 2018).

The Trust continues to take the following measures to address current levels of absence:

- AACE associates have now completed their Review of Attendance Management within NIAS. The findings and recommendations of their Report have been accepted and a Good Attendance Programme structure is currently being developed to implement the recommendations;
- Recruitment is ongoing for an HR Lead for Attendance Management. An appointment to this post is anticipated for Quarter 2, 2019/20;
- BSO Internal Audit have completed their audit of compliance with the current Attendance Management Policy/Procedure and an action plan to take forward their recommendations is being finalised;
- Flu vaccination campaign commenced at the end of October 2018 – 45.7% of frontline staff received vaccination through NIAS peer vaccination programme as at 28 February 2019;
- Collaborative working within regional HSC on Attendance Management workstreams;
- Workstreams under the Health & Well-Being Programme ongoing including: Unison Partnership Project; Peer Support Project; Health & Wellbeing workshops for staff.

GOOD ATTENDANCE WORKSHOP (25 MARCH 2019)

UPDATE TO TRUST BOARD (4 APRIL 2019)

1.0 Introduction

Work continues within the Trust to identify improvements in terms of attendance management, staff support and health and well-being initiatives. In recognition, however of its higher than average sickness absence levels in comparison to HSC and NHS Ambulance Trusts, in November 2018 NIAS invited the Association of Ambulance Chief Executives (AACE) to assist and review its management of attendance (with a particular focus on operational front-line and control room staff). In February 2019 Trust Board considered and accepted AACE findings and recommendations for improving attendance levels within NIAS. At the same time in February 2019, Internal Audit provided only limited assurance to NIAS on Absence Management following its review undertaken in October/November 2018.

2.0 Good Attendance Workshop

In the context of the AACE and Internal Audit Reports on Absence Management, on 25 March 2019 a NIAS Good Attendance Workshop took place. The purpose of the workshop was to bring key stakeholders together to consider AACE and Internal Audit recommendations; agree key deliverables and agree how work streams could be taken forward with the overarching objective of improving NIAS absence levels. The workshop was attended by AACE together with wide cross section of staff from Management; Operational Front-Line Managers / Staff; representatives from the Human Resources Team and Trade Unions.

3.0 Outputs from Good Attendance Workshop

Following presentations from AACE and constructive group work at the workshop, the following was agreed:-

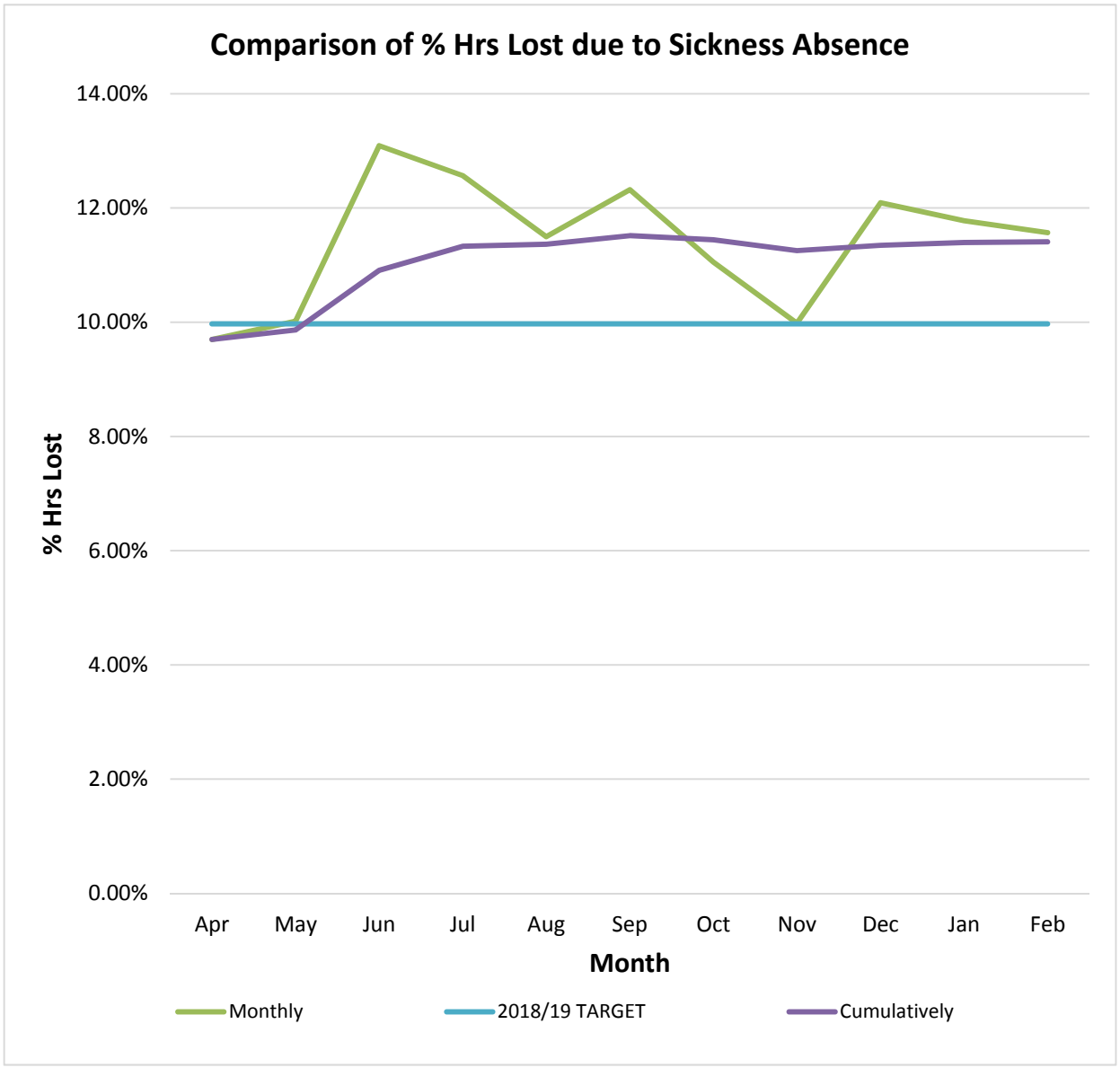
- that a Programme Board and related structures should be established to take forward AACE / Internal Audit recommendations.
- that each of the recommendations could be taken forward under four key themes which should form Project Teams identified as:-
  - Review of Attendance Policy and related procedures
  - Operations Directorate Priorities/Improvements
  - Occupational Health Improvements
  - Health & Wellbeing Improvements
- that key deliverables be identified from the recommendations and prioritised with quick/high impact actions being identified to deliver early change. A summary of key deliverables are outlined below.

4**.0 Way Forward**

Directly following the Good Attendance Workshop on 25 March 2019, an inaugural meeting of the Programme Implementation Team took place during which a Good Attendance programme structure was agreed. The Good Attendance Programme Board is scheduled to meet on a monthly basis with AACE continuing to support this programme of work on an ad-hoc basis. It is the intention to provide Trust Board with an update on this key programme of work on a regular basis.

GOOD ATTENDANCE PROGRAMME DELIVERABLES

PROJECT 1: REVIEW OF ATTENDANCE POLICY & RELATED PROCEDURES	PROJECT 2: OPERATIONS DIRECTORATE PRIORITIES & IMPROVEMENTS
KEY DELIVERABLES: ❖ Review Attendance Management Policy / Procedure. ❖ Review associated policies / procedures to support implementation of the revised Attendance Management Policy / Procedure, inc Lighter Duties Policy etc. ❖ Develop of Management Resource to support implementation of revised Policy / Procedure, inc Training, Mgmt Toolkit, DDA Guidance etc. ❖ Re-launch revised Policy / Procedures. ❖ Explore HR best practice and roll out across the Trust. ❖ Develop and deliver a communications plan. ❖ Review governance arrangements for reporting of absence and related corporate reports.	**KEY DELIVERABLES:** ❖ Review and establish Senior Managers performance management systems for Attendance Management to inc monitoring of (timely) escalation through Policy/Procedure. ❖ Review the provision & source of timely information reports to identify and deliver on areas of improvement. ❖ Explore local best practice and roll out across Directorate. ❖ Review the role of RMC and utilisation of GRS in relation to managing attendance inc staff reporting of sickness and contact arrangements, and develop appropriate systems/processes/protocols. ❖ Review Operational Directorate staff absence reporting methodology to reflect best practice. ❖ Review of Operational Directorate processes for management of sickness certificates. ❖ Ensure local recording of Attendance Management activity ❖ Review of R2W practices inc establishing a system to ensure timely undertaking of interviews, review of template documentation for completion and a system that ensures related forms are signed and dated ❖ Joint review of Operational Directorate Annual Leave Procedure ❖ Develop and deliver a communications plan linked to this work stream.
PROJECT 3: **OCCUPATIONAL HEALTH IMPROVEMENTS**	**PROJECT 4:** **HEALTH & WELLBEING PRIORITIES**
KEY DELIVERABLES: ❖ Specify what is required from an Occupational Health Service for NIAS ❖ Review specification against existing Occupational Health Services and identify gaps ❖ Scope provision for enhanced or new local Occupational Health Services ❖ Develop an outline business case for investment in Occupational Health Services to meet identified requirements and gaps ❖ Develop and deliver a communications plan linked to this work stream.	**KEY DELIVERABLES:** ❖ Invest in the Joint Partnership Health & Well Being priorities, as identified in the partnership survey and agree a related annual work plan to deliver on these ❖ Embed peer support ❖ Consider formal post-incident support & related “Stand Down” ❖ Review arrangements to support mental health and well-being and make recommendations for improvements ❖ Develop and deliver a communications plan linked to this work stream.



ABSENCE CATEGORIES / REASONS WITH MORE THAN 1% ABSENCES (APR 18 – FEB 19) INCLUDE:

Mental Health	27.32%
Other Reasons	24.08%
Back problems + Injury / Fracture + Other Musculosketal problems	19.67%
Accident / Untoward Incidents at work	10.07%
Gastrointestinal problems	6.52%
Asthma, Chest, Resp.	2.81%
Tumours and Cancers	2.11%
Heart, Cardiac & Circulatory Problems	1.59%
Influenza	1.08%
ENT	1.04%

ABSENCE REASONS RECORDED WITHIN "OTHER REASONS" CATEGORY (APR 18 – FEB 19) INCLUDE:

General Debility	70.97%
Hospital Investigation	9.36%
Post Surgery Debility	17.14%
Chronic Fatigue	1.51%

ABSENCE CATEGORIES WITH LESS THAN 1% ABSENCES (APR 18 – FEB 19) INCLUDE:-

Burns/Poisoning/Frostbite/Hypothermia; Dental/Oral Problems; Endocrine/Glandular Problems; Eye Problems; Genitourinary & Gynaecological Conditions; Headache/migraine; Infectious Diseases; Nervous System Disorders; Pregnancy related; Skin Conditions; Substance Abuse; Viral Illness.

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Staff to Achieve High Quality Performance (to promote a culture of performance management, developing sound systems for managing performance and underperformance issues effectively and constructively)

England Ambulance Services	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**	**Sept 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**	**Jan 2019**	**Feb 2019**
East Midlands Ambulance Service NHS Trust	4.85%	4.72%	5.07%	5.47%	5.66%	5.45%	5.09%	5.10%	Not available at time of print	Not available at time of print	Not available at time of print
East of England Ambulance Service NHS Trust	5.68%	5.54%	5.67%	5.84%	5.88%	6.06%	6.00%	6.63%			
Yorkshire Ambulance Service NHS Trust	5.66%	5.23%	5.15%	5.09%	5.43%	5.29%	5.70%	6.12%			
South Central Ambulance Service NHS Foundation Trust	4.96%	5.13%	5.68%	6.18%	6.49%	6.24%	6.07%	6.22%			
London Ambulance Service NHS Trust	4.99%	5.02%	5.31%	5.20%	5.42%	5.20%	5.45%	5.41%			
S/East Coast Ambulance Service NHS Foundation Trust	4.84%	4.41%	4.34%	4.87%	4.86%	5.20%	5.19%	4.84%			
North East Ambulance Service NHS Foundation Trust	6.40%	6.01%	6.18%	6.11%	6.00%	5.63%	5.79%	5.30%			
North West Ambulance Service NHS Trust	5.33%	5.36%	5.20%	5.45%	5.68%	5.78%	5.77%	5.95%			
West Midlands Ambulance Service NHS Foundation Trust	3.36%	3.25%	3.10%	3.28%	3.26%	2.97%	3.58%	3.47%			
South Western Ambulance Service NHS Foundation Trust	4.58%	4.57%	4.61%	5.02%	5.31%	5.32%	5.33%	5.74%			
By Staff Group - Ambulance	*5.10%*	*4.90%*	*5.03%*	*5.19%*	*5.41%*	*5.31%*	*5.34%*	*5.47%*			
By Organisation Type - Ambulance	*5.01%*	*4.89%*	*4.98%*	*5.18%*	*5.34%*	*5.26%*	*5.37%*	*5.49%*			
	2017/18	**2018/19**									
Scottish Ambulance Service	7.67%	Not available									
	Apr-Jun 17	**Jul-Sep 17**	**Oct-Dec 17**	**2017**	**Jan-Mar 18**	**Apr-Jun 18**	**Jul-Sep 18**	**Oct-Dec 18**	**Jan-Mar 19**		
Welsh Ambulance Service	6.30%	6.90%	7.40%	6.80%	8.10%	7.50%	7.60%	Not available at time of print			
Information Source:											
1. NHS Digital (www.digital.nhs.uk)											
2. IDS Scotland (www.isdscotland.org)											
3. Stats Wales (www.statswales.gov.wales)											

Section 1: **Human Resources & Corporate Services**

HRCS KPI: **Complaints and Compliments**

The Trust have received a recent recommendation from Internal Audit to report on open complaint cases and from the next Trust Board meeting, this report will be modified to reflect these cases. Trust Board are advised that there are currently 65 open complaints and action plans have been developed in relation to addressing these.

Total complaints received to date:	118	**For same period last year:**	126

HANDLING TIMES OF COMPLAINTS FOR 2018-19

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	%	2017-2018	
Complaints Received	8	12	7	4	29	11	9	13	3	7	15		**118**		**133**	*100%*
Total A&E & PCS Activity	***27600***	***29922***	***28815***	***28405***	***28631***	***27842***	***29914***	***29544***	***28867***	***30170***	***27,584***		***317294***			
% Complaints/Activity	***0.03%***	***0.04%***	***0.02%***	***0.01%***	***0.10%***	***0.04%***	***0.03%***	***0.04%***	***0.01%***	***0.02%***	***0.05%***		***0.04%***			
Acknowledged within 2 working days	8	11	7	4	16	11	9	13	3	7	14		**103**	*87%*	**133**	*100%*
Acknowledged after 2 working days	0	1	0	0	13	0	0	0	0	0	1		**15**	*13%*	**0**	*0.0%*
Response within 20 working days	0	0	2	0	2	0	0	2	0	0	0		**6**	*5%*	**29**	*22.0%*
Response after 20 working days	4	0	0	0	0	0	1	0	0	0	0		**5**	*4%*	**30**	*23.0%*
Complaints Investigations ongoing	4	12	5	4	27	11	8	11	3	7	15		**107**	*91%*	**74**	*55.0%*
Cases referred to NI Ombudsman (cases ongoing)	0	0	2	1	1	0	0	0	0	0	0		**4**		3	

NATURE OF COMPLAINTS RECEIVED 2018-19

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017-18	%	2017-2018	
Staff Attitude	3	2	3	0	9	3	3	5	1	3	5		37	*31%*	**52**	*39%*
Ambulance Late/No Arrival	1	4	1	3	11	6	3	6	1	4	5		45	*38%*	**43**	*32%*
Quality of Treatment & Care	4	5	0	1	7	2	2	0	0	0	3		24	*20%*	**24**	*18%*
Suitability of Equip/Vehicle	0	0	0	0	0	0	0	0	0	0	0		0	*0%*	**2**	*2%*
Other	0	1	3	0	2	0	1	2	1	0	2		12	*10%*	**12**	*9%*
Patient Property	0	0	0	0	0	0	0	0	0	0	0		0	*0%*	**0**	*0%*
TOTAL	**8**	**12**	**7**	**4**	**29**	**11**	**9**	**13**	**3**	**7**	**15**	**0**	**118**		**133**	

COMPLIMENTS RECEIVED 2018-19																
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2018-19**		**2017-18**	
RECEIVED	25	17	11	17	15	22	23	30	19	11	14		**204**		**298**	
SERVICE AREA OF COMPLIMENTS RECEIVED																
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2018-19**	***%***	**2017-18**	
Accident & Emergency	24	14	10	15	14	21	22	25	17	11	12		**185**	*90.7%*	**274**	*92%*
Control	1	0	1	2	1	0	0	4	0	0	0		**9**	*4.4%*	**14**	*5%*
Patient Care Service	0	3	0	0	0	0	1	1	0	0	2		**7**	*3.4%*	**6**	*2%*
Voluntary Car Service	0	0	0	0	0	0	0	0	0	0	0		**0**	*0.0%*	**0**	*0%*
Other	0	0	0	0	0	1	0	0	2	0	0		**3**	*1.5%*	**4**	*1%*
TOTAL	**25**	**17**	**11**	**17**	**15**	**22**	**23**	**30**	**19**	**11**	**14**	**0**	**204**		**298**	

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Trust Priorities

CLOSED COMPLAINTS: JANUARY / FEBRUARY 2019

First received	Closed	Subject (primary)	Subject (CH8)	Description (Policies)	Outcome	Action taken (Investigation)
22/08/2018	20/01/2019	Quality of Treatment & Care	Quality of Treatment & Care	Complainant alleges that the ambulance crew were rough when treating her and she was left with bruising to the arm.	Complaint not upheld. The investigation has shown that the crew acted appropriately and followed clinical guidelines. Apology issued for the perceived negative experience.	Letter of explanation and apology issued for the patient's negative experience.
19/01/2018	03/01/2019	Quality of Treatment & Care	Quality of Treatment & Care	Complainant alleges that she should have been examined in greater detail and taken to the A&E Department.	Complaint partially upheld. Records indicate that the patient was given the opportunity to attend A&E, but declined. The investigation has shown that the patient assessment and clinical observations were not as comprehensive as they should have been.	Letter of explanation and apology issued. Crew to be counselled on completion of patient report forms and carrying out relevant and appropriate clinical observations.
10/10/2018	10/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Father making complaint after his son sustained fracture to ankle and was allegedly informed by the Clinical Support Desk (CSD) that he would need to transport him to hospital himself.	Complaint not upheld. The investigation has shown that the actions of the CSD paramedic were reasonable and appropriate.	The complaint was resolved locally by NIAS Clinical Lead. A verbal explanation was given to the complainant and the matter was discussed. The complainant is content with the explanation and advice given. Informal resolution letter issued. No further actions necessary.
11/09/2018	03/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Patient had to wait over 2 hours for an emergency ambulance after suffering a stroke.	Complaint upheld. The investigation has shown that the response time to the patient could have potentially been made quicker. It is also evident that the demand for ambulances was high and there were a number of operational staff shortages along with lengthy turnaround times at EDs.	Letter of apology and explanation issued.

21/08/2018	08/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Complaint around the delay in getting connected to the 999 Operator at Emergency Control.	Complaint upheld. Due to a shortage of Control staff and a high volume of 999 calls, there was a delay in receiving incoming emergency calls.	Letter of explanation and apology given. The reasons for the delay in getting through to EAC were explained to the complainant. Assurances were provided around what steps NIAS are taking to address the problem.
26/02/2018	05/02/2019	Quality of Treatment & Care	Quality of Treatment & Care	Patient was involved in a RTC. When crew arrived they examined patient and concluded at scene patient had no injuries.. Patient stated that he was in pain and was asked by crew to get out of car and make her way to ambulance, when patient was examined in A&E she was advised she had suffered from severe abdominal injuries and broken bones and had to have surgery to rectify this.	Complaint not upheld. The investigation has shown that the assessment and treatment provided was adequate and appropriate.	A letter has been issued to the complainant explaining the outcomes of the investigation and demonstrating the actions of the crew.
21/08/2018	14/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Unhappy with response time for emergency ambulance.	Complaint upheld. The delay in responding to this call was due to the number of ongoing emergency calls at this time.	A letter apologising and explaining the reasons for the poor response was issued.
03/09/2018	20/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Complaint in relation to the delay of an ambulance for a patient that was suffering from abdominal pain.	Complaint upheld. The investigation has shown that staff shortages and a high volume of calls, contributed to delayed response times.	Letter of apology and explanation given for the delayed ambulance.
21/08/2018	08/01/2019	Quality of Treatment & Care	Quality of Treatment & Care	Complainant alleges that a NIAS driver was exceeding speed limit whilst driving, complainant stated that when they arrived at hospital PCS driver was abrupt and dropped patient out of wheelchair.	Complaint upheld. Due to the nature of the complaint the matter will be referred to the Trust's Disciplinary process.	A letter of apology and explanation was issued. The complainant was advised that the matter is to be further investigated under the Disciplinary process.
22/08/2018	12/02/2019	Staff Attitude/Behaviour	Staff Attitude/Behaviour	Complainant allegations that a NIAS staff member made inappropiate comments about her and that she was refused treatment.	Complaint not upheld. The investigation has shown that the patient refused treatment. The complaint has been addressed locally by the Area Manager who has spoken to the complaint and provided necessary advice.	No further actions identified. A letter has been issued to the complainant advising them to contact the Trust should they any further concerns.

29/05/2018	14/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Complaint regarding arrival time of emergency ambulance that was required for patient suffering from a seizure.	Complaint upheld. The investigation has identified that the demand for ambulance at this time was high. Although NIAS did eventually despatch an ambulance, this was stood down as Control was informed that the patient was being transported to hospital by a family member.	A letter of apology and explanation was issued which outlines the high volume of calls at the time of the call.
05/10/2018	07/01/2019	Staff Attitude/Behaviour	Staff Attitude/Behaviour	Crew allegedly made derogatory comments about patient and allegedly opened a number of drawers within patients home.	No further contact was made from the complainant after letter issued and phone call made.	No further actions identified.
20/08/2018	29/01/2019	Quality of Treatment & Care	Quality of Treatment & Care	Complainant unhappy with comments made by paramedic on arrival. Concerns were also raised around the quality of the treatment provided.	Complaint upheld. The investigation has shown that the treatment and behaviour of the crew fell short expected standards.	Letter of apology and explanation issued. The crew have been referred to their Clinical Support Officer (CSO) to undergo relevant training. A verbal warning was issued to one of the crew for their behaviour at the call.
21/12/2018	11/02/2019	Staff Attitude/Behaviour	Staff Attitude/Behaviour	Member of the public has reported an incident of dangerous driving by a NIAS staff member. Submitted dash footage to support complaint.	Complaint upheld. The investigation and dash camera footage has shown that the standard of driving by the NIAS staff member, was below the expected standard.	Letter of apology and reassurance issued. The NIAS staff member has been referred to undertake relevant training and a reflective practice exercise.
22/08/2018	21/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Complaint around the wait for an emergency ambulance for a road traffic collision.	Complaint upheld. The investigation has shown that an incorrect location was entered onto the Control system and the ambulance arrived at an incorrect location. This contributed to the poor response time to the call.	A letter of apology and explanation for the delay has been issued. The control staff concerned have been given the necessary additional training.
01/08/2018	21/01/2019	Quality of Treatment & Care	Quality of Treatment & Care	Complainants' mother was being transported to eye clinic in Non-Emergency Vehicle, PCS vehicle was involved in RTC. Concerns at why complainants' mother was not assessed after the accident and concerns of her safety.	Complaint not upheld. The investigation has shown that all occupants that were involved in the RTC were checked over and asked if they wished to attend A&E, but all declined and were able to continue on with their journey.	A letter of explanation has been issued explaining what actions were taken after the RTC.

22/08/2018	14/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Complaint regarding the delay of an ambulance for a patient that had fallen from his bike.	Complaint upheld. The delay in providing an ambulance was due to a high demand ambulances at the time of the call. The first ambulance that became available was dispatched.	Letter of apology issued. An explanation was provided for the delayed ambulance.
30/07/2018	21/01/2019	Transport, Late or Non-arrival/Journey Time	Transport, Late or Non-arrival/Journey Time	Complaint around the delay of an ambulance to a patient that suffered from a fall and subsequently fractured their hip.	Complaint upheld. The investigation has shown that delays to calls on this day were due to a combination of staff shortages and the high demand for ambulances.	Letter of apology and explanation given for the late ambulance.

TB/04/04/2019/06

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Medical Director
4 April 2019
(January-February 2019)

Medical Directorate Performance Report for Trust Board

Emergency Planning & Business Continuity	
	At the time of writing the potential impact of an EU Exit remains unclear pending clarification from the UK Government on the anticipated date of change on 29 March. The Department of Health locally has been leading on preparation across the HSC with Trusts being tasked to prepare on a potential worst case scenario, i.e. a hard border with the Republic of Ireland and withdrawal from the EU Common Travel and Customs arrangements. Within NIAS, work is in progress to address fuel stocking capability, and assurances have been received regarding supply of pharmacy, medical equipment (and specifically defibrillator consumables). Regional working parties led by the Department of Health are addressing other wider issues included below: • Supply of medical equipment; • Provision of pharmaceutical supplies; • Implications for non-EU staff and staff who live across the border; • Cross-border ambulance response for emergency calls and in the event of a major incident; • Elective cross-border care (transfer of patients to and from ROI for specific procedures e.g. paediatric cardiac surgery in Dublin). NIAS has been tasked along with other HSC bodies to provide regular sitreps on any impact related to EU Exit and actions taken to mitigate these. The recruitment process for 24/7 HART response has concluded with staff scheduled to take up post on 1 April.
Risk Management	
Corporate Risk Register	The Trust's Corporate Risk Register is presented monthly to SEMT, and to the Assurance Committee as a standing agenda item. The format of this presentation has been updated in order to highlight new, deleted or altered risks. Following recommendations from Internal Audit, the Corporate Risk Register is now included with Trust Board papers and appears as an Appendix to this report. The Local Risk Registers of each Directorate are presented to the Trust's Assurance Committee on a rolling basis to ensure that all are considered during the year.

Incident Reporting Procedures	The review of SAIs and other incidents continues to present a considerable challenge due to the small governance team within NIAS and competing pressures, particularly within the Medical Directorate and also the Operations Directorate when contribution is required in order to finalise reports. This has led to significant delays in the submission and completion of reports which has been noted by an Internal Audit review of the management of incidents, SAIs, complaints and litigation. In line with Internal Audit processes, NIAS has reviewed the report and will develop an action plan in order to address the key findings. This will require input from the Medical Directorate and Human Resources / Corporate Service Directorate in particular, with a longer term review of resourcing to address the issue. The management of SAIs regionally is also under review by RQIA as part of the actions identified following the publication of the Inquiry into Hyponatraemia-Related Deaths. NIAS has been asked to submit four sample cases for discussion. NIAS continues to participate in the learning outcomes review from SAIs regionally with a composite report of Untoward and Serious Adverse Incidents being reported at each meeting of the Assurance Committee. New SAIs are reported weekly at SEMT. NIAS is represented on multiple regional workstreams relating to the 96 recommendations of the O'Hara Report into hyponatraemia-related deaths in Northern Ireland. This involves staff from multiple levels within the organisation up to Non-Executive Directors and the Chair of Trust Board. Within the list of recommendations, there are many that apply directly and indirectly to NIAS, particularly around the area of Duty of Candour and Management of Investigations, while there are a small number that have no direct relevance to the context of an Ambulance Service. The Department has given clear direction that a regional approach should be taken rather than Trusts introducing disparate approaches. The topic remains a standing item on the agenda of the Learning Outcomes Review Group.
Outcomes from Reports, Alerts, etc.	Regular reports on adverse incidents including SAIs involving NIAS are provided to the Assurance Committee. In addition, the Medical Director reports on any Coroner's reports, medication and device alerts, NICE guidance and regional learning letters which are applicable to the context of an Ambulance Service. All of these areas are eligible for discussion at the Trust's Learning Outcomes Review Group which is aimed at disseminating relevant learning from incidents across the entire Service.
Clinical Care	

Infection Prevention & Control	Following the removal of previous improvement notices and their replacement with one improvement notice relating to Trust-wide areas of governance and training, RQIA undertook a further unannounced inspection of Ballymena ambulance station. A formal report is awaited but feedback at the time commented favourably on improvements at station level relating to the cleanliness of facilities and vehicles, as well as staff knowledge and a clear evidence trail supporting the arrangements in place. The Chief Executive has written to RQIA seeking an extension of the current review period until the end of June 2019 in order to allow time for a fuller development of the IPC Training Strategy which is key to the latest improvement notice. A business case has been submitted to the Department seeking support for all of the factors necessary for sustained improvement including long-term provision of dedicated vehicle cleaners, updates to estate in order to meet compliance with IPC standards, and hardware and software required to facilitate the real-time audit process.
Regional Community Resuscitation Strategy	**Community** All 11 Council areas have discussed the possibility of including Community Resuscitation within Health and Wellbeing of the Community Plans. The following Councils have a Community Resuscitation Action Plan in place – Ards & North Down, Lisburn & Castlereagh, Mid Ulster Council & Antrim and Newtownabbey Council. Armagh, Banbridge & Craigavon are in process of setting up a Lifesaver action group. Fermanagh and Omagh have confirmed that they will also progress an action group for Community Resuscitation and are currently identifying the partners to invite. Derry and Strabane are in the process of identifying dates and progressing their Health & Wellbeing plans. **AEDs** • An AED interactive mapping database has now gone live on NIAS website and all Councils have been made aware and are keen to also include the link on their respective websites too. • Currently in the process of developing an A5 flyer regarding registration of defibs. • Currently scoping the idea of an identifiable sticker on registered defibs to let members of the public know it is registered. **Community First Responders** • GoodSam App Project team has met to progress the work of GoodSam which will be launched in June 2019 • All documentation, processes and training relating to CFR Schemes are being reviewed.

	• Discussions have taken place with interesting parties regarding new CFR Schemes. • New Patient Report Forms have been developed in partnership with the Community First Responder Co-ordinators. **Schools** Heartstart Teacher training is now progressing across 6 teacher training venues. Both update training for existing teachers and initial training for new teachers is taking place and the feedback has been very positive. **Data** 2017/18 data for Out of Hospital Cardiac Arrest is in the process of being submitted to Warwick University as part of the OHCA UK registry. **BASICS Doctors** A number of specially-trained doctors across Northern Ireland continue to provide voluntary support to NIAS at serious incidents on a 24/7 basis. Funding was identified to equip all of these doctors with AEDs and clinical response bags in line with those used by the HEMS Service.
Regional Electronic Ambulance Communications Hubs (REACH) Project (previously ePRF)	The business case for introduction of an electronic Patient Report Form (ePRF) received the support for capital from the Department of Health and Department of Finance in June 2017. A Project Board led by the Chief Executive has been established and work has now commenced on the procurement. Stage 2 of the procurement process has now completed. NIAS has now received the financial envelope and has carried out a financial evaluation. A preferred supplier has been identified and all procurement documentation returned to PALS. The Full business case has been completed for review by HSCB. Costs are within the original estimates of the OBC. Revenue costs are reduced compared with original estimates. HSCB have issued a letter of support for the Full Business Case (Feb 2019) and PALS have been notified to issue the letter of intent to award contract to the preferred supplier. The procurement plan remains on track.
Appropriate Care Pathways	The Appropriate Care Pathways aim to enhance patient care by offering them a choice as to the care they receive. As a result fewer patients are transported to the ED. NIAS non-conveyance

	dropped slightly to just under 25% in Jan / Feb 2019. On 4 February 2019, the new Older Persons Assessment Unit (OPAU) pathway went live in Craigavon which enables NIAS paramedics to refer patients with frailty related conditions directly to this specialist unit. The Safeguarding Pathway was reviewed and updated in Feb 2019. Other key events which occurred in January / February were: **Research** The draft MOU has between NIAS and SHSCT has been produced and is awaiting sign off. **ED Turnaround Times** Dr Roberts and the Patient Safety Forum have been leading a piece of work around ED turnaround times. There were a number of outputs including the ED waiting room referral pathway. The Medical Directorate assisted Dr Roberts with his presentations to the various Trust SEMTs. **Frailty** Approximately 50% of patients who call 999 are over the age of 65. In February 2019, a short pilot was commenced whereby a Consultant Geriatrician and a paramedic co-responded to patients over the age of 65 with frailty related problems. This pilot is due to be completed by March 2019. **Nursing Home Engagement** Members of the medical directorate presented at a number of nursing home engagement events whereby they highlighted the role of NIAS and the NIAS ACPs. A joint training session was also held in Belfast whereby NIAS and a Consultant Geriatrician facilitated a teaching session to care home managers on “recognising the deteriorating patient and when to call NIAS”. **Social Prescribing** Two members of staff attended the social prescribing conference in Craigavon. **Penthrox** A pilot assessing this new form of analgesia has now concluded. The evaluation found that this drug has a likely benefit for patients attended by NIAS, most likely in the setting of acute traumatic injury. A Patient Group Directive will need to be developed but it is likely that this drug could be made available to both paramedics and EMTs. An evaluation of the financial impact is now underway.

	Clinical Support Desk The CSD MTS evaluation is complete and was presented to SEMT. Partnership working is underway between the Clinical Support Desk and the PSNI. Police officers can now contact CSD directly where there are protracted on-scene times awaiting NIAS attendance. Furthermore, a pilot is now underway whereby PSNI contact NIAS directly on the 999 system to request an ambulance rather than go through PSNI control. This enables a more accurate triage of PSNI calls and also offers the CSD team the opportunity to re-triage calls. **Frequent Callers** A "Demand Management" conference was held in Mossley Mill in February with over 80 senior stakeholders present including members of PSNI; NIFRS; PHA; HSCB and Trusts. The aim of the event was to demonstrate that multi agency input will be required to manage "frequent callers" but that all agencies benefit from managing them. **Street Triage** Following the meeting with the Perm Sec, the CMO called a meeting with all stakeholders to discuss the expansion of the Multi Agency Triage Team (MATT). The aim is to increase the catchment area to include Belfast. A training event was held in Feb and an additional 8 paramedics have joined the MATT team. NIAS also worked with PNSI and SEHSCT colleagues to produce a short BBC Newsline articles to demonstrate the benefits of this service.
Helicopter Emergency Medical Service (HEMS)	The HEMS Service continues to respond to serious trauma calls across Northern Ireland in line with the activity originally projected during the implementation phase. The Clinical and Operational Leads are now exploring the potential to deploy the aircraft to a wider range of calls where the critical care skills of the doctor/paramedic team could provide significant benefit to patients. Meetings have been held with the Department of Health to explore the potential for secondary transfers of patients with time-critical conditions e.g. patients with acute stroke being transferred to the regional centre in Belfast for thrombectomy. While numbers of these transfers are low, the potential to impact on the primary trauma response must be considered and one option would be to deploy the second aircraft in an air ambulance role. In this configuration an aircraft could potentially fly 24/7 between designated landing sites at peripheral hospitals and the RVH. NIAS and the charity partner Air Ambulance Northern Ireland (AANI) continue to meet on a regular basis to review areas of operational, financial and more recently clinical performance.

	Funding has been obtained from a charitable source to provide infrastructure to AANI for the prehospital administration of blood products to trauma patients. HEMS paramedics are employed by NIAS but the medical cover continues to be provided by consultants in addition to their own regular employment which is a variation from the original intention that this would be incorporated within their Trust job plans. This has the potential to threaten full coverage of the HEMS Service if staff cannot be released as was originally agreed by Trust Chief Executives. The paramedics were originally employed on a temporary contract for a one-year duration given the uncertainty over timing of the introduction of the service, but it has already been agreed to extend these contracts in order to provide continuity within the service. The potential for employing some paramedic staff on a permanent basis is being considered alongside the rotation of other paramedics as a secondment.
Personal Public Involvement / Patient Client Experience	
Patient and Client Experience Standards (PCES)	The Patient Experience Workplan for 2018/19 includes: • continued collection of patient stories and work with the PHA and service users on the evaluation of the stories in order to ensure learning from 10,000 More Voices leads to improve services; • engagement with the Comms Team on options for a NIAS 10,000 More Voices awareness and promotional campaign; • continued promotion of 10,000 More Voices and gathering of more stories from patients and staff, reviewing progress and learning from results with service users; • promotion of the pilot of the Appropriate Care Pathways survey; • launch ACP survey on falls with SE Trust Falls Team; • re-launch 10,000 More Voices staff survey; and • learning from results – ensuring that learning is shared with senior management and lessons learnt are used in training and service delivery. The Trust continued to promote 10,000 More Voices and gather more stories from patients and staff, review progress and learn from results with service users. Over 330 survey questionnaires had been returned for the generic survey and 24 as part of the ACP pilot survey, covering all aspects of the service, including emergency 999 response, Patient Care Service and ambulance control. The results from feedback have been very positive and reflect a high degree of satisfaction in terms of compliance with the patient experience standards. The vast majority of patients (90%) described their experience as either positive or strongly positive.

	Further work is underway to use 10,000 More Voices as a learning and engagement tool for the Transformation and Modernisation Programme around Transforming Your Care and Appropriate Care Pathways. A pilot of a separate survey on Appropriate Care Pathways has been developed and is being implemented. Staff attitude, behaviour and communication are continuing themes emerging from complaints and we continue to work to address these issues through internal processes including training. We will also prioritise staff attitude and will raise awareness of and communicate the patient experience standards across all staff groups through learning and development programmes including induction training. Considerations around proposed strategy and structure for PCE have been impacted by staff changes, and will also be affected by proposed wider structural changes in the Trust which go beyond the remit of this report. These remain under development.
Personal and Public Involvement (PPI)	The Trust's Personal and Public Involvement (PPI) Strategy outlines its commitment to involving key stakeholders such as service users, carers and their representatives in the development of services. During this reporting period, work continued on reviewing NIAS's PPI strategy and structure, and meetings in that regard remain ongoing. Considerations around proposed strategy and structure have been impacted by staff changes, and will also be affected by proposed wider structural changes in the Trust which go beyond the remit of this report. These remain under development. The Trust has continued engagement and consultation on a range of transformation policies in development, alongside a specific focus on the PPI standards, taking into account the Department of Heath's recently published guidance on co-production and co-design. Work has continued during this reporting period on developing a significant public and staff engagement programme, particularly in relation to the consultation on the new Clinical Response Model which closed on 18 January 2019. As part of this consultation, significant engagement activities have been carried out, including meetings with Local Commissioning Groups. The Trust intends to build on this work and further enhance its approach to PPI as part of the implementation phase of the CRM programme.
Clinical Education and Training	

	Following Formal programme approval by the Health and Care Professions Council (HCPC) in December 2018, the first cohort of 47 students commenced the NIAS/UU Foundation Degree in Science in Paramedic Practice (FdSc) on 7 January 2019. This cohort is made up entirely of NIAS Emergency Medical Technicians (EMTs), who gained direct entry to undertake the second year of the programme and will now be engaged full time on the course until October 2019. Successful completion provides eligibility to apply to HCPC to register as a Paramedic. The FdSc comprises elements of taught sessions, self-directed study and practice placements. The placements will occur in both ambulance and some non-ambulance (e.g. Hospital) settings. Delivery of the ambulance placements will be supported by Paramedics acting as Practice Educators and Clinical Support Officers in the role of Lead Practice Educators Throughout NIAS Divisions. Some of the Clinical Training Officers are continuing studies towards Higher Education qualifications. throughout NIAS An increased number of Core Training programmes including two AAP courses and a 4th (of 4 in-year) ACA course, continued in January and February. To enable the facilities in RACTC at HQ to be used for the Paramedic programme, provision for these courses has been made at other venues, with two being held in Belfast and the other on the UU Campus at Magee. These AAP and ACA programmes are part of a significant commitment to train sufficient numbers of staff at those levels, to enable backfill of positions and assist in workforce stabilisation as staff move on to training for other grades. (Note to enable 48 Paramedics to be trained and vacancies addressed, the plan is to also train 96 EMTs and 96 ACAs). Delivery of annual Continuing Education programme (Post Proficiency - PP) which had run through October to December was put on hold over the Christmas and New Year period. This day of CE/PP incorporating various skills and information, has an additional focus on upskilling our EMTs to provide additional interventions and drug therapies. Originally planned to run until Christmas, this was extended into the new year to allow capacity for training associated with the Paramedic programme, whilst minimising the release of frontline operational staff. A second day of CE/PP which was scheduled to run January – March 2019 will be postponed until after April. This means the deferment of clinical updates including resuscitation, Post-resuscitation care and mandatory eLearning. This is due to operational pressures and the associated limitations on release of staff for training at a time when all the other courses are also ongoing. RACTC and the transformation team continue to collaborate with the HSC Clinical Education Centre who are delivering a programme of voluntary, short courses open to both EMTs and paramedics alike.

	A recruitment trawl is ongoing for Clinical Support Officers to fill a number of permanent and temporary vacancies. The temporary vacancies, which are having an impact on training capacity, are due to a number of secondments to other roles, such as Clinical Training Officers, HEMS and Transformation projects. Work is also ongoing to increase the number of Clinical Training Officers to provide more capacity to meet the increased training and education commitment.

EMERGENCY PLANNING REPORT FOR JANUARY-FEBRUARY 2019

KPI No		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2	**No of Potential Major Incidents**	**1**	**2**		**1**	**3**		**1**			**1**	**1**	
	No of Declared Major Incidents			**1**	**1**								
	No of Airport alerts												
	Belfast International Airport												
	Belfast City Airport	**1**			**1**	**1**					**1**	**1**	
	City of Derry Airport												
	St Angelo Airport												
	Newtownards Airfield												
	Other airfields												
	Business Continuity		**2**	**1**	**2**	**3**	**3**	**7**	**7**		**7**	**13**	
	Hazardous Material Incidents (HART calls)												
	HART pre-planned deployments	**1**	**1**	**1**	**2**	**1**	**3**					**2**	
4	**Training sessions**	**1**	**3**	**1**	**1**	**3**	**4**	**8**	**3**		**4**	**2**	
	Emergency Planning	**3**	**2**	**1**	**2**	**2**	**4**	**3**	**6**	**4**	**4**	**4**	
	HART	**4**	**6**	**1**	**1**		**6**	**3**	**8**	**1**	**1**	**1**	
	Business Continuity			**1**									
5	**Exercises**												
	Live	**2**	**1**	**2**			**1**					**1**	
	Tabletop							**1**	**1**		**1**	**2**	
	Observer				**1**								
6	**Updates or amendments to MIP**												
	Events		**5**			**2**	**2**		**1**				
	HART Calls/ deployments	**67**	**97**	**93**	**106**	**76**	**96**	**99**	**92**	**100**	**83**	**59**	
	GOLD operational												

Potential Major Incidents

On 19 January 2019 @ 15.26 NIAS received a 999 call to the junction of Windyhill Road and Isle Road, Coleraine for a report of a road traffic collision. Tasked to the scene 8 A&E crews, 1 Intermediate Care Vehicle crew, 2 Rapid Response Vehicles, 4 Officers, 2 HART call signs, Helimed 23 and Mobile Control Vehicle & Emergency Equipment Vehicle. 3 hospitals were put on alert to receive casualties.

On 1 February 2019 @ 18.46 NIAS received a call for a bomb alert for a “car bomb” in the grounds of the Altnagelvin Hospital, Londonderry. Tasked to the scene were 1 Rapid Response Vehicle, 7 Officers and the Emergency Equipment Vehicle & Mobile Control Vehicle. The decision was made to task Officers only in the initial stages until the incident was either escalated or stood down. A short divert was put in place to allow safety to be assessed in relation to access to the Emergency Department. At 19.21 in consultation with the PSNI the incident was stood down and all services returned to normal.

Major Incidents

There were no declared Major Incidents during this period.

Airport Alerts

On 14 January 2019 @ 21.03 NIAS received an airport alert to the George Best Belfast City Airport for reports of an emergency landing of a Dash 8 with reports of issues with the rear door. The plane had 46 persons on board. Tasked to the scene 4 A&E crews, 1 Rapid Response Vehicle, 2 Doctors, 1 HART call sign, 7 Officers, the Mobile Control Vehicle and the Emergency Equipment Vehicle. Belfast and South-East Trusts were alerted and the Antrim, Craigavon, and Causeway Hospitals were alerted. The plane landed safely, no patients were identified and the incident was stood down at 21.25.

On 22 February 2019 @ 13.23 NIAS received an alert to the George Best Belfast City Airport for an aircraft making an emergency landing with a “Hydraulic failure”. Tasked to the scene 2 A&E crews, 3 Patient Care Service / Intermediate Care Vehicle crews, 6 Officers, 1 Doctor, 2 HART call signs and the Mobile Control Vehicle & Emergency Equipment Vehicle. Belfast Trust and South Eastern Trust were alerted to the potential major incident. The plane landed safely and the incident was stood down at 13.57.

HAZMAT / Hazardous Area Response Team (HART) deployments

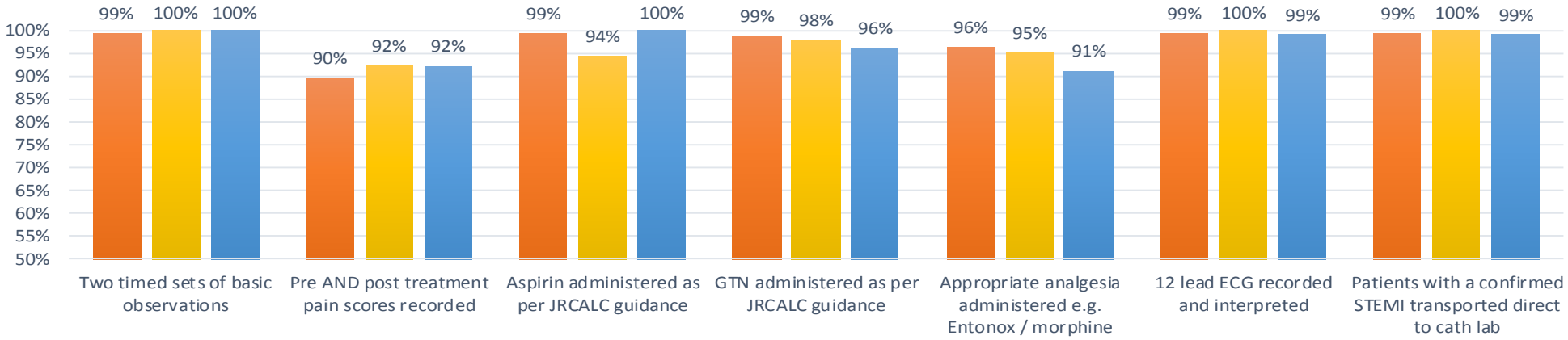
88 = Deployments with Breathing Apparatus skills/ HAZMAT deployments
22 = Restricted space
13 = In-land Water Operations
0 = Incident at height
1 = Mountain rescue
18 = HAZMAT

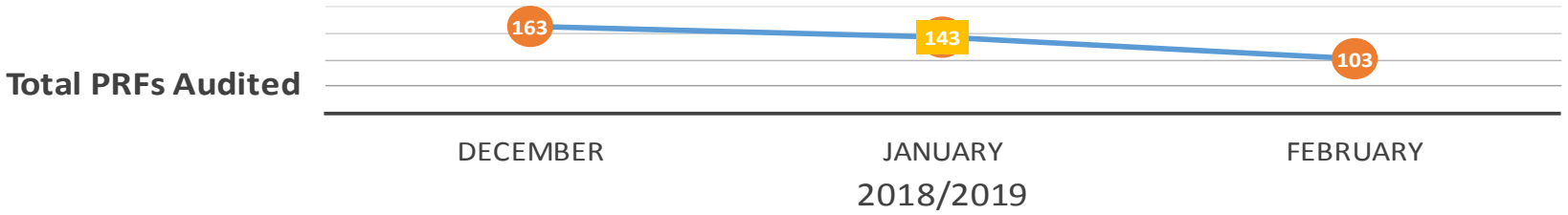
William Newton
Assistant Director of Emergency Planning

Northern Ireland Ambulance Service
Health and Social Care Trust

ACUTE CORONARY SYNDROME

QUALITY IMPROVEMENT COMPLIANCE





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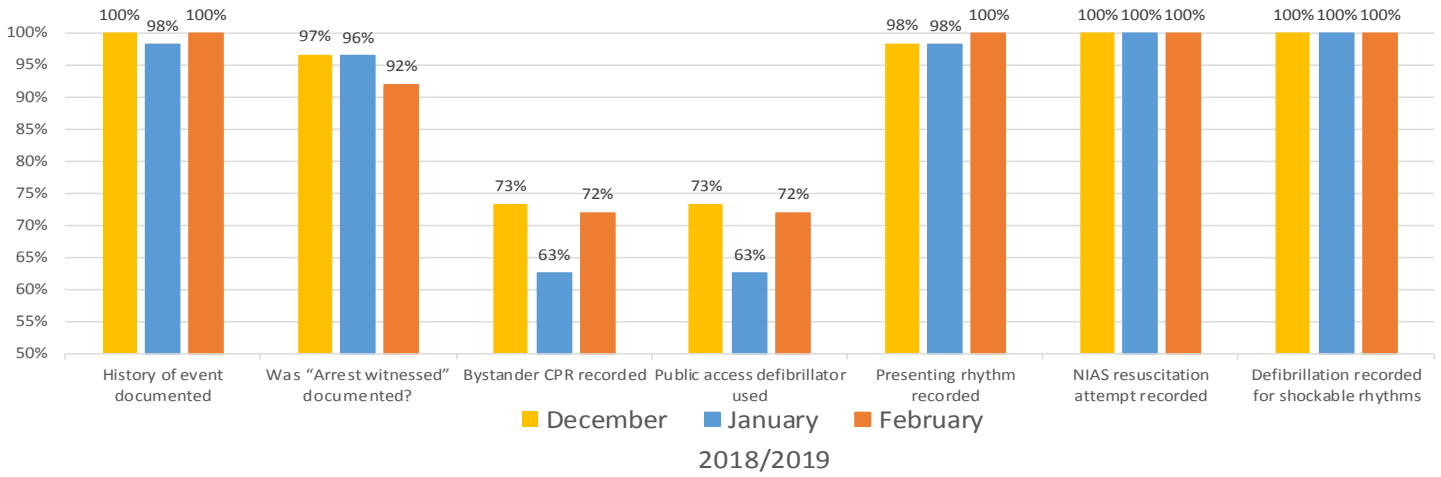
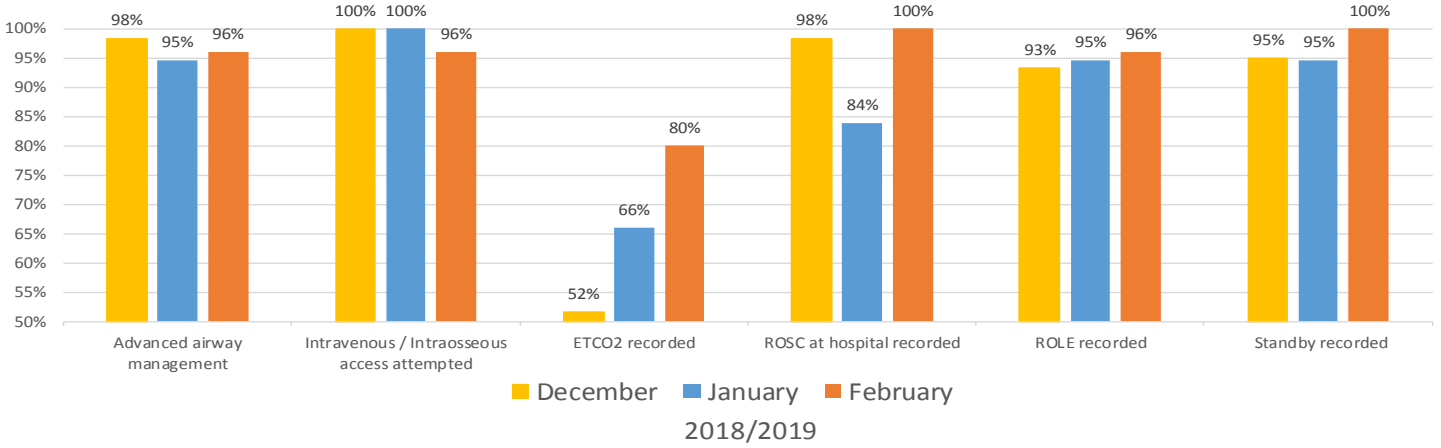
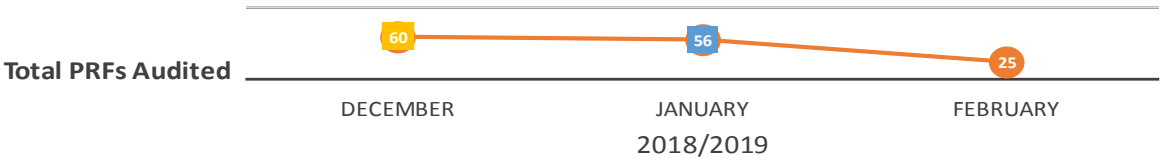
CARDIAC ARREST

QUALITY IMPROVEMENT COMPLIANCE







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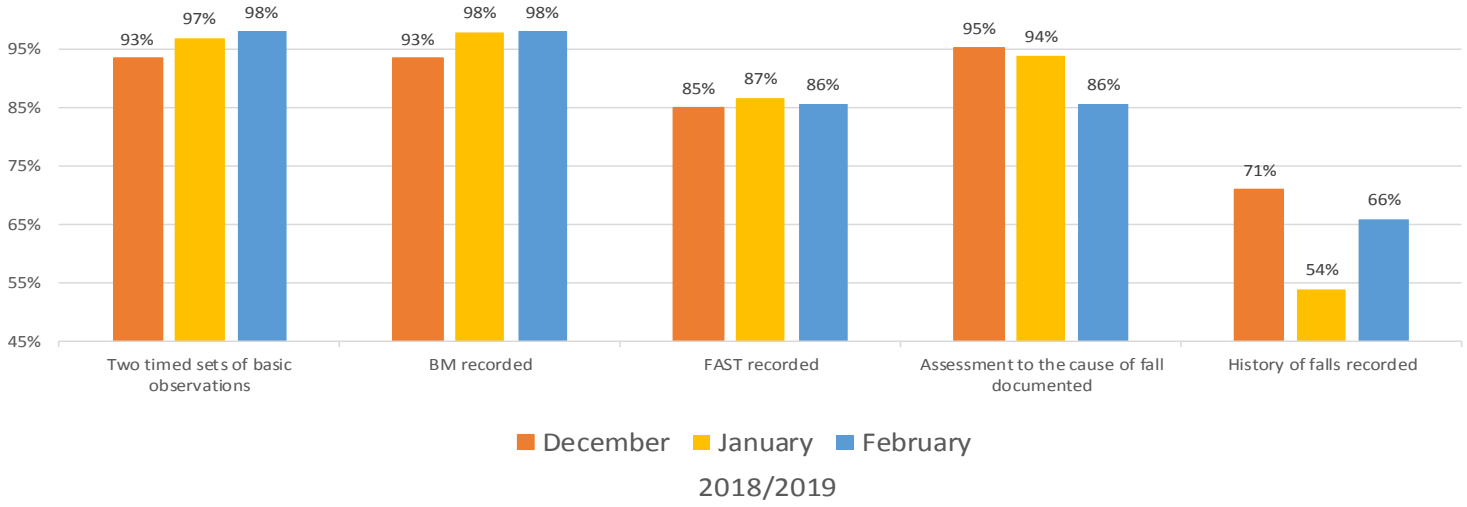
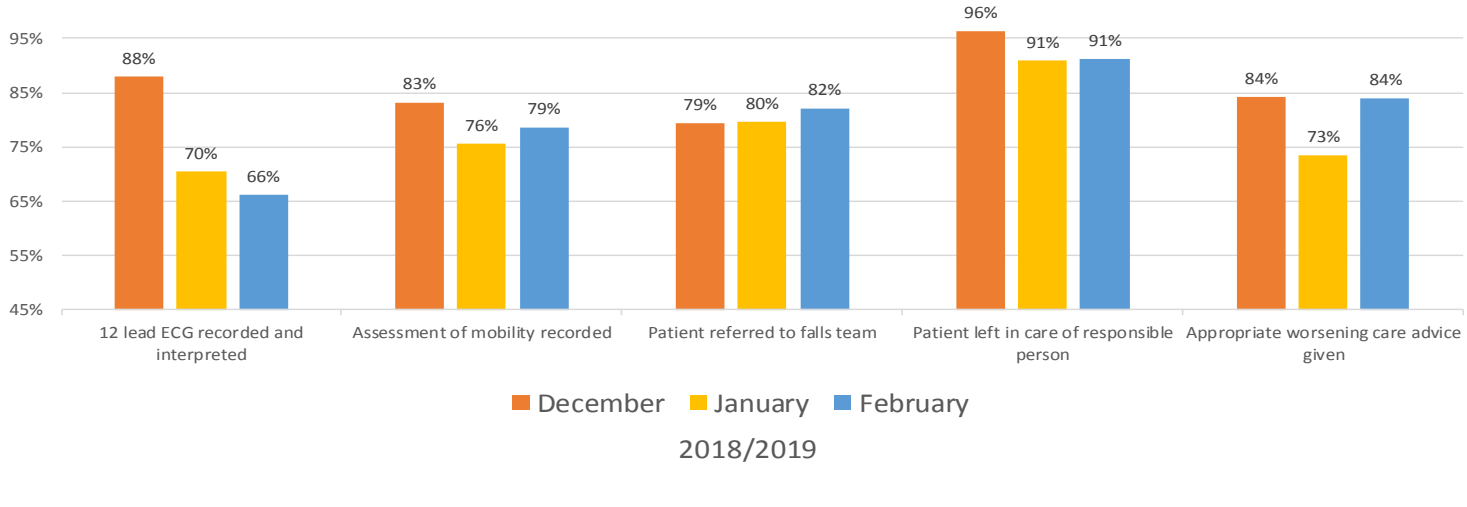
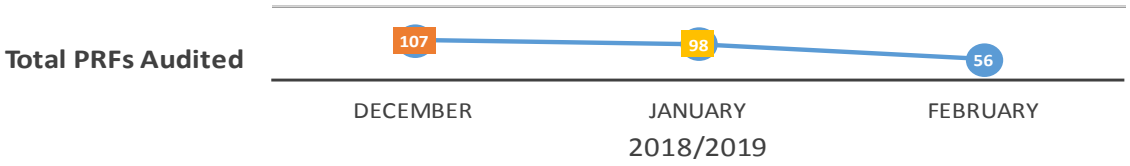
FALLS

QUALITY IMPROVEMENT COMPLIANCE







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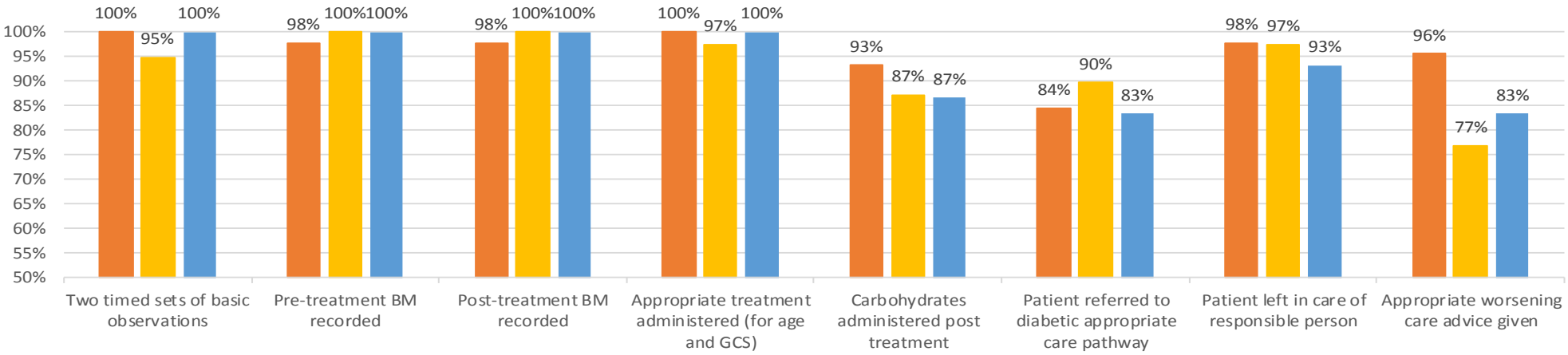
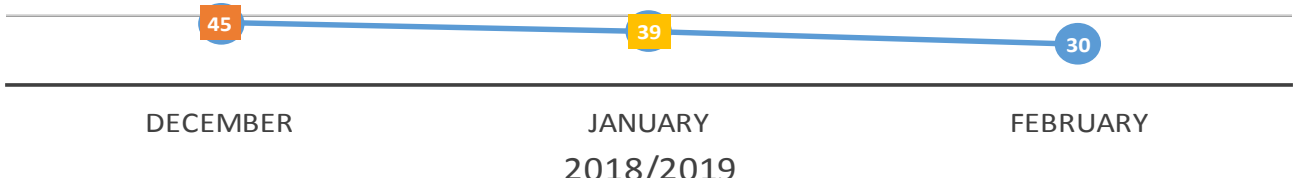
HYPOGLYCAEMIA

QUALITY IMPROVEMENT COMPLIANCE



Total PRFs Audited



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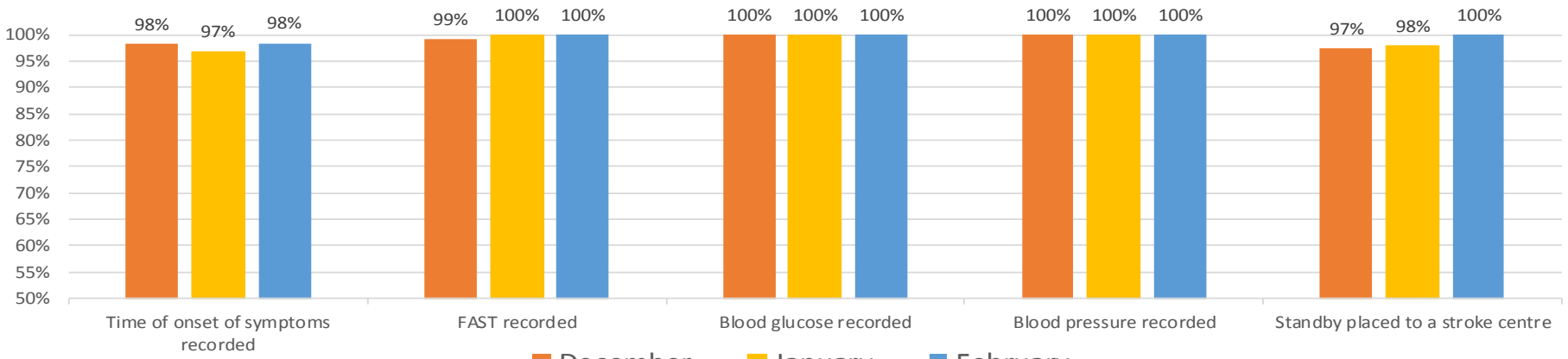
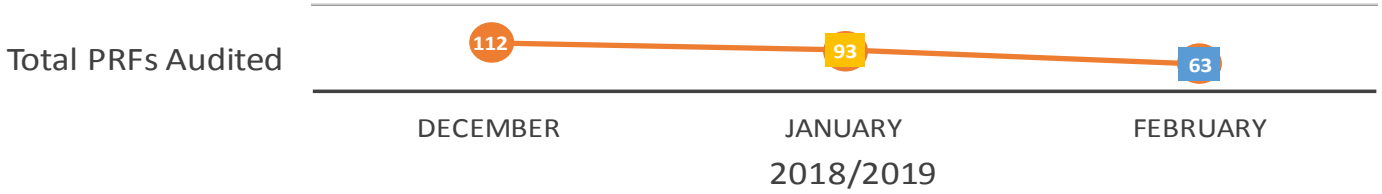
STROKE

QUALITY IMPROVEMENT COMPLIANCE





TB/04/04/2019/07

Return to Agenda

TRUST BOARD REPORT

OPERATIONAL DIRECTORATE

Reporting to February 2018

Emergency & non emergency Ambulance Control Reports

EAC Call Taking Statistics

Emergency Ambulance Control has three designations of call covered by Automatic Call Distribution (ACD): Emergency, Routine and Urgent / HCP.

Emergency Call Activity

The number of "999" calls being answered is continuing to riset,this trend on increasing "999" calls each year is evident from the statistics shown in the table below.

Month	Year 2014-15	Year 2015-16	Year 2016-17	Year 2017-18	Year 2018-19
Apr	14988	16079	16321	17403	17598
May	15433	16795	17437	18365	19864
Jun	15911	16321	17030	17173	19263
Jul	16633	16266	17773	18352	19170
Aug	16244	16814	17728	18486	19125
Sep	16244	15802	16803	17994	19335
Oct	15803	16701	18282	18208	19267
Nov	15860	16083	16979	18236	19102
Dec	18088	18494	20340	24020	22418
Jan	16590	16989	17630	20444	20035
Feb	16138	16188	16181	17756	19066
Mar	16872	17740	17523	20233	
Total	**194804**	**200272**	**210027**	**226670**	**214243**

As well as taking calls from the general public NIAS also takes calls from hospitals, GP surgeries and other health care professionals. These types of call are classified as Health Care professional (HCP) calls and have a small dedicated team who deal with processing these calls.

As part of contingency arrangements we answer "999" calls from Scotland as part of the Buddy arrangement. From the 2nd May 2018 we enabled electronic call passing between NIAS and the Scottish Ambulance Service where if either Control Room takes calls for the other they are automatically populated on each others command and control screen and Ambulance resources can be dispatched as normal.

999 Call Answer Times

Key Performance Indicator

NIAS aims to answer telephone calls as quickly as possible and the target is 95% of all Emergency calls answered in two seconds.

The table below shows the performance on call answering by month from April 2018 to February 2019 and an increase in the average percentage time to answer Emergency calls.

CALL ANSWERING PERFORMANCE CHART 2018/19

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Emergency	89.43	84.51	82.03	74.39	81.72	83.29	91.67	87.51	85.91	91.92	85.78
Routine	90.41	88.88	87.72	80.70	84.10	91.52	94.65	91.14	88.83	94.12	91.40
HCP/Urgent	66.74	90.33	90.30	85.45	84.91	90.41	94.63	93.26	90.10	94.44	93.36

- Call answering shows a higher achieved target for Routine calls due to all staff having the skill sets to handle them.
- The target of 95% 999 call taking is yet to be achieved – new recruitment in EMD levels would be expected to improve this performance level however overall increases in call volumes has impacted this figure particularly in December 2018 and January 2019 as each of these months exceeded the 20,000 call mark.
- EMDs are required by the IAED to remain on the line for certain health critical situations. They remain on the line until one of NIAS operational resources is in attendance at the scene. High volumes of incidents and reduced levels of cover can impact on availability of call takers resulting in delays. The average delay is 5 seconds for the average 4% of calls not meeting the 2 second standard.
- Measures introduced have seen improvement in answering HCP calls
- Further measures to cut down on non-call related routine calls have also been introduced

Emergency & non emergency Ambulance Control Reports

EMD Award Scheme

NIAS has an EMD award scheme in place awarding certificates and badges for randomly selected calls with overall "High Compliance" and for calls with exemplary (100%) Customer Service. Other awards are for Baby Born, Cardiac Life Saver & Non-Cardiac Life Saver. In order to attain these specific awards the call must be reviewed as "Compliant" or "High Compliance".

The table below shows the level and number of awards attained by EMDs for the reporting period as well as the previous year 2017-18 and the year to date. A number of calls are also currently under assessment for possible awards.

Type	Level	January & February 2018	Year (Apr 17 – Mar 18)	Year to Date (Apr 18 – Mar 19)
999 High Compliance	Bronze	1	14	5
	Silver	2	8	10
	Gold	0	17	6
	250			2
Exemplary Customer Service	Bronze	1	3	5
	Silver	0	8	2
	Gold	0	13	6
Baby Born		1	2	9
Cardiac Life Saver		0	5	4
Non-Cardiac Life Saver		0	1	5

RESPONSE TIME PERFORMANCE REPORT YEAR END REPORT

For April 2018 to February 2019

Summary of Trends:

1. Cumulative NI Cat A performance from April 2018 - February 2019 = 37.7% (8.3% decrease for same period last year 46.0%)
2. Average response time across Northern Ireland for Cat A response in February 2019 was 14 minutes 46 seconds.

3. Total cumulative Emergency Call demand for April to February 2019 (including Cat HCP activity) has decreased by -0.8% = -1,616 calls for the same period last year.
4. NIAS has projected Cat A performance at 39%. Actual achieved 32%
5. Trends for ambulance turnaround times greater than the standard (i.e. 30 mins) continue to heavily impact on NIAS response and availability. It is noted that in the February 2018 there was an increase in the number of lost hours at the Royal Victoria and Altnagelvin Hospital and a decrease in lost hours at the Ulster Hospital and Craigavon Area hospital.

DISCLAIMER

Please note that due to system issues the data provided below may be subject to change at a later stage. Please use in a cautionary manner at this time.

Key Performance Indicator: Resources are deployed in line with the Category/Code and measured through Key Performance Indicators

When the call taking process is completed calls are categorised for deployment as per table:

Call type	Category / code	Key Performance Indicators
999 Potentially immediately life threatening	A (Purple/ Red)	< 8 minutes
999 Serious but not life threatening	B (Amber)	< 21 minutes
999 Neither life threatening or serious	C (Green)	< 60 minutes
Healthcare Professional Calls (HPC)(GPs who 'book' and ambulance after seeing a patient and deciding they need to be admitted to hospital within a set time frame)	HCP Calls	1 hour 2 hours 3 hours 4 hours
Routine	Routine	As agreed with caller and call taker

KEY PERFORMANCE INDICATORS (KPIs) for the Year 2017/18
From April 2016, 72.5% of Cat A (potentially immediately life threatening) calls to be responded to within 8 minutes, 67.5% in each Local Commissioning Group area (LCG) with 95% of Cat A have a conveying resource <21 min
95% of Category B Response <21 mins
95% Category C Non- Health Care Professional <60mins
Health Care Professional (formally GP Urgent) within agreed target of either 1, 2, 3, 4, hours

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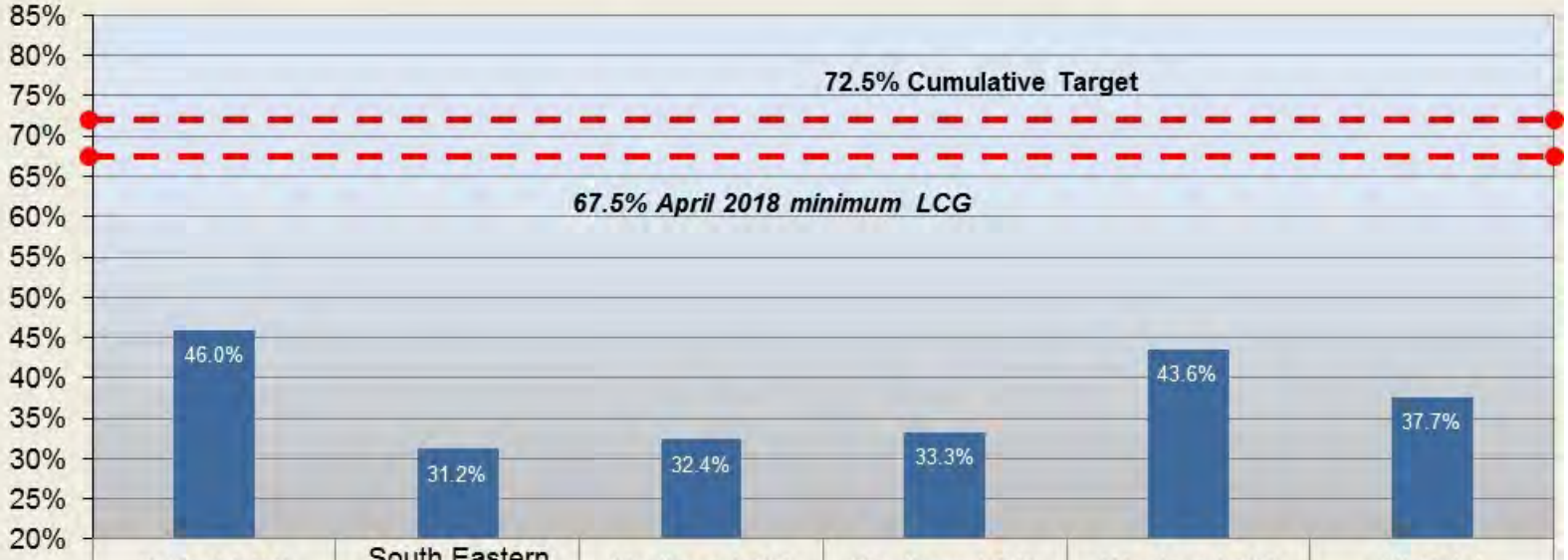
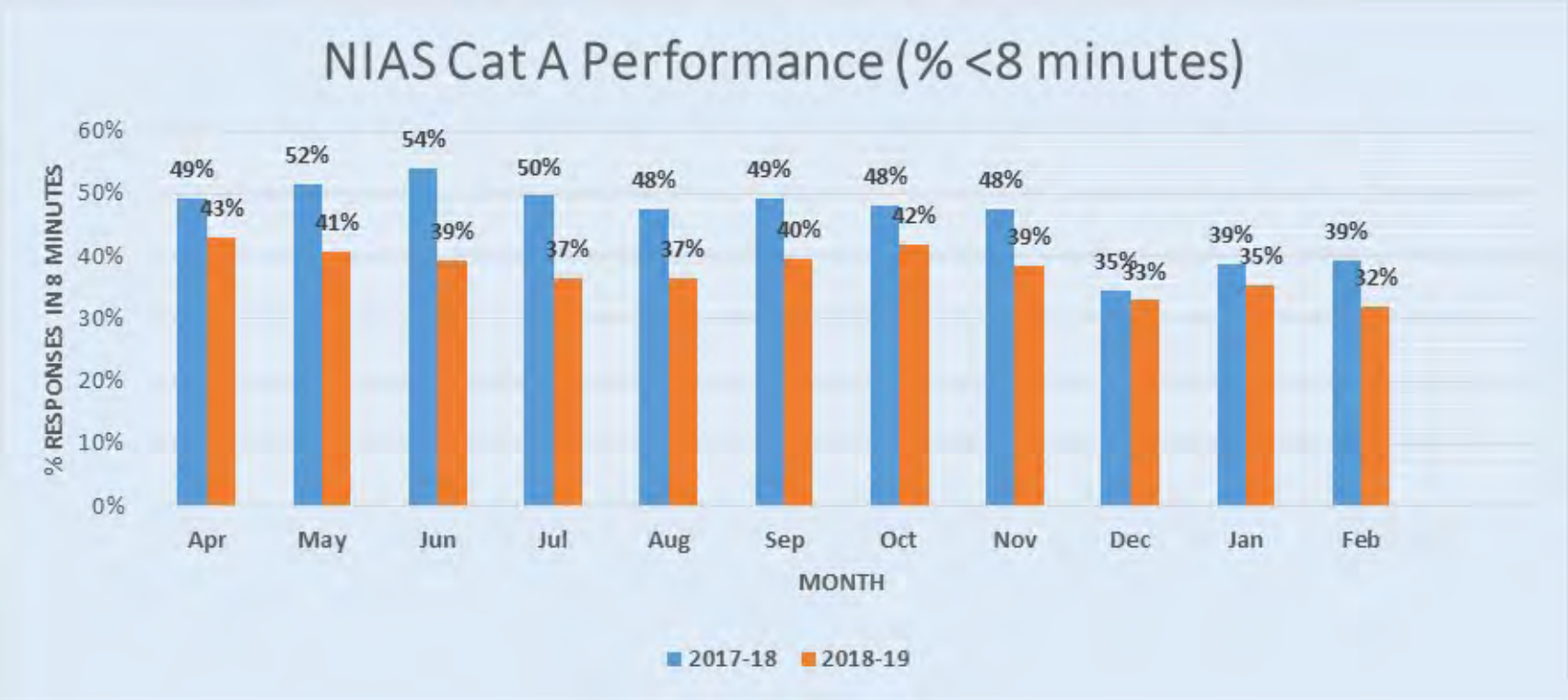
% Cat A Calls Responded to Within 8 Minutes
Cumulative from April 2018 to end February 2019



	Belfast LCG	South Eastern LCG	Northern LCG	Southern LCG	Western LCG	NI Total
% Cat A Within 8 Min	46.0%	31.2%	32.4%	33.3%	43.6%	37.7%
Cat A within 8 min	6,504	3,057	3,969	3,048	3,689	20,267
Total No. of Cat A	14,143	9,800	12,255	9,159	8,469	53,826

From April 2018, 72.5% of Category A (life threatening) calls are to be responded to within eight minutes, 67.5% in each LCG area.
*Disclaimer may be subject to change at a later date.


NIAS Cat A Performance (% <8 minutes)
% RESPONSES IN 8 MINUTES
60%
50%
40%
30%
20%
10%
0%
49%
43%
52%
41%
54%
39%
50%
37%
48%
37%
49%
40%
48%
42%
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33%
39%
35%
39%
32%
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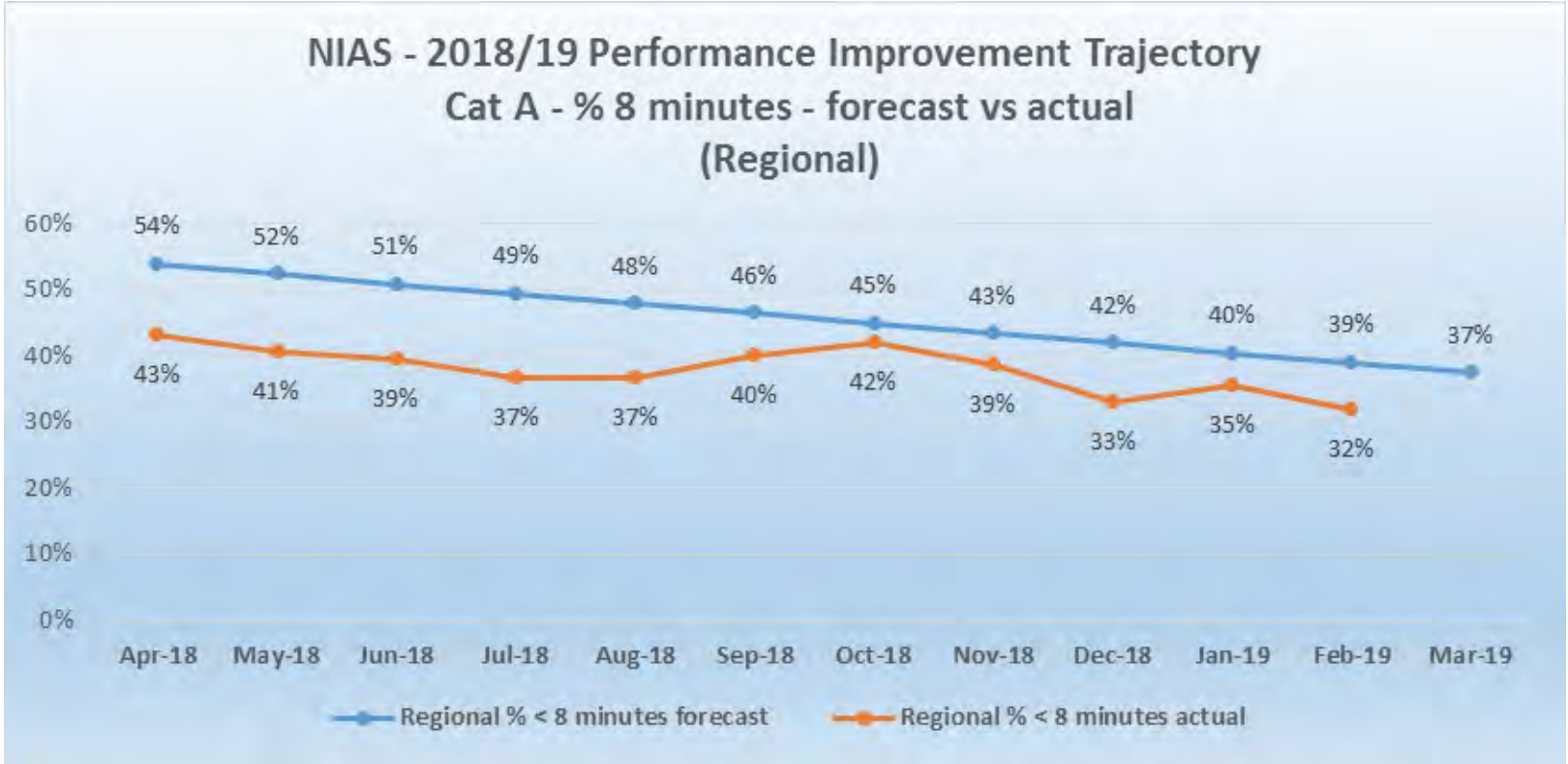
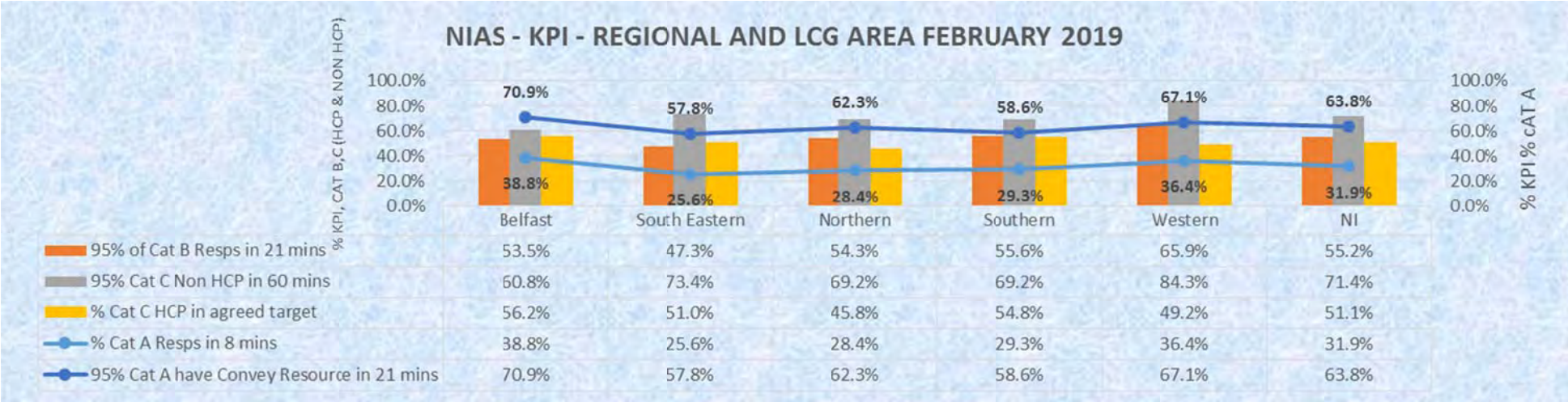
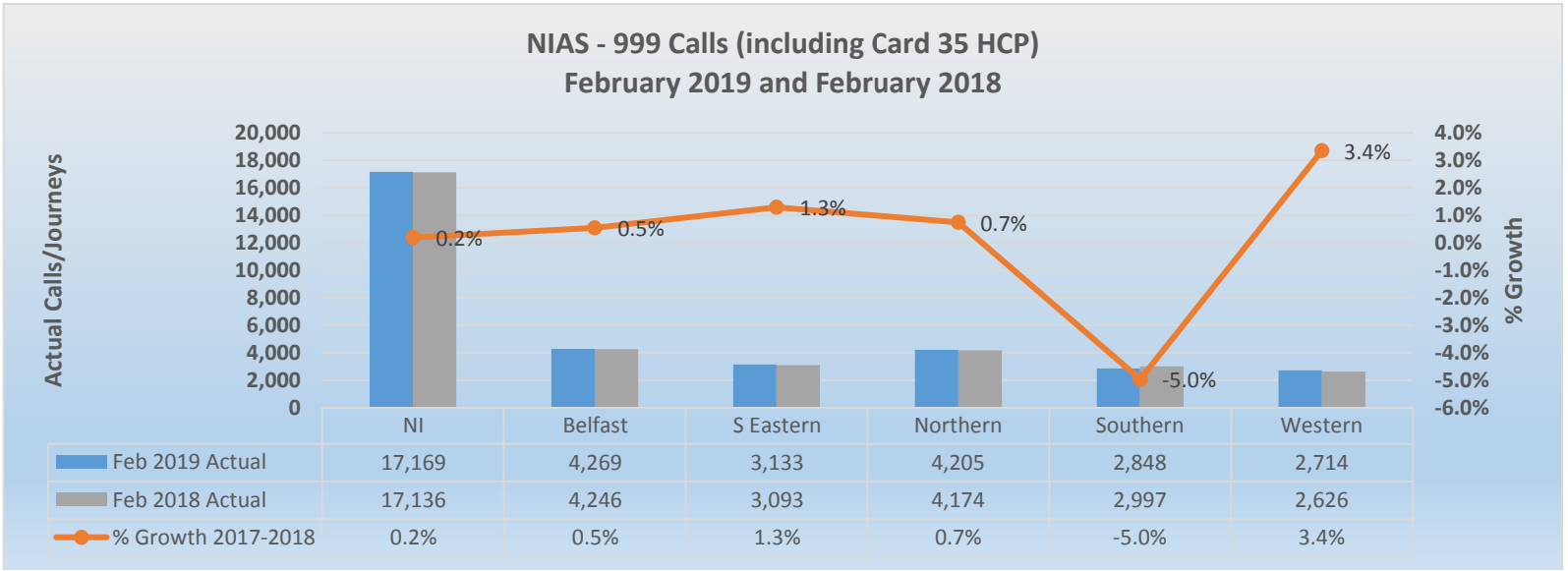
MONTH
2017-18
2018-19

Cat A Performance – Performance Improvement Trajectory



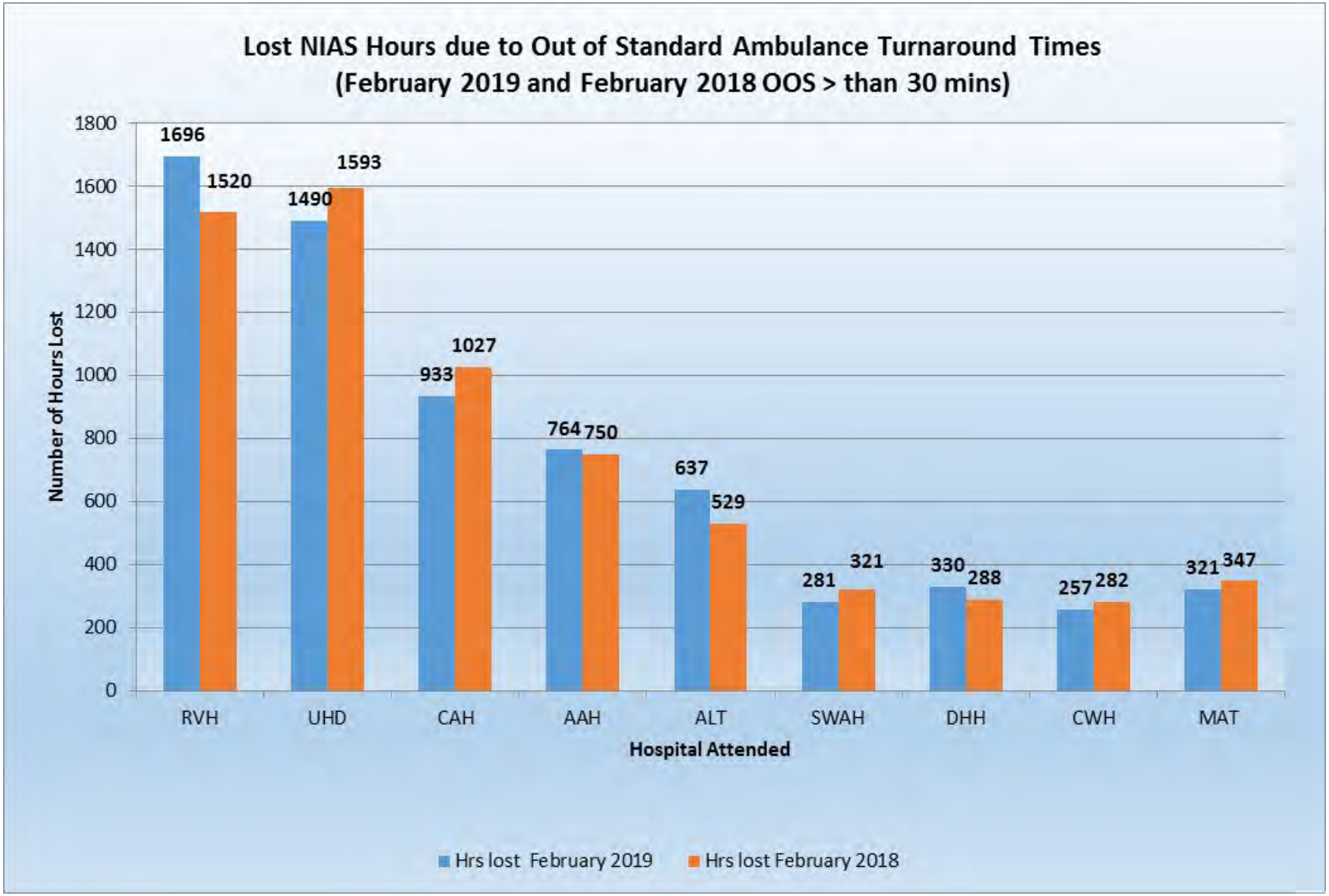


	Belfast	South Eastern	Northern	Southern	Western	NI
95% of Cat B Resps in 21 mins	53.5%	47.3%	54.3%	55.6%	65.9%	55.2%
95% Cat C Non HCP in 60 mins	60.8%	73.4%	69.2%	69.2%	84.3%	71.4%
% Cat C HCP in agreed target	56.2%	51.0%	45.8%	54.8%	49.2%	51.1%
% Cat A Resps in 8 mins	38.8%	25.6%	28.4%	29.3%	36.4%	31.9%
95% Cat A have Convey Resource in 21 mins	70.9%	57.8%	62.3%	58.6%	67.1%	63.8%



	NI	Belfast	S Eastern	Northern	Southern	Western
Feb 2019 Actual	17,169	4,269	3,133	4,205	2,848	2,714
Feb 2018 Actual	17,136	4,246	3,093	4,174	2,997	2,626
% Growth 2017-2018	0.2%	0.5%	1.3%	0.7%	-5.0%	3.4%

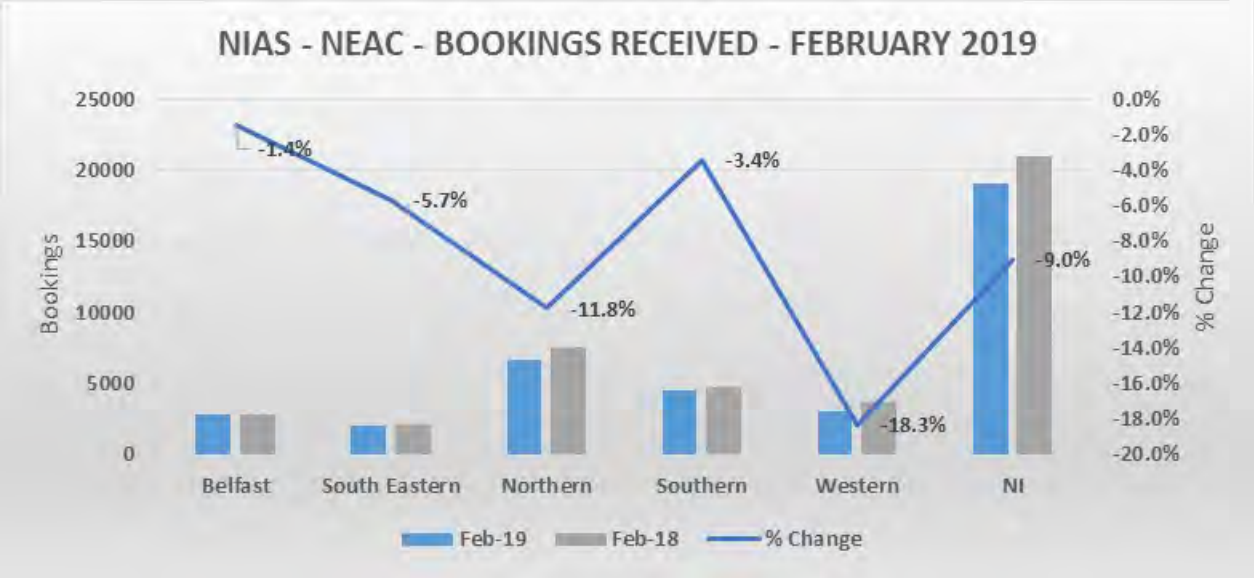
Key Performance Indicator: Ambulance Turnaround at Emergency Departments within 30 minutes – Feb 2019 V Feb 2018



Key Performance Indicator: Provide non-urgent transport of patients across Northern Ireland through its Patient Care Service (PCS) to locally agreed specifications

	NEAC BOOKINGS AND JOURNEYS - FEBRUARY 2018/19						
Bookings	LCG AREA	Belfast	South Eastern	Northern	Southern	Western	NI
	Feb-19	2778	2065	6652	4551	3028	**19074**
	Feb-18	2817	2189	7539	4710	3707	**20962**
	% Change	-1.4%	-5.7%	-11.8%	-3.4%	-18.3%	**-9.0%**

Completed Journeys	LCG AREA	Belfast	South Eastern	Northern	Southern	Western	NI	
	Feb-19	2073	1411	5177	3621	2400	**14682**	
	Feb-18	1738	1418	5196	3344	2529	**14225**	
	% Change	19.3%	-0.5%	-0.4%	8.3%	-5.1%	**3.2%**	
Completed Journeys	Journey Type	Outpatient	Discharge	Transfer	Admission	Second Crew	Home Assessment	Total
	Feb-19	11063	2363	1106	130	16	4	**14682**
	Feb-18	11736	2693	971	169	10	6	**15585**



CATEGORY A PERFORMANCE: AVERAGES AND OUTLIERS

Feb 18

REGIONAL CATEGORY A PERFORMANCE: TOTAL NUMBER OF RESPONSES

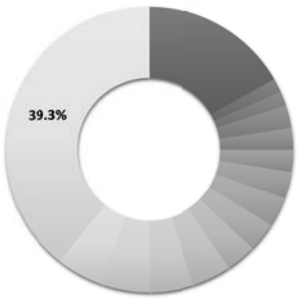
NORTHERN IRELAND REGIONAL TOTAL

TOTAL NUMBER OF CATEGORY A RESPONSES	Number of Category A responses required to exceed Regional target (72.5%)
4666	3383
AVERAGE RESPONSE TIME (MM:SS)	1550 responses below target
14:46	

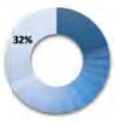
	BELFAST HSCT	SOUTH EASTERN HSCT	NORTHERN HSCT	SOUTHERN HSCT	WESTERN HSCT
Total number of Cat A responses	1145	893	1071	849	708
Number required to exceed LCG target (67.5%)	773	603	723	574	478
Number of category A responses at scene within 8 mins	587	289	362	269	326
%	51.3%	32.4%	33.8%	31.7%	46.0%
	186 responses below target	314 responses below target	361 responses below target	305 responses below target	152 responses below target
Average response time [mm:ss]	12:05	17:24	15:27	16:35	12:35

REGIONAL CATEGORY A PERFORMANCE SUMMARY

Northern Ireland Ambulance Service Health and Social Care Trust



Category A Performance		%	Cumulative %
Within 8 minutes	1833	39.3%	39.3%
Within 8 - 9 minutes	250	5.4%	44.6%
Within 9 - 10 minutes	254	5.4%	50.1%
Within 10 - 11 minutes	234	5.0%	55.1%
Within 11 - 12 minutes	204	4.4%	59.5%
Within 12 - 13 minutes	156	3.3%	62.8%
Within 13 - 14 minutes	155	3.3%	66.1%
Within 14 - 15 minutes	155	3.3%	69.5%
Within 15 - 16 minutes	142	3.0%	72.5%
Within 16 - 17 minutes	116	2.5%	75.0%
Within 17 - 18 minutes	114	2.4%	77.4%
Within 18 - 19 minutes	119	2.6%	80.0%
Within 19 - 20 minutes	76	1.6%	81.6%
Within 20 - 21 minutes	73	1.6%	83.2%
Over 21 minutes	785	16.8%	100.0%
Total	4666		



BELFAST HSCT

Response Time	N	%	Total
< 8 m	587	51.3%	51.3%
8 - 9 m	83	7.2%	58.5%
9 - 10 m	81	7.1%	65.6%
10 - 11 m	73	6.4%	72.0%
11 - 12 m	43	3.8%	75.7%
12 - 13 m	38	3.3%	79.0%
13 - 14 m	36	3.1%	82.2%
14 - 15 m	23	2.0%	84.2%
15 - 16 m	26	2.3%	86.5%
16 - 17 m	21	1.8%	88.3%
17 - 18 m	16	1.4%	89.7%
18 - 19 m	15	1.3%	91.0%
19 - 20 m	9	0.8%	91.8%
20 - 21 m	8	0.7%	92.5%
21 + m	86	7.5%	100.0%
Total		1145	

SOUTH EASTERN HSCT

Response Time	N	%	Total
< 8 m	289	32.4%	32.4%
8 - 9 m	47	5.3%	37.6%
9 - 10 m	43	4.8%	42.4%
10 - 11 m	44	4.9%	47.4%
11 - 12 m	36	4.0%	51.4%
12 - 13 m	37	4.1%	55.5%
13 - 14 m	33	3.7%	59.2%
14 - 15 m	36	4.0%	63.3%
15 - 16 m	20	2.2%	65.5%
16 - 17 m	33	3.7%	69.2%
17 - 18 m	25	2.8%	72.0%
18 - 19 m	27	3.0%	75.0%
19 - 20 m	23	2.6%	77.6%
20 - 21 m	13	1.5%	79.1%
21 + m	187	20.9%	100.0%
Total		893	

NORTHERN HSCT

Response Time	N	%	Total
< 8 m	362	33.6%	33.8%
8 - 9 m	45	4.2%	38.0%
9 - 10 m	55	5.1%	43.1%
10 - 11 m	54	5.0%	48.2%
11 - 12 m	50	4.7%	52.8%
12 - 13 m	40	3.7%	56.6%
13 - 14 m	41	3.8%	60.4%
14 - 15 m	42	3.9%	64.3%
15 - 16 m	44	4.1%	68.4%
16 - 17 m	24	2.2%	70.7%
17 - 18 m	36	3.3%	73.9%
18 - 19 m	37	3.5%	77.4%
19 - 20 m	23	2.1%	79.6%
20 - 21 m	24	2.2%	81.8%
21 + m	195	18.2%	100.0%
Total		1071	

SOUTHERN HSCT

Response Time	N	%	Total
< 8 m	269	31.7%	31.7%
8 - 9 m	37	4.4%	36.0%
9 - 10 m	37	4.4%	40.4%
10 - 11 m	34	4.0%	44.4%
11 - 12 m	39	4.6%	49.0%
12 - 13 m	24	2.8%	51.8%
13 - 14 m	32	3.8%	55.6%
14 - 15 m	34	4.0%	59.6%
15 - 16 m	35	4.1%	63.7%
16 - 17 m	23	2.7%	66.4%
17 - 18 m	26	3.1%	69.5%
18 - 19 m	26	3.1%	72.6%
19 - 20 m	15	1.8%	74.3%
20 - 21 m	15	1.8%	76.1%
21 + m	203	23.9%	100.0%
Total		849	

WESTERN HSCT

Response Time	N	%	Total
< 8 m	326	46.0%	46.0%
8 - 9 m	38	5.4%	51.4%
9 - 10 m	38	5.4%	56.8%
10 - 11 m	29	4.1%	60.9%
11 - 12 m	36	5.1%	66.0%
12 - 13 m	17	2.4%	68.4%
13 - 14 m	13	1.8%	70.2%
14 - 15 m	20	2.8%	73.0%
15 - 16 m	17	2.4%	75.4%
16 - 17 m	15	2.1%	77.5%
17 - 18 m	12	1.7%	79.2%
18 - 19 m	14	2.0%	81.2%
19 - 20 m	6	0.8%	82.1%
20 - 21 m	13	1.8%	83.9%
21 + m	114	16.1%	100.0%
Total		708	

REGIONAL CATEGORY A PERFORMANCE: OUTLIERS - NUMBER OF RESPONSES EXCEEDING 15 MINUTES

BELFAST HSCT

Response Time	N
15 - 30 mins	143
30 - 45 mins	18
45 - 60 mins	9
Over 60 mins	11

SOUTH EASTERN HSCT

Response Time	N
15 - 30 mins	239
30 - 45 mins	61
45 - 60 mins	13
Over 60 mins	15

NORTHERN HSCT

Response Time	N
15 - 30 mins	300
30 - 45 mins	61
45 - 60 mins	10
Over 60 mins	11

SOUTHERN HSCT

Response Time	N
15 - 30 mins	269
30 - 45 mins	57
45 - 60 mins	9
Over 60 mins	8

WESTERN HSCT

Response Time	N
15 - 30 mins	147
30 - 45 mins	32
45 - 60 mins	5
Over 60 mins	7

Data Disclaimer

Please note there may be slight amendments to the data due to system changes and/or data quality issues that may arise. Please use this data with caution and necessary disclaimer.

NIAS ESTATES UPDATE

Government, Departmental Policy and Reporting Update

DOH Asset and Estates Management Branch has instructed all Arms' Length Bodies (ALB) to create a Memo of Understanding (MOU) for occupancy of other Trust or ALB Properties (to include the term, cost, cleaning schedules, dilapidations responsibilities). This will replace informal arrangements that currently exist and will result in a Cost Recovery Charge from the landlord to NIAS. Directorate of Legal services are drafting MOU for all relevant Health properties that NIAS occupies.

DOH Asset and Estates Management Branch has instructed all Arms' Length Bodies to create a Service Level Agreement (SLA) for property maintenance and repair to define response and scope. NIAS received clarification at the recent SIG that Trusts who have capital assets are funded to maintain these buildings. It is likely that the SLA for maintenance will point maintenance; repair and minor works liability to the capital owner of the building i.e. NIAS would not be responsible for maintain buildings it does not own.

DOH will issue the State of the Estate Report 2018/19 to NIAS Chief Executive by end of March 2019. This is the Departments view of NIAS Estate and Management of same by the Trust. At the most recent Strategic Investment Group (SIG) meeting, the Department highlighted the fact that NIAS estate is in a poor condition with a high proportion of non-compliant estate - attributed to under investment.

House of Lords Science and Technology Select Committee have issued a white paper favouring a presumption of "Off Site Manufactured "Buildings – i.e. Modular Buildings will be the de facto method used to deliver new builds.

The Business Services Consultancy report on the transfer of the former Health Estates Investment Group to CPD has been completed and published to the steering group; this report highlights the following high priority needs:

a) New SLA between department of Health and Department of Finance.
b) New Local Operating Agreement between NIAS and CPD to establish clear support framework , roles and responsibilities to deliver Capital Build Projects effectively and to ensure that CPD are clearly acting in NIAS best interests.
c) NIAS, CPD and the Department must increase technical capability within their own organisations.

Clinical Sluice Programme

6 out of 11 internal fit out Clinical Sluices underway / due for completion in or around 31st March 2019; all of Balance due to commence in March 2019. The remainder of the Sluice Programme were planned as modular solutions with site works, other preliminaries and service connection undertaken by the FM Contractor (See Above).

NIAS has received confirmation that the SBS Framework allows for the modular manufacturer to provide site works, other preliminaries and services connection and

on this basis I have asked the modular manufacturer to quote for an all-inclusive price to deliver the remainder of the sluice programme in 2019/20

10 Year Capital Plan

NIAS Head of Estates, in conjunction with CPD, has created a 10 year estates capital bid programme in response to a Departmental request. The Estate bid is aligned to the draft estate strategy and takes into account recommendations contained with the demand capacity review.

The value of NIAS 10 year estate bid is currently £92m; however when the whole NIAS bid is known this is subject to change. The Capital Bid does not include Compliance Spend, deemed as Revenue Spend by NIAS Finance and the Department of Health. The Department has requested further detail, which has been supplied in the form of Strategic Outline Case detail for each of the 13 Estates Capital Bids

HQ Capacity

A Review is underway, conducted by the new CPD design team of the viability of NIAS HQ based upon current staffing requirements and planned increases.

It is expected that this review will highlight significant issues with the current usage of NIAS HQ building and as a contingency NIAS has instructed Land and Property Services to search for alternative locations; a number of sites have been identified

Alternative proposals have been submitted for consideration for additional modular accommodation to be sited within the carpark at NIAS HQ.

NIFRS

NIAS and NIFRS Service Level Agreement expired in 2014. NIFRS and NIAS are in discussions to formalise a licence agreement to facilitate NIAS using NIFRS property however the Departmental Guidance on MOU may negate this need. DLS, on NIAS behalf has requested that NIFRS formally adopt this approach

Collaboration

NIAS has instructed the Design Team to undertake a feasibility study NIAS using the NIFRS site at Boucher Road to inform a wider debate and feasibility of collaboration , with NIFRS , in general

Compliance

NIAS has embarked upon a series of estates surveys covering fire risk assessments, Health and safety, legionella and asbestos. Remedial works are prioritised based on risk. All results due by end Q4 2018/19

Fleet Section:

Objective 1: To provide a professionally managed, safe and reliable ambulance Fleet, which supports the operational model for service delivery.

Key Performance Indicator: Replace around 20% of fleet annually.

- 23 A&E Ambulance for 2019 built and currently being Quality checked
- 26 PCS Ambulances for 2019 currently in build for completion march 2019
- 12 Response Cars currently in build for completion march 2019
- 2 Specialist vehicles currently in build for completion march 2019

Key Performance Indicator: Age of fleet should be less than 5 years old.

The percentage of all vehicle types less than 5 years old has increased and will continue to do so as the Trust continues to make new vehicles operational.

Compliance with the age of fleet key performance indicators is described in the following table:

Fleet Profile 18/19	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
(% less than 5 yrs old)													
Emergency Ambulances	80	80	80.2	82.8	83.6	93.1	99.1	99.1	99.1	99.1	99.1	99.1	99.1
Non-Emergency Ambulance	79.2	80	80	80	78.4	79.3	82.9	86.5	88.3	87.4	90.2	92.90	92.9
Rapid Response Vehicles	88.3	88.3	88.3	86	62.8	67.4	69.8	79.1	88.3	81.4	81.4	81.40	79.07
Support Vehicles	58.8	59.6	56.8	56.8	50	56.8	56.6	58.5	64.2	66.0	66.0	68.50	68.5
Fuel Used & C02 Generated 2017/18	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Allstar Fuel card Purchases	131030	144952	126049	128202	121485	114819	114196	117391	126166	126977	133565	133655	120216
NIAS Bunkered Sites	18676	19912	16153	20791	20016	20820	22145	22483	22762	24309	24589	24129	21890
Total Fuel (Litres)	149706	164864	142201	148994	141501	135639	136341	139874	148928	151285	158153	157785	142106
Total CO2 (1 Litre x 2.6391kgs) Generated	395089	435093	375283	393210	373435	357965	359818	369140	393036	399257	417382	416410	375032
MOT Pass Rate 2017/18	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
No of vehicles presented for MOT	38	35	24	24	24	18	10	7	19	29	31	28	45
No of vehicles passed MOT first time	36	34	23	20	23	16	8	6	16	28	31	28	44
First Time MOT Pass Rate (%)	94.74%	97.14%	95.83%	83.33%	95.83%	88.89%	80.00%	85.71%	84.21%	96.55%	100.00%	100.00%	97.78%
Miles covered	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Total Fleet Mileage	482239	641810	619605	670256	652306	589690	615258	624616	679519	656798	634771	587335	

TB/04/04/2019/08

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT

February 2019 (Month 11)

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently reporting a surplus of £175k for the eleven months ending 28 February 2019 (Month 11), subject to key risks and assumptions. In particular, Accident & Emergency staff are currently being paid at Band 4 and Band 5 on account, without prejudice and subject to the outcome of the matching process. The Trust continues with the assumption that the Board will fund the full legitimate costs of Agenda for Change for NIAS. The provision of operational cover to backfill staff who have taken up positions on the foundation degree programme for Paramedics has been challenging, resulting in an underspend against core budget. The Trust is seeking to address this through a range of measures, including voluntary overtime and the use of Voluntary and Private Ambulance Services.

The Trust has previously forecast a breakeven position at year end, subject to and without prejudice assumptions made in relation to Agenda for Change, efficiency savings and investment. This forecast breakeven was dependent on a number of significant assumptions, particularly in regards to the deliverability and expenditure on training, ambulance receivers, VAS/PAS and estates work. However, the impact of vacancies in core budgets has resulted in an underspend in January and February 2019 that is likely to be sustained until the end of the financial year. The ability to fill these vacancies is limited by the willingness of staff to commit to overtime shifts and also capacity within the Voluntary and Private Ambulance sector.

Financial position at the end of February 2019 (Month 11)

Financial Breakeven Assessment (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Costs		8,954	13,465	17,941	22,383	27,041	31,635	36,276	41,026	45,744	51,899	
Other Expenditure		2,917	4,037	5,870	7,125	8,360	9,603	10,986	12,329	14,802	16,283	
Expenditure Total		11,871	17,502	23,811	29,508	35,401	41,238	47,262	53,355	60,546	68,182	
Income		134	201	277	334	401	468	615	692	813	895	
Net Expenditure		11,737	17,301	23,534	29,174	35,000	40,770	46,647	52,663	59,733	67,287	
Net Resource Outturn		11,737	17,301	23,534	29,174	35,000	40,770	46,647	52,663	59,733	67,287	
Revenue Resource Limit (RRL)		11,737	17,302	23,535	29,175	34,993	40,763	46,644	52,660	59,804	67,462	
Surplus/(Deficit) against RRL		0	1	1	1	(7)	(7)	(3)	(3)	71	175	0

NIAS Trust Board Budget Report at February 2019

			YTD		
(£ 000s)		FYB	Budget	Actual	*Variance*
Chief Executive's Office					
	Payroll	178	164	165	(1)
	Non-Payroll	77	72	70	2
Chief Executive's Office Total		**255**	**236**	**235**	**1**
Director of Finance					
	Payroll	1,272	1,512	1,502	10
	Non-Payroll	793	743	738	5
Director of Finance Total		**2,065**	**2,255**	**2,240**	**15**
Director of HR					
	Payroll	1,324	1,349	1,346	3
	Non-Payroll	786	733	716	17
Director of HR Total		**2,110**	**2,082**	**2,062**	**20**
Dir of Ops (incl Divisions & RCC)					
	Payroll	49,118	45,065	44,276	789
	Non-Payroll	12,116	11,360	12,017	(657)
Dir of Ops (incl Divisions & RCC) Total		**61,234**	**56,425**	**56,293**	**132**
Medical Director					
	Payroll	4,562	4,619	4,610	9
	Non-Payroll	2,732	2,740	2,742	(2)
Medical Director Total		**7,294**	**7,359**	**7,352**	**7**
NIAS Total					
	NIAS Total Payroll	**56,454**	**52,709**	**51,899**	**810**
	NIAS Total Non-Payroll	**16,504**	**15,647**	**16,282**	**(635)**
NIAS Total		**72,958**	**68,356**	**68,181**	**175**

Underlying this overall financial forecast is a complex budgetary position. There are a range of vacancies creating underspends against the pay budget. The level of underspend is reduced by overtime costs to provide operational cover. There are also significant levels of sickness absence that can create a financial pressure beyond budgeted levels. Expenditure on Voluntary and Private Ambulance Services and also the Voluntary Car Service to offset these vacancies and maintain cover and performance is creating a corresponding pressure on the non-pay budget. NIAS is also coordinating some Voluntary and Private Ambulance Service activity on behalf of other HSC Trusts. The cost of this is being recharged to the respective HSC Trust.

The provision of operational cover to backfill staff who have taken up positions on the foundation degree programme for Paramedics has been challenging, resulting in an underspend against core budget. The Trust is seeking to address this through a range of measures, including voluntary overtime and the use of Voluntary and Private Ambulance Services.

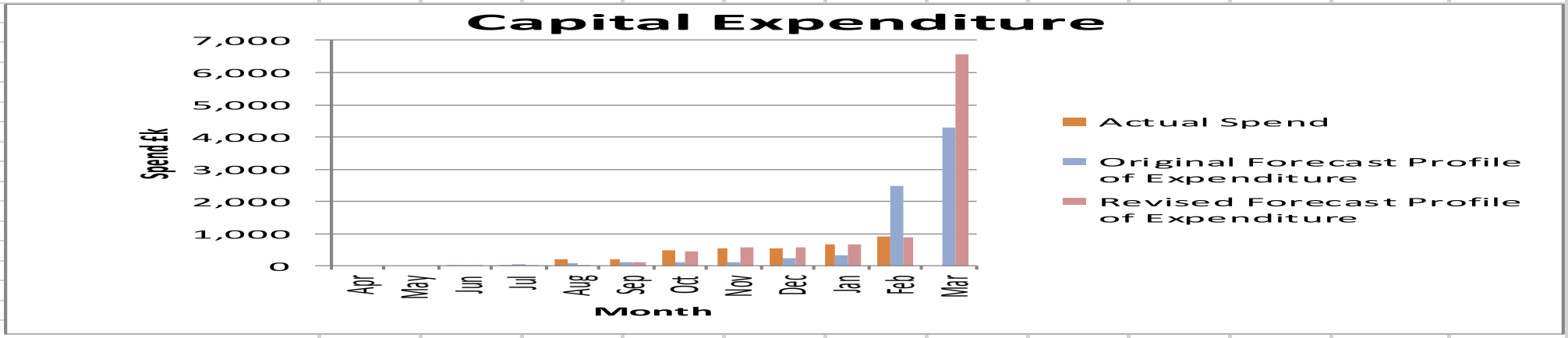
There are a number of income assumptions included in this financial position. The Trust continues to work with HSCB and other stakeholders to highlight emerging cost pressures and service changes with a view to achieving objectives and maintaining financial balance.

The Trust is also required to identify and deliver savings proposals to address a forecast £0.827m savings requirement in 2018/19.

Capital Spend

The Trust is currently forecasting a Capital Resource Limit (CRL) allocation of £6.566m (Previously £5.904m). The adjustments to the CRL allocation include latest estimates for specific ICT Schemes. The allocation also allows the Trust to continue with planned cyclical fleet replacement. Resources had previously been earmarked for a replacement ambulance facility in the Southern Division, subject to business case approval, procurement and implementation in the current financial year. It has not been possible to achieve these requirements within the year and the Trust will update and submit a revised business case for this project in due course. The Department of Health have issued revised guidance on the reporting of capital expenditure. This includes detailed monthly reporting and forecasting of levels and profiles of spend. The Trust continues to engage with the Department of Health in relation to capital expenditure forecasts. Forecast levels and profiles of expenditure can vary for a number of reasons, not least as a result of tender exercises and also supplier capacity and project risks and lead times. The capital requirements for all projects are continually reviewed and any changes in the forecast profile and level of expenditure will be reflected in further adjustments to the CRL allocation.

Cumulative Capital Spend (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Fleet	0	0	0	0	0	0	0	0	7	7	67	
Estate	0	0	0	0	0	0	0	0	0	0	0	
Medical Equipment	0	0	0	0	0	0	0	0	0	0	0	
ICT Schemes	0	0	13	18	197	197	459	459	459	548	713	
General Capital	0	0	0	13	23	23	23	85	85	110	118	
Actual Spend	0	0	13	31	220	220	482	544	551	665	898	0
Original Forecast Profile of Expenditure	0	0	20	58	80	100	102	114	239	344	2,494	4,294
Revised Forecast Fleet & General	0	0	0	0	0	0	0	118	125	125	184	4,197
Revised Forecast ICT	0	0	13	31	31	103	459	459	459	541	713	2,369
Revised Forecast Profile of Expenditure	0	0	13	31	31	103	459	577	584	666	897	6,566



Prompt Payment of Invoices

The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% (increased from 60%) of invoices within 10 working days (14 calendar days) has also been set.

Performance by number of invoices paid for each of these measures is shown below.

A range of plans are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary. Performance for the full year has been reviewed and updated at the end of February 2019.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Total bills paid	987	2,050	1,823	1,739	1,579	1,693	2,312	2,056	2,057	2,223	1,832		20,351
Total bills paid within 30 calendar days of receipt of undisputed invoice	948	1,924	1,613	1,644	1,466	1,606	2,219	1,940	1,920	2,063	1,689		19,032
% bills paid on time	96.0%	93.9%	88.5%	94.5%	92.8%	94.9%	96.0%	94.4%	93.3%	92.8%	92.2%		93.5%
Total bills paid within 10 working days (14 calendar days)	639	1,259	1,121	1,026	1,144	1,309	1,730	1,509	1,363	1,258	992		13,350
% bills paid on time	64.7%	61.4%	61.5%	59.0%	72.5%	77.3%	74.8%	73.4%	66.3%	56.6%	54.1%		65.6%

Business Services Organisation (BSO) Procurement & Logistics Service (PaLS) Key Performance Indicators (KPI's)

The Business Services Organisation provides a range of services to The Trust, including Procurement and Logistics Services (PaLS), Legal Services, Technology Services and Internal Audit. New reporting arrangements for the Service Level Agreements have identified Key Performance Indicators (KPI's) in respect of Purchasing and Supply. Performance against these KPI's to the end of February 2019 (Month 11) is as follows:

Key Performance Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Average Processing Time Per Requisition Days (Target 5 Days)	3.86	5.46	5.59	6.09	3.94	3.78	4.66	3.89	4.18	4.85	4.83	
Percentage of Products Supplied on First Request % (Target 95%)	98.90%	98.80%	98.80%	99.20%	99.00%	99.40%	99.50%	97.03%	99.26%	98.89%	97.30%	
Number of Lines Issued (Stock and Non Stock Line)	1,683	1,444	1,516	1,439	1,505	1,239	1,596	1,543	1,843	1,756	1,552	
Value of Spend £k (Stock and Non Stock)	255	608	208	447	322	492	673	2,931	915	577	2,379	

Information Technology Systems - System Availability

Robust procedures are in place to confirm ongoing availability of Trust systems. Any system failures are reported in this section.

Jan – Feb Telephony failures

Several repeat instances of calls not being able to be answered have been experienced on the Avaya voice platform for the Northern Ireland Ambulance service since January 2019. The impact for the incidents have varied in severity with the latest incident from 19th February having significantly the most impact (due to the length of the outage). This outage impacted multiple calls across the entire platform for a significant period of the day, not all calls were getting through to agents and call screen display information was not available for the duration of the incident, agents had reduced functionality and even though they were ready not all calls were going through.

Following initial investigation into the most recent failure Engineers found several issues on both the telephony servers. Logs indicated a number of memory issues which appear to have been going on for a period of time which will require further investigating. These issues have been escalated to the telephony switch manufacturer 'Avaya' for in-depth analysis of logs and a resolution to the issues.

During the periods of disruption no calls were lost or Ambulance despatch effected and the electronic call passing contingency arrangements with Scotland Ambulance Service worked well.

Information Technology Systems - Developments

Any system developments are reported in this section.

Work is progressing on the implementation of a replacement Mobile Data system with our new providers Terrafix. The target completion date for full implementation across all the NIAS fleet is end June 2019.

The procurement process for an Electronic Patient Record system is now complete with a preferred supplier identified and contract awarded. Implementation of the system will commence in the next financial year.

Cyber Security: A HSC Cyber Security Programme Board has been set up to define Cyber Security assessment standards for HSC organisations and to undertake or commission assessment of achievements against those standards. The Board will also make recommendations on priority actions and required investment to address gaps and further proactive cyber security measures and be in position to provide a transparent statement on the status of Cyber Security and preparedness for the HSC. Funding has been identified By HSCB for each HSC Trust to procure and implement network device scanning and network vulnerability scanning software.

ICT Help Desk Performance

Key* - Immediate 4 Hours, Urgent 1 Day, High 2 Days, Medium 3 Days, Low 7Days

	January			February		
Target to Respond to 95%	No of Calls	Within time	Actual	No of Calls	Within time	Actual
Immediate	7	7	100%	10	10	100%
Urgent	51	51	100%	41	41	100%
High	2	2	100%	7	7	100%
Medium	630	624	99%	584	569	97%
Low	1051	1051	100%	834	834	100%
Total	1741			1476		

ICT Planned Maintenance January 2019 – system upgrades Critical Systems

	Availability	**Maximum down time**	**Actual**	**Exceeded Maximum Down Time**
C3 A&E	740	4 Hours	0.20	No
C3 PCS	740	4 Hours	0.15	No
Pro-QA	740	4 Hours	0	No
ICCS A&E	740	4 Hours	0	No
ICCS PCS	740	4 Hours	0	No
DTR	740	4 Hours	1	No
Voice Recorder	740	4 Hours	0.20	No
Defib	740	4 Hours	0.10	No
Mobile Data	740	4 Hours	0	No

These are business critical systems which manage front line resources and need to be available on a 24/7 365 basis.
It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.

ICT Planned Maintenance January 2019 – system upgrades Corporate Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	
E-mail	206	4 Hours	0	No	These are business support systems which need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
File Server	206	4 Hours	0	No	
Virtual Server	208	2 Hours	0	No	
BlackBerry	206	4 Hours	0	No	
Promis	206	4 Hours	0.15	No	

ICT Planned Maintenance February 2019 – system upgrades Critical Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	
C3 A&E	740	4 Hours	0.15	No	These are business critical systems which manage front line resources and need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
C3 PCS	740	4 Hours	0.15	No	
Pro-QA	740	4 Hours	0.10	No	
ICCS A&E	740	4 Hours	0	No	
ICCS PCS	740	4 Hours	0	No	
DTR	740	4 Hours	0	No	
Voice Recorder	740	4 Hours	0.15	No	
Defib	740	4 Hours	0.10	No	
Mobile Data	740	4 Hours	0	No	

ICT Planned Maintenance February 2019 – system upgrades Corporate Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	
E-mail	206	4 Hours	0	No	These are business support systems which need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
File Server	206	4 Hours	0.15	No	
Virtual Server	208	2 Hours	0	No	
BlackBerry	206	4 Hours	0.10	No	
Promis	206	4 Hours	0.15	No	

Information Governance/Informatics – Developments: 01/01/2019 to 28/02/2019

Developments in the provision of Information are reported in this section.

- ***Control Assurance – Information Management: 76% Substantive Achieved through Self-Assessment for 2017/18. Action Plan for outstanding items developed. This work continues to be a priority of the Trust. Along with outstanding Priority 1 Audit Recommendations relating to Information Governance aspects relating to Information Asset Register and Data Flow Exercise. Work in this area has been ongoing and templates for an Information Asset Register and Data Flow template have been created and information gathering has been completed in Finance and ICT, HR and Corporate Services including Regional Ambulance Training Centre, Medical Directorate including Emergency Planning/Risk Management, Operations in HQ, Resource Management Centre. Visits to local Division Areas ongoing.***
- ***General Data Protection Regulations (to replace Data Protection Act 1998 in May 2018) – Action Plan Monitoring,***
- ***Supporting Medical Directorate and Transformation Collaborative with Quality Improvement Templates and data analysis. These continue to be developed and monitored. Includes Falls, Hypoglycemia, Acute Coronary Syndrome, Cardiac Arrest (refer to Medical Directorate section of report for reporting)***
- ***ACP monitoring aspects reviewed. ACP pathways continued to be monitored and reviewed. Ad hoc datasets have been provided to support further initiatives as required ie quality improvement***
- ***Informatics and business intelligence to support Transformation and Information Collaborative workflows continue to be worked on as required***
- ***Supporting work and data streams in Frequent Caller Monitoring and Information Markers including policy/procedures and analytics***
- ***Ad hoc datasets to support winter pressures including hospital turnaround times, patient flows, community first responder dashboard, paediatric attendances, trauma injuries etc***
- ***Patient Report Forms and 999 calls to support inter-face incidents, Serious Adverse Incidents, Child Protection Issues, Vulnerable adults etc; PRFs to support quality assurance of Quality Improvement***
- ***Development of new Community First Responder Patient Report Form in partnership working*** **with Community Resuscitation Lead**
- ***AED (Automatic External Defibrillators) Location Interactive Tool being updated on monthly basis***
- ***Interactive tool developed to support Frequent Caller Activity***
- ***Interactive tool developed to support HEMs Activity***
- ***Interactive tool developed to support Clinical Support Desk Monitoring***
- ***Out of Hospital Cardiac Arrest Report for 2017/18 being finalised including patient outcomes to support Community Resuscitation Strategy including new dashboard presentation output***

The Information Team has developed a suite of reports to support performance management which includes daily, weekly, monthly analysis of operational performance; hospital turnaround times; non-emergency transportation etc. These are shown in the Operations section of this Report. Clinical indicators are available in the Medical Directorate's section. Assurance in the area of IG is sought through the Information Governance Steering Group, chaired by DOF&ICT as SIRO with Medical Director as Caldicott Guardian. Minutes are reported to Assurance Committee.

INFORMATION GOVERNANCE SUMMARY OF FREEDOM OF INFORMATION, GENERAL DATA PROTECTION REGULATIONS (SUBJECT ACCESS), PSNI REQUESTS AND SOLCITOR ENQUIRIES PROCESSING LEVELS

Summary 2018/19 requests compared with same period in 2017/18:

	April 18 – Feb 19	April 17 – Feb 18	% Increase / (Decrease)
1 Freedom of Information Requests Received	204	147	39%
1a Freedom of Information Questions Received	688	562	22.4%
2 General Data Protection Regulations, Subject Access Requests Received	74	29	155%
3 Police Service of Northern Ireland Requests Received	464	439	5.7%
4 Solicitor Enquiries Requests Received	546	571	-4.5%
Total (1a) not included in Count	**1288**	**1186**	**8.6%**

1. FREEDOM FOR INFORMATION ACT (2000) – REQUESTS FOR INFORMATION – 01/04/2018 to 28/02/2019

Freedom of Information Act (2000) relates to any information held in an electronic or manual format and can be accessed by anyone who requests it. Exemptions are limited and unless they specifically apply, information must be released. Personal information is accessible using the General Data Protection Regulations (see following)

2018-19 Data

Freedom of information	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Feb-19	Total Feb-18
Number of Requests Received	19	6	26	24	15	12	31	20	10	23	18		**204**	147
Number of Questions Received	67	18	74	49	61	31	115	80	33	60	100		**688**	562
Completed Requests processed within 20 days or less	11	5	23	21	11	10	23	20	9	17	8		**158**	88
Completed Requests exceeding 20 days	6	1	2	2	2	2	3	0	0	3	1		**22**	47
REQUESTS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	1	1	6		**8**	
REQUESTS Still being processed (outside 20)	1	0	0	1	2	0	5	0	0	2	3		**14**	
Stood Down	1	0	1	0	0	0	0	0	0	0	0		**2**	
Number of Records Fully Disclosed	44	17	69	42	33	29	79	78	31	43	23		**488**	
Vexatious Requests	0	0	0	0	0	0	0	0	0	0	0		**0**	
Number of Records for which records not held	3	1	0	4	0	2	0	0	0	4	0		**14**	
Requests where exemptions wholly/partially applied	0	0	0	0	0	0	2	2	1	8	0		**13**	
Questions stood down	5	0	5	0	0	0	0	0	0	0	0		**10**	
QUESTIONS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	1	3	29		**33**	
QUESTIONS Still Being Processed (outside 20)	15	0	0	3	28	0	34	0	0	2	48		**130**	
Referrals for Independent Review	0	0	0	0	0	0	0	0	0	0	0		**0**	
Appeals to the Information Commissioner	0	0	0	0	1	0	0	0	0	0	0		**1**	
Requestor Type														
Member of Public	3	1	9	8	3	6	15	5	6	9	6		**71**	
Local Government	1	0	0	0	0	0	1	0	0	0	0		**2**	
Staff Member	2	3	10	10	6	4	6	4	2	4	5		**56**	
Media	3	0	3	2	1	2	4	1	0	6	2		**24**	
Student	2	0	0	0	0	0	0	0	0	2	0		**4**	
Commercial Company	2	1	2	2	3	0	3	3	0	1	1		**18**	
Solicitor	0	0	0	0	0	0	0	0	0	0	0		**0**	
WhatDoTheyKnow.com	5	1	2	2	2	0	2	6	1	1	4		**26**	
NHS	0	0	0	0	0	0	0	0	1	0	0		**1**	
Trade Union	0	0	0	0	0	0	0	1	0	0	0		**1**	

%age completed within 20 working days	
Apr '18 - Feb '19	77.45%
Apr '17 - Feb '18	59.86%

Data will be subject to amendments.

2. DATA PROTECTION ACT 1998/GENERAL DATA PROTECTION REGULATIONS – SUBJECT ACCESS MONITORING

The Data Protection Act 1998 (replaced with the General Data Protection Regulations/DPA 2018 on 25 May 2018) allows an individual to have the right to see and/or receive a copy of personal data held about them on both electronic and manual records and to have any incorrect data amended or deleted.

Processing (Subject Access) for the Period 01/04/2018 to 28/02/2019

General Data Protection Regulations/Data Protection Act 2018 – Subject Access	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 18 – Feb 19	April 17 – Feb 18
Number of Requests Received	2	3	8	2	9	6	6	7	6	14	11		74	29
Completed Requests processed within 40 days or less (from 25 May 2018 standard is 30 days)	2	1	5	2	7	4	5	5	2	11	8		52	24
Completed Requests exceeding 40 days (from 25 May 2018 standard is 30 days)	0	1	1	0	1	2	1	0	0	0	0		6	4
Requests still being processed in line with 40 days (from 25 May 2018 standard is 30 days)	0	0	0	0	0	0	0	0	0	0	0		0	0
Outstanding Requests exceeding 40 days (from 25 May 2018 standard is 30 days) and still being processed	0	1	1	0	1	0	0	2	4	3	3		15	
Identity Not Confirmed/Fee Not Received and therefore could not be further processed	0	0	1	0	0	0	0	0	0	1	0		2	1
Patient	2	1	1	1	0	3	1	1	3	10	3		26	13
NIAS Staff Member	0	0	1	0	3	2	4	4	3	1	1		19	8
External Agency ie Solicitor acting on behalf of patient/staff	0	1	6	1	6	1	1	2	0	1	4		23	8
Relative of Patient	0	1	0	0	0	0	0	0	0	2	3		6	0

- There are a number of DPA requests from 2017/18 that remain outstanding relating to staff requests for disciplinary files, HR records etc - these are currently being prioritised

3. POLICE SERVICE OF NORTHERN IRELAND REQUESTS – Police Acts, Common Law 01/04/2018 to 28/02/2019

Purpose: for the prevention, investigations and detection of crime; for apprehension and prosecution of offenders; or to prepare a file for Coroners Court etc.

Requests include the release of call incident logs, 999 calls, radio transmissions, staff names/shift patterns, Patient Report Form, and staff witness statements in line with legislative requirements to assist with PSNI investigations, for example, investigation of fatal road traffic collisions, murder enquiries, alleged assaults.

Requests will relates and include the release of call incident logs, 999 call, staff names and shift patterns, Patient Report Form, staff witness statements in line with legislative requirements to assist with PSNI investigations for example, investigation of fatal road traffic collisions, murder enquiries, alleged assaults etc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 18 – Feb 19	Apr 17- Feb 18
Number of Requests Received (based on receipt of correspondence date)	29	44	33	32	40	47	50	32	43	60	54		464	439

4. SOLICITOR ENQUIRIES 01/04/2018 to 28/02/2019

Requests for Information which fall under the remit of the Data Protection Act 1998/General Data Protection Regulations and/or Access to Health Records (NI) Order 1993

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 18 – Feb 19	Apr 17- Feb 18
Number of Requests Received (based on receipt of correspondence date)	54	39	47	42	53	58	58	56	27	58	54		546	571

5. DEPARTMENT OF HEALTH – REQUESTS FOR INFORMATION

Processing for the Period 01/04/2018 TO 28/02/2019

DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr 18 – Feb 19
Assembly Questions (Oral)	0	0	0	0	0	0	0	0	0	0	0		0
Assembly Questions (Written)	0	0	0	0	0	0	0	0	0	0	0		0
CORs/SCORs Received	1	1	2	0	2	1	4	0	0	2	2		15
TOFs Received	0	0	0	0	0	0	0	0	0	0	0		0
INVs Received	0	0	0	0	0	0	0	0	0	0	0		0

As no Government is currently in operation within Northern Ireland, requests have been limited since March 2017

6. PRF V PATIENT NUMBERS COMPARISON

18/19 - PRF v PATIENT NUMBERS COMPARISON

Summary

Month	Emergency Response(s) which arrived on scene	Patient Journeys where a patient has transported to a hospital: Emergency	Routine	Total	Number of PRF's completed for the treatment of a patient. Completed PRFs (Formic)	Difference between Emergency Responses and completed PRF's	Difference Patient Journeys and completed PRF's
April 2018	15611	12298	341	12639	14794	-817	+2,155
May 2018	16710	13238	356	13594	15734	-976	+2,140
June 2018	16172	12694	344	13038	15291	-881	+2,253
July 2018	16117	12694	334	13028	14912	-1,205	+1,884
August 2018	15862	12539	314	12853	15065	-797	+2,212
September 2018	15881	12577	331	12908	15246	-635	+2,338
October 2018	16414	13166	372	13538	16093	-321	+2,555
November 2018	16561	13229	326	13555	16501	-60	+2,946
December 2018	17217	13679	233	13912	16144	-1,073	+2,232
January 2019	16965	13575	279	13854	13388	-3,577	-466
February 2019	15023	12057	245	12302	6182	-8,841	-6,120
March 2019				0		+0	+0
Total	178533	141746	3475	145221	159350	-19,183	+14,129

Emergency Response(s) which arrived on scene only counts as 1 record irrespective of the number of resources that arrive on scene.
There will always be more Emergency responses than patient journeys as patients do not always respond.

All patient contact should result in a PRF being completed, and consequently the number of completed PRF's should always be higher that the Emergency Response(s) which arrived on scene figure.

Please note figures for 2018/2019 are provisional and will rise as data processing is ongoing.

TB/04/04/2019/09

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee
Wednesday 14 November 2018 11am
Board Room, NIAS, Knockbracken Healthcare Park, Belfast

PRESENT	Mr T Haslett	Non-Executive Director (Chair)
	Mr W Abraham	Non-Executive Director
	Mr D Ashford	Non-Executive Director
IN ATTENDANCE	Mrs N Lappin	Trust Chair
	Mr M Bloomfield	Chief Executive
	Dr N Ruddell	Interim Medical Director
	Mrs S McCue	Director of Finance & ICT
	Ms R O'Hara	Director of HR & Corporate Services
	Mr B McNeill	Director of Operations
	Mr F Orr	Assistant Director of
	Mrs K Keating	Risk Manager
	Ms L Charlton	IPC Lead
	Mrs J McSwiggan	Note-taker

1.0 Welcome and Apologies

Apologies were noted from Mr A Cardwell, Non-Executive Director and Dr J Livingstone, Non-Executive Director.

2.0 Procedure

2.1 Declaration of Potential Conflicts of Interest

No potential conflicts of interest were declared.

2.2 Quorum

The Committee was confirmed as quorate.

2.3 Confidentiality of Information

The Chair reminded those present that some information, such as that relating to specific patients, requires confidentiality, and that meetings should otherwise be open and transparent.

3.0 Minutes of the Assurance Committee Meeting held on 5 September 2018

The Committed Chair thanked J McSwiggan for the comprehensive Minutes and these were presented for noting, having previously been circulated, agreed and signed by the Committee Chair.

4.0 Matters Arising

Matters arising are covered within the Agenda.

4.1 Action Points

Progress against action points arriving in the previous meeting was noted.

5.0 Chairman's Business

The Chair had no business to report.

6.0 IPC Progress Update

The Committee noted that the current improvement notices relating to corporate leadership and accountability of the Trust had a review date of October 2018, and it is anticipated that RQIA will revisit NIAS in the near future, with a particular focus on governance and assurance arrangements. It was noted that RQIA will also wish to speak to the Non-Executive Directors as part of this process.

L Charlton referred to the IPC, hygiene and cleanliness assurance mapping document within the papers and made specific reference to gaps in assurance and actions required to address.

L Charlton summarised the Trust's performance against each of the IPC KPIs for Q2 (Jul-Sept 2018).

It was highlighted that the compliance standards are challenging but are in keeping with those in use by other Ambulance Services across the UK. The Committee noted that these standards will also allow the Trust to identify good practice, areas for improvement and potential resource issues which would facilitate seeking Commissioner support to fund these.

It was noted that while the vehicle deep cleaning frequency of every two weeks is more frequent than other Ambulance Services, this is the result of a complex range of factors and is not comparing like with like. The Trust will continue to use the data from Docworks to inform decision making at the internal vehicle cleaning group re future model.

In addition to highlighting areas of non-compliance, the Committee welcomed the use of photos within Docworks audits to acknowledge good practice.

The Committee thanked L Charlton for her comprehensive work in this area, and commended the hard work of all involved in the programme of improvements.

The Committee sought assurance that the Trust will be able to embed these improvements and sustain compliance with these standards, and the following were highlighted:

- There is meaning and purpose behind the improvement programme;
- The recruitment of an IPC Lead Nurse will commence soon;
- The NI IPC Forum will be providing Ambulance Service-specific link training to allow the Trust to train its own IPC champions;
- The appointment of dedicated cleaning operatives;
- A wider structural review looking at facilitating Station Officers and Station Supervisors to focus on key areas such as IPC rather than administrative duties;
- A dedicated resource for environmental cleanliness is included within the business case;
- The need for every Directorate to include IPC within relevant business cases moving forwards is recognised.

7.0 Standing Agenda Items

7.1 Assurance Framework Update

It was noted that a fundamental review of the framework is taking place, with a mapping exercise being conducted against each area.

K Keating outlined the planned approach and format of the Assurance Framework. The actions taken (e.g. comprehensive benchmarking with other Trusts, meeting with policy leads, cross-referencing against Internal Audit findings and the Trust Board Delivery Plan) to ensure that all key risk areas are identified were outlined. It was noted that the model selected is specifically designed to ensure coverage across all areas with the involvement of all policy leads. The three lines of defence within the framework will help provide the assurance required.

It was agreed external oversight of the framework would also add value, and K Keating advised that the individual components will be benchmarked to provide additional assurance. The value of the mapping index in particular was acknowledged. It was suggested that access to this as a live document outside the planned cycle of presentation would also be beneficial.

The Committee thanked K Keating for her comprehensive work to date and acknowledged this very positive step.

7.2 Corporate Risk Register

It was noted that a SEMT workshop had provided an opportunity for a fundamental review of the Corporate Risk Register in conjunction with outstanding Internal Audit recommendations.

7.3 Local Risk Register Review (HR)

The common themes of capacity resources and elements of restructuring were noted. It was noted that significant work is being undertaken around health and wellbeing of staff. Issues arising in the recent health and wellbeing survey were noted, and the Committee welcomed the recruitment of a temporary Welfare Manager and the leadership training programme being rolled out.

7.4 Local Risk Register – Chief Executive

It was noted that health and wellbeing is a Trust-wide issue and the motivation of an engaged workforce was again highlighted by this risk register.

7.5 Serious Adverse Incidents

No specific incidents to be highlighted.

It was noted that RQIA will be reviewing incident management across all Trusts in early 2019. The Committee was reminded that there has been no dedicated resource allocated to the management of SAIs. A NIAS workshop had recently reviewed the outstanding issues and as a result a temporary resource has been allocated to assist in this area.

It was requested that the Committee also be updated on SAIs that have been closed, and the associated lessons learned. It was noted that the Learning Outcomes Review Group review and cascade the learning from SAIs.

Action: Summary sheet / composite report to be provided for next meeting with total number, live and closed SAIs and the learning from these.

7.6 Incident Data

The addition of the summary sheet to draw out the main themes was noted. There is no change to the main themes within the report. Transmission issues with Corpuls were highlighted and assurance that the provision of care remains on course despite these issues was provided. The increase in RIDDOR reporting was highlighted, and the positive impact of the H&S Advisor's work in this area was noted.

7.7 Coroner's Reports & Letters

None within this reporting period.

7.8 Medical Device Alerts

None within this reporting period.

7.9 NICE Guidelines and Departmental Advisory Notices

None within this reporting period.

7.10 Pharmacy & Medicines Management

No independent station inspections by the Departmental team had taken place during this reporting period.

Belfast Trust Pharmacy had undertaken an inspection of HEMS arrangements. No significant issues had been raised, and any actions required are being undertaken by the HEMS Operational Lead.

8.0 Standing Agenda Items

8.1 Health & Safety Committee

Noted, with uniform provision specifically for pregnant and menopausal staff being highlighted. It was noted that the Uniform Committee is progressing this issue in conjunction with the H&S Committee.

Action: Director of Operations to brief Trust Chair on this issue in advance of her meeting with AACE.

Action: Director of HR & Corporate Services and Risk Manager to consider the inclusion of near miss reporting data in the next report.

8.2 Fire Compliance Group

No meeting had been held within the reporting period.

8.3 Facilities & Support Group

No meeting had been held within the reporting period.

8.4 Information Governance Steering Group

Noted, with cybersecurity and the data mapping exercise being highlighted.

8.5 Medical Equipment Group

Noted.

8.6 Infection Prevention & Control Group
Noted – already covered under Agenda Item 6.0 (IPC Progress Update).

8.7 Emergency Preparedness & Business Continuity Group
No meeting had been held within the reporting period.

8.8 Learning Outcomes Review Group
Noted.

8.9 Joint PSNI/NIAS Clinical Care Working Group
Noted.

8.10 Community Resuscitation Strategy Implementation Group
Noted. The Committee noted in particular the potential of the GoodSAM app. Clarification on one Council's stance on community resuscitation was noted, and an update will be provided to the Committee following engagement work by the Community Resuscitation Lead.

9.0 Additional Items

9.1 Controls Assurance Standards
It was noted that there have been no developments since the last Assurance Committee meeting.

9.2 Clinical Education Update
The Clinical Education Mid-Year Update was presented and noted.

The Committee was pleased to note progress towards the introduction of the FdSc Paramedic Programme. It was noted that the supporting documentation provided to HCPC in advance of their approvals visit in October had been highly commended by the approvals team, and they advised that they would be recommending the Programme for approval without conditions at their December panel meeting.

The Committee wished to record its thanks to F Orr and his team for an excellent report and the huge amount of work undertaken, particularly in the area of third level education.

The Committee also acknowledged the significant contribution of L Rafferty, the previous post-holder, in this area over a number of years prior to her retirement in July.

9.3 Mandatory Training Compliance Report
The annual review of mandatory training compliance was presented and noted. The impact of the delay in post-proficiency training on compliance was noted.

9.4 RQIA Audits & Inspections re: Restraint & Seclusion – update / developments in rest of UK
It was noted that the Trust awaits a report from RQIA on this review.

9.5 Updated Referral and Transport Policy and Guidance
Noted.

9.6 NIAS Major Incident Plan
Noted.

9.7 HSC Risk Management Model including Regional Risk Matrix
It was noted that the licence for the current model has now expired, and that the Trust's existing Risk Management Policy already adheres to the adopted ISO standard.

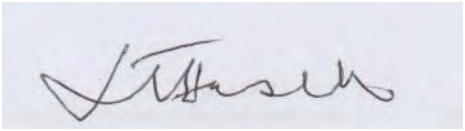
9.8 HSC Travel Audit
This letter from the Department of Health was noted. NIAS had been asked to highlight this to Assurance Committee and Audit Committee.

10.0 Any Other Business

No other business to be raised.

Date of Next Meetings

Dates for 2019 meetings to be agreed.

Signed:  **Date:** 6 December 2018

(Trevor Haslett, Chairman)

TB/04/04/2019/10

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a meeting of the Audit Committee held on Tuesday, 29th January 2019 at 12:30pm in the Boardroom, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT:	Mr W Abraham	Non-Executive Director (Chair)
	Mr D Ashford	Non-Executive Director
IN ATTENDANCE:	Mrs S McCue	Director of Finance & ICT
	Mr A Phillips	Assistant Director of Finance
	Mrs T Steele	Financial Accounts Manager
	Mr S Knox	NI Audit Office
	Mr B Clerkin	ASM
	Mrs C McKeown	BSO Internal Audit
	Mr D Charles	BSO Internal Audit
Minute Taker	Mrs S McMullan	Senior Secretary

Welcome and Introduction to Meeting

Mr Abraham welcomed everyone to the meeting of the Audit Committee and thanked all members for their attendance.

Mrs McCue introduced the Committee to Mrs Tina Steele. She informed the Committee that Mrs Steele had commenced with the Trust at the beginning of January 2019 as the Financial Accounts Manager for the Trust on a temporary basis.

1.0 Apologies

Mr Abraham noted Mr T Haslett's (Non-Executive Director) apology.

2.0 Declaration of Potential Conflict of Interest and Confirmation of Quorum

No conflicts of interest were declared and the meeting was confirmed as quorate.

3.0 Minutes of the previous meeting of Audit Committee

The minutes of the previous Audit Committee meeting held on Thursday, 11th October 2018 subject to minor amendments were approved.

4.0 Matters Arising

4.1 Mid-Year Assurance Statement (Final)

Mrs McCue advised that this is the final version and is presented to the Audit Committee for information purposes. Mr Phillips informed the Committee that the Statement had been slightly amended from the version approved at the

October meeting, after minor comments from the Department of Health. Mr Abraham commended everyone on their hard work in finalising the document.

5.0 Chairman's Business

Mr Abraham informed the Committee that there is a Trust Board Workshop on 31st January 2019. He continued that today's meeting is good preparation ahead of the workshop.

6.0 Internal Audit

6.1 Progress Report

Mrs McKeown presented the Progress Report highlighting performance against the Key Performance Indicators. Two reports are being presented today and three audits were currently in progress.

Board Effectiveness 2018-19

Mrs McKeown advised that a Limited level of assurance was being provided. She confirmed that discussions have been ongoing between Internal Audit, the Chair and the Chief Executive who appreciate the issues and the measures required in order to improve performance in this area.

Mrs McKeown highlighted the one significant finding regarding the review of the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions. The finding relating to Board minutes was discussed, and whilst they are not expected to be verbatim the minutes are currently not sufficiently detailed with the discussion / debate that took place. Mr Abraham requested that some internal guidance be issued to provide a clearer picture of what is expected from minute takers.

Action point: Practical standard / in-house minute taking guide to be sought and issued to relevant staff members.

Mr Abraham queried if a summary of this Committee meeting should be presented to Trust Board. Mrs McCue noted that timing is an issue in this respect, advising that the minutes taken today will not be available for the Board meeting next week. It was agreed that a short summary in bullet points should be presented to a Trust Board meeting following an Audit Committee where minutes are not yet available.

The DoH Board Self-Assessment tool was discussed. Mrs McKeown advised that the completion of the assessment is an annual requirement and noted that the guidance contains the basics and fundamentals and is still currently active. Mr Charles suggested external facilitation may be helpful to the Trust. The Self-Assessment should be completed by the Trust Board rather than by one individual.

Mr Abraham stated that NIAS does not currently have a Board Secretary. Mrs McCue advised that there is currently no specific funding available for that role.

Mr Abraham suggested that this a topic that could be raised at the Trust Board Workshop on 31st January.

Action Point: BSO to review what Board Secretariat resources other Trust's have.

Mr Abraham stated that receiving Board papers 3 days prior to a meeting is insufficient time to review the papers, adding that electronic versions are difficult to look at especially with larger documents. There was a discussion regarding the use of electronic tablets to view papers and Mrs McCue advised that Mr A Watterson was currently looking into this area. It was suggested that an Executive Summary for each paper should be provided.

Mr Abraham noted concerns highlighted in the survey relating to Trust Board meetings; namely that the papers are high in volume and sometimes difficult to understand.

Mrs McKeown highlighted that a small number of Trust Board meetings were poorly represented by Non-Executive Directors and that the meetings were potentially imbalanced and the quorum should be reviewed.

Mrs McKeown highlighted that the NIAS Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions are dated 2014, which is too long without being reviewed. Mrs McCue stated whilst she is aware this is not best practice, the appointments of both a new Chief Executive and Chair has posed a problem in reviewing these Orders and that the Trust needs stability in order to carry out such a review.

Absence Management 2018-19

Mrs McKeown advised that a Limited level of assurance was being provided and that this was the first audit in this area. Mrs McKeown advised that one significant finding had been identified: namely initial contact, management availability; return to work interviews; and occupational health. Mrs McKeown highlighted that the Attendance Management Policy and Procedure does not include reference to the role of the Resource Management Centre. She added that the policy is developed towards administration staff and this needs to be reviewed to include operational staff.

Mr Abraham advised that absence was a topic of ongoing interest and concern at Trust Board. There was a discussion regarding the duty of care to staff and the level of management engagement and challenge in the absence process.

6.2 Shared Service Audits

Mrs McKeown presented this paper noting the level of assurance provided in two audit areas.

7.0 External Audit

Mr Knox advised that in 2018, the NI Audit Office carried out an extensive procurement exercise across the public sector. Mr Knox advised that ASM were

recently awarded the contract for NIAS for a five year period commencing 2018-19. Mr Clerkin advised that the Audit Strategy would be presented at the next Audit Committee.

8.0 For Approval

No items presented for approval.

9.0 Any Other Business

9.1 Fraud Update

Mr Phillips advised that the Trust had two current fraud cases, of which one was recently closed and the other was still at the investigative stage with nothing proven to date.

Mr Phillips also advised that the payroll matches from the National Fraud Initiative exercise for 2018-19 were now available for review.

11.0 Date, Time and Venue of Next Meetings

Next meeting is scheduled for Tuesday 12 March 2019, 2.00pm in the Finance Meeting Room, NIAS Headquarters. Mr Abraham requested, that if this date poses a problem for anyone to advise as soon as possible.

Signed: William Abraham Date: …12/03/2019……

Northern Ireland Ambulance Service Health and Social Care Trust

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