Northern Ireland Ambulance Service
Health and Social Care Trust

# CSR Phase 1 and 2

Monitoring Report

AUGUST 2011

# 1 Background

1.1 Along with all other Health Trusts in Northern Ireland, The Northern Ireland Ambulance Service (NIAS) was required to deliver an average 3% per annum cash releasing efficiency savings over the period 2008-11. In the financial year 2008/09 the saving required was £1.236 million, rising to £2.719 million in 2009/10, and increasing again to £4.449 million by 2010/11 from a baseline budget of £49.436 million. In setting the context, it is important to note that the Trust secured more investment from the Comprehensive Spending Review (CSR) than it was required to release through efficiency savings however investment was conditional on the delivery of savings. The CSR investment was specifically designed to improve ambulance response and supporting service development to provide an effective and efficient ambulance service.

1.2 NIAS presented its proposals for Efficiency Savings and Comprehensive Spending Review (CSR) Investment for this period for public consultation in November 2008 and following a twelve week consultation period and a further period of decision making, published a Final EQIA and Consultation Report in July 2009. Within this final document, NIAS gave a commitment to monitor the implementation of the proposals and to publish a report of the results of this monitoring. This document provides these results along with further information around the implementation of the proposals and the monitoring undertaken.

1.3 NIAS were unable to implement proposals to release efficiency savings during 2008-09, whilst policy development, consultation and decision-making were ongoing. However the cash releasing requirements of the CSR programme were recurrent and cumulative and the savings to be released during Year 2 (2009-10) had to then include those proposed for 2008-09. The Trust implemented the changes in 3 planned phases with Phase 1 beginning in October 2009, Phase 2; December 2009 and the final phase operating from 01 April 2010.

1.4 Within this context, NIAS still met its statutory duty to achieve financial balance year on year. The Trust was able to maintain financial balance during this period largely as a consequence of administration savings, over achieving on our absence management target and through other non-recurrent initiatives.

1.5 This document relates to monitoring information gathered during first two phases of implementation which was the period between October 2009 and March 2010. It will set out the following:

i. Background to the changes

ii. What we said we would do including;

- Did we achieve our policy aims?

iii. What we said we would monitor including;

- How we implemented the changes and developed monitoring systems
- How we monitored and managed the impact on staff
- How we monitored and managed the impact on service delivery

iv. Updated assessment of impact

v. Conclusions

# 2 What we said we would do

## General Policy Proposals

2.1 In its consultation document the Trust proposed that the majority of efficiencies would be released through the reconfiguration of frontline emergency resources, resulting in reduction in planned emergency ambulance hours of cover. Under these proposals, Comprehensive Spending Review investment would be used to increase the hours of paramedic cover provided by Rapid Response Vehicle paramedics. The Trust put forward recommendations to secure efficiency savings through the measures outlined below. An outline of progress against these is provided below:

| Proposal | Action Taken |
|---|---|
| • The application of absence management measures including new rostering technology, thereby reducing spend on overtime. | • New rostering technology has been introduced along with robust absence management systems. |
| • The application of recently-introduced technology to increase the number of patients carried per non-emergency journey for PCS ambulances and Voluntary Cars. | • Revised booking systems and improved planning and use of mobile data technology. |
| • The in-house servicing of the Trust's | • In-house servicing arrangements for |

| | |
|---|---|
| fleet where possible and appropriate, such as servicing of cars and non-emergency ambulances and ancillary components.<br>• Establishing a system review to reduce spend in Training and Administration with an emphasis on use of new and existing technology to reduce expenditure. | ambulance vehicles and delivered necessary savings in this area.<br>• The Trust reviewed the delivery of training and administration in order to release the necessary savings. The quality of training delivered to staff was not affected. |

## Key Policy Proposal

2.2 As indicated, the majority of savings were to be realised through the re-profiling of planned hours of Ambulance Paramedic Response cover by reducing double crewed emergency ambulance response hours of cover, whilst increasing the proportion of Paramedic Rapid Response hours to emergency ambulance hours. In essence the proposals were to:

| Proposal | Action taken |
|---|---|
| • Reduce the hours of cover, provided by traditional A&E emergency ambulances, by 70,080 hours over the three year period. | • This figure related to hours of cover to be reduced over the three phases. Against this target over phases 1 and 2 the Trust reduced the hours of cover provided by traditional A&E ambulances by |

| | |
|---|---|
| • Use Comprehensive Spending Review (CSR) investment to increase hours of Rapid Response Vehicle (RRV) Paramedic cover by 131,400 hours.<br><br>• Use CSR investment funds to introduce clinical triage into NIAS Ambulance Control centre, to offer clinically appropriate alternatives to ambulance attendance and transportation to hospital for 999 calls, where the patient does not present with an immediately life-threatening condition. | 30,112.4 over phases 1 and 2.<br>• This figure related to hours of cover to be reduced over the three phases. Against this target over phases 1 and 2 the Trust planned 67, 210 RRV Paramedic response hours.<br>• Clinical Triage has been introduced to the NIAS Emergency Control Centre. |

2.3 The following criteria were used to determine the locations where this model would operate:

- Revised hours will be during the hours that RRV will operate most effectively and the hours when non-emergency 999 calls will be subject to clinical triage in ambulance control.

- Revised hours will be in locations where there is more than one emergency ambulance currently available twenty-four hours per day.
- Revised locations should be in areas where there is potential for support from neighbouring ambulance locations.
- Revised locations will take account of requirements to meet other PfA priorities while continuing to provide other essential services, such as non-emergency GP calls and inter-hospital transfers.

Having undertaken monitoring in respect of Phases 1 and 2 NIAS can confirm that proposals were implemented in a way which complied with the established criteria.

## Rural Considerations

2.4 In recognition of concerns regarding provision of service in rural areas, it was decided that the reduction of A&E cover would be in ambulance locations where there was more than one 24/7 ambulance planned to operate to protect ambulance cover and response in less-densely populated areas.

2.5 In addition, NIAS further developed plans for phases 2 and 3 to ensure that a higher proportion of savings would be released from urban areas in order to lessen the impact on less densely populated areas, with increased RRV paramedic response hours where these work particularly well.

2.6 RRV paramedics operate most effectively when demand is high and when the majority of emergency calls are suitable for lone worker deployment. Demand is highest during daytime and evening (until 02.00 hours) and NIAS designed hours of RRV Paramedic cover to reflect this.

2.7 As indicated in our consultation on these proposals, the key principle applied to deliver the modernised service as efficiently and effectively as possible is that of matching demand and supply. Demand analysis matches demand on an emergency ambulance service against the resources available to service it. Its purpose is to inform the scheduling of those resources effectively to meet clinically sound service delivery standards. It is a support to the judgement of experienced managers and staff; not an absolute prescription.

## Implementation of the changes

2.8 As indicated in the Final EQIA and Consultation Report, published in July 2009, the criteria was applied to the areas identified resulting in a model of reduced A&E response hours and increased RRV Paramedic response hours. NIAS gave a commitment that the net result in these areas would be increased paramedic response hours.

2.9 The table below outlines the detail of the A&E response hours taken out of and RRV Paramedic response hours invested in each of the areas over the first two phases of implementation.

| Area Affected | A&E Hours removed during Phases 1&2 (shown as hours pa) | RRV Paramedic Response Planned Hours | Net Change in Planned Hours |
|---|---|---|---|
| **Belfast** | **12,122** | **23,360** | **11,238** |
| Ardoyne | 2,659 | 5,840 | 3,181 |
| Bridge | 3,832 | 5,840 | 2008 |
| Purdysburn | 5,631 | 11,680 | 6,049 |
| **South Eastern** | **5,318** | **12,670** | **7,352** |
| Downpatrick | 2,659 | 3,910 | 1,251 |
| Lisburn | 2,659 | 5,840 | 3,181 |
| Bangor | | 1,460 | 1,460 |
| Derriaghy | | 1,460 | 1,460 |
| **Northern** | **5,214** | **18,980** | **13,765** |
| Ballymena | 2,086 | 5,840 | 3,754 |
| Larne | 3,129 | 5,840 | 2,711 |
| Coleraine | | 1,460 | 1,460 |
| Carrickfergus | | 5,840 | 5,840 |
| **Southern** | **7,456** | **10,740** | **3,284** |
| Armagh | 834 | 1,460 | 626 |
| Dungannon | 5,162 | 3,440 | -1722 |
| Craigavon | 208 | 5,840 | 5,632 |
| Newry | 1,251 | | -1,251 * |
| **Western** | **Efficiency savings removed in Phase 3** | | |
| Altnagelvin | | 1,460 | 1,460 |
| | | | |
| **NI TOTAL** | **30,110** | **67,210** | **37100** |

***N.B. figures are rounded to nearest whole number***

*Note: CSR investment in additional RRV paramedic response hours specifically in Newry station were implemented in the first quarter of Phase 3. In Phases 1 and 2, additional RRV paramedic response hours allocated to the Southern area provided cover to Newry and other stations, operating dynamically throughout the region.

2.10 Releasing the savings means the equivalent of a reduction of 88 wholetime equivalent posts (44 Paramedic and 44 Emergency Medical Technician).

Implementation of the model required changes to shift patterns in affected areas for staff resulting in, in some cases, staff working from different locations. However, the Trust was able to achieve this without any compulsory redundancies.

## Did We Achieve Our Policy Aims?

2.8 Having implemented Phases 1 and 2 by 31st March 2010, the Trust considers that the aims of the key policy proposal as set out in our consultation document have been achieved as described below.

| Aim | Update |
|---|---|
| • Protect and enhance the capacity of the ambulance service to provide rapid paramedic response and treatment to emergencies. | • CSR funding was used to invest in additional Rapid Response Vehicles and RRV Paramedic posts in order to achieve this. |
| • Deliver efficiency savings in line with Health Department requirements. | • Savings required during Phases 1 and 2 were delivered. |
| • Support and sustain improvements in response times recorded in 2007/08. | • Table 1 and 2 in Appendix A provide detail around the increased activity levels faced by the Trust during this period and performance achieved. They indicate that the number of Category A 999 calls to the service increased significantly during this period. However the Trust was able to reach more of these calls with a paramedic response within 8 minutes |
| • Facilitate service plans to extend provision of paramedic Thrombolysis throughout Northern Ireland. | • All paramedics within NIAS are now trained to deliver Thrombolysis throughout the region. |
| • Transform the service from a model prioritising patient transport to a more patient focused clinical model of pre-hospital care where the most clinically appropriate care options | • Implementation of this model has prioritised emergency paramedic response to the most critically ill patients, clinically appropriate prioritisation of ambulance |

| | |
|---|---|
| are provided for patients promptly, including emergency paramedic response, clinical treatment and ambulance transportation, where appropriate. | transportation and alternatives where appropriate. |

# 3 WHAT WE SAID WE WOULD MONITOR

3.1 The Trust gave a commitment to monitor the implementation of the changes as follows:

| **Objective** | **Monitoring system** | **Comment** |
|---|---|---|
| To improve response times for Category A calls in line with ministerial targets | Measurement of Category A performance reports. Monthly reports will be provided to Trust Board and published on NIAS website. | NIAS introduced a number of processes to monitor impact of CSR changes as part of the Performance Management and Improvement agenda. these included:<br>• Weekly performance Management Meetings with local area managers to discuss performance and action plans for improvement<br>• Development of a centralised data management system for data analysis and reporting via a shared folder<br>• Information of performance posted on NIAS website through publication of Trust Board reports<br>• Introduction of automated processes set up to forward weekly data and analysis to Commissioners |

| | | |
|---|---|---|
| | | • Held regular meetings with LCGs to discuss local issues affecting performance<br><br>• Weekly reports provided to Health and Social Care Board and Commissioners |
| To maintain the capacity to transport clinically urgent patients effectively to hospital | Measurement of conveying response to Category A calls, against target of 95% of calls within 21 minutes<br><br>Monthly reports as set out above | • Included in systems set out above |
| To manage demand to reduce the proportion of 999 category c calls taken to hospital | Measurement of % of Cat C calls taken to hospital<br><br>% of Cat C calls accessing alternative care pathways<br><br>Monthly report as above<br><br>Evaluation of pilot of clinical triage to include assessment of patient experience. | • Captured within management information systems developed |
| Achieve financial balance | Income v expenditure in balance<br><br>Monthly report | • Captured within established financial reporting systems |
| Avoid compulsory redundancies and monitor impact of proposals on staff | Quarterly report on implementation plan to Trust Board<br><br>CSR Consultative Group work programme and reports | • CSR Joint Consultative Forum included representation from management implementation team and trade union representatives |

## How we implemented and monitored the changes

3.2 As indicated previously, the Trust reprofiled shift patterns in the identified areas in order to implement the changes. This was planned through a programme of engagement with trade union representatives to minimise the impact on staff and build mitigating measures into the planning process. A CSR Joint Working Group was established with the Trust's four recognised Trade Unions, to facilitate consultation and engagement in this regard.

In addition local consultation took place between local management and staff together with their local Trade Union representatives in the implementation of the proposals.

## How we managed the impact on staff

3.3 Following consultation, an agreed process was developed to manage the movement of staff who would be affected by the proposals. The overall aim of the process was to ensure that security of employment would exist for employees whilst recognising that changes may occur to the Service, which could ultimately affect overall numbers and grades of staff employed. The process identified a system of redeployment for staff, which would minimise the impact on directly and indirectly affected staff, including the introduction of vacancy controls and the freezing of staff transfers.

It was agreed that any staff required to be displaced from their base station would be given priority to return to their base station under the Staff Transfer process.

3.4 In addition to agreeing a process for the move of affected staff, a set of principles was agreed regarding the development of staff shift patterns which would form the basis of shift pattern changes in the affected stations. It was agreed that the overarching principles, when developing the new shift patterns, should take consideration of Agenda for Change (HSC Staff Terms and Conditions), the Working Time Directive, the needs of the Service and consideration of work life balance issues for staff.

3.5 In terms of implementing the changes using the agreed processes it was agreed that consultation at local level should supplement the consultation undertaken via the CSR JCG in order for the changes to be implemented with the least impact possible to staff. This allowed trade union representatives and affected staff further input into the new shift patterns and facilitated further correspondence and meetings as appropriate with individual staff affected by the changes. It enabled, where possible, individual staff who were displaced to be presented with alternative options in order to provide them with an opportunity to select their preferred option.

3.6 Within the EQIA, a potential adverse impact on staff was identified in respect of the implementation of the changes, particularly for those with caring responsibilities. The collaborative approach as detailed above in managing the potential impact on staff was designed to mitigate against this impact from the outset and the direct engagement between managers and affected staff provided an opportunity for staff to identify further impacts and discuss mitigation.

3.7 In addition the management of vacancies, for example, in respect of the recruitment to RRV Paramedic positions, was timed in a way to create vacancies from those taking up positions in order to reduce the potential for staff affected by the changes to be moved. Ultimately, whilst some staff moved position within the rota only six members of staff across the affected stations were moved to a different station, having decided on the options presented to them. Furthermore, the Trust offered additional opportunities for staff not operating as paramedics to retrain in order to become qualified paramedics.

These measures were in addition to the mitigating measures set out within the EQIA which includes, for example the availability of Work Life Balance Policies.

3.8 As indicated in 2.10, Implementing the changes in terms of the reduction of A&E response hours had the effect of removing 88 whole time equivalent (WTE) posts from Service, however, the Trust was able, through this implementation process, to manage the changes in a way that avoided compulsory redundancies in line with the commitment provided in the EQIA document.

3.9 The Trust recognises that increased activity levels coupled with these changes means Accident and Emergency ambulance crews and Rapid Response Vehicle paramedics are responding to more calls. The Trust recognises that this is to the benefit of patient care.

The reduction on A&E vehicles and consequently conveyancing capacity coupled with increased activity levels has placed additional pressure on remaining A&E crews. Historically the Trust has experienced some pressure in standing crews down for meal breaks during periods of peak activity, which can include around lunch-time.
In order to address this, the Trust has established a working group including representation by trade union representatives.

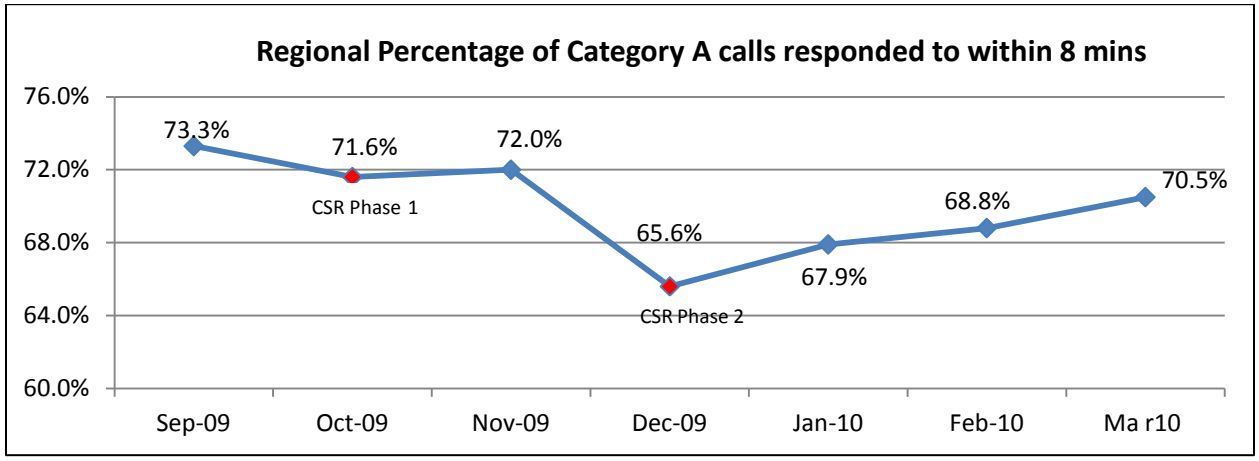
## How we monitored the Impact on Service Delivery

3.10 In order to monitor information around Service delivery, the Trust reviewed available data and commissioned further data collection in respect of provision of a conveying response (i.e. how quickly we provide an ambulance vehicle which could transport patients to hospital). This was in response to concerns raised during the EQIA that there may be an adverse impact in this respect. In addition, information was collected in respect of the RRV paramedic contribution to the Trusts performance in responding to Category A, life threatening calls.

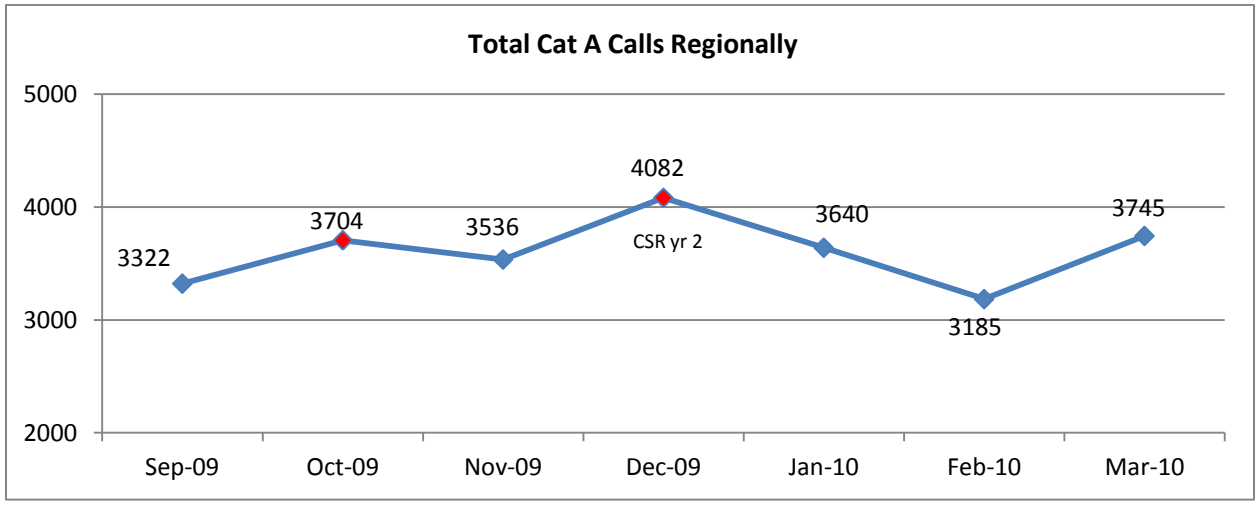
### Category A Performance

3.11 Consideration of ambulance performance must take account of the ever changing environment in which we operate. The changes were implemented from October 2009 and the baseline date provided for comparison is September 2009. Factors such as increased activity, winter pressures, requests for diverts, adverse weather conditions, and bed pressures across HSC also impacted on performance. Accordingly variances in performance for NIAS during this period cannot be wholly attributed to the CSR

changes. It is not possible to differentiate between these factors, which impact on performance.




3.12 Category A performance was measured against Ministerial PfA Target 2009/10 which stated: "From April 2009, 70% of Cat A ambulance calls should be responded to within 8 minutes (with a performance in individual LCG areas at least 62.5%) increasing to an average of 72.5% by March 2010 (and not less than 65% in any LCG area)".




CSR Phase 1

## Key Trends in Category A Response Performance

3.13 In summary, the graphs indicate that Regional Cat A performance in September 2009 was 73.3%.

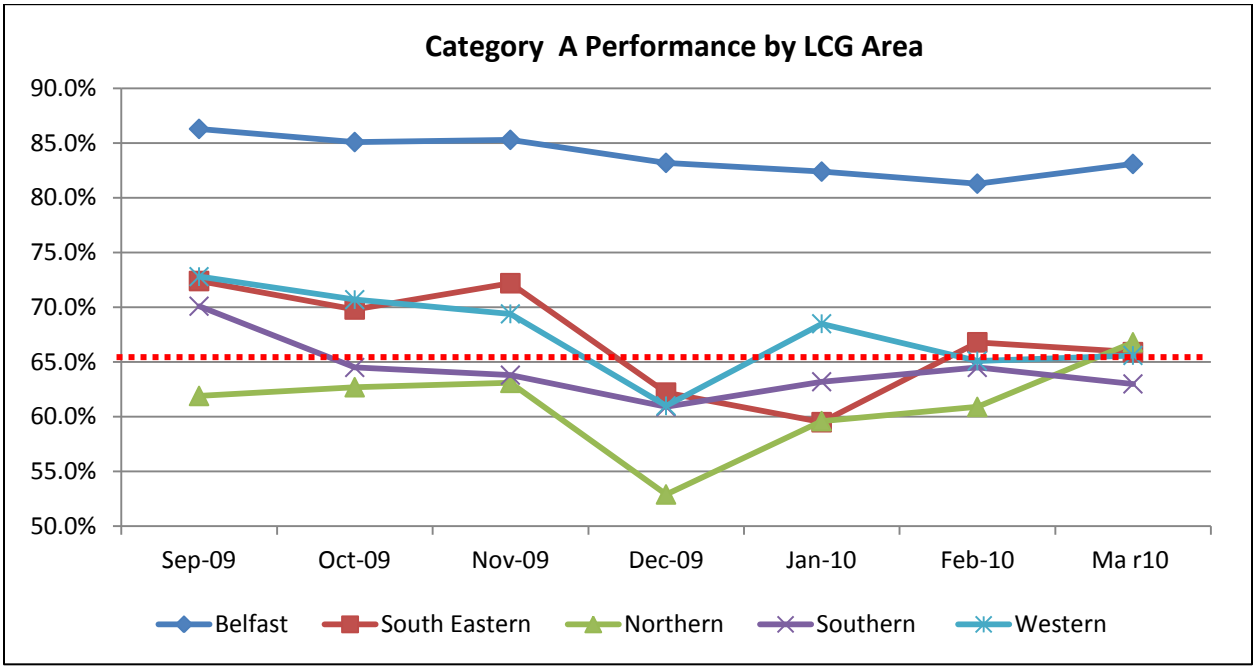
Whilst performance reduced slightly in October 2009, after the implementation of CSR phase 1 changes, performance still achieved the PfA target both regionally and across all the LCG areas.

3.14 In December 2009, after the implementation of CSR Phase 2 changes, performance dropped to 65.6% regionally. The drop in performance was mirrored across the individual LCG areas. December, January and February were particularly challenging across the region but especially in the Northern and Southern Division. The key challenges in this respect were increased call volumes and adverse weather conditions. The Trust's Operations Team developed a Performance Improvement Plan to address these issues.

In January and February 2010, Cat A performance improved steadily, as the Performance Improvement Plan was implemented, achieving 70.5% regionally by March 2010.

3.15 It is important to note that cumulative performance for Cat A calls responded to within 8 minutes increased by 4% regionally when compared to March 2009. The most

notable improvement was in Northern Division (with an increase of 5.7% from the previous year) and Southern Division (with an increase of 6.6% from the previous year).

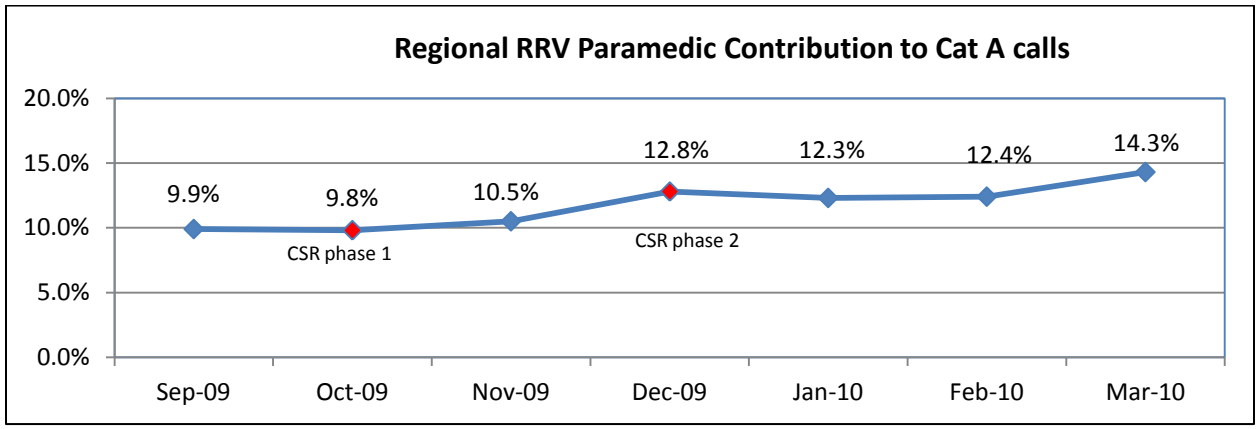



## Contribution of RRV Paramedic Response

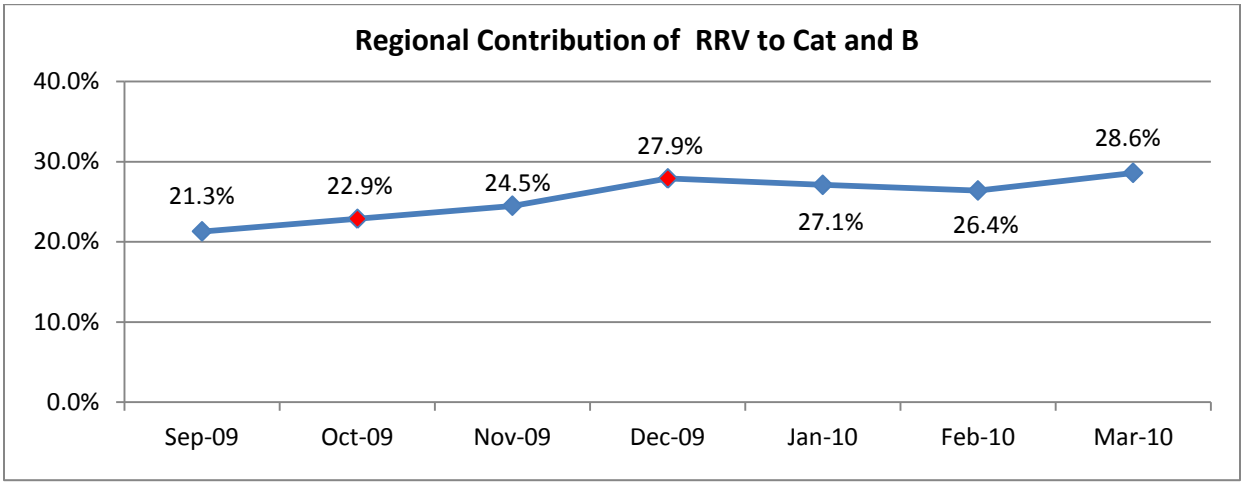
3.17 As indicated in our consultation document CSR investment was used to provide additional paramedic response hours.

3.18 CSR funds enabled investment in additional RRV paramedic response, building on a small existing core or RRV paramedics which was previously provided through DHSSPS Emergency Programme Fund investment. It is not possible to break down the contribution of the CSR element only to Category A performance. However monitoring the total RRV paramedic response hours available in Phases 1 and 2 demonstrate the following trends:

- The table below shows the contribution of RRV paramedics who were first at scene within 8 minutes for all Category A calls. RRV paramedics currently do not yet treat and refer or treat and leave. These models are being explored in conjunction with other healthcare professionals and stakeholders.




- When a Category A call is received and an RRV paramedic deployed, additional information received whilst the paramedic is en route to the call, may on occasion result in the call being recategorised as a Category B call.
- As can be seen from the table below, there was a steady increase in RRV contribution to Categories A and B performance from 21.3% in September 2009 to 27.9% in December 2009 reaching 28.6% in March 2010.



- RRV contribution to cat A and B performance was considerably stronger during the day shift (08.00 – 20.00). In some areas such as Belfast and South Eastern LCG areas the contribution was almost three times as much as during the night shift (20.00 – 08.00) contribution.

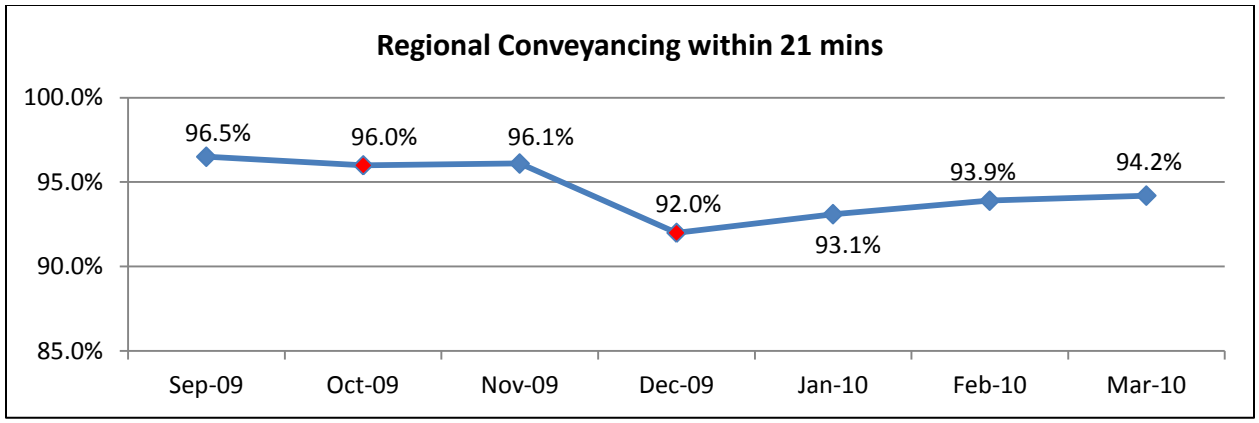
3.20 Given as indicated previously that this model was largely targeted at urban areas RRV paramedic contribution was as expected higher in urban locations rather than rural.

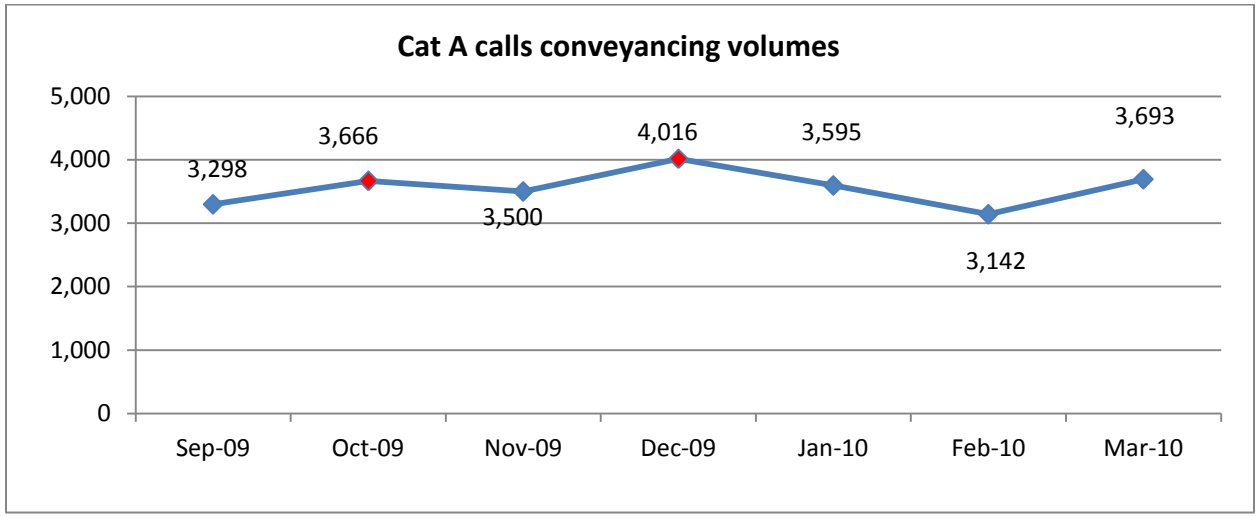
3.21 In conclusion, the CSR investment into increased RRV paramedic response hours has made a significant contribution to improving response times.

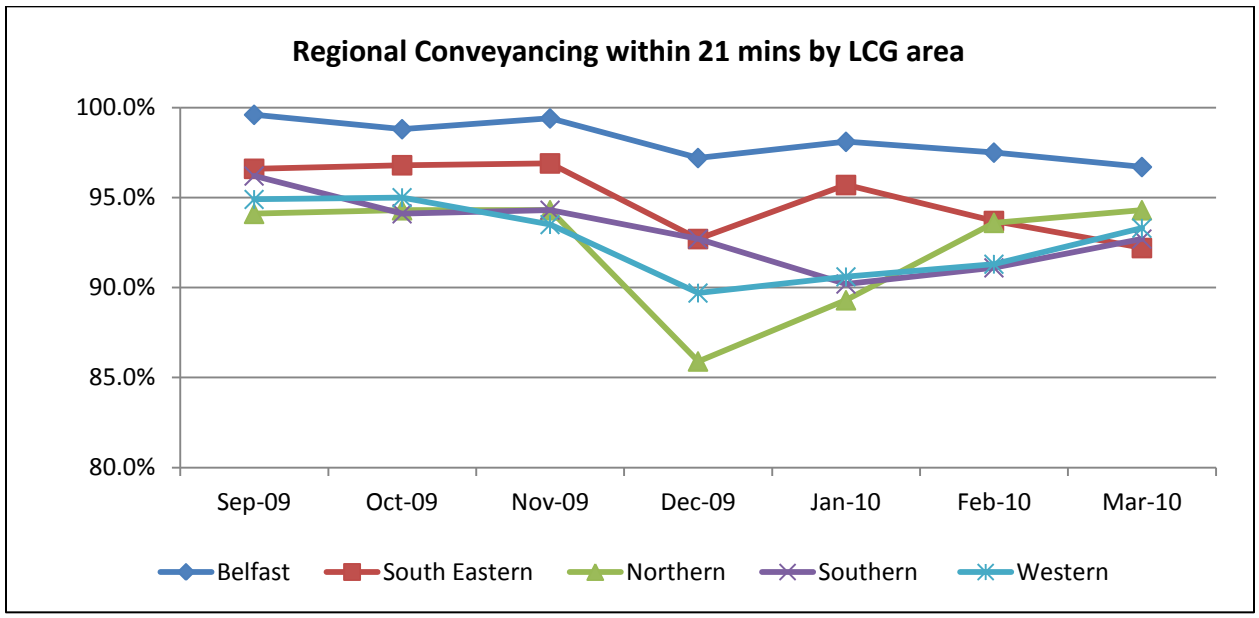
## Monitoring of Conveyancing Information

3.22 As indicated in our monitoring commitments, performance in this regard was measured against the target of 95% of Cat A calls where conveying ambulances is at scene within 21 minutes.

3.23 As can be seen in the graphs below performance in Category A conveyancing within 21 mins is directly linked to the volume of Category A calls received, e.g. performance dropped to 92% conveyancing in Dec 2009 (from 96.1% in November) whilst volumes increase by nearly 15% ( 516 call more) for the same timeframe.


Regional Conveyancing within 21 mins
100.0%
95.0%
90.0%
85.0%
96.5%
96.0%
96.1%
92.0%
93.1%
93.9%
94.2%
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10


Cat A calls conveyancing volumes
5,000
4,000
3,000
2,000
1,000
0
3,298
3,666
3,500
4,016
3,595
3,142
3,693
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10


Regional Conveyancing within 21 mins by LCG area
100.0%
95.0%
90.0%
85.0%
80.0%
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Belfast
South Eastern
Northern
Southern
Western

3.24 In keeping with the trend of a reduction in Category A performance in December 2009, the greatest impact on conveyancing response was measured in December 2009 (introduction of CSR phase 2 changes) across the region and individual LCG areas.

It is worth noting that the activity during this month was higher across all categories of calls with a substantial increase in demand (for Cat A calls in particular) of 23.4% regionally compared to September 2009.

3.25 Northern and Western divisions were particularly challenged during December 2009 with an increase in Cat A calls of 14.1% and 21.3% respectively compared to the September baseline.

Overall performance improved in January, February and March reaching a regional average of 94.2%.

3.26 Consequently it is clear that the combination of increased activity levels along with the removal of A&E response hours has put pressure on the Trust's ability to achieve the target of a patient conveying vehicle for 95% of Category A calls in 21 minutes.

3.27 In order to address this during the period outlined, the Trust has introduced the following mitigating measures:

- Increased conveyancing opportunities with the introduction of Intermediate Care Vehicles (ICVs) to support emergency cover, specifically in more rural areas when clinically appropriate.
- Belfast Division piloted the introduction of Intermediate Care Vehicles operating as support to A&E. This model has proven particularly effective in addressing some of the conveyancing needs.
- Introduced additional resources at specific times (e.g. 16.00 to 24.00) to support Doctors' urgent calls and transfer request thereby freeing A&E resources. This was and still is very effective in the Northern Division.

3.28 Information in this respect will continue to be monitored through the 3rd phase of implementation of the changes and further mitigating measures considered as appropriate.

## Rural Areas

3.29 During the EQIA consultation some concern was expressed that rural areas may be particularly impacted by the changes. As indicated previously, the Trust had built considerations into the criteria for selection of affected locations which meant that the model largely operated in urban areas (locations with more than one 24/7 A&E ambulance and locations where there would be potential support from neighbouring ambulance stations).

3.30 Looking at the picture at Local Commissioning Group (LCG) level, the pattern for more rural LCG's reflected the general picture of increased activity levels, ability to sustain Category A response performance by the end of phase 2 of the implementation of the changes, dipping in December 2009, and an impact in respect of response times of conveyancing vehicles.

3.31 The Trust is committed to engaging with all stakeholders in respect of their experiences of using our Services. NIAS is committed to continuing to explore options to address concerns in respect of access to Ambulance Services in rural areas. The Trust intends to engage with rural communities through its Personal and Public Involvement programme about their experiences of our services.

## 4 Category C Clinical Triage

4.1 As indicated previously and within our consultation document, CSR funding was also used to provide clinical triage within our Regional Emergency Medical Despatch Centre (REMDC). In this scheme clinicians triage appropriate less urgent Category C calls in order to determine whether alternative care pathways or ambulance response would be clinically appropriate to meet their needs.

4.2 The table below indicates that during phases 1 and 2, 336 patients (4.0% of all Category C calls received by NIAS) were dealt with by an Alternative Care Pathway (no ambulance response) and a further 438 (5.3%) were dealt with by a non-emergency ambulance response.

| | | | Accessing Alternative Care Pathway | | | Triaged to a 999 ambulance response | | | Triaged to a non999 ambulance response | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Month | Total Cat C calls received | Cat C Calls Triaged | Number of calls | % of calls triaged | % of all Cat C calls | Number of calls | % of calls triaged | % of all Cat C calls | Triaged to GP urgent response | % of calls triaged | % of all Cat C calls |
| Oct-09 | 1367 | 291 | 56 | 19.2 | 4.1 | 149 | 51.2 | 10.9 | 86 | 29.6 | 6.3 |
| Nov-09 | 1393 | 279 | 60 | 21.5 | 4.3 | 147 | 52.7 | 10.6 | 72 | 25.8 | 5.2 |
| Dec-09 | 1551 | 377 | 65 | 17.2 | 4.2 | 224 | 59.4 | 14.4 | 88 | 23.3 | 5.7 |
| Jan-10 | 1439 | 267 | 40 | 15.0 | 2.8 | 170 | 63.7 | 11.8 | 57 | 21.3 | 4.0 |
| Feb-10 | 1200 | 285 | 50 | 17.5 | 4.2 | 188 | 66.0 | 15.7 | 47 | 16.5 | 3.9 |
| Mar-10 | 1427 | 356 | 65 | 18.3 | 4.6 | 203 | 57.0 | 14.2 | 88 | 24.7 | 6.2 |
| | 8377 | 1855 | 336 | 18.1% AVG | 4.0% AVG | 1081 | 58.3% AVG | 12.9% AVG | 438 | 23.5% AVG | 5.2% AVG |

**Outcomes of GP Clinical Triage for the period October 2009 to March 2010**

4.3 However, when looking exclusively at the outcome of calls that actually underwent clinical triage during this period, it was noted that the 336 patients receiving care by an alternative pathway (including referral to the patient's own GP or OOH provider, referral to another primary care community service, or simple advice and reassurance) represented 18.1% of calls and the 438 who received a non-emergency ambulance response represented 23.5%. Providing a non-emergency ambulance response rather than an emergency response allows increased flexibility in ambulance deployment, improving responsiveness for any higher category ambulance calls in the area.

4.4 The evaluation of this pilot concluded that the development of this system had the potential to continue to ensure appropriate clinical care for Category C patients and provide further support to the A&E tier in responding to Category A calls.

Further detail on the information collected in respect of the management of Category C calls during the period is provided at Appendix C.

4.5 During the public consultation on the CSR proposals indications were received from the Carers representatives that the use of alternative care pathways was felt to be of particular value, especially when this allowed for a patient's condition to be safely managed at home rather being unnecessarily referred on to secondary care. Aside from improving operational responsive, signposting patients to a safe, more appropriate care pathway ultimately offers a higher quality service and overall improved patient experience.

## 5 Finance

5.1 As indicated previously in the financial year 2008/09 the saving required was £1.236 million, rising to £2.719 million in 2009/10, and increasing again to £4.449 million by 2010/11 from a baseline budget of £49.436 million.

5.2 NIAS did not implement the full range of proposals to release efficiency savings during 2008-09 because consultation and decision-making were ongoing. The Trust was able to comply with its duty to achieve financial balance as a consequence of administration savings, over achieving on our absence management target and through receiving some non-recurrent income.

5.3 This position continued for a large part of 2009/10 until the year 1 and year 2 savings requirements were fully implemented in October and December 2009. Again, the Trust was able to maintain financial balance during this period largely as a consequence of administration savings, the implementation of a contingency plan and through receiving some non-recurrent income.

5.4 NIAS is committed to seeking ways to improve and modernise the delivery of its Service. During the same period, NIAS secured additional investment funds of £2.5m in 2008/09 rising to £4m in 2009/10 to support modernisation and reform. There was also additional investment in specific areas to support changes in acute service provision, for example in Sperrin Lakeland and Mid Ulster.

5.5 These amounts exceed the amounts required as part of the cash releasing requirements over the CSR period 2008-2011and have been invested to support Service delivery, improvement and modernisation. Finally, the Trust invested £6.53m in 2008/09 and £2.97m in 2009/10 to support capital investment in fleet, estate, medical Equipment and IT.

# 6 Updated Assessment of Impact

6.1 In the Final EQIA and Consultation Report, NIAS concluded that the key groups of people affected by the changes outlined were;

- The local populations in the areas affected by the changes.
- A&E staff

The following table outlines the initial EQIA assessment of impact and an updated assessment based on monitoring undertaken.

Updated Assessment of Impact Based on Monitoring

| **Section 75**<br><br>**Category** | **Initial EQIA Impact**<br><br>**identified** | **Updated Assessment of Impact** | **Mitigating Measures** |
|---|---|---|---|
| Religious Belief | **Differential Impact**<br><br>Prior to implementation all A&E staff were identified as potentially being impacted. Of these 59% are from the Protestant Community, 39% Roman Catholic.<br><br>42% of the populations in the areas identified as affected over the three year period (i.e. those impacted by hours in and hours out) are Roman Catholic and 45% Protestant with 13% other or none. | **Differential Impact**<br><br>This impact remains as identified in the original EQIA. Of the actual staff affected by the implementation of the changes, 52% were from the Protestant Community, 47% from the Roman Catholic and 1% other.<br><br>The populations affected were as identified in the original document.<br><br>The net result of the changes was increased paramedic response hours.<br><br>Since the EQIA was undertaken activity levels for the Trust have continued to rise however Category A performance has improved. Whilst there has been some impact on the response times of a patient conveying resources in December 2009, this reflected a general dip in performance due to other factors. Ultimately the Trust was able to recover standards in this respect, ending the year with a conveyancing response of 94.2% against a target of | **Mitigation around impact on staff.**<br><br>Section 3 provides detail on the way in which the Trust implemented changes and of the measures applied to mitigate against an adverse impact on staff. These include involving Trade Union representatives in the development of revised shift patterns and a set of principles around how affected staff would be redeployed in addition to opportunities for affected staff to retrain. |

| | | | |
|---|---|---|---|
| | | 95%. | **<u>Mitigating Measures applied in respect of impact of changes on service users.</u>**<br><br>Whilst there was an initial dip in Category A ambulance response times when CSR changes were first implemented this subsequently recovered. Although there was a further dip in December 2009 that impacts on performance cannot be solely attributed to this policy. As set out previously within the document increased activity levels and adverse weather conditions were also significant factors in this regard. This document has outlined mitigating measure applied to address any impacts identified. The Trust priority has continued to be paramedic response to Category A patients. The Trust contends that during Phases 1 and 2, the net result of the changes was increased paramedic response hours and consequently impact on service delivery has not been adverse. |
| Political Opinion | **Potentially differential impact** when considering community background of staff profile. | **Differential Impact** as set out previously when linking community background to political opinion. | |

| | | |
|---|---|---|
| Racial Group | **None Identified** | **None identified** |
| Age | **Differential Impact**<br><br>57% of patients who access the A&E ambulance service are over 50 and are therefore more likely to be affected by these proposals.<br><br>Of the staff actually affected, 41% were between 45 and 59 and 57%between 30 and 44. | **Differential Impact**<br><br>A&E Patients are those service users most affected by the changes. NIAS does not consider the impact of this specific policy to have been adverse given Category A performance has ultimately improved and conveyancing response times have recovered during Phases 1 and 2. |
| Marital Status | **None identified** | **Differential Impact**<br><br>64% of staff actually affected were married. |
| Gender | **Differential Impact**<br><br>78% of A&E staff potentially impacted were identified as male | **Differential Impact**<br><br>Of the staff affected by the changes 78% were also male. |
| Disability | **Differential Impact**<br><br>Following consultation we changed this assessment from no impact to differential impact, to | **Differential Impact**<br><br>Assessment remains as described. |

| | | |
|---|---|---|
| | reflect the correlation between age and disability. | |
| Dependants | **Potential adverse impact** in respect of A&E Staff identified Changes to shift patterns which may result in staff being required to move to work from a different station may have an adverse impact on those with caring responsibilities. | **Adverse Impact**<br><br>The Trust recognised that changing shift patterns and moving staff could adversely impact on those with caring responsibilities. Mitigating measures applied in this respect are set out in Section 3. |
| Sexual orientation | None identified | None Identified |

# 7 Conclusion

7.1 In conclusion, as set out at the beginning of this document, the Trust committed to developing systems to monitor achievement of the following key objectives:

- To improve response times for Category A calls in line with ministerial targets.
- To maintain the capacity to transport clinically urgent patients effectively to hospital
- To manage demand to reduce the proportion of 999 category C calls taken to hospital
- To achieve financial balance
- To avoid compulsory redundancies and monitor the impact of the changes on staff

7.2 Detail has been provided of the systems established to monitor this and the progress made in this regard. The changing environment e.g. Acute Service changes and challenges to performance such as increased activity levels have also been described. Where impacts have been identified mitigating measures undertaken have been outlined.

7.3 Consultation, decision making and planning for implementation impacted on the actual implementation date of the changes and consequently the timeframe for phases 1 and 2 is relatively short, condensed into the six month period covered by this report.

7.4 The Trust recognises there have been impacts of the changes on staff and in terms of in particular conveyancing response times. However the Trust has worked to mitigate these impacts as set out within the document and will continue to monitor these during Phase 3 and will seek to mitigate these as appropriate. A further report will be produced following analysis of Phase 3 monitoring information.

7.5 This has all been undertaken in a very challenging period for the Trust generally as matters such as significant increases in demand for our Service, Acute Service changes within HSC and adverse weather conditions all impacted on our performance.

Ultimately the Trust was able to implement the changes without compulsory redundancies and to comply with its duty to achieve financial balance.

7.6 NIAS continues to work to prioritise improved patient care and this is reflected in advances such as the introduction of clinical performance indicators around the management of Diabetes, Epilepsy and the provision of Thrombolysis treatment all designed to improve patient outcomes. Robust governance arrangements are in place with regular reporting to Trust Board. The Trust also has received a positive response to a clinical and social care governance inspection undertaken by the Regional Quality and Improvement Authority. The Trust is committed to continuing to improve service delivery in line with its Corporate Plan 2011-14.

# Appendix A

**Table 1: Improvement in response times for Category A Calls from 2007 to 2010**

| | 2007-08 | | | 2008-09 | | | 2009-10 | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Average Calls Per day | Variance from previous year | | Average Calls Per day | Variance from previous year | | Average Calls Per day | Variance from previous year |
| **Total Cat A Calls** | 39575 | 108 | 4526 (12.9%) | 38760 | 106 | -815 (-2%) | 42499 | 116 | 3739 (9.6%) |
| **Response in 8 mins** | 24476 | 67 | 5083 (26.2%) | 26146 | 72 | 1670 (6.8%) | 30383 | 83 | 4237 (16.2%) |

**Table 2: Trends in Category A response from 2007/08**

| | 2007/08 | | | 2008/09 | | | 2009/10 | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Calls** | **%** | **Trend** | **Calls** | **%** | **Trend** | **Calls** | **%** | **Trend** |
| **Regional** | 24476 | 61.8% | ↑ | 26145 | 67.5% | ↑ | 30573 | 71.5% | ↑ |
| **LCG** | | | | | | | | | |
| Belfast | 12928 | 72.7% | ↑ | 13662 | 77% | ↑ | 10185 | 85.6% | ↑ |
| South Eastern | | | | | | | 5069 | 68.7% | |
| North | 4737 | 49.4% | ↑ | 5092 | 56.8% | ↑ | 6285 | 62.7% | ↑ |
| South | 3304 | 52.4% | ↑ | 3538 | 59.1% | ↑ | 4393 | 65.3% | ↑ |
| West | 3508 | 59.5% | ↑ | 3853 | 63.6% | ↑ | 4641 | 68.7% | ↑ |

*% = percentage of Cat A calls responded to within 8 minutes compared to total number of Cat a calls responded to*
*Trend =comparison of response with same period for the previous year*