Northern Ireland Ambulance Service
Health and Social Care Trust

CSR Phases 1-3

Monitoring Report

September 2012

1 Background

1.1 During 2008-11 Health Trusts in Northern Ireland were required to deliver an average 3% per annum cash releasing efficiency savings over the period. For the Northern Ireland Ambulance Service Health and Social Care Trust, the quantum of savings required were £1.236 million for the financial year 2008/09, 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 addition to the requirement to release savings Comprehensive Spending Review (CSR) investment was also available to deliver service improvements. NIAS was able to secure more CSR investment than efficiency savings required however investment was conditional on the delivery of the savings.

1.2 In November 2008 NIAS launched a period of formal consultation including an Equality Impact Assessment (EQIA) in respect of its proposals for the release of efficiency savings and plans for the use of CSR investment. Following this consultation and a further period of decision making the Trust published the results of this consultation, EQIA and decision making in July 2009. As indicated work around the consultation and decision making for proposals began within 2008-09 which meant release of savings did not begin until the end of this process. Implementation of the changes operated in three planned phases with Phase 1 beginning in October 2009, Phase 2 in December 2009 and the final phase operating from 01 April 2010.

1.3 NIAS gave a commitment to monitor the implementation of the proposals and to publish a report of the results of this monitoring. In fulfilment of this commitment the Trust published a Monitoring Report in respect of the first two phases in August 2011. This further monitoring report provides the results of the monitoring of the three phases, providing updated information to cover the full CSR period from 2008-11.

1.4. This report provides updated information which relates to the full three phases in respect of the following elements:

i. What we said we would do including:
   - Did we achieve our policy aims?

ii. 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

iii. Updated assessment of impact

iv. 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 fleet where possible and appropriate, such as	• In-house servicing arrangements for ambulance vehicles and delivered

servicing of cars and non-emergency ambulances and ancillary components. • Establishing a system review to reduce spend in Training and Administration with an emphasis on use of new and existing technology to reduce expenditure.	necessary savings in this area. • 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.	• Over the three year period the Trust reduced the hours of cover provided by traditional A&E ambulances by 70,027 hours commensurate with shift patterns identified (see Page 9 for further detail).

• Use Comprehensive Spending Review (CSR) investment to increase hours of Rapid Response Vehicle (RRV) Paramedic cover by 131,400 hours. • 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.	• Over the three years the Trust increased the hours of Rapid Response Vehicles (RRV) Paramedic cover by 120,290 hours (see Page 9 for further detail). • Clinical Triage has been introduced to the NIAS Emergency Ambulance 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.

2.4 Having undertaken monitoring in respect of the implementation of the proposals NIAS can confirm that proposals were implemented in a way which complied with the established criteria.

Rural Considerations

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

2.6 In addition, NIAS further developed plans for the three phases 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. (Please refer to the table on page 9 for the breakdown by station).

2.7 RRV paramedics operate most effectively when demand is high, in areas of dense populations 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 planned hours of RRV Paramedic cover to reflect this.

2.8 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.

Updated information on the implementation of the changes

2.9 As indicated in the Final EQIA and Consultation Report, published in July 2009, the criteria to select shift for change 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.

2.10 The table overleaf outlines the detail of the A&E response hours taken out of and RRV Paramedic response hours invested in each of the areas affected.

	A&E Hours out	RRV Hours in	Nett Result in Paramedic Response Hours
Belfast	**22030**	**30660**	**8630**
Ardoyne	2659	7300	**4641**
Broadway	4276	5840	**1564**
Purdysburn	7509	11680	**4171**
Bridge End	7586	5840	**-1746**
South Eastern	**12436**	**24350**	**11914**
Ards	0	0	**0**
Bangor	3207	7300	**4093**
Downpatrick	2659	3910	**1251**
Ballynahinch	0	0	**0**
Newcastle	0	0	**0**
Derriaghy	0	1460	**1460**
Lisburn	6570	11680	**5110**
Northern	**9282**	**28730**	**19448**
Ballycastle	0	0	**0**
Coleraine	0	2920	**2920**
Ballymoney	0	0	**0**
Larne	3129	5840	**2711**
Ballymena	2086	5840	**3754**
Antrim	0	0	**0**
Carrickfergus	0	5840	**5840**
Whiteabbey	2086	5840	**3754**
Magherafelt	1981	3910	**1929**
Cookstown	0	0	**0**
Southern	**12826**	**22420**	**9594**
Craigavon	2711	11680	**8969**
Banbridge	0	0	**0**
Dungannon	3207	3340	**133**
Armagh	0	1460	**1460**
Kilkeel	0	0	**0**
Newry	3780	5840	**2060**
(Divisional Relief)	3128	0	**-3128**
Western	**13453**	**14130**	**677**
Limavady	0	0	**0**
Altnagelvin	3989	7300	**3311**
Northland Road	0	0	**0**
Strabane	0	0	**0**
Castlederg	0	0	**0**
Omagh	6388	5370	**-1018**
Enniskillen	0	1460	**1460**
(Divisional Relief)	3076	0	**-3076**
NIAS TOTAL	**70027**	**120290**	**50263**

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

2.11 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?

2.12 Having implemented the changes 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. • Deliver efficiency savings in line with Health Department requirements. • Support and sustain improvements in response times recorded in 2007/08 which was the baseline used for the purpose of comparison.	• CSR funding was used to invest in additional Rapid Response Vehicles and RRV Paramedic posts in order to achieve this. • Efficiency savings required were delivered. • This document provides detail around the increased activity levels faced by the Trust during this period and performance achieved,demonstrating how 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. Additional paramedic levels of cover have contributed significantly to this objective.
• 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 are provided for patients promptly, including emergency paramedic response, clinical treatment and ambulance transportation, where appropriate.	• Implementation of this model has prioritised emergency paramedic response to the most critically ill patients, clinically appropriate prioritisation of ambulance 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: • Weekly performance Management Meetings with local area managers to discuss performance and action plans for improvement • Development of a centralised data management system for data analysis and reporting via a shared folder • Information of performance posted on NIAS website through publication of Trust Board reports • 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 • 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 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 % of Cat C calls accessing alternative care pathways Monthly report as above 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 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 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 In order to minimise the impact of the change of shift patterns over the three phases these changes were introduced together. Consequently the impacts for staff over the three phases were reflected in the Phase 1 and 2 report. This is described below.

3.4 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.

3.5 As a mitigating measure for staff affected 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.

3.6 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.

3.7 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.

3.8 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.

3.9 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. Whilst some staff moved position within the rota, some staff moved from their base station having decided on the options presented to them. Only six members of staff required to move station have not been moved back to their base station. 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.

3.10 As indicated in 2.11, 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.

3.11 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.

3.12 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

3.13 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

3.14 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

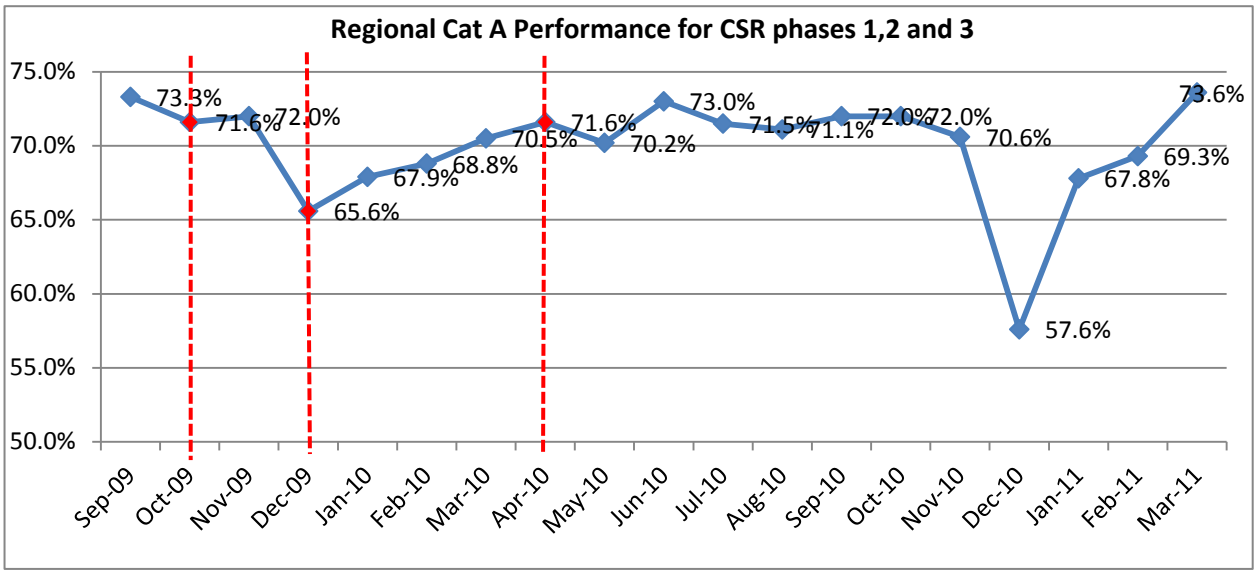
increased activity, winter pressures, requests for diverts, adverse weather conditions, and bed pressures across HSC also impacted on performance. Accordingly variances in performance for NIAS during this period cannot be wholly attributed to the CSR changes. It is not possible to differentiate between these factors, which impact on performance.

3.15 During 2009/10 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)”.

3.16 During 2010/11 Category A performance was measured against an increased target which stated that: “From April 2010, an average of 72.5% of Category A ambulance calls should be responded to within 8 minutes increasing to an average of 75% by March 2011 (and not less than 67.5% in any LCG area)”.

Key Trends in Category A Response Performance

3.17 In summary, the graphs below demonstrate that Regional Cat A performance in September 2009 was 73.3%, at the beginning of Phase 2 in December 2009 it was 65.6% and at the beginning of Phase 3 in April 2010 it was 70.5%.

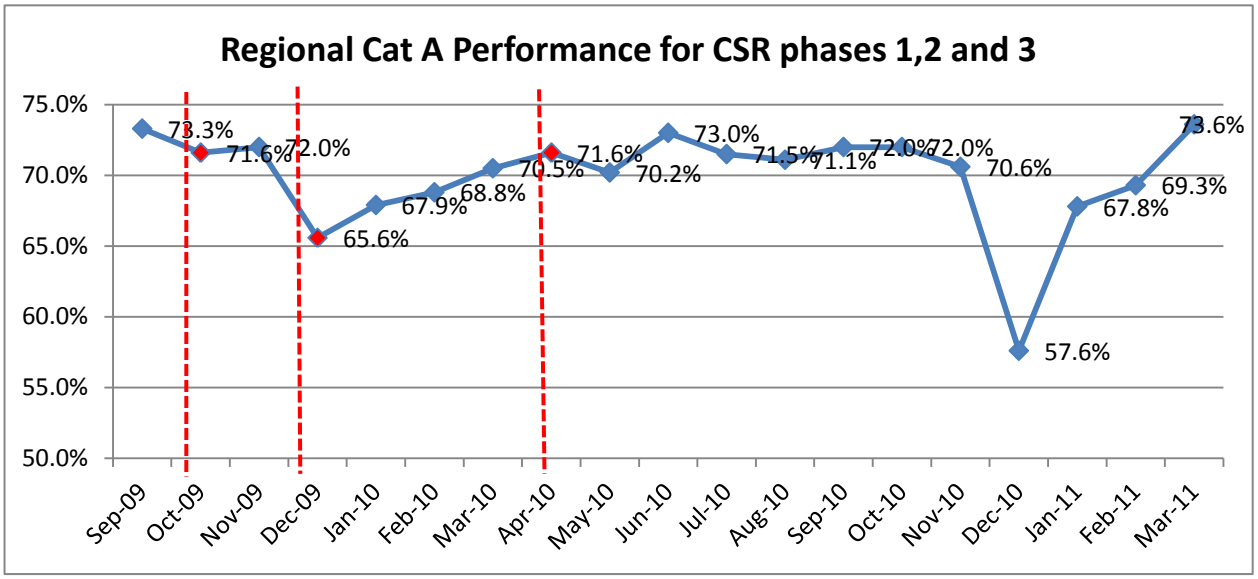


3.18 Whilst performance reduced slightly in October 2009, after the implementation of CSR phase 1 changes, performance still achieved the PfA target both regionally and across all the LCG areas.

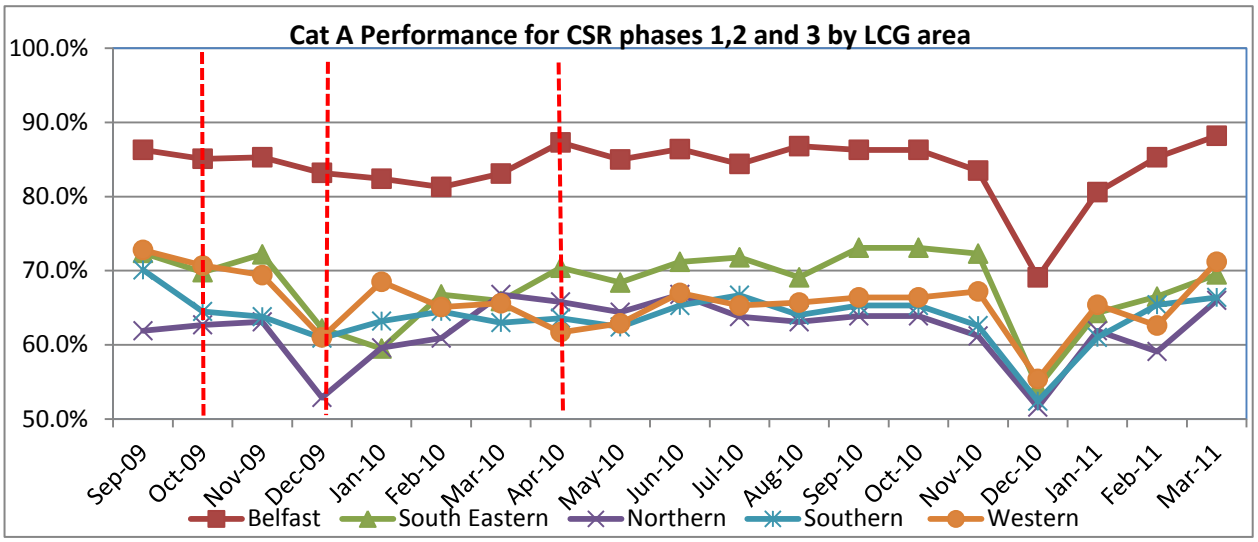
3.19 In December 2009, after the implementation of CSR Phase 2 changes, performance dropped to 65.6% regionally. The drop in performance was mirrored across the individual LCG areas. December, January and February were particularly challenging across the region but especially in the Northern and Southern Division. The key challenges in this respect were increased call volumes and adverse weather conditions. By the end of March 2010 regional Category A performance was 70.5% (therefore missing on the regional PfA target by 2%) and Category A performance at LCG level was achieved everywhere except for Southern LCG (where it missed the 65% target by 2%). Following the implementation of Phase 3 CSR changes, the Trust's

Operations Team developed a Performance Improvement Plan to facilitate the achievement of the Category A target during 2010/11.

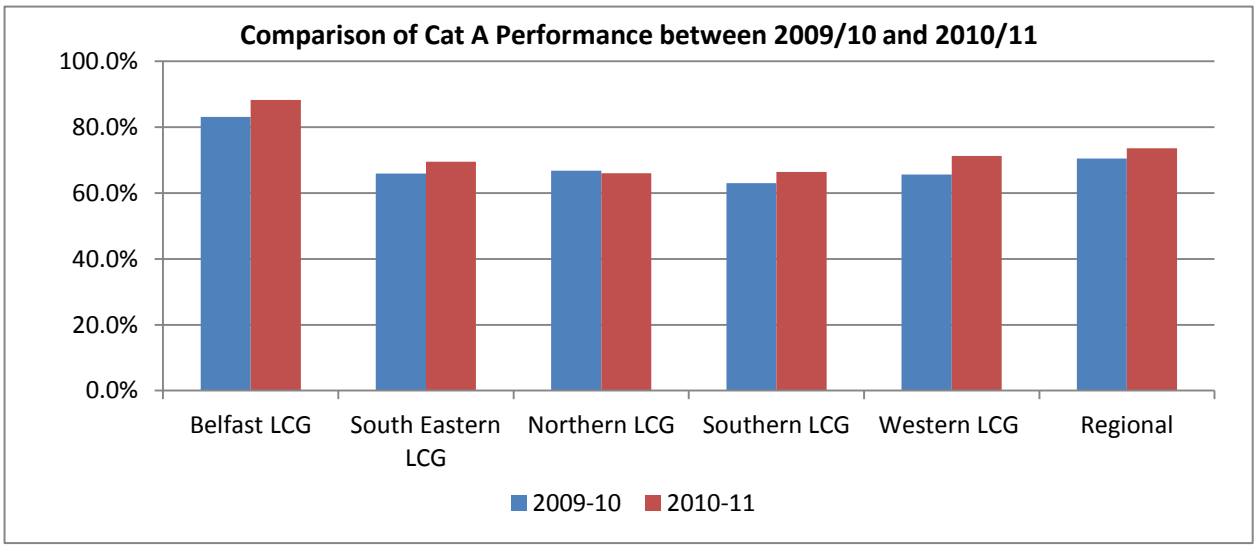
3.20 As can be seen from the graph below, NIAS achieved a regional Category A performance of 73.6% in March 2011 (thereby missing the regional target by 1.4%). However, this level of performance in Cat A was higher than before any of the CSR changes were introduced.



3.21 The local LCG target of 67.5% was achieved across the Belfast, South Eastern and Western LCGs. Northern LCG and Southern LCG missed the target by 1.5% and 1.1% respectively. However their performance was higher than the previous year for the same timeframe.



3.22 This improvement in Category A response times is particularly positive given the 10.7% increase in emergency activity across Northern Ireland and the 5.9% increase in the proportion of Category A calls as a percentage of all emergency calls received between Sep 2009 and Mar 2011). The severe weather during December 2010 also adversely affected all response times as can be clearly seen in the graphs above.



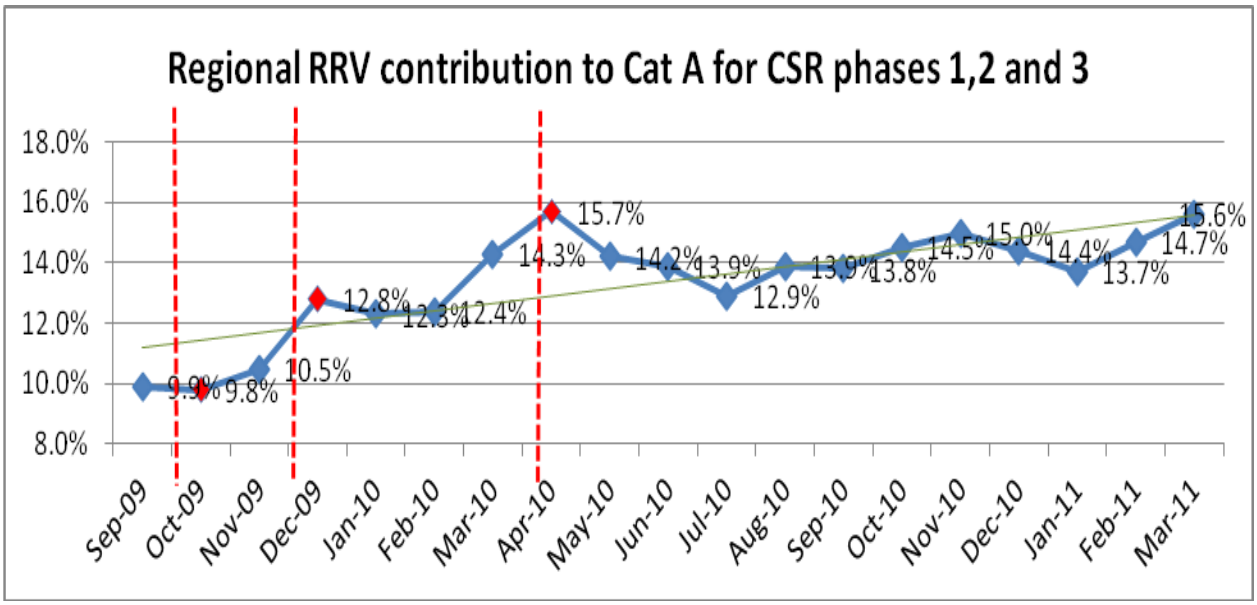
3.23 The graph above shows the improvement in performance for Category A response times between 2009-10 (following the implementation of CSR Phases 1 and 2) and 2010-11 (CSR Implementation Phase 3).

Contribution of RRV Paramedic Response

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

3.25 CSR funds enabled investment in additional RRV paramedic response, building on a small existing core of 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, 2 and 3 demonstrates 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.



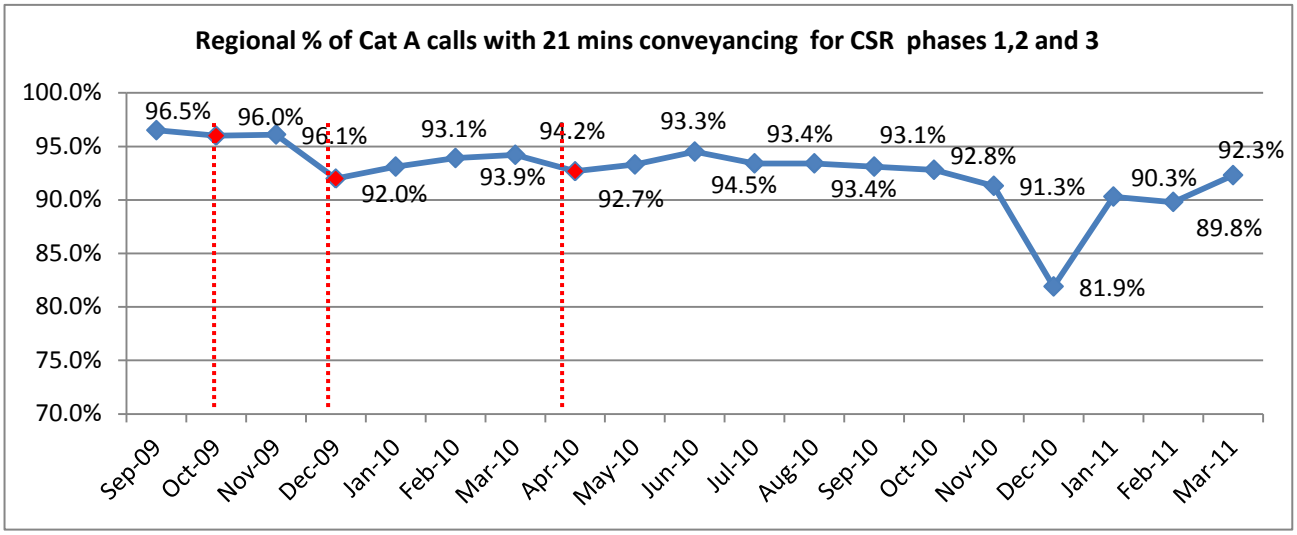
- As can be seen from the above table there was a steady increase in RRV contribution to Category A performance from 9.9% in September 2009 to 12.8% in December 2009, increasing further to 15.7% in March 2010 and maintaining 15.6% by March 2011.
- RRV contribution to Cat A performance is considerably stronger during the day shift (08.00 – 20.00). In some areas such as Belfast and South Eastern LCG areas the contribution is almost three times as much as during the night shift (20.00 – 08.00) contribution.

3.26 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.

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

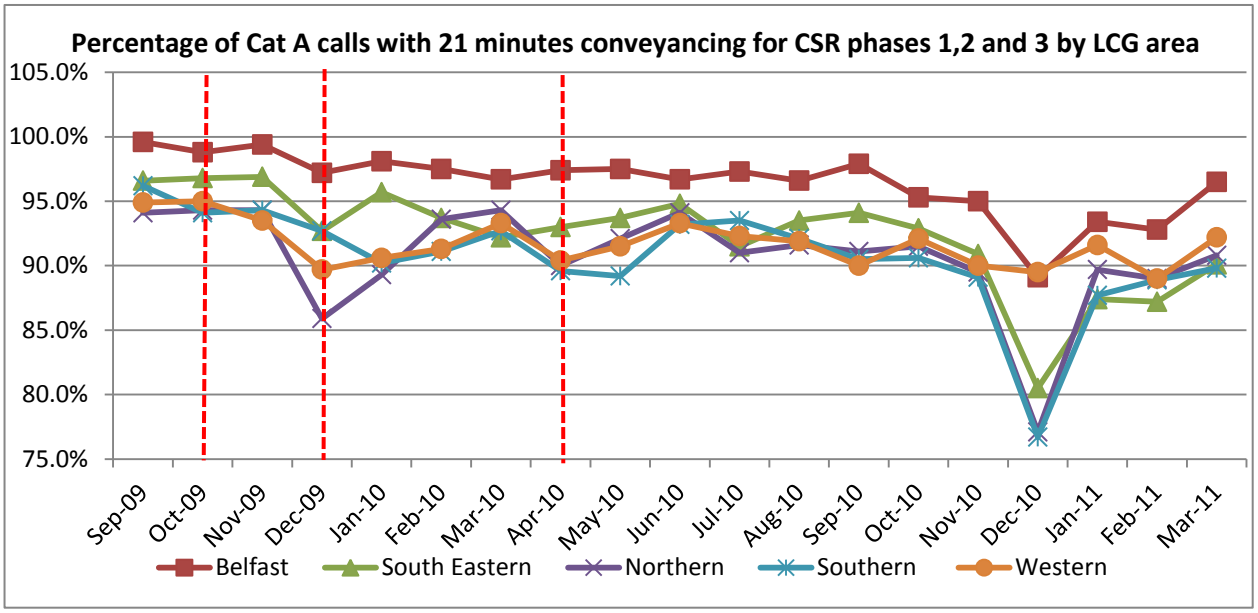
Monitoring of Conveyancing Information

3.27 When developing monitoring systems for the implementation of CSR changes, NIAS developed an internal target of 95% of Cat A calls where conveying ambulances is at scene within 21 minutes.



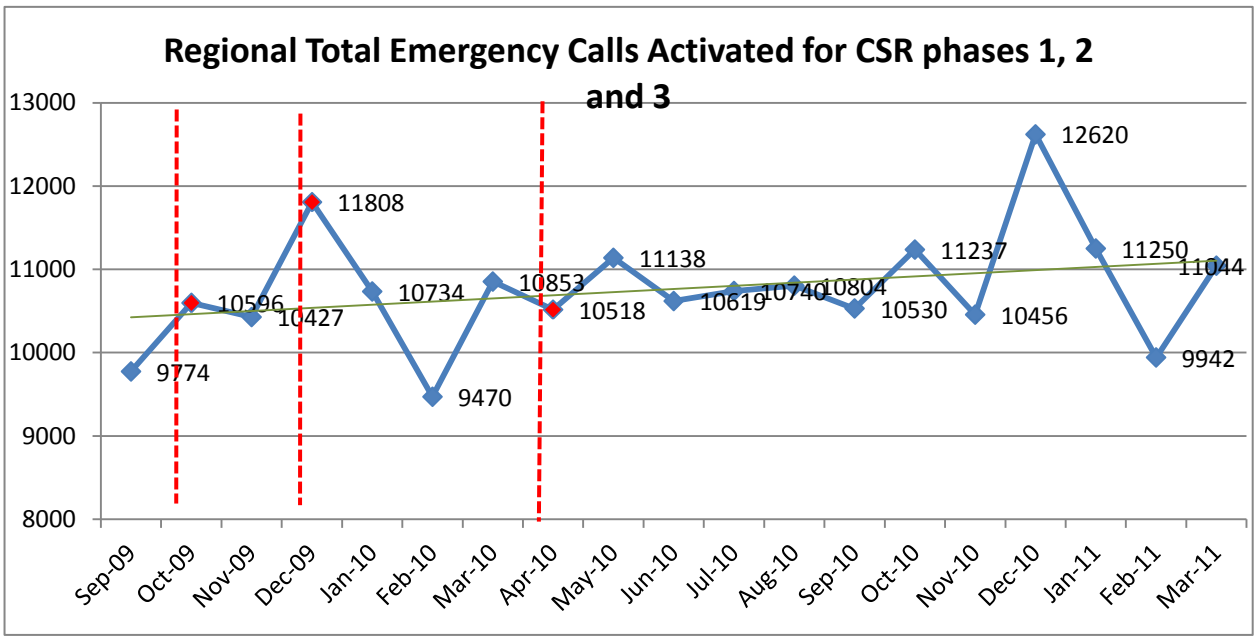
3.28 As can be seen in the graphs above, performance in Category A conveyancing within 21 mins is directly linked to the volume of Category A calls received, e.g. performance dropped to 92% conveyancing in Dec 2009 (from 96.1% in November) whilst volumes increased by nearly 15% (516 calls more) for the same timeframe and it dropped to 81.9% in Dec 2010 (from 91.3% in Nov 2010) whilst volumes increased by 27.3% (919 calls more) for the same timeframe. Adverse weather conditions also affected response times at this time of year.

3.29 The trends highlighted above are replicated across the individual LCGs as can be seen from the graph below.



3.30 In keeping with the trend of a reduction in Category A performance in December 2010, the greatest impact on conveyancing response was measured in December 2010 across the region and individual LCG areas. This was due to the severe weather conditions affecting the country at the time.

3.31 It is worth noting that regionally emergency activity during December 2010 was 29.1% higher than September 2009 with Category A calls making up 35.3% of all emergency calls responded to.



3.32 As demonstrated by the table above, the target of a patient conveying vehicle for 95% of Category A calls in 21 minutes proved very challenging for the Trust. However it is important to note that a number of factors would have contributed to this in addition to the CSR changes, most notably a dramatic increase in activity levels experienced by NIAS.

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

- Increased capacity 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 ICVs operating as support to A&E. This

model has proven particularly effective in addressing some of the conveyancing needs. This model has now been rolled out regionally and is proven very effective when used at known times of pressure and in conjunction with hospital Trusts' Emergency Departments.

- 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.

Rural Areas

3.31 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).

3.32 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 3 of the implementation of the changes, dipping in December 2009 and December 2010 and an impact in respect of response times of conveyancing vehicles.

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 outlines the numbers of Category C calls which were received by the Trust, triaged and then either referred to an alternative care pathway, triaged to a 999 response or triaged to a non 999 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
Apr-10	1247	267	36	13.5	2.9	206	77.2	16.5	39	14.6	3.1
May-10	1834	267	52	19.5	2.8	182	68.2	9.9	52	19.5	2.8
Jun-10	1635	192	34	17.7	2.1	125	65.1	7.6	42	21.9	2.6
Jul-10	1693	320	51	15.9	3.0	193	60.3	11.4	89	27.8	5.3
Aug-10	1627	270	52	19.3	3.2	151	55.9	9.3	75	27.8	4.6
Sep-10	1635	378	39	10.3	2.4	266	70.4	16.3	93	24.6	5.7
Oct-10	1649	434	65	15.0	3.9	318	73.3	19.3	75	17.3	4.5
Nov-10	1697	419	65	15.5	3.8	313	74.7	18.4	61	14.6	3.6
Dec-10	2213	539	82	15.2	3.7	390	72.4	17.6	82	15.2	3.7
Jan-11	1940	477	76	15.9	3.9	352	73.8	18.1	86	18.0	4.4

Feb-11	1589	412	51	12.4	3.2	290	70.4	18.3	101	24.5	6.4
Mar-11	1790	395	61	15.4	3.4	305	77.2	17.0	68	17.2	3.8
AVG/MTH	1607	345.8	55.6	16.4	3.5	231.8	66.0	14.3	72.3	21.3	4.5
TOTAL	28926	6225	1000			4172			1301		

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

4.3 Having piloted the clinical triage during October 2009 and March 2010, the Trust undertook an evaluation of this system.

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.

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 and £5.4m in 2010/11 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, £2.97m in 2009/10 and £4.62m in 2010/11 to support capital investment in fleet, estate, medical equipment and IT.

5.6 The Trust delivered all required CSR savings and maintained financial balance in each financial year across the CSR period 2008-2011.

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.
- NIAS 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 **Category**	**Initial EQIA Impact** **identified**	**Updated Assessment of Impact**	**Mitigating Measures**
Religious Belief	**Differential Impact** Prior to implementation all A&E staff were identified as potentially being impacted. Of these 59% are from the Protestant Community, 39% Roman Catholic. 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** 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. The populations affected were as identified in the original document. The net result of the changes was increased paramedic response hours. 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.** 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>** Whilst there was an initial dip in Category A ambulance response times when CSR changes were first implemented this subsequently recovered. Although there were further dips in December 2009 and December 2010 additional factors such as increased activity levels and adverse weather conditions also contributed to this. Whilst response times of patient conveyancing vehicles have been affected over the CSR period this has also been affected by other factors. The Trust priority has continued to be paramedic response to Category A patients and over this period we have ultimately increased paramedic response hours and responded to more Category A patients quicker.
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** 57% of patients who access the A&E ambulance service are over 50 and are therefore more likely to be affected by these proposals. Of the staff actually affected, 41% were between 45 and 59 and 57%between 30 and 44.	**Differential Impact** 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 response performance has ultimately improved.
Marital Status	**None identified**	**Differential Impact** 64% of staff actually affected were married.
Gender	**Differential Impact** 78% of A&E staff potentially impacted were identified as male	**Differential Impact** Of the staff affected by the changes 78% were male.
Disability	**Differential Impact** Following consultation we changed this assessment from no impact to differential impact, to reflect the correlation	**Differential Impact** Assessment remains as described.

	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** 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 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 particularly in respect of the use of Intermediate Care Vehicles to support the A&E tier in terms of conveyancing

7.4 In conclusion, NIAS was able to implement Efficiency Savings and changes from CSR investment without compulsory redundancies and to comply with its duty to achieve financial balance. This was achieved during an unprecedented period of challenge in Health and Social Care in Northern Ireland. Activity levels have continued to rise and NIAS has ultimately increased paramedic response provision to life-threatening Category A calls and has consequently been able to respond to more patients more quickly than before.

7.5 The target set by NIAS in respect of conveyancing was not always met however the Trust contends that the clinical requirements of patients were prioritised as we delivered increased paramedic response hours used to improve paramedic response to more patients in Category A potentially life-threatening emergency situations.

7.6 As these changes have now become mainstreamed within the Trust's service delivery, the Trust has moved to integrate the monitoring of this work through fortnightly performance management review meetings with senior operational managers.

Appendix A

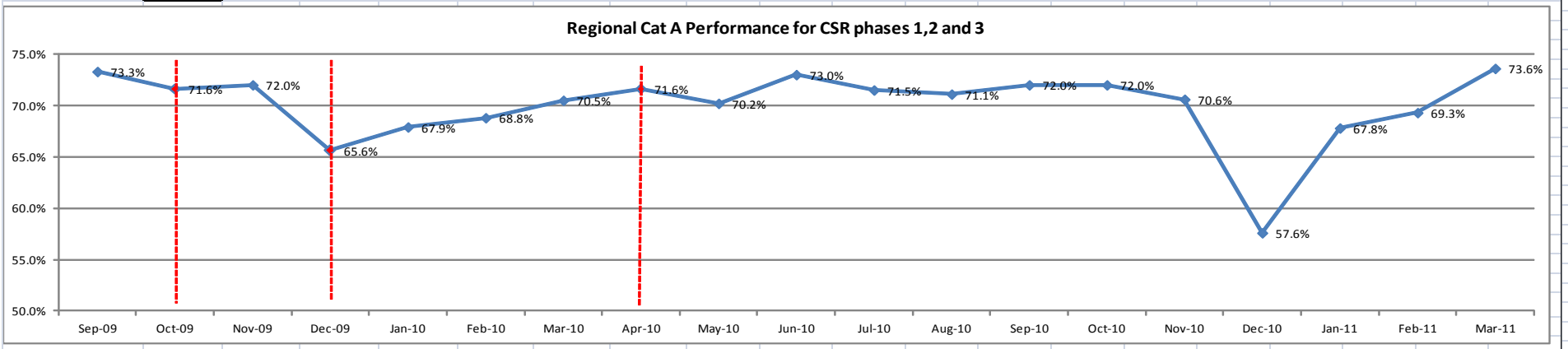
Additional Information

Table 1 - Percentage of Cat A calls responded to within 8 minutes (*)

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	**73.3%**	**71.6%**	**72.0%**	**65.6%**	**67.9%**	**68.8%**	**70.5%**	**71.6%**	**70.2%**	**73.0%**	**71.5%**	**71.1%**	**72.0%**	**72.0%**	**70.6%**	**57.6%**	**67.8%**	**69.3%**	**73.6%**
Belfast	86.3%	85.1%	85.3%	83.2%	82.4%	81.3%	83.1%	87.3%	85.0%	86.4%	84.4%	86.8%	86.3%	86.3%	83.5%	69.1%	80.6%	85.3%	88.2%
South Eastern	72.4%	69.8%	72.2%	62.2%	59.5%	66.8%	65.9%	70.4%	68.4%	71.2%	71.8%	69.1%	73.1%	73.1%	72.3%	54.3%	64.3%	66.5%	69.5%
Northern	61.9%	62.7%	63.1%	52.9%	59.6%	60.9%	66.8%	65.8%	64.4%	66.8%	63.8%	63.1%	63.9%	63.9%	61.2%	51.6%	61.9%	59.1%	66.0%
Southern	70.1%	64.5%	63.8%	60.9%	63.2%	64.5%	63.0%	63.6%	62.4%	65.3%	66.7%	64.0%	65.3%	65.3%	62.6%	52.4%	61.0%	65.4%	66.4%
Western	72.8%	70.7%	69.4%	61.0%	68.5%	65.1%	65.6%	61.7%	62.9%	67.0%	65.3%	65.7%	66.4%	66.4%	67.2%	55.4%	65.4%	62.6%	71.2%

(monthly data only - not cumulative)*

	Achieved target	
	Substantially achieved target	(within 1% variance)
	Partially achieved target	(within 2.5% variance)
	Target not achieved	(above 2.5% variance)



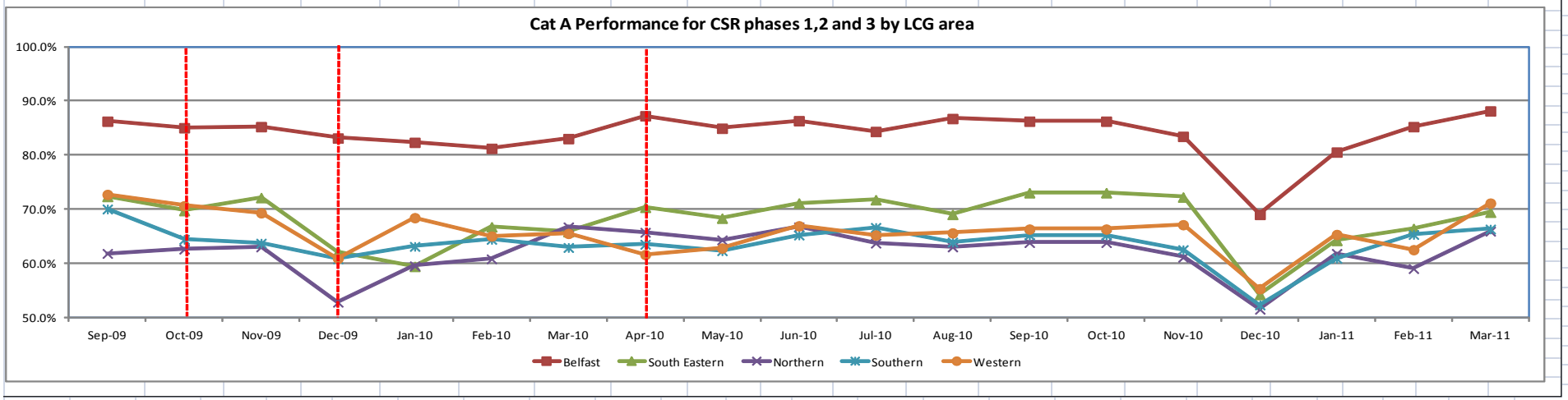
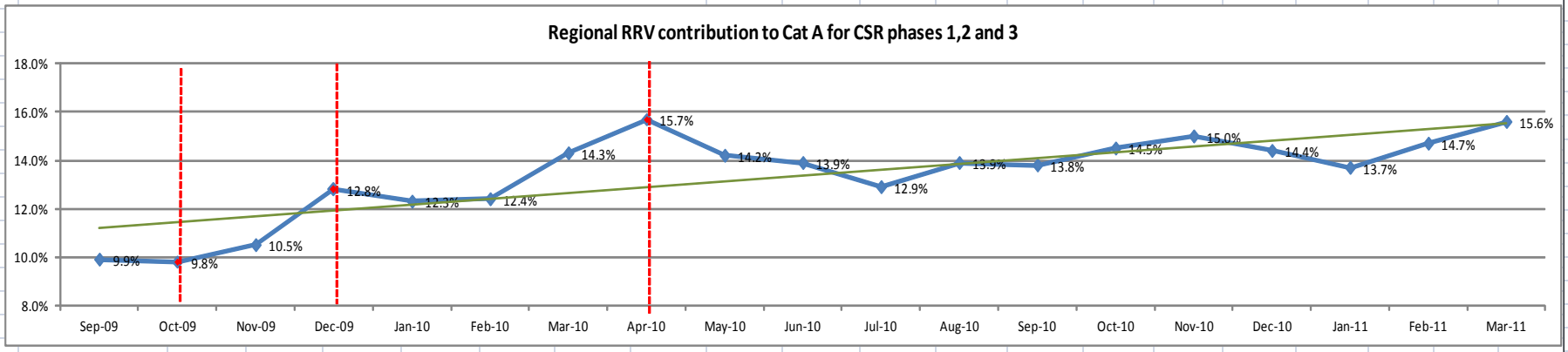


Table 2 - RRV contribution to Cat A calls (*)

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	**9.9%**	**9.8%**	**10.5%**	**12.8%**	**12.3%**	**12.4%**	**14.3%**	**15.7%**	**14.2%**	**13.9%**	**12.9%**	**13.9%**	**13.8%**	**14.5%**	**15.0%**	**14.4%**	**13.7%**	**14.7%**	**15.6%**
Belfast	11.4%	12.5%	12.4%	19.0%	16.3%	17.3%	22.0%	23.3%	22.2%	21.8%	21.8%	20.5%	19.8%	23.1%	26.1%	24.3%	24.1%	29.7%	25.3%
South Eastern	7.6%	6.5%	8.3%	9.8%	8.3%	10.6%	9.0%	15.9%	15.1%	17.2%	14.1%	15.7%	14.1%	13.8%	19.1%	18.2%	18.0%	20.4%	18.8%
Northern	11.7%	10.9%	10.1%	12.0%	13.3%	11.7%	14.0%	15.8%	15.1%	15.4%	14.8%	16.6%	16.1%	16.0%	14.3%	13.7%	14.6%	15.4%	16.8%
Southern	8.4%	8.4%	12.3%	11.0%	11.1%	11.4%	11.0%	16.7%	16.4%	12.5%	13.3%	15.1%	15.7%	17.8%	14.1%	16.1%	15.1%	16.2%	16.9%
Western	8.1%	7.8%	7.8%	7.0%	8.9%	7.9%	8.5%	14.5%	10.0%	10.2%	8.3%	7.3%	8.1%	10.3%	12.8%	9.4%	6.7%	7.0%	9.3%

(*) These figure show monthly (not cumulative) contribution when no other resources reached the scene within 8 minutes for a full day (24 hour period). RRVs operate from 8.00am to 2.00 am.



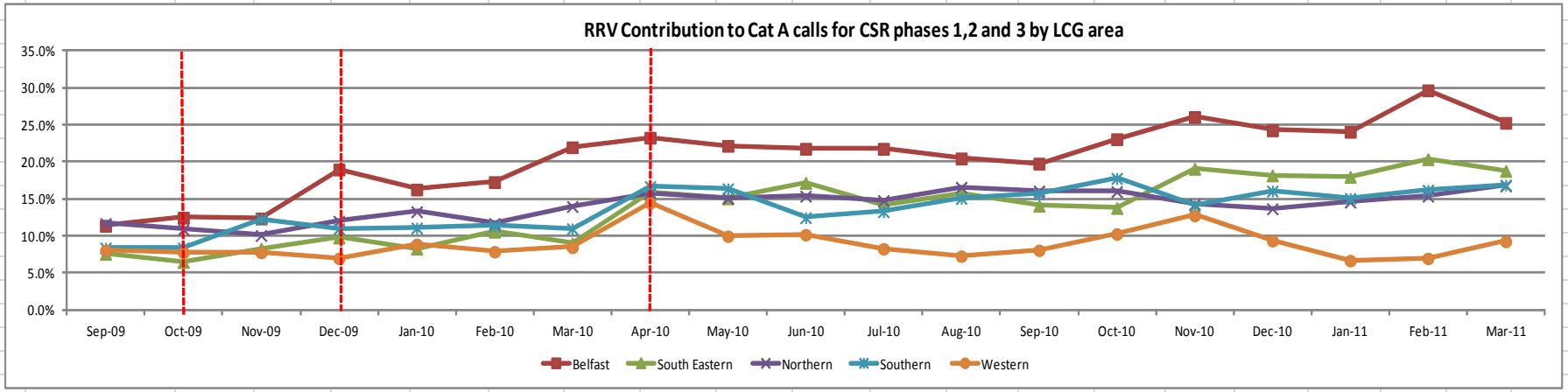
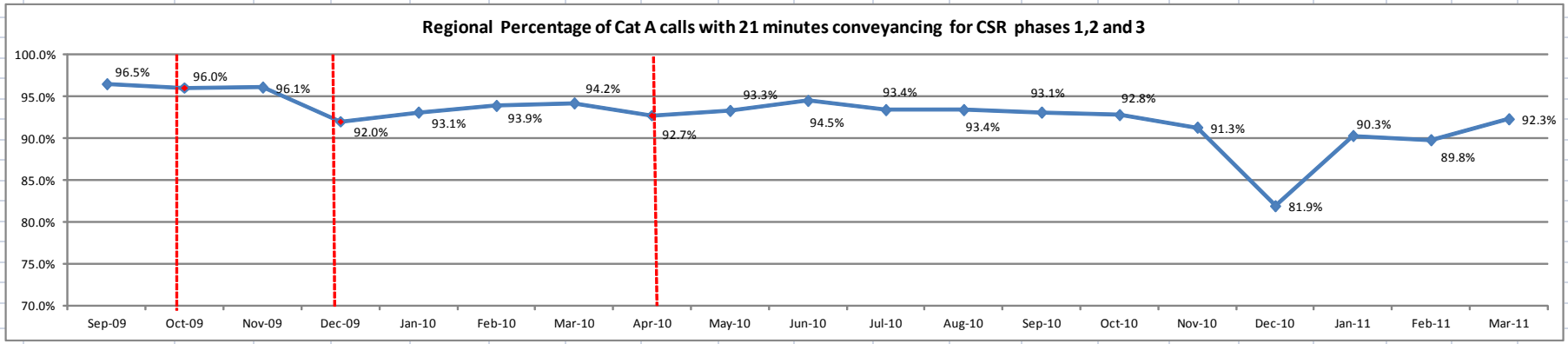


Table 3 - Percentage of Cat A calls with 21 minutes conveyancing

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	**96.5%**	**96.0%**	**96.1%**	**92.0%**	**93.1%**	**93.9%**	**94.2%**	**92.7%**	**93.3%**	**94.5%**	**93.4%**	**93.4%**	**93.1%**	**92.8%**	**91.3%**	**81.9%**	**90.3%**	**89.8%**	**92.3%**
Belfast	99.6%	98.8%	99.4%	97.2%	98.1%	97.5%	96.7%	97.4%	97.5%	96.7%	97.3%	96.6%	97.9%	95.3%	95.0%	89.1%	93.4%	92.8%	96.5%
South Eastern	96.6%	96.8%	96.9%	92.7%	95.7%	93.7%	92.2%	93.0%	93.7%	94.8%	91.5%	93.5%	94.1%	92.9%	90.9%	80.5%	87.4%	87.2%	90.1%
Northern	94.1%	94.3%	94.3%	85.9%	89.3%	93.6%	94.3%	90.0%	92.1%	94.1%	91.0%	91.6%	91.1%	91.5%	89.5%	77.1%	89.7%	89.0%	90.8%
Southern	96.2%	94.1%	94.3%	92.7%	90.2%	91.1%	92.7%	89.6%	89.2%	93.2%	93.5%	92.1%	90.5%	90.6%	89.1%	76.7%	87.7%	88.9%	89.8%
Western	94.9%	95.0%	93.5%	89.7%	90.6%	91.3%	93.3%	90.4%	91.5%	93.3%	92.3%	91.9%	90.0%	92.1%	90.0%	89.5%	91.6%	89.0%	92.2%

(monthly data only - not cumulative)*

	Achieved target
	Substantially achieved target (within 1% variance)
	Partially achieved target (within 2.5% variance)
	Target not achieved (above 2.5% variance)



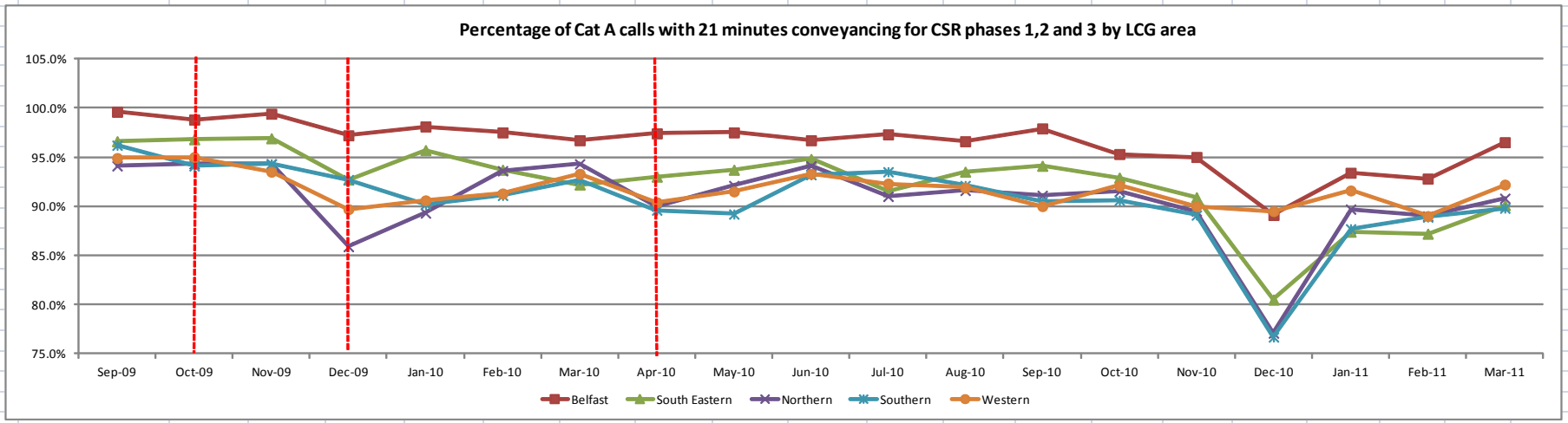
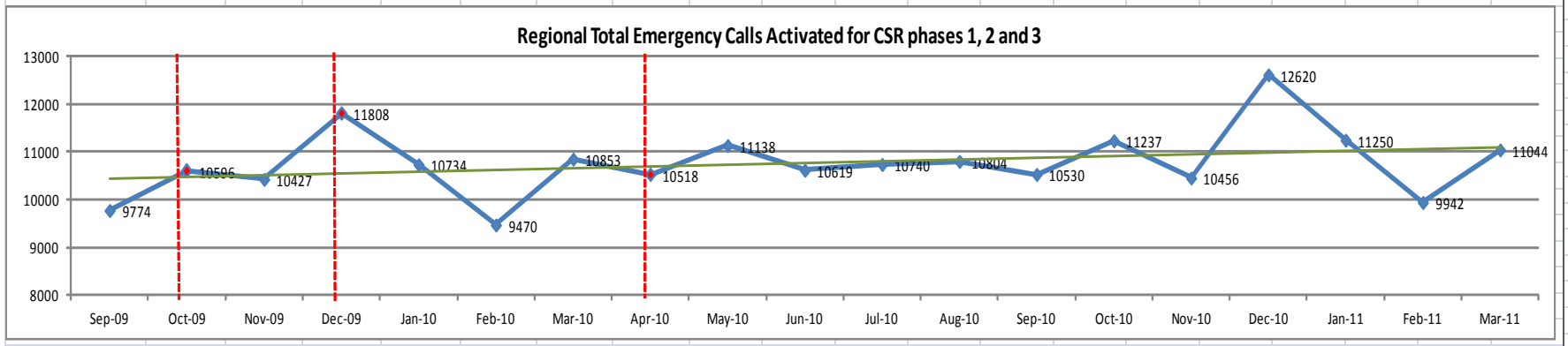


Table 4 - Total Emergency Calls Activated

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	**9774**	**10596**	**10427**	**11808**	**10734**	**9470**	**10853**	10518	11138	10619	10740	10804	10530	11237	10456	12620	11250	9942	11044
Belfast	2573	2880	2796	3199	2868	2484	2910	2809	2843	2865	2784	2811	2695	3099	2830	3309	2936	2700	2966
South Eastern	1665	1807	1846	2121	1867	1689	1921	1829	2007	1914	1861	1884	1901	1938	1823	2280	1990	1669	1981
North	2568	2680	2628	2898	2663	2347	2651	2538	2833	2558	2776	2688	2630	2666	2465	2953	2698	2411	2559
South	1597	1691	1671	1858	1745	1570	1809	1751	1773	1724	1690	1752	1776	1871	1788	2205	2005	1711	1836
West	1371	1538	1486	1732	1591	1338	1562	1591	1682	1558	1629	1669	1528	1663	1540	1873	1621	1451	1706



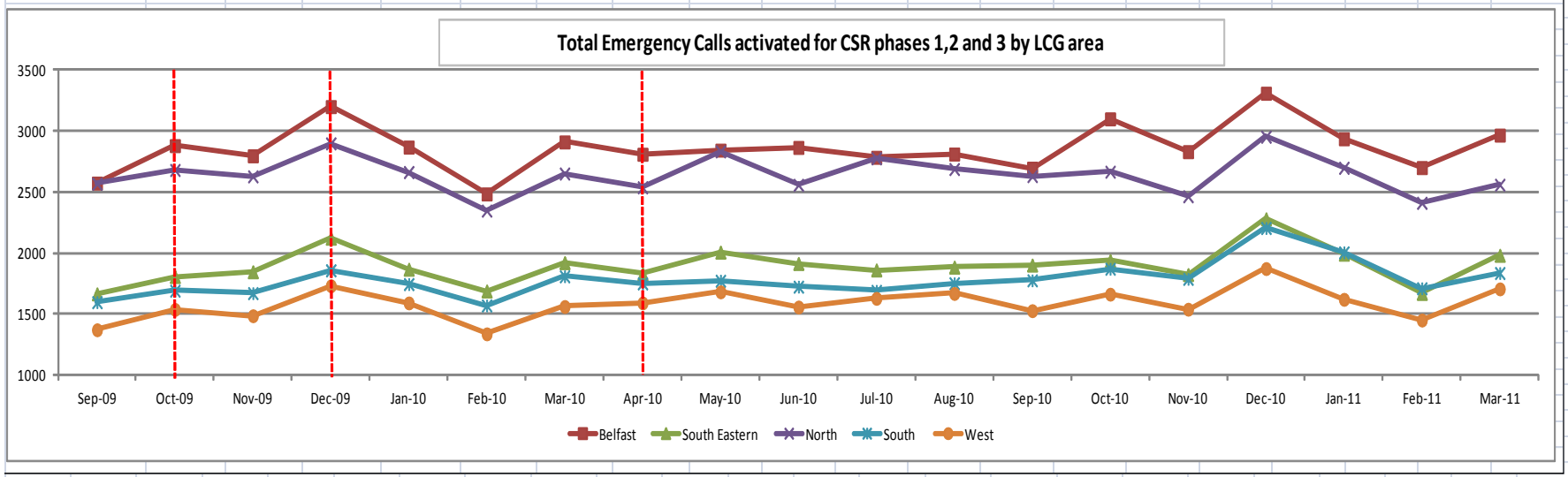
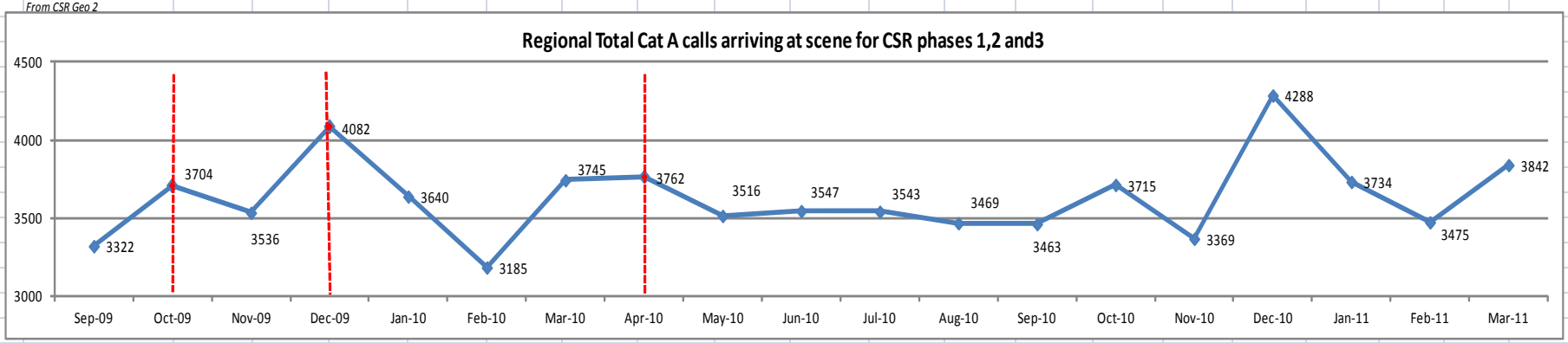


Table 5 a - Total Cat A calls arriving at Scene

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	3322	3704	3536	4082	3640	3185	3745	3762	3516	3547	3543	3469	3463	3715	3369	4288	3734	3475	3842
Belfast	902	1005	1005	1159	998	822	1058	1073	992	977	1029	959	919	1042	948	1178	1024	984	1054
South Eastern	558	630	586	725	615	545	672	642	604	602	624	570	592	673	581	760	652	565	681
Northern	817	904	838	943	848	716	865	844	784	836	742	829	814	827	761	951	808	799	873
Southern	531	561	574	647	557	518	583	627	588	550	567	558	585	569	551	758	661	560	616
Western	514	604	533	608	622	524	567	576	548	582	581	553	553	604	528	641	589	567	618

From CSR Geo 2



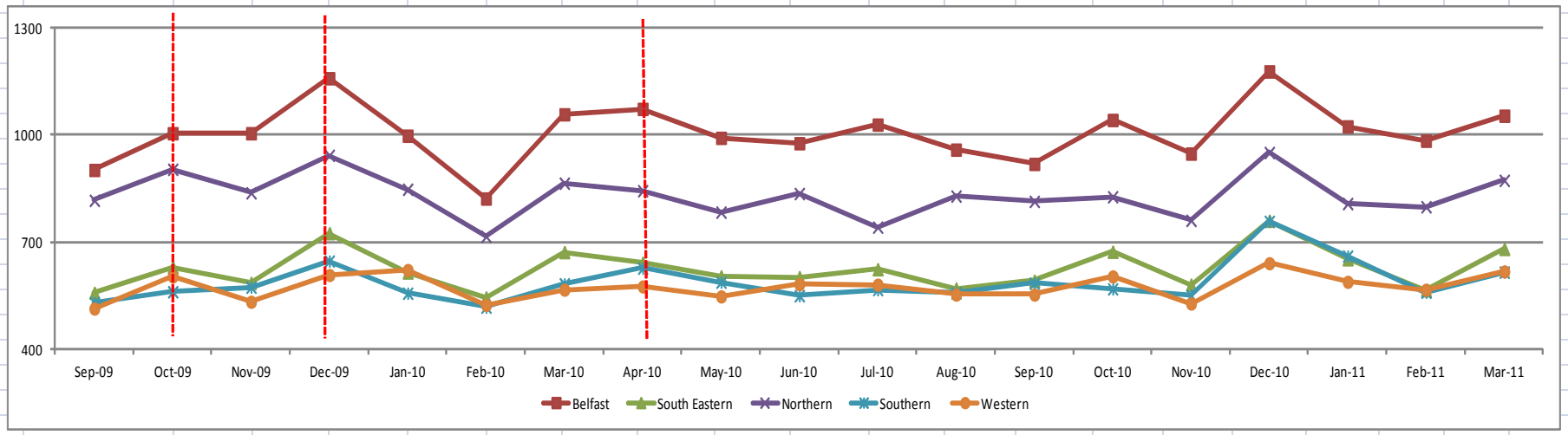
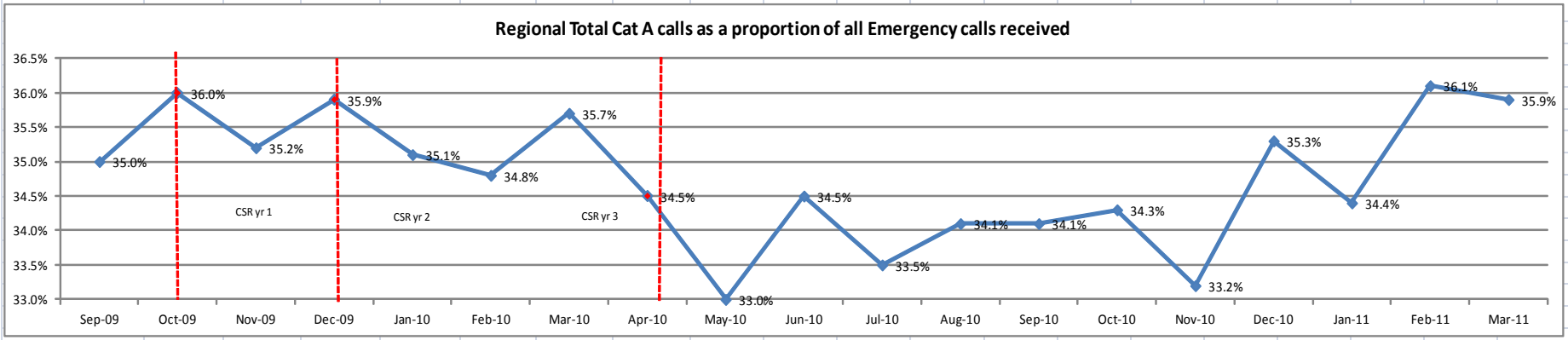


Table 5b - Total Cat A calls as a proportion of all calls received

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	**35.0%**	**36.0%**	**35.2%**	**35.9%**	**35.1%**	**34.8%**	**35.7%**	**34.5%**	**33.0%**	**34.5%**	**33.5%**	**34.1%**	**34.1%**	**34.3%**	**33.2%**	**35.3%**	**34.4%**	**36.1%**	**35.9%**
Belfast	36.0%	35.9%	37.1%	37.4%	35.9%	36.5%	37.5%	36.4%	35.4%	37.1%	35.8%	35.5%	35.5%	34.8%	34.3%	36.6%	35.9%	37.5%	36.6%
South Eastern	34.6%	35.9%	32.6%	35.3%	33.9%	33.3%	36.2%	33.9%	31.2%	33.7%	31.8%	32.2%	32.0%	36.0%	32.9%	34.6%	33.9%	34.9%	35.4%
North	32.7%	34.6%	33.3%	33.6%	33.0%	31.6%	33.8%	31.9%	30.6%	30.0%	31.0%	31.1%	32.0%	32.3%	31.9%	33.5%	31.1%	34.2%	35.1%
South	34.5%	34.4%	35.8%	36.6%	33.2%	34.3%	33.4%	34.8%	32.1%	34.2%	34.0%	34.7%	34.3%	31.7%	31.8%	35.8%	34.4%	34.0%	34.8%
West	39.0%	40.8%	37.5%	37.0%	40.5%	39.4%	37.6%	35.8%	35.7%	38.5%	35.5%	37.8%	37.4%	37.7%	35.6%	35.7%	37.8%	40.5%	37.5%



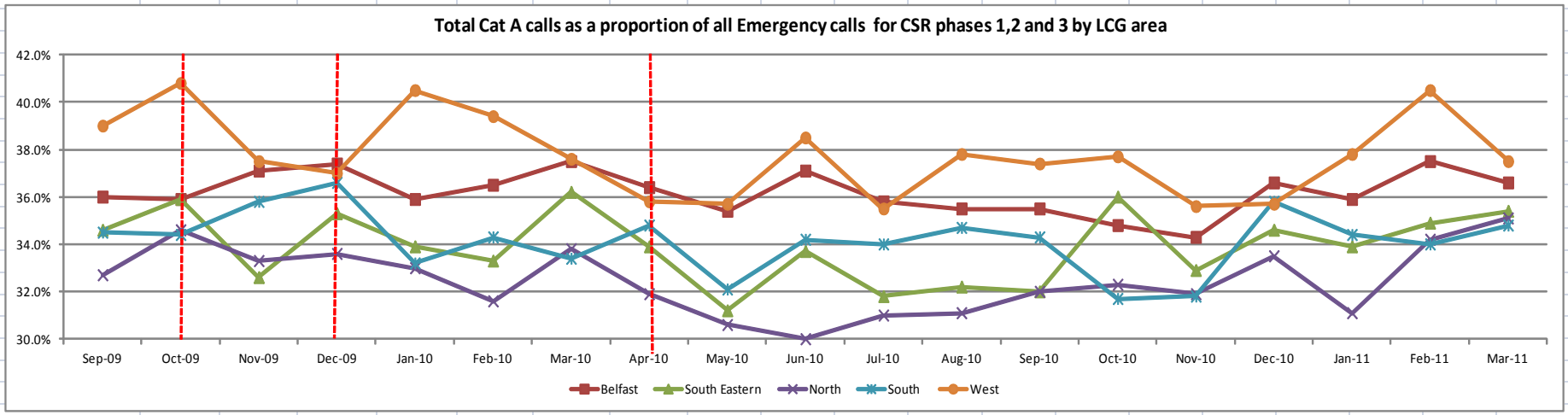


Table 6 - Conveyancing of Cat A calls within 21 minutes

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional	**3,181**	**3,521**	**3,363**	**3,693**	**3,348**	**2,951**	**3,479**	**3416**	**3440**	**3294**	**3188**	**3259**	**3178**	**3388**	**3024**	**3433**	**3320**	**3074**	**3493**
Belfast	893	980	988	1,105	960	845	1,011	989	975	981	914	914	882	973	888	1027	940	895	995
South Eastern	535	609	567	664	583	508	606	588	583	580	517	531	546	619	521	594	563	482	604
North	761	841	783	792	749	662	801	756	814	684	738	727	733	743	668	713	712	706	785
South	509	523	533	594	495	462	535	566	521	519	515	533	523	504	481	569	569	490	543
West	483	568	492	538	561	474	526	517	547	530	504	554	494	549	466	530	536	501	566