COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Efficiency Savings in the Northern Ireland Ambulance Service

08 October 2009

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mrs Dolores Kelly
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:

Mr David Galloway	) Department of Health, Social Services and Public Safety
Mr Liam McIvor	)
Mr Brian McNeill	) Northern Ireland Ambulance Service
Dr David McManus	)

The Chairperson (Mr Wells):
I hope that this session will not last as long as the previous one. I welcome Liam McIvor, Brian McNeill and David McManus from the Northern Ireland Ambulance Service (NIAS) and David Galloway from the Department of Health, Social Services and Public Safety. I invite you to make a short presentation, after which members will ask questions.

Mr David Galloway (Department of Health, Social Services and Public Safety): I will set out the key policy aim of the emergency response service that is provided by the Northern Ireland Ambulance Service, after which I will hand over to Liam McIvor to outline the NIAS's efficiency plans.

The NIAS makes a valuable contribution to the healthcare that is provided for the population of Northern Ireland, from the delivery of emergency pre-hospital medical care to support for patients with less urgent and long-term medical conditions. The commonly held perception is that the job of an ambulance service is to take seriously ill people to hospital to begin their emergency care. However, in recent years, there have been many advances in emergency care and an increasing recognition across the world about the role that highly trained and skilled paramedics can perform.

Ambulance services, including the NIAS, employ highly skilled staff who are trained in emergency medicine and have access to the latest life-saving equipment and drugs. That allows ambulance services to bring life-saving treatment to patients as rapidly as possible, regardless of their location. Under the previous model, patients could avail themselves of such interventions only after they had reached hospital and were under the supervision of a doctor. As a result, the key issue for the best ambulance services is not how quickly they can get patients to a hospital, but how quickly a skilled paramedic can reach the patient to provide emergency or life-saving care at the scene.

Research shows that survival rates decrease by 10% every minute between the time of a patient's collapse and the commencement of life support. Rapid-response paramedics have existed in Northern Ireland since 2003 and have made a significant contribution to improving care for seriously ill patients. The introduction of more rapid-response paramedics aims to speed up the rapid response of ambulance services and save more lives. Studies conducted in the University of Ulster and in England have demonstrated that rapid-response vehicles (RRVs) reach patients faster than traditional ambulances.

There are practical reasons for that. An RRV can be released from a call as soon as it hands the patient over to an ambulance crew, whereas a traditional ambulance is tied up with a single call for much longer, because it must deliver the patient to hospital before it is free to take further

calls. Several other countries have recognised the importance of the speed of the initial paramedic response and have deployed paramedics on motorcycles to help negotiate heavily built-up or congested areas more quickly.

Ambulance services in the UK and elsewhere are at various stages in their evolution from that traditional role. The Department's 2005 paper, 'Taking Healthcare to the Patient', outlined the need to move progressively towards a paramedic-led emergency care model. That is why the performance of the Northern Ireland Ambulance Service and other ambulance services across the United Kingdom is measured by their ability to reach category A calls, which are life-threatening, within eight minutes.

We are not seeking a response that will result in people being taken to hospital immediately. We want an eight-minute response that will enable a paramedic, who has the necessary skills and equipment, to provide life-saving care for the patient as soon as possible. That will lead to better outcomes for patients.

Since April 2009, our target has been to respond to 70% of category A calls within eight minutes. That target will increase to 72·5% in March 2010. The Ambulance Service is also required to achieve specific targets in rural areas. In each local commissioning group (LCG), a minimum of 65% of category A calls must be responded to within eight minutes. Overall, 73·9% of category A calls are responded to within eight minutes. In each LCG, more than 65% of category A calls are responded to within eight minutes. That represents a vast improvement in performance in the past few years, and it demonstrates the impact that the modernisation measures that have already been taken have had on the Ambulance Service.

The Minister has made substantial investment in ambulance services during the period of the comprehensive spending review (CSR). Capital investment of £17·4 million will deliver 146 new vehicles. Over the next decade, capital investment will ensure that the Ambulance Service has a modern ambulance fleet. It will also address many of the difficulties that have been experienced by ensuring the replacement of vehicles in a timely manner.

In common with the rest of the Health Service, the Ambulance Service must deliver 3% efficiency savings, which amounts to £8·3 million during the CSR period. However, some £12 million is being reinvested to improve services. Rapid response is a key element of the

Ambulance Service's programme of reform and modernisation. The introduction of the more front-loaded ambulance response is an important element of the plans to modernise the Northern Ireland Ambulance Service in the years ahead, and it is consistent with the Department's policy aims on the delivery of emergency care.

The Chairperson:

On my first day as the Chairperson, I was interviewed on Radio Ulster, along with Mr Brian McNeill. Someone rang in and demanded my resignation three minutes after I had started the job because of the issue of RRVs. I am sure that the sea change from standard ambulances to RRVs will dominate members' questions.

It strikes me as odd that, although the idea of RRVs has been around for years, you introduce them only when suddenly facing 3% efficiency savings. You say that RRVs were always a wonderful idea and that you would have brought them in anyway, but most people perceive their introduction as a response to the need to cut the budget. Is that the case? Why did you not introduce RRVs five or ten years ago, when you were not facing the pressure of budgetary cuts?

Mr Liam McIvor (Northern Ireland Ambulance Service):

Thank you for the invitation to meet the Committee again. David has said quite a lot, so I will get into the meat of the discussion rather than making another presentation.

We have had rapid-response vehicles in place since 2003. I joined the service as director of operations in 2002. One of the first things that we did was to bid, through the Executive programme funds as they were then, for funding for digital trunk radio, rapid-response vehicles, and an upgrade to the command and control system to introduce automatic medical dispatch and clinical prioritisation. We secured some funding, but it was enough for only the four rapid-response vehicles that we introduced. I recall that you asked a question about bull bars around that time.

The Chairperson:

Those have now gone.

Mr McIvor:

Bull bars have gone, but that was part of the development. Bull bars were in place to hold a

winch to enable us to pull vehicles out of difficulty, but an alternative has been put in place. Since that time, we have been bidding for extra funds to enable us to enhance the service. In 2004 or 2005, a further injection of funds was ploughed into the provision of additional intermediate care ambulances. Those are non-emergency ambulances that can transport patients who do not require an emergency ambulance. It is a case of continuing that pattern of investment. Subsequently, we made further bids for additional rapid-response vehicles; however, those bids did not come to fruition until recently. The bids have now been incorporated into our proposals to realign services.

I would have preferred the Ambulance Service not to have to make efficiency savings and the investments that are being made in the service to be ploughed fully into rapid-response units on top of what is already there. Unfortunately, that is not within my gift. My point is that the bids for RRVs existed before the efficiency savings were announced. Bids for the additional rapid-response units and other measures were made in the past seven, eight, and nine years following the strategic review in 2000. The issue is the timing of the bids and the fact that they coincide with the efficiencies.

The Chairperson:
I am sure that any other question that I have will be covered by other members, so I will stick to efficiency savings. According to reports, the Ambulance Service will have a deficit of £1·5 million. Where does that deficit stand now, and how do you hope to address it?

Mr McIvor:
As reported at the last Trust board meeting, we project a deficit of £1·5 million. We have shared that information with the Department and the Regional Health and Social Care Board. We are waiting for them to confirm whether the deficit is, in fact, at that level. We are in discussion with them about the application of income and potential slippage. We have also suggested a number of ways in which the deficit could be addressed. Discussions are continuing with the Department and the board. Over the next week or so, I hope that we will have further clarity on the scale of the problem and how we will move forward.

The Chairperson:
I am delighted to hear about the introduction of 146 new vehicles. As you know, there was a bit of publicity a couple of years ago about whether money should be allocated to the Ambulance

Service for new vehicles or to the Folk and Transport Museum. I hope that the vehicle in Dungannon that had 430,000 miles on it has now been decommissioned.

Mr McIvor:

Yes, I think that that it has gone.

The Chairperson:

It was quite extraordinary for such a vehicle to have had so many miles on it.

Mr Gardiner:

It should be in a museum.

The Chairperson:

I agree.

Mr Easton:

Thank you for your presentation. Your proposals have now been agreed by the Minister. We debated a motion in the Assembly that addressed concerns about your proposals for RRVs and normal ambulances. Did the Minister ever ask you to reconsider your proposals after that motion was debated about four or five months ago?

Mr McIvor:

We conducted a consultation exercise and considered the responses to that. We incorporated those into the executive summary that we presented to the Minister. We took on board the responses to the consultation process.

Mr Easton:

Are you saying that you did not respond to the debate in the Assembly?

Mr McIvor:

That was part of the engagement process. We also had quite a bit of media attention when MLAs and the public expressed their views on the issue. We took on board all of that when we considered the proposals. We were aware of the debate in the Assembly and read the transcript of it. The debate, therefore, formed part of our thinking and consideration as we developed the

proposals.

Mr Easton:

Many of the trusts have a second set of proposals: do you?

Mr McIvor:

The recommendations that were sent to the Minister in July identified that the changes will not impact on areas for which only one 24/7 ambulance was proposed; that they will concentrate on areas of relatively high density; that the investment in rapid-response vehicles will also focus on those areas to manage the change, and that we will commit wholeheartedly to monitoring the impact of the changes throughout the process and to reflect on any subsequent changes.

Mr Easton:

Did the Ambulance Service have a second set of proposals?

Mr McIvor:

The Minister considered a series of recommendations that he received from the trust in July. It reflected —

Mr Easton:

Did the Minister approve that series of recommendations?

Mr McIvor:

He approved it in September.

Mr Easton:

Finally, I wrote to you about staff who were concerned about the ambulance cover in Bangor, which is the third largest town in Northern Ireland.

The Chairperson:

I hope that your question is not about an individual consistency matter.

Mr Easton:

It is not. Staff were concerned about a threat to discipline those who spoke to elected

representatives. Will you give me an assurance that that was not the case?

Mr McIvor:

There was no threat to staff. Ambulance Service staff are entirely within their rights to speak to their public representatives; we have not barred anyone from doing so. I assure you that no disciplinary process has taken place as a result of that situation. Trade union representatives would not tolerate us going down that path.

Mr Easton:

OK; that is reassuring. Thank you.

Mrs Hanna:

I agree with the proposal for the non-emergency transport. I could never understand why, years ago, ambulances collected people to take them to regular hospital appointments. It would be good to change that, and it would free up ambulances. I am not exactly sure what your proposals are, but are you talking about regular transport?

Mr McIvor:

A range of measures has been proposed to try to manage demand at the non-critical end of the scale. Quite a number of 999 calls are received from patients who may not require an ambulance to attend, or even take them to, hospital. We are trying to sift those out at the earliest possible stage — when the telephone call is made — and present an alternative to the patient.

The other benefit of that is the reduced impact on the accident and emergency units in the hospitals, because they do not see as many patients. Alongside that, we have ambulances that are crewed by two ambulance care attendants, who transport patients to hospital and take them home when they are discharged.

We are considering whether they could also transport patients who do not require the attendance or intervention of a paramedic. The measures are intended to manage demand, reduce the demand on the 999 service and to reduce the requirement of emergency ambulances to transport non-emergency patients. We feel that we could reduce the extent to which those ambulances transport non-emergency patients.

Mrs Hanna:

I have one more question about the decision-making process in relation to whether to deploy rapid-response vehicles or emergency ambulances. You will be aware of the concern about that. Is a rapid-response vehicle crewed by only one person when responding to a medical emergency? Recently, there was an incident in England about which it was said that, because of work safety protocols that do not allow staff to work alone, the driver of the rapid-response vehicle could not approach the patient. The patient had a heart attack and died. Such incidents scare people. In an emergency, it would not be helpful to have only one person in the vehicle if he or she is unable to approach the patient. How do you decide which vehicle to send? The arrangements do not appear to be satisfactory.

Mr McIvor:

I cannot speak about the practice in England, but the Northern Ireland Ambulance Service does not slavishly follow what occurs there. One key difference is that our rapid-response vehicles are manned by paramedics.

Mrs Hanna:

An RRV is manned by one paramedic.

Mr McIvor:

Yes. However, in England, the rapid-response units are manned by non-paramedics. In Northern Ireland, we want to provide the highest level of care by way of rapid-response paramedics, and my medical director and director of operations strongly impressed to me that that is their view.

Mrs Hanna:

Can one paramedic approach and deal with a patient?

Mr McIvor:

Yes.

Mrs Hanna:

Are there not any work safety issues?

Mr McIvor:

There are work safety issues, but those apply to a single person or to several persons. Paramedics will attend some scenes that are unsafe, and they will, therefore, have to make a risk assessment and, possibly, secure additional help. The other way in which we have mitigated any problems is that, when the 999 call comes in, we assign not only a rapid-response vehicle but the nearest emergency ambulance. As soon as we get the call and establish the location, we send the nearest responding units — the nearest emergency ambulance and, if one is nearby, a rapid-response vehicle. If it seems that the emergency ambulance will get to the scene before the rapid-response vehicle, we may stand down the rapid-response vehicle — but that does not happen the other way round. We recognise that, in the case of category A calls, which means that the situation is potentially life-threatening, the greater likelihood is that the patient will have to be transported to hospital. We send both vehicles to such life-threatening situations.

Mrs Hanna:

Do you use the rapid-response vehicle because the ambulance may, perhaps, be further away, and will, therefore, take longer to get there? However, if an ambulance can get there before the rapid-response vehicle —

Mr McIvor:

In that case, the ambulance goes to the scene and will arrive before the paramedic in the rapid-response vehicle.

Mrs Hanna:

Are rapid-response paramedics used only when an ambulance will take longer to get to the scene?

Mr McIvor:

If the ambulance is going to take longer to arrive, I want a paramedic to be at the scene as soon as possible. There is another benefit to that: if a rapid-response paramedic and an ambulance are at an incident when another life-threatening call comes in from the area, I can task one or other of them to that new call. We have had instances in which the rapid-response paramedic who has arrived at an incident is dealing with a patient and an ambulance is en route, when a life-threatening call is received about another incident just down the road. In such cases, the ambulance is dispatched to the new life-threatening call, and another ambulance is sent to provide

backup to the rapid-response paramedic.

I will cite another example to demonstrate how dynamic the situation can be. An ambulance and a rapid-response paramedic were at a particular scene when a call came in about an unconscious child in the vicinity. The rapid-response paramedic was sent to the incident involving the child. By maintaining that resource in the area, we maximise the paramedic response to life-threatening calls.

The other way in which we seek to ensure that the ambulance provides backup to the rapid-response paramedic is by diverting ambulances that may be attending calls that are not life-threatening. An ambulance that is on its way to a call that is not life-threatening when a life-threatening call comes in, or is the nearest ambulance to a life-threatening call, will be diverted. We are able to plot the positions of vehicles now that we have satellite navigation systems and mobile data systems.

I want to provide the Committee with some degree of reassurance. I have just read the information for September, and one of the key questions is whether we are providing backup to rapid-response vehicles quickly? Across Northern Ireland, a traditional emergency ambulance was on the scene of more than 95% of category A life-threatening calls within 21 minutes. That is as a result of the measures that we are taking. I cannot say the same for non-life-threatening calls, nor do I feel that the same speed of response is required. In monitoring the process, we will continue to measure the response to category A life-threatening calls to ensure that we are continuing to provide that level of response.

Ms S Ramsey:

Your presentation was interesting, particularly in light of the earlier presentation from the unions on the CSR cuts. Some of what you said demonstrates a common-sense approach to the CSR. However, we must live in the real world, and people have a fear of the unknown. Parallel to that, as long as people receive the appropriate care and that proper facilities are available, people do not care who arrives first at the scene.

You are the chief executive of the Northern Ireland Ambulance Service, and you want to make your organisation the best in the world. In an ideal world, if you did not have to make cuts within the CSR period, would you prefer to have more ambulances or rapid-response paramedics at your

disposal?

Mr McIvor:

In an ideal world, if I did not have to reduce the service, I would invest in more rapid-response paramedics. However, I would monitor the situation to keep the balance right. As I said, an emergency ambulance gets to 95% of category A life-threatening calls within 21 minutes. Even by putting more ambulances on the road, I do not think that I would improve that figure much. However, an increase in rapid-response paramedics will also enable me to get an ambulance with a paramedic to more category A life-threatening calls within eight minutes. I appreciate that the numbers are difficult to understand. However, perhaps the key point is that more rapid-response paramedics would enable me to distribute my resources more widely throughout the community.

We have succeeded in improving the response times across Northern Ireland in the five local commissioning groups, formerly the four health boards. I do not want to lose focus on improving performance, not only in the big urban areas, but across Northern Ireland. That is a different and bigger challenge. I would say that that is the biggest challenge for the future, and one that is common to most ambulance services throughout the UK. Those ambulance services do not measure their performance by discrete local government areas or local commissioning group areas, but on performance throughout the areas covered by their service.

In an ideal world, I would invest in more rapid-response paramedics, as they are highly skilled personnel who can intervene and bring care to the patient. However, I would continue to back that up with the capacity to bring patients to the hospital as quickly as possible.

Ms S Ramsey:

I commend the work of the Ambulance Service in light of some prominent attacks — fair play to you.

Mrs D Kelly:

Thank you for your presentation.

Have you considered introducing a shared rapid-response service, combining the Ambulance Service, the Fire and Rescue Service and the PSNI, particularly in rural areas? You have achieved a target of attending 74% of Category A emergencies within eight minutes. Are the

other 26% of cases, in which that target is not achieved, concentrated in particular geographical locations across the North? As part of the review, have you considered establishing protocols with health authorities in border areas and the provision of a rapid-response service to towns and villages along the border?

The executive summary states that there will be a:

"System review to reduce spend in Training and Administration with an emphasis on use of new and existing technology to reduce expenditure."

We have all learned, through bitter experience, that new technology that is not properly designed can often be costly. Will the review be carried out in-house or by external consultants? Everyone wants to know that front-line services will not be affected, so what areas have been hit to make savings in administration?

You said that absence management contributed to some of your efficiency savings. What are your targets for the incoming year, and how do they compare with other areas in the Health Service?

The Chairperson:

There are about six questions for you there.

Mr McIvor:

I should have written them all down, but, if I try to work my way back through them, I hope that you will keep me right.

Absence targets have been established by the Department through the priorities for action. We, in common with every trust, are required to move towards 5·5% or 5·2% of average time lost due to sickness. Last year, we achieved a 1% reduction to 6·99%. It will be challenging, but we are progressing to the next stage. It may take a little longer to achieve the target, but we are putting the right processes in place to try to drive down absences.

The blanket figure across the health system does not take account of the particular circumstances of the Ambulance Service. Our figure of 7% compares not unfavourably with other UK services.

Administration costs relate principally to vacancy control and the use of agency staff. We are working to reduce agency staff numbers and to deliver the target. Approximately 10% of savings are being applied to administration costs.

Mrs D Kelly:
The employment of agency staff when there are vacancies is penny wise and pound foolish.

Mr McIvor:
You are quite right, and that is why we must manage that rather than impose a blanket ban. We still need an administration system. We are the smallest trust, but that does not absolve us from any of the responsibilities of the others. We still must ensure that we pay our staff, that correct disciplinary and grievance processes are in place and that there are processes for managing freedom of information requests.

However, we are scrutinising our internal administration, principally at headquarters, to try to bring down our costs in that area. We also have to consider issues such as the security of the building and the use of flights and travel to conferences. There is only one ambulance service in Northern Ireland, so, if we are to try to influence what happens in the UK and learn from there, we have to maintain links. We can also do that through teleconferencing.

We have arrangements in place on cross-border co-operation. We have a memorandum of understanding with the ambulance services in the Republic of Ireland with which we carry out joint training. In fact, Chairperson, joint training recently took place in Newry and Ballykinler, which are in your constituency. The protocols are in place to allow us to access ambulance services in the Republic of Ireland and for them to seek assistance from us. However, my take on that is that most of the assistance goes from us to them rather than from them to us. Unfortunately, they were unable to assist us at a recent incident in Belleek, and we had to revert to calling on a crew from Castlederg. We share the lessons that we learn from each incident, and I am in contact with my colleague from the South. My point is that I do not rely on the service from the South. I rely on an emergency ambulance from the Northern Ireland Ambulance Service getting to the scene as quickly as possible. The protocol that remains in place is: send the ambulance.

Mrs D Kelly:

Some 26% of the calls are not responded to within the target time: are those calls concentrated in a particular area or areas?

Mr McIvor:

The fact that performance is highest in the Belfast area is linked to population density. Some areas provide us with particular challenges. The 26% of calls to which you referred is spread across the five local commissioning groups (LCGs). From memory, the performance of the northern and southern LCGs is approximately 65%, the western LCG achieves between 70% and 72, and the figure for the south eastern LCG is approximately 70%.

Within the LCGs, areas such as the Ards Peninsula, south Armagh, the Glens of Antrim, the Sperrin Mountains and the far south-west have lower performance levels. They also tend to have much lower levels of ambulance activity. That is part of the dilemma faced by the service. We should address that by, as I said, developing our response capacity internally and distributing it as effectively as possible.

We are also engaged with the Department in the development of first responders, on which, it is best to say, the jury is out in England. A recent report found that first responders did not contribute a great deal clinically. However, they can contribute by making a response and by doing so equipped with a defibrillator. How far we address and develop that is a policy question that requires further consideration.

Your other point was about working with other agencies, such as the Fire and Rescue Service. We have engaged with the Fire and Rescue Service in developing a first response, but that development has largely been put on hold because of a court case in GB involving fire officers who were advised not to carry out first response. The patchy nature of first response in GB has thus stifled development with the Fire and Rescue Service here.

We developed an initiative with the Police Service, and we continue to page the police to attend calls. However, improvements in our response times have largely negated the impact of those types of first-response initiatives. For example, a pilot project in north Belfast revealed few instances in which the first response got to the scene before the ambulance. That tends to drive down enthusiasm for the project, because when the first responder arrives there is nothing little

more to be done.

We discussed the issue at a public meeting in south Armagh, where, as I said, the reception from public representatives was not particularly positive. The main issue centred on the perception of first response as an alternative to an ambulance, whereas it must be seen as complementary. We recognise that there times when we will not get to scenes as quickly as we would wish, particularly in certain areas. Our priority must still be to get care to the patient as soon as possible and to follow up on that. If that care consists of a trained layperson with a defibrillator providing cardiac first response, I am entirely behind it. I also support public access to defibrillators as another means of providing cardiac first response.

A point was made about the cost of technology, and the service has invested quite heavily in that. It has not been easy, and we faced plenty of difficulties. Just yesterday, however, I spoke to colleagues in Altnagelvin who told me that we now have a robust radio system, which we did not have several years ago, that covers from the far north to the south-west. It is a guaranteed system that we share with the PSNI and the Fire and Rescue Service and that could, potentially, be shared by other services.

The vehicles now have satellite navigation, which is a big step forward, although it is still not perfect. The mapping is not perfect because the information that enables us to plot the position of vehicles is not totally accurate, but it is a damn sight better than it was. We use the technology creatively but practically, and we are building resilience into it to enable us to have a significant degree of assurance that we can maintain it. In any case, if the radio were to go down, we would use the mobile phone as backup. If the satellite navigation system were to go down, we would radio the control centre for advice.

Dr Deeny:

Thank you, gentlemen, for your presentation. Liam, I might give you a rest and ask David some questions.

It takes a while to get used to the idea of a rapid-response vehicle. I presume that a qualified person decides on whether a call belongs in category A. I could not agree more with Carmel's point that many hours were wasted down the years on sending ambulances to transport people who were not sick. I assume that, if an emergency ambulance and an RRV were in the depot, the

emergency ambulance would be sent out to a category A call. Is it correct that an emergency ambulance and an RRV are sometimes dispatched together?

Mr McIvor:
Yes.

Dr Deeny:
Last Tuesday, while I was at the Assembly, an ambulance came to our health centre because a man's leg had been bleeding. It turned out that he had pierced an artery, and he almost bled to death. He was put on a drip in the health centre, and the ambulance came very quickly, for which I commend you. The situation was much more serious that my partners originally thought; he had been bleeding as he made his way the full length of the car park. If an RRV were to arrive at a situation that turned out to be an emergency, how often would an emergency ambulance then be dispatched? Have you carried out an audit on that?

The worry is that the full story might not be picked up immediately, particularly by a member of the public. I take it that, if a medical person were to say that a case was urgent, an ambulance would be dispatched. A member of the public might not know whether a case is urgent, so how would that information be teased out? It could be an emergency, and my worry is that it could take 30 minutes for an RRV to get to a rural area, such as the one in which I live. If it were to turn out to be a major emergency, the lost time could be the difference between life and death.

Dr McManus:
We have a priority dispatch system (PDS), and I will ask Brian, as director of operations, to talk about the dispatch arrangements.

All the staff who work in the regional dispatch centre taking calls and dispatching ambulances are trained to an internationally recognised standard in the use of the advanced medical priority dispatch system, which is used by the vast majority of ambulance services in Europe and North America. That system uses the information that the caller provides to categorise the calls. For example, when a call arrives on the 999 system, we use the technology to try to identify the location of the phone from which the call was made. Once we have established the location of the emergency, the dispatch process for the ambulance starts immediately, while the call-taker remains on the line with the caller.

Every call starts life in category A as a potentially life-threatening emergency call. A series of questions is asked, starting with determining the chief complaint, which could be a fall, a road traffic collision, a headache, shortness of breath, chest pain, and so on. A series of questions is then asked that require the answer “yes”, “no” or “don’t know”. Those questions seek information on how long the symptoms have been present, how old the patient is, whether they are conscious, whether they are breathing, and so forth. For example, if the call is about chest pain and the patient is over the age of 35, or unconscious, or sweating and short of breath, it remains a category A emergency call. Sometimes, it can take a while for the answers to change the call to a category B or category C call, neither of which is urgent nor life-threatening.

The questioning also aims to identify the problem, so that the call-taker can provide initial first aid management advice over the phone while the ambulance is responding to the call: for example, they may issue advice to stop a haemorrhage by applying pressure or by elevating a limb. The call-takers and dispatchers who use that system are subject to a quality assurance process. The process uses a random sample of their calls, and those are reviewed by training officers in ambulance control. GPs or hospital doctors who telephone the emergency system and identify themselves are not subject to that questioning. They are asked only about the nature of the emergency, and, if it is a life-threatening call, an ambulance is dispatched. There is no questioning to try to triage a call from a doctor. The dispatch programme is a dynamic process with a flexible response, and Brian is probably best placed to speak about it.

Dr Deeny:

Have you carried out research or an audit on the number of RRV responses that had to be followed up with an emergency ambulance?

Mr McNeill:

I will address that when I finish talking about the dispatch process.

When a member of the public makes a 999 call, it comes through to the control room. When the call-taker identifies the address and telephone number, that information appears immediately on the computer. Our technology is so sophisticated that, if the call is from a landline, we can automatically identify its location from the BT code, and that is plotted on the map in front of the dispatcher.

Although the caller is taken through the prioritisation process that David described, we already know the location of the call. We are already looking at the other computer screen to see where the closest available response vehicle is located. At that point, the call is classified as a 999 call, which is a category A life-threatening call. The dispatcher will identify and deploy the closest available response unit, which could be an A&E ambulance or a rapid-response vehicle.

If an A&E vehicle and an RRV are en route to an incident when a call is downgraded to category C, the dispatcher will stand down the A&E vehicle because it is now a low-grade emergency call, and there may be another high-priority job for that vehicle. If the call is category B, which is serious but not life-threatening, the dispatcher will stand down the rapid-response vehicle and allow the A&E vehicle to respond. The idea is that the patient will probably need transportation to hospital, and the rapid-response vehicle can be kept in reserve for the next emergency call. If the call is category A, particularly high-grade calls such as cardiac arrests, the dispatcher will continue to send both vehicles. We make no excuse for that, because even if two paramedics are on the scene at a cardiac arrest, the patient receives much better care.

There is a low incidence of such calls in the overall total of calls received. However, that dynamic process happens within two minutes of the call coming in. One team deals with the caller, takes details and provides advice. On the other side of the room, a team determines how we can get to that patient as quickly as possible and decides on the most appropriate response. Those judgements are based on the use of the technology, the experience of the controller and the details provided by the caller.

Between April and September 2009, RRVs made a 14% contribution to achieving the target for category A response by getting to the scene first. As Liam said earlier, in about 95% of those cases, an A&E vehicle has been provided within the 21-minute time frame.

As the performance targets show, the balance, to which we referred earlier, works. Currently, at peak times, approximately 18 cars operate throughout Northern Ireland to complement the A&E vehicles. The 14% contribution from that resource is, therefore, significant.

Dr McManus:

Brian provided the figures for ambulance response times. In the context of the arrival of a rapid-

response vehicle, we are reliant on information that is provided by the caller, and we are doing more detailed work on that. However, when the rapid-response paramedic arrives, he or she may, either through their intervention or because of an intervention that a carer has made, be able to identify that transport to hospital is not required. Many conditions can be managed at home, and, if necessary, referred to community teams, and so on. We are developing that area of work, so that those who need to go to hospital do so, but we also want to be able to direct, refer and provide appropriate care at home or in the community to others who do not require hospitalisation.

Mrs McGill:
Thank you for your briefing. My main question is about rural areas. I saw the figures for the Western Health and Social Care Trust. Liam said that, when the four boards existed, the targets were all being met, but I did not think that that was the case. I did not think that the eight-minute target response time was being achieved.

If I have the correct figures, some of the boards were not too far outside the target. By March 2009, board areas achieved their individual targets of attending 62·5% of category A calls within eight minutes. However, for about four months, the Western Health and Social Services Board fell below that target. Its performance did not fall far below the target, but my point is that the target is not set at 100%, and I do no want us to lose sight of that fact. Over a number of months, the Western Health and Social Services Board attained a performance of between 67·8% and 62·2%.

I remain somewhat concerned about rural areas. I want you to reassure me that there will not be difficulties. In his preface to the annual report, the chairperson states that rural areas have been by far the toughest challenge. There is talk of some kind of re-profiling or change vis-à-vis urban and rural areas, perhaps by reducing what is available in urban areas and bringing it to rural areas. Is that the case?

Mr McIvor:
I share your concern about the response to rural areas. As I said, that is probably the biggest challenge that we face. We have to continue to deliver the full quantum of the work for emergency and non-emergency calls. Performance will vary from month to month, but we achieved the target over the course of the year. We have achieved it in the first quarter of this

year. We achieved — and even exceeded — the target that was set by the Minister. I am not sure to which figures you refer. I do not have them in front of me.   I would need to go back over those with you. The performance will be variable.

Mrs McGill:

The figures are contained in the 2008-09 annual report of the Western Health and Social Care Trust. Perhaps I did not get the numbers quite right. I understand and welcome your reassurance, but I have one other point.

Mr McIvor:

You also asked a question about the balance between rural and urban areas. The key to that is the dynamic deployment of the available resources. Some members of the Committee have had an opportunity to visit the control centre, and I am happy to extend an invitation for all the others to do so. It is a question of understanding how we can move to deploy resources to maintain cover in rural areas. The rapid-response vehicle is key to that, because it is not involved in transporting patients. It is the resource over which I can maintain most control, because I know that it will not be sucked away by a hospital requesting that a patient be taken to Belfast for an assessment. I keep my paramedic response in the area, so that I can distribute it according to the demand. By increasing the number of rapid-response vehicles, I increase the capacity to maintain the resource in a particular area.

Mrs McGill:

I have one final point. Have you any data or evidence on the time taken by the responding vehicles that do not meet the eight-minute target? That would be helpful. Dolores Kelly also asked about the locations of those areas in which that target was not met. It is important to see whether there is a pattern in particular areas. That information would be valuable for people in those areas.

Mr McIvor:

Performance information is presented at public meetings of the trust's board, and the documents for those meetings can be found on our website. Performance deals not only with the category A eight-minute response but with category B calls, category C calls, and so on. The numbers show the performance of responses within both eight and 21 minutes.

Mrs McGill:

My apologies; I did not see those figures. I found no information about the responses that took longer than eight minutes: how many took 10, 15, or 25 minutes, and so on.

Mr McIvor:

Sorry, we are talking at cross purposes. The information is not broken down to that level. The performance —

Mrs McGill:

It would be important to have that information.

The Chairperson:

I have allowed a bit of latitude, but this evidence session is supposed to be about efficiency savings, not targets. If I have missed anything, I will, no doubt, see it reported in the Strabane media next week anyway.

Mrs McGill:

It will appear in the 'Strabane Weekly News' and the 'Strabane Chronicle'.

The Chairperson:

Perhaps, at the request of Mrs McGill, you would furnish us with more detail on how many responses do not meet the eight-minute target, as that information may not be readily available. Other than that, you have answered our questions extremely well.

Mr McIvor, I was most impressed to learn that you once drove an ambulance. You started your career on the ground.

Mr McIvor:

I think that you mean to refer to my colleague Mr McNeill.

The Chairperson:

The other day, someone told me that they knew Mr McNeill before he became famous, as it were, because he drove an ambulance. I was impressed.

Dr Deeny:

They had to put him off the road because he was too dangerous.

The Chairperson:

Thank you very much for giving evidence and providing us with a level of detail that is in stark contrast to that provides by some of the other trusts. Of course, your organisation is also a trust. We keep forgetting that there are six trusts, not five. Thank you very much, it has been most helpful.

Mr McIvor:

Thank you again. The Committee has an open invitation to visit us. If we can help in any way, we would be happy to facilitate you.