Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Ambulance Service — Proposed Pay Band Changes: UNISON Briefing

26 June 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Conall McDevitt
Ms Maeve McLaughlin

Witnesses:

Mr Richard Dundas	UNISON
Mr Brian Ferguson	UNISON
Mr Alistair Long	UNISON
Mr Mark Quigley	UNISON
Ms Anne Speed	UNISON

The Chairperson: I welcome the representatives from the trade union who are here today. We will try to make this session last for 45 minutes. We must also hear from the Ambulance Service, and it will be given 44 minutes. Can I ask you to make your presentation? We will go to questions from members after that.

Ms P Bradley: I declare an interest as a member of UNISON.

The Chairperson: I thought that you were going to say, "I declare an interest as somebody who has used the Ambulance Service." *[Laughter.]* OK. I do not know who is taking the lead.

Ms Anne Speed (UNISON): Good afternoon, everybody.

The Chairperson: Anne, will you introduce your team?

Ms Speed: I will, indeed. I am Anne Speed, UNISON's head of bargaining and representation. With me is Brian Ferguson, who is a regional organiser with UNISON, and Mark Quigley, Alistair Long and Richard Dundas, who are elected lay representatives from the Ambulance Service (NIAS). We represent the overwhelming majority of Ambulance Service staff — about 700 of its 1,100 employees.

Thanks, once again, to the Committee for Health, Social Services and Public Safety for facilitating the presentation of this evidence. I think that you have been very good to us over the past number of months. We appreciate it, because the Health Committee's role is so important for scrutiny and oversight. In these very difficult and challenging times of restricted budgets, pressures on trusts and all that, the scrutiny of public bodies by elected representatives is so important. We value and respect it. So, thank you for that.

We will read our evidence into the record. Three colleagues will take that in turn. We are then open to questions from members. We will try to do that as speedily as we can. Alistair is kicking off.

Mr Alistair Long (UNISON): The Northern Ireland Ambulance Service and the chief executive, as the accountable officer, have signalled their intention to replace existing emergency medical technician (EMT) staff with a lower-grade and lesser-qualified trained paramedic assistant or emergency care attendant (ECA), which is how the role is known in the rest of the UK. NIAS has said that that is being done to meet the efficiency savings that the Department of Health, Social Services and Public Safety (DHSSPS) has imposed. In various meetings with trade unions, NIAS has documented proposals for the introduction of the paramedic assistant/ECA role and has given assurances on having a paramedic in every ambulance. UNISON intends today to give the Committee a very different view on the NIAS proposals and to allow you to ask actual serving ambulance staff, paramedic and EMT, just what those proposals mean in reality and not as figures or statistics on a paper or PowerPoint presentation.

The first point of interest to the Committee might be NIAS's own figures that show that the downgrading and deskilling of EMTs has the potential to produce to a saving of £1·6 million in 15 years. UNISON questions why you would downgrade and deskill a group of staff that has served Northern Ireland with distinction for many years during the very worst of the Troubles. Those staff attended incidents such as the Enniskillen Memorial Day bombing, the McGurk's bar bombing, the Omagh bombing, the Shankill bombing and the Loughinisland shootings, to name but a few of Northern Ireland's atrocities. That is being done to save a potential £1·6 million in 15 years from the salaries of those staff. That is, surely, morally repugnant and wrong to all here.

Staff who are employed by the Prison Service or the Police Service were not treated in that manner when changes were implemented. Current ambulance staff should be ring-fenced and protected for their remaining service life, which would not be much longer. The cost impact would be minimal.

The second point that UNISON would like to make is that the paramedic assistant/ECA role is inherently flawed and entirely unsuitable for the rural geography of Northern Ireland. Evidence from all over the UK, including Scotland and Wales, shows more and more services rejecting that role, EMTs being actively recruited and less-well-qualified staff being trained up to the EMT standard. UNISON asks why NIAS would introduce a role that has been withdrawn as a failure elsewhere in the UK and that is seen as not suitable in a front line accident and emergency vehicle.

Mr Mark Quigley (UNISON): The Scottish Ambulance Service is recruiting ambulance technicians, as advertised at www.scottishambulance.com. The closing date for applications for vacancies is 28 June 2013.

The Welsh Ambulance Services NHS Trust has been working in partnership with Skills for Health, the sector skills council for all health employers, including the NHS. It has no plans to introduce the ECA role and will retain the emergency medical technician grade in all front line ambulances.

The East of England Ambulance Service, which is known as a failing trust, is withdrawing from its policy of replacing EMTs with ECAs, as quoted in the board's turnaround plan. That plan states:

> *"We will re-launch the Band 4 role in Emergency Operations and keep this role as a career pathway within the Trust. We will recruit to roles at Band 4 in Emergency Operations and will not phase out these roles from our structure. We will set out the scope of practice for these Band 4 roles."*

The full report is attached in the file.

The West Midlands Ambulance Service, under its chief executive officer, Anthony Marsh, is also decommissioning the ECA role. It is recruiting emergency medical technicians. That information can be verified at www.wmas.nhs.uk. The closing date for that is 15 July 2013.

The Manchester ambulance service is in the process of retraining its current ECAs up to EMT level and is recruiting additional staff to the EMT grade. That information can also be found at www.mwas.nhs.uk, where the EMT role and training are advertised.

The South Western Ambulance Service Trust commissioned a report into the impact of the introduction of an emergency care attendant role. The report concluded that the role was not fit for purpose. That is also attached in the Fusion Communications report, which we sent you.

Mr Richard Dundas (UNISON): The Northern Ireland Ambulance Service Trust has attempted to give weight to its proposal by stating that, as with the roles that they would potentially replace, the paramedic assistant would not be a Health and Care Professions Council (HCPC) regulated professional. That comment adds no weight to the trust's proposal. Neither the emergency medical technician nor the paramedic assistant/emergency care attendant is registered with the HCPC. However, that does not detract from the professional requirement of the role. Registration may be a requirement for all healthcare professionals in the future.

Registration has no bearing on the clinical skills that an autonomous ambulance practitioner is required to provide. However, it is important to reiterate the qualifications that an autonomous emergency medical technician must have to practice. They must be proficient in all aspects of ambulance aid and ambulance driving and must have an Institute of Health Care Development (IHCD) health and care limited qualification. All emergency medical technicians are issued with a trust-generated certificate on completion of the residential ambulance technician course. Additionally, after one year's experience and on successful completion of the required assessments, they are issued with the full IHCD certificate. It is only after that lengthy process that the emergency medical technician is qualified.

Contrast that with the reality that the paramedic assistant/ECA would have no formal qualification, would be able to work on a front line ambulance after minimum training and would have no requirement for additional on-the-job experience, as they would have no skills or ability to assess and treat patients. The required skills and scope of practice to ensure safe and effective patient care would not be an issue for the paramedic assistant/ECA, as they would have no responsibility to ensure safe and effective patient care. That responsibility would fall entirely on the paramedic, irrespective of the situation, incident or number of casualties. That will delay the assessment and treatment of potentially critically injured or ill patients. For instance, at the scene of a multi-casualty road traffic collision in a rural area of Northern Ireland, that role would actually endanger lives. Currently, an EMT will assess and treat patients autonomously, and decisions can be made about who the most critically injured patients are. It is not uncommon for two EMTs to be crewed together on ambulances. It stands to reason that if you increase the number of non-paramedic staff, you must increase the number of occasions when two non-paramedic staff will be crewed on an ambulance. That shows as flawed and short-sighted the assurance that NIAS will have a paramedic on every ambulance.

Mr Long: NIAS has previously stated that, due to the acute hospital reconfiguration, which has already taken place and to further reconfigurations signalled by Transforming Your Care (TYC), patients are in the care of ambulance personnel for longer. As such, it is appropriate and necessary that a paramedic treat those patients. UNISON asks: why then would you increase the number of non-paramedic staff who are at a lesser grade, less well trained and less qualified than at present? In ambulance services in England, where such proposals have been implemented and paramedic assistants are employed under titles such as emergency care attendants, those ECAs have ended up working together as emergency crews. The impact of that has been ambulances arriving at the scenes of 999 calls with no paramedic and two non-autonomous staff.

The Health and Social Care Board's commissioning plan states that "treat and leave" protocols should be put in place by November 2013. That is in line with the Minister's overall aim to reduce admissions to emergency departments. The replacement of EMTs with non-autonomous paramedic assistants would serve only to increase such admissions, as those staff would not be trained or qualified to carry out such protocols.

The Northern Ireland Ambulance Service has given assurances to the Minister before. It assured the Minister that the introduction of the front-loaded rapid response model would improve response times. That has not been the case. At the same time, the Minister was assured that all category A 999 calls, where lives are threatened, would receive a response from a rapid response paramedic and the nearest available emergency ambulance. An internal memorandum clearly demonstrates NIAS's intention to give such assurances and then to act in contravention of them.

NIAS will use, as its evidence base, a principle that it claims has been widely implemented throughout healthcare, regionally and nationally, that means that lead clinicians take clinical responsibility for the patient and that they would be adequately supported by an assistant, as happens in nursing and physiotherapy. UNISON refutes that as flawed thinking when it is read across into the pre-hospital field in which ambulance staff exist. You cannot possibly compare a nurse on a ward, or in an A&E, who has an immediately contactable and available senior colleague, such as a doctor or consultant, or, indeed, more senior nursing staff, to the pre-hospital environment, where ambulance staff are on their own, in a ditch with an overturned car at 3.00 am. It is for that reason that the ambulance services and regions are pulling away from the paramedic assistant/ECA role or resisted its introduction in the first place.

This briefing and the attached evidence bundle clearly demonstrate that the Northern Ireland Ambulance Service proposals will not deliver an ambulance service that is capable of meeting the needs of the people of Northern Ireland. It will not improve patient care but will be detrimental to it, and it has the potential to endanger public safety. It will not reduce hospital admissions but will lead to an increase in them, as per every other ambulance service that has introduced that model.

Ms Speed: I want to share with you additional information that came to us yesterday about an incident that happened in London. That incident involved an ambulance crew that was made up of trainees, or people who are trained to a lesser standard to the staff that we have here. We thought that we would share it with you because it makes a point. You might like to take the information that I am passing round.

We are available for questions.

The Chairperson: Thank you very much for that and for the paperwork that you sent us.

I have a couple of questions. Some members have indicated that they want to ask questions, but I ask all members to indicate now whether they want to speak. There is a time limit on both presentations, and I do not want members to speak longer on the basis that only a couple of questions have been asked and answered and then people thinking that they are going get in at the end. So members should indicate now or within the next five minutes or they will not get to ask a question. What happens is that I allow people to ask three or four questions on the basis that others do not want to, and then everyone else wants to come in.

I do not want to come across as flippant, but I need to ask this question for the record. If this proposal from the Ambulance Service goes ahead, does it mean that double the amount of ambulances will be available?

Ms Speed: Absolutely not.

Mr Quigley: With the efficiency savings over the past three or four years, the number of ambulances that are available to the public has been cut by quite a substantial number in certain areas. Those stations that are normally the biggest have lost a vehicle. We know of no plans whatsoever to increase the number of ambulances that are available to the public. What you have at the moment is a considerable number of vacancies at emergency medical technician level. The trust proposes to fill those with these paramedic assistants, as well as to downgrade the existing emergency medical technicians and to deskill them to this paramedic assistant level.

The Chairperson: OK. So it is not as though the proposals that are coming forward will take two paramedics out of the one ambulance and put one into another?

Mr Quigley: No.

Mr Long: Can I clarify that? This is purely an efficiency saving. It is a method of saving money; it is nothing to do with putting additional trainee clinical-skilled staff on the road. It is purely a method of saving money, so there will definitely be no increase.

The Chairperson: Will one of you please outline for me the difference between the role of the emergency medical technician and that of the proposed paramedic assistant?

Mr Dundas: The main difference, Sue, is in their autonomy. Currently, an EMT can practice autonomously. I am an EMT; I can even go out on my own to treat patients. I have been sent on my own in an ambulance to treat patients. I can be crewed with another trainee or a lesser-qualified member of staff, if my crewmate is not available, and attend calls. However, the ECA is unable to treat or assess patients autonomously. They are not trained to assess or treat patients or to make those decisions. From the Ambulance Service's point of view, the paramedic will take such decisions. However, from our point of view, that will not always be the case. If you increase the number of non-paramedic staff, you have to increase the number of times that two non-paramedics will attend a call. In the previous four shifts that I have done for the Ambulance Service, the most recent one being on Sunday, I was on with another EMT. So I have done four shifts in a row with another EMT. If you increase the number of non-paramedic staff, you are bound to increase the number of times that we will be crewed together.

To me, the essence of the difference between the two roles is in my ability to treat a patient, to assess them and to make a decision about what we are going to do. That comes into its own in a multi-casualty situation. For instance, I work and live in the Mournes. If you have a car crash in the Mournes, and there are many of them, where you have two, three or four patients, you will be waiting another 35 to 40 minutes for another vehicle to arrive. It might be longer, maybe slightly shorter, but that is the time frame that you are looking at. If I am crewed with a paramedic, I can go to any other patient and assess them, and we can make a decision about which patient is the most critically injured. We can decide to treat those patients at the scene or decide that the others are sort of all right and that we will treat the most critically injured. However, if that paramedic is on with an ECA, that ECA will not be able to assess those other patients. He will literally be standing beside the paramedic asking, "What can I get you? What do you need?" That is the big difference. This is life and death stuff, folks.

The Chairperson: Taking the scenario that you just outlined, are you suggesting that replacing the EMTs with paramedic assistants will endanger patients?

Mr Dundas: Yes.

Ms Speed: My observation of that consideration over the past couple of years, but mostly within the past 12 months, is that it has arisen because of the pressure on the trust to make savings and cuts in its budget. There was a review of how it might deliver the service with less money. At no stage was the proposal presented to us based on improving the quality of care or scientific or medical evidence that this works best. Even as late as yesterday evening, when the Minister came to do a public accountability session, the question arose in the context of pressures on the trust to deliver the service with reduced capacities and moneys. There was no shift in the conversation or evidence given that this works best for patient safety or quality of care. An examination of the trends in England is that it has arisen due to pressure on the NHS. Real crises are now emerging in a number of ambulance trusts. Alistair has some authority to speak on that, because he sits on a committee in UNISON. How many new ambulance trusts are on that committee?

Mr Long: I sit on a national occupational group that is representative of Scotland and Wales and the 12 NHS trusts throughout the UK. That group has a mixture of those who had introduced this model. However, as cited in the evidence, a number of trusts are now pulling away from it, and, as recently as yesterday, the chairman of the chief executives in England recommended that this role should not exist and should be withdrawn.

The Chairperson: OK. Thank you for giving us information in the paper about some of the other trusts that have gone down that road and are now pulling back from it.

I will now open up the meeting to questions from other members.

Mr McCarthy: Thank you very much for your presentation. I regard the Northern Ireland Ambulance Service as number one. It has served our community for years, and long may that continue.

Some of you referred to the 'Transforming Your Care' document, and in that, several points are made about the Ambulance Service, including the:

"training of NIAS paramedic staff to support the model".

Could you describe the overall staffing structure of the Ambulance Service that you feel would be necessary to support the Transforming Your Care proposals?

Ms Speed: We have some difference of opinion on the Transforming Your Care proposals.

Mr McCarthy: Yes, we all do.

Ms Speed: As such, we have not engaged with the trust on the detail of that other than on this substantive matter of reconstructing — or downgrading, as we see it, or deskilling — the workforce. So that conversation has not really been had. We believe that, by and large, the current structure meets the service's needs, but we have a view about resources and numbers.

Mr Long: We feel that we have the gold standard in our structure and skills mix, and we do not want to see that watered down or in any way changed. That standard of staff is needed if Transforming Your Care is to be used to do more work in the community. It would require an increase in staff, because there will be a further increase from every trust asking us to put resources in. So instead of deskilling or decreasing, that will certainly require an increase. However, there are no figures as yet to say what that increase will be.

Ms Speed: There is a parallel concern that we are not necessarily presenting to the Committee today. That is connected to the possibility of a reliance on private support or service provision in this field. However, that is only beginning to emerge, and questions are arising in individual trusts about how they are trying to supplement the Ambulance Service.

The Chairperson: We will be going into more detail on Transforming Your Care and that issue, so I ask that we focus on this specific matter, because the Committee is doing a substantial piece of work on it. I am not saying that it is not important, but let us deal with this.

Kieran, let me bring in others, and I will let you back in at the end.

Mr McCarthy: OK. I will probably have forgotten by then, but go ahead.

The Chairperson: You will not. Write it down. Trust me. *[Laughter.]* What you are saying is generating a lot of questions, but I have to give everybody a chance.

Mr Beggs: Thanks for your presentation and written submission. It indicates that a number of sizeable ambulance authorities are moving away from the system that is being proposed. So that rings alarm bells for me.

You indicated in your presentation that it is not uncommon for two emergency medical technicians to be crewed together on ambulances. If that is dispensed with, potentially two staff of a lesser grade could be crewed together. How common is that? I am shocked; I thought that every ambulance had a paramedic. How often does that happen?

Mr Dundas: It was me who raised that, Mr Beggs. I am an EMT, and on the past four shifts that I did in the Ambulance Service, I was crewed with another EMT. That is not uncommon. I could not give you a statistically accurate figure of how many EMTs are crewed together throughout the year; the Ambulance Service could provide you with that. I am sure that it would do it without your being required to submit a freedom of information request. However, that situation is common.

Mr Quigley: The entire proposal that the Ambulance Service is putting forward is based on what is called the paramedic-led model, which means that, when possible, a paramedic is on every ambulance. As you heard from Richard, though, that is not always possible due to the availability of staff.

The other part of that proposal is to put paramedics in cars — rapid response paramedics. That is the front-loaded model. I am one of those paramedics; I work in a rapid response vehicle. To put it politely, I am very nervous about these proposals, because if I go out in a car to a multi-casualty accident, which could involve anyone in this room or their family — two cars, four people in each; eight patients — I am on my own trying to treat eight patients who could all be critically ill.

It is my ultimate nightmare that the crew that turns up to me has only one autonomous practitioner because that would leave us with four patients each. At present, that call would be attended by two paramedics, a paramedic and an EMT or two EMTs. That splits that workload in three automatically. The absolute nightmare would be if they sent two paramedic assistants to me because then I have two people to fetch and carry equipment for me, but I still have eight patients.

Mr Beggs: The Committee should pursue that issue to see how often that happens.

The Chairperson: You can come in on that same question, Roy, when the Ambulance Service witnesses are here.

Mr Beggs: Thank you.

Mr McDevitt: I was flicking through the Fusion Communications report from Wales that you kindly sent us, and I was taken by the statistic that 90% of people who apply to be an ECA there apply only so that they can become a paramedic. What is the pay difference between an entry-level ECA and an entry-level EMT? Are we just giving people the opportunity to get into work so that they can be paid for it while they do their training to do the job they really want to do?

Mr Dundas: I can speak only for the top of the pay bands, and, because we are on incremental pay, you can have a vast difference. The difference between the top of the ECA pay band, which is band 3 in Agenda for Change, and the top of the EMT pay band, which at the minute is band 4, is £4,000. In fact, it is £3,725. *[Laughter.]*

The Chairperson: You would know that you are a country man because you have it right down to the last penny. *[Laughter.]*

Mr Dundas: Every penny counts.

Ms Speed: Richard plays a role in job evaluation in the structure of Agenda for Change agreements with the trusts. Therefore, he is quite knowledgeable about that. If he says that that is the figure, that is the figure.

Mr McDevitt: How many EMTs are there in the Northern Ireland Ambulance Service at the moment?

Mr Long: There are now fewer than 180 EMTs.

Mr McDevitt: You said that there was a load of vacancies. How many vacancies are there?

Mr Long: There should be up to 300, approximately.

Mr McDevitt: Perhaps 100 or 120 vacancies?

Mr Long: Yes, thereabouts.

Ms Maeve McLaughlin: The briefing note points out the calculation of £1·6 million in potential savings. Is that strictly calculated on the deskilling of staff? It is over 15 years. If you are looking at that on the face of anybody — I am not suggesting this — advocating efficiency savings, it is a time as well. Is the figure simply based on staff deskilling?

Mr Dundas: The figure came directly from a briefing by the Northern Ireland Ambulance Service. It reflects the fact that, under Whitley, some of our staff are entitled to up to 15 years' pay protection. That means that if EMTs are deskilled or downgraded, they still have to be paid their salary for up to 15 years. After 15 years, you will be looking at an efficiency saving of £1·6 million.

Ms Maeve McLaughlin: My second question is about the risk that you have identified to the provision of service and, in a lot of cases, to health and safety and to life. Has an impact assessment been done on those proposals? I have heard about the experience in England. Has an impact assessment been done not only on the equality issues in the area of employment but on the impact on communities?

Ms Speed: We have not got to that stage yet. We hope that we will be able to convince the trust to look in another direction to address the pressures that it faces financially and come up with other suggestions. We hope to have it removed from the table before we ever get to that space. I will not in any way presume to speak for the Minister, but I got the impression from the way in which he was posing the questions yesterday evening that he is not entirely convinced of this. He asked for our views, not in a formal setting but in an informal one, and we briefly shared those views. To be fair, he did not get the full impact, but I am sure that he will have sight of our submission. I got the impression that he had had sight of it and that that was why he asked us.

Ms Maeve McLaughlin: An impact assessment would not be ruled at some stage if it is needed?

Ms Speed: If we have to use all the resources and tools to convince those who have responsibility for the service to think again, we will use every means that we have. However, at the moment, we are trying to make the arguments based on the experience of others. We are trying to use the front line experience of our membership to advance our arguments.

Mr Dunne: Thank you for your presentation. Recently, I had a meeting with the chief of the Ambulance Service on a constituency issue, and I realised that there are two levels of provision. The first is the emergency blue-light service, which is managed through the Ambulance Service headquarters, while the second service is managed through the control centre at Altnagelvin Hospital. Can you distinguish the difference in those roles? Is there a need for EMTs to be involved in both services, which are obviously providing different levels of service?

Mr Dundas: They are not involved in both services.

Mr Dunne: They are not?

Mr Dundas: No. The first service, which is controlled by our emergency ambulance control at Knockbracken, is the emergency service. The other service is controlled by the non-emergency ambulance control centre at Altnagelvin Hospital.

Mr Dunne: I did not want to use the term "non-emergency" for ambulances.

Mr Dundas: That is exactly what it is. That service deals purely with doctors' urgent calls, discharges and routine outpatients. It is not an emergency service but a patient-care service.

Mr Quigley: Those ambulances are not crewed by EMTs.

Mr Dundas: They are crewed by emergency care attendants.

Mr Dunne: Is that a different grade again?

Mr Long: No, there are ambulance care attendants (ACAs) and emergency care attendants, and the former crew the non-emergency ambulances.

Mr Dundas: Sorry.

Mr Dunne: How would that fit in with the technician role? Is the technician role more suited to that work?

Mr Long: Absolutely not. Ambulance care attendants are trained to a level of care in the back of an ambulance. The highest level of care that they would provide would be to administer oxygen en route to someone who may be short of breath. Other than that, they provide basic care. The role of an emergency medical technician is quite different. An EMT provides autonomous emergency care in the back of an ambulance. There is a big difference.

Mr Dunne: They are not generally used in —

Mr Long: They are never used. There is no crossover.

Ms Speed: The ambulance has been described by the chief executive as the A&E in the ambulance until it gets to the hospital. That is how it would be seen.

Mr Dunne: To clarify, you are talking about emergency cases —

The Chairperson: Blue lighters.

Mr Dunne: Your concern is that the EMTs are going to be downgraded?

Mr Dundas: That is certainly my concern.

Mr Dunne: You made the point earlier that you went out with a colleague recently, as that was the only cover that you had recently.

Mr Dundas: It happened four times in a row.

Mr Dunne: Does that happen regularly?

Mr Dundas: Well, I can speak only for myself. The past four 12-hour shifts that I have done have all been with EMTs. I am aware of other people having done it as well. I have not trawled throughout the Northern Ireland Ambulance Service, but it is certainly a regular occurrence.

Mr Dunne: Do you deem that a risk?

Mr Dundas: No.

Mr McCarthy: Whether you or we like it or not, the 'Transforming Your Care' document is the document that the Department is going by. There are some parts that we like and some parts that we do not like.

The Chairperson: OK. Everyone knows everyone else's views on Transforming Your Care. We are dealing specifically with this issue, and I thought that it was important to get the ambulance personnel in today to look at it. We are also going to talk to the Ambulance Service Trust and will tease out some of these answers.

We are not getting into the rights and wrongs of TYC. If there are other issues there, we can come back to them. It is important to ask questions of the Ambulance Service Trust based on what you have told us.

Ms Speed: There are areas —

The Chairperson: I just want to finish this point, Anne. As a Committee, are we going to link up with the Department and the Minister to see what the thinking is behind what the Minister is or is not going to sign off on? Those are the hard questions that we need to ask of the people who are making the next presentation.

Ms Speed: I am sorry for interrupting you, Chairperson. There are areas of development on which we have open minds. We have engaged in a lot of initiatives. In a presentation last night, the chief executive officer outlined a number of initiatives that we have embraced. However, this one is a step too far, and we have very serious concerns. It is not often that you would find the front line service coming in before the Health Committee to talk passionately and advocate clearly that something is a very bad idea. That is why we wanted to come to tell you that.

The Chairperson: You are more than welcome. I have said it time and time again that we could end up spending our days looking at paperwork, and it is good to get presentations from those on the front line. I hope that I do not see you in a professional capacity, whether as EMTs or in rapid response. I just do not want to see you.

Mr Dundas: I hope that you do not see a paramedic assistant. *[Laughter.]*

The Chairperson: It would be just my luck.

Ms Speed: Chair, I want to ask my colleague Brian Ferguson, who is the lead negotiator with the team, which I sometimes join, and has dealt with the Ambulance Service for a number of years, whether he wants to add anything.

Mr Brian Ferguson (UNISON): As you have outlined, you have professionals who have given evidence on the potential loss of life if the Northern Ireland Ambulance Service were to go down this route.

The Chairperson: You are more than welcome to stay. The sun is out, but you can sit and listen to the presentation that we are going to receive from the Ambulance Trust, and we will be asking some of those questions. Once again, thank you very much.

Ms Speed: We may return. We just have to consult with one another.