Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

# OFFICIAL REPORT (Hansard)

## Ambulance Service — Proposed Pay Band Changes: Northern Ireland Ambulance Service Trust Briefing

26 June 2013

# NORTHERN IRELAND ASSEMBLY

# Committee for Health, Social Services and Public Safety

## Ambulance Service — Proposed Pay Band Changes: Northern Ireland Ambulance Service Trust Briefing

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

**Witnesses:**

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|---|---|
| Ms Sharon McCue | Northern Ireland Ambulance Service Trust |
| Mr Liam McIvor | Northern Ireland Ambulance Service Trust |
| Dr David McManus | Northern Ireland Ambulance Service Trust |
| Mr Brian McNeill | Northern Ireland Ambulance Service Trust |
| Ms Roisin O'Hara | Northern Ireland Ambulance Service Trust |

**The Chairperson:** Thank you for your briefing paper. Who will be taking the lead in the presentation?

**Mr Liam McIvor (Northern Ireland Ambulance Service Trust):** I will do a quick introduction before handing over to Brian McNeill, the director of operations.

I appreciate the opportunity to come to speak to the Committee on our savings plan. To set it in context, we are one of six trusts, of which we are the smallest, with a budget of roughly £60 million. Through the first comprehensive spending review programme for 2008-2011, we were required to save 9%. In the current round, for 2011-14, the requirement is that we save £3 million, which is roughly 5%. We have come up with a range of proposals for doing that, which we have shared through our trust delivery plan. I am happy to give you some of the information around the savings that you have identified for paramedic assistants.

**Mr Brian McNeill (Northern Ireland Ambulance Service Trust):** Sorry, I am just trying to get the presentation up and running.

**The Chairperson:** Do you need the Wi-Fi code?

**Mr McNeill:** I do not think so, Chair. Just bear with me one second.

**The Chairperson:** You can do the introductions, Liam, instead of putting Brian on the spot.

**Mr McIvor:** We have Sharon McCue, director of finance; Roisin O'Hara, director of human resources and corporate services; Dr David McManus, the medical director; and Brian McNeill, director of operations. Some of us have been here before.

**Mr McNeill:** I will try to keep this very brief. Thank you for presenting us with the opportunity to introduce our proposals for developing and bringing the paramedic assistant role into the Ambulance Service.

What are we aiming to achieve? As an organisation, we want to continue with our concept of developing a paramedic-led front line service for Northern Ireland. We respond to our emergency and urgent calls using paramedics and rapid-response vehicles and a combination of paramedics, emergency medical technicians (EMTs) and a paramedic in training on our front line double-crew A&E vehicles.

The new proposal would see us developing double-crew vehicles with a paramedic, with that paramedic supported by an EMT, a paramedic in training or the new paramedic assistant. The concept is about developing a confident, competent skill mix to deliver safe, high-quality care and being able to adapt quickly to changing models of service delivery.

We have been working at developing the model for some time. We have been recruiting and training, through our regional training school, paramedics to fill all paramedic vacancies commensurate with funding. We have been developing and recruiting paramedics to our rapid-response front line service, and we have achieved that objective. We have also introduced a clinical support framework through the development of clinical support officers in the field, who work with front line staff and ensure that the quality and safety agendas are taken forward. We are now in a position in which we have vacancies at EMT level, and we have to make a decision as to how we fill those vacancies. We feel that the time is now right for us to progress with the introduction of the paramedic assistant role.

We are promoting the model on the basis of some key principles. Paramedic assistants are not a new concept. They are used widely throughout the UK. There are various models and levels of competency. The principles that we are abiding by are that we continue to recognise and promote the professional accountability of paramedics. As you know, with the current Francis report, the clinical risk agenda and the governance agenda being high on everyone's radar, the paramedics are the highest skilled members of staff, and we want to ensure that, when members of the public require an emergency and urgent response, that that grade of staff is responsible for their clinical care throughout that whole experience.

We want to continue to support the professional development of paramedics, as we have done through contributions from our HR and medical teams to the development of guidelines and protocols, regionally and nationally. We want to continue to focus on the outcomes of paramedic intervention, as opposed to just measuring our contribution to the wider healthcare agenda through response times. We feel that it is important that we start to contribute to clinical quality indicators, which will develop and enhance the paramedic role and the support role.

The benefits realisation will enhance clinical safety. The new model will ensure that the paramedic will always meet the clinical needs of the patient, irrespective of the chief complaint or the reason why the patient called the ambulance. We also believe that it is important that that paramedic be supported by a competent assistant or support worker. As I said, at this point in time, that will take the form of an EMT, a paramedic in training or a paramedic assistant.

We will plan, as always, to adhere to our responsibilities and obligations under equality and consultation requirements in our implementation plan. We realise that the proposal will release savings. However, we had plans, and we envisaged reinvesting those savings in the organisation. Given the current economic environment, we, like all the other trusts, are required to make efficiency savings, and we will use the savings that we make through the proposal to offset the efficiencies that are required of us. However, the proposal also creates an opportunity for us to redeploy staff who may be impacted on by other elements of the efficiency savings plans, and it will assist the trust in avoiding any redundancies.

To conclude, we believe that the introduction of paramedic assistants will further enhance the front line model of a paramedic-led service and help to achieve the best possible health and well-being outcomes for patients.

**The Chairperson:** Thank you. As I said at the start, thanks very much for the paper that you provided to the Committee.

We accept that the driver for this proposed change is savings.

**Mr McNeill:** No, it is not all about savings.

**The Chairperson:** It is part of your savings plans.

**Mr McNeill:** It is now part of our savings plans. It was being developed prior to the requirement to make the savings, and savings will be accrued as a consequence of it. Rather than do what we did previously, which was to look to adjustment of cover on front line services, we now have an opportunity to offer those savings up to offset the efficiencies while maintaining the existing levels of cover.

**The Chairperson:** Let me get this clear in my head, Brian. You are saying that the plans were in place anyway but that they are now part of the savings plan to help meet the efficiency savings that the Department is telling you to make.

**Mr McNeill:** That is correct.

**The Chairperson:** Therefore, technically, those will not be efficiency savings, because you were going to do it anyway.

**Mr McNeill:** We were going to proceed with the introduction of paramedic assistants in any case, prior to the current round of efficiency savings requests. That is correct.

**The Chairperson:** Where did the idea come from?

**Mr McNeill:** As I am sure you are aware, the concept of an assistant supporting a professional has been in the health service for quite some time through nursing, midwifery and allied health professions. We are aware that, quite a number of years ago, services in the UK introduced the concept of emergency care assistants as a means of addressing recruitment and workforce plan problems and achieving performance targets. We learned a lot of lessons by reviewing and studying that, although we are not following the same model as was introduced there.

**The Chairperson:** You are not following the same model as England? The unions have told us that some of the trusts in England are now pulling back.

**Mr McNeill:** As far as I am aware, most trusts in the UK have an emergency care assistant/concept care worker in place. We are introducing a paramedic assistant. In doing so, we have reviewed the skill set and scope of practice that is required to support the paramedic. We have assessed the risks of introducing the paramedic assistant. We believe that the model, the training programme and the competencies that we require of them will mean the provision of a safe service. It is not like any generic UK model.

**The Chairperson:** Liam, what is the Department's view of the proposal? I assume that it has told all the trusts that there is a need for a percentage of savings to be made through efficiencies. You came up with that as part of your plans anyway, lifted it from those plans and said that it is part of your efficiency savings. Has the Department said that, as you were doing that anyway, you can find more money through efficiency savings? Are you aware of the Minister's view of the proposal?

**Mr McIvor:** The trust delivery plan has been shared with the healthcare board. I have just recently received approval from the board to proceed with engaging it.

**The Chairperson:** The board has given approval for you to do this?

**Mr McIvor:** The board has approved the trust delivery plan. The board has applied some caveats to it. It wants us to assure it that we follow appropriate legal advice and the normal processes for HR, and so on. We are happy to do that. I am happy — indeed, I am keen — to engage with our trade union side representatives. I have not had any direct contact from the Department or the Minister about this.

**The Chairperson:** The board has given you agreement to —

**Mr McIvor:** The board has come back and approved the trust delivery plan, which incorporated this. The key differential in our proposal is that, unlike other services in the UK that have manned their rapid-response vehicles by non-paramedics — staff who are not qualified to the level of paramedic — we have always, since the introduction of rapid response in Northern Ireland, which is probably going back around10 years, maintained that they will be manned by a paramedic. We feel that the person from the Ambulance Service with the highest clinical skill set should deliver that immediate care. Likewise, we have maintained that the paramedic will be the lead practitioner on the emergency ambulance. There are concerns that some services in England have manned their emergency ambulances with non-paramedic staff. I have reiterated to the board, through the proposals, that that is not what we intend or wish to do. We, as a service, have held to that principle throughout.

**The Chairperson:** OK. I will come back with a few questions afterwards, but other Committee members have indicated that they want to come in.

**Mr McDevitt:** I apologise that I have to leave soon. Is there always a paramedic on an ambulance today in Northern Ireland?

**Mr McIvor:** We always plan to have a paramedic on an ambulance. If there is short-notice absence or we are unable to cover that shift with a paramedic, we will cover it with paramedic in training. If we do that, we identify it as a non-paramedic ambulance, and it is directed towards lower-priority, lower-acuity urgent calls. Through recruiting and training a significant number of paramedics in the past number of years, we have now achieved the paramedic cover that we need. I cannot offer a guarantee that there will always be a paramedic on an ambulance, because that plan sometimes falls apart at very late notice.

**Mr McDevitt:** Are the new paramedic assistants autonomous operatives?

**Mr McNeill:** No, the paramedic is the lead clinician. The paramedic assistant is, as the name suggests, an assistant worker. Take a call cycle: the paramedic assistant will be the person who conveys the paramedic to the scene; the paramedic will then assume responsibility for the assessment, treatment and management of the patient at the scene and in transport to an appropriate facility; and the paramedic assistant will assist in the manual handling and moving of the patient, with the equipment and all those other aspects of the job.

**Mr McDevitt:** They are called EMTs, right?

**Mr McNeill:** That is correct.

**Mr McDevitt:** In the current grading, EMTs are, more often than not, autonomous?

**Mr McNeill:** Not to the same extent as a paramedic.

**Mr McDevitt:** They are autonomous.

**Mr McNeill:** No, the paramedic is the person who is always responsible for the patient in the event of there being a two-person crew.

**Mr McDevitt:** We have just heard evidence from an EMT who told us that, in the past four shifts that he has worked in the south Down area, he has been crewed with another EMT. Therefore, by definition, they are autonomous because there was no paramedic.

**Mr McNeill:** As the chief executive explained, we endeavour and plan to have a paramedic in every vehicle.

**Mr McDevitt:** I understand that, but it is a factual question. Is an EMT autonomous? Yes or no?

**Mr McNeill:** EMTs are autonomous if they are responding to lower-grade emergency calls.

**Mr McDevitt:** That is OK, but an EMT —

**The Chairperson:** It does not matter what they are responding to. To clarify, we were told stuff in a previous session, and we are trying to get answers. Nobody is criticising the fact that it might happen because of staffing issues. This is about getting to the facts.

**Mr McDevitt:** An EMT is autonomous, but a paramedic assistant will not be autonomous.

**Mr McNeill:** A paramedic assistant will work within the scope of practice under the direction of the paramedic.

**Mr McDevitt:** I am really sorry — I do not mean to be funny — but it is a yes or no answer.

**Mr McNeill:** No. This is a very important point for me to get across to you as well. By virtue of the fact that an EMT, if crewed with another EMT, will have to deal with, engage with, move and treat low-category, low-acuity patients, he or she could be deemed to be autonomous. However, where an EMT is working with a paramedic, the paramedic assumes overall responsibility and accountability for the clinical management of the patient.

**Mr McDevitt:** We would all hope that there is always a paramedic on an emergency ambulance in Northern Ireland. However, as Liam pointed out, and as I think you have conceded, Brian, there is not always a paramedic on an emergency ambulance. That is just a fact. It is sometimes not possible for whatever reason, and that is life. Therefore, we know, as a matter of fact, that, in Northern Ireland, ambulances are dispatched with EMTs onboard who act autonomously. My simple question is this: when you have paramedic assistants, what will happen in the scenario of a paramedic not being available? Would you intend to dispatch an ambulance with two paramedic assistants on board? Would they act as autonomously as an EMT would today?

**Mr McNeill:** Our proposals are broadly encompassing; this is a high-level description of what we plan to do. We will be putting in place systems whereby we would ensure that, if a paramedic assistant and EMT or two paramedic assistants were working together, they would not be responding to category-A life-threatening calls. They would be responding to urgent calls and calls that would not require autonomous practitioners or intervention using advanced skills. That is how we would mitigate that scenario.

**Mr McDevitt:** A reasonable person could only conclude from that answer that the level of cover will go down.

**Mr McNeill:** I do not follow how you reach that conclusion, given that our plan is to ensure that we still have a paramedic in every front line vehicle and every rapid response vehicle.

**Mr McDevitt:** But you do not. You do not have a paramedic in every vehicle. There are situations, every day, where, for one reason or another, a paramedic is not available.

**Mr McNeill:** In those situations, we do not send the vehicle without the paramedic to high-acuity calls.

**Mr McDevitt:** But you are proposing to deskill and still resource the vehicle with two people: potentially two people of lower skill than the level of skill available to you today.

**Mr McNeill:** No. We are planning to develop a model that has three tiers. One tier is emergency response to life-threatening calls and calls that require paramedic interventions. The second is response to urgent unscheduled care. The third is routine care. Emergency response will be targeted at rapid response vehicles and A&E vehicles with a paramedic and an assistant. The urgent and unscheduled care will be targeted at EMTs or intermediate care vehicles, which is another grade of staff that we have. Routine care is currently done by our patient care service staff. We will develop

that model and put in place systems and checks to mitigate what you have described as a deskilling. Any patient with a life-threatening call can still expect a paramedic response. That is our objective.

**The Chairperson:** Is that over 15 years?

**Mr McNeill:** Over 15 years?

**The Chairperson:** Is this to save the £1·6 million?

**Ms Roisin O'Hara (Northern Ireland Ambulance Service Trust):** If it includes working through to the point when the technician workforce would move to the new band-3 role, that would be a 15-year period, because our arrangements protect staff on their current salary for a 15-year period, depending on years of service, age, etc. That is their contractual entitlement. So, looking at the proposal and when we would get to a situation when there may or may not be a technician working in the workplace, yes, that could be 15 years.

**The Chairperson:** So is the proposal in the future to get rid of the EMT forever?

**Mr McIvor:** Yes. It is to move from a paramedic and EMT, to a paramedic and paramedic assistant workforce. If it is done through natural wastage, it would take about 15 years.

**The Chairperson:** Before I bring Kieran in, roughly when did the board agree to this?

**Mr McIvor:** I got the letter towards the tail end of last week.

**The Chairperson:** And you are unsure of what the Minister's view is?

**Mr McIvor:** I have had no direct contact from the Department.

**Mr McCarthy:** I want to follow on from what has been said. I think, Liam, in your response to the Chair on the experience across the water, you said that you were confident that this could be done without fatalities. We heard earlier that there was a case in London, I think, last month, where trainee paramedics were sent. The patient, unfortunately, died, and the coroner said that, had there been a proper response from the ambulance service, that may not have happened. You are taking a gamble. You are trying to save money. Everybody wants to save money, but not at the price of a patient's life, surely.

**Mr McIvor:** I understand what you are saying, Kieran. The key distinction that I am making is that we are maintaining a paramedic-led service. We are maintaining a service in which all the rapid response vehicles have paramedics and where we put a paramedic into an emergency ambulance. On the very few occasions when we do not have a paramedic, we direct those ambulances that are not paramedic manned to the lower-acuity calls. The other backstop — this is where we differ from some of the other services — is that, if a crew attends a patient whose condition has changed, and they request rapid response or paramedic assistance, they get that paramedic response. The case you cited is, I presume, the one where two technicians or trainees were sent out. In our circumstances, they would not be sent to a life-threatening call.

**Mr McCarthy:** You are talking about a crew being sent —

**The Chairperson:** Sometimes, you do not know whether it is life-threatening until you get there.

**Mr McIvor:** You are quite right.

**The Chairperson:** I asked this same question of the unions: have you any evidence to give us, or can you point us in the direction of any evidence, to show that replacing the EMTs with paramedic assistants would not endanger patient safety?

**Mr McIvor:** The lead professional would be the paramedic. The incidents being cited are when there was no paramedic on an ambulance and they were being sent to an emergency call. We sift all the calls coming in through our clinical triage. About 40% of calls are potentially immediately life-threatening. That is probably an overestimate, because we will always err on the side of caution.

Therefore, 60% of the workload is going to be not immediately life-threatening cases. That is the difference. That is the room we have, and we push the non-paramedic workforce towards that. Indeed, within that 60%, there is further classification into calls that are not life-threatening but urgent, and calls that are neither life-threatening nor urgent — that could be someone who has had chronic back pain that has got worse, or other incidents that David could tell you about. You will have heard on 'The Nolan Show' about incidents of what are termed time-wasting calls that do not require an emergency ambulance. Therefore, there is scope to direct that workload. I emphasise that the vast majority of my ambulances are manned by paramedics and will continue to be manned by paramedics. That is where the safety of the service lies. That is the highest-level clinical professional I have.

**Mr McCarthy:** You are talking about a crew. We heard from some of the chaps about what happens in serious road accidents where there are multiple injuries and probably deaths, but only one person is in a rapid response vehicle. How on earth is that individual going to cope with such a disaster in front of him? One person, to deal with maybe six, seven or eight —

**Mr McNeill:** When that call comes in, the control team would identify it as a road traffic collision. We know from experience that there is usually more than one patient involved in a road traffic collision. Therefore, not only do we send a rapid response vehicle, which may be the closest vehicle, but we follow that up by sending additional A&E vehicles to support them and transport the patients.

**Mr McCarthy:** Will that always be the case?

**Mr McNeill:** That has always been our policy and will continue to be so.

**The Chairperson:** This is part of the overall savings plan of the Ambulance Trust.

**Mr McNeill:** Do you mean what I have just described?

**The Chairperson:** No; this proposal.

**Mr McIvor:** It is part of our savings plan.

**The Chairperson:** So, whatever the rights and wrongs of it, it is all about cost-effectiveness. It is all about saving money.

**Mr McIvor:** No; it is not about saving money. It is about —

**The Chairperson:** With all due respect, Liam said that it was part of the savings plan and you said it was part of the efficiency savings. Would this proposal be on the table if it was not about saving money?

**Mr McIvor:** There is a saving. We are required to make a saving. However, I want to make a saving without reducing the number of ambulances that I have on the road.

**The Chairperson:** I appreciate that.

**Mr McIvor:** I would much rather have been able to take the saving that arises from this and turn it into extra ambulances. I say that in response to the question you asked a while back. We are not exempt, unfortunately, from the savings. I pointed out in my annual report two years ago that the level of investment in the Northern Ireland Ambulance Service is the second lowest in the UK. It is equivalent to 10p per person per day. I want to make it very clear that, if there are more savings coming out, they are coming out of a very small pot.

I came up with a proposal that maintains the numbers of ambulances on the road; that allows me to make the required savings; but, really importantly, allows us to maintain a paramedic-led service. I feel that the safety of the patient is protected by keeping that paramedic-led service.

**The Chairperson:** That is fair enough. I would not argue against that, Liam, but we need to be clear that this is part of a savings strategy.

**Mr McIvor:** It is. If there were not savings to be made, this would have been an opportunity for us to invest.

**The Chairperson:** And double the amount the ambulances.

**Mr McIvor:** Not quite double, but I would certainly like to improve and increase them.

**The Chairperson:** Do not always assume, Brian, that we are your enemy. We are well aware of the pressures that some trusts are under. We ask questions to get to the bottom of that.

**Mr McNeill:** I appreciate that.

**The Chairperson:** It is part of the savings plan and efficiency drive, and the fact that the board signed off on it last week.

**Mr Beggs:** You said that the vast majority of ambulances were crewed by a paramedic. What percentage is not?

**Mr McIvor:** Over 90% of ambulances are crewed by a paramedic.

**Mr McNeill:** I can give you an example of what happens —

**Mr Beggs:** I do not want an example. Could you give me a percentage of the number of ambulances that do not have a paramedic?

**Mr McNeill:** We endeavour to cover 100% of the hours that we are funded for. We are achieving around 98%.

**Mr Beggs:** That is a high percentage. Thank you.

**Mr Dunne:** Thanks for coming, folks. Are we getting more paramedics as a result of this exercise?

**Mr McIvor:** No. There is no change.

**Mr Dunne:** No increase?

**Mr McIvor:** No increase. We will, in parallel, ask what number of paramedics we need, because I want to move as far as I can from any reliance on overtime. If that means that I need to or have an opportunity to recruit more paramedics, it will not be as a direct result of this, but I would not exclude that in the future.

**Mr Dunne:** You have been recruiting.

**Mr McIvor:** We have indeed.

**Mr Dunne:** So you are increasing the number that you have?

**Mr McIvor:** I just need to clarify that. We have been recruiting and increasing the number up to the establishment because, when there were acute service changes in the likes of Magherafelt and Downpatrick, going back as far as even Omagh, and additional emergency ambulances were brought on, we then had to get into a recruitment programme for paramedics. It takes two years between a paramedic being recruited and going out trained. We were not given two years' notice of Omagh, Downpatrick or those other changes, so we had a period when we were still catching up but we have now caught up with that.

**Mr McNeill:** The paramedic-in-training programme is important to us. We bring people in to go through the two-year training programme. We may not have a job for them at the end because of vacancies being filled and lack of funding. However, they are available in the labour market should we need to use them as bank staff or, in the event of an acute service change coming on line quickly, we can recruit very quickly, knowing that those people are available. In years gone by, we had to start

from scratch and wait two years for them to come out the other end. That is a positive consequence of our strategy.

**Mr Dunne:** How do you propose to manage the EMT grades within the organisation: those who will be surplus to requirements?

**Ms O'Hara:** In the first stage, we propose to fill the vacancies. We have several vacancies, and that would be the first step in bringing in the new grade of staff. We would then have to get into consultation with our trade unions in relation to people's choices within that, and we would go into an organisational change mode. We have experience of that through our comprehensive spending review three-year change, when 83 staff jobs went, and we managed to do that without redundancies. We did that through redeployment, other investments, shaping up the paramedic role, and people going through the training school. We have good experience and a good relationship with the trade unions in working through those issues in the past. We would sit down with the individuals. Some technicians may want to have the opportunity to retrain as a paramedic, and we would be keen to do facilitate that.

**Mr Dunne:** How long would that take?

**Ms O'Hara:** That depends on the accreditation of their prior learning and whether we can fast-track them into, perhaps, a one-year programme whereby the Health and Care Professions Council (HCPC) would register them as paramedics, having gone through that bit of the programme. We would have to engage on how long that would take, but the worst-case scenario would be the two-year training programme. We could offer that option to some of our technicians who wished to avail themselves of that opportunity. We would then be in a situation where we would be deciding how to move that forward. If we were moving it forward in the next financial year, for example, we would be talking about the protection arrangements. That is where some of our technicians come in, although some may retire during that time as well, naturally. Those who stay will come under the protection arrangements. That is where the 15 years comes in, because some of them will continue to be paid.

**Mr Dunne:** They would not lose pay, effectively.

**Ms O'Hara:** I think that most of them will have at least five years' protection. It depends on how many years' service they have, and their age. Quite a few of them would have between 10 and 15 years' protection.

**The Chairperson:** That is assuming that the Minister signs off on the proposal.

**Ms O'Hara:** Yes.

**The Chairperson:** Prior to the proposal going to the board, was there any discussion, negotiation or even meetings with unions?

**Ms O'Hara:** The unions have requested to meet us. We have met them —

**The Chairperson:** Did you meet them prior to the proposal going to the board?

**Ms O'Hara:** No.

**The Chairperson:** OK. That is fair enough.

**Mr Brady:** Thanks for your presentation. I must preface any questions or remarks by saying that the Ambulance Service does a very good and difficult job. I think that we all appreciate that.

I have a couple of questions. Is it the case that the paramedic assistants — the emergency care assistants (ECAs) — will have no formal qualifications but would be able to work in a front line ambulance after minimum training with no requirement for additional on-the-job experience as they will have no skills or ability to assess and treat patients?

**Mr McNeill:** Can you repeat that? I did not catch all of that.

**Mr Brady:** Is it the case that ECAs will have no formal qualifications but would be able to work in a front line ambulance after minimum training and would have no requirement for additional on-the-job experience as they will have no skills or ability to assess and treat patients? It goes back to the question that Conall asked about their ability to be autonomous.

**Mr McNeill:** Again, on that concept of autonomy, like EMTs, paramedic assistants will work within their scope of practice and follow protocols on which they are trained and assessed. That is how the system will operate. We anticipate that paramedic assistants will either come from, as Roisin described, EMTs who have decided that they want to migrate to that role, from our patient care service — people who will have been in the organisation working on the non-emergency tier — or we may get to a point at which we have to recruit directly from the public. They will go through a training programme, which will give them all of the skills that are required to fulfil the role. On the point about them having no experience in managing or dealing with patients, that will be addressed through the training programme. However, ultimately, the need for those skills sits firmly with the paramedic because he or she has responsibility and is accountable for the management, treatment and assessment of the patient.

**Mr Brady:** I understand that. However, will ECAs have the same role in dealing with patients as EMTs?

**Mr McNeill:** We will not be using ECAs; we will be using paramedic assistants. They will not have the same role as EMTs in the existing model.

**Mr Brady:** In the evidence base in the briefing that you have given us, it is proposed that current and future EMT vacancies and positions that are currently filled by EMTs will be filled by paramedic assistants. Presumably, in future they will be ECAs, as opposed to what you currently have. They will not have the same skill levels.

**Mr McNeill:** That is correct.

**Mr Brady:** You spoke about people migrating from one grade to another. Why would someone want to do that and get paid less for doing the same job?

**Mr McNeill:** They will be protected, and they may —

**Mr Brady:** Well, that is the issue. Eventually, you will run out, presumably.

**Mr McNeill:** Eventually, we will phase them out. That is true. I suppose that, perhaps, the answer to your question would be better explained by explaining how we got to the situation in which we have such a narrow gap between EMTs and paramedics. That is because, as paramedic training and education has evolved, the base pool of staff to progress to become paramedics were EMTs. We developed that skill set. We also continued to freeze recruitment of EMTs while we invested in developing that skill set. Ultimately, we want to reach a position where all patient contact and all time spent with patients will be done by paramedics, which is not always the case at this point. It is the case only if it is a routine call. However, with regard to life-threatening and urgent calls, the responsibility and the accountability will be with the paramedics; therefore, there is no need to have the assistant trained up to the level of an EMT or paramedic.

**Mr Brady:** You also said that the Ambulance Service:

> *"has invested significant resources over recent years to ensure, as far as reasonably possible, that responding emergency ambulance vehicles are staffed by paramedics."*

Presumably, situations will arise where there will be no paramedics. If you eventually have ECAs as opposed to better qualified people, what would happen? It is such a fundamental service. If someone goes out to an emergency, it does not matter how good your acute services are, because, if you do not make it from point A to point B and are not treated by people who are really well qualified, it will not matter. Ultimately, we are talking about people's lives. I am not being disrespectful, but there seems to be a lot of spin around the changes. From my experience over many years of dealing with the trusts and all the rest of it, it is always about saving money. I understand what you are saying, but some of it, if not all of it, can be aspirational.

**Mr McNeill:** That is probably the reason why we have been waiting until this point to introduce the paramedic assistant, because we needed to fill all of our paramedic positions, we needed to build up a relief tier to cover leave and sickness, and we needed to bring in an educational establishment that would give us another buffer in the event of short-term notice of absence. As I said, our plans are to endeavour to ensure that every front line vehicle will have a paramedic and that every rapid response vehicle will have a paramedic. We have other contingency plans in place, which I do not need to go into now.

**The Chairperson:** Liam, you want to come in, but I want to ask you a straight question. If I happened to be the lucky person who won €93 million yesterday — I am not — and if money were no object, would you, as chief executive, be introducing paramedic assistants?

**Mr McIvor:** I would, and I will tell you why: the difference means that I could introduce more ambulances. If I had a fixed budget — say I got an extra £10 million — would I spend it on ambulances that had an assistant and a paramedic? Absolutely, because I would probably get 22 ambulances instead of 20 or 18, and, to me, that is the key difference. Those extra four ambulances with a paramedic on them —

**The Chairperson:** I will give you that, because I asked the unions earlier whether that meant that we could double the number of ambulances on the road and they said no. You would be happy introducing paramedic assistants if it doubled the number of ambulances.

**Mr McIvor:** As long as the ambulance still had a paramedic.

**The Chairperson:** That is fair enough.

**Mr Beggs:** As I read this, the programme will, ultimately, save £1·6 million a year. If you did not do this, would you have to put out fewer ambulances?

**Mr McIvor:** Potentially, that would be one of the consequences, because 80% of my budget goes on staff and 90% of my staff are at the front line.

**Mr Beggs:** I have been looking at information provided to us about how the East of England Ambulance Service has responded. In its April 2013 turnaround plan, it is seeking to fill the following posts: band-6 specialist paramedics; band-5 paramedics; band-4 technicians; and band-3 emergency care assistants. Specifically, it is planning to relaunch band 4 for emergency operations, the technicians, and to keep that role as "a career pathway" in the trust. If you do away with that band in the Northern Ireland Ambulance Service, what would be the career path for a new paramedic?

**Ms O'Hara:** I can take that one. The training that we provide in Northern Ireland is different to the training that is done in some by some of our English counterparts, including the Ambulance Service that you specify. In our two-year HCPC-approved paramedic training programme, you can come into it with no prior experience. It is not reliant on having completed the technician programme. Brian alluded earlier to the fact that, five or six years ago, we recruited our paramedics solely from our technician workforce. They came through and did additional training, but now we have a two-year paramedic training programme that stands alone. Therefore, people have a career pathway through that, and technicians have availed themselves of that and have come in and trained as paramedics through that two-year programme.

**Mr Beggs:** One of the issues in the report on the east of England was that the plan is to try to tackle staff morale issues and to introduce a clear career progression route. If there is a progression route in any organisation, it improves morale. I assume that almost half your staff who are out on the front line are being downgraded. That will drastically affect morale. What consideration did you give to the adverse staff morale that will result and to the removal of the natural progression that currently exists?

**Mr McIvor:** The initial phase of this, and the one that is in the plan, is the £495,000 savings in the first instance to fill the vacancies. Therefore, personnel will not be downgraded in the first instance. We need to engage with the trade unions and our staff, and move it forward to address the very points that you are making, but it has to be on the basis of what we see for the future and the career pathway.

We have introduced career pathways. We introduced band 6 clinical-support officers, who are paramedics who are at the next level. We have introduced a clinical pathway for people who can

come through the service. We also have a career pathway whereby staff in our patient care service who are ambulance care attendants can apply and become paramedics, and, indeed, many of them have done so and are really enjoying the role and are very successful in it. There is a career pathway through the Ambulance Service.

I appreciate what the East of England Ambulance Service is doing; that is one way of doing it. It is a service that is responding to particular pressures over there. That is something that we have to continue to work through, but we are being prudent in the sense that, in the first instance, in this element of the plan, we are saying that the only savings that we have identified so far are aligned to filling current vacancies. That gives us time to pause and draw breath.

**The Chairperson:** OK. Thank you. That was quite useful, on the back of the presentation that we had earlier. We will decide on our next steps, but I want to take the opportunity to thank you for providing us with the information and for your presentation. On behalf of the Committee, I just want to say that Mickey is right — Kieran mentioned it earlier — that this in no way reflects any Committee view on ambulance personnel. We believe that you do fantastic work and have done so over the years. Front line services have our full support. We just want to make sure that we get it right. Thank you again.