

IMPLEMENTATION OF THE STRATEGIC

REVIEW OF THE AMBULANCE SERVICE

EQUALITY IMPACT ASSESSMENT

Department of Health, Social Services and Public Safety
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Executive Summary

1. The Health Social Services and Public Safety Family (HSSPS) Family of Organisations, which consists of the Department of Health, Social Services and Public Safety (DHSSPS) together with the Health and Social Services (HSS) Boards and Trusts, including the Northern Ireland Ambulance Service (NIAS) Trust, and associated special Agencies, are committed to fulfilling their responsibilities to promote equality of opportunity under Section 75 of the Northern Ireland Act 1998. They are also committed to implementing the Government's New Targeting Social Need (TSN) policy and promoting good relations between different groups in the exercise of their functions.
2. This Equality Impact Assessment (EIA) of the proposals contained in the paper "Implementation of the Strategic Review of the Ambulance Service" – the Implementation Plan - has been conducted and agreed jointly by the Department and NIAS. This EIA is based on an initial analysis of the Implementation Plan and takes into account the views expressed during a period of consultation.

Consultation

3. The initial draft Assessment, along with the Implementation Plan were sent to 110 individuals and groups in November 2001. The targeted individuals and groups covered a wide range of interests including those members of the public who had replied to the earlier consultation on the report on the Strategic Review of the Ambulance Service – "Mapping the Road to Change". A consultation pro-forma was included with the consultation documents to facilitate responses. The Department and

NIAS also held a number of public meetings on the proposals and meetings with specific interest groups. All together 68 people and organisations responded and some 90 people overall attended meetings with Departmental officials.

Initial EIA

4. The initial EIA addressed the main areas in which it was considered likely that the possibility of equality implications could arise. These were the Medical Priority Dispatch System (MPDS), response times, ambulance control centres and Patient Care Services (PCS). It considered that:
 - the introduction of MPDS would realise positive benefits overall but that there could be potential problems for non-English speaking persons of different racial groups who could experience communication difficulties;
 - the response time targets would not result in any adverse impacts as such or give rise to any significant differential impacts;
 - there were potentially differential equality impacts arising from the centralisation of ambulance control (females, people with dependents) and changes to the protocols for accessing the PCS service (older people, disabled people).
5. At an overall level the EIA concluded that there was no evidence that the Department's proposals would adversely impact on any of the Section 75 equality groups. It did however: (i) identify the potential for some

differential impacts; and (ii) identify mitigating actions which could be taken to reduce the possibility of differential impacts.

6. The majority of respondents agreed with the overall conclusion of the initial EIA and welcomed the Department's commitment to take mitigating action on proposals which have the potential for adverse impact on Section 75 equality groups. The consultation did however support the initial conclusions in terms of potential impacts on specific equality groups and also identified a potential impact that the introduction of MPDS could have on persons with physical or sensory impairment or learning disabilities and elderly or very young people.

Conclusion

7. Full consideration has been given to the responses received and the issues raised during the consultative process. The comments expressed during the consultation have been helpful and, as far as possible, have been reflected in the final EIA. The views and comments expressed during the consultation have been summarised and along with the Department's response will be issued along with this report to all those who contributed to the consultation. These documents will also be available on request to other interested parties and a copy will be placed on the Department's website. With regard to the specific actions which will be undertaken as a result of the EIA, these include:

- monitoring and evaluating the Medical Priority Despatch System in one area (Eastern Board) and specifically considering any potential equality implications raised by this prior to roll-out;

- monitoring implementation of all the recommendations including improvements in response times;
- within the overall framework for improving response times, utilising local views prior to deploying additional ambulance locations;
- conducting a full EIA on the development of protocols for PCS;
- specifically addressing equality issues raised by this EIA in the business case for centralising controls.

Monitoring

8. The key to ensuring that all the issues raised by the EIA are addressed will be effective monitoring and this will take place on at least an annual basis through monitoring meetings between the DHSSPS and the Ambulance Service.

1.0 INTRODUCTION

1.1 This Equality Impact Assessment (EIA) addresses the Department's proposals for taking forward the recommendations of the Strategic Review of the Northern Ireland Ambulance Service "*Mapping the Road to Change*" which was published in February 2000. The implementation proposals are set out in the Implementation Plan "*Implementation of the Strategic Review of the Ambulance Service*", which was published in November 2001.

1.2 Section 75 of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

1.3 In addition, without prejudice to the above obligation, public authorities must also, in carrying out their functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

- 1.4 Schedule 9 of the Act requires public authorities to prepare Equality Schemes, which should state, inter alia, the authority's arrangements for assessing the likely impact of policies adopted, or proposed to be adopted, by the authority on the promotion of equality of opportunity. Schedule 9 also requires a public authority, in publishing the results of an assessment, to give details of any consideration given to measures, which might mitigate any adverse impact of that policy on the promotion of equality of opportunity, and alternative policies which might better achieve the promotion of equality of opportunity.
- 1.5 Equality Schemes are in place for the Department of Health, Social Services and Public Safety and all Health and Social Services Boards and Trusts, including the Northern Ireland Ambulance Service (NIAS) Trust.
- 1.6 The proposals contained in the “Implementation of the Strategic Review of the Ambulance Service” have implications for the provision of services across Northern Ireland. Proposals for conducting equality impact assessments on a region-wide basis were submitted by the Department and its associated bodies to the Equality Commission for Northern Ireland in June 2001. This EIA has been conducted and agreed jointly by the Department and NIAS as a region-wide impact assessment in accordance with those proposals. It also reflects the comments and views made during consultation on the Department’s proposals.

2.0 BACKGROUND

2.1 Ambulance Service

2.2 The Northern Ireland Ambulance Service (NIAS) Health and Social Services Trust provides Emergency Ambulance Services, Urgent Ambulance Services and Patient Care Services throughout Northern Ireland.

2.3 The Trust, which employs over 700 staff, has four operational divisions which provide ambulance services to the four Health & Social Services Board geographical areas. Ambulance responses in each divisional area are directed by one of the four ambulance Service Control Centres.

2.4 Performance standards specified in the Patient's Charter and in contracts measure the percentage of ambulances arriving at an incident within specified times from receipt of a 999 or "urgent" call. The targets are:

- 95% of emergency calls to be answered within 18 minutes in the Eastern HSS Board area, and within 21 minutes in the Northern, Southern and Western Board areas
- 50% of emergency calls to be answered within 8 minutes in all areas
- in 95% of calls by health professionals classified as "urgent", ambulance services are required to deliver patients to hospital within 15 minutes of the arrival time specified by the health care professional.

2.5 **Strategic Review**

2.6 In 1998, the Department set up a team to review the provision of ambulance services and identify opportunities for improvement. The report of this strategic review "*Mapping the Road to Change*" was issued for consultation in February 2000 with a deadline for responses of 30 June 2000.

2.7 Overall there was a positive response to the Strategic Review Report and the majority of responses were supportive of the major key recommendations. Concerns were, however, expressed that the recommendations had not been costed in detail. It was also felt that further work was needed to analyse more fully the implications of the proposals.

2.8 In November 2000, the Department and NIAS established an Implementation Steering Group to oversee and guide the work of 7 Project Groups, each tasked with considering the full implications of specific aspects of the Strategic Review and the timeframe within which the recommendations could be implemented. This work has been completed and the Minister has endorsed detailed plans to secure improvements to the availability and quality of ambulance services.

2.9 **Implementation Proposals**

2.10 The Department's Implementation proposals are set out in the Implementation Plan under 2 key themes:

- service enhancement through IMPROVING RESPONSE TIMES; and
- service enhancement through IMPROVING THE QUALITY OF CARE

2.11 Under IMPROVING RESPONSE TIMES, among other things, proposals are made for a programme of phased improvement of performance targets which will require investment in a range of control technology and communications.

2.12 Under IMPROVING QUALITY proposals are made for:-

- enhancing the skills of ambulance staff; and
- establishing a formal system of clinical governance within NIAS.

2.13 Proposals are also made for a number of measures designed to support the provision of effective and efficient ambulance services. These include new arrangements for the 4 HSS Boards to commission services on a partnership basis.

2.14 The Department recognises that the speed of implementation of the proposals will be governed by the availability of funding. The most pressing priorities (improving ambulance control, securing additional vehicles and staff, and improving the clinical skills of staff) have therefore been identified. The Department has also developed three, 6-

year scenarios for implementation of most of the recommendations based on the availability of funding.

2.15 Consultation

2.16 The Implementation Plan was published in November 2001 along with an initial Equality Impact Assessment (EIA) and a consultation pro forma to assist respondents in submitting their views. These documents were sent to 110 individuals and groups in November 2001. The targeted individuals and groups covered a wide range of interests including those members of the public who had replied to the earlier consultation on the report on the Strategic Review of the Ambulance Service. The Department and NIAS also held a number of public meetings on the proposals and meetings with specific interest groups. All together 68 people and organisations responded and some 90 people overall attended meetings with Departmental officials.

2.17 The initial EIA was based on a consideration of the potential differential impacts which would be likely to occur under implementation of the proposals in the Implementation Plan. When potential differential impacts had been identified, these impacts were quantified as far as possible in order to inform the subsequent consultation process.

2.18 The initial analyses, which are outlined in more detail below, identified a broad range of potential impacts which would be expected to effect most people. However, some of the recommendations would be likely to make a particular impact on some of the 9 equality groups. The following table identifies the main recommendation areas along with the groups which would be expected to experience particular impacts.

Recommendation Area	Categories Potentially Differentially Impacted
Improving Response Times	Marital Status, Disability, Religion, Political Opinion.
Medical Priority Dispatch System (MPDS)	Ethnic Groupings (where English is not the first language).
Separation of Accident & Emergency and Patient Care Services	All the equality groups with the exception of gender.
Centralisation of Controls	Gender (Women), People with Dependents.

2.19 In order to gain as many informed opinions as possible on the EIA, the Department, in partnership with NIAS, held a series of public meetings along with a number of targeted meetings in areas with a particular interest in the Implementation Plan (eg. with the Glens of Antrim Concerned Residents Group). The public meetings were advertised in the three main daily newspapers and the local press and a number of organisations, representative of the various equality groups, were specifically invited to attend and/or organise meetings at which the particular concerns of their members could be addressed. In particular,

groups representing disabled people and older people were targeted. A full list of the meetings and groups contacted is given at Annexe 1.

- 2.20 The response to the consultation exercise was initially slow and there was a low level of interest from the voluntary groups approached, both in terms of the suggestion that they might arrange special meetings and to the suggestion that they attend some of the pre-arranged meetings. An approach to the voluntary sector suggested that this apparent lack of interest may be due to a general sense of consultation fatigue and overload leading to organisations “cherry picking” the issues with which they particularly wished to engage.
- 2.21 Nevertheless, some of the public meetings were well attended, particularly those which attracted the interest of local groups who, while primarily interested in the issue of service provision in their areas, consisted in some cases of older people or those with dependents who were able to give their perspective.
- 2.22 As the consultation deadline of 15 February 2002 approached reminders were issued to all those who had not replied and, in response to requests from interested parties for more time, the Department continued to accept responses after that date. A number of meetings were also held after the period of consultation “formally” ended. A list of all those organisations and individuals who responded is at Annexe 2.

3.0 FOCUS OF EQUALITY IMPACT ASSESSMENT (EIA)

3.1 The Department (DHSSPS) and its associated bodies are committed to promoting both equality of opportunity and good relations and, implementing the Government's New Targeting Social Need (TSN) policy. Specific areas of concern within the DHSSPS business area include:

- the inequalities which exist in health, many of which are associated with differences between affluent and deprived communities;
- the difficulties in accessing services faced by people in rural areas; and
- that people in some of the Section 75 equality groups may not, for various reasons, use health and social services to the same extent as people from other population groups with similar levels of morbidity.

3.2 Against this background the overall aims are:

- to promote equality of opportunity of access to health and social services for people in equal need;
- to ensure equity in the allocation of resources, reflecting as far as possible variations in need across the country; and

- through New TSN, to tackle inequalities in health and social well-being, and in the need for, and access to, health and social care.

3.3 In assessing the impact of the Steering Group's proposals on the Section 75 equality groups, the EIA considers the extent to which the proposals support or contribute to these aims. In particular, it focuses on:-

- whether the proposals for improving ambulance response times help to achieve equity of response between people and areas;
- whether the proposals for investment of resources have been addressed objectively with consistency between areas; and
- whether monitoring systems are in place which would, on an on-going basis, identify inequity in the provision of ambulance services and facilitate targeting of service development and investment in line with the Department's equality and New TSN objectives.

3.4 The EIA addresses, in particular, the following areas in which it was considered that the possibility of equality implications arising seemed more likely:

- Medical Priority Dispatch System
- Response times
- Ambulance Control Centres

- Separation of Patient Care Services and A&E Services

4.0 MEDICAL PRIORITY DISPATCH SYSTEM (MPDS)

4.1 Introduction

4.2 In serious emergency calls, the speed of an ambulance response can make the difference between life and death. At present emergency ambulances in Northern Ireland are deployed on the basis of “first come first served”- the speed of response depends not on the condition of the patient but on the volume of calls then being responded to and how far away the nearest ambulance might be.

4.3 Medical Priority Dispatch System (MPDS) is a system of prioritising emergency calls according to the seriousness of the patient's condition and then delivering the appropriate level of ambulance response. Under MPDS, ambulance control staff establish the seriousness of the incident or the patient's condition by asking the caller a series of questions. Calls are then prioritised into the following categories:

- Category A – immediately life threatening calls (concerning victims of illness or trauma who may benefit from life-saving help on scene within minutes).
- Category B- serious calls (concerning patients with conditions benefiting from emergency care that requires a more conventional degree of urgency).
- Category C- not life threatening or serious calls (concerning patients requiring an urgent rather than emergency response, by ambulance or other means).

4.4 The system, which is now in operation in many countries, should enhance ambulance efficiency and speed of response for the most serious cases by sending vehicles to them first. The Ambulance Service may not necessarily send an ambulance immediately to a patient suffering minor or non-threatening injury. In the most trivial cases an option for the Service may be to advise the caller to consult their GP and/or attend a hospital casualty department by their own means.

4.5 **Potential benefits and disadvantages**

4.6 In serious cases, how soon an ambulance responds can make the difference between life and death. It is estimated that an additional 3,200 cardiac arrest victims could be saved each year if all ambulance services in England responded to 90 per cent of the most serious incidents within eight minutes.

4.7 Other potential benefits of priority dispatch arise from increased use of telephone medical advice to callers prior to ambulance arrival, the maintenance of key skills through the more appropriate deployment of paramedics to the most serious incidents, and a decline in emergency vehicle accidents through fewer "lights and siren responses".

4.8 Introducing MPDS may also mean slower responses than at present for cases that are not immediately life-threatening. There is also the possibility that a stressed or confused caller may result in call prioritisation that does not fully reflect the seriousness of the patient's condition.

4.9 However, experience of MPDS in other countries suggests that, provided proper telephone procedures are adhered to, any risks which may be involved in these aspects are far outweighed by the reduction in risk for those patients with high priority conditions for whom response times will be improved.

4.10 **Consideration of available data**

4.11 Research on epidemiology of 999 calls suggest that a typical distribution is as follows

Category A (immediately life threatening)	25%
Category B calls (not immediately life threatening but potentially serious)	60%
Category C calls (not life threatening or serious)	15%

4.12 **Assessment of Impacts**

4.13 Overall the introduction of MPDS and call prioritisation should realise positive benefits for all Section 75 equality groups, in that the system will improve response times to category A life threatening emergency calls. The performance standards for response to category B calls will be as for the current Patient Charter standard which requires the Ambulance Service to respond to 95% of all emergency calls within 18 minutes in the Eastern Board area and 21 minutes in other Board areas. The provision of online advice to callers will be of benefit to all the equality groups and,

for example in the event of cardiac arrest and airway obstruction, could actually help save lives.

4.14 The initial equality analysis did however identify a potential adverse impact for non-English speaking callers and responses to the consultation did flag up a potential adverse impact for elderly people, very young people or people with learning disabilities or sensory impairment. The Department accepts that these groups may have difficulty understanding and using the system and that this has the potential for an adverse impact. Conclusions in terms of each of the equality categories are set out below.

4.15 **Between men and women generally:**

No adverse impact.

4.16 **Persons of different age:**

MPDS prioritises any incident involving children as a category A and thus merits an emergency response. This will have a positive impact on this age group. It has however the potential to impact adversely on older people or very young people who may have difficulty understanding and using the system.

4.17 **Persons with or without a disability:**

The prioritisation of calls will provide opportunities for arranging more appropriate transport for category C callers within this equality group. There is however the potential for an adverse impact on people with learning disabilities or sensory impairment.

4.18 Persons of different marital status:

No adverse impact.

4.19 Persons of different religious beliefs:

There is no evidence of adverse impacts from global experience. Under MPDS, protocols can be devised to highlight sensitivities in relation to the medical response for some religious beliefs.

4.20 Persons with/without dependants.

No adverse impact.

4.21 Persons of different political opinion.

No adverse impact.

4.22 Persons of different racial group

Potential adverse impact for non-English speaking callers, particularly with dispatchers providing on line advice.

4.23 Persons of different sexual orientation

No adverse impact

4.24 Mitigating Factors and Response to EIA

4.25 Under the current arrangements, it is essential that a caller is able to communicate their problem and location to ambulance dispatchers. This means that under the existing system there is already a potentially adverse impact against those who experience communication difficulties. There is no doubt, however, that the more involved communication required under MPDS could be more difficult for those who already find it difficult to communicate under less stressful circumstances.

4.26 Nevertheless, the potential benefits of MPDS are such that it is considered a prerequisite to improving response times in line with the Implementation Plan. Improved deployment of ambulances potentially benefits all groups and will be likely to mitigate against the potential adverse impacts. (Although this is difficult to quantify exactly).

4.27 On occasions where communication difficulties impact on the priority allocated to a call, the aim of NIAS will be to ensure that all risks are taken into consideration and the patient protected at all times. To this end protocols will be developed and introduced under which, where there is doubt, the call will be placed in the higher response category.

4.28 NIAS will also publicise how the new system works to ensure that the public know how best to access and use it appropriately.

4.29 Monitoring and Evaluation

4.30 NIAS will pilot and evaluate the system in one area before it is introduced across all Board areas and will continue to monitor its

application, including the collection of information which will help assess the impact of MPD on the Section 75 equality groups.

5.0 **RESPONSE TIMES**

5.1 **Introduction**

5.2 An ambulance service must respond rapidly to people who need emergency medical help. Traffic congestion, distance to travel, and road conditions can all affect how long an ambulance needs to respond to each call. So it is not realistic to expect absolute equity of access across the whole of the region. However, an aim of the Strategic Review and the Implementation Proposals is to minimise inequities, and it is reasonable to expect that where inequities in response times are identified targeted measures are taken to meet needs and improve response times, within a realistic expenditure framework.

5.3 **Consideration of available Data**

5.4 Current response time performance locally does not provide equity of access to ambulance services for all citizens. When measured at NIAS Ambulance Service Division level, the percentage of emergency calls that can be met within the 8 minute response standard with the current resources and arrangements is above 50% for East and West Divisions only. The North and South Divisions are only able to reach 46% of all calls within 8 minutes. Within those figures, there is considerable variability of performance across the constituent Local Government Districts (LGD). Table 1 shows current performance by LGD.

Table 1: Performance by Local Government District

LGD	Current
Antrim	48%
Ards	47%
Armagh	45%
Ballymena	47%
Ballymoney	44%
Banbridge	18%
Belfast	72%
Carrickfergus	14%
Castlereagh	60%
Coleraine	43%
Cookstown	44%
Craigavon	56%
Derry	70%
Down	33%
Dungannon	47%
Fermanagh	39%
Larne	48%
Limavady	30%
Lisburn	62%
Magherafelt	35%
Moyle	33%
Newry	52%
Newtownabbey	67%
North Down	30%
Omagh	41%
Strabane	67%

5.5 The Steering Group proposes the phased programme of target response times shown below:

**Phase 1 - 50% all calls within
8 minutes by Board**

**Phase 2 - 75% all category A
Calls within 8 minutes by Board**

**Phase 3 - 90% all category A
Calls within 8 minutes by Board**

**Phase 4 - 75% all category A
Calls within 8 minutes by LGD**

**Phase 5 - 90% all category A
Calls within 8 minutes by LGD**

5.6 Achieving these targets will involve the introduction of a number of new communication and control systems and new initiatives such as Rapid Responders and First Responders. It will also require investment in additional ambulance locations, ambulances and crews. The following approximate areas are proposed for the new ambulance locations: Clough/Seaforde, Saintfield, Bangor, Portaferry, Killyleagh, Swatragh, Carnlough, Carrickfergus, Ballygawley, Belcoo and Feeny.

Phase 1 – Assessment of Impact on Equality Groups

5.7 Although the response time targets for Phase 1 are set at Board level, it is recognized that there will still be a large degree of variability within these areas in terms of response times to individual communities. It is important to investigate, therefore, whether any of the equality groups living within these areas will be differentially affected by the proposals. It was decided that electoral ward would be an appropriate geographical level at which to conduct the analysis. Full details and the results of all analyses undertaken are available from the Department. Details of data sources are provided in Annex 3.

Analysis

5.8 Wards/LGDs were grouped according to their percentage increase in the proportion of calls responded to within 8 minutes before and after implementation of Phase 1 (including those wards that experienced no improvement). The numbers in each equality group were then aggregated for each separate grouping of ward/LGD and calculated as a proportion of the total group to which they belonged. The proportions of each equality group experiencing different levels of response time improvement could then be compared. This was done separately for each of the 7 groups for which data were available while a more qualitative comparison was undertaken for racial group (see Annex 3).

5.9 In addition to this analysis, wards/LGDs were then separated into two categories, those which met the Board response target (i.e., 50% or more of calls being responded to within 8 minutes) at the end of Phase 1 and those which did not meet this target. The equality group profiles were

then examined for each of the two categories of wards. This analysis allowed conclusions to be drawn in relation to whether any differential improvement in response times could be justified on the grounds of having achieved a more equitable outcome.

Summary Results:

Equality Group	Phase 1
Gender	N
Age	N
Marital Status	P
Disability	P
Religious Belief	N
Dependants	N
Political Opinion	P
Racial Background	N

N = No differential Impact

P = Potential Impact

- 5.10 The only groups which appear to be differentially impacted upon from Phase 1, where the impact is not redressing an imbalance in access, are marital status, disability and political opinion. The impact is favourable in respect of those with a disability, whilst the results of the political opinion analysis, whilst showing a differential impact for ‘Others’ (i.e., non-Unionists and non-Nationalists) should be viewed with caution due to the relatively small size of this group. In addition, the differential impact in favour of those persons who are ‘unmarried’ is not overly large.

Phase 2 – Assessment of Impact on Equality Groups

5.11 As with Phase 1, the implementation of Phase 2 response targets will have differential impacts at sub-Board level. Again, electoral ward was chosen as the unit of analysis where possible.

Analysis

5.12 From the predicted response time data, it was possible to identify those wards where 75% or more of calls would be met within the 8 minute target and those where the proportion would be less than 75%. The equality group profile of each of the 2 categories of wards was then examined to determine if there would be a differential impact on any of the groups arising from the implementation of Phase 2.

Summary Results:

Equality Group	Phase 2
Gender	N
Age	N
Marital Status	P
Disability	P
Religious Belief	P
Dependants	N
Political Opinion	P
Racial Background	N

N = No differential Impact

P = Potential Impact

5.13 Unlike with Phase 1, although it is possible to examine the outcome of Phase 2 by equality group, in the absence of baseline data no firm conclusion can be drawn whether implementation would have a differential impact. However, analysis of potential outcomes does provide an indication of which equality groups would not receive the same level of advantage at the end of Phase 2 and where measures may therefore need to be taken in order to lessen any differential impacts (it is possible that any such impacts may be redressed in the later phases of the implementation plan). The groups which the analyses show may be experiencing differential impact are the ‘unmarried’, ‘able bodied’, ‘non-catholic’ religious groupings and those of a ‘non-Nationalist’ political opinion.

Consultation Responses

5.14. A number of respondents to the consultation exercise considered that the phased programme of response targets had the potential to disadvantage religious and political categories because of the distribution of these groups across the population. The initial equality impact assessment of the impact during phases 1 and 2 of implementation supports the view that there would be differential impacts but suggests that such impacts are unlikely to be significant.

5.15. The proposed locations for additional A&E vehicles and crews were also considered to have the potential for a differential impact by “political opinion” for some specific groups.

Mitigation and Response to EIA

- 5.16 It is important to understand that, by definition, improving response times results in positive and not adverse impacts since actions under this heading improve existing responses and do not impact against any area or group. This does not mean, however, that there are no differential impacts since improving response times to achieve improvements overall means targeting resources to achieve the best overall result. This means that response times would improve to a greater extent in some areas (although obviously these areas would have demonstrated poorer response times in the first place).
- 5.17 Accordingly, some groupings could understandably ask why response times in their areas were not improving as much as in areas populated by other groupings. While this is a reasonable question, it can be argued that the need to bring response times up to uniform standards across all areas, as far as possible, outweighs the advantage in targeting specific equality groupings to ensure that one group is not disproportionately advantaged over another. The latter approach would, in fact, prolong differences which already exist between groups and areas.
- 5.18 In addition, the proposal to move from local commissioning to commissioning by the four HSS Boards acting in partnership should promote consistency in approach, priorities and standards in the delivery of ambulance services across the region. All groups should experience improvement as the full five phases of the programme are rolled forward.
- 5.19 While not a specific Section 75 grouping, those in rural areas experience particular difficulties in terms of response times and this is something

which additional A&E locations can only relieve to a certain extent given the isolation and poor road networks in some rural areas. However, proposals for investment in new initiatives such as Rapid Responders and First Responders should do much to minimise the impact of these inequities. In relation to the additional locations these will in each case be determined taking into account local community knowledge and practical considerations as and when the opportunity arises to provide these locations.

Monitoring

5.15 In implementing Phases 3-5 of the response time targets some refinements to the Implementation Plans will be necessary to ensure that the equality groups in respect of whom some differential impacts were identified after Phase 1 and 2, are not differentially impacted in the later Phases. As the Phases are implemented, NIAS will continue to monitor response times and these will be used, to provide analyses in terms of the Section 75 categories as above.

6.0 AMBULANCE CONTROL CENTRES

6.1 Introduction

6.2 Ambulance Control Centres play an important role in ensuring an appropriate ambulance response to an emergency incident. The NIAS Trust has 4 Area ambulance control and communication centres located at:

- Belfast, (Eastern Division) (28 staff)
- Antrim (Northern Division) (14 staff)
- Craigavon (Southern Division) (12 staff)
- Derry (Western Division) (12 staff)

6.3 The Strategic Review considered whether improvements in effectiveness and economies in provision could be achieved by consolidating operations into a smaller number of centres. The Review concluded that a single control centre would allow a number of gains to be made, including more efficient and uniform call handling and reduced technical and revenue costs. Fewer staff would be required to maintain the current level of service, although new developments such as MPDS will generate additional staffing requirements.

6.4 A subsequent appraisal study undertaken by Mason Communications Ltd (Consultants) identified significant shortcomings in the current arrangements. The appraisal study concluded that there were benefits to be gained from a reconfiguration of the NIAS command, control, communications and IT infrastructure – in particular the migration of the

control functions into a single, A&E/PCS Control Centre and also from combining the headquarters with a single Centre.

6.5 A Business case for the proposal submitted by NIAS has evaluated a number of options. Their preferred option, which was arrived at without taking the New TSN policy into account, was a combined Headquarter and Central Control Centre at the Knockbracken Healthcare Park in South East Belfast, with the use of the existing Western Control Centre at Altnagelvin, Derry, providing a 'back-up' facility for A&E control, as well as acting as the main control centre for Patient Care Services (see paras 6.22 and 6.23 below).

6.6 This impact assessment reviews the equality implications of merging the Control Centres. In addition, it considers the proposals in regard to the New TSN policy, to which the Executive Committee is committed. Should a decision be taken to centralise Control Centres, New TSN will be a key consideration in the location of any new/merged Control Centre(s).

6.7 **Consideration of available data/information**

This impact assessment, for illustrative purposes, specifically considers the potential impact of centralising the A&E Control with a second back-up Control. This does not mean, however, that other configurations would not be considered on the basis of responses from the consultation exercise.

6.8 It is estimated that a new Central Control Centre would require 60 staff. The exact numbers and grades of staff required will be determined

following a pilot evaluation of the Medical Priority Dispatch system. A breakdown by grade is noted below:

New Central A&E Control

Grades	Staff
Control Manager	1
Personal Assistant	1
Accreditation/Trainers	2
Supervisor	4
AO 2 Officers	14
CA 1 call takers + MPDS	27
CA 2 assistants	11
Total Staff	60

6.9 A 'back-up' Control Centre would require 19 staff. A breakdown by grade is noted below.

Patient Care Service Control Centre

Grade	Staff
Control Manager	1
Personal Assistant	1
Planning Officers	2
Radio Operators	2
Relief Officer	1
CA 1 assistant	12
Total Staff	19

6.10 It is expected that an increase in the total number of control room staff would be required to operate the Medical Priority Dispatch System and this would fully compensate for any loss of jobs resulting from creating a Central Control. There would be no expectation of compulsory redundancies. There could be staff who would not wish to transfer to a new centre, and therefore there could be a number of voluntary redundancies and potential applications for early retirement.

6.11 The need for a new Central A&E Control to be staffed by experienced and trained staff is fully recognised. It would be necessary to rely and build upon the expertise of control room staff currently in post. All staff in the existing control centres would be invited to transfer into the new Control Centre. All staff will also be given the opportunity of applying for the posts in a ‘back-up’ Control Centre.

6.12 Posts would be filled on the following basis:

Grade	Post to be filled by:
Control Manager	Open Competition
Personal Assistant	Open Competition
Accreditation/Trainers	Competition restricted to AO1/2 Officers or above
Supervisor	Competition restricted to AO1/2 Officers or above
AO 2 Officers	Competition restricted to AO1/2 Officers or above
Planning Officers (PCS)	Competition restricted to AO1/2 Officers or above

Relief Officer (PCS)	Competition restricted to AO1/2 Officers or above
Radio Operators	Competition restricted to CA1/2 Assistants or above
CA 1 call takers + MPDS	Competition restricted to CA1/2 Assistants or above
CA 2 assistants	Competition restricted to CA1/2 Assistants or above

- 6.13 Regardless of the configuration ultimately decided upon, the rights and terms and conditions of service of existing staff be fully safeguarded. These safeguards are set out in the Whitley Ambulance Staffs Handbook and cover pay, pensions and other terms and conditions of employment. Protection arrangements as set out in the Ambulance Staffs Handbook would apply to any staff unsuccessful at securing a post at the level of their existing grade. Travelling expenses for excess miles travelled incurred as a result of transfer will be payable. Allowances for increased travel times would not be payable. Removal expenses would not be payable to those who move home to be closer to their new place of work.
- 6.14 Every effort would be made to offer alternative employment within NIAS or the wider HPSS to those not wishing to transfer. Any necessary redeployment will be carried out in accordance with the principles for redeployment set out in the Ambulance Staffs Handbook and the Whitley General Council handbook, and will follow full consultation with NIAS recognised Trade Unions.
- 6.15 The Strategic Review also identified that a single Control Room would have higher overall workloads and therefore may require shift patterns to

be revised. This view is further supported by consideration of factors affecting the efficient operation of the existing four Control Centres. These factors include the pressure on staff associated with 12 hour shifts, levels of sickness, compliance with the EU Working Time Directive and practical considerations such as cover for meal breaks. An 8 hour shift pattern is also more cost effective for the Service. Consequently, NIAS intend to revise shift patterns and introduce an 8 hour shift pattern within the new Central A&E Control.

6.16 A profile of the staff in the existing four Control Centres is outlined below.

Existing Control Centre Staff by grade:

Grade	Staff
Control Manager	4
Personal Assistant	-
Accreditation/Trainers	-
Supervisor	-
AO 1/2 Officers	22
CA 1/2 assistants	39
Total Staff	71

6.17 Impact Assessment

6.18 The analysis of the staff profile shows that nearly 56% of control room staff are male and 44% female, nearly 62% are Protestant and 32% Roman Catholic, none are disabled and none are from a minority ethnic community. No details are held on the political opinion or sexual

orientation of staff. However, there is no reason to believe that any of these would show significant differences from the workforce and the population at large. A survey to establish the marital status of staff and those with dependants is under way.

6.19 Because the locations of the Central A&E control and ‘back-up’ facility have not yet been decided, it is not possible at this stage to assess fully the implications for staff. However, the proposals could have the following implications:

- i. work/life balance difficulties may arise from increased travelling times between staff’s homes and the new Centres;
- ii. staff may experience transport difficulties where public transport is inconvenient, for example for shift workers, and they do not have access to a car; and
- iii. some of those who wish to move their home closer to their place of work may have constraints associated with their domestic or personal circumstances.

6.20 Given their personal circumstances, females and staff with dependants could be more likely to be affected by the possible implications identified at (i) to (iii) above. In this event, these difficulties may be reflected in a disproportionate number of existing female staff not being in a position to accept posts in the new Central A&E Control. It would rest with NIAS to seek to ensure that any imbalances in the staffing of the Centre are addressed. However, at this stage and at an overall level, this assessment

reveals no evidence of significant differential impact on staff within any of the nine Section 75 categories.

6.21 In determining the location of a new Central Control, it would be important to give careful consideration to the (New TSN) policy which, among other things, aims to increase employment opportunities in areas of greatest social need. It is also noted that the Report of the Acute Hospital Services Review recommends that consideration should be given to locating support services such as the ambulance control outside Belfast.

6.22 The original Business Case for a new Centre proposed by NIAS identified various options and the selection of their preferred option (location at Knockbracken in South East Belfast) was based upon an assessment of a number of factors, including the relative costs and benefits of the options and affordability. As regards consistency with the new TSN policy, the preferred location for the new Centre selected in that business case was clearly not in an area of high deprivation and the New TSN policy was not explicitly considered in the Business Case options. Accordingly the Department asked NIAS to review the Business Case and, in particular, to consider other locations taking into account the New TSN policy and the responses received to the consultation on the Department's proposals for taking forward the Strategic Review. (At the time of writing, NIAS are in the process of revising the Business Case).

Consultation Responses

6.23 Respondents agreed with the initial assessment that centralisation of ambulance control could impact adversely on staff in general and female

staff and those with dependents, in particular. They also suggested that a decision to locate in the Eastern Ambulance Division had the potential to disadvantage staff in other Health and Social Services Board areas.

Respondents suggested several different locations for locating the Control Centres but there was little by way of detailed evidence for one location above another.

6.24 Mitigation

6.25 In summary, regardless of the configuration of Control Centres ultimately decided upon and their location consideration would need to be given to the following measures which would mitigate any adverse impact:

- i. The payment of transfer related expenses (Para 6.13);
- ii. All staff to be offered jobs in new Control Centres (Para 6.11);
- iii. Terms and conditions of staff to be safeguarded (Para 6.13);
- iv. NIAS to ensure that any imbalances in staffing which may arise will be addressed (Para 6.20);

6.26 Conclusion

6.27 NIAS is reviewing the Business Case for these proposals and will, in particular, consider other locations for the Central A&E Control taking into account the New TSN Policy and responses received to the Consultation Paper. As part of the evaluation of the options for locations,

NIAS will identify and assess the equality implications for staff transferring to new places of work.

7.0 SEPARATION OF PATIENT CARE SERVICES FROM A&E SERVICES

7.1 Introduction

7.2 As well as providing A&E ambulance services, NIAS provides a non-emergency ambulance service called Patient Care Services (PCS). PCS are planned activities such as inter-hospital transfers, bringing patients to hospital and returning them to home after clinics or in-patient discharge. Journeys include the transfer of some high dependency patients as well as more routine patient transfers.

7.3 A practice has developed over time whereby A&E vehicles undertake some Patient Care Service work. The arrangements can result in difficulties for both tiers of the system. Emergency and urgent work takes priority, resulting at times in PCS users experiencing unacceptable delays. Conversely, the capacity to respond to A&E incidents may be compromised by A&E vehicles being deployed on PCS work.

7.4 The Strategic Review recommended a total separation of A&E and PCS services. Having considered the experience of separation of the two functions in Great Britain, the Department has concluded that maximum gains can be had from an arrangement whereby PCS remains within NIAS control, but day-to-day operational management should be separate.

7.5 There will be investment in PCS so that regular or routine use of A&E vehicles for PCS work is not needed. It is also proposed that protocols should be reviewed and enforced in relation to what types of patients can

access PCS. It is recommended that the new system should ensure that only patients who are unable due to clinical condition to travel by alternative means, are booked into PCS.

7.6 **Consideration of available data/information**

7.7 Changes to effect the separation of the day-to-day operational management of A&E and PCS are unlikely to affect patients directly provided additional PCS resources are invested to offset the removal of A&E capacity. Any proposals for changes in staffing, when worked out, will be the subject of consultation with staff and their trade unions.

7.8 New protocols on the types of patients who can access PCS will have implications for patients and staff.

7.9 Nearly 90% of patients being transported to hospital by ambulance are outpatients and just over 70% are of walking mobility. In the event of response protocols being introduced it is likely that it is these types of activity which will experience the largest reductions in service.

7.10 In the absence of available data on the characteristics of PCS users it was necessary to investigate which wards had above average levels of activity and whether any equality groups were disproportionately represented in these areas. This assumes that the patients being transported generally have the same characteristics as the ward in which they live.

7.11 Data (again at ward level) was obtained on PCS activity which management consultants had previously used in their modelling work for the NIAS Strategic Review. This data provided a 7 month snapshot of

PCS activity from 1 June to 31 December 2001, and could be broken down by patient mobility (i.e. whether the patient needed a wheelchair, a stretcher or could walk) and the reason for the transport (i.e. outpatient appointment, hospital admittance, discharge or transfer).

7.12 Analysis

7.13 For each individual ward, the percentage of patients that were ‘walking cases’ and the percentage of journeys that were outpatient journeys were calculated. The wards were then separately split into the following categories:

- Those with an above and below average proportion of ‘walking cases’; and
- Those with an above and below average proportion of outpatient attendances.

7.14 The equality group profiles of each sub-group of wards were then compared in order to establish if any of the equality groups were disproportionately represented in those wards where journeys could potentially be reduced.

7.15 Summary Results:

Equality Group	Phase 2
Gender	N
Age	P
Marital Status	P
Disability	P
Religious Belief	P

Dependants	P
Political Opinion	P
Racial Background	P

N = No differential Impact

P = Potential Impact

7.16 The purpose of these analyses was not to seek to draw conclusions regarding adverse impacts, as this is impossible in the absence of clearly defined protocols. Rather, the analyses highlight the need to ensure that protocols are clearly based on clinical need. Any untargeted reductions in services in respect of walking cases or outpatient journeys (which form the majority of all journeys) could lead to adverse impacts across all equality groups with the exception of gender.

7.17 The four Board Commissioning Group intends to develop and publish for consultation a strategy for providing PCS. This will include details of the protocols to be adopted for accessing PCS. At this stage, it will be possible to assess fully the equality implications for the Section 75 groups of a more defined set of proposals. The Department and NIAS have therefore agreed that this assessment should be included in the programme of 'regional' equality impact assessments to be carried by Health Social Services and Public Safety bodies in the period.

7.18 In preparation for this it is proposed to initiate action to collect the following information which is not currently held:

- Profile of PCS users by Section 75 categories
- Profile of patients who use the service on grounds of medical need

Consultation Responses

- 7.19 There was considerable concern that restrictions in access to PCS could disadvantage elderly people, single parents, disabled people and those on lower incomes, particularly those living in rural areas.
- 7.20 There was however also an acknowledgment that with careful implementation there was no reason why the proposed changes would disadvantage any group.
- 7.21 The Department will ensure that the revised protocols for accessing PCS will be subjected to a full equality impact assessment, monitored and evaluated. The key criterion of success will be to ensure that those groups most in need of the Service receive an acceptable level of service based on their need.

8. CONCLUSION

- 8.1 Because of geography and road networks, access to ambulance services on an equal basis for everyone is probably unobtainable within realistic resource constraints. The Strategic Review of the Ambulance Service and the working of the implementation proposals aim, however, to minimise inequities which are known and acknowledged to exist by the Department and NIAS.
- 8.2 These factors are reflected in this Equality Impact Assessment which, at an overall level, foresees no significant adverse impact on any of the Section 75 equality groups of the proposals themselves. The EIA does, however, identify the potential for some equality implications to arise depending on how the detailed actions to implement the proposals are further developed and put into effect. The Assessment flags up these aspects and, based on the initial analyses undertaken and the subsequent consultations, identifies mitigating actions which either will be taken, or should be taken, as circumstances arise.
- 8.3 It will be necessary for equality aspects to be kept under review over the five phases of the programme for improving ambulance services. The EIA notes where monitoring to assess the implications of changes is necessary. In one area (Patient Care Services) it recommends that a full equality impact assessment should be carried out of the strategy and protocols which are to be developed. The Department will monitor the equality implications of its proposals through the mechanisms for monitoring implementation of its proposals.

8.4 A key aim of this document is to set out the genuine views and concerns which were raised and give a meaningful response to those views and concerns. The views and comments expressed during the consultation exercise on the Implementation Plan and the initial EIA have been summarised and will be issued to all those who contributed to the consultation along with the Department's response.

Annexe 1

CONSULTATION ON THE IMPLEMENTATION OF THE STRATEGIC REVIEW OF THE AMBULANCE SERVICE

MEETINGS

Glens of Antrim Concerned Residents Group
Moyle District Council
Newry & Mourne District Council
Northern Health & Social Services Council
Omagh District Council

PUBLIC MEETINGS

Banbridge
Carrickfergus
Downpatrick
Limavady
Newtownards
Omagh

SPECIFIC GROUPS INVITED TO ATTEND

Mr R Cooke	South Tyrone Hospital
Mr J Keys	Member of the public
Action Mental Health	Belfast HQ
Age Concern NI	Belfast
Disability Action	Belfast
Help the Aged	Belfast HQ
Alexander Road Community Association	Limavady
Alzheimer's Disease Society	Belfast HQ
Arthritis Care	Limavady
Arthritis Care	Omagh
Chest, Heart & Stroke Assoc	Belfast
Chinese Welfare Association	Belfast
CKS Senior Citizens Club	Omagh
Falls Community Group	Belfast
Gay & Lesbian Youth NI	Belfast
Handicapped Association	Omagh
Indian Community Centre	Belfast
Community Development Initiative	Limavady
Multiple Sclerosis Society	Limavady
NI Anti Poverty Network	Belfast
NI Gay Rights Assoc	Belfast
Omagh Rural Association	Omagh
Roe Valley Disability Action Group	Limavady

Annexe 2

CONSULTATION ON THE IMPLEMENTATION OF THE STRATEGIC REVIEW OF THE AMBULANCE SERVICE

RESPONDENTS

Altnagelvin Hospitals HSS Trust

Ards Borough Council

Armagh City & District HSS Community Forum

Armagh & Dungannon HSS Trust

Ballymena Borough Council

Belfast City Hospital Trust

Lughaidh Bhrighde – Paramedic Supervisor, Cookstown

BMA N.I. – General Practitioners Committee

BMA N.I. – Mr L Roche

Carrickfergus Borough Council

Castlereagh Borough Council

Causeway HSS Trust

Causeway HSS Trust – Consultant General Surgeon

Central Emergency Planning Unit

Central Services Agency

CNAC – Miss Irene Duddy

Dr Reggie Cooke – South Tyrone Hospital

Cookstown District Council

Councillor David Barbour

Craigavon Borough Council

DETI

Donard Commissioning Group

Down / Lisburn Trust – Ward Manager

Dungannon and South Tyrone Borough Council
Eastern HSS Board
Eastern Health & Social Services Council
Equality Commission For Northern Ireland
Glens of Antrim Concerned Residents Group
Greenpark Healthcare Trust
Health & Social Services Board Chief Executives Group
Homefirst Community Trust
John Keys – Member of the Public
Lisburn Borough Council
Dr N Lynch – Drumhaw Health Centre
Mater Hospital Trust
John McBride – Member of the Public
John McCready – Member of the Public
Alan McKinney – GMB, Local NIAS Rep
Vidar Melby – Senior Lecturer in Nursing
Mr Alan Murray – Private Sector Consultant
Newry and Mourne HSS Trust – Director of Nursing
NIAS – Local Ambulance Paramedic Steering Committee
N&W Belfast HSS Trust
Newry and Mourne District Council
NI Human Rights Commission
NI Ombudsman
North Down Primary Care Organisation
Northern Ireland Ambulance Service (NIAS) Trust
Northern Health & Social Services Council
North Western Health Board – Co Donegal
OFMDFM
Omagh District Council

Ordnance Survey NI

PSNI

Roads Service

The Royal Hospitals Trust

Rev Martin Smyth MP

South & East Belfast Primary Care Group

Southern Health & Social Services Council

Kevin Taylor – Rushe, Taylor & Simpson

Ulster Hospitals Trust

UNISON – Northern Ireland

United Hospitals HSS Trust

Unknown Consultee

Western Health and Social Services Board

Western Health & Social Services Council

DATA SOURCES

Annexe 3

Response Time Data

1. The response time data were obtained from a predictive model developed by consultants (MSA/Ferndale) as part of the original Strategic Review Project. This model had previously been validated against 1997/98 NIAS data and, once validated, was then capable of estimating response time data at small area level such as electoral ward. For the purposes of this impact assessment, estimates were made of the number of emergency incidents occurring in each ward at 2002 (ie the base case) and the numbers which would be met and unmet within the Board target of 8 minutes both before and after full implementation of Phase 1.
2. The Phase 2 target was to meet 75% of all Category A calls within 8 minutes at Board level. Category A calls are those where the patient's life is in imminent danger (i.e. heart attack, stroke, etc...) and time is of paramount importance. It was not possible to compare the baseline situation with the position after implementation of Phase 2, as there is currently no MPDS available to provide data on Category A calls. Therefore, the total number of Category A calls received from each ward was estimated in addition to the numbers which would be met and unmet within 8 minutes at the end of Phase 2 (this data was again supplied by MSA/Ferndale).

Equality Group Data

3. Data was also obtained from a variety of sources on the number of each equality group living in each ward or, where ward level data were unavailable, living in each Local Government District (LGD). However, no data were available in respect of sexual orientation and only broadly estimated LGD level data were available in respect of racial group. Sources are shown in the Table overleaf.

Equality Group Data Sources

<i>Equality Group</i>	<i>Source of Data</i>	<i>Analysis Unit</i>
Men and Women Generally	Northern Ireland 1991 Census	Electoral Ward
Persons of different marital status	Northern Ireland 1991 Census Small Area Statistics	Electoral Ward
Persons with different Religious beliefs	Northern Ireland 1991 Census Small Area Statistics	Electoral Ward
Persons with/without Dependants	Northern Ireland 1991 Census Small Area Statistics	Electoral Ward
Persons with/without Long-Term Illness	Northern Ireland 1991 Census Small Area Statistics	Electoral Ward
People of Different Ages	Nobel Dataset 2000 Estimate (Northern Ireland Measure of Deprivation)	Electoral Ward
Persons of Different Political Belief	First Preference votes cast in June 2001 District Council Elections	Local Government District
Persons with/without a Disability	Social Security (GIS) as at March 2000	Electoral Ward
Persons from Different Racial Backgrounds	Estimates provided by the Centre for Racial Equality (Dated –Jan 2001)	Local Government District