National Ambulance Service
National Framework Agreement
Practitioner Deployment

1.0 BACKGROUND

1.1 This National Agreement has been developed in line with and following consultation under the auspices of the Public Service Agreement 2010 - 2014

2.0 RATIONALE FOR THE AGREEMENT

2.1 The National Ambulance Service (NAS) intends to deliver quality and sustainable Pre Hospital Emergency Care Services vis a vie effective deployment of appropriately qualified staff.

2.2 This requires the implementation of robust and deliverable deployment models, including rostering, that are reflective of current staffing and skill mix levels and that are focused on matching the appropriate skill mix to those patients whom may potentially benefit from the requisite knowledge, skills and attitude of each level of practitioner.

2.3 In January 2011, HIQA published Response Times and Quality Standards for Pre Hospital Emergency Care. In order to affect an improvement trajectory in response times performance, the NAS has developed a Performance Improvement Action Plan which has identified the need to accelerate the implementation of segregation of services in conjunction with the full implementation of the PHECC EMS Priority Dispatch (see Appendix I) and Inter Facility Patient Transfer Standards. The NAS views this as a significant enabler to implementing appropriate Practitioner Deployment.

2.4 One of these KPIs requires NAS to record the number of calls where an Advanced Paramedic was advised by AMPDS that actually received an Advanced Paramedic. This is currently averaging between 35-40%. In other words, approximately 2/3 of 999 calls that would likely benefit from the skills of an Advanced Paramedic do not have an Advanced Paramedic dispatched to them.

2.5 In order to achieve the desired improvement trajectory in response times performance benchmarked against the HIQA Response Times and Quality Standards, the NAS must ensure that all personnel registered at the levels of Paramedic and Advanced Paramedic with PHECC are targeted at EMS provision.

2.6 Consequently, the purpose of this National Framework Agreement is to:

A. Set out a roadmap and vision for the future development of the National Ambulance Service that is clear and unambiguous to all Practitioners

B. Provide for the staffing of appropriate deployment models to meet the needs of the public Health Service

C. Provide for effective rostering systems to ensure appropriate staffing of any deployment models

D. Ensure the NAS is in a position to support changes to acute hospital services and the rollout of the HSE's Clinical Care Programmes

E. Ensure effective utilisation of public resources through the appropriate tasking of each skill level to meet patients needs

F. Ensure that each level of Practitioner continues to achieve appropriate clinical practice to facilitate Continuing Professional Competence (CPC).

G. Facilitate the implementation of the NAS Performance Improvement Action Plan

H. Set out an Implementation Plan that provides for a phased transition to a modern deployment methodology that takes account of current and planned clinical and operational developments

3.0 CONTEXT OF THE AGREEMENT

3.1 Paramedics are trained to deal with the full range of pre hospital injury and illness, including supraglottic airway insertion, automated external defibrillator (AED) use, and administration of a specific drug set, as specified by the Pre-Hospital Emergency Care Council (PHECC).

3.2 Advanced Paramedics have an additional skill set that allows the delivery of advanced life support (ALS) interventions for high acuity patients, including intravenous (or intraosseous) cannula insertion, endotracheal tube insertion, delivery of an enhanced medication set, including controlled drugs and intravenous fluid administration for blood loss, amongst others.

3.3 The PHECC EMS Priority Dispatch Standard sets out the criteria to be applied to each and every 999 call in order to determine which level of Practitioner is appropriate to meet the patient's needs.

3.4 The Advanced Medical Priority Dispatch System (AMPDS) is an Emergency Medical Dispatch (EMD) system used around the world by ambulance services to prioritize, based on medical need, all emergency calls.

3.5   AMPDS provides a unified system used to dispatch appropriate aid to medical emergencies thereby operationalising the PHECC EMS Dispatch Standard. It includes systematized caller interrogation and pre-arrival instructions. The caller responses are used as inputs for appropriate response categorisation.

3.6   Calls are categorized into 6 categories (Echo, Delta, Charlie, Bravo, Alpha, Omega), these categories determining the urgency of each call, Echo being the most urgent, Omega the least urgent.

3.7   NAS uses AMPDS in it's Control and Performance function to allow appropriate call prioritization. AMPDS specifies those calls that require either an EMT, Paramedic or Advanced Paramedic. All Echo and Delta calls and a small number of Charlie calls require an Advanced Paramedic.

3.8   The HSE is currently consolidating some acute hospital services into bigger, more central facilities. Acute surgery is no longer present in a number of smaller hospitals, and Emergency Departments in some smaller hospitals have either closed or are no longer 24 hour facilities. Certain categories of patients identified as requiring specialized care are now bypassed by NAS to more appropriate facilities, e.g. major Trauma, Paediatrics, and Obstetrics. As the HSE Clinical Care Programmes are rolled out, other patient categories will also be preferentially transported to larger facilities e.g. Stroke and Acute Coronary Syndromes patients.

3.9   The implication for NAS of this (in terms of Practitioner Deployment) are that NAS are now caring for sicker patients for longer periods of time. The time from 999 call to handover of the patient to the Emergency Department team is now often significantly longer. These patients require improved structure in the delivery of pre hospital emergency care so that those patients whom require advanced interventions receive the care they require.

4.0 KEY PRINCIPLES SUPPORTING THE AGREEMENT

4.1 In compliance with PHECC Standards and in the best interests of the public, it is the intention of the HSE to ensure that as far as practicable, all emergency/urgent services are delivered by PHECC Registered EMTs, Paramedics and Advanced Paramedics in various modes of deployment.

4.2 In compliance with PHECC Standards, the best interests of the public and in line with NAS objectives to professionalize and enhance the delivery of pre hospital emergency care, it will be mandatory for all staff eligible to register as a Paramedic or above and for those staff who are currently registered at the level of Paramedic or above, to secure and maintain PHECC registration at the Paramedic level as a minimum.

4.3 In compliance with PHECC Standards and in the best interests of the public, it is the intention of the HSE to ensure that as far as practicable, all clinical levels are tasked in line with the PHECC EMS Dispatch Standard.

4.4 Any use of the Intermediate Care Service will also be in compliance with and support of the implementation of the PHECC EMS Priority Dispatch Standard.

5.0 ADVANCED PARAMEDIC SELECTION PROCESS

5.1 The key focus of the Advanced Paramedic Selection Process will be to ensure availability of candidates for education as Advanced Paramedics with a view to meeting the deployment needs of the NAS and wider HSE

5.2 The Selection Process (see Appendix II) is the national standard for all such selection events.

5.3 The Terms and Conditions of Attendance (see Appendix III) is the national standard for all nominations to this level of service.

6.0 ACCEPTANCE OF PROFESSIONAL RESPONSIBILITIES BY PROFESSIONALS

6.1 Since the establishment of the Pre Hospital Emergency Care Council in 2000, the operational workforce of the NAS has progressed from a vocationally based system of training to a system of third level supported education.

6.2 Additionally, the process of professional registration has provided a professional framework, embodied in a code of conduct which requires registrants to uphold the principles normally expected of a healthcare profession.

6.3 In order to uphold these professional responsibilities, it is essential that all Practitioners place the patient at the centre of our service.

6.4 A key step in accepting these responsibilities is acknowledging that current registration of all personnel working on any form of emergency response vehicle as a Paramedic or above is mandatory

6.5 Of key importance, practitioners must also commit to:

A. Maximum use of resources to achieve the greatest effect

B. Partnership with NAS Leadership to deliver quality services

C. Supporting the elimination of restrictive work practices

D. Adopting a mindset of flexibility in all things focused on patient care and optimisation of resources

7.0 EDUCATION AND COMPETENCY ASSURANCE

7.1 In order to support a professional workforce and encourage the necessary professionally motivated flexibility that is required, it is essential that the NAS has in place a nationally guided and consistently implemented Education, Development and Competency Assurance Plan.

7.2 The key focus of any such plan must be the:

A. Supporting professional competency at all levels

B. Support of future clinical developments and standards

C. Support the NAS's Workforce Planning requirements

D. Efficient and focussed utilisation of all educational resources

7.3 The Head of Education and Competency Assurance has developed such a plan which has been approved by the NAS Leadership Team.

7.4 It is essential that both the NAS Leadership and staff representatives support the prioritisation of scarce resources to deliver it's objectives in a consistent, time framed and cost efficient way.

8.0 CLINICAL GOVERNANCE STRUCTURES

8.1 The delivery of high quality clinical care requires the provision of clinical governance which seeks to:

A. Provide medical leadership and support

B. Learn from errors and near miss events

C. Measure and evaluate the quality of care delivered

D. Support a culture of clinical supervision

8.2 In this regard, the NAS has established a Medical Directorate led by a full time Medical Director and part time Deputy Medical Director who provides the required leadership to deliver improved clinical effectiveness.

8.3 The Medical Directorate also benefits from the sessional availability of an Area Medical Advisor in each of the three NAS Areas who support the work of the Medical Directorate and support the Area Operations Manager on local clinical issues.

8.4 In addition to strategic and tactical medical direction and support, NAS has in place operational clinical support for all Practitioners provided through 24/7 telephone advice through direct contact with appropriately qualified and experienced medical practitioners

8.5 In this context, it is essential that all professionals including their representatives acknowledge and accept the importance of implementing these measures in support of patient care.

9.0 EFFECTIVE CONTROL AND DISPATCH ARRANGEMENTS

9.1 A well educated and appropriately resourced professional workforce can only deliver effective healthcare to those most in need if appropriate triage and prioritisation systems are in place to connect patients in need with the available skill mix. In line with international best practice and recommendations from the Health, Information and Quality Authority (HIQA), the NAS has implemented the Advanced Medical Priority Dispatch System (AMPDS) to it's Control and Performance function.

9.2 The implementation of AMPDS provides the NAS with the ability to deploy Cardiac First Responders, Emergency First Responders, Emergency Medical Technicians, Paramedics and Advanced Paramedics in line with the PHECC EMS Dispatch Standard. In early 2011, HIQA published Response Times Standards which require the NAS to deploy Advanced Paramedics to both Delta (potentially life threatening) and Echo (life threatening) calls in the first instance. Consequently, Control Supervisors and Staff are now certified as Emergency Medical Dispatchers.

9.3 In order to work towards achieving the challenges associated with HIQA Response Times and Quality Standards, it is essential that the NAS has the capability to dispatch the nearest available resource to every incident. In this regard, the NAS has established a National Control Reconfiguration Project with a view to establishing a primary communications centre in Tallaght and a hot (live) secondary centre in Ballyshannon.

9.4 A key element of the reconfigured Control and Performance function will be to implement alternative care pathways for low acuity calls such as Omega calls, ultimately resulting in a decrease in the volume of inappropriate EMS resource attendances. Such an approach is often referred to and "Hear and Refer" or "Hear and Treat"

9.5 In the future, it is probable that such procedures will be complimented by the development of new Clinical Practice Guidelines that empower a Practitioner to "Treat and Refer" or "Treat and Discharge"

10.0 ROSTERING ARRANGEMENTS THAT MATCH PATIENT DEMAND

10.1 In the context of the models set out at Section 12 below, it is essential that Area Operations Managers are empowered to engage with staff locally so as to establish effective rostering arrangements within predetermined parameters and timeframes that will deliver the model most appropriate to any given area within any existing NAS Area.

10.2 While roster development should occur at the level closest to the staff working that roster as possible, it is essential that any roster strictly adheres to a national framework.

10.3 Key elements of any framework must ensure that:

A. The allocation of any crew or resource to any call to be based on the Ambulance Control system, and in particular, the nearest available resource to be dispatched to an AS1/AS2 call as deemed appropriate by Ambulance Control staff

B. Control Supervisors are the primary decision maker with regard to the efficient and effective deployment and allocation of resources, including vehicles and manpower

C. All skill levels (EMT, Paramedic and Advanced Paramedic) are effectively deployed and that patients receive a high quality service

D. Separate rostering of Advanced Paramedics and Paramedics to ensure Advanced Paramedics are focussed on the calls they have received the additional training for while ensuring that every Paramedic continues to respond to all types of calls

E. Pending the introduction of ICS in a given area, Ambulance crews containing an Advanced Paramedic will not be dispatched to AS3 calls in the first instance but will be kept available to respond to those life threatening calls for which they have received the additional training, i.e. all Delta (AS1), Echo (AS1) and any GP Emergency (AS2) calls

F. In line with international best practice on EMS education, ensuring that each Paramedic has the opportunity to work with, learn from and be mentored by an Advanced Paramedic

G. Fostering a team concept at Station level rather than just at crew level, i.e. every staff member should be capable of providing the highest levels of care, regardless of whom they are working with

H. Two Advanced Paramedics must not be rostered together

11.0 CONTINUOUS QUALITY IMPROVEMENT

11.1 As outlined in Section 8 of this Framework Agreement, the NAS has establishing a Medical Directorate to oversee and lead the evolution of clinical governance and improving clinical effectiveness.

11.2 In conjunction with the Education and Competency Assurance Team and supported by Area Operations Managers, it is essential that the concepts of clinical audit and clinical supervision are embedded and supported by both leadership, staff and their representatives.

11.3 At a minimum, it is essential that Practitioners at all levels and their immediate Supervisors adopt and support a culture of data collation and submission, incident/near miss reporting and learning through reflective practice.

11.4 Additionally, the process of informal PCR review at Station level needs to become the norm whereby Supervisors review completed PCRs with a view to providing constructive informal (and formal if necessary) feedback on excellence and/or room for improvement where appropriate.

11.5 It is the intention of NAS to support these principles by the full implementation of an electronic PCR system will provides automated audit and Practitioner access to and reflection on their own individual practice

11.6 Randomised audit must become the norm if Practitioner practice is to be evaluated and measured with a view to providing an evidence base for supporting or modifying what we currently believe to be best practice.

11.7 In order to support Continuous Professional Competence, it is essential that staff accept personal responsibility for their professional development, e.g. through elearning. This professional commitment enables NAS Leadership to focus available resources on supporting staff in the provision of competency assurance based education and opportunities.

11.8 A key element of Continuous Professional Competence includes clinical supervision. The key role of existing Supervisors is to "operationally and clinically supervise a complement of staff during their shift". In this context, NAS intends to deploy a limited number of existing Supervisors, who are also Advanced Paramedics, primarily in a Rapid Response Vehicle model to act as Clinical Supervisors. These staff will receive appropriate mentorship and eventually tutor training and will become the backbone of the 'on the ground' clinical governance and undergraduate support infrastructure.

11.9 The key roles of a Clinical Supervisor will be:

A. To act as a Responder to appropriate emergency calls

B. To clinically supervise other Practitioners and provide both formal and informal feedback

C. To act as a mentor for Undergraduate and Postgraduate Paramedics and Advanced Paramedics

D. To take the lead at multi casualty incidents

E. To act as a clinical champion of Pre Hospital Emergency Care among other Healthcare Professionals

12.0 MODELS OF DEPLOYMENT

12.1 Deployment models must consider a range of factors including:

A. Spatial and Demand Analysis

B. Practitioner numbers

C. Cost of implementation

D. Local Geography and Demographics

E. Activity levels

F. Efficiency of current rostering arrangements

G. Capacity of available activity to support competency assurance

H. Configuration of acute services

I. Availability of alternative care pathways

J. Status of the HSE's Clinical Care Programmes

K. CPC requirements

12.2 In considering all of these issues, the NAS has prioritised a number models in the following order, however, it is important to note that in most areas, a mixture of models may be appropriate depending on the local HSE change priorities:

This is a draft document and can only be considered as such. This document will be subject to change pending finalization of associated discussions. Some of the data contained within this document, e.g. Station details may be inaccurate and will need to be validated

Priority	Principal Roles
Priority 1 **Advanced Paramedic / Paramedic crew on Emergency Ambulance**	Dispatched to all Echo, Delta, some Charlie and some GP Urgent Calls Ensures Paramedics have the opportunity to work with, learn from and be mentored by an Advanced Paramedic. Every staff member should be capable of providing the highest levels of care, regardless of whom they are working with
Priority 2 **Paramedic / Paramedic crew on Emergency Ambulance**	Dispatched to 999 and GP Urgent calls where Advanced Paramedic not required or in support of Priority 1 resource, e.g. Cardiac Arrest Every staff member should be capable of providing the highest levels of care, regardless of whom they are working with
Priority 3 **Advanced Paramedic / Paramedic* Solo Response**	Dispatched to 999 Calls based on available skill level supported by the dispatch of the nearest available transporting resource Efficient model of deployment where uneven numbers of staffing are in place
Priority 4 **Advanced Paramedic/Paramedic rotating through Hospital Emergency Department**	Secure clinical experience opportunities for Practitioners with a view to maintaining Continuous Clinical Competence Familiarity with key clinical personnel, building relationships and trust Involved in ongoing management of patient in the ED phase Provides key element of Specialist Retrieval Teams where based at Model 4 hospitals
Priority 5** **Advanced Paramedic based in Primary Care Centres**	Secure clinical experience opportunities for Practitioners with a view to maintaining Continuous Clinical Competence Advanced life support delivered speedily to high acuity patients in remote areas Contribution to alternate care pathway options rather than traditional ED attendance
Priority 6** **Advanced Paramedics based in HEMS**	Advanced life support delivered speedily to high acuity patients in remote areas Provides mentorship and training to other emergency services such as Paramedics in the Irish Coastguard

*Subject to have twelve months post qualification experience

**In time, it may also be appropriate to task Paramedics to these models

13.0 OPERATIONAL DEPLOYMENT/TASKING

13.1 Ambulance Control is the primary decision maker with regard to the efficient and effective deployment and allocation of all resources.

13.2 All Deployment decisions will be made by Ambulance Control in compliance with the PHECC EMS Priority Dispatch Standard and in line with Control Procedure – NASCC005 – Practitioner Deployment (see Appendix IV)

13.3 Practitioner colleagues may request support from a higher skill level

13.4 At the commencement of each tour of duty, Practitioners reporting for duty at their designated Station will be tasked to either a single crew or dual crewed vehicle based on the number of staff reporting for duty, skill mix available and the service requirements on the day.

13.5 Resources will then be deployed on a dynamic basis to spatially important standby points in line with a Tactical Deployment Plan

14.0 CLASSIFICATION OF STANDBY POINTS

14.1 No Standby Points should be used unless risk assessed and the star rating has been agreed by local management and staff.

14.2 Standby Points must be located strategically to ensure effective response to patients. Safe sign off of Zero star standby points enables RRVs to be utilised in conjunction with Policy – NASWS011 – Protections of Lone Workers (see Appendix V).

14.3 Standby Points are designated a star rating dependent on the facilities available at that location, i.e.:

0 Stars   A 0 star point has no facilities i.e. roadside location

1.0 hour (60 minutes) Maximum. This can be extended through mutual agreement between the staff member/members and Ambulance Control.

1 Star   A 1 Star point has limited facilities e.g. toilets and basic refreshments and is suitable for unlimited standby.

There is unlimited maximum standby duration at a 1 Star Point

2 Stars   A 2 Star point has full dedicated facilities including communications and rest area. This is suitable for:

- Meal break
- Facilities break
- Vehicle check and restocking
- Has facilities that make it suitable for unlimited standby

Please note it is rare for such facilities to be in a high demand area so it is unlikely that sites such as this are in the Tactical Deployment Plan; therefore time at these points should be at Ambulance Control discretion. Not all 2 Star points have restocking facilities. **There is unlimited maximum standby duration at a 2 Star point.**

3 Stars   **Ambulance Station -** Full dedicated facilities including communications and rest area. This is suitable for a meal break, facilities use, and vehicle check/restocking.

Special   Some points have a variety of facilities and may be used for refreshments points and limited standby; this may be due to co-location in another building e.g. some Fire Stations, Garages, Shopping Centres, Airports, etc. or proximity to the public. The standby time at points such as these will be agreed locally between local management and staff following a risk assessment and rated in line with this procedure.

15.0 TACTICAL DEPLOYMENT PLANNING

15.1 Performance in terms of responsiveness, utilisation and patient outcomes can all be improved by a more dynamic approach to the deployment of available resources relevant to the spatial and temporal patterns of demand. To these ends, Tactical Deployment Planning (TDP) is the process by which recommendations are to be made as to where sufficient resources should be placed in the busiest locations from time to time as demand dictates.

15.2 As demand changes throughout the day, the Plan changes to reflect the priorities in the particular hour. Dispatchers also have the ability to allocate resources to each Standby Point and visualise the current coverage on a map.

15.3 The Dispatcher uses the prioritised lists and visualisation of geographic cover as a guide, along with their professional judgment, to place resources at Standby Points most likely to have a call at any particular time of the day. This means that resources will be closer to the location of the next call, so that a resource can get to the incident quicker and be clear of that incident ready for another in a shorter overall time period.

15.4 100% compliance with the plan is not to be expected. This would mean that all resources are in the right place at the right time, all waiting for the next incident. In practice, as the resources are better allocated to the areas of greatest demand, their utilisation rises and they rarely are waiting for a call. The plan needs to be used by Dispatchers with some visibility of the geography of the operational area to ensure that Point to Point movements are prudently instructed.

15.5 Each Standby Point is listed on the Plan in priority order based on the demand in this hour. If the Dispatcher can cover the highest priority posts, responsiveness is likely to improve because the resources will be close to where the next incident will take place.

15.6 Decisions on deployment are the responsibility of the individual Dispatcher with guidance for optimum deployment provided by the Tactical Deployment Plan.

16.0 FRONT LOADING MODEL

16.1 The immediate priority for NAS is to connect the right patient with the right resource in the shortest possible time. As time moves on and many of the developments referred to in this Framework Agreement are implemented, NAS will need to move Practitioner Deployment towards the Front Loading Model.

16.2 Key enablers of the Front Loading Model include roll out the Intermediate Care Service, development of Alternative Pathways for low acuity calls and the implementation of Treat and Refer Clinical Practice Guidelines

16.3 We currently know that Rapid Response Vehicles and, in some areas community/ co-responder schemes, can often get to the scene faster than traditional ambulances, and can provide assessment and care until back-up arrives.

16.4 "Front-loaded model" is an expression used to describe a reduction in the proportion of traditional ambulances in a fleet and an increase in the proportion of Rapid Response Vehicles

16.5 Rapid Response Vehicles with a Paramedic or Advanced Paramedic on board may obviate the need for a traditional ambulance, particularly as some cars can transport patients to hospital or other care setting.

16.6 Community/ co-responder schemes are best used in areas where an 8 minute first response is more challenging due to the isolation of the area/ low demand levels. Community responder schemes are not a substitute for an ambulance response and dispatch of the two responses should be concurrent.

16.7 Sending a single response rather than two to appropriate Category 1 calls frees up resources for other calls and helps to optimise performance around Delta/Echo response standards. Deployment of RRVs needs to be fast, with use of dynamic deployment to gain maximum benefits in terms of performance.

16.8 A national CAD system will allow the auto-paging of community/ co-responders when a call is received in the area covered by the scheme.

16.9 Appropriate targeting of community/ co-responder schemes is necessary to ensure that they are not sent to calls that are beyond their competence to deal with, i.e. Cardiac First Responders to Echo calls only.

17.0 NEW MODEL OF ROSTERING

17.1 The National Ambulance Service operates a system of rostering known as Minimum Establishment Levels. Effectively, this means that only the minimum amount of staff required to resource service delivery are rostered for duty.

17.2 In this model, most absences are covered to ensure that the minimum level of service is provided frequently resulting in crises which must be managed by Supervisors and/or Managers resulting in a disproportionate amount of effort.

17.3 The Minimum Establishment model of rostering provides a very structured working life for up to 60% to 70% of the workforce, however, the balance of the workforce must rely on the full application of Structured Leave arrangements to enjoy some degree of stability. In the context of short notice absence, this percentage of the workforce invariably endures short notice changes to their working arrangements.

17.4 Additionally, this model provides no surge capacity to cope with peaks in demand.

17.5 The NAS proposes to implement a new model of rostering known as the Minimum Maximum or Over Establishment model of rostering. In this model, all staff are rostered and assigned to a Station.

17.6 The key principles of this model are that:

A. All staff are provided with structured working arrangements

B. Staffing levels fluctuate within a minimum and maximum range as a consequence of all forms of leave

C. Supervisors and Managers are not faced with the ongoing challenge of covering shifts

D. Low levels of leave result in additional manpower which often coincides with peak periods of demand

E. Improved working arrangements will contribute to improved morale for all staff

18.0 PARAMETERS FOR ROSTER DESIGN

18.1 It is imperative that the staff who will work any roster are intimately involved in it's design.

18.2 In order to ensure compliance with legislation responsibilities, it is essential that any roster developed complies with the following parameters:

A. The number of shifts in any given location must be dictated by service demand based on hour of day and day of week, bearing in mind the principles of Over Establishment

B. In the context of longer journey times to hospitals, shifts in the same Station (where more than one shift on duty) or across a number of Stations (where there are a number of single resource locations in a given area) should have overlapping shifts with a minimum of two hours overlap, with all shifts starting at the top of the hour.

C. Where rosters are 12 hour shifts, no rostered period will exceed 4 shifts in any 7 consecutive days. Where rosters are 8 hour shifts, no rostered period will exceed 5 shifts in any 7 consecutive days. Off duty days must be consecutive each week to facilitate appropriate resting.

19.0 REST PERIODS

19.1 Section 11 of the Organisation of Working Time Act 1997, entitles employees to a continuous rest period of 11 hours in each working day. All rosters are constructed in compliance with this entitlement.

19.2 All calls designated as an emergency (e.g. emergency transfer) must be responded to up to and including finishing time. In practice, such incidents would only occur where no alternative crew were available.

19.3 Should such a situation arise, then:

19.3.1 Section 4, Subsection 1 of the Organisation of Working Time Act 1997 outlines that Section 11 shall not apply, as respects a person employed in shift work, each time he or she changes shift and cannot avail himself or herself of the rest period referred to in Section 11.

19.3.2 Section 5 of the Organisation of Working Time Act 1997 outlines that an employer shall not be obliged to comply with Section 11, 12, 13, 16 or 17 where due to exceptional circumstances or an emergency (including an accident or the imminent risk of an accident), the consequences of which could not have been avoided despite the exercise of all due care, or otherwise to the occurrence of unusual and unforeseeable circumstances beyond the employer's control, it would not be practicable for the employer to comply with the section concerned.

19.3.3 Accordingly, the shortening of an 11-hour rest period because of an emergency, does not automatically confer an entitlement to any defined rest period. In such rare occasions, common sense will apply in ensuring the relevant crew are fit for duty.

20.0 IMPLEMENTATION OF THE AGREEMENT

20.1 This Framework Agreement supersedes any agreement which has the potential to impede it's full implementation

20.2 All parties to this agreement share collective responsibility to ensure this agreement is implemented fully throughout the NAS without the need for further local negotiation other than on those elements which are clearly specified.

20.3 The parties agree that there is no scope for local variance from the provisions of this agreement

20.4 The parties agree not to support any individual or collective challenge to this agreement in any forum

20.5 Where there is slippage in the Implementation Timeframes which are beyond the control of the parties, e.g. Government Moratorium on Recruitment, then the parties will re-engage with a view to agreeing a revised timeframe of the relevant phase.

21.0 IMPLEMENTATION TIMEFRAME

21.1 This Framework Agreement will ultimately result in a fundamental change in direction for NAS in terms of service delivery models and the provision of high quality care by healthcare professionals.

21.2 In order to achieve full implementation, a number of key enablers are inter dependent and it is for this reason that the full implementation of this National Framework Agreement can only happen on a phased basis as set out below:

21.3 PHASE 1 (IMMEDIATE)

A. Full support for any measures where NAS is required to support changes at small hospitals, e.g. Roscommon General Hospital

B. Two Advanced Paramedics will not be crewed/work together where there are alternative crewing/working options e.g. change roster positions, split crews, etc. All other staff will co-operate with these measures

C. Ambulance Control will allocate the most appropriate resource to AS1 calls in line with the PHECC EMS Priority Dispatch Standard as operationalised via AMPDS

D. Ambulance Control will allocate the most appropriate resource to AS2 calls based on requests and or interaction with General Practitioners

E. Ambulance Control will allocate the appropriate resource to AS3 calls in line with the PHECC Inter Facility Patient Transfer Standard immediately i.e. Advanced Paramedics will not be dispatched to AS3s unless no other option is available

F. NAS will continue to train Advanced Paramedics with a view to targeting assignment on the HSE's change priorities

21.4 PHASE 2 (SHORT TERM – 8 WEEKS FROM DATE OF AGREEMENT)

A. The process of implementing Sections 6.1 and 6.2 of the National Framework Agreement – Intermediate Care Service will be completed

B. Stations that can be described as "Low AS3 %" Stations (see Appendix VI) will complete the process of redesigning and implementing separate Advanced Paramedic and Paramedic rosters to allow for the rotation of staff /skill mix to ensure exposure to incident and skill retention

C. In the context of Section 12, allocation to Dual Crewed (DCV) or Single Crewed (SCV) will be determined by local needs, staff numbers and resource availability

D. Each of the 3 NAS Areas will establish a Roster /Standby Point Adjudication Group consisting of 2 management and 2 IARC Nominees who will have the final say in any situation where staff and managers cannot agree on a new roster or standby point

21.5 PHASE 3 (MEDIUM TERM – UP TO MAXIMUM 2 YEARS FROM DATE OF AGREEMENT)

A. Each of the 3 NAS Areas will identify 10 Stations within which the Minimum Maximum (Over Establishment Level) Model of Rostering can be implemented. The implementation of this model in those Stations will be completed within a further 8 weeks (16 weeks from date of the Agreement) with a review period of a further 8 weeks (24 weeks from date of the Agreement) during which any issues arising will be addressed. On successful completion of the review, all Stations will transition to this new model of rostering no later than a further 24 weeks

B. As soon as ICS begins to impact positively on Stations that can be described as "Medium or High AS3 %" Stations (see Appendix VII), they will complete the process of redesigning and implementing separate Advanced Paramedic and Paramedic rosters to allow for the rotation of staff /skill mix to ensure exposure to incident and skill retention. This process will be completed within 8 weeks of the impact of ICS.

C. Using the existing Spatial and Demand Analysis data provided by PHECC, staff and management representatives will identify, risk assess and rate Standby Points in each location identified where an Ambulance Station does not currently exist

D. Each of the 3 NAS Areas will establish a Roster /Standby Point Adjudication Group consisting of 2 management and 2 IARC Nominees who will have the final say in any situation where staff and managers cannot agree on a new roster

21.6 PHASE 4 (LONG TERM)

A. When the implementation of ICS is approaching completion, Stations that can be described as "Medium or High AS3 %" Stations (see Appendix VII), will complete the process of redesigning and implementing separate Advanced Paramedic and Paramedic rosters to allow for the rotation of staff /skill mix to ensure exposure to incident and skill retention. This process will be completed within 8 weeks of the impact of ICS in any remaining location.

B. Following implementation of "Hear and Refer" or "Treat and Refer" Guidelines, the NAS will commence the implementation of the Front Loading Model with particular emphasis on those areas where performance against the HIQA Response Times and Quality Standards requires improvement

C. It is difficult to predict the exact impact of these changes in coming years, and for this reason, the parties may need to reflect on and amend some of the provisions set out in this Agreement to ensure that the required outcomes are delivered. Should this be necessary, that review will be initiated in line with Section 23 of this Framework Agreement.

22.0 EFFECTIVE DATE OF AGREEMENT

22.1 Version 1.0 of the National Framework Agreement – Practitioner Deployment, dated 2nd August 2011 is agreed and signed off on behalf the HSE (National Ambulance Service) and IARC representing those Trade Unions who hold negotiation rights for operational grades within the National Ambulance Service

23.0 REVIEW DATE OF THE AGREEMENT

23.1 The operation of this agreement may be reviewed at any time at the request of either party to the agreement.

23.2 The agreement will be reviewed after three years from the date of signing the agreement.

_____   _____
Robert Morton   John McCarrick
Assistant National Director   National Organiser, SIPTU

_____   _____
Date: Date:

_____   _____
XXXXXXXXXX   XXXXXXXXXXXX
Workforce Support Manager   Chairman, IARC SIPTU

_____   _____
Date: Date:

The details of this National Framework Agreement have been reviewed by the HSE Corporate Employee Relations Service to ensure conformity with the provisions of the Public Service Agreement 2010 – 2014. The HSE agrees to honour any commitments contained therein including the relevant provisions in relation to loss of earnings.

_____   _____
XXXXXXXXXX   Date:
Corporate Employee Relations

This is a draft document and can only be considered as such. This document is subject to ongoing change pending finalization of all ongoing discussions. Some of the data contained within this document, e.g. Station details may be inaccurate and will need to be validated

This document will be incorporated into a broader suite of policies for easy access and dissemination to all staff and managers.

APPENDIX I

EMS Priority Dispatch Standard - Version 1 (December 09)
Dispatch standards
Calls received for emergency medical assistance shall be prioritised using ProQA from AMPDS
The dispatch cross referecne (DCR) table six level priority classification as approved by PHECC shall be utilised
The EMS response to each of the six priority levels shall be as outlined in the table below
The principles for dispatchers shall be applied when dispatching resources to an emergency medical incident

Clinical Status	Code	Description	Essential Response	Response to scene	Vehcile type	Recommended Response	Additional extra response	Non EMS resources
1 Life threatening	Echo	Life threatening – Cardiac or respiratory arrest	Ambulance with minimum Paramedic	Lights and siren	CEN B ambulance	a) Advanced Paramedic. b) Responders (minimum CFR) c) Minimum 3 to 4 practitioners or responders on scene	Ambulace Officer according to operational requirements	Fire Service, Garda, Coast Guard, Utility services as required
	Delta	Life threatening other than cardiac or respiratory arrest	Ambulance with minimum Paramedic	Lights and siren	CEN B ambulance	a) Advanced Paramedic. b) Responders (minimum EFR) if able to get to scene prior to ambulance.	Ambulace Officer according to operational requirements	Fire Service, Garda, Coast Guard, Utility services as required
2 Serious not life threatening	Charlie	Serious not life threatening – immediate	Ambulance with minimum Paramedic	Lights and siren	CEN B ambulance	Advanced Paramedic for appropriate conditions	Ambulace Officer according to operational requirements	Fire Service, Garda, Coast Guard, Utility services as required
	Bravo	Serious not life threatening – urgent	Ambulance with minimum Paramedic	Lights and siren	CEN B ambulance		Ambulace Officer according to operational requirements	Fire Service, Garda, Coast Guard, Utility services as required
3 Non serious or life threatening	Alpha	Non serious or life threatening	Ambulance with minimum Paramedic	Normal traffic (no lights or siren)	CEN A or B ambulance		Ambulace Officer according to operational requirements	Fire Service, Garda, Coast Guard, Utility services as required
	Omega	Minor illness or injury	Ambulance with minimum EMT	Normal traffic (no lights or siren)	CEN A or B ambulance		Ambulace Officer according to operational requirements	Fire Service, Garda, Coast Guard, Utility services as required

Principles for dispatchers

1 The nearest available ambulance shall be tasked to the highest priority incident
2 The 'recommended response' other than an ambulance shall be dispatched if resources are available
3 Dispatchers shall have discretion to override ProQA to assign a higher priority to an incident
4 An ambulance tasked to lower priority incident may be diverted to higher priority incident when resources are limited
5 The Dispatcher may preserve the availability of ambulances by queing Alpha and Omega priority incidents until sufficient resources are available
6 When response is delayed Dispatchers shall inform the caller of estimated time of arrival
7 The Dispatcher shall make contact with caller if ambulance response is slow (> 20 minutes) to verify patient's condition and review priority of incident

APPENDIX VI

LOW AS3 PERCENTAGE STATIONS

SOUTH		NORTH LEINSTER			WEST		
Middleton	Dungarvan	Monaghan	Longford	Swords	Clifden	Kilrush	Carndonagh
Fermoy	Tipperary	Virginia	Athlone	Maynooth	Carraroe	Ennistymon	Dungloe
Youghal	New Ross	Castleblayney	Edenderry	Tallaght	Loughrea	Newcastle Wt	Donegal
Millstreet	Enniscorthy	Ardee	Birr	Athy	Belmullet	Roscrea	Ballyshannon
Macroom	Gorey	Dunshauglin		Baltinglass	Ballina	Scarriff	Killybegs
Kanturk	Carlow	Navan		Arklow	Boyle	Thurles	Manorhamilton
Castletownbere	Cashel	Cavan					
Clonakility		Dundalk					
Skibbereen							
Kenmare							
Caherciveen							
Dingle							
Listowel							

APPENDIX VII

MEDIUM AS3 PERCENTAGE STATIONS

SOUTH		NORTH LEINSTER			WEST		
Killarney	Wexford	Drogheda	Tullamore	Naas	Roscommon	Nenagh	Carrick on Sh
Bantry				Wicklow	Ballinasloe		
Mallow							

HIGH AS3 PERCENTAGE STATIONS

SOUTH		NORTH LEINSTER			WEST		
Tralee	Clonmel	Drogheda	Mullingar	St. James	Galway	Ennis	Letterkenny
Cork	Waterford		Portlaoise	Loughlinstown	Castlebar	Limerick	Sligo
	Kilkenny						Stranorlar***
							Lifford***

***Will require review to determine appropriateness of continuing services at Lifford and using Stranorlar for AS3s