# Chapter 40 Health Service Executive

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## The Dublin Ambulance Service

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40.1 Prior to 1960 the provision of health services, including the ambulance service, was the responsibility of local authorities. Under the Health Authorities Act, 1960 statutory responsibility for the provision of health services for Dublin city and county was vested in the newly established Dublin Health Authority. Agreement was reached at that time between the local authorities and the Dublin Health Authority that the local authorities would continue to provide an ambulance service in the Dublin area on behalf of the Dublin Health Authority.

40.2 The arrangement continued when the Eastern Health Board was established under the Health Act, 1970 as one of the regional health boards replacing the Health Authorities. In 1983 the arrangement ceased in the Dun Laoghaire/Rathdown area and the Eastern Health Board assumed responsibility for the ambulance service provision in that administrative area.

40.3 In 2000, the Eastern Health Board was split into three regional health areas. Following this, one of those regional health authorities – the East Coast Area Health Board – assumed a coordinating role for the ambulance service in the region. Subsequently, the Health Service Executive (HSE), on its establishment in 2005, assumed responsibility for the ambulance service countrywide.

## Current Service Provision

40.4 In practice, two ambulance services provide full time, year round services in Dublin city and county - the Dublin Fire Service (DFS) and the HSE Ambulance Service.

40.5 In 1998, the Health Board and the DFS Command and Control ambulance functions were brought together in one location in a purpose built unit in Townsend Street, Dublin. The purpose of that move was to integrate both services with a view to achieving the most efficient and effective use of resources and ensuring the optimal quality of patient care.

40.6 The National Ambulance Service (NAS) was established by the HSE in 2005 and provides both emergency ambulance services and patient transport services. Its Eastern Region provides an ambulance service covering counties Dublin, Kildare and Wicklow. The Eastern Region has a staff complement of 242. This includes patient transport staff, ambulance controllers, EMTAs[137], managers and administration staff, as well as managers and administration staff of the National Ambulance Service College. Figure 145 details the allocation of the staff complement of the HSE ambulance staff Eastern Region.

[137] Emergency Medical Technician (Advanced).

**Figure 145 HSE Eastern Region Ambulance Staff – July 2009**

| Category | Numbers |
|---|---|
| Ambulance Staff | 183 |
| Patient Transport Staff | 15 |
| National Ambulance College | 12 |
| Administration, etc. backup | 11.5 |
| Management/Supervisor | 14 |
| Vacancies | 6.5 |
| **Total** | **242** |

40.7 The HSE Eastern Region provides the service with 55 ambulances including four spare vehicles. In addition, a motorcycle unit provides rapid response to emergency calls. The service also provides a dedicated national neonatal and mobile intensive care retrieval service. As well as responding to emergency calls the HSE service also provides inter-hospital transfers of patients and responses to urgent calls from doctors. Figure 146 details the deployment of the ambulances in the HSE Eastern Region.

**Figure 146 HSE Eastern Region Ambulances – July 2009**

| Region | Maximum On Duty | Spares[a] | Total |
|---|---|---|---|
| **Dublin City and County** | | | |
| James's Street | 7 | 7 | 14 |
| Tallaght | 1 | 1 | 2 |
| Swords | 2 | 1 | 3 |
| Loughlinstown | 4 | 3 | 7 |
| **Other Eastern Region** | | | |
| Wicklow | 3 | 3 | 6 |
| Arklow | 1 | 1 | 2 |
| Baltinglass | 1 | 1 | 2 |
| Maynooth | 1 | 1 | 2 |
| Naas | 4 | 4 | 8 |
| Athy | 2 | 2 | 4 |
| **National Services** | | | |
| Loughlinstown[b] | 2 | — | 2 |
| James's Street[c] | 3 | — | 3 |
| **Total** | **31** | **24** | **55** |

Notes:

a The additional spare ambulances are required to allow duty commencement if existing crews have not returned to base when a shift is due to start. Routine servicing and breakdown is also accommodated within this complement by moving ambulances from one location to another when necessary.

b Two incident response ambulances are based in Loughlinstown.

c Two neonatal and one mobile intensive care ambulances are based in James's Street.

40.8 The DFS provide emergency response only. There is an agreed protocol that the nearest available ambulance responds to any emergency. The DFS provides its services from ten locations throughout Dublin City with eleven ambulances and three spares.

## Arrangements with DFS

40.9 The HSE meets the costs of the DFS. The HSE pay the DFS for 105 personnel plus 10% for supervisory costs to provide the ambulance service. However, no formal procurement process for the appointment of the DFS to provide an emergency ambulance service has been entered into.

40.10 In June 1998, the Eastern Health Board and the Dublin Corporation Fire Brigade drew up a draft agreement on the provision of emergency ambulance services. The draft agreement gave rise to a complaint to the European Commission in which it was claimed that it should have been the subject of prior advertising in accordance with the requirements of EU Directive 92/50.

40.11 The European Commission asked the European Court of Justice to declare that, in permitting the provision of emergency ambulance services without having undertaken any prior advertising, Ireland had failed to fulfil its obligations under EU Treaties and the general principles of Community Law. The Commission claimed that the maintenance of an agreement without any prior advertising constituted a breach of the rules of the EU Treaty and thereby of the general principles of Community Law, in particular the principle of transparency.

40.12 The European Court of Justice rejected the contention of the Commission and determined that neither the Commission's arguments nor the documents produced demonstrated that there had been an award of a public contract, since it is conceivable that Dublin City Council provides emergency ambulance services in the exercise of its own powers derived directly from statute. Moreover, the mere fact that, as between two public bodies, funding arrangements exist in respect of services does not imply that the provision of those services constitutes an award of a public contract which would need to be assessed in the light of the fundamental rules of the Treaty.

## Cost of the DFS Emergency Service

40.13 The HSE meets the following costs of the DFS

- the payroll costs of staff
- superannuation[138]
- a 10% charge for supervision.

40.14 Dublin City Council have also sought payment from the HSE for additional cost elements. However, the HSE disputed that these should be chargeable since it never agreed to bear the cost of the items involved. The disputed areas relate to

- Swords ambulance service
- recruitment and training costs
- control room (16 staff) costs
- advanced paramedic service.

40.15 In 2006 following protracted negotiations, the HSE agreed to retrospectively pay for the disputed elements and paid Dublin City Council arrears of €2 million in that year and a further €1.09 million in 2007. At the end of December 2008, the remaining disputed amount was €2.9 million including €381,958 claimed by Dublin City Council as a cost of living increase.

[138] The superannuation charge is calculated at 1/7$^{th}$ of the net wages expenditure.

40.16 The payments by the HSE to Dublin City Council for the years 2004 – 2008 are detailed in Figure 147.

**Figure 147 Reimbursement to Dublin City Council 2004 – 2008**

| Year | Payments[a] |
|---|---|
| | € |
| 2004 | 6,833,519 |
| 2005 | 7,454,748 |
| 2006 | 9,454,748 |
| 2007 | 11,017,625 |
| 2008 | 9,306,396 |

Note:

a €2.9 million claimed up to 31 December 2008 is disputed and remains unpaid.

## Service Framework

40.17 There is no service level agreement in place between the HSE and the DFS to provide emergency ambulance services in Dublin. The absence of a service level agreement and agreed performance indicators militates against effective measurement of the performance of the ambulance service provided by the DFS and any comparison with the service provided by its own ambulance service.

40.18 The reporting relationship for the HSE to the Department of Health and Children and Dublin City Council to the Department of Environment, Heritage and Local Government does not facilitate integrated planning. The issue is further complicated by the fact that the structure involves two separate groups of employees with different pay, terms and conditions of employment and staff representation.

40.19 The primary objective of the NAS is to provide clinically appropriate and timely pre-hospital care and transportation services. The provision of high quality ambulance services requires the NAS to operate in partnership with a wide range of statutory and private organisations. It also involves working closely with other health care providers at primary and community level in both acute and community care settings.

## Communications Systems

40.20 Since the co-location in 1998 of the Health Board and the DFS Command and Control ambulance functions in the same purpose-built unit in Townsend Street, efforts have been made to establish an appropriately integrated centre with a suitable single management framework. The HSE informed me that in 1998 when the Command and Control service commenced operations, the DFS purchased a computer aided dispatch system. Its primary function was to assist in responding to fire calls. A module was purchased subsequently to deal with call tracking and dispatch of fire service ambulance vehicles. The HSE stated that this additional module had created ongoing operational difficulties in the pursuit of integration into a single system.

40.21 An independent report[139] recommended significant changes in relation to the future arrangements for the provision of a communications infrastructure in the overall ambulance services. The main recommendations were

139 Communications in the Ambulance Services 2005, (The Mason Report).

- establish four health service call centres - one to support each HSE administrative area
- provide an integrated communications service support for multidisciplinary providers in support of holistic patient services
- deal with all health service communications needs from those centres.

40.22 It recommended that the centres provide the following services

- ambulance emergency dispatching
- inter-hospital critical care transfers
- patient transport services - stretcher based at an intermediate care level
- bed monitoring services
- patient transport services through contractors
- all out-of-hours medical on-call services
- specialist health support services such as public health nursing, social workers, etc. that are needed out of hours
- primary care centres
- patient advice and referral services.

40.23 The current HSE position in relation to the establishment of four health service call centres is that further evaluation is required in order to identify if the service can in fact be provided by two call centres. The Accounting Officer informed me that he believed the functions listed in the report should be provided as in many other countries.

## Review of the Service

40.24 A Review Group on the ambulance service provision within Dublin city and county was established in October 2005 and reported in February 2007. It was a joint HSE and Dublin City Council group which also included the CEO of a UK regional ambulance service. A UK company specialising in the analysis of data for the emergency services was engaged to support the work of the Review Group.

40.25 The HSE and Dublin City Council felt there was a need to review all aspects of ambulance operations excluding routine patient transport services that are exclusively managed and delivered by the NAS. An important reason which gave impetus to the review was the fact that the response times for the delivery of emergency ambulance services in Dublin city and county were considered very low in comparison with similar cities around the UK and Europe. The eight minute response time for emergency responses in Dublin city and county is achieved in approximately 25% of cases and this compares poorly in relation to the eight minute response time in general of 75% of cases in England for dealing with life threatening calls.

40.26 The Review Group concluded that the existing ambulance service provision with services delivered by two different organisations using two differing communications systems and associated software did not align with many of the goals and aims of the requirements of all of the strategic reports[140] on the ambulance services and the Health Service Reform Programme.

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[140] 1. The Review Agenda on the Ambulance Services (1993). 2. Strategic Review of the Ambulance Service (2001). 3. Quality and Fairness – A Health System for You (2001). 4. The Health Service Reform Programme (2003). 5. Mason Report on Communications in the Ambulance Service (2005). 6. Communications and IT Strategy, NAS (2006).

## Significant Issues Identified by Review Group

40.27 In regard to command and control arrangements, the Review Group found that the two control centres, while located in the same room, operated and dispatched the ambulance resources in Dublin city and county as two separate entities in which there seemed to be very limited integration on the deployment of those services. While some co-ordination of 999 calls took place in the Townsend Street centre, it was the view of the HSE that this system was not sufficiently integrated to provide seamless ambulance services to the population of Dublin city and county. It was perceived that this service was fragmented and the existence of this situation undermined one of the main objectives of the Health Service Reform Programme.

40.28 The Review Group commented that the lack of a single point of contact for all ambulance calls for Dublin city and county was not a satisfactory arrangement for supporting the needs of patients or clinicians seeking the ambulance service. It noted that there was a lack of integration of control services and service delivery.

40.29 The Group also reported that the nearest ambulance resource is not always dispatched to meet the needs of the patients requesting services.

40.30 On the matter of value for money, the Review Group noted that the two separate stand-alone systems led to duplication and entailed each of the two having infrastructure and supporting systems.

40.31 In relation to clinical and financial risks, the Review Group observed that the approach to service delivery left the HSE exposed to clinical and financial risks. The absence of a Service Level Agreement for the provision of existing services was an issue that needed to be urgently addressed in order to mitigate those risks and provide a system of financial and clinical accountability.

40.32 The Review Group issued a set of recommendations in the areas of governance, operations, clinical effectiveness and quality. These are set out in Annex A.

## Audit Concerns

I asked the Accounting Officer what action had been taken or is proposed

- to better align the ambulance service delivery with HSE strategic aims and
- to address the concerns outlined in the Review Group report and move to an organisational structure on the line of its recommendations.

I also sought information about the value for money being achieved under current operational arrangements and the status of the disputed claims made by Dublin City Council.

## Views of the Accounting Officer

40.33 The Accounting Officer informed me that the HSE would be establishing a formal Memorandum of Understanding with the DFS which would identify service delivery requirements. He acknowledged that the reporting relationship of both organisations to two different government departments did create differing priorities and impacted on integrated planning. Future service delivery options were complicated by the existence of different terms and conditions of employment, different retirement arrangements, clinical skill retention challenges and different organisational cultures coupled with the fact that both the HSE and Dublin City Council had different overall service objectives and responsibilities.

40.34 In response to my query on the 2007 review report, the Accounting Officer informed me that new thinking had emerged since the publication of the report in regard to the capacity and capability of the HSE and DFS to provide this service. This new thinking would take account of both response time performance and routine patient transport services. The core change was that the HSE was purchasing an Advanced Medical Priority Dispatch System which would identify life-threatening emergencies and identify the appropriate resource requirements. The ambulance controller would lead the caller through a series of questions which would determine the life threatening nature of the emergency. This activity internationally equated to between 5% and 15% of all emergency calls. This would provide a mechanism for the HSE to dispatch resources to the highest priority call and therefore improve response times. The Accounting Officer noted that the response time for Dublin city and county was currently 50% within 8 minutes however this reduced to 23% - 27% when Kildare and Wicklow calls were included in the reporting framework.

40.35 The Accounting Officer added that two organisations in the same building using two different computer aided dispatch systems was neither operationally, clinically nor financially appropriate. Any future service delivery arrangements agreed with the DFS would need to ensure that one computer aided dispatch system and associated technology was capturing the operational activity and dispatching ambulance resources whether they belonged to the HSE or the DFS.

40.36 In regard to command and control arrangements, the Accounting Officer stated that since 1998, there had been many attempts to integrate the two systems but this had never been achieved for a variety of reasons. The only solution was to purchase a dedicated computer aided dispatch system for ambulance related activity.

40.37 Concerning the lack of integration, he stated that departmental policy would only be realised with investment applied to ensure integration of service provision. The Accounting Officer noted that it was important to dispatch the nearest resource, which did not always happen. He stated that this was mainly due to a lack of synchronisation of resources, two computer aided dispatch systems and procedural and processing issues.

40.38 The Accounting Officer accepted that there were value for money concerns about how the ambulance service was provided in the Dublin city and county area and that a new approach to developing command and control services was required. This could be achieved by having two HSE control centres for the whole country dealing with health related issues from emergency service provision to out-of-hours social services. Such an approach would ensure a single system for emergency call receipt and dispatch irrespective of which agency was responding.

40.39 Noting that the current system had inherent risks that needed to be managed on an ongoing basis he went on to say that this management time and effort could be put to better use. The HSE needed to have an immediate and long-term plan to address these risks. The Memorandum of Understanding in relation to the services must include sound clinical governance arrangements, key performance indicators, complaint and investigation procedures and value for money targets. The long-term plan must be that there were only two command and control systems with associated technology for the country.

40.40 The Accounting Officer stated that while the core recommendations of the Review Group were never achieved, a number of the softer recommendations of the Review Group had been implemented. The main reason for this lay in the fact that both organisations were awaiting the outcome of the European Court of Justice decision on public procurement. Time had elapsed and whilst there were interim arrangements which needed to be put in place, the long-term strategy, as stated in relation to other services aspects, must be to have two command and control centres for the country dealing with all health related services of an emergency nature.

## Conclusions

Currently, emergency ambulance services in Dublin city and county are made available through a mix of directly provided services administered by the HSE and services procured by the HSE from the DFS. The arrangements with the DFS have not been the subject of a formal agreement. €9.3 million was paid to Dublin City Council in 2008 in respect of the DFS ambulance service.

The limited integration of both ambulance services raises concerns about the service quality delivered as measured by response time to emergency calls. The duplication of communication and overhead costs militates against achieving value for money.

It appears necessary to review the economy and efficiency of the overall arrangements taking account of manning levels and the cost of each service.

Ultimately, if the present arrangements are maintained, better coordination or integration of the service is necessary in order to provide a transparent, measured service where costs are related to service objectives, and service levels are the responsibility of a single accountable officer.

The Accounting Officer has noted that this issue will need to be tackled in the context of a restructuring of service communication system and he summarised the steps that now need to be taken, in order to align ambulance service delivery with the HSE strategic aims, in the following terms

- interim business arrangements with the DFS need to be formally addressed through a Memorandum of Understanding
- option appraisals and cost benefit analysis need to be conducted to determine the future of the ambulance command and control services for the country which would include services for Dublin city and county based in Townsend Street
- decisions need to be taken based on analysis and project teams need to be established to deliver the objectives.

# Annex A Recommendations from the Review of the Ambulance Service Provision within Dublin City and County, February 2007

The Review Group made specific recommendations. The overriding principle guiding the Review Group's recommendations was that any member of the public or health professional have a single point of contact with the emergency ambulance services serving Dublin city and county and get a response from the nearest appropriate emergency care resource in the shortest possible time period. The recommendations are grouped under three headings - organisation governance, operations and clinical issues.

### *Organisation Governance*

- A Strategic Management Board for the Communications Unit be established to set policy and to agree strategy for the operation of the Communications Unit.
- An Operational Management Group be appointed to oversee the daily operations of the Centre.
- A Partnership Working Group be established to deal with the normal partnership issues around the operations of the Communications Unit.

### *Operations*

- An integrated Command and Control Unit comprising of staff from the DFS and the NAS be set up to receive, prioritise and dispatch all emergency, urgent and critical care patient transfers.
- The Control Unit be located in one physical area, share common communications infrastructure and share software systems which will identify all incoming and outstanding ambulance calls and monitor all ambulance fleet resources on an ongoing basis.
- The DFS continue to do Emergency Department work, but that this should be extended to deal with urgent and inter-hospital critical care transfers as well.
- The overall ambulance fleet be required to respond to all emergency, urgent and critical care transfer work as one unit of service provision.
- All staff engaged in the delivery of ambulance services, both in the control area or on road operations, to participate in joint training programmes/exercises to ensure consistency in actions and operational responses.
- A key requirement that both services take a combined strategic and tactical approach to planning and resourcing their services to introduce effective Tactical Deployment Plans (TDP) for ambulance response. This approach is essential to ensure that response times are improved from the current level.
- There should be a realignment of ambulance resources to ensure that all resources are directly mapped against service demand.
- The patient transfer service workload be removed from the emergency vehicle resource base. Research has shown that, for each vehicle removed from this activity, an increase in response times of 1.4% to 1.8% per vehicle results.

- Further resources be allocated to the development of Community First Responder Schemes[141].
- Further research be carried out while these recommendations are being implemented to determine if additional ambulance units are required.

### *Clinical*

- A clinical governance group be established to oversee the quality and effectiveness of patient care from the point of call receipt to the stage where the patient is handed over to the care of another health professional.
- The NAS and DFS services subscribe to full clinical accountability, and that any identified risks are mitigated immediately and all actions in the context of the Health, Safety and Welfare at Work Act, 2005 are complied with.

[141] The Scheme provides an initial local response to stabilise the patient until trained medical personnel arrive. This will improve the response time for those communities with a low population density which are not near the normal ambulance resource centres.