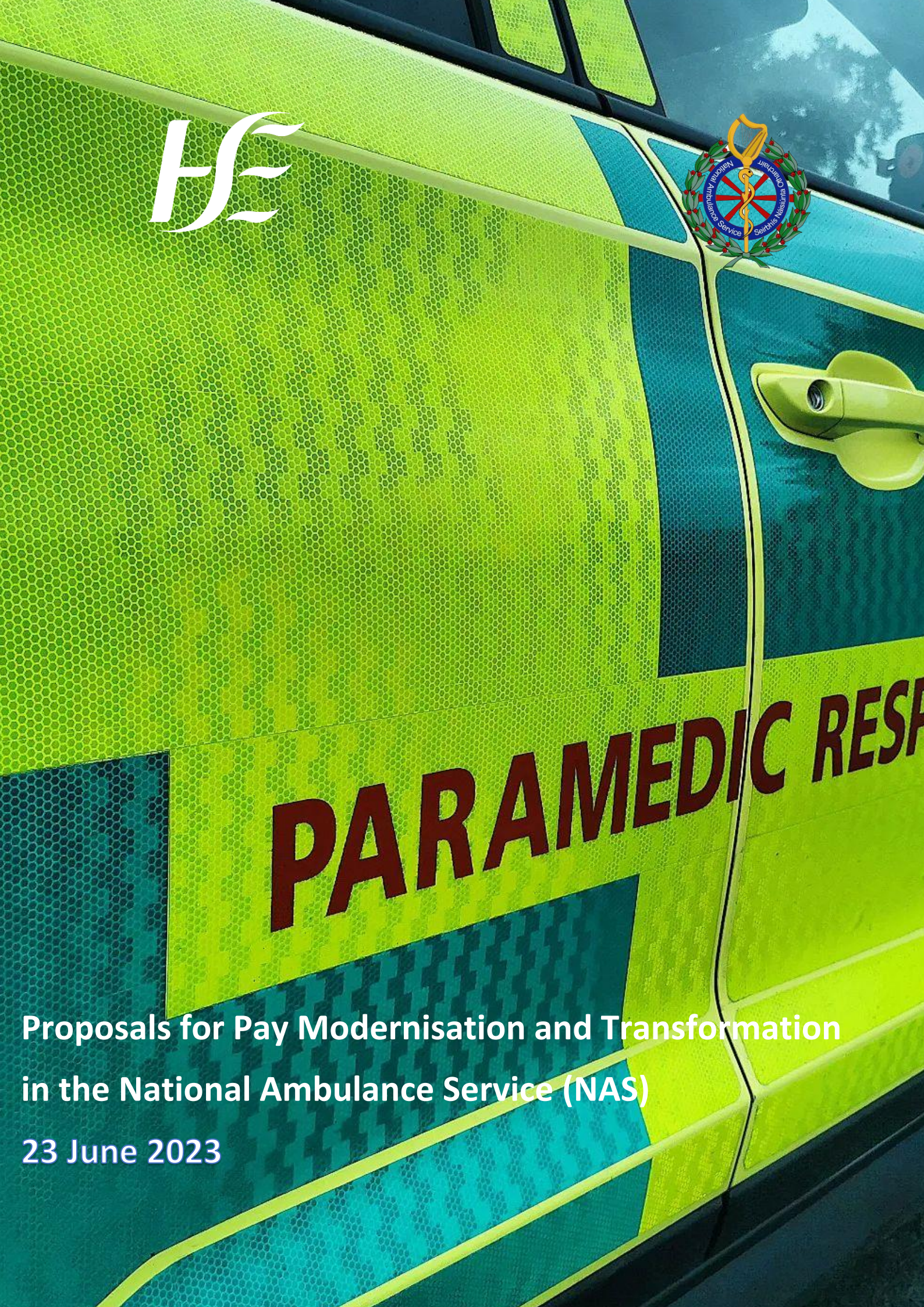

Proposals for Pay Modernisation and Transformation in the National Ambulance Service (NAS)

23 June 2023

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Sections:

1. Context and Consultation

1.1. NAS has seen significant developments over the past decade and more, especially in the role and professionalism of its front-line staff. However, it has been recognised that job descriptions/person specifications have not necessarily been updated to reflect these changes and current service care, delivery and practice.

1.2. In the case of the Advanced Paramedic, no job description exists. In view of this, following ongoing discussions and engagements with the support of the HSE's National Employee Relations Service (NERS) and under the auspices of the Workplace Relations Commission (WRC) in December 2018, the HSE and SIPTU/UNITE agreed to commission an independent review and examination of current Emergency Medical Technician (EMT), Paramedic, and Advanced Paramedic related roles within NAS.

1.3. In January 2019, arising from that WRC facilitated process, Terms of Reference for an independent review was agreed. The document ***"Review and Examination of current EMT, Paramedic and Advanced Paramedic roles in the National Ambulance Service"*** is the output of this work which was finalised by the authors (Sean McHugh/Tony Crabtree) on the 30 May 2020. The Recommendations could be summarised as requiring the HSE and trade unions to engage on:

A. Review and update the roles, duties and responsibilities of each grade
B. Consider changes that have taken place in the ambulance service in order to address the anomalies that have arisen
C. Identify clear career paths and structures
D. Address issues relating to recruitment and retention
E. Make recommendations on the appropriate grading structure including updated salary scales

1.4. In June 2021, NAS commenced a structured programme of engagement with the trade unions on the outcome of the review. Given the significant impact of Covid on engagement, the parties committed to complete the outstanding work within 6 months. By the end of 2021, work was completed on agreeing new job specifications that:

A. Reflect the increasing numbers within the workforce that are education to QQI Level 8 or Level 9
B. Recognise that the professional regulator (PHECC) have decided to develop a Degree Level Training and Education Standard
C. Prepare the ground work for the advent of Specialist Paramedics (Department of Health have indicated an intention to address primary legislation)
D. Provide clear career pathways for various levels of clinicians and the interplay between different roles

1.5. Throughout the engagement and consultation process, the parties have been mindful of our collective obligations under the current Building Momentum Agreement. In this regard, the parties recognise that the progression of these proposals are most likely to be considered within the framework of discussions on a successor agreement to Building Momentum.

2. Scope

2.1 These proposals encompass grades and groups often referred to as "road staff". Conversely, the NAS Organisational Re-Design Programme encompasses the core, technical and support grades and functions of NAS. While both the NAS Organisational Re-Design Programme and these Proposals for Pay Modernisation and Transformation in the National Ambulance Service (NAS) are complementary to each other, they are mutually exclusive and encompass different and separate aspects of the organisation and workforce.

2.2 In this context, the following existing grades ARE within the scope of these proposals:

- Grade Code (413Y) Emergency Medical Technician (Intermediate Care Operative)
- Grade Code (6132) Emergency Medical Technician (Intermediate Care Operative)
- Grade Code (6133) Emergency Medical Technician (Intermediate Care Operative)
- Grade Code (6463) Paramedic
- Grade Code (6463) Advanced Paramedic (AP)
- Grade Code (6464) Paramedic Supervisor (PS)
- Grade Code (6120) Clinical Paramedical Supervisor (CPS)

All other existing grades (as of the 31 May 2023) are **NOT** within the scope of these proposals

3. Relevant Background

3.1 Since 1978, NAS has evolved considerably and has rapidly advanced in the provision of pre-hospital emergency care, critical care and retrieval and urgent or community care. These proposals highlight and reflect the transformative changes in care provision provided by NAS staff which has and continues to occur over recent years. Staff are academically qualified and registered healthcare professionals operating in line with the Training and Education Standards established by the Pre Hospital Emergency Care Council (PHECC). However, this professional transformation is not reflected in terms of appropriate remuneration or status as health and social care professionals.

3.2 The current pay structure within NAS is considerably out of line with comparable professionals and is heavily and disproportionately reliant on an allowance and overtime driven culture which can affect staff perception of value and recognition and unconsciously affect appetite for and openness to change. At a time when the wider health service and government policy needs NAS staff to play an ever changing role in the transformation of health care delivery, this is a clear barrier to progress.

3.3 Therefore, these proposals seek to ensure that the roles, responsibilities, reward and recognition arrangements are fit for future purpose and enable and underpin the next phases of transformation.

3.4 The roles, responsibilities and clinical capability of NAS staff has grown dramatically since the last pay agreement in 1997 and is completely unrecognizable since the 1978 productivity/flexibility agreement. There have also been other major developments, such as the introduction of core and specialist roles like “Advanced Paramedic”, which are not reflected in the present structure. The grading and salary structure used by the HSE has not evolved in any way since they were introduced and these proposals seeks to address the lack of evolution of grades and salaries in line with the advancements in the service to date.

3.5 NAS clinical staff are autonomous, highly trained and educated health and social care professionals, working in a largely unsupported and occasionally hazardous environment. Staff exercise autonomous clinical judgement, deliver complex and lifesaving care including the administration of medications, perform lifesaving interventions and make complex decisions about specific care pathways and the recognition of death.

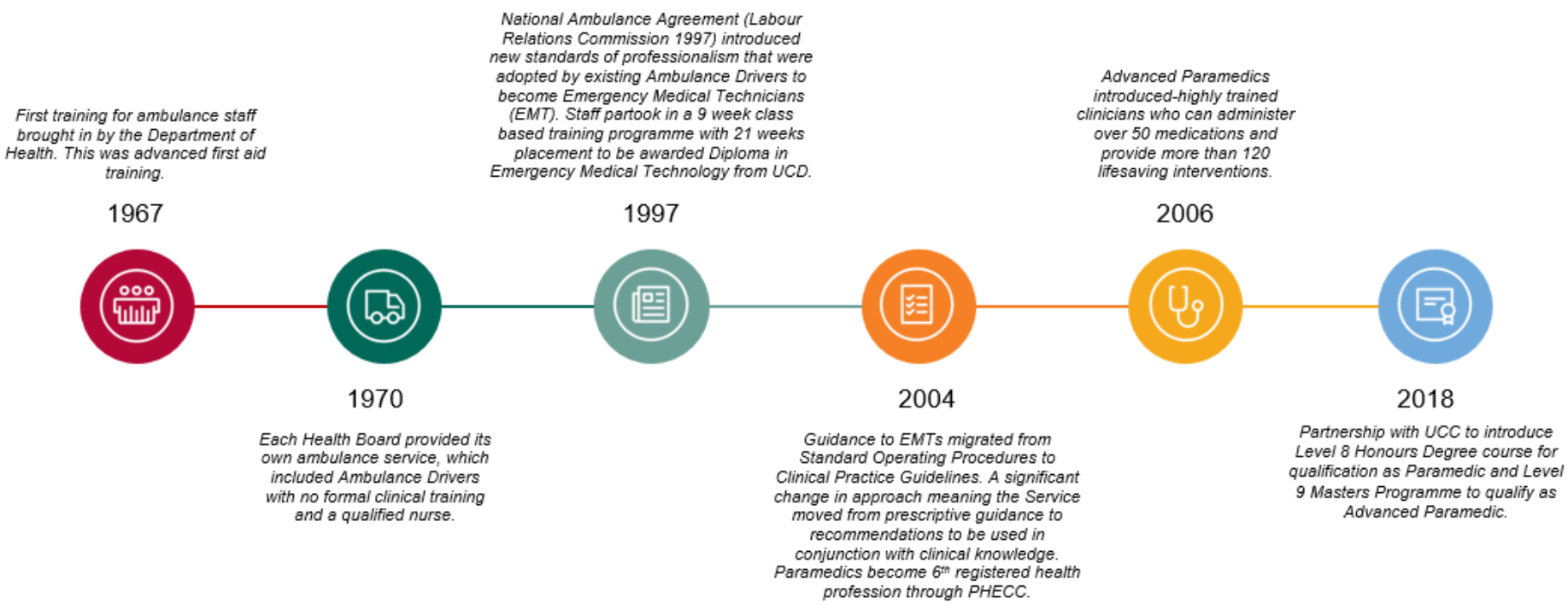
3.6 All staff are registered health care professionals with PHECC and are held to their exacting requirements and standards, including the Code of Ethics and Professional Conduct and the Fitness to Practice regime. Professional development requirements ensure that staff proactively and continuously engage in upskilling and training to meet the ever expanding needs of the health service in providing impactful patient care.

3.7 NAS has seen major developments in terms of clinical advancements and professionalism of its clinical staff since 1997. Job descriptions and grading structures have not however been updated to reflect these changes and the much altered level of service delivered by NAS staff. Due to the lack of review over this timeframe, NAS clinical staff are not categorised as health and social care professionals. Furthermore, many of the central clinical roles either do not have a designated grade or have an inconsistent salary structure or inaccurate job description:

	Current grade used	Fit for purpose?
ICO	For salary purposes EMTs are considered ICOs. Registered as EMTs with PHECC.	• Salary not reflective of educational and clinical attainment of ICOs since PHECC was introduced.
Paramedic	For salary purposes Paramedics are considered EMTs. Registered as Paramedics with PHECC.	• EMT salary is inconsistent with PHECC registration and job description • Salary not reflective of third level educational and clinical attainment of Paramedics since PHECC was introduced.
Advanced Paramedic/ Community Paramedic/ Critical Care Paramedic	No Advanced Paramedic/ Community Paramedic salary grade exists. Staff are paid according to their substantive grade (e.g. EMT) and paid an "Advanced Paramedic Allowance". Registered as Advanced Paramedics under PHECC	• Confusing and inconsistent approach to grading Advanced Paramedics due to current treatment. For example, the Advance Paramedic allowance is awarded at a flat rate to staff whose primary grade is either Emergency Medical Technician (i.e. Paramedic) or Leading Emergency Medical Technician. This results in Advanced Paramedic personnel being remunerated at varying rates. • Salary not reflective of advanced educational and clinical attainment of Advanced Paramedics since PHECC was introduced.
Paramedic Supervisor	No salary structure or grade exists.	• No grades exist for these new posts, both currently use a "Leading EMT" grade code for HR purposes. • Paramedic Supervisor involves working on an emergency ambulance and management of a Station, including significant staff management responsibility.
Clinical Paramedical Supervisor	New grade code created but incorrectly aligned to "Leading EMT" grade code.	• Clinical Paramedical Supervisor holds an AP qualification and involves working on an emergency ambulance and provides clinical and governance oversight to clinical care of patients.

The following timeline outlines the chronological progression of pre hospital emergency care since 1967:

Figure 1: Evolution of NAS Training and Education Standards



4. Professional Regulation

4.1 Since 2000, PHECC has acted as the agency responsible for setting standards for training and education for pre hospital emergency care practitioners. All NAS clinical staff are subject to rigid registration, professional, training and education standards in order to secure registration as a healthcare professional - i.e. EMT/ICO, Paramedic or Advanced Paramedic. This registration, along with ongoing professional development, must be kept up to date in order to maintain current registration. This change was a catalyst for the professionalization of these clinical roles as a whole, with robust measures in place to ensure standards are maintained.

4.2 A significant shift in ability occurred in 2004 where NAS moved from using a basic, limited and prescriptive range of Standard Operating Procedures (SOPs) to guide clinical staff to adhering to Clinical Practice Guidelines (CPGs) issued by PHECC.

4.3 This heralded a change from clinical staff merely carrying out orders as per instruction and in a prescriptive manner, to clinical staff who were clinically trained to a standard determined independently by PHECC and were empowered to determine the appropriate course of care under the guidance of CPGs. Since this period, the level of clinical ability and the quality of care to patients has progressed significantly.

4.4 This advancement in clinical ability across staff is a key enabler allowing the service to move from an emergency medical service to a mobile medical service - a central tenet of Sláintecare. A key benefit of this new model of care is a reduced reliance on the conveyance of patients to acute settings, with NAS clinical staff now able to effectively manage and provide care for suitable patients without conveyance. This has positive benefits across the wider health service network.

4.5 As noted in the Crabtree/ McHugh report 2020, the last meaningful review of salary and grade levels was conducted by the Benchmarking Body in 2002 and 2007. The present structure does not reflect the professionalization and clinical advancements of clinical NAS staff since this time, and is also inconsistent, confusing and poorly aligned to the wider HSE system and the NAS's present and future needs.

5. Purpose

5.1 In addition to finalisation of future proofed job specifications, these jointly developed and presented proposals reflect the outstanding recommendation from the McHugh/Crabtree Report, i.e. to make *"recommendations on the appropriate grading structure including updated salary scales"*. In this regard, the proposals set out to address the final aspects of the WRC facilitated process in 2018. The recommendations herein will need to be considered by the HSE NERS prior to submission to the Department of Health (DoH) with a view to securing a referral of these recommendations to the Department of Public Expenditure and Reform (DPER) in the context of the next round of national pay discussions. In particular, the proposals seek to:

A. Address the historical pay structures within NAS which are bespoke, complex, out of alignment with the wider HSE and promote resistance to change.
B. Re-categorise NAS clinical grades (new entrants since 2019) whom are benchmarked at a minimum of QQI Level 7 and above (a significant and growing numbers are educated to QQI Level 8 or Level 9) as Health and Social Care Professionals
C. Recognise NAS clinicians are autonomous practitioners whom deliver complex care in high risk and dynamically changing environments
D. Introduce greater accountability due to defined roles, ownerships and responsibilities
E. Modernise the allowance regime of all operational/clinical grades through the removal of all qualification and location/travel allowances from the pay structures and streamline premia payments associated with unsocial hours, weekend and shift work
F. Enable a generational shift in organisational culture through improved recognition
G. Address the current workforce attraction and retention challenge
H. Recognise the scale of transformative cooperation to date and address outstanding barriers to continuing modernisation
I. Prepare for the future with a clear progression path for NAS staff to enable the rollout of related Sláintecare initiatives

5.2 These proposals recommend that the current grades should be modernized so that the NAS grading and salary structures support and enable the continuing professional evolution required to facilitate the implementation of Sláintecare. Ultimately, these proposals also seek to establish a clearer and more appropriate grading structure and career pathways for these important roles.

5.3 Para-medicine is an increasingly unique healthcare profession in that clinicians encounter a wide array of patients whilst working autonomously in an unsupported and dynamic environment. Occasionally, the environment can be hazardous and extremely challenging. NAS clinicians have significant clinical knowledge and ability as well as exceptional soft skills and personal resilience in order to deal with these challenging and diverse situations.

5.4 The contribution of the NAS workforce to the rapid evolution of urgent and emergency care in Ireland demonstrates a clear capacity to rapidly embrace change and re-configuration. In order to ensure that NAS continues to recruit and retain its valued staff, the gap between salary recognition and NAS staff capability needs to be addressed. The advancements in clinical ability and standards of each of the predominant grades is addressed over subsequent pages.

6. Scope of Practice

6.1 Since 1978, there has been significant, positive advancements in the clinical ability and the overall professionalization of NAS staff. Most notably, key advancements since the establishment of the Emergency Medical Technician (EMT) grade in 1997 has greatly progressed the clinical ability of the service. From this point, NAS clinical staff continued to evolve which has led to the introduction of three clinical levels namely:

Emergency Medical Technician (EMT):

A. Must be PHECC registered as an Emergency Medical Technician (EMT)
B. Must be privileged to practice on behalf of the HSE
C. In the absence of modernised grade codes, currently paid as a Driver of Patient Transport on Public Roads
D. This role is designed to provide a comprehensive and dedicated Patent Transport/ Intermediate Care Service and respond to appropriate 999 calls in line with the PHECC EMS Dispatch Standard
E. The ICO is registered as a PHECC EMT who has received additional training in patient moving and handling, patient care and comfort, safe driving and operational procedures
F. Operate on ICO vehicles, which are staffed with two ICOs

Paramedic:

A. Must be PHECC registered as a Paramedic
B. Must be privileged to practice on behalf of the HSE
C. In the absence of modernised grade codes, currently paid as an EMT
D. Primary provider of pre hospital emergency care in Ireland
E. Qualification as Paramedic delivered through UCC Level 8 Honours Programme since 2018
F. Prior to 2019 was delivered through UCD Level 7 Programme
G. Responds to all 999 emergencies and works in a variety of roles

Advanced Paramedic (AP):

A. Must be PHECC registered as an Advanced Paramedic
B. Must be privileged to practice on behalf of the HSE
C. In the absence of modernised grade codes, currently paid as an EMT and receives a qualification allowance which is equivalent to 23% of basic salary
D. Undertakes significantly invasive and advanced lifesaving interventions including needle cricothyrotomy, needle thoracentesis and endotracheal intubation
E. Provider of pre hospital emergency care to patients experiencing immediately life threatening illness or injury
F. Qualification as an Advanced Paramedic delivered through UCC Level 9 Masters Programme

6.2 The grading and salary structure used by the HSE for these clinical levels has not evolved in any meaningful way since they were introduced. The staff and trade union perspective is that public sector pay increases do not reflect the significant advancements in clinical ability, professionalization and the development delivered over this time period. These advancements have provided significant benefit to service users and the wider health service, something which was particularly evident during the recent pandemic.

6.3 Where new roles have been introduced, e.g. the Advanced Paramedic, and in the absence of corresponding developments in HR structures, the HSE has used a series of different grades and allowances in order to distinguish between the clinical and supervisory roles.

6.4 The lack of cohesion in the development of grades and salaries in line with the concomitant progression in clinical ability, risk and responsibility, causes a number of issues, such as:

Not reflective of significantly increased clinical ability

Present structure does not reflect the significant advances in clinical ability required to be achieved to move level

Difficulty attracting and retaining clinical staff

Uncompetitive and unattractive salary rates are detrimental to both attracting and retaining clinical staff

Individuals in same role but on different pay scales

NAS staff in the same role may be on totally different pay scale depending on how their salary was initially calculated

Perceived lack of transparency

The present system of salary grades is quite complex leading to a perceived lack of transparency around salary scales. This leads to consistent negative feedback from NAS staff

6.5 Addressing these issues will appropriately reflect the professionalization of staff and the reality of the demands and responsibilities of their roles. It will also assist with addressing ongoing issues related to recruitment and retention of NAS staff in a time where demand is projected to increase significantly by approximately 107% over the period 2017 to 2027.

6.6 The current pay structure of the grades encompassed by these proposals need to be revised in tandem with an unequivocal commitment to a continuing programme of modernization and reform. The tables below outline the grade structure and pay scales for current roles:

Title	Grade	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Level 8	Level 9	Level 10	Level 11
ICO	ICO	31,723	33,158	34,670	35,072	36,059	36,912	38,142	39,416	40,738		
PARAMEDIC	EMT	31,335	33,409	34,243	35,605	36,351	36,917	37,818	38,730	39,634	41,445	**43,114 LSI**
ADVANCED PARAMEDIC*	EMT with AP	41,730	43,804	44,638	46,000	46,746	47,312	48,213	49,125	50,029	51,840	**53,509 LSI**
PARAMEDIC SUPERVISOR	LEMT	34,921	36,127	37,160	38,517	39,882	41,244	42,609	45,188	**47,021 LSI**		
PARAMEDIC SUPERVISOR*	LEMT with AP	45,316	46,522	47,555	48,912	50,277	51,639	53,004	55,583	**57,416 LSI**		
CLINICAL PARAMEDIC SUPERVISOR*		45,316	46,522	47,555	48,912	50,277	51,639	53,004	55,583	**57,416 LSI**		

**includes qualification allowances where relevant*

7. Current Challenges and Risks

The current scenario has led to a number of challenges and risks, including:

Challenges

A. Basic salaries are not reflective of the level of education, risk and responsibility of NAS clinicians and cause retention and recruitment issues
B. NAS intends to establish the "Specialist Paramedic" role to include the current Community Paramedics to support the roll out of Sláintecare - the present grade and salary structure does not support these important developments
C. NAS clinicians are not recognised or remunerated in line with other healthcare professionals
D. Pay scales are confusing and inconsistent
E. Gross income is disproportionately dependent on multiple allowances
F. Current grading and salary structures do not represent the significant advancement in clinical ability, training and development across clinical NAS staff
G. Perception that salary does not aptly reward staff's significant and ongoing investment in training and development
H. Recognition of clinical ability and related salary issues contributes to industrial relations activity and regular use of the State's industrial relations machinery
I. Grading and salary structure do not support clear career progression or pathways that all staff can relate to

Risks

A. Ongoing risk of IR exposure due to inconsistent grading and salary structure
B. Reduced staff morale due to perception that clinical advancement and professionalization has not been recognised
C. Poor staff retention and attraction due to lack of attractiveness of current pay structures, which is not in line with clinical ability, investment in training and development and exposure to risk
D. Current structure does not allow for future proofing of the NAS and is an inhibitor to the service's ability to continue to rollout important progressive plans
E. Real risk of industrial action due to the lack of progression of a modernised agreement since 1997

8. Drivers of Change

8.1 Between December 2019 – December 2022 (37 months), there were 777,821 patient attendances by emergency ambulance personnel. Over one quarter of patients attended had a life-threatening complaint or a condition that would result in serious ill-health in the absence of immediate on-scene treatment/stabilisation and immediate safe transfer to the appropriate acute hospital facility. With the notable exception of patients attended by Community Paramedics or hospital outreach programmes led by NAS, patients attended by emergency ambulance personnel are conveyed to a hospital facility unless they decline ambulance transfer. This meant that from December 2019 to December 2022, over 88% of patients attended by emergency ambulance personnel were transferred to a hospital facility.

8.2 Between September 2021 and December 2022, 21,656 patients have been signposted via the NEOC Clinical Hub. This hub is staffed by doctors alongside our experienced nurses. 33% of callers received advice on self-care or referral to a community-based service (e.g. their own GP, a community pharmacist, or other community service). This avoided almost 7,370 unnecessary emergency transfers to an ED.

8.3 Between September 2021 and December 2022, 5,462 patients have been attended by Community Paramedic services. All patients were seen and treated in their own home or community. 59% of patient attended avoided transport and/or admission to hospital. NAS's partnership with hospital outreach projects such as Beaumont, Tallaght, Waterford and Limerick Pathfinder programmes. A total of 1,225 patients had been attended to via this care pathway. This patient centred care model has proven the concept that paramedic involvement in Irish community-based care help deliver care at the patient home, up to 49% of patients avoiding an acute hospital admission following attendance of a pathfinder team.

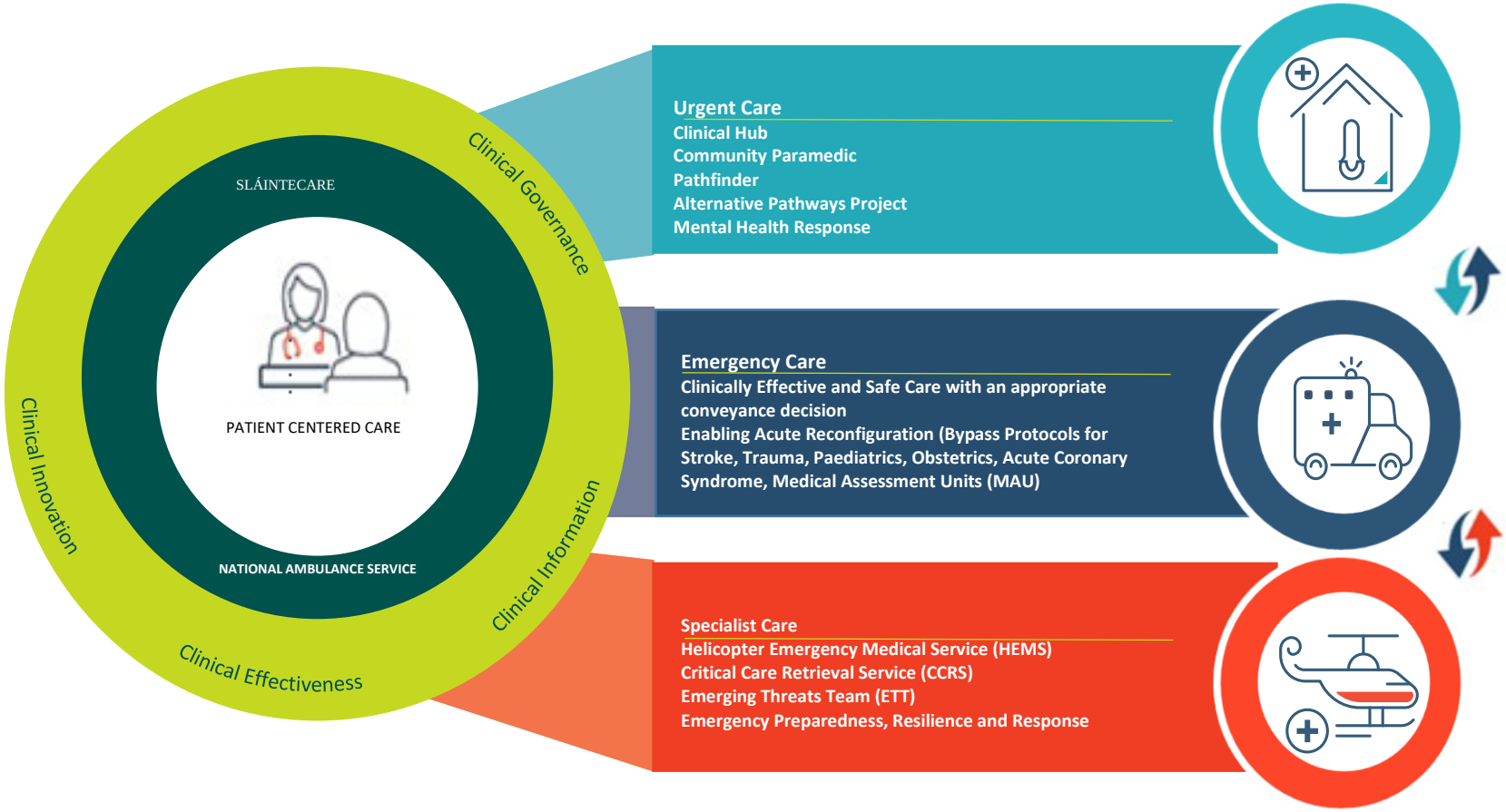
8.4 In summary, our data shows the high proportion of NAS services already dedicated to our older population and that provision of high acuity, emergency care remains a core function of NAS. There is a need to facilitate community-based care for a larger proportion of patients attended to. The merit of doctor involvement in the NEOC Clinical Hub has been demonstrated and the value of community-based paramedic care has been proven. In this context, NAS is ideally positioned to scale up the availability of such services and in doing so, facilitate the implementation of Sláintecare

8.5 NAS Model of Patient Care – Delivering Sláintecare in order to deliver Sláintecare and ensure the best possible experience and outcomes for our patients, the NAS will build on the Model of Patient Care introduced in the NAS Strategy Vision 2020.

8.6 As set out in Figure 2 below, our patient care model is based on three categories of care – Urgent Care (ED Avoidance/Admission Avoidance), Emergency Care and Specialist Care:

NAS Model of Patient Care – Delivering Sláintecare

Figure 2 – Patient Centred Care



Urgent Care (See, Treat and Refer)	
Scenario 1 (Clinical hub Example)	Kate is a 20-year-old student living with her family. She has insulin-dependent diabetes and is found in a collapsed state at home by her mother who rings 112/999.

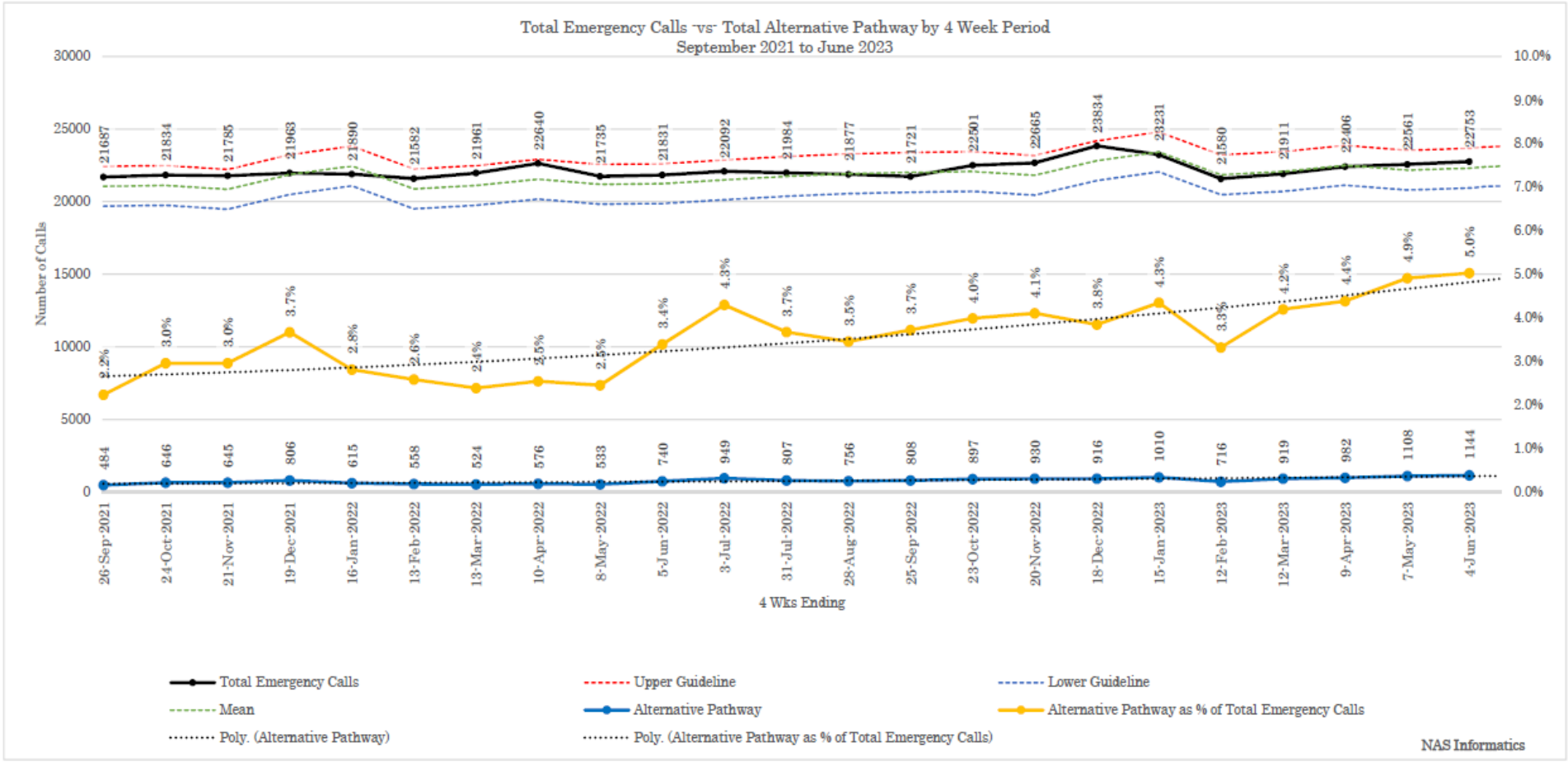
2020	2021 - 2031
The potentially serious nature of the call is identified by the Call Taker and the Dispatcher immediately sends an emergency ambulance crew and an Advanced Paramedic (AP) in a rapid response vehicle to attend Kate. The crew arrive, establish that Kate is having a hypoglycaemic episode and begin treatment. The AP administers intravenous dextrose and Kate responds quickly, becoming fully conscious. Kate and her mother are transferred to the closest Emergency Department for further assessment and monitoring. Kate remains in the care of the emergency ambulance crew until space and staff for emergency department triage are available Kate is fully recovered when she is reviewed by the emergency department doctor and is not admitted to the hospital.	The immediate and potential serious nature of this call is identified by the Call Taker and the Dispatcher sends an emergency ambulance crew and an AP in a rapid response vehicle to attend Kate. The crew arrive and establish that Kate is having a hypoglycaemic episode and begin treatment. The AP administers intravenous dextrose and Kate responds quickly, becoming fully conscious. The AP releases the emergency ambulance crew, completes Kate's immediate care needs and advises that an appointment with Kate's diabetic team is made. The AP arranges a follow-up call from the Clinical Hub to Kate on the following day to check on her status and reinforce the advice for her to see her diabetic team.

Scenario 2 (Sláintecare example)	Mary lives in a small rural village. She is a 76 years old, has a chronic lung condition, lives alone and has had three recent admissions to the ED due to exacerbation of her lung condition. She has had a fall today with no apparent injuries.

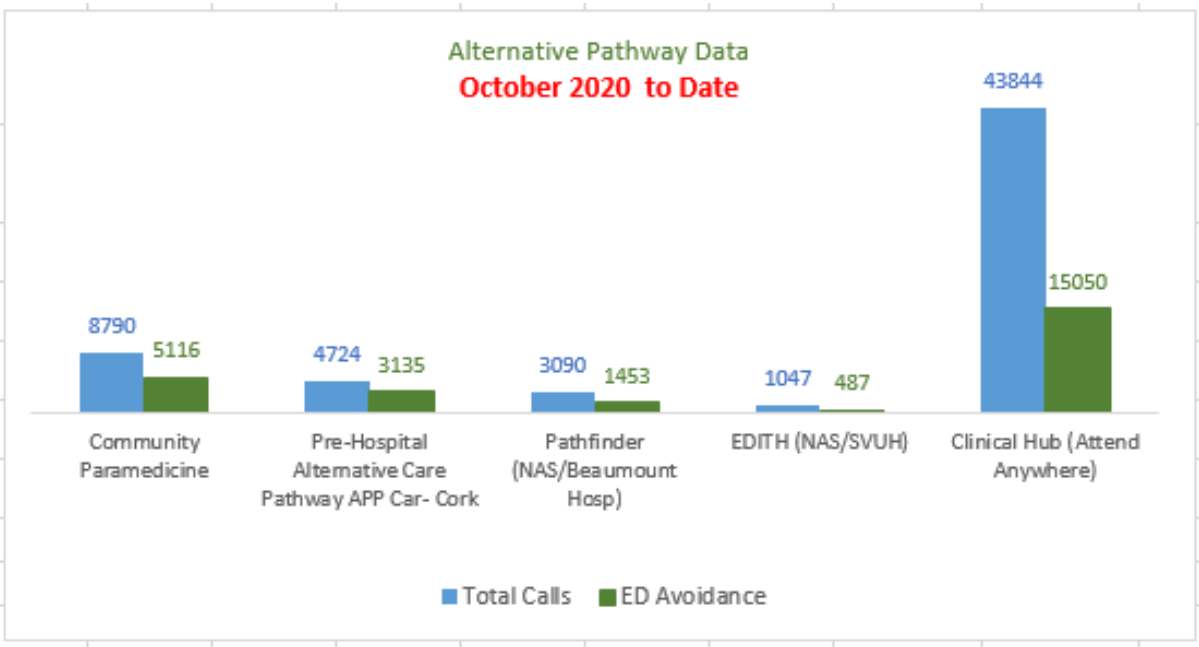
2020	2021-2031
The call taker categorises Mary's call and the Dispatcher arranges for the next available emergency crew to attend Mary. The attending emergency ambulance crew assess Mary and transfer her to the nearest emergency department. Due to emergency department capacity and the stability of Mary's medical condition, the crew are unable to perform an immediate handover. In-hospital capacity is also reduced, so Mary spends a long time in the emergency department. Mary remains in hospital for an extended period as the Advanced Nurse Specialist in respiratory care had to reduce the number of patients that can be seen in their assessment facilities.	The Call Taker categorises Mary's call and the Dispatcher arranges for a Community Paramedic (CP) to attend Mary. The CP carries out a comprehensive medical assessment – exacerbation of Chronic Obstructive Pulmonary Disease (COPD) confirmed. Together with Mary, the CP liaises via tele-link with Mary's GP to agree any necessary changes to Mary's medication and care plan. The GP revises Mary's prescription electronically and the local pharmacy arrange delivery of her medication. The CP arranges for the local Community Occupational Therapist (COT) to attend Mary. The COT assesses Mary and her home environment, identifies trip hazards and areas that can be adapted to Mary's needs. The COT provides Mary with advice and equipment, rearranges areas where there are immediate fall risks, and organises a follow-up visit for railings to be fitted where needed. The CP also arranges for an Advanced Nurse Practitioner in respiratory care to attend Mary later in the day and ensures that Mary is comfortable and safe before leaving. Mary remains living independently at home.

Specialist Care		
Scenario 3 (Trauma System for Ireland Example)	Tom is a 25-year-old motorcyclist who has been involved in a high speed road traffic collision in a rural area on a Saturday afternoon.	
	2020	2021 - 2031
	The immediate and serious nature of the call is identified by the Call Taker and the Dispatcher sends an emergency ambulance crew and an AP to the scene. The Dispatcher also requests the Emergency Air Support desk send the Helicopter Emergency Medical Service (HEMS) – staff includes an AP. The ground crews arrive before HEMS and recognise that Tom has a traumatic brain injury, and an isolated femur fracture. He is combative and agitated, has vomited and is not able to maintain his airway. The crews work together to stabilise Tom and fly him to the closest hospital that can provide neuroprotective anaesthesia. Upon hospital arrival, Tom is handed over to a team who immediately perform a rapid sequence intubation, providing airway protection and neuroprotective anaesthesia. Bedside ultrasound confirms that Tom does not have any significant bleeding in the chest or abdomen. After performing computerised tomography scans, the closest neurosurgical centre is contacted and an inter-hospital transfer via road is organised. A team incorporating an anaesthesia registrar, a senior emergency department staff nurse and two emergency ambulance crew member's transfers Tom to the neurosurgical centre. Tom is handed over to the waiting hospital team and brought to theatre.	The immediate and serious nature of this call is identified by the Call Taker and the Dispatcher sends an emergency ambulance crew and an AP to the scene. The Dispatcher also requests the Emergency Air Support desk send the Helicopter Emergency Medical Service (HEMS) – staff now includes a Critical Care team. The ground crews arrive before HEMS and recognise that Tom has a traumatic brain injury and isolated femur fracture. He is combative and agitated, has vomited and is not able to maintain his airway. The crews work together to stabilise Tom. The HEMS Critical Care team perform roadside rapid sequence intubation providing airway protection and neuroprotective anaesthesia. They also perform a roadside ultrasound and confirm that Tom does not have any significant bleeding in the chest or abdomen. This means that they can take the time to traction Tom's fractured femur thereby preventing further blood loss. If required, the Critical Care team can also administer blood products. Based on the initial clinical assessment and the fact that Tom's condition has been stabilised, the Critical Care team makes the decision to fly Tom to the major trauma centre, reducing delays to vital treatment and eliminating the need for inter-hospital transfer. On arrival, the receiving team immediately continue Tom's major trauma treatment.

8.7 The progress made by NAS staff is contributing to an overall reduction in demand on ED services across the HSE and the NAS workforce has demonstrated the capacity to increase the percentage of patients whom can receive safe and effective care away from the traditional ED pathway:



8.8 Since 2020, a significant number of patients have benefitted from the initial work done in this area of healthcare delivery:



8.9 Key SlainteCare related developments have included:

A. Expansion of the Clinical Hub to provide "Hear and Treat" services, thus avoiding ED attendance
B. Community Paramedics to work with General Practitioners and the Integrated Care Programme for Chronic Disease Management to increase the numbers of patients who can be treated and supported away from an acute hospital
C. Pathfinder Teams to work with the Integrated Care Programme for Older People to support older and frail patients to remain well at home
D. Alternative Pathway Project (APP) involving an EMT and Specialist Registrar responding to and treating more 999 callers at home
E. Supporting the roll out of specialised acute services such as the Trauma Strategy for Ireland and the centralisation of hyper acute care for Stroke and Acute Coronary Syndrome
F. Introduction of Paramedic led "Treat and Discharge" protocols to ensure patients receive the right care in the right place.
G. New referral pathways for Paramedics to Medical Assessment Units and Local Injury Units
H. Introduction of new interim measures to improve Ambulance Turnaround Times at EDs including Hospital Ambulance Liaison Persons, Fit2Sit, Rapid Handover Protocol and ED Cohorting

9. Proposed Pay Scales

9.1 These proposals present an opportunity to re-calibrate clinical staff grading structures so that they are fit for purpose, present clear and transparent career pathways, and in doing so, enable a continuing programme of modernization and reform. The table below outline the revised grade design and proposed pay scales for current roles:

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Level 8	Level 9
EMT	33,683	35,817	36,649	38,183	39,810	41,461	43,119	44,820	45,657
PARAMEDIC	42,183	43,210	44,311	45,440	46,614	49,183	51,685		
SPECIALIST PARAMEDIC	44,966	45,901	47,117	48,308	49,705	52,157	54,612	56,722	
PARAMEDIC SUPERVISOR	43,566	45,000	46,234	47,650	48,900	52,157	53,612		
CLINICAL PARAMEDIC SUPERVISOR	48,300	49,562	50,800	52,035	53,279	54,591	55,983	57,871	60,500

9.2 The rationale for selecting the above pay scales can be broadly described as follows:

EMT

Comparable to other registered Healthcare Professionals where the employee requires a minimum FETAC Level 6 qualification and is providing direct patient care in an unsupervised environment

Paramedic

Comparable to other registered Healthcare Professionals where the employee requires a minimum QQI Honours Degree and is providing direct patient care in an unsupervised environment. Also comparable to the pay structure of other Principal Emergency Service workers

Specialist Paramedic

Comparable to other registered Healthcare Professionals where the employee requires a minimum QQI Level 9 Master's Degree and is providing specialist patient care in an unsupervised environment but also providing specialist advice to colleagues. Also cognizant of the current Advanced Paramedic Allowance which would be abolished.

Paramedic Supervisor

Comparable to other registered Healthcare Professionals where the employee requires a minimum QQI Honours Degree and is providing direct patient care in an unsupervised environment but is also responsible for the operational supervision of other registered healthcare professionals.

Clinical Paramedic Supervisor

Comparable to other registered Healthcare Professionals where the employee requires a minimum QQI Level 9 Master's Degree and is providing specialist patient care in an unsupervised environment but also providing specialist advice to colleagues. Also cognizant of the current Advanced Paramedic Allowance which would be abolished.

Allowances - Qualifications

These proposals include the abolition of all qualification allowances including the Cardiac and Advanced Paramedic allowances for all beneficiaries of these proposals

Allowances - Location

These proposals include the abolition of all location allowances including the Travel or "Dublin" allowance for all beneficiaries of these proposals

Allowances - Premia

These proposals include the of abolition of all current pensionable (Shift, Saturday, Sunday and Unsocial Hours) allowances as well as current Holiday Premia arrangements for all beneficiaries of these proposals and the introduction of a single pensionable "Rostered Allowance", graduated in value to match the specific rostering requirements of service needs:

I. *Requirement to work the hours of 08.00 hours to 20.00 hours on a 5/7 basis (12/7): 15% of Basic*
II. *Requirement to work the hours of 08.00 hours to 00.00 hours on a 5/7 basis (16/7): 20% of Basic*
III. *Requirement to work on a 24/7: 30% of Basic*

Reduced Hours

Where any proposed beneficiary works reduced hours, then both Basic Salary and the financial value of the graduated "Rostered Allowance" are reduced on a pro rata basis.

9.3 The rationale for selecting the above approach to allowances can be broadly described as follows:

A. The current allowance based contribution to gross earnings is disproportionate
B. The nature of current allowances is significantly out of line with most other healthcare workers
C. The payroll management environment is cumbersome, complex and prone to under and overpayments
D. The calculation of arrears is laborious and contentious
E. There are custom and practice arrangements whereby staff whom may not qualify for shift premia receive both shift and holiday premia
F. There are no graduated arrangements in place which reflect the variability in shift working commitments

Assimilation

In line with arrangements applying to a range of other registered healthcare professionals, assimilation between current and proposed pay scales for those existing staff encompassed by these proposals would be based on corresponding points.

10. Future Roles

10.1 There is a clear need to address the effectiveness of existing supervision structures that have limited time for staff supervision and organisational audit and compliance requirements such as Health and Safety Statements and Level 1 Audits.

10.2 In this context, the parties agree to the phased introduction of a supernumerary role of Station Manager, capable of providing direct patient care in an unsupervised environment but primarily responsible and accountable for the management of other registered healthcare professionals and the full gambit of audit and compliance functions in one or more Service Delivery Hubs. This new role is also comparable to other Principal Emergency Service workers whom perform leadership roles at major emergencies or serious incidents.

10.3 The HSE expects up to 90 such posts will be required across NAS, depending on the size and location of current and future Service Delivery Hubs. There is no basis for such roles to work 24/7 with location assignments determining whether the post attracts the proposed 15% or 20% Rostered Allowance. These posts will be promotional posts and therefore posts will be filled in the normal way, i.e. open recruitment competition.

10.4 Over time, these posts will effectively negate the need for the Paramedic Supervisor role, hence NAS will not fill any current or future Paramedic Supervisor vacancies.

10.5 The HSE is also concerned about the availability of effective professional development, internship development and practice facilitator capability at a time when the NAS clinical workforce is projected to expand significantly up to 2031.

10.6 In this context, the parties have agreed to the introduction of a supernumerary role of Clinical Practice Facilitator, where the employee requires a minimum QQI Level 9 Master's Degree, providing specialist patient care in an unsupervised environment, providing specialist advice to colleagues and responsible for supporting and facilitating the clinical and professional development of a wide range of students and trainees as well as registered healthcare professionals under the direction of a Paramedicine Tutor.

10.7 The HSE expects that up to 100 such posts will be required across NAS, depending on overall numbers of staff in post by 2031. These roles will not be required to work 24/7 with most posts expected to attract the proposed 15% Rostered Allowance. These posts will be promotional posts and therefore posts will be filled in the normal way, i.e. open recruitment competition.

10.8 Over time, these posts will effectively negate the need for the Clinical Paramedic Supervisor role, hence NAS does not intend to fill any Clinical Paramedic Supervisor posts beyond transitioning those existing Paramedic Supervisors whom are registered as an Advanced Paramedic with PHECC as of the 31 May 2023.

10.9 The table below outline the proposed pay scales for these two new roles:

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Level 8	Level 9
STATION MANAGER	47,335	48,810	50,284	51,762	53,249	54,984	56,722		
CLINICAL PRACTICE FACILITATOR	53,070	55,065	57,162	59,295	61,455	62,553			

11. Human Resource (HR) Implications

11.1 A number of transactional HR implications would arise from these proposals which can be described as follows:

11.2 Grade Codes

A. ***EMT*** – existing grade would require an updated pay scale
B. ***Paramedic*** – no grade code exists so a new grade code is required
C. ***Specialist Paramedic*** – no grade code exists so a new grade code is required
D. ***Paramedic Supervisor*** – existing grade would require an updated title and pay scale
E. ***Clinical Paramedic Supervisor*** - existing grade would require an updated pay scale
F. ***Station Manager*** - no grade code exists so a new grade code is required
G. ***Clinical Practice Facilitator*** - no grade code exists so a new grade code is required

11.3 Job Descriptions

Draft job descriptions have been developed for each role

11.4 Eligibility Criteria

Draft eligibility criteria have been developed for each role

11.5 Allowances

A new payroll code would be required to facilitate the introduction of the 3 proposed bands of "Rostered Allowance":

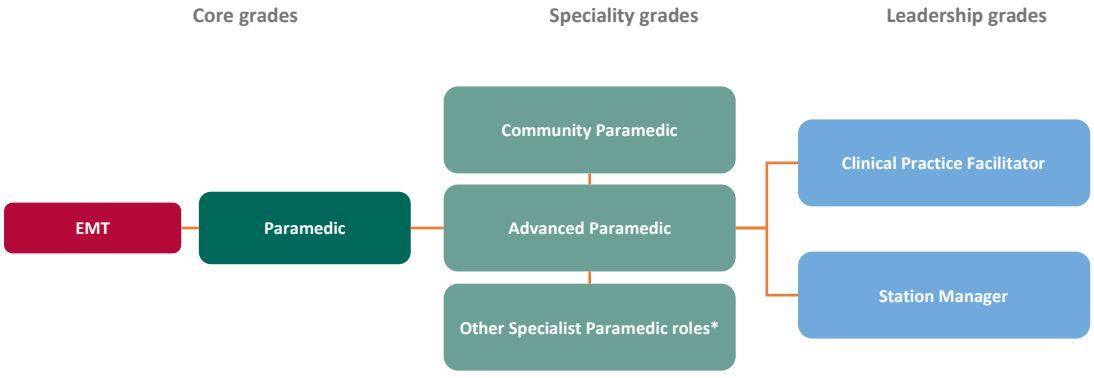
- 15% of Basic Salary
- 20% of Basic Salary
- 30% of Basic Salary

11.6 Industrial Relations

A new National Pay Modernisation and Transformation Agreement would be required which would supersede every previous agreement, recommendation, adjudication or conciliation outcome relative to the roles encompassed by these proposals.

The trade unions who are parties to these proposals also recognize the importance of maintaining the integrity of any such agreement and would commit not to quote these measures as precedence for any other grade, group or sector.

11.7 Future Career Pathways



11.8 Starting Pay on Promotion

For future promotions and in line with other health and social care professionals, the value of the differential is added to the employee's current salary and rounded to the nearest salary point on the higher scale. **Reference**: *Department of Health and Children Circular No. 152/2000 issued 18 December 2000.*

11.9 Annual Leave Arrangements

The provisions of the current NAS National Framework – Structured Leave (V7 signed 17 January 2007) will continue to apply, with the notable exception of inclusion of the new public holiday in February approved by Government.

Modernisation of rostering arrangements as provided for in Section 12.4 (B) will render the Relief Arrangements element of the current NAS National Framework – Structured Leave (V7 signed 17 January 2007) obsolete. In this regard, the parties are agreed that the current NAS National Framework – Structured Leave (V7 signed 17 January 2007) will be incorporated into a new Pay Modernisation and Transformation Agreement.

11.10 Working Hours

Full time working hours for each role encompassed by the scope of these proposals will be those applicable as of the 31 May 2023. Working hours will continue to be averaged over the lifetime of any rostering period.

11.11 Opt Out Clause

The parties recognise that the average weekly earnings for 39 hours (including current basic and all allowances) for a small group (estimated at less than 30) staff could potentially suffer a nett loss as a consequence of these proposals.

The parties are agreed that no one encompassed within the scope of these proposals should suffer a nett loss for working 39 hours. Therefore, where any staff member encompassed by these proposals can identify a subsequently verified nett loss based on their weekly 39-hour earnings, then they can opt out of these proposals and not be a beneficiary in any way.

The HSE has confirmed that any individual who identifies a subsequently verified nett loss based on their weekly 39-hour earnings, but does not opt out of these proposals, will not have any basis for a subsequent loss of earnings claim. Any staff member opting out of these proposals would still continue to receive any other increases that may arise under the Public Service Agreement.

12. Enabling Transformation

12.1 The parties recognize the need to identify clear and tangible savings to contribute to the costs of these proposals. In this regard, the parties are agreed that on acceptance of these proposals, a new National Agreement for the National Ambulance Service (NAS), to supersede all previous agreements, would include:

A. Abolition of the 1997 National Ambulance Agreement and all subsequent and related clarifications and adjudications (1998-2005), and in particular consolidation of allowances and double time for rest day working

B. Abolition of all qualification allowances including the Cardiac and Advanced Paramedic allowances (HR Circular 011/2009), all location allowances including the Travel or "Dublin" allowance, all Shift, Saturday, Sunday and Unsocial Hours allowances as well as current Holiday Premia arrangements

C. The abolition of any rostered overtime arrangements in any location

D. Elimination of all remaining on call arrangements including in every and any location where any form of on call type arrangement exists

E. Full adoption of the PHECC Minimum Crewing Model – EMT and Paramedic crew (see specific section)

F. Practices which inhibit the full utilisation of any relief factor so as to ensure every hour of locum requirement for any reason is covered in the first instance by relief personnel, including short notice changes to rosters, in line with the provisions of the Organisation of Working Time Act 1997, to address unforeseen absences.

12.2 The parties also recognize the need for the time bound development of a comprehensive new Pay Modernisation and Transformation Agreement for NAS that would supersede all previous agreements, adjudications and relevant circulars including but not limited to:

A. 1978 Ambulance Agreement (each respective former Health Board version)

B. National Framework Agreement – Role, Functions and Conditions for the Contracting and Deployment of Private Ambulance Services and Agency Sourced Staff (noting the provisions of national public service agreements)

C. National Framework Agreement – LEMT Deployment (in line with Paragraphs 10.4 and 12.3 (G) of these proposals, the parties have agreed to the introduction of a new role of Station Manager, for which both the salary and role have been agreed under this Proposal)

12.3 The new agreement will also recognise and formalise ongoing co-operation with the following transformative arrangements:

A. PHECC EMS Dispatch Standard including deployment of EMT, Paramedic and Advanced or Specialist Paramedic to urgent and emergency calls

B. PHECC Regulatory Frameworks (Community Paramedic, etc.) and the Fitness to Practice Process

C. Introduction of the Emerging Threat Team and a widening of its scope to include emergency planning, preparedness and all specialist response capabilities

D. Expansion of the Critical Care Retrieval Service (CCRS) and the implementation of the Strategy for Aeromedical Provision in Ireland (HEMS)

E. In line with the NAS Workforce Plan, the expansion and tiering over time, of the Intermediate Care Service, and expansion of the NAS Tertiary Educational capacity from 2 NAS College Campuses to 6 sites by the end of 2025

F. Use of external service providers in line with the NAS Capacity Action Plan (NASCAP)

G. Cooperation with the NAS Organisational Re-Design Programme and improved career pathways designed to improve attraction and retention. In particular, the related re-design of operational supervisory, management and professional development structures

H. Implementation of the Service Delivery Hub and Spoke Model (EDPs including use of other State assets, e.g. Fire Stations)

I. Implementation of Staff Bank arrangements and family friendly working arrangements including part time and shorter working week arrangements

J. Implementation of the Fleet and Asset Coordination Centre and adoption of new vehicle types including the implementation of renewable energy sources

K. Implementation of Alternative Care Pathways including the NAS Clinical Hub, Pathfinder, EDITH, Alternative Pathway Project, Mental Health, Community Paramedic and See, Treat and Refer initiatives including Treat, Refer or Discharge at scene

L. Mentoring and practice development arrangements for an increased number of students and interns across a number of professions

M. Diversification of the NAS workforce including multi-disciplinary working with nursing, medical and health and social care professionals

N. Transition of all remaining NAS staff to central NAS Time Return in Tullamore, adoption of NiSRP HR and Payroll Self Service and payment through PayPath (Electronic Funds Transfer)

12.4 The new agreement will also facilitate the implementation of the following proposed transformative arrangements:

A. Adoption of and compliance with the pay provisions relating to the Health and Social Care Professionals Staff Category including overtime rates, qualification requirements and remuneration for rostering commitments

B. Modernisation of rostering and scheduling arrangements that abolish the current two tier system of rostered/relief and the introduction of improved centralised and technology enabled arrangements for rostering and scheduling.

C. In line with Paragraph 12.4 (B), a rolling review of all existing rosters which will include a minimum shift overlap of two hours in any location, with more than one resource on duty at a time to reduce the impact of late finishes for staff and delayed responses for patients.

D. Commitment to the full utilisation of eLearning platforms such as NAS Moodle and HSELand to increase staff access to professional development and achieve a reduction in staff abstraction from live duty

E. Introduction of a new EMT to Paramedic apprenticeship programme and the introduction of additional university direct entry CAO paramedicine programmes and interns to increase the future recruitment pool

F. Development of a Volunteer Model and support for Schools Programmes and Recruitment Fairs that promotes Injury Prevention, volunteerism and interest in a career in the National Ambulance Service

G. It is accepted that any new agreement would recognise NAS staff for all educational standards, up to and including QQI Level 8 (Paramedic and related grades) and QQI Level 9 Specialist Paramedic and related grades).

H. Introduction of new technologies including Staff APP, personal issue ePCR devices, Telehealth technology and Body Cams if collectively deemed to be a required control measure to violence and aggression

I. Introduction of a NAS based WELLNAS Programme integrating NAS provided Occupational Health, Staff Wellbeing, Critical Incident Stress Management, Clinical Psychology, Physiotherapy supported Return to Work and the HSE provided Employee Assistance Programme

12.5 **Culture and Engagement**

The trade unions who are party to any new agreement will commit to maintaining the full integrity of that agreement and will not support any individual or collective attempt to circumvent, veto, deviate from or undermine that agreement in any forum or through any process including the HSE Grievance Procedure, the Workplace Relations Commission or the Labour Court. For the avoidance of doubt, the parties to such an agreement would adopt a monitoring KPI that would focus on ensuring a continuous reduction in industrial relations activity and claims supported by any trade union.

12.6 Agreement to Implement the PHECC Minimum Crewing Model Standard

Arising from a programme of engagement with the Irish Ambulance Representative Council (SIPTU/UNITE), it is agreed as part of the transformation of NAS service delivery, that the PHECC Minimum Crewing Model is accepted by all parties as the basis of the NAS Operating Model. The purpose of this agreement is to enable NAS to accelerate solutions to the following:

- Significant mismatch between demand and capacity – increase on duty resources
- Career pathway for Emergency Medical Technicians (EMTs)
- Implementation of a BSc. Honours in Paramedic Studies Apprenticeship

It is also important to recognise the challenges that NAS will face to recruit and educate Paramedics through a 3-year Level 8 degree program to meet our workforce requirements as set out in the NAS Strategy to 2031

Future Development of the Intermediate Care Service (ICS) - The development of the NAS ICS remains a key organisational objective demonstrated by the major recruitment campaigns in 2022 and 2023. In line with the PHECC EMS Dispatch and Inter facility Standards, it is planned to continue to grow the ICS to meet the needs of NAS and the wider health system in areas as follows:

Service	**Role**	**Crewing Model**	**Standard**
Dedicated ICS	To support the needs of individual acute hospitals within HSE Health Regions, e.g. inter-hospital facility transfers, discharging to support patient flow, acute repatriation and outpatient procedures and clinics where an ICS resource is deemed clinically appropriate by the requesting acute hospital.	2 x EMT Crew	PHECC Inter facility Standard
Flexible ICS	Provision of a service to be able to respond to low acuity 999 calls, Urgent request from GPs in a community setting, responding to inter-hospital transfers from acute hospital facilities, including P37.	2 x EMT Crew	PHECC Inter facility Standard PHECC EMS Standard
Emergency Response	EMTs working alongside their colleagues at Paramedic/Specialist Paramedic on front line EAs responding to all calls as required.	Paramedic or Specialist Paramedic and EMT	PHECC EMS Standard Relevant P37 calls requiring Paramedic care

In line with the NAS Strategy to 2031, NAS will continue to seek new development funding through the annual estimates process, to continue to increase capacity across ICS, ETT and EO services in line with the NAS Workforce Plan

To achieve the above aims, NAS will assign newly recruited EMTs to both the Intermediate Care Service, the Emerging Threat Team and Emergency Operations on a 2:1:2 basis demonstrating a clear commitment to expanding each of these service functions and noting that ETT staff continue to provide additional capacity to ICS Operations.

Where PHECC change or amend the Minimum Crewing Model, then NAS and the parties to this agreement accept that the above arrangements will require review. In the absence of such a review, NAS will aspire to move beyond the Minimum Crewing Model by 2031.

13. Expected Benefits

In addition to the modernization agenda set out above, the following benefits are also envisaged:

Patient Benefits

A. Safeguard availability and the advanced clinical ability of the service
B. Improved patient outcomes due to enhanced clinical abilities
C. Appropriate recognition will deliver benefits for the patient, supporting ongoing development of the service to provide a 'gold standard' of paramedic professionals
D. The high level of third level education undertaken by NAS clinical staff translates to a higher level of patient care - appropriate recognition of this training will attract more people into the service and encourage grade progression
E. NAS staff can become a potent contributor to the delivery of primary care in a context where the wider GP workforce is challenged with workload and staffing
F. Support the transformation of wider healthcare, e.g.:

Example 2:

Community Paramedic deployed to Wexford following the fire at Wexford General Hospital resulting in a daily reduction of 6-8 patients per day being conveyed to an Emergency Department. With an average conversion rate of 27% between ED attendance and hospital admission and an average length of stay of 7 days for under 75 years' patients. This represents a potential reduction of 420 acute bed days per month, thus improving access for patients to urgent and emergency care.

Example 1:

The SVUH/NAS ED in the Home (EDITH) responds to approximately 250 patients per month with 91% of those patients not requiring conveyance to an Emergency Department. The majority of these patients are over 75 years of age with the average length of stay in an acute hospital being up to 15 days each. This represents a potential reduction of 3,405 acute bed days per month, thus improving access for patients to urgent and emergency care.

Health Service Executive Benefits

A. Addressing the residual outcomes from a WRC facilitated process in December 2018
B. Implementation of subsequent recommendations of McHugh/Crabtree Review and Examination of Current EMT, Paramedic and Advanced Paramedic roles
C. Reduced risk and IR exposure due to improved and appropriate alignment with the wider HSE
D. Improved workforce attraction and retention for the NAS in a period where demand is expected to grow by over 100% over the coming years
E. Ensures appropriate recognition of NAS staff's advanced clinical ability since 1997
F. Improved cultural indicators, such as reduced use of HR/ IR processes and DAW complaints
G. Streamlined, transparent grading structure
H. Sets the service up for future evolution of roles, with job descriptions fit for purpose for present and future staff requirements
I. Ability to strategically prepare for the future with a clear progression path for NAS staff
J. Enhanced clinical ability of Paramedics enables rollout of Sláintecare strategy. This will evolve the NAS model of care to bring in line with international best practice

K. Greater accountability due to defined roles, ownerships and responsibilities
L. Improved staff outputs and job satisfaction through appropriate recognition and pay scale
M. Adoption of this new structure would end the practice of paying double time for working on rest days as per the 1997 Pay Agreement and move the service to HSE standard overtime rules as per HSE Terms and Conditions
N. An end to the outdated and no longer fit for purpose 1997 Pay Agreement, including consolidation of allowances arrangements - resulting in a more structured and well defined salary scale which serves current and future needs
O. Harmonisation of remuneration arrangements with the HSE's Terms and Conditions Guidelines

14. Cost of Implementation

The gross cost of implementation of these proposals is set out below:

Proposed Job Grade	Estimate Increased Cost		Estimated WTE per grade 20/6/23
EMT	€	1,376,614	408
Paramedic	€	16,182,702	1200
Specialist Paramedic	€	4,031,343	271
Paramedic Supervisor	€	1,478,288	144
Clinical Paramedic Supervisor	€	1,555,990	112
Total Estimated annual cost	**€**	**24,624,937**	**2,135**

Offset Savings

The modernisation agenda underway and proposed is predicted to achieve a range of significant savings, both within NAS and the wider HSE including:

A. Removal of the current allowances – Advanced Paramedic, Cardiac Allowance and Holiday Premia
B. Removal of Double time overtime for Rest Day Working
C. Removal of all current payroll and allowance based anomalies
D. Removal of Consolidation of Allowances for overtime calculation
E. Adoption of PHECC Minimum Crewing Model
F. Reduction in overtime expenditure related to higher level of absenteeism
G. Reduction in Coroner costs due to calling out GPs to pronounce death in a community setting
H. Reduction in staff abstraction for professional development purposes
I. Delivery of Alternative Care Pathways has generated savings for the wider HSE which are reported on weekly:

Running Totals - Alternative Pathway Data
October 2020 to Date

Alternative Care Pathway	Total Calls	ED Avoidance Numbers	ED Avoidance %	ED Attendance	ED Attendance %	Average ED Cost per Patient €	Estimated Cost Savings €
Community Paramedicine	8790	5116	58%	3674	42%		€997,620
Pre-Hospital Alternative Care Pathway APP Car- Cork	4724	3135	66%	1587	34%		€611,325
Pathfinder (NAS/Beaumount Hosp)	3090	1453	47%	1644	53%		€283,335
EDITH (NAS/SVUH)	1047	487	47%	549	52%		€94,965
Clinical Hub (Attend Anywhere)	43844	15050	34%	28686	65%		€2,934,750
	61,495	25,241	41%	36,140	59%	€195	€ 4,921,995

The introduction of Alternative Care Pathways by NAS to the wider population has allowed an increasing number of 999 patients to avoid ED attendance and hospital admission. These pathways include the Clinical Hub, Community Paramedic, Pathfinder and the Alternative Pathway Project. These Sláintecare related care pathways do not provide direct savings to NAS but do need to be recognised in the overall savings arising from these proposals.

In this context, the following sets out the expected and potential nett cost in Year 1:

	€ Amount
Current Cost	€102,597,282
Proposed new scales cost	€127,222,219
Potential Gross Costs	**€24,624,937**
NAS Direct Savings	
Allowances – Advanced Paramedic / Cardiac / Holiday / Shift / Consolidation / Saturday / Sunday	€5,500,000
Overtime – change from double to time plus half - rest days	€300,000
Crewing Model Changes	€550,000
Reduction in staff abstraction for professional development purposes (7,188 hours)	€185,000
Potential Nett Costs (exclusive of SláinteCare related savings)	**€18,089,937**
SláinteCare Initiatives (projection based on 2023 performance (first 24 weeks))	
Estimated System wide savings from ED Avoidance Measures (Clinical Hub, Pathfinder, Community Paramedic, Alternative Pathway Project (APP)) (€195 per patient not conveyed to ED – Average 218 per week)	€2,218,172
Estimated System wide savings from Admission Avoidance (52% of over 75 years patients (13 of 218 patients per week – AvLoS* 7 days x €446 per bed night))	€2,117,777
Estimated System wide savings from Admission Avoidance (27% of under 75 years' patients (52 of 218 patients per week – AvLoS* 3 days' x €446 per bed night))	€3,630,476
Recognition of death (cost avoidance – GP payments to pronounce death in the community) (3848 patients x average €260 per callout)	€1,000,480
Potential System savings to HSE & S38 Hospitals (SláinteCare related savings) and Coroners	**€8,966,905**
Potential Nett Costs (inclusive of SláinteCare and NAS related savings)	**€9,123,032**

**AvLoS = Average Length of Stay Medical Patients*

15. Conclusion

As an organization, NAS has made considerable progress in implementing a significant reform agenda whilst continuously striving for clinical performance and efficiency in the delivery of our services.

Despite the challenges we have faced, we are proud to say that our staff have remained individually and collectively dedicated to the delivery of high quality and safe patient care. We recognize that the success of our organization is dependent on the quality and commitment of our staff, and therefore we must ensure that our staff feel valued and supported so that we can continue to put the needs of patients at the heart of everything we do.

In this context, these proposals seek to position the NAS workforce to be a core contributor to and enabler of the wider shift in models of care. In doing so, these proposals seek to ensure a clearer and more appropriate grading structure for these important roles.

Through the implementation of these proposals, we will create an improved employee experience, optimize the work environment and build a sustainable and resilient workforce.

Successful progression and adoption of these proposals will support the ongoing development of NAS to provide leading edge changes to the way urgent and emergency care services are delivered in Ireland by a professional workforce whom feel valued, recognized and empowered to deliver on the most significant Ambulance Service work place reform since 1978.

16. Submission

This document reflects the outcome of discussions, engagement and consultation originating from a process facilitated by the WRC. The parties to these proposals are cognizant of current challenges, the need to respond to public expectation for change and service improvement and the reality that decision makers will need to consider many competing demands for investment.

For its part, these proposals reflect an ongoing commitment by the NAS workforce to ongoing transformation and innovation which is evidence based and grounded in a once in a generation pandemic.

In this context, the parties below submit and commend these jointly developed and agreed proposals (**v4 finalised on the 23 June 2023**) to the HSE's National Employee Relations Service (NERS) with a view to recommendation to both the Department of Health and the Department of Public Expenditure and Reform for consideration and prioritization in the next round of national pay discussions on a successor agreement to the current Building Momentum.

_____	_____	_____	_____
Robert Morton	**Ted Kenny**	**Brian Hewitt**	**Greg Lyons**
Director	**Sector Organiser**	**Regional Officer**	**Chairperson**
NAS	**SIPTU**	**UNITE**	**IARC**

Date: 23 June 2023

17. Appendices

Appendix I - ***"Review and Examination of current EMT, Paramedic and Advanced Paramedic roles in the National Ambulance Service"***

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