Consultation response pro-forma

A Community Resuscitation Strategy

for Northern Ireland

Name and address of organisation or individual responding:

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Note: If you wish to respond to some or only one of the questions, please do so. The Department will welcome and will consider all responses.

1 Given the case that has been made for having a community resuscitation strategy, in section 2 of this document, do you agree that the Vision and Objectives that are proposed for the strategy are a good basis for action? We would welcome any amendments that you may wish to suggest.

Yes, these objectives (section 3) are welcomed, but need to build on what is already working, and not replace all that is already working well.

Significant coordination will be required to bring all the objectives together within a reasonable timescale and to measure their impact.

2 The core of the Strategy will be the set of actions that will further the Objectives.

a. We would welcome your views on any of the proposed actions set out in section 4.

- PHA – communication strategy is a good idea, but needs to build on successes eg the Vinny Jones advert from BHF. Resuscitation Council UK have won worldwide awards for their new CPR training app/dvd.

- Data exist on assessing barriers to people performing CPR – several worldwide studies will tell us this.

- As regards commissioning a model of community resuscitation, this is what CRDOs in each Trust have done working in departments with strong affiliation/partnership with Resuscitation Council UK and the European Resuscitation Council.

  The figures for Heartstart 2012 say 31,000 school children trained in Northern Ireland.

  Page 30 refers to 60,000 potential employees in HSC - are they going to be released for training and will senior experienced personnel be available to provide the training?

- NIAS will engage with CPR training providers to ensure consistency of approach In Northern Ireland. There is a need to provide training using current Resuscitation Council UK guidelines with recommendation for maximum hands-on manikin time rather than tutorials.

- NIAS will provide information/guidance about AEDS including signage. There is already national guidance from BHF and Resuscitation Council UK, and separately European Resuscitation Council.

b. If you believe that there are any other potential actions that could further the Objectives but have been omitted, we would welcome your suggestions.

Build on current services and ring-fence a budget for this priority activity.

Increase recognition of pre-arrest situations and prevention of cardiac arrest.

3 Bearing in mind that early resuscitation is vital for the survival of a person who suffers an out-of-hospital cardiac arrest (OHCA), are there any groups of people who in your view should be targeted or prioritised for CPR training?

Cardiac rehabilitation patients and their families would be prime targets. Also, target people working in leisure facilities, restaurants, shopping centres, sports venues, stations/training and airports. Larger employers should also be encouraged to adopt training.

4 We would welcome your views on

a. how best to promote public understanding of the importance of immediate bystander intervention in the event of an OHCA, and

Media campaigns such as the BHF Vinny Jones advert and use of the free Resuscitation Council (UK) Lifesaver interactive film which has won various e-learning and education awards.

b. how best to address the concerns that make some people apprehensive or reluctant to intervene.

- Introduction of good Samaritan Act.
- Increased education about low risk of infection.
- Increased availability of face masks.
- Publishing personal stories of those who have intervened successfully eg Youtube.

5 Given that the resources available for the Strategy will be finite, and that the current financial climate makes it unlikely that significant additional resources will become available in the near future, we would welcome your ideas on how value for money might be maximised in pursuing the Objectives of the Strategy.

CRDOs in Trusts have made a significant impact, and this has been a cost-effective way of providing training and initiating cascade training systems.

Dedicating and protecting staff time to develop training programmes will be essential for successful implementation

6 The Service Framework for Cardiovascular Health and Well-being seeks to promote access to CPR training in three broad categories of settings: schools, workplaces and communities. We would welcome your views on how the provision and the uptake of CPR training could be promoted in any of these settings.

- CPR should be mandatory in schools – perhaps as part of key stage 3.
- Team sports at school and college level should require training.
- Trainers need to be highly visible with their success promoted.
- Staff should be released in work places and trained by their local cascade trainer. The RCPE has a number of trained staff within its own workforce.
- Numbers trained needs to be reported regionally.

7 We would welcome your views on whether employers should be encouraged to offer CPR training to staff who are not trained first aiders, and how this might be done.

Yes, cascade training with Community Resuscitation Development Officers training a cascade trainer. Staff need not be first aid trained.

RCPE has found this is reassuring to visitors and those who rent space in the College and to its staff – it brings commercial benefit.

8 We would welcome your views on

a. the siting of automated external defribillators (AEDs), for example in busy public spaces, and

Public access defibrillators need to be available in sports grounds, schools etc but also in remote communities with clear accountability for checking and maintenance, with NIAS and members of the public having clear knowledge of location.

Secure locations are essential with signage similar to that used to guide the public to emergency exits.

b. how to ensure that AEDs in busy public spaces and in other places are accessible in the event of a cardiac arrest.

As above.

9 Progress in delivering the Strategy will be monitored; the effectiveness of the Strategy and of the specific actions that it comprises will be reviewed periodically. How best should we monitor and assess the impact of the Strategy over time?

Need accurate baseline data on number of out of hospital cardiac arrests, if CPR had been started by a by-stander, who they were trained by, what time the ambulance was activated, what time they arrived, initial rhythm and resuscitation details including whether an AED was deployed, and the length of time from collapse to deployment.

This will require deliberate investment in IT systems to enable efficient and effective data collection.

10 Please provide any other comments or suggestions that you feel could assist the development and/or delivery of the Strategy.

Need to build on local success – provide continued funding for CRDOs in post in Trusts. Concerns have been expressed by physicians in Northern Ireland about NIAS having responsibility for oversight/co-ordination of this strategy. There is within Northern Ireland a very active, motivated body of resuscitation training officers, employed by Trusts, working co-operatively between Trusts to provide training. These members of staff should perhaps have a management structure and adequate staff resourcing which would allow them to be instrumental in developing and delivering this strategy. Investment will be critical to making this laudable vision a reality.

Statutory equality duty

11 Section 75 of the Northern Ireland Act 1998 requires public bodies, in carrying out their functions in relation to Northern Ireland, to have due regard to the need to promote equality of opportunity and to have regard to the desirability of promoting good relations.
http://www.legislation.gov.uk/ukpga/1998/47/section/75
Before it is adopted this Strategy will be screened for the purposes of s75, in order to decide whether an Equality Impact Assessment should be carried out. With this in mind, the consultation on the draft Strategy is an opportunity to invite people to identify any concerns that may need to be addressed. If in your view any element of the Strategy has the potential to have an adverse impact on any group of people defined by reference to any of the nine distinctions in s75(a), we would be grateful for any evidence – quantitative or qualitative – that should be considered before this Strategy adopted.

Responses must be returned by **Friday 14 February 2014** and should be emailed to DHSSPS Population Health Directorate at cpr@dhsspsni.gov.uk, or posted to

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