Northern Ireland Ambulance Service
Health and Social Care Trust

A meeting of Trust Board to be held at 10am on
Thursday 1 October 2020 via Zoom (due to Covid-19)

AGENDA

1	Welcome & Declarations of Conflict of Interest	***Click on links to navigate:***
2	Minutes of the previous meeting of the Trust Board held on 27 August 2020 **For Approval**	TB01/10/2020/01
3	Matters Arising	
4	Chair's Update **For Noting**	
5	Chief Executive's Update **For Noting**	
6	REACH Project – Update **For Noting**	Presentation
7	2020/21 Seasonal Flu Vaccination Programme **For Approval**	TB01/10/2020/02
8	The Management of Infection Prevention and Control Incidents and Outbreaks Policy **For Approval**	TB01/10/2020/03
9	Update on Covid-19 **For Noting**	Presentation
10	Report on NIAS Learning from Covid-19 **For Noting**	TB01/10/2020/04
11	Performance Report **For Noting**	TB01/10/2020/05
12	Application of Trust Board Seal **For Noting**	No paper

13	NIAS Future Surge and Winter Resilience Plan 2020/2021 **For Noting**	TB01/10/2020/06
14	Rebuilding HSC Services Phase 3 **For Noting**	TB01/10/2020/07
15	Date & venue of next meeting: **10am on Thursday 26 November 2020** **Arrangements to be confirmed**	
16	Any Other Business	

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

A meeting of Trust Board to be held at 10am on
Thursday 1 October 2020 via Zoom *(due to Covid-19)*

TB/01/10/2020/01

Return to Agenda

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 27 August 2020 at 10.00am via Zoom (due to Covid-19)

Present:	Mrs N Lappin	Chair
	Mr W Abraham	Non Executive Director
	Mr J Dennison	Non Executive Director
	Mr T Haslett	Non Executive Director
	Mr M Bloomfield	Chief Executive
	Mr P Nicholson	Interim Director of Finance
	Dr N Ruddell	Medical Director (joined the meeting at 10.10am)
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement
	Mr B McNeill	Clinical Response Model (CRM) Programme Director
	Ms R O'Hara	Programme Director – Strategic Workforce Planning
	Ms M Paterson	Director of Performance, Planning & Corporate Services
	Ms S Sellars	Board Apprentice
	Mrs C Mooney	Board Secretary
	Mr C McCracken	Graduate Management Trainee
	Ms A Quirk	Board Apprentice
	Ms S Williamson	Programme & Change Manager (for agenda item 6 only)
Apologies:	Mr D Ashford	Non Executive Director
	Mr A Cardwell	Non Executive Director
	Ms M Lemon	Interim Director of HR
	Mr R Sowney	Interim Director of Operations

1 **Welcome, Introduction & Apologies**

The Chair welcomed members and thanked them for facilitating today's meeting. She confirmed that there were no conflicts of interest in any items to be discussed.

In Mr Sowney's absence, the Chair noted that today would be his last Board meeting as Interim Director of Operation following the appointment of Ms Rosie Byrne to the post. The Chair said that she wished to record the Trust's sincere appreciation for the significant contribution made by Mr Sowney. She added that the Trust had greatly benefited from his experience and expertise over the last 18 months and said she would speak to Mr Sowney to convey the Trust's thanks.

2 **Previous Minutes (TB27/08/2020/01)**

The minutes of the previous Trust Board meeting held on 18 June 2020 were **APPROVED** on a proposal from Mr Haslett and seconded by Mr Dennison.

3 **Matters Arising**

There were no Matters Arising.

4 **Chair's Update**

Commencing her update, the Chair referred to the visit to Trust HQ by the Primary Minister, Mr Boris Johnston, the Secretary of State for NI, Mr Brandon Lewis, and the Minister for Health, Mr Robin Swann, on 13 August.

The Chair advised that it was her understanding that NIAS HQ had been identified by the Secretary of State as a potential location for the visit by the Prime Minister. She believed that this was following the previous visit made by the Secretary of State and the Minister when they had met members of staff and had spoken to them about their experiences during Covid-19. The Chair said that the value placed by the Secretary of State and the Minister on those delivering public services had been very clear. She commended all involved in the arrangements for the visit which had been a hugely positive experience.

The Chair reported that, since the last Board meeting, she had attended the EMT graduation ceremony. She explained that training for this group of students had been stood down to allow the Trust respond to Covid-19 which had made this a particularly challenging programme. Training had since been reinstated to

ensure the Trust had a continuous flow of frontline staff. She said that she had had the pleasure of joining students at Magee University and had the opportunity to express her thanks to the Trust Training Officers who had found innovative ways to deliver training courses.

The Chair advised that she had also visited Derriaghy Station and had given blood as part of the Covid-19 Antibody Seroprevalence Study to determine whether individuals have been exposed to the virus. She said that she had been very impressed by the facility and had seen at first hand the donning/doffing station and the processes which had been put in place around Covid-19. The Chair advised that no-one in the station had tested Covid-19 positive and believed that this demonstrated the effective processes put in place to keep staff safe.

Continuing her report, the Chair advised that she and other HSC Chairs had met with the Minister via Zoom. She said that the Minister had heard how Chairs might assist on the co-production and co-design work being taken forward by the Rebuilding Programme Management Board.

The Chair said that members would be aware of Care Opinion which was formally launched on 1 August 2020 and she welcomed the fact that families and patients had an opportunity to feedback on their experiences in real time.

The Chair also advised that a publication, 'HSC Promoting Equality, Good Relations and Human Rights' targeted at HSC organisations had recently been launched. She explained that the document had been designed to assist Board members to understand how they ensured equality, good relations and human rights were promoted within the organisation. The Chair commented that she had had an opportunity to have some input to the document before it had been finalised and she referred in particular to the section setting out responsibilities for Board member around Section 75 for example. She said that copies/web link would be distributed to members for their attention and added that she had asked for a presentation to be made to a future Board meeting.

Concluding her report, the Chair reminded members that a Board workshop would be held on 3 September to look at assurance in further detail.

Members **NOTED** the Chair's report.

5 Chief Executive's Update

At the Chair's request, Mr Bloomfield commenced his report. He advised that, over the summer months, focus continued across the HSC on the rebuilding programme. He indicated that, along with other Trusts, NIAS published its Phase 2 plan and said that this had been included in the Board papers for today's meeting. He advised that work was now underway to develop a rolling six month plan with a particular focus on the next three months.

Mr Bloomfield reminded the meeting that the Rebuilding Management Board (RMB), which met weekly, had been established by the Minister to oversee this work. He explained that the initial focus had been around the resumption of services such as elective care, orthopaedics and urgent and emergency care. He said that the Trust had been asked to provide an update on the CRM programme to the RMB meeting at the end of September and emphasised the importance of progressing this work through the rebuilding agenda. Mr Bloomfield added that it was likely that any issues attracting significant funding would be progressed through the rebuilding programme.

Continuing, Mr Bloomfield indicated that the RMB had recently established a Winter Pressure Subgroup to plan for challenges this winter in the context of Covid-19 and a potential second surge. He added that the Subgroup also met on a weekly basis and explained that the main focus of that work to date had been on the flu vaccination programme. Mr Bloomfield indicated that the vaccination programme was more important than ever in terms of ensuring health care workers were vaccinated to protect themselves, their colleagues, families and patients.

Mr Bloomfield advised that the DoH had set a target of 75% to be achieved by all HSC organisations. He indicated that the regional performance last year was 42% with NIAS achieving an uptake rate of 67% and said that this excellent outcome had been as a result of the significant contribution made by Ms Laura Coulter, Area Manager (West) who led on the Trust's vaccination programme. Mr Bloomfield explained that the DoH had requested Trust Flu Plans to be submitted by 4 September and he said that discussions were

ongoing with other Trusts to determine how NIAS could provide support to them through the expansion of the mobile vaccination team led by Ms Coulter.

Mr Bloomfield said that members will have had sight of the media reporting around the levels of cover and associated response times in South Down and Newry and Mourne areas. He explained that it had been inaccurately reported that areas had been left without cover because individual stations did not have crews operating out of these stations. Mr Bloomfield advised that, during the night in question, there were eight out of ten crews in the Southern Division on duty. He pointed out that this level of cover was not unusual.

Continuing, Mr Bloomfield said that this has attracted media coverage and criticism from some elected representatives. He indicated that he and Mr Sowney attended a meeting with the local MP and party colleagues and had met virtually with the Newry and Mourne District Council.

Mr Bloomfield acknowledged that, while cover had improved, challenges remained as a result of a number of staff not being available for frontline duties due to Covid-19. He explained that the Trust had staff who had taken very little leave during the pandemic and it was now important for them to do so for their own wellbeing. He further acknowledged that staff were not as willing to work additional overtime as had been the case during the height of the pandemic.

Mr Bloomfield said that the Trust recognised the challenges associated with cover. He said that the Minister had mentioned these during the Prime Minister's visit and fully understood the circumstances and the way in which the service was managed as a regional service. Mr Bloomfield stressed the fact that, while there were no crews working out of a particular station, this did not mean there was no cover. He added that the main reason for reduced cover at any time of the year related to the need to increase staffing. Mr Bloomfield indicated that the Trust had ongoing staffing issues due to vacancies and staff off on long-term sick leave.

Mr Bloomfield welcomed the fact that the recently graduated EMTs had now joined the operational service and he said that the 8th and 9th cohorts of EMTs who graduated from the recent programme demonstrated the extent of training provided by the Trust. He

indicated that these EMTs immediately commenced operational service and two further programmes had started at the beginning of August with a view to these individuals graduating in December and further strengthening the NIAS workforce. Mr Bloomfield reported that, at the start of August, he had met with ten qualified paramedics and EMTs who had joined NIAS from other services. He advised that the Paramedic Foundation Degree would resume at the start of September with 48 students, who had been back in service and working operationally as EMTs, returning to full-time education.

Mr Bloomfield advised that the Trust had recently received an additional allocation of £5 million from the June monitoring round in respect of paramedic education and said that this allowed the Trust to plan for the third cohort of students. He said that, at the previous Board meeting, he had expressed disappointment that the Trust had been unsuccessful in its bid for transformation funding and had submitted a subsequent bid to the June monitoring round.

Mr Bloomfield said that the Chair had mentioned visiting Derriaghy Station and said that Directors had been unable to undertake visits more recently in the context of Covid-19. However, he reported that he had been able to spend some time visiting staff in Newry and Craigavon Stations. He said that he always found it useful to meet with staff and get feedback on how they felt the Trust supported them during Covid-19.

Mr Bloomfield advised that he had also continued with the virtual staff engagement sessions with the focus now on thematic sessions.

Referring to the fact that this was Mr Sowney's last Board meeting, Mr Bloomfield took the opportunity to convey his thanks and appreciation for the contribution made by Mr Sowney.

He acknowledged the fact that it had been important for the Trust to appoint a substantive Director of Operations and said that there had been a good response to the recruitment advertisement, both locally and from outside NI. Mr Bloomfield said that interviews had been held on 26 August and the panel had offered the post to Ms Rosie Byrne. He said that Ms Byrne had a wide range of experience and was most recently the Assistant Director of Unscheduled Care in the HSCB.

He reminded the meeting that the Trust had also welcomed Mr Neil Sinclair as Assistant Clinical Director for Paramedicine at the start of August and said that Mr Sinclair would work within Dr Ruddell's team.

Concluding his report, Mr Bloomfield referred to the 'Muckamore Abbey Hospital - Report of the Independent Leadership and Governance Review', a copy of which had been shared with members, and said that he has asked Ms Charlton to review the report's findings and recommendations with a view to bringing back an assessment to a future Board workshop or future Board meeting for discussion. Mr Bloomfield encouraged Non-Executive and Executive Directors to familiarise themselves with the detail of the report.

The Chair thanked Mr Bloomfield for his report which was **NOTED** by members.

6 **NIAS Strategy Implementation Methodology (TB27/08/2020/02)**

The Chair welcomed Ms Sarah Williamson, Programme and Change Manager, to the meeting.

By way of introduction, Ms Paterson explained that the paper proposed a high level methodology for delivery of the NIAS' Strategy to Transform 2020-2026 'Caring Today, Planning for Tomorrow' and she advised that the approach agreed with the Senior Management Team had been to include staff, service users and stakeholders.

Ms Williamson thanked Ms Sellars for proof-reading the documentation. In terms of the development of the paper, Ms Williamson advised that she and Ms Charlton had met with PHA colleagues to seek their advice in relation to service user involvement as well as discussing with other ambulance services to ascertain how they had progressed similar work.

Ms Williamson highlighted key points within the document. The first related to the fact that the methodology proposed the establishment of a Strategy Implementation Board with service users and staff involvement. She acknowledged that there would be staff involvement across all workstreams.

Ms Williamson indicated that the document explained the work of the Implementation Board and the co-production methodology which sought to include service users and staff throughout the work to deliver on the Strategy. She welcomed members' feedback and thoughts on this.

Ms Williamson then drew members' attention to the governance section of the paper which proposed a programme methodology with a view to establishing a Programme Management office with programme managers supporting this in terms of performance managing and monitoring KPIs. Ms Williamson sought members' views on the frequency of reports to Trust Board.

With regard to the Terms of Reference for the Strategy Implementation Board, Ms Williamson advised that Directors had held workshops with their teams and, with support from herself and AACE, had populated the spreadsheets at Appendix A. Ms Williamson explained that Appendix A represented the objectives over the next two year period and that Ms Paterson had been designated as the Senior Responsible Officer.

Mr Dennison said that the paper was comprehensive and said that he had been struck by the additional work to be taken forward. He stressed the importance of pulling this work together in a co-ordinated way. Mr Dennison questioned the naming of the 'Strategy Implementation Board' and emphasised the need to ensure the Terms of Reference connected with the work of the Strategy Board. He welcomed this as a mechanism to provide the Trust Board with updates as work progressed.

The Chair suggested that it might be more appropriate for reports to be received at Committee level in the first instance with a high-level report being submitted to the Trust Board.

Mr Bloomfield reminded the meeting that the Strategic Plan had been launched nearly six months' previously. He expressed frustration that, for obvious reasons, there had been a hiatus where it had not been possible to progress the Plan in the way which had been envisaged. However he very much welcomed the progress which is now being made. Mr Bloomfield said that, during the staff engagement sessions, the Chair and he had made a commitment that the Plan would be taken forward and he welcomed the fact that

the paper before the Board provided a framework within which to progress the Plan.

The Chair described the Plan as comprehensive and believed that it clearly set out the work to be taken forward.

Responding to Mr Dennison's comment, Ms Paterson suggested that, rather than Implementation Board, the name of the overarching body should be Strategy Implementation Group.

The Chair said that SMT had not expressed concern in relation to the workload associated with the implementation methodology and on that basis, she sought a proposer from members.

On a proposal from Mr Bloomfield, which was seconded by Mr Dennison, the Board **APPROVED** the NIAS Strategy Implementation Methodology.

The Chair thanked Ms Williamson for her attendance and her input to the document and she withdrew from the meeting.

7 **Proposal for a NIAS Rebuilding Management Board Working Group (TB27/08/2020/03)**

At the Chair's request, Ms Paterson introduced this agenda item by explaining that the proposal for a NIAS Rebuilding Management Board Working Group had come around in response to Covid-19 and legacy issues which prevented the reconfiguration of HSC services. She reminded members that the DoH had published a new strategic framework setting out areas for priority action. In order to support this work, the DoH had established the Rebuilding Management Board with the aim of restoring the optimising service delivery in the context of Covid-19, embedding learning, implementing service models and planning for the future. Ms Paterson indicated that NIAS, and other Trusts, had been asked to establish a local implementation structure with key membership and responsibilities.

Ms Paterson acknowledged the challenges in establishing such structures due to the capacity within the senior management structure within the Trust.

She drew members' attention to diagram 1 which set out the proposed structure for local implementation of the Rebuilding Programme. Ms Paterson reminded the meeting that there were 28 workstreams within the Rebuilding Management Board and acknowledged that the Trust would be challenged in ensuring adequate representation. She stressed that the aim would be to ensure NIAS was represented with one voice and acknowledged that the proposed structure would evolve as the workstreams developed and as NIAS understood the scale of the work required for implementation.

Mr Abraham sought further clarification around the context of the sub-groups and whether the ultimate aim was to restore services to their original state prior to the pandemic or to re-envisage the HSC.

In response, Ms Paterson referred to the establishment of the Rebuilding Management Board by the DoH. She explained that this Management Board had identified 28 priority workstreams to be progressed through the HSC in terms of the reorganisation of service and restoration of work that had been lost during the pandemic.

Mr Bloomfield pointed out that the Minister and Permanent Secretary were on record as having stressed that it was not the aim to restore HSC services to December 2019 status but to build on the changes which had taken place and to ensure transformation was recommenced by accelerating some of the changes which had already been introduced.

Continuing, Mr Bloomfield acknowledged the magnitude of work to be undertaken across the 28 workstreams and recognised that some had limited impact on NIAS. However, he said, changes to acute services, for example provision of services in different hospitals, required input from NIAS. Mr Bloomfield said that it would be important for the Trust to be involved in such discussions and explained that the NIAS Rebuilding Management Working Group enabled the Trust to participate in these groups.

Mr Abraham acknowledged the importance of the Board being engaged in this work and sought clarification on how this would be done.

Ms Paterson explained that the proposal was to establish a Working Group which could be dynamic and flexible and ensure representation on each of the working groups as well as presenting a consistent voice moving forward. She added that the Working Group would provide assurance to SMT and Trust Board around the decisions which had been taken in a planned and responsible manner.

The Chair reminded the meeting that the Trust had liaised closely with DoH around the launch of the Trust's Strategic Plan in March and the direction of travel therein. She said that, as Chair, she would not be concerned at the Trust being presented with any unexpected issues. However the Chair said it would be important to clarify that this did not mean that, as services were reconfigured across Northern Ireland, there would not be any impact upon how the Trust delivered its core services and she re-emphasised the importance of the Trust having full participation in such discussions.

Stressing the gravity of this work, Mr Abraham said that he would like to see the linkages to the existing governance matrix framework in order to ensure monitoring as work progressed.

The Chair recognised this as a valid point and said it would be important to ensure that, while the Trust Board still retained accountability for the delivery of the service, there was documentation in relation to decisions taken. She was of the view that the proposed structure would ensure that the appropriate linkages were in place and that Trust Board would have oversight of work being undertaken. The Chair suggested that there would be opportunities for members to express any concerns they may have as work was progressed.

Mr Bloomfield, agreeing with the points made by the Chair, said that in recent meetings with elected representatives, his views had been sought on the decision taken by the Southern Trust to close the Daisyhill ED and the resultant impact on NIAS. Mr Bloomfield explained that, because the Trust had been fully involved in discussions with Southern Trust colleagues, he had been able to assure the elected representatives of NIAS' involvement in these deliberations.

Continuing, Mr Bloomfield referred to the 'No More Silos' action plan which was currently awaiting Ministerial approval but which had

been reported in the media. He referred in particular to the proposals to establish telephone triage in Trusts so that patients could telephone ED prior to arrival; to have ambulance only EDs and to have ambulance receiving areas which would help address the issue of ambulances queueing at EDs. He explained that each Trust had been asked to produce plans to take forward the actions proposed within 'No More Silos', subject to Ministerial approval.

Mr Bloomfield emphasised that it would be for these reasons to ensure NIAS' involvement in discussions with other Trusts as to their plans around the 'No More Silos' action plan and to be clear around the potential impact on ambulance services. Therefore, he said, it would be important to have the structure as proposed within the paper in place to ensure a consistent approach and to ensure that NIAS could support other services.

Mr Haslett expressed concern at the amount of work being progressed by DoH and the capacity of the Trust to deliver this. He referred to the composition of the Working Group and said that, had it not been for the recent recruitment of senior staff, there would have been a significant workload placed on existing SMT members for example.

Mr Haslett asked whether it would be possible to map the various Working Groups and the initiatives being taken forward as well as those individuals participating on them. He suggested that it would also be important to include within the mapping the priorities which had been set over the last 2-3 years and believed the considerable workload involved would become clear through the mapping.

The Chair pointed out that, not only was this work being DoH driven, it was also being driven by the Minister and she stressed the importance of the Trust Board ensuring that Ministerial priorities and policies were reinforced. The Chair said that she was of the view that this particular direction of travel did not differ significantly from the direction of travel adopted by the Trust in its Strategic Plan which had been endorsed by the Minister. She pointed out that the Trust had been asked to establish local implementation groups and the proposal before the Board set out how it intended to do so.

Mr Bloomfield acknowledged Mr Haslett's comments in relation to volume of work needing to be progressed. He indicated that the Trust had been requested to produce a number of plans, for

example, a Winter Pressures Plan, Surge Plan, Flu Plan and acknowledged that, while such plans might have been produced in different formats and to different timescales, they would have been produced by the Trust. Mr Bloomfield accepted that the Trust was now in a better position to progress these given the recent recruitment of senior staff.

Mr Abraham stressed the importance of clearly understanding the gravity of the plans under development with a focus on key linkages. He was of the view that, while SMT would receive regular updates, it would be imperative that the Trust Board received updates in a more systemic manner and suggested that consideration should be given to making this a Standing Item on Trust Board agenda if appropriate. It was his view that, in doing so, this would strengthen its importance.

Ms Paterson suggested that the newly established People, Finance & OD Committee could link with Trust Board and Mr Dennison, as Chair of the Committee, indicated his support for this proposal.

The Chair thanked everyone for their comments and said that work would now be taken forward to ensure Trust Board had a key role in ensuring a more obvious oversight to this work.

On a proposal from Mr Abraham which was seconded by Mr Haslett, the Board **APPROVED** the NIAS Rebuilding Management Working Group.

8 **Performance Report (TB27/08/2020/03)**

The Chair advised that an element of the Performance Report had been omitted from members' papers and apologised for this oversight.

Ms Paterson explained that the Emergency Ambulance Control had three designations of call covered by the Automatic Call Distribution (ACD) system which managed all incoming Emergency, Routine and Urgent/HCP calls.

She reported that, in respect of Emergency Call (999) activity in July, 17,763 emergency calls had been received, ie approx. 570 calls per day. Ms Paterson indicated that, as well as taking calls

from the general public, NIAS also received calls from hospitals, GPs and other health care professionals.

Referring to the 999 Call Answer Times which was a Key Performance Indicator, Ms Paterson advised that the EAC currently aimed to answer calls as quickly as possible with a target of 90% of all emergency calls being answered within five seconds. She added that it was envisaged that this target would change to a mean target in 2020 in line with other UK Ambulance Services.

Ms Paterson reported that call answer performance was over 90% for April, May, June and July 2020 and that, compared to the same month last year, the number of calls received each month had been lower but the difference narrowed from 11% less in April to 3% less in July.

The Chair referred to the update which Ms McNamara had given to the June Trust Board meeting on the work being taken forward to improve call answering and suggested that it would be helpful for Trust Board to receive information on outlier calls, ie number/nature of those calls being answered outside the five seconds.

Ms Paterson agreed to speak to Mr Sowney in relation to this.

She reported that ambulance turnaround times averaged 40 minutes over the period April – June and while attendances were at hospital were lower, reconfiguration due to Covid-19 arrangements had resulted in lengthened clearing times.

Ms Paterson drew members' attention to section 3 of the paper which captured information relating to Cat 1 improvement, for example the workplan, monthly performance figures through to the various acuity levels. She added that demand had generally been lower between April-June for all categories. Ms Paterson pointed out that, as demand increased, and in line with last year's demand, the Trust was now starting to see performance slip.

Mr Bloomfield reminded the meeting that work was being taken forward to improve Cat 1 response times and acknowledged that the Trust was below the performance standard. He highlighted Cat 2 performance which had been strong and which had only recently deteriorated when demand had increased.

Ms Paterson reported that an Early Alert had been submitted to the DoH in respect of the turnaround times. She added that a regional meeting had taken place to understand how best to resolve the challenges presented and said that Trusts were committed to supporting and finding out how resources could be unlocked from EDs to allow crews get back onto the road. She advised that the Trust had supplemented the Clinical Support Desk (CSD) with additional resources to ensure that appropriate alternative care was provided wherever possible so that conveyance to hospital could be reduced.

Expanding on this point, Dr Ruddell advised that the Trust was currently recruiting staff to CSD to ensure appropriate capacity was reinstated to assist in determining those calls which were suitable for alternative emergency support. He added that, during Covid-19, the Trust had been reliant on Clinical Support Officers to fill these roles.

Ms Paterson referred to the HR section of the performance report and acknowledged that there were currently some discrepancies on the data in relation to staff sickness levels. She explained that there were variations on how such data was collated and advised that currently information was collated by RMC and by managers through HRPTS. Ms Paterson cited the example of a member of staff who had been undertaking light duties and not available to participate on a rota but who had not been sick. She added that HRPTS also recorded those members of staff off on short/long term absence and said that there were variations in how such information was recorded. Ms Paterson said that such discrepancies would be addressed through the progression of performance reporting.

She reported that there had been a reduction in hours lost during May and June. She advised that a number of staff on long-term sickness absence had returned to work while a number of staff on short-term sickness absence had returned to assist with the Trust's response to Covid-19.

The Chair was of the view that it would be particularly helpful for Committee Chairs to have access to the breadth of information available. She explained to Ms Quirk that Ms Paterson was progressing a review of performance information being presented to the Board.

Continuing, Ms Paterson reminded the meeting that a number of HR activities had been stood down in the context of Covid-19 and cited the example of formal attendance management processes which had been suspended in line with regional activity. She said that the Trust continued to adopt a partnership approach with Trade Unions and said that there was a considerable challenge to the Trust in terms of sickness. Ms Paterson pointed out that approximately 160 staff were absent from the rota, either due to light duties or Covid-19 abstractions and said that Trade Unions continued to work with HR colleagues to resolve these issues and to support staff to return to work.

Mr Haslett referred to section 3 of the report and was of the view that there had been improvement since the introduction of the new clinical response categories and acknowledged the deterioration in relation to hospital turnaround times. He sought further detail in relation to what arrangements had been put in place to address these.

In Mr Sowney's absence, Mr Bloomfield said that he recognised the deterioration in turnaround times and acknowledged that this was as a result of the arrangements which had been put in place because of Covid-19. He cited an example of the reduction in physical capacity within EDs because of social distancing, thereby resulting in crews being unable to transfer patients into the care of EDs and having to care for them in ambulances outside ED.

Mr Bloomfield referred to the earlier discussion around the action plan 'No More Silos' which focussed on unscheduled care. He reminded members that a proposal within this action plan was the introduction of ambulance receiving areas which would assist in turnaround times with appropriate escalation measures in place. Mr Bloomfield said that two particular issues of concern had been highlighted by the DoH, namely delays in ambulance turnaround times and the discharge of complex patients from hospital.

However, Mr Bloomfield said, while the action plan put forward proposals to address such issues, it would be necessary to take forward work in relation to improving in-hospital flow. He said that the Trust continued to raise these issues on a regional basis. He reminded members of the Early Alert which had been raised with the DoH and which had resulted in discussions at operational level as well as Dr Ruddell discussing the issues with his Medical

Director colleagues. Mr Bloomfield acknowledged the risk to patients and said it would be important for the Trust to maintain a focus on this.

Agreeing with the points made by Mr Bloomfield, Dr Ruddell commented that, while there had previously been delays in terms of ambulance turnaround times, Covid-19 had certainly exacerbated the issue. He was of the view that there was an increased risk to patients caused by delays and turnaround times whether that had come about as a result of not being able to identify resources to respond to the most urgent cases in the community or as a result of patients having to be cared for in the back of ambulances outside EDs for considerable lengths of time.

Dr Ruddell confirmed that he had raised his concerns with Medical Director colleagues and acknowledged that a number of Trusts were making every effort to facilitate a quick turnaround for ambulance crews. However he further acknowledged that more work was required.

The Chair thanked members for their comments on the performance report which was **NOTED** by members.

9 **Corporate Plan Progress Summary Report – as at September 2020 (TB27/08/2020/04)**

Introducing this agenda item, Ms Paterson extended her thanks to Mr McCracken who had provided support in the collation of detail around the actions.

She explained that the Summary Report represented the mechanism to report on the delivery of Year 1 of the Trust's Corporate Plan and clarified that the priority actions had been taken from the Trust's Strategic Plan. Ms Paterson advised that progress would be reported through the Strategic Implementation Group but she thought it would be useful for members to receive the initial progress report at today's meeting.

Ms Paterson said that the Chief Executive was keen to ensure that Covid-19 did not prevent progress on implementing the Plan. She advised that the RAG status attributed to progress demonstrated that 48% of the actions intended to be delivered by December were either on track or would be completed by then. Ms Paterson

clarified that this did not mean that 44% would not be delivered in part or in full. She indicated that it would be important for members to recognise that some of the work intended for Year 1 would be partially completed due to DoH plans having to be progressed by the Trust.

Ms Paterson pointed out that the actions for delivery by December 2020 were very much linked to the Corporate Plan agreed by the Trust Board and said that the Summary Report also provided comments pertaining to specific actions.

The Chair thanked Mr McCracken for his input to this work and said that she had found it to be a helpful and encouraging document. She acknowledged the significant work undertaken to achieve 48% of actions either completed or on track for completion and commended the ongoing focus which all concerned have given to ensuring delivery of corporate objectives.

Ms Sellars sought clarification around the term 'culture dashboard'.

By way of explanation, Ms Paterson advised that the HR Directorate would like to see a series of matrices developed to understand some success criteria around, for example, benchmarking, culture, organisational behaviour, staff services, engagement with staff and understanding how the Trust can capture such data to demonstrate progress made in that area.

The Chair thanked Ms Paterson for her report which was **NOTED** by members.

10 **NIAS Annual Report and Final Accounts for the year ended 31 March 2020 (TB27/08/2020/06)**

The Chair commented that the Trust Board had had sight of the Annual Report and Final Accounts now on a number of occasions with a number of iterations being made before being submitted to the Comptroller and Auditor General for consideration.

Before passing to Mr Nicholson, the Chair declared an interest in this agenda item in relation to her role of Chief Commissioner with the Charity Commission.

The Chair reported that the documentation had now been certified by the Comptroller and Auditor General and laid before the Assembly. The Chair commended Mr Nicholson and all involved in the production of the Annual Report and Final Accounts and said that, given the context of Covid-19, it was, in her view, a huge achievement to have produced such comprehensive documentation.

Mr Nicholson thanked the Chair for her comments and said he would pass these on to all concerned. He went on to advise that the majority of the papers for Trust Board comprised the NIAS Annual Report and Accounts for the year ended 31 March 2020 and also the NIAS Charitable Trust Funds Accounts and Trustees Annual Report for the same year. Mr Nicholson pointed out that today's meeting represented the formal publication of these documents and said that this was the last stage in the extended process of production, audit, approval and certification.

Continuing, Mr Nicholson indicated that there was significant information contained within the documents and acknowledged that it would be difficult to highlight one particular area over another. However, in summary, he said that the documents outlined a year of change and challenge for the Trust as well as outlining a range of performance measures, service delivery and successes along with challenges faced through the year, not least culminating in the global pandemic towards the end of the period covered by the documents. Mr Nicholson was of the view that, while many of these challenges had continued into the new financial year, the work and efforts to date put NIAS in a strong position to deliver and improve in the future.

The Chair thanked Mr Nicholson for his comments and the NIAS Annual Report and Final Accounts for the year ended 31 March 2020 were **NOTED** by members.

11 **Rebuilding HSC Services Phase 2 (TB27/08/2020/07)**

The Chair reminded members that Phase 1 of the Rebuilding HSC Services covering the month of June had been discussed at the Trust Board meeting on 27 May. She added that the DoH had taken the lead in developing the Phase 2 Plans which covered July – September. The Chair indicated that, while the Phase 2 plan had

been shared with members via e-mail at the end of June, the Plan was here today for noting.

Ms Paterson confirmed that the Phase 2 plans had been published by the DoH on 10 July and work was now underway to develop the Phase 3 plan which would cover October-December with a focus on a six-month rolling plan. She added that the Phase 3 was to be submitted to the DoH by 23 September and undertook to share the plan with members prior to submission.

Continuing, Ms Paterson said that it was important to ensure that the Trust's Phase 3 plan was in line with other Trust organisations in delivering the recovery plans. She pointed out that the only NIAS activity which had not been restored to pre-Covid-19 levels was the Community First Responder Scheme and she said that this would now be the focus of the Phase 3 plan.

Ms Paterson advised that, coupled with the development of the Phase 3 plan, the Trust had been asked to develop six-month surge and winter resilience plans to accompany the Phase 3 plan. She pointed out that the DoH was currently giving consideration to allowing these plans, along with the Trust's Financial Plan, to be considered as the Trust Delivery Plan for 2020-21.

The Chair suggested that Ms Paterson's comments might address some of the concerns expressed earlier by Mr Abraham in relation to the work being proposed and the direction of travel.

Members **NOTED** the NIAS Rebuilding HSC Services Phase 2 plan.

12 **Policy for the Recording of Early Alerts to the DoH (TB27/08/2020/08)**

Introducing this agenda item, the Chair commented that, when revising the Trust Standing Orders, consideration would be given to whether policies need to be approved by Trust Board.

Dr Ruddell explained that the policy aimed to promote and provide a unified regional and organisational wide system for the reporting, recording, review and analysis of all Early Alerts.

Dr Ruddell explained that the policy had already been brought to the attention of the Trust's Assurance Committee and comments made

there had been incorporated into the version before members. He advised that the reporting of Early Alerts was the system through which the DoH was notified of any issues which were likely to create significant public interest. Dr Ruddell indicated that the Policy incorporated updated guidance received from the DoH around their expectations and he referred members to Appendix 1 of the policy which set out the criteria for reporting an incident as an Early Alert.

He clarified that there was some detail which was specific to NIAS in terms of accountability.

Mr Dennison said that, in reading the policy, there was no reference to the importance of making Non-Executive Directors aware of any issues which were likely to create significant public interest and he suggested that this should be included.

The Chair said that, while she understood and agreed with the point being made by Mr Dennison, as it was a regional policy, the Trust was limited in terms of what amendments could be made.

Dr Ruddell acknowledged Mr Dennison's comment. He reminded the meeting that, as the Early Alert Policy was a regional policy, he suggested that the procedure should be amended to include this point.

Ms Charlton indicated that notification to Chairs and Non-Executive Directors was a recommendation within the IHRD, specifically the Clinical and Social Care Governance group.

The Chair welcomed the fact that the procedure would be amended to include reference to the need to notify the Trust Chair and Non-Executive Directors.

Following this discussion, the Chair proposed that the Board **APPROVE** the adoption of the regional policy as it has been adapted for use within NIAS. This proposal was seconded by Mr Abraham.

13 **Committee Minutes (TB27/08/2020/09)**

The Chair drew members' attention to the Committee minutes and proposed that each Committee Chair would bring a brief report on the work of their respective Committee to the Board meeting. She

suggested that the report would be very much based on the minutes allowing each Committee Chair to decide what should be highlighted to the Board. The Chair said that members of other Committees could then seek clarification or further information upon reading the report.

The Chair also suggested the establishment of a repository where all Committee minutes and papers would be available to all members to read at their convenience.

Mr Abraham endorsed the Chair's suggestion and said it would be important to avoid duplication.

The Chair asked Mrs Mooney to e-mail members to seek their views.

14 Date of next meeting

The next Trust Board meeting will take place on Thursday 1 October 2020. Arrangements to be confirmed.

15 Any Other Business

15.1 Boardroom Apprentice

Ms Quirk thanked the Board for the opportunity to join the meeting and said she looked forward to working with them into the future.

15.2 Assurance to Trust Board

Ms Charlton said that members would be aware from media reports in relation to colleagues in Craigavon ED and PSNI having to self-isolate as a result of positive staff testing.

She said that she wanted to take the opportunity to assure the Board that work was continuing under the auspices of the Recovery Cell and through Trust Directorates to ensure all necessary preventative measures were in place such as the installation of perspex screens; removal of chairs and desks and ensuring surgical face masks were worn by frontline staff. She acknowledged the challenges for staff of wearing PPE when caring for patients and added staff were now

required to wear masks when not caring for patients. Ms Charlton said that communications highlighting the risk and potential impact on service delivery were being continuously reinforced to staff.

The Chair thanked Ms Charlton for her comments and said the Trust Board would be happy to assist in reinforcing the messaging around social distancing. She commented that, while everyone was aware of the need to do so, it was easy to lapse back into routine behaviour.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 12.15PM.

SIGNED: _____

DATE: _____

TB/01/10/2020/02

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	1 October 2020
Title of paper:	NIAS 2020-21 Seasonal Flu Vaccination Programme
Brief summary:	The Trust is cognisant that co-infection between Flu & Covid-19 leads to poorer outcomes for those who are infected. The Trust will face considerable challenges this year in coping with winter pressures alongside the potential for a further wave of Covid-19. However the Trust has robust plans in place and is committed to achieving the highest possible uptake of flu vaccinations amongst NIAS operational staff.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 1 & 29 September 2020
Prepared and presented by: **Date:**	Laura Coulter, Area Manager (West) 24 September 2020

NIAS FLU Programme 2020/2021		
Senior Responsible Officer	Dr Nigel Ruddell, Medical Director	Areas of Focus- Best Practice Guidelines
Project Leads	Laura Coulter, Western Area Manager	1. Committed Visible Leadership and ownership
Plan Sign Off		2. Flu Steering Group
Version	0.1	3. Peer Vaccinators
Last Update	26/08/2020	4. Accessible and Flexible Flu Vaccinations
		5. Communication Strategy and Plan
		6. Data for Reporting and Improvement

Reference	Project Area / Activities 2020-2026	Activity Owner	Target Date	Start Date	Finish Date	% complete	Best Practice Rag Status	Evidence of achievement	Key Risks / Obstacles	Dependencies	Delayed (days)	Comments
1.0	**Committed Visible Leadership and ownership**											
1.1	Board endorse the strategy and commitment to achieving the highest possible uptake of influenza vaccinations amongst staff.	Dr Nigel Ruddell	01/10/2020	01/10/2020	01/10/2020	In Progress - On track		Recorded in Trust Board Minutes		Attendance at Trust Board by all members		
1.2	Board lead is nominated for Trust, sits on Flu Steering Group and is accountable for the Flu programme in the Trust.	Dr Nigel Ruddell	08/09/2020	08/09/2020	08/09/2020	Completed		Recorded in SEMT Minutes				Flu Steering Group will consist of SEMT members and will have weekly oversight at SEMT meeting with update through Health and Safety Committee to Trust Board 01/10/2020
1.3	Trust has in place the required resources (adequate supplies of vaccine with cold chain measures, budget, and sufficient numbers of Peer vaccinators) to successfully deliver the Flu programme.	Dr Nigel Ruddell	28/09/2020			In Progress - On track			Availability of vaccine	Availability of vaccine		
1.4	All Board Members continue to support the campaign and receive Flu Vaccination and publicise.	Dr Nigel Ruddell/John McPoland	01/10/2020	01/10/2020	01/10/2020	In Progress - On track		Recorded in Trust Board Minutes		Attendance at Trust Board by all members		Invitation for Board members to obtain vaccination at Board Meeting. Incorporated into communication to staff to publicise.
1.5	All Trust Directors have personal accountability for the implementation of the Flu Programme within their Directorate and achievement of target.	Trust Directors/Carol Mooney	08/09/2020	08/09/2020	08/09/2020	Completed		Recorded in SEMT Minutes				Weekly oversight of programme to ensure effective support is provided to delivery team.
1.6	Directors to nominate and have in place Directorate leads responsible for leading the implementation of the Flu programme within the Directorate and sufficient numbers of Peer vaccinators are fully trained to meet the requirements for administering flu vaccination.	Trust Directors/Carol Mooney	08/09/2020	15/09/2020		In Progress - On track		Recorded in SEMT Minutes				Trust Directors nominate lead for supporting delivery of effective programme within their directorate.
1.7	A Trust Flu Vaccination Plan approved by the Board/ Executive Team and submitted to the Department by 4 September 2020.	Dr Nigel Ruddell	01/09/2020	01/09/2020	04/09/2020	Completed		Recorded in SEMT Minutes				SEMT approved plan 01/09/2020- Trust Board approval of plan 01/10/2020.
1.8	Identify lower uptake areas and ensure sufficient numbers of Peer Vaccinators to target these areas.	Dr Nigel Ruddell	08/09/2020			In Progress - On track		Recorded in SEMT Minutes				Weekly oversight of programme to support delivery team in lower uptake areas.
2.0	**Flu Steering Group**											

2.1	A Trust wide Flu Steering Group is in place including: Board level representation, Directorate leads, Occupational Health, Human Resources, Communications, Peer Vaccinators, Pharmacy, Infection Prevention Control, IT, Estates and Facilities, Trade Unions.	Dr Nigel Ruddell	08/09/2020			In Progress - On track		Weekly SEMT with Trade Union engagement with Human Resources.				
2.2	Flu Steering group to meet (frequency to be determined by the Trust) from August 2020 and to coordinate and report on the Trust Flu Programme.	Dr Nigel Ruddell	01/09/2020			In Progress - On track		Weekly Minutes collected at SEMT				
2.3	Directorate leads to have in place local implementation teams and plans from August 2020.	Dr Nigel Ruddell	08/09/2020			Not Started		Will be nominated on 08/09/2020				
3.0	**Peer Vaccinators**											
3.1	Medical Director and or Director of Nursing to participate as Peer Vaccinators.	Dr Nigel Ruddell	01/10/2020	01/10/2020		In Progress - On track		Record for communications to organisation				Dr Nigel Ruddell to provide vaccinations to Board Members to demonstrate leadership.
3.2	Peer vaccinators, ideally at least one in each clinical area is identified, trained, released and empowered to vaccinate from mid-September.	Laura Coulter	25/09/2020	03/08/2020	19/09/2020	Completed		Shielding staff/alternate duties/ad hoc OT designated.	Risk Assessment/ OH required for shielding staff.			70 x Peer Vaccinators recruited
3.3	Peer Vaccinators have access to and trained in the Trust recording system.	Laura Coulter	21/09/2020	17/08/2020	19/09/2020	Completed		Established recording system in place	Access to IT			
3.4	Peer Vaccinators have the required PPE to undertake vaccinations.	Laura Coulter	25/09/2020	10/08/2020	19/09/2020	Completed		Appropriate PPE available in all NIAS locations				Adequate PPE in NIAS Flu Vehicles & mobile Flu Boxes. Additional PPE available in station.
3.5	Weekly updates monitoring performance on the number of vaccinations by peer vaccinator.	Laura Coulter	02/10/2020	28/09/2020		Not Started						
3.6	Recognition is provided to all Peer Vaccinators with Top (10) Vaccinators receiving special recognition awards.	Dr Nigel Ruddell	08/09/2020			Not Started						SEMT to consider how/if this will be progressed internally.
4.0	**Accessible and Flexible Flu Vaccinations**											
4.1	A full list of Peer Vaccinators published on the staff intranet and within their respective Directorates.	Laura Coulter	28/09/2020	21/09/2020	21/09/2020	Completed		70 x Peer Vaccinator names on Intranet & WhatsApp/Email.	Co-ordination			
4.2	Arrange suitable venues for easy access drop in / roving clinics across all localities to maximise accessibility (Social Distancing and Covid safety measures to be in place).	Laura Coulter	28/09/2020	25/09/2020		In Progress - On track		Ambulance Stations/Dispatch Points	Social Distancing in busier stations			
4.3	Schedule for 24-hour mobile vaccinations to be agreed at Directorate/local level to ensure staff (day / night / part-time) have the opportunity to access either pre during or post shift patterns.	Laura Coulter	03/09/2020	25/09/2020		In Progress - On track		Meetings with Peer Vacs per division scheduled from 3/9/2020 onwards	Flexibility of Peer Vaccinators to match demand			
4.4	Use outreach or mobile services (drive through / NIAS Ambulances) to offer flu vaccinations particularly in hard to reach areas and or staff.	Laura Coulter	28/09/2020	01/07/2020	21/09/2020	Completed		5 x Flu Vehicles located in 5 x divisions	Social Distancing/Covid issues increasing timings			

4.5	Identify and target areas that have had low uptake.	Laura Coulter	28/09/2020	01/07/2020		In Progress - On track		Uptake records from previous years examined	Difficulty in interpretation				
4.6	Explore the option for off-site and out of hours access, for eg. by providing vouchers for flu vaccination at a community pharmacy.	Laura Coulter	21/08/2020	21/08/2020		Completed		Electronic vaccination record form for community pharmacists developed by PHA to be shared with NIAS to dedicated email address					
5.0	**Communication Strategy and Plan**												
5.1	A communication strategy and plan is in place setting out the following elements	John McPoland/Laura Coulter	03/09/2020			In Progress - At Risk		Preliminary discussions re use of social media platforms					
5.2	The branding	Laura Coulter	10/08/2020	15/07/2020	15/09/2020	Completed		Use of NIAS Flu Bug on vehicles/correspondence/ merchandise					Merchandising complete for pens/stickers etc
5.3	Launch days for campaign	Laura Coulter	29/09/2020			In Progress - On track							
5.4	Key messaging / myth busting;	John McPoland/Laura Coulter	26/08/2020	26/08/2020		In Progress - On track		Initial emails/WhatsApp to alert staff to upcoming campaign	Staff access to email/social				
5.5	Channels of Communication, including social media, screensavers, intranet and internet, website, pod-casts staff brief, leaflets, pop ups, posters, lift wraps, etc.;	John McPoland/Laura Coulter	17/08/2020	17/08/2020		In Progress - On track			IT access				
5.6	Drop in clinics and mobile vaccination schedule published electronically, on social media and on paper;	John McPoland/Laura Coulter	21/09/2020			Not Started							
5.7	Weekly communications celebrating uptake;	John McPoland/Laura Coulter	02/10/2020			Not Started							
5.8	Phases of campaign, building awareness, encouraging uptake;					Not Started							
5.9	Key personnel, to be featured including Chief Executive, Directors, Peer Vaccinators, Staff Trade Unions;					In Progress - At Risk		Regional work on joint statement with TUs re: Flu Vaccination programme.					
5.10	Use of the power of Networks, Senior Leadership Groups, TJNCF, LNC, Executive Teams, Directorate Teams;		29/09/2020			In Progress - On track							
5.11	Clear accessible communication on where, how and when staff can access the flu vaccination;	John McPoland/Laura Coulter	28/09/2020	21/09/2020		In Progress - At Risk							
6.0	**Data for Reporting and Improvement**												
6.1	An effective recording and data base system is in place providing real time data on the number, locality, and staff group of Flu vaccinations undertaken.	Laura Coulter/West Div Admin	10/08/2020	10/08/2020	21/09/2020	Completed							
6.2	Data collated and presented on a weekly basis to the Executive Team.	Laura Coulter	02/10/2020			Not Started							
6.3	Weekly updates / dashboard are publicised on intranet and staff briefs including the uptake by Directorate and Staff groupings.	John McPoland/Laura Coulter	02/10/2020			Not Started							

6.4	Data monitored on ongoing basis to ensure plans are agile and adjusted to target areas as required.	Laura Coulter/West Div Admin	02/10/2020			Not Started						
7.0	**Incentives and Rewards**											
7.1	Board to agree on incentives and rewards											
7.2	Incentives and rewards to be publicised.											
7.3	Wards / Departments display flu uptake on their safety boards.	Divisional Managers	02/10/2020			Not Started			Buy in from managers			
8.0	Support to HSC System											
8.1	Link with Blood Transfusion to detemine criteria and numbers of mobile staff.											

TB/01/10/2020/03

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	1 October 2020
Title of paper:	The Management of Infection Prevention and Control Incidents and Outbreaks Policy
Brief summary:	This policy has been developed to provide guidance on the management of any incident/ outbreak of infection. This will be achieved through the identification, risk assessment and management of an Infection Prevention and Control (IPC) incident or outbreak. The priority in the management of an IPC incident/outbreak is to protect health by promptly identifying the source, implementing necessary measures to prevent further spread or recurrence, ensuring appropriate medical attention for those infected and communicating with patients/clients, staff and the public. Incident/outbreak management processes can also help to inform learning and to contribute towards the future management of IPC incidents and outbreaks.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 15 September 2020
Prepared and presented by: **Date:**	Ruth Finn, IPC Lead Lynne Charlton, Director of Quality, Safety & Improvement 24 September 2020

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**The Management of Infection Prevention and Control Incidents and Outbreaks**		
Author(s):	Ruth Finn, IPC Lead		
Ownership:	Lynne Charlton, Director of Quality, Safety and Improvement		
Date of SEMT Approval:		**Date of Trust Board Approval:**	
Operational Date:		**Review Date:**	
Version No:	1.1	**Supercedes:**	N/A
Key Words:	Incident, Outbreak, Infection, Infection Prevention and Control, Communicable Disease, Contact, Contract Tracing		
Links to Other Policies/ Procedures:	Infection Prevention and Control Policy, NIAS, 2018 Business Continuity Plan, NIAS, (date) Emergency Response Plan, NIAS, (date) Northern Ireland Infectious Disease Incident / Outbreak Plan, Public Health Agency, September 2018		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
29.06.20	1.0	Infection Prevention and Control Lead	NEW
30.07.20	1.1	Infection Prevention and Control Lead	Updated with comments from NIAS Business Continuity Lead
24.09.20	1.2	Director of Quality, Safety & Improvement	Updated definition of an outbreak

1.0 INTRODUCTION:

This policy has been developed to provide guidance on the management of any incident/ outbreak of infection. This will be achieved through the identification, risk assessment and management of an Infection Prevention and Control (IPC) incident or outbreak. The priority in the management of an IPC incident/outbreak is to protect health by promptly identifying the source, implementing necessary measures to prevent further spread or recurrence, ensuring appropriate medical attention for those infected and communicating with patients / clients, staff and the public. Incident/outbreak management processes can also help to inform learning and to contribute towards the future management of IPC incidents and outbreaks.

1.1 Background:

The Northern Ireland Ambulance Service (NIAS) has an obligation to manage any incident/outbreak of infection to prevent nosocomial transmission and to protect patients, staff and visitors.

1.2 Purpose/Objective:

Purpose

This policy is designed to provide a framework for the investigation and control of an incident/outbreak of infection or infectious disease within the NIAS.

Objectives

- To enable the identification and define the parameters of an IPC incident/outbreak
- To provide agreed definitions for minor and major outbreaks
- To provide a structured format for the management of IPC incidents/outbreaks
- To ensure a streamlined approach to IPC incident /outbreak management taking account of the overlap with business continuity, emergency planning and major incident management
- To provide clarification around roles and responsibilities in relation to IPC management
- To provide congruence within NIAS with the Northern Ireland Outbreak Plan (Sept 2018)
- To ensure adherence to best practice in terms of management of IPC incidents/ outbreaks
- To provide guidance on accessing resources required during an IPC incident/ outbreak

2.0 SCOPE:

This policy applies to all staff within NIAS and to any other individual or provider working for or on behalf of NIAS in any capacity.

3.0 ROLES/RESPONSIBILITIES:

Trust Board and Chief Executive:

- Ensure that IPC is a core part of Trust business, clinical governance and patient safety programmes
- Ensure awareness of and compliance with IPC policies generally and this policy specifically in order to manage IPC incidents or outbreaks
- Be aware of legal responsibilities to identify, assess and control risk of infection
- To promote a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC
- The Chief Executive has overall responsibility for effective management of an outbreak or incident.

Director of Quality, Safety and Improvement:

- Reports directly to the Chief Executive and Trust Board on all issues pertaining to IPC including in relation to Incidents and Outbreaks
- Promotes a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Ensures that all IPC policies are adhered to and provides assurance of this to Trust Board and the Chief Executive via the existing Trust assurance structures
- Is responsible for the oversight of the management of outbreaks and incidents or for the appropriate delegation of this function dependent on severity of the situation or potential impact of severity including on core organisational functions
- To be responsible for the convening, chairing and direction of Incident/ Outbreak Management Teams (ICT/OCT) as required for the management of IPC incidents/ outbreaks
- Responsible for triggering escalation in response to an IPC incident/outbreak such as business continuity, major incident or control and command with support of SMT
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC.

Trust Directors:

- Promote a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Ensures that staff and services under their remit adhere to NIAS policies and procedures in relation to IPC and incident/outbreak management
- Supports the organisation to ensure collectively that best practice in IPC is consistently applied and delivered within NIAS
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC

- To support in the management of staff where non-adherence to IPC Trust policy and procedures has been identified
- To assume membership of incident/ outbreak management teams in relation to IPC incidents/ outbreaks as requested
- At the request of the ICT/ OCT to assume lead role in relation to aspects of incident/outbreak management to support the work of the ICT/ OCT or to act as an expert resource
- To fully support the work of the incident/ outbreak management team is relation to IPC incidents/ outbreak management including in the allocation of appropriate resources as required (financial, workforce, administrative etc…)

Area Managers:

- Ensures that staff and services under their remit adhere to NIAS policies and procedures in relation to IPC and incident/outbreak management
- Promotes a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Supports the organisation to ensure collectively that best practice in IPC is consistently applied and delivered within NIAS
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC
- To act as role model in relation to IPC
- To support in the management of staff where non-adherence to IPC Trust policy and procedures has been identified
- To support with actions required arising from outbreaks/incidents with respect to their areas of responsibility
- To undertake all duties that they are commissioned with by the ICT/ OCT in a timely manner, diligently and with due care and attention
- To recognise when their own limitations in terms of ability or scope to undertake actions have been exceeded and to ensure concerns re this are escalated appropriately

IPC Lead:

- Ensures that all staff and services within the organisation adhere to NIAS policies and procedures in relation to IPC and incident/ outbreak management
- Promotes a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Supports the organisation to ensure collectively that best practice in IPC is consistently applied and delivered within NIAS
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC
- To act as role model in relation to IPC
- To support the work of the ICT/ OCT as required
- To support the Director of QSI in any aspect of Outbreak/ incident management that is required
- To act as a subject matter expert in the provision of IPC advice and guidance to the ICT/ OCT, to act as a liaison with other sources of expert advice such as local health protection unit

- To support staff in relation to incident/outbreak management through provision of support, advice, training and guidance
- To remain professionally up to update and to retain and grow specialist expertise in relation to IPC and incident/outbreak management
- To advise on the management of staff where non-adherence to IPC Trust policy and procedures has been identified.

Training Lead, Divisional Training Officers, Training Officers and Clinical Support Officers:

- Ensures that all staff and services within the organisation adhere to NIAS policies and procedures in relation to IPC
- Promotes a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Supports the organisation to ensure collectively that best practice in IPC is consistently applied and delivered within NIAS
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC
- To support the work of the ICT/OCT where any training needs are identified by the ICT/ OCT
- To undertake audit and practice supervision at the request of the ICT/ OCT
- To act as role model in relation to IPC
- To maintain accurate training records in relation to IPC and to provide training figures for assurance on request and at agreed intervals to Trust IPC group, Trust Assurance Group, relevant Director or ICT/ OCT
- To support in the management of staff where adherence to IPC Trust policy and procedures has been breached through the provision of education/ training support where required.

Station Officers and Station Supervisors:

- Promotes a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- Ensures that all staff and services within the organisation adhere to NIAS policies and procedures in relation to IPC
- Supports the organisation to ensure collectively that best practice in IPC is consistently applied and delivered within NIAS
- Be willing to hold self and others to account in terms of organisational performance in relation to IPC
- To support the work of the ICT/ OCT where it relates to area of responsibility, to ensure timely completion of actions, to ensure that actions are completed diligently and with due care and attention
- To recognise when their own limitations in terms of ability or scope to undertake actions have been exceeded and to ensure concerns re this are escalated appropriately to Area Manager and ICT/ OCT for support
- To manage staff where non-adherence to IPC Trust policy and procedures has been identified

Individual Staff Member:

- Promotes a culture of high expectations in relation to IPC to ensure that patients receive safe, effective, high quality, patient focussed care and services and to ensure that patients, staff and visitors are protected from nosocomial transmission of infection
- To adhere to NIAS policies and procedures in relation to IPC. To respectfully challenge others where IPC non-compliance is observed to reduce the risk of nosocomial transmission of infection. To escalate concerns through line manager or IPC team regarding concerns that they have not been able to action within their own remit or where they identify a serious concern
- Where requested to support the work of the ICT/ OCT, to ensure timely completion of actions, to ensure that actions are completed diligently and with due care and attention
- To recognise when their own limitations in terms of ability or scope to undertake actions have been exceeded and to ensure concerns re this are escalated appropriately to Line Manager and ICT/ OCT for support
- Supports the organisation to ensure collectively that best practice in IPC is consistently applied and delivered within NIAS
- To be aware of, to have read, to have fully understood and to comply with all NIAS IPC policies and procedures.

4.0 KEY POLICY PRINCIPLES:

The basic principles of IPC incident/outbreak control are:

1. Control the source / potential source (may be animal, human or environmental);
2. Control the mode of spread;
3. Protect persons at risk
4. Continue surveillance of the impact of control measure

Recognition of an outbreak

An outbreak will often first be recognised as an ‘unusual’ or ‘unexpected’ incident which, following on-going risk assessment by the incident team, is recognised as an outbreak. Either an Incident or an Outbreak might demand significant resources.

Incidents/ Outbreaks can present and evolve in different ways:

1. Acute – lead to a sudden increase in numbers of cases, and is often associated with a point source;
2. Persisting – develop over a number of days and weeks, and often involve a disease in which person to person spread is common (with or without an initial point source) and/or continued exposure to the suspect source/food etc.

An outbreak should be considered when there are:

- two or more people experiencing a similar illness, are linked in time or place;
- a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred;
- a single case of certain rare diseases, such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio; or a suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

Severity assessment

There are no clear definitions or tools to establish severity. However the terms major and minor outbreaks are in common usage.

In general the following working definitions should be employed:

A minor incident/outbreak is when the Infection Prevention and Control Team (IPCT) can advise on the incident using their existing resources, drawing on individuals within the Trust and not disrupting the function of the service significantly. A minor ICT/ OCT may be formed to co-ordinate actions.

A major outbreak is where action requires resources greater than are routinely available to the IPCT, where action is likely to seriously disrupt the running of the organisation or where the outbreak has serious consequences outside the Trust. To manage a major outbreak a Major Outbreak Control Team (OCT) will be required to co-ordinate actions. A single case of certain epidemiologically important disease e.g. nosocomial legionellosis or diphtheria may require a Major OCT to manage the situation.

In some situations incidents/outbreaks may give rise to significant public health concerns. On occasion, outbreaks may be of such a magnitude or consequence that there is a significant impact on services throughout the region or nation. Within Health and Social Care, if there are Trust specific or regional service continuity issues which cannot be managed internally the Health and Social Care Board will take the lead regionally. Representation will be sought from Trusts in this situation and it is critical that those undertaking these roles have full organisation oversight and sufficient decision making authority. In this situation the Northern Ireland Infectious Disease Incident / Outbreak Plan, Public Health Agency, September 2018 will be utilised to manage the situation.

Reporting procedure

Any member of staff who suspects an outbreak must report this to the person in charge of their area, for example Station Officer, who will inform the Infection Prevention and Control Team (IPCT). It is most important that staff act promptly if an outbreak is suspected.

Staff in the area must immediately enhance their infection prevention and control procedures to transmission based precautions and adhere to any advice issued by the IPCT.

Following notification, the IPCT will take immediate steps to collect information from affected areas to determine whether an outbreak is occurring and give initial advice on control measures.

Initial investigations will determine:

- Whether an outbreak is occurring
- An assessment of the severity of the situation
- Whether the outbreak is confined to one area or whether there are implications for other areas/services

Minor Outbreak management

Minor Outbreak Control Team (OCT)

Where the IPCT has assessed that a minor outbreak is occurring, the IPCT will convene an Outbreak Control Team (OCT) through the office of the Director of Quality and Safety. The exact composition and working arrangements of the group will vary from outbreak to outbreak depending on the nature, extent and location of the situation.

The OCT may include as required:

- Infection Prevention and Control Practitioner
- Infection Prevention and Control Lead
- Director of Quality and Safety/deputy
- Medical Director/deputy
- Station Officer
- Area Manager/ Control manager as appropriate to affected service
- Environmental Cleanliness Lead
- Estates representative
- Fleet representative
- Occupational Health
- HR representative
- Communications representative
- Administrative support

Minor Outbreak Management Team

- IPCT informs the Director of QSI who will be kept informed of progress.
- OCT convened and led by Area Manager with assistance and advice from IPCT
- IPCT and affected area representatives present the available information
- IPCT informs Public Health Agency
- IPCT updates PHA Daily Alert Bulleting
- Plans for future action are drawn up

These may include:

- Further microbiological/epidemiological investigations
- Management of cases
- Decisions on station closure
- Decisions on vehicle off road
- Decisions on control measures
- Decisions on need for environmental / equipment decontamination
- Information to staff on the situation and the proposed action
- Information to patients and relatives
- Corporate communication
- Further meetings if required.

A short report should be prepared by the IPCT at the end of the outbreak for the IPC and Environmental Cleanliness bimonthly meeting.

Director of QSI responsible for updating of Senior Management Team (SMT) at least weekly and more frequently where required.

Major Outbreak Management

Major Outbreak Control Team

If the Infection Prevention and Control Team or the Minor Outbreak Control Team, consider that the outbreak is major, a request to escalate to a major outbreak should be made to the Director of QSI. The Director of QSI will then make the final decision on the outbreak status.

Members of Major OCT who may be required:

- Infection Prevention and Control Team
- Director of QSI (CHAIR)
- Chief Executive or Deputy
- Medical Director or deputy
- Other relevant members of Executive Team to include Director/s of affected area/s
- Area Manager
- Station Officer
- Occupational Health Representative
- Business Continuity Lead
- Emergency Planning Lead
- Environmental Cleanliness Lead
- Estates Lead
- Consultant in Health Protection, PHA
- Corporate Communication
- Administrative support (consider loggist function)
- Co-opted members appropriate to situation

Where food or water is suspected as a source, it may be appropriate to have local environmental health officer as a member of Major OCT.

Other representatives may be co-opted at the discretion of the Chair e.g. Director of HR, Director of Estates, Director of Finance etc…..

Additional expertise from the NI Public Health Agency (PHA) and the Reference Laboratories can be obtained.. In outbreaks/incidents of consequence to the Trust the Director of QSI will chair the OCT.

Functions of the Major OCT

The Chair will allocate responsibility to specific individuals who will then be accountable.

The group will review the need for co-opting other staff, for example Clinical Training Lead, as relevant to the outbreak.

Initially the group will meet frequently, according to the speed of development of the outbreak in order to establish the extent and progress of the outbreak and review progress on outbreak investigation and control. Frequency of meetings will be situation and context dependent but in the case of a major outbreak may initially be required daily.

Investigations

Agree and co-ordinate decisions on investigations.

Epidemiological investigations:

- Agree on a case definition
- Define population at risk and list of suspected/confirmed cases
- Characterise cases by time, place and person
- Consider analytical studies e.g. case control.
- Screening of contacts and/or the environment

Laboratory investigations:

- Arrange for appropriate testing of specimens including referral to Reference Laboratories if necessary. Support for this will be through PHA.

Control measures

Assess risks to patients, staff and visitors and define control measures seeking advice from local and national experts where indicated.

Control measures may include:

- Antibiotic therapy/prophylaxis
- Immunisation
- Service/ Station/ Vehicle closure or restriction
- Staff education in infection prevention and control measures
- Decontamination of stations, offices, vehicles or equipment

Staff must work with the IPCT to ensure all control measures are strictly adhered to and to gather information as required in a timely fashion.

Treatment

Ensure all affected patients/staff are being optimally treated. This may involve advice, support and input from NI PHA.

Communication

- Consideration should be given to the how details of the outbreak are to be communicated
- Media statement to be prepared
- Agree a media spokesperson and a strategy for dealing with the media and other enquiries.
- Establish clear channels of communication and provide clear instruction and information for staff and patients,
- The need for a helpline should be considered
- Ensure regular updates are provided for the Public Health Agency, HSCB and DHSSPS.
- Communication with other Trusts and regional groups (e.g. Critical Care Network of Northern Ireland) as necessary

Escalation

It is recognised that, when managing a major IPC incident/ outbreak, it may also be necessary to invoke other process such as Command and Control, Emergency Planning and Business Continuity to support the organisation. It is critical therefore that there is representation from these services areas on the OCT. Escalation and invocation of these additional processes should be undertaken on a risk assessed basis. Requirement for escalation should be considered and the decision making around same recorded at each meeting of the OCT. The Director of QSI will be responsible for communicating the need for escalation to the Senior Management Team.

Record keeping

All those involved in the incident/outbreak management are responsible for keeping clear, accurate and comprehensive records of their involvement. In addition, the OCT should nominate an individual, preferably an appropriately trained loggist, to create a detailed timeline of all the events and information related to the incident/outbreak, including the rationale behind decisions taken.

The Chair of the ICT/OCT is ultimately responsible for ensuring that detailed minutes are available for each meeting. Administrative support should be identified for this function as a high priority. This should include if appropriate an Actions log, Decisions log and an Issues log, kept by a trained loggist. The minutes will:

- document the rationale and date for all decisions taken;
- record and date all actions agreed and by whom they should be taken;
- remain confidential.

All correspondence and minutes of meetings should be filed together in chronological order. In addition, individual members of the OCT should keep personal logs of their activities and include details of information received, conversations held and meetings attended.

All documentation, including computer-generated information relating to the incident/outbreak, must be retained and regular back-ups of electronically stored information made.

Other Considerations

In an incident/outbreak of any significant size or impact (i.e. could not be managed by routine arrangements), consideration should be given to the establishment of an ICT/OCT Situation Room to manage the case management, laboratory results, surveillance and flow of information in the response to the incident/outbreak.

End of the Outbreak

The end of the incident/outbreak does not necessarily coincide with the end of the incident/outbreak investigation. The incident/outbreak may be ostensibly over, but the work of the ICT/OCT continues until the investigation is complete. Due to the incubation period of the causative organism, it may not be possible to declare the formal end of the incident/outbreak for some time.

The ICT/OCT will decide when the outbreak is over, usually informed by the on-going risk assessment and should be considered when:

1. there is no longer a risk to health that requires an ICT/OCT to conduct further investigation or to manage control measures;

2. The number of cases has declined and/or returned to baseline levels;

The agreed date for the end of the outbreak should be agreed and documented and an outline plan agreed to 'stand' back up the OCT should it be required. Thresholds and timelines for re-convening should be agreed and recorded.

An agreed number of incubation periods have passed

At the end of the outbreak the OCT will meet with to review the situation with the following objectives:

- To review the experience of all those involved in the management of the outbreak
- To carry out a debrief and identify any shortfalls encountered or highlight positive outcomes
- To revise the Incident/Outbreak Policy if necessary
- To produce a written report. This will include a full review of the outbreak, its cause, management and recommendations for changes in procedures to prevent a further recurrence, to be submitted/reported to the IPC/ EC bi monthly meeting and to the Trust Senior Management Team

5.0 IMPLEMENTATION OF THE POLICY:

5.1 Dissemination:

- Directors and Assistant Directors will disseminate to all staff.
- It is available on the Internet and SharePoint so that all employees and members of the public/stakeholders can easily have access.
- During an IPC Incident/ Outbreak this policy will be circulated to all members of the OCT.

5.2 Resources:

During an IPC Incident/outbreak it is recognised that there may be additional resource requirements including:

- Additional staffing
- Additional cleaning hours input
- Additional PPE and other consumables
- Input from services which may interrupt or threaten their normal work streams
- Increased administrative support
- Consideration of other structures required to support the incident managment or organisation such as 'Control and Command' etc……

5.3 Exceptions:

This Policy applies to all those working within, providing services to, or acting on behalf of the Northern Ireland Ambulance Service Health and Social Care Trust. There are no exceptions.

6.0 MONITORING:

This policy will be monitored by the IPC and Environmental Cleanliness Group.

Following each Incident/ Outbreak the policy will be reviewed by the OCT to ensure that the policy met the needs of the group through a final learning review meeting.

7.0 EVIDENCE BASE/REFERENCES:

Infection Prevention and Control Policy, NIAS, 2018

Business Continuity Plan, NIAS, (date)

Emergency Response Plan, NIAS, (date)

Northern Ireland Infectious Disease Incident / Outbreak Plan, Public Health Agency, September 2018

8.0 CONSULTATION PROCESS:

- Co-produced by IPC and Business Continuity Lead

- Circulated to SMT for comment

- Circulated to Trade Unions for comment

- **Circulated to Operational Staff for comment (Area Managers, Station Officers, Vehicle Cleaning Supervisors, Fleet Officer)**

9.0 EQUALITY STATEMENT:

In line with duties under Section 75 of the Northern Ireland Act 1998; Targeting Social Need Initiative; Disability Discrimination Act 1995 and the Human Rights Act 1998, an initial screening exercise, to ascertain if this policy should be subject to a full impact assessment was carried out on the (Insert Date)

The outcome of the equality screening for this policy undertaken (pending) is:

Major impact ☐

Minor impact ☐

No impact ☐

10.0 SIGNATORIES:

Lead Author Date

Chief Executive Date

Appendix ()

Duties of the ICT/OCT may include:

1. Appointing a Chair (bearing in mind the requirement for continuity)
2. Taking minutes to record decisions and actions
3. Reviewing evidence (epidemiological, microbiological and environmental)
4. Determining that there is an incident or outbreak
5. Defining cases and identification of cases or carriers as appropriate
6. Identifying the population at risk
7. Identifying the nature, vehicle and source of infection by using microbiological, epidemiology and environmental health expertise
8. Regularly conduct a dynamic risk assessment whilst the outbreak is on-going
9. Agreeing and advising appropriate control measures
10. Developing a strategy to deal with the incident/outbreak and allocating individual and organisational responsibilities for implementing actions agreed
11. Investigating the incident/outbreak, implementing control measures and monitoring their effectiveness, using laboratory, epidemiological and environmental health expertise
12. Ensuring adequate manpower and resources are available for the management of the outbreak
13. To assess the potential impact of the outbreak/incident on service activity issues within the Trust and communicate/escalate issues as appropriate through both management and clinical accountability lines. Consider establishing a service continuity subgroup if warranted.
14. Ensuring that in the absence of a team member, a competent deputy is made available
15. Ensuring appropriate arrangements are in place for out of hours contact with all ICT/OCT members
16. Preventing further cases elsewhere by communicating findings to national agencies
17. Obtaining assurance that recommended control measures / actions have been implemented
18. Keeping relevant local agencies, DOH, the general public and the media appropriately informed

19. Providing support advice, and guidance to all individuals and organisations directly involved

20. Considering the potential staff training opportunities for the outbreak (attendance at the ICT/OCT is at the discretion of the chair)

21. Identifying and utilising any opportunities for the acquisition of new knowledge about communicable disease control

22. Declaring the conclusion of the incident/outbreak, based on the on-going dynamic risk assessment and preparing a final report

23. Evaluating lessons learnt

Suggested Terms of Reference of ICT/ OCT:

- To investigate the source and cause of the incident/outbreak

- To implement measures necessary to control the incident/outbreak. To monitor the effectiveness of the control measures

- To provide clear communication to the population affected, the media and other health and social care services within and outside the region, as appropriate

- To review learning arising as a result of the incident/ outbreak.

Appendix ()

The role of Chairperson of the ICT/OCT is a critical senior function. An outline of this role is described below, administrative support will be required in order to fully discharge this function.

Incident/Outbreak Control Team Chair

- To convene the ICT/OCT and, with the members of the ICT/OCT, ensure membership is appropriate
- To ensure all actions, including control measures, case-finding and investigations, are implemented as agreed at the Incident/Outbreak Control Team
- To ensure accurate and timely notes of the ICT/OCT meetings and records of the decisions made, actions agreed, issues identified are kept and updated.
- Following agreement from the members of the ICT/OCT to consider and as appropriate, declare an outbreak
- To identify what additional resources / personnel might be needed and ensure that these requirements are escalated to the senior management team. This would also involve considering relevant business continuity arrangements, which could vary depending on the nature and phase of the outbreak / incident.
- To consider the establishment of relevant subgroups to facilitate the work of the ICT/OCT e.g. Environmental Health / Communications / Cleaning subgroup/ Audit group
- To agree with the ICT/OCT who will lead the media response
- To ensure appropriate bodies and officers are kept informed and updated, including local Councils, local GPs and nurses
- To co-ordinate the written final report on the incident/outbreak and to ensure that the recommendations are acted upon
- To ensure the constructive debrief is held and lessons learned disseminated and acted upon as necessary
- To ensure all documentation relating to the incident/outbreak is correctly managed and disseminated, incorporating information governance and data protection requirements
- Keep the Director of Public Health and/or Assistant Director informed of key development

Appendix ()

First Meeting

	Agenda Item	Notes
1	**Introductions and Apologies**	
2	**Agree Chair** **Agree Administrative support**	
3	**Background/ Situation Update**	
4	**Constitution of ICT/OCT** **Roles and responsibilities of ICT/OCT**	
5	**Incident /outbreak policy**	
6	**Investigations** a. Epidemiological b. Microbiological c. Environmental d. Staff	
7	**Agree case definition**	
8	**Current risk assessment -** severity; uncertainty; spread; intervention; context **Requirement for Escalation (SMT, DOH, PHA)** **Risk Register**	
9	**Action plan** - **Responsibility for drawing up/ maintaining** - **Elements for inclusion** - **Responsibility for actions**	

10	**Control Measures** - Environmental - IPC precautions - Decontamination - Estates issues - Audit - Training	
11	**Resources required**	
12	**Communications:** a. Public b. Media c. Healthcare providers d. Other stakeholders e. Helpline f. Early Alert/ SAI	
13	**Any Other Business**	
14	**Date of next meeting**	

Appendix () – Subsequent meetings

	Agenda Item	Notes
1	**Introductions and Apologies**	
2	**Agree minutes of last meeting**	
3	**Background/ Situation Update**	
4	**Investigations** a. Epidemiological b. Microbiological c. Environmental d. Staff	
5	**Revisit case definition**	
6	**Current risk assessment -** severity; uncertainty; spread; intervention; context **Requirement for Escalation (SMT, DOH, PHA)** **Risk Register**	
7	**Action plan** - **Review of previous actions** - **Addition of new actions**	
8	**Control Measures** - Environmental - IPC precautions - Decontamination - Estates issues - Audit - Training **Resources required**	
9	**Communications:** a. Public b. Media	

	c. Healthcare providers d. Other stakeholders e. Helpline f. Early Alert/ SAI	
10	**Any Other Business**	
11	**Date of next meeting**	

Appendix ()

Outline report for close of outbreak

All reports and other documents produced by the ICT/OCT must comply with the requirements of the Data Protection Acts 1994 and 1998. For that purpose reports and other documents will anonymise any sensitive personal information and references to patients and businesses will be numerical and alphabetical, respectively.

Executive Summary

Introduction/Background: Brief narrative of circumstances and chronology of outbreak

Investigation:

- Case Definition
- Epidemiological
- Microbiological
- Environmental
- Chemical

Results:

- Epidemiological
- Microbiological
- Environmental
- Chemical

Control Measures Conclusions/Recommendations:

- a statement on the causes of the incident/outbreak, including any failures of procedures or breaches of legislation
- referrals to other agencies for their actions
- comments on the conduct of the investigation
- comments on any training needs identified by the investigation and performance against agreed standards

Appendices:

- Results of statistical analyses
- Epidemiological Report
- Surveillance Report form
- Press statements

TB/01/10/2020/04

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	1 October 2020
Title of paper:	Report on NIAS Learning from Covid-19
Brief summary:	This paper is compiled from interviews, group discussion, learning tools with considerable feedback from across the organisation on NIAS' response to COVID-19.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 15 September 2020
Prepared and presented by: **Date:**	Conor McCracken, Graduate Management Trainee Sarah Williamson, Programme & Change Manager Lynne Charlton, Director of Quality, Safety & Improvement 24 September 2020

Learning from COVID-19: A summary Report

V.6 for Review

Table of Contents

1.0 Introduction

1.1. Aim

The aim of this paper is twofold. Firstly to identify learning from the first stage of the response of NI Ambulance Service to the COVID-19 pandemic and secondly to make recommendations in regard to any response to future surges of the pandemic. The paper will highlight what worked well throughout the initial response, areas which caused challenges for NIAS as an organisation and for staff, and finally discussion/recommendations on how this response could be improved.

1.2. Background

In January 2020, through news coverage and information being released by the Department of Health and Public Health England, NIAS became aware of the outbreak of a novel virus in China, and, as a result, the Emergency Planning Department began to review our Influenza plan and business continuity arrangements.

On 31st January in line with the Infectious Diseases Plan, an Incident Management Team (IMT) was established and tasked with the sufficient deployment of the Trusts' resources and effective management of NIAS's response to COVID-19. A corporate move towards developing departmental surge plans was initiated. In addition, NIAS started a service wide initiative to fit test all staff for masks, setting up a team of testers whilst engaging with our own internal stores department and Business Services Organisation to secure essential PPE supplies.
Intelligence and Information was gathered from the HSCB, National Ambulance Resilience Unit (NARU), the Public Health Agency and Public Health England to inform NIAS's approach and to ensure that our clinical and operational responses were in keeping with National best practice.

On 11th March 2020, Coronavirus was declared a Global Pandemic by the World Health Organization. Northern Ireland had no deaths at this time as a result of the virus but numbers of confirmed cases within the province were on the rise.

On 11th March 2020, once initial scoping was complete and surge planning had commenced, the Chief Executive implemented a command and control structure to effectively manage NIAS's response.

The UK went into 'Lockdown' on 24th March 2020.

The data provided below displays the impact of COVID-19 on NIAS throughout March and April 2020. It is intended to update this to show the data until end of July, 2020 but this has not be possible at the point of circulation.

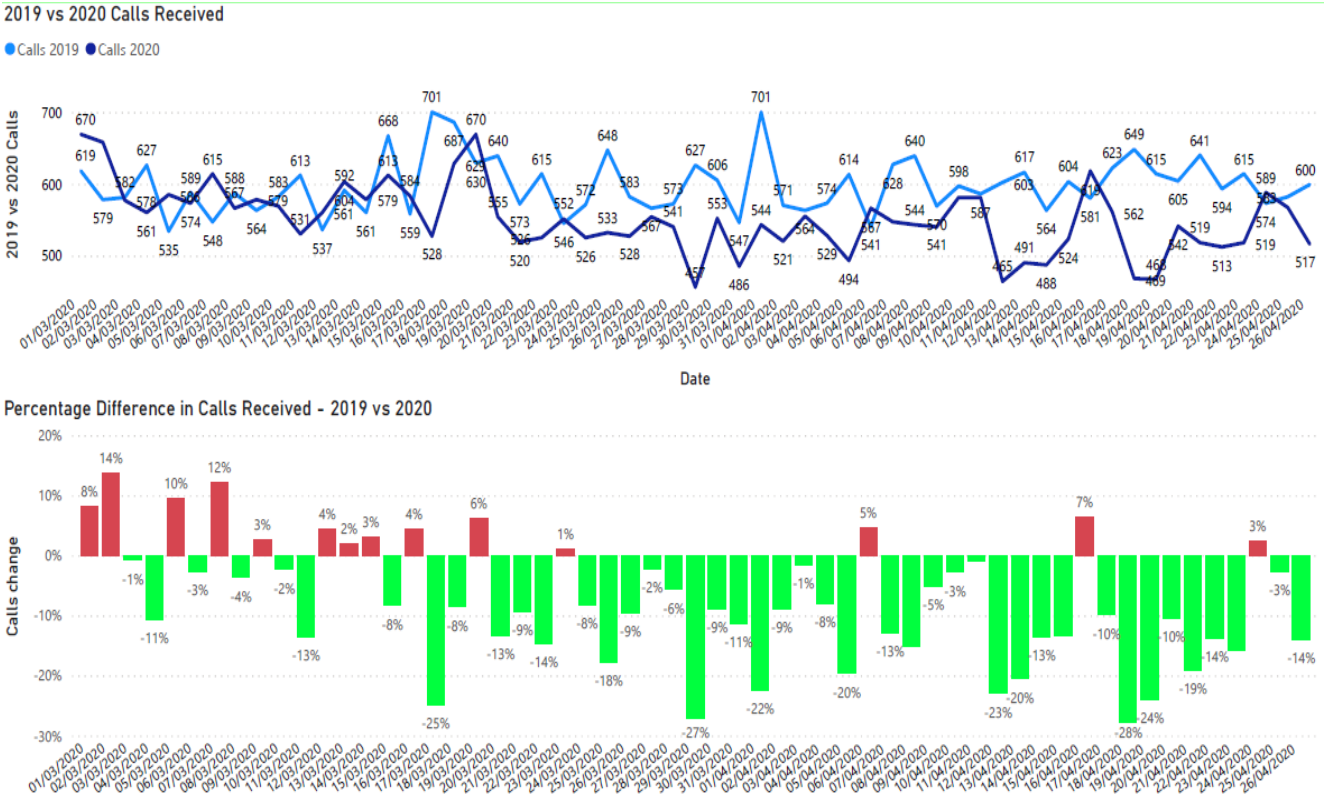
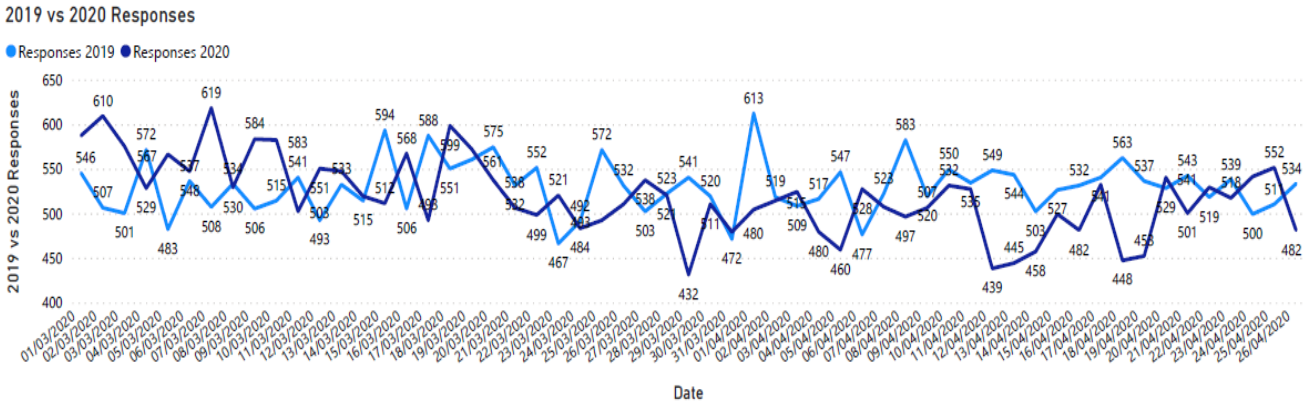


Table 1: Call Volumes

Throughout March and April 999 calls received were consistently lower compared to 2019 call figures for the same time period. This demonstrates that the public were aware of the challenges which confronted NIAS and whole of HSCNI and were therefore less likely to call 999. However, it should be noted that this does not provide the whole picture in regard to the workload of EAC as they continued to take significant numbers of calls from NIAS staff and Health care Professionals etc.



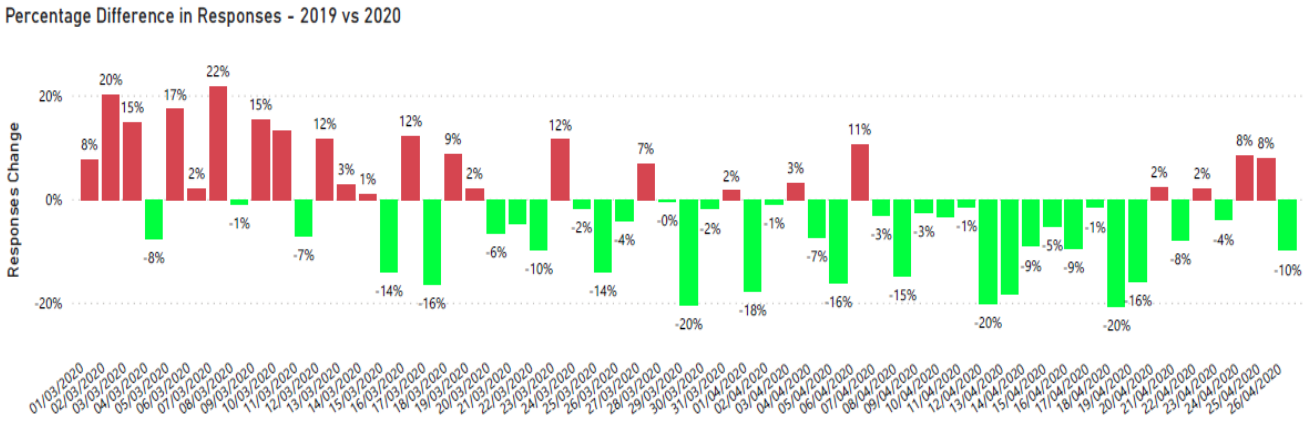


Table 2: Call Responses

Call Responses were consistently down throughout April 2020. This can be explained by an increased use of the Clinical Support Desk, which was expanded during the COVID-19 response and further because new “do not send” protocols were implemented within EAC.

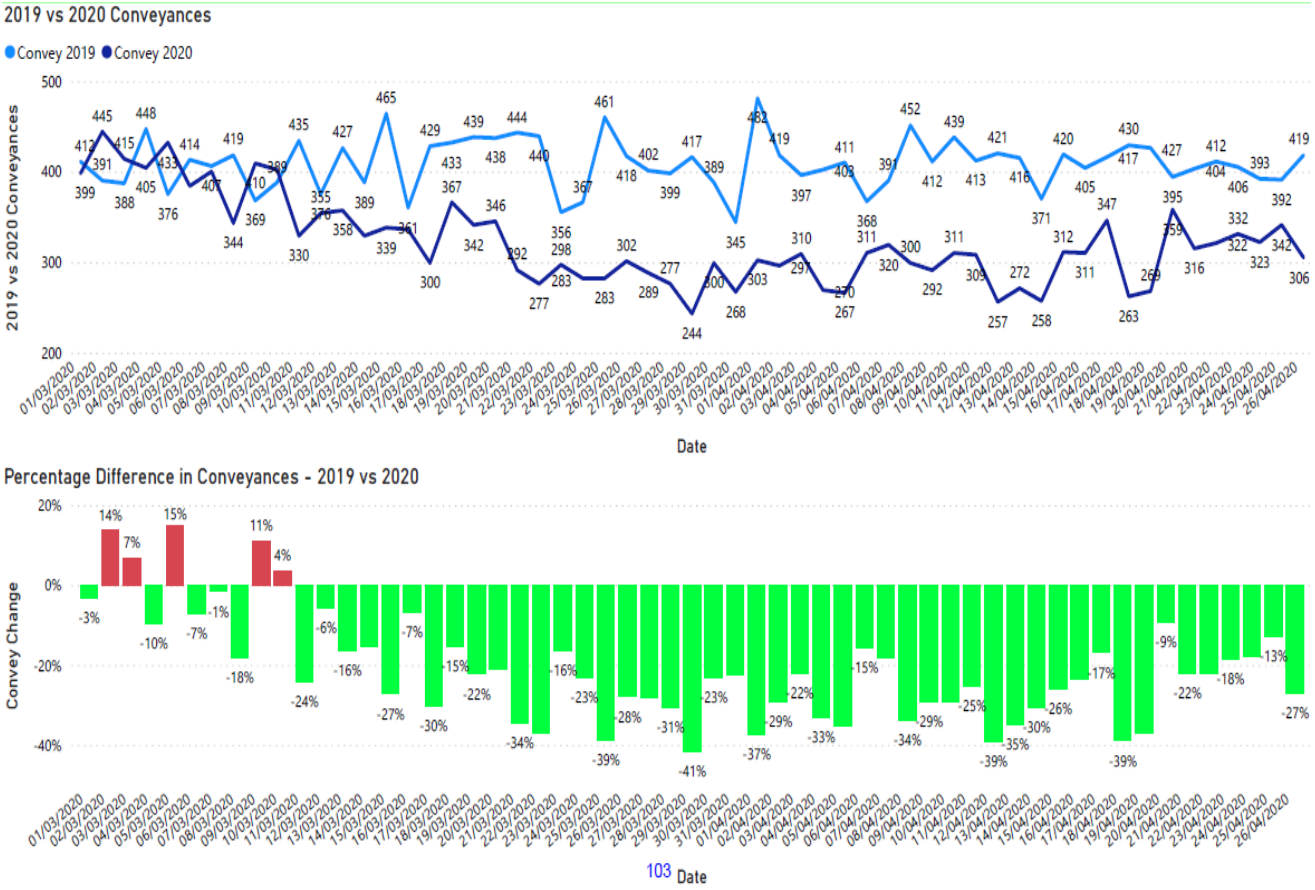


Table 3: Conveyance Rates

Conveyance rates to Emergency Departments were consistently down throughout March and April compared to the same time period in 2019. This demonstrated that our frontline staff made strong use of alternative care pathways and that our patients were less willing to travel to Hospitals due to the risk of contracting COVID-19.

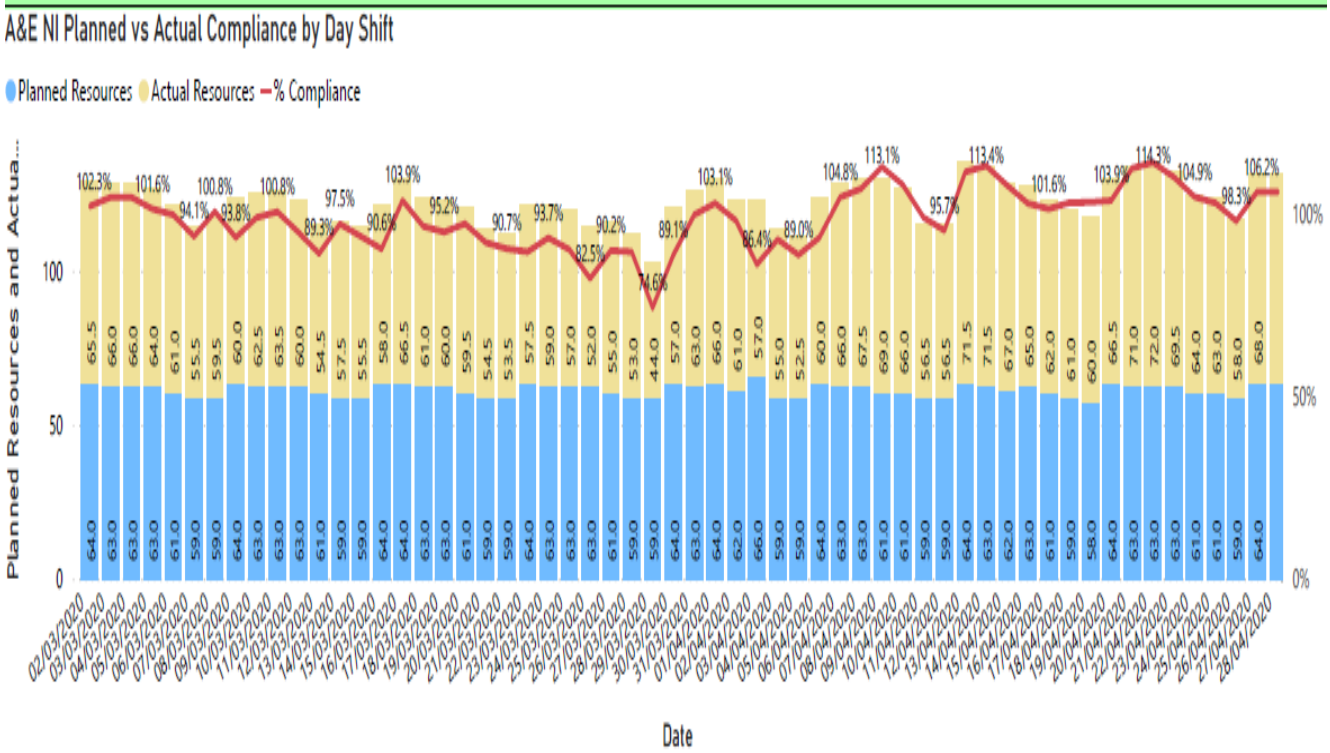


Table 4: Planned resources/Actual resources

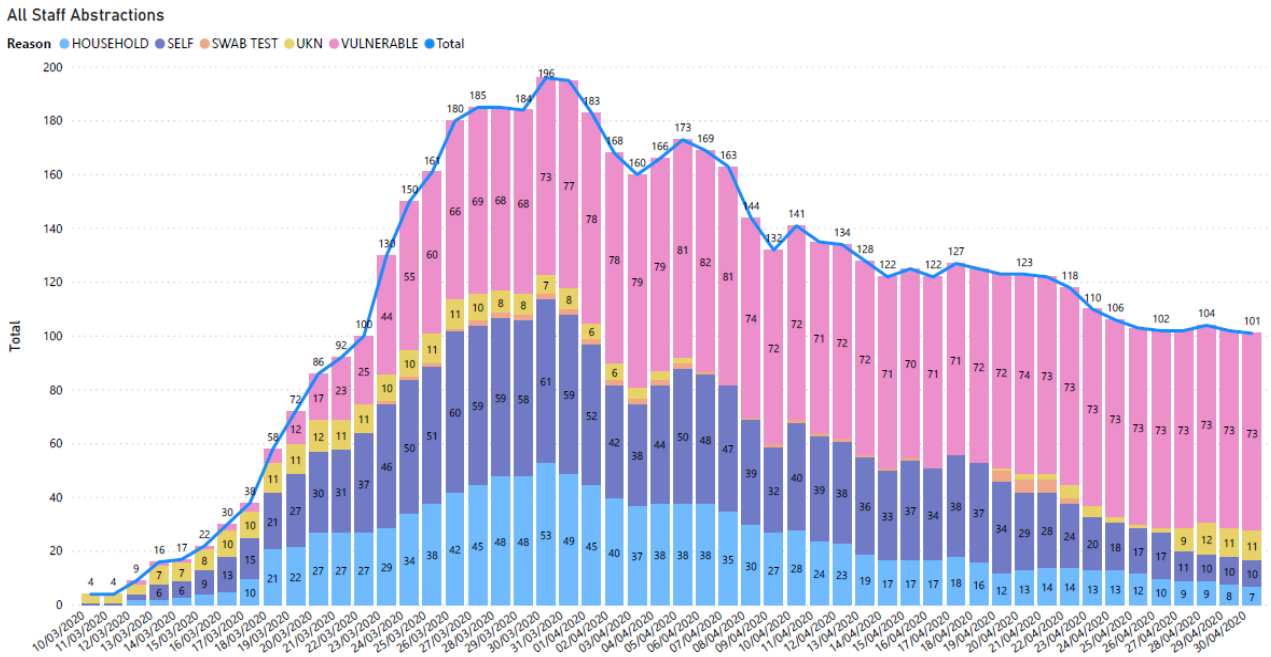


Table 5: Abstractions

The two tables above illustrate that despite high levels of staff abstractions throughout March and April resource levels remained high. Ultimately, this is because staff were redeployed to provide further cover and because there was a real commitment from staff to ensure NIAS were able to continue to provide excellent care to our patients throughout a challenging period.

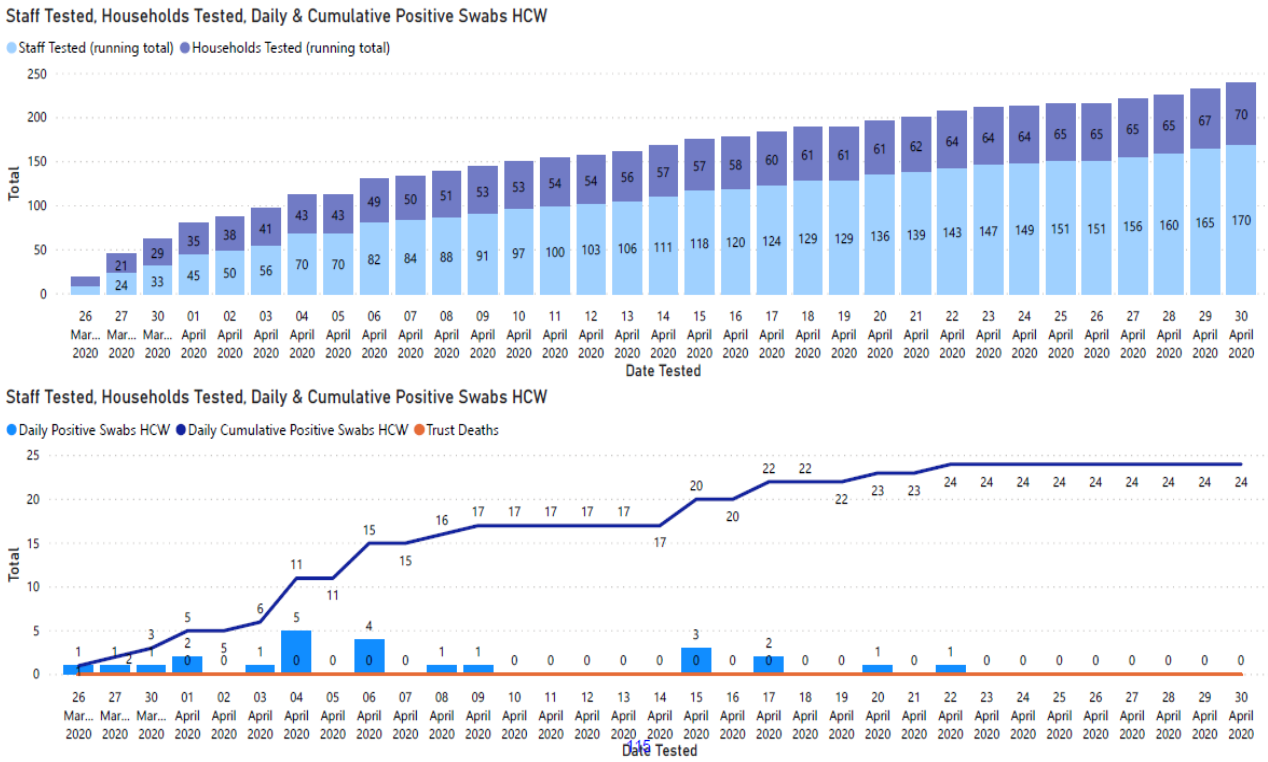


Table 6: NIAS COVID Testing

The data above shows the number of COVID-19 tests which were carried out on NIAS staff and their families throughout March and April. Numbers of positive tests throughout this time period remained low.

2.0 Methodology

It is recognised that the recovery phase, following the initial response to the COVID-19 pandemic, has provided NIAS with a unique learning opportunity. A Learning From COVID-19 Framework was developed by the Transformation Manager under the leadership of the Director of Safety, Quality and Improvement. The framework, drawing on harvesting tools from IHI and tools being developed in parallel by other HSC Trusts, had the ambition to extensively engage with staff from across the organisation, in all areas, to learn what went well and what could be improved. It was approved by SMT and Trust Board. The key objectives of the Learning Framework are:

- Preparedness for subsequent waves or resurgence of COVID-19
- Learning which might influence recovery
- Learning which might encourage sustainability of innovative practice
- Learning for the organisation in terms of communications and decision-making.

The feedback gathered has subsequently informed any recommendations included. A range of approaches were taken to target feedback in all of the areas outlined above, including:

- Engaging with NIAS Operational staff at a variety of Emergency Departments (RVH, Antrim Area Hospital, Ulster Hospital, Craigavon & Altnagelvin) (approx. 60 staff, including HALOs and Cleaning Crews)
- Completion of Learning Tools at Station Level (12 staff in total engaged)

- The NIAS/Unison Partnership and the Leadership Centre holding 5 focus groups to offer staff the opportunity to tell their story (number TBC)
- Issuing learning tools to Directorate Leads and Cell leads (46 staff engaged)
- 1:1 Interviews with Chief Executive, Directors and Assistant Directors (7 engaged)
- 1:1 Interviews with Cell Leads and Directorate Leads (5 Cell leads/members engaged)
- Group Zoom call with Area Managers (4 Area Managers engaged)
- 1:1 Discussions with Station Officers (2 Stations Officers engaged)
- 1:1 Discussions with members of staff from EAC (4 EAC staff engaged)
- 1:1 Discussions with Staffside leads (2 staff engaged)
- 1:1s with staff from a variety of team including NEAC, RMC (2 staff)

Further learning opportunities offered but without uptake have included:

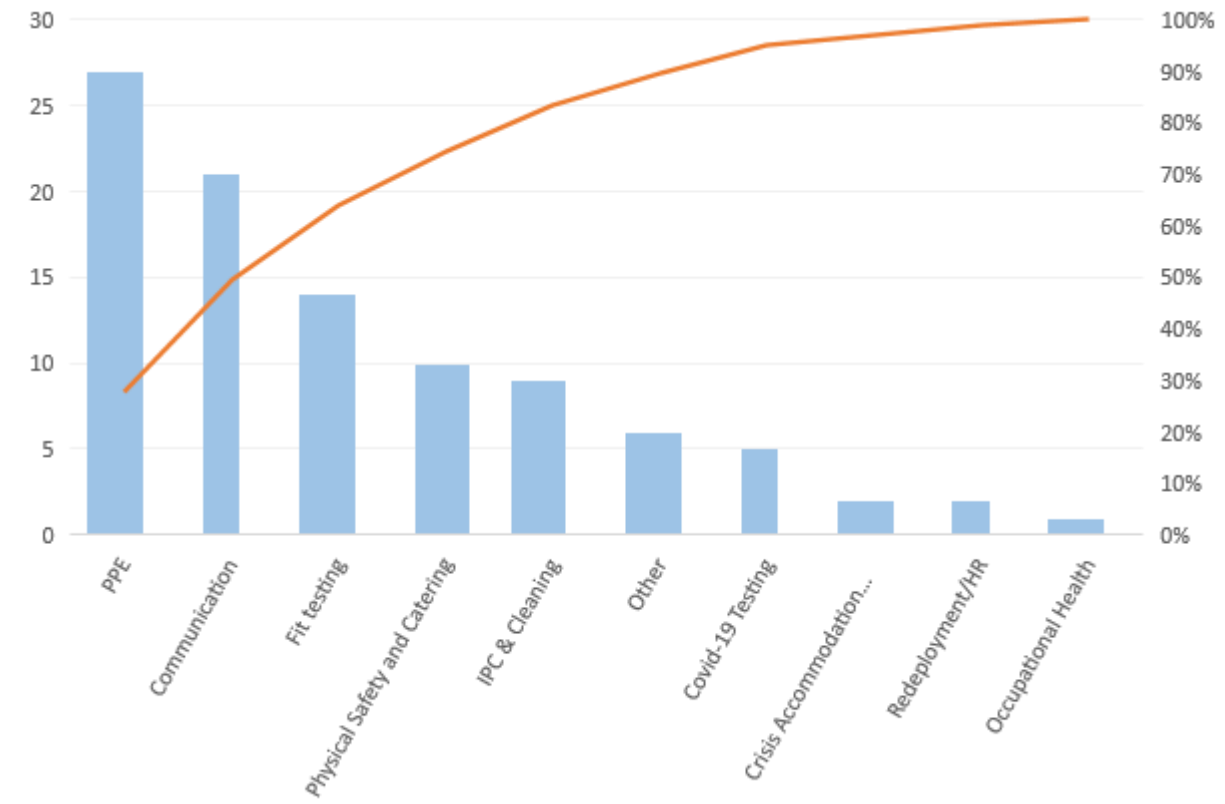
- 2 x Senior Management Zoom Sessions
- An EAC Zoom session

Most of this analysis was carried out by a Graduate Management Trainee seconded to NIAS who is a registered Social Worker. Through this extensive range of interviews, group sessions, conversations and completed written tools along with the NIAS/Union Partnership focus groups over 180 staff have been directly engaged with.

Learning has been rich and has included a wide range of issues both in regard to what worked well and where we can improve. Ultimately, it was recognised by the vast majority who engaged that COVID-19 was a completely unknown disease and that NIAS and the whole of HSCNI had to learn and react quickly to an ever-changing landscape. The learning in this paper should be analysed, and adapted to support planning for future surges of COVID-19 and for any similar infectious outbreaks in the future.

Feedback from frontline staff is a very important element of this exercise. The challenges discussed by frontline crews have been themed and put into a Pareto Chart to help with the identification of our main areas for improvement.

Fig 1. Pareto chart showing Covid-19 response challenges identified by Frontline Crews



3.0. Themed Learning

Learning has been grouped thematically with more generalised feedback following this.

3.1. Personal Protective Equipment (PPE)

Throughout the first stage of the response to the COVID-19 pandemic the supply of adequate and suitable PPE in a timely manner was, and continues to be, a high priority work stream for NIAS. On 1st April 2020, a NIAS PPE Cell was set up to oversee key PPE supply and demand during the response to COVID-19. The PPE Cell met on a daily basis and included; a member of the Clinical Service Improvement Team who was the lead on PPE Distribution alongside the Stores/Procurement lead, Emergency Planning, RMC, Fleet and IMT.

PPE Usage: The steps taken by the PPE Cell meant that NIAS have been able to successfully procure and store high quantities of PPE. Since April 2020 this has included but is not limited to:

- Approx. 36,000 FFP3 masks
- Approx. 34,500 Visors
- Approx. 204,000 Aprons

PPE Cell Learning: Two members of the PPE Cell have contributed to the learning for this paper; one through engagement in a 1:1 discussion and the other through completion of a structured Learning Tool.

Things, which worked well:

- Strong partnership working between PPE Cell and Operational staff
- Simplified process (once established) for acquiring PPE at station level from centralised stores
- Good governance based upon a 'supply and demand' model
- Daily stock-take of Station store to monitor levels of PPE across the organisation
- "Request of Need' initially on a daily basis as demand reduced this moved to designated days
- Risk based approach to supply and distribution

Challenges:

- Low levels of PPE during the early stages of the response
- Previous process for ordering PPE via BSO e-procurement by station meant there was no single point of contact to monitor throughput of PPE for NIAS
- BSO leading on Regional PPE procurement means there is limited control over the items NIAS receive.
- BSO's supply approach was based on 'proportionate push'

Operational Management Learning: Operational Managers have contributed to the learning in regard to PPE during zoom sessions and 1:1 discussions.

Things, which worked well:

- Commitment from staff at station level to support the process set up by the PPE Cell
- Designated "Champions" on station
- Non-patient facing staff couriering PPE from Central Stores to Stations
- Despite challenges Stations never ran out of PPE- which may be because NI did not reach the surge that many expected
- PPE Cell lead and stores worked extremely hard and did a great job in challenging circumstances

Challenges:

- Low levels of FFP3 masks at certain stations particularly in the early phase of the pandemic
- It is perceived by some that learning from previous epidemics/pandemic in regard to quantities of PPE required had not been implemented and NIAS was not prepared
- Supplying FFP3 masks with stickers with an updated expiration date without communicating the rationale behind this to Operational Management or staff prior to release was heavily criticised

Staff Learning: When engaging with A&E and PCS crews issues in regard to PPE, both positive and negative, were raised 36 times. PPE was the most mentioned topic of all the learning topics. Crews noted challenges in regard to:

- Quality of certain items of PPE: mainly white aprons, and masks, which loop around ear. Staff have suggested that these items of PPE are not suitable
- Model of FFP3 mask changing 3-4 times
- Expiry dates being refreshed on stockpiled FFP3 masks

The issues highlighted are important to address but there must be recognition that the current procurement process through BSO means NIAS does not have full control over the PPE provided. Communicating this to staff is therefore extremely important.

PPE Second Surge Recommendations:

- *Reconvene PPE Cell with the same staff who successfully managed PPE during the first phase of the pandemic*
- *Ensure the PPE Cell meet on a frequent basis and that decision-making is shared contemporaneously so all stakeholders are aware*
- *Re-initiate daily stock checks and request of need*
- *Ensure support is identified to courier PPE to Stations*
- *Attempt to Identify 1 or 2 masks with BSO colleagues which can be prioritised for NIAS staff*
- *Work collaboratively with BSO to procure aprons which are more suitable for professionals working in pre-hospital care*
- *If pandemic PPE stock is nearing expiration date or contains already expired items this should be communicated to staff prior to release*
- *Actively communicate with staff about the quantities of PPE that have been acquired and used*

3.2. Staff Communication

NIAS recognised the importance of consistent and clear communication with staff throughout the COVID-19 response. To achieve this a Staff Communication Cell was formed and a Single Point of Contact (SPOC), for communications advice and dissemination of information, was identified. This was made up of the NIAS Communications Team with lead responsibility delegated to the Media and Communications Manager.

A variety of methods and platforms were used to communicate with staff: Team Briefings, E-mail, WhatsApp, SharePoint, JRCALC, Website, and External facing Social Media Channels. This list continues to develop with the introduction of platforms such as Page Tiger.

Communication Cell Learning:

What worked well:

- Significant growth in WhatsApp Group membership. This group had approx. 250 members pre-COVID-19 and this number is now approx. 800+
- Anecdotal data suggesting staff satisfaction with communication improved during the COVID-19 response
- Videos from Senior Management worked well but at times could be shorter
- Support from Boardroom Apprentice and member of staff from HSC Leadership Centre

Challenges:

- Communication cell being resourced by a small number of staff
- Striking a balance between ensuring staff were up to date with information and not overloading them since guidance changed so quickly

Staff Learning: Communication was raised by 29 crews/HALOs during engagement sessions at E.Ds. There was a wide variety of preferences for information.

What worked well:

- Station Officers working on a rota basis offered supportive communication to crews
- Supervisors removed from front-line duties to address provide support and communication on Covid-19 issues face to face with staff
- HALO at EDs were considered to be an essential tool in regard to keeping crews up to date about changes at local Emergency Departments
- A number of staff thought the WhatsApp group worked well but suggested content should only include COVID-19 specific guidance

Challenges:

- Frontline crews are not provided with the time to check updates prior to shift
- No access to electronic devices to check updates at home or on Ambulance
- WhatsApp group included information which was not essential
- Hospital Trusts not actively communicating with Halos or crews in regard to admissions and offloading processes

3.3. Operational Guidance

In the early stages of the NIAS response to the growing threat of Coronavirus, the Trust became aware of the difficulty that operational staff were having in keeping up to date with the ever-changing guidance on personal protective equipment (PPE) and case definitions. To simplify version control, the Trust developed the NIAS Operational Guidance for Incidents involving Coronavirus (COVID-19). As of 07.08.20 version 9 of this document has been released.

Staff Learning:

- Staff struggled to keep up with Operational guidance as it regularly changed
- Staff thought that CSOs could have been a useful resource to update on changes in this document
- Staff are rarely provided with the time to read and understand such critical documentation

Staff Communication & Operational Guidance Second Surge Recommendations:

- *Consideration to be given to a COVID-19 specific WhatsApp group that would subsequently be used for only for essential COVID-19 guidance*
- *Communication cell to be resourced with appropriate levels of staff*
- *NIAS representation at Regional Emergency Care Huddles to identify early issues at local hospitals and communicate this to frontline staff*

- *Include at least one HALO in NIAS daily Huddle, this could be as a watching/listening brief*
- *Ensure REACH project is not delayed. Provision of electronic devices for staff is vitally important*
- *Continue to issue Operational Guidance Summary document each time (included in last three versions) the Operational Guidance is issued which outlines the changes from the previous document*
- *CSOs to maintain a presence at Station Level to offer support, advice and guidance to staff specifically in regard to the changes made to clinical guidance*

3.4. Fit Testing

The Clinical Training Manager (T) coordinated and advertised Fit Testing Clinics for staff with approximately 30 Fit Test Operators delivering testing across the region and Clinics held in all Divisions. Fit Testing was carried out across the Trust on multiple sites over long days with a range of different masks as the need to utilise those from different suppliers has developed.

Common Learning from Fit Testing Cell, Operational Management and Staff:

- Operational staff became frustrated and fatigued because of repeated Fit Testing due to the model of FFP3 mask changing multiple times
- Frustration amongst Area Managers and Fit Testers because a number of staff refused to remain ensure they had no facial hair interfering in the fitting of their mask
- Due to operational pressures it was difficult for and Operational staff to get stood down for testing

Fit Testing Cell Learning:

What worked well:

- Fit Testing representative on daily Huddle was useful because it enabled the Fit Testing team to stay up to date with operational issues
- The testing team worked extremely hard to identify staff for testing
- Use of WhatsApp worked well as a communication tool about testing opportunities

Challenges:

- Use of spreadsheets on laptops that were not linked to a centralised database was a limitation
- No access to printers to print copies of Fit Testing certificates

Operational Management Learning: Operational Management raised concerns that Fit Testing should have been completed long ago. Some felt the lack of Fit Testing prior to the COVID-19 pandemic demonstrated a lack of preparedness from NIAS.

Staff Learning:

What worked well:

- All staff spoken to were Fit Tested
- Mobile Fit testing worked well especially when at Hospitals and Stations

- Staff were reassured that there was a hood available if Fit Testing failed

Fit Testing Second Surge Recommendation:

- *Firmer guidance to be included in Fit Testing Policies/Procedures regarding need to ensure there is no facial hair interfering in the fitting of the mask*
- *An SOP for Fit Testing to be circulated (this has been developed)*
- *Routine/Scheduled Fit Testing should be a requirement. Staff suggested this be completed at yearly PP Training*
- *Dedicated Fit Testing team, not just during the COVID-19 response – should include a coordinator with responsibility for Fit Testing*
- *Endeavour Control prioritise standing down staff who need to be Fit Testing*
- *Informatics to manage and control centralised Fit Testing Database*
- *Robust audit and assurance processes should be in place to ensure Fit Testing is carried out in HSE standard*

3.5. Infection Prevention and Control (IPC) & Cleaning

IPC Cell learning:

What worked well:

- Representation on IPC Sub-Group of Health Silver
- Support of IPC Nurse from RQIA
- Hand washing campaign prior to COVID-19 surge

Challenges:

- IPC team felt they did not have the capacity to support and engage staff at Emergency Department and on the road as much as they would have liked
- Lack of clarity in regard to IPC's contribution to NIAS command structures
- Lack of incident/outbreak plan

Operational Management learning:

What worked well:

- Cleaning crews were "phenomenal" and the service was set up extremely quickly- this is a step towards "Make Ready"
- Operational Managers showed commitment and were able to support staff in regard to IPC guidance

Staff learning:

What worked well:

- The enhanced Vehicle cleaning was widely appreciated. Having access to this at Hospital sites produced the best results because it was easier to access
- Station cleaning was enhanced to daily cleans with the addition of a second touch point clean
- Availability of good levels of cleaning products

Challenges:

- Frustration amongst frontline staff in regard to the levels of PPE recommended for certain procedures e.g. Nebulisation & CPR
- Conflict with Hospital Trusts when being asked to don and doff PPE in certain areas of the hospital and/or different guidelines for PPE usage for procedures in EDs
- Operational Managers reminded crews that despite the availability of cleaning crews that there is still a need for them to clean their own vehicles when necessary

IPC & Cleaning Second Surge Recommendations

- *Continued IPC representation at Health Silver Sub-Group*
- *Clarification of where and how IPC contribute to command structures*
- *IPC Team to be expanded (this is underway)*
- *Develop and implement policy on The management of Infection Prevention and Control Incidents and Outbreaks (this is underway)*
- *Recognition of cleaning crews through social media or event*
- *Consideration to be given to longer term investment in enhanced cleaning crews*
- *Clarity regarding levels of PPE which are more consistent across hospital/pre-hospital*

3.6. COVID-19 Testing

In response to the COVID-19 pandemic NIAS established a swab testing facility at Derriaghy to provide screening that would enable staff that were self-isolating to return to work. Initially training was provided to a Clinical Training Officer and two Clinical Support Officers. They then trained further staff to take swab samples.

Swab Test Cell Learning

What worked well:

- Located in a reasonably central area for a majority of NIAS staff
- Ability to establish a secondary team in the West as required
- Robust IPC and swabbing processes in place
- Quick turnaround of tests and results for NIAS staff
- A personalised point of contact for all NIAS staff in relation to symptomology, swabbing advice and concerns
- Ability to ensure appropriate support was available for staff who tested positive
- Ability to reduce staff absence due to COVID-19
- Innovative uses of Data to understand how the virus was impacted our organisation and our staff

Challenges:

- Constantly changing advice from PHE and thus OSU in regard to isolation polices
- Use of multiple OH providers to give advice. Some staff were advised to stay off anyway ‘just in case’. If there is a second wave this could potentially cause a massive staff absence issue

Operational Management Learning:

Operational Managers were impressed with the COVID-19 testing provided by NIAS. Importantly the testing facility ensured 200 staff were able to return to work safely. Concerns were raised that this service was led by too few staff and must be resourced better in case of a second surge.

Staff Learning:

What worked well:

- Wide availability of testing slots and quick access to results
- Positive feedback about the role of OSU in arranging testing
- Having a direct contact in the testing team reassured staff

Challenges:

- Testing not regular enough. Staff felt they should be all be tested on a regular basis especially during winter months
- Staff not informed if crewmate or someone close tested positive. Concerns this could lead to further spread if asymptomatic
- Some staff received varied guidance on isolation policies

COVID-19 Testing Second Surge Recommendations

- *Consideration to be given to surveillance testing*
- *Clear NIAS Track and tracing policies to be widely distributed and enforced*
- *Ensure swab testing team structure is agreed prior to any second surge*
- *Continue to have the ability to provide this service in the West if and when needed*

3.7. Operational Support Unit (OSU)

NIAS created an Operational Support Unit (OSU) to relieve the pressure on EAC and to give staff a single point of contact for support. The Operational Support Unit was comprised of an Infection Prevention Control Lead, Operational Officers and Emergency Planning Officers in the first instance and then moved to IPC Leads, Officers and other managers (both clinical and non-clinical) and Clinical Support Officers.

OSU Cell learning:

What worked well:

- OSU provided a clear point of contact for staff with worries, concerns, fears throughout the response to the pandemic
- Having an identified lead for the OSU
- Call volume levels dictated the hours the service was available and times changed depending on demand
- Written guidance and folders and standardised forms

Challenges:

- Consistency of message provided was difficult to achieve because the guidance from PHE kept changing. In addition, staff came from a diverse range of roles and had varied levels of experience.

- Information available about the role/scope of OSU was not always clear. One of the key aims of the OSU was to reduce the pressure on EAC, which was caused by taking high levels of calls from staff who needed support/advice in regard to the ever-changing guidance. EAC Management who engaged in this learning process suggested EAC continued to take high levels of these types of calls throughout the response.
- Shift pattern meant OSU staff were not regularly in contact with each other and new guidance was issued frequently.

Operational Management learning: Operational Managers were supportive of OSU and its aims. Recognition that staff stepped up to deliver this function and were committed to this.

Staff learning: A small number of the staff who were involved in this engagement process had utilised OSU. The feedback was positive and staff appreciated the signposting support.

OSU Second Surge Recommendations

- *OSU team, with appropriate experience and knowledge, to be identified and trained before any future surge so this can be put in place immediately in the case of a second surge*
- *OSU lead to be identified from the offset*
- *Clarity on the role of OSU to be provided and then communicated appropriately to staff across the organisation*
- *Daily OSU Huddle to ensure staff maintain contact and awareness of who is included in the team and to check in on guideline changes etc.*

3.8. Crisis Accommodation (CAT)

CAT Cell Learning:

What worked well:

- Commitment from staff, many of whom took on CAT work in addition to their substantive posts
- Daily CAT teleconferences which provided opportunities for members of the team to ask questions, share concerns and to make an effective contribution to the process
- Flexible rota developed to meet the needs of the service
- 67 staff provided with accommodation
- Collaboration between some of the Trusts e.g. Northern and Western agreed to provide accommodation to NIAS staff

Challenges:

- Lack of clarity in regard to who was leading on Crisis Accommodation at a regional level
- Many hotels which could have provided accommodation were closed due the pandemic
- CAT members had little experience of services or procurement in the early stages and many had to adapt to new ways of working very quickly
- Initially CAT were not involved in daily Ops huddles and were not clear in relation to command structures

CAT Second Surge Recommendations

- CAT to be participate in Ops huddles from the outset of any future surge

- Consideration to be given to supplying the team with support from Procurement professionals
- Consideration to be given to CAT participation in command structure i.e. representation on Silver and Bronze
- Work is in progress to develop a CAT Toolkit which will simplify the re-establishment of the CAT function within the Trust in the event of a subsequent COVID-19 wave, or similar crisis

4.0. Operations Learning

General learning

What worked well:

- Station Officer enhanced cover was highlighted as being extremely helpful by Tactical Cell members
- Daily Huddles worked well and ensured good communication of operational issues
- Catering was appreciated and helped relieve an everyday pressure during the pandemic response
- Frontline staff provided each other with support, advice and guidance throughout a very challenging period
- Staff who engaged with the Peer Support service thought this was positive and worked better during the COVID-19 response because the service was readily available and also utilised proactive calls
- Staff who utilised Crisis Accommodation were happy with the service. This worked particularly well in the Western Trust Area.

Challenges:

- Lack of appropriate showering/cleaning facilities at some stations
- Social distancing in stations can prove difficult. There were also challenges with social distancing when cleaning crews were based at stations
- Use of Independent Providers was necessary but required a co-ordinated approach in relation to PPE
- Tasks being put on Operational Management despite their workload already being significant. An example is the distribution of food supplies to stations
- No access to zoom in certain stations. With meeting now being held virtually this can cause significant issues

Operations Second Surge Recommendations:

- *Catering should be dialled up in the event of a second surge. Consideration should be given to having a wider variety of food. This could also be utilised at other times of increased demand e.g. winter pressures and New Years Eve*
- *Appropriate support to be provided to Officers to distribute food supply across divisions/stations*

- *Ensure plans are in place to restart Crisis Accommodation service immediately in the event of a second surge*
- *Explore the potential of Station Officer cover as business as usual*
- *In the event of a second surge the Daily Ops Huddles should again expand to include COVID-19 response cell leads & HALOs*
- *Consideration to be given to further enhancing showering and cleaning facilities across all stations*

4.1. Emergency Ambulance Control (EAC) & Non-Emergency Ambulance Control (NEAC) COVID-19 Response

EAC

What worked well:

- Set-up of dual operations utilising site 5.This was done extremely quickly with support from IT Department
- EAC staff showed commitment and effort to deliver excellent patient care during challenging times
- New ways of delivering training e.g. the utilisation of training videos which EAC staff can access at any time to refresh their training and knowledge

Challenges:

- Data that presented reduced volume of 999 calls did not provide a fair representation of the challenges encountered by EAC staff. Different types of calls, for example from Healthcare professionals, remained the same or increased. This meant workload often increased
- Call performance was scrutinised heavily during the COVID-19 response. No consideration was given to the impact of new protocols on this performance
- Staff burnout, especially noticeable after COVID-19 response, because of high levels of extra hours/cover were provided.
- Site 5 can no longer be used as a training facility, meaning there is no dedicated EAC training location
- Training staff did not have access to appropriate recording technologies to make professional training videos. Often these had to be developed using mobile phone cameras
- Recruitment processes delayed by approximately 1 month
- Cross-site supervisory cover was difficult to provide. This meant Site 5 could at times be left without supervisory staff
- Impact of ED closure in the Southern Trust put caused significant challenges with resourcing which caused significant challenge for the South Controller.

EAC Second Surge Recommendations:

- *EAC specific cell or silver sub group to be set up to provide the support of subject matter experts*
- *Provide on-site welfare support for EAC staff*
- *Put systems in place to ensure staff overtime is monitored*
- *Data shared should be representative of the whole workload of EAC staff not just 999 call volumes.*
- *Appropriate equipment to be procured and supplied to EAC training team to facilitate the promotion of new forms of training*

NEAC

What worked well:

- Introduction of 24hr service worked well and staff were happy to work the 24hr rota
- Supporting EAC by taking responsibility for the Doctor Desk

Challenges

- NEAC staff felt vulnerable because they were unable to social distance
- Screens to protect staff have only recently been installed. Staff in NEAC thought this took too long
- Priority given to movement of IT equipment in other areas of the organisation caused difficulties for NEAC when trying to move desks and make changes to NEAE layout etc.
- Lack of onsite Management and challenges in regard to regular and consistent communication with Senior Management

4.2. Clinical Support Desk (CSD)

What worked well:

CSD staff resource was increased dramatically during the response phase due to redeployment of CSOs who were suitably qualified Training delivered to re-deployed staff was over the course of a week. This training usually takes 2-4 weeks to complete and a further 4-6 weeks to consolidate new skills learnt.

Identification of clinical leads for the CSD desk and creation of a Band 7 role to provided clinical oversight and take responsibility of potentially difficult outcomes in the midst of the pandemic.

24/7 CSD cover

Challenges:

- CSD paramedics removed from operational shifts. This has had a massive detrimental impact on morale. There have since been several resignations and an increase in sickness, which may not be all related to loss of Ops shifts directly but it has had an impact on decision making for some staff, resulting in difficulties in staff retention
- Recovery phase has created issues because CSD no longer has the same level of resource as it did during the response phase – staffing levels dropped by around 40%, with CSOs being put back into substantive roles and staff leaving
- Staff burnout is creating significant issues now. It is becoming an increasing concern due to the reliance on CSD to support demand management.

CSD Second Surge Recommendations:

- *Early identification and training of extra CSD staff resource. In the event of a second surge, these staff members can then be utilised to increase the capacity of CSD without delay – some of the CSOs have continued to work on the desk on an overtime basis and would be able to work on CSD with ease.*
- *Development of a CSD Bank*
- *Rolling recruitment would be hugely beneficial. This could include permanent and bank. Staff leaving should be offered bank contracts, without having to go through the full recruitment process.*

4.3. Patient Care Service (PCS)

What worked well:

- PCS crews enjoyed working A&E support shifts and extended hours andwould welcome this continuing
- A&E Crews benefited from the support offered by PCS throughout the response
- Oncology & Renal patients continued to receive support throughout the COVID-19 response despite other outpatient work being postponed
- Some PCS staff were trained to carry out patient assessment observations

Challenges

- Capacity of PCS dropped to 20-30% because of social distancing requirements
- Voluntary Car Service was stood down due to a number of risks. This caused frustration for the drivers who wished to continue
- VAS & PAS use increased dramatically because VCS was stood down. This comes with significant expense to the organisation

PCS Second Surge Recommendations:

- *COVID-19 risk assessments to be completed for VCS drivers to ensure this service can continue*
- *Consideration to be given to providing VCS drivers with protective screens for their cars*
- *Consideration should be given to PCS again moving to 24hr rota to support Emergency work*
- *Consideration should be given to PCS vehicles being fitted with the appropriate apparatus to secure emergency equipment*
- *Expand patient assessment training*
- *Consideration to be given to training PCS staff in blue light driving. This would provide a further resource to A&E service*
- *Explore ways in which capacity can be increased in PCS vehicles e.g. separation of rear cabin*

4.4. Resource Management Centre (RMC)

What worked well:

- RMC presented daily recovery with daily Ops Huddle. This meant issues could be identified early and ideas shared on how to address these
- Supervisors provided with laptops to enable them to work from home if needed
- High levels of cover across division throughout COVID-19 response phase was helpful
- Support of OSU and Silver to address issues e.g. staff who were symptomatic etc.

Challenges:

- Many frontline staff have not taken leave throughout the response phase and have now acquired significant levels of leave which will be difficult to manage appropriately
- Screens to protect RMC staff were late to be installed. This made staff feel vulnerable
- RMC are now giving out advice to staff who are symptomatic or who have been in contact with a symptomatic colleague. This can be challenging out of hours without the appropriate support

5.0. Medical Directorate & RATC Learning

What worked well:

- Contingencies plans agreed with external stakeholders to support NIAS if surge reached "worst case scenario"
- Frequent caller team was invaluable throughout the response
- Expansion of CSD Team supported the essential service of clinical triage
- Community First Responders were able to support other services e.g. swabbing in nursing homes and PPE distribution
- RATC staff were able to contribute to a wide range of areas during the COVID-19 response
- Quick adoption of new ways of delivering training to ensure social distancing requirements could be met e.g. virtual and video based

Challenges:

- Having to stand down essential services to support COVID-19 response e.g. HEMS & Community First Responders
- Northern Ireland context is not always appreciated in UK wide guidance
- Guidance was rapidly changing, this was difficult to communicate
- Training Officers and CSOs being used to carry out Fit Testing and deliver food to stations was not a beneficial use of their skills
- Postponing training of Paramedics and EMTs has a significant knock on effect to workforce plans

Medical Directorate & RATC Second Surge Recommendations:

- *Contingency plans to be regularly communicated with frontline staff*
- *Decisions should made to be in line with NIAS context i.e. consideration to be given to geographical situation*
- *Training Officers and CSOs to be used in positions that will make fully use their high levels of clinical knowledge and skills*

- *Appropriate ICT input regarding hardware and software to be provided to RATC to ensure virtual training needs are met going forward*

5.1. HEMS

What worked well:

- HEMS teams were quickly trained to support critical and rapid inter-hospital transfers during COVID-19
- Despite loss of some the functionality of the control room and working off web based C3 and telephone with control, HEMS continued to respond to patients who were in need of critical pre-hospital medical interventions

Challenges:

- Once re-instated ground crews were not aware that the service was available and instances where HEMS may have been required to support ground crews, the team was not requested
- Perception that HEMS is an add on service rather than core business to the ambulance service
- HEMS airdesk was relocated to MLK this impacted on the ability of the desk to effectively interrogate calls that may need a HEMS response.

5.2 HART

What worked well:

HART tasking: During the initial stages of the outbreak HART were tasked with the admission and inter-hospital transfer of **ALL** confirmed cases of COVID-19 regionally, this significantly reduced pressure on operational resources at a time of high uncertainty. Using flexible working arrangements, NIAS HART provided a 24/7 response, responding to direct requests from the Chief Medical Officer and the Department of Health to treat and transfer confirmed cases of COVID-19 using recognised UK wide HART safe working practices in keeping with a High Consequence Infectious Disease (HCID) response.

HART management of COVID-19 operational activity: During the initial stages of the outbreak NIAS HART managers also responded with operational crews to suspected COVID-19 case to ensure safe working practices were being adhered to, this involved the development of donning and doffing guidance (PPE protocols) which were adapted from the HART HCID capability.

NIAS Bronze Officer training provided by HART: Following the spread of COVID-19 and to ensure resilience for NIAS by sharing specialist capability learning acquired in the early stages of the response, HART managers supported the delivery of COVID-19 champion training. This training, aimed at Station Officer and Supervisor level, provided details of the importance of PPE management and also the practical application of the skills in a real world environment through the development of action cards and aide memoirs. This information ultimately was collated and became the foundation for the NIAS Operational Guidance Document.

NIAS HART/PSNI Pilot: NIAS HART management in conjunction with PSNI senior officers (Assistant Chief Constable level), designed, developed and deployed a partner agency response aimed at increasing NIAS operational resilience.

NIAS HART COVID-19 UK transfers: In keeping with HART HCID preparations, the management, treatment and transfer of patients to High Level Infectious Units (HLIUs) in Great Britain was and remains the responsibility of NIAS HART. This significantly reduces pressure on operational resources as these transfers typically are complex and protracted in nature.

Challenges:

During the COVID-19 response the NIAS HART manager and HART Advisor/NILOs were reallocated to Silver Command, this resulted in HART operations, including COVID-19 responses, being delivered without managerial oversight contrary to established safe systems of work and HART Standard Operating Procedures.

Recommendations for Future Surge:

Due to the significant challenges faced by PSNI Officers when undertaking ambulance duties NIAS HART identified that should there be future requirements for support to NIAS from PSNI (outside of the group of staff involved in the pilot) this should be identified as early as possible with training/familiarisation undertaken at the earliest possible opportunity and particularly prior to any surge in demand.

6.0. Corporate Functions (HR, ICT, Finance and Staffside)

What worked well:

HR

- HR well represented at the HR Cell of the Regional Health Silver group
- There were huge workforce implications due to staff having to shield or work on reduced duties. HR team put a wide range of supports in place to support these staff and overcome any issues
- Peer support service completed proactive welfare calls and these were well received
- Remote working with the ability to complete check-ins via Zoom
- Management felt empowered to make dynamic and quick decisions
- Significant piece of work completed in regard to staff psychological safety during the pandemic
- Staff wellbeing service represented at daily huddles

ICT

- Daily ICT planning meetings
- Participation in daily NI Digital Response to COVID-19 meetings (Infrastructure)
- Made Ready Site 5 as alternate EAC which included: Additional 20x Telephony, Additional 20x C3 CAD, Additional 20x ICCS, Additional 20x Voice Recording
- Dedicated ICT staff
- Re-allocating REACH project staff to core ICT Support Team
- CAD Hardware Replacement – Weeks of planning and communication between ICT, EAC and Supplier

Finance

- Finance team were able to access Citrix keys and all staff now have laptops enabling the team to work remotely

- Station Officers emailing claim forms rather than sending in hardcopies
- Finance team were able to maintain contact whilst working at home using daily and weekly Zoom sessions

Staffside Learning:

- Release of staff to fulfil union duties was welcomed. This provided more time to engage with members and resolve issues
- Increased engagement with Senior Management including involvement in a variety of groups

Challenges:

HR

- Some Mangers in HR did not feel appropriately plugged into Command Structures
- Command Structure poorly communicated
- No clear lead identified for HR Cell
- HR Team engaged in significant work in regard to the Regional Workforce Appeal, however, this did not yield high levels of benefit
- HR records are currently held in hardcopy paper format, this caused challenges for homeworking
- The nature of the service and work carried out by HR means there is limited scope to stand down business as usual
- HR staff are required to work with large spreadsheets and other recording systems which are not easily compatible with the current IT infrastructure and resources that are provided for home working

ICT

- Silver Control in Director of Ops Office – not adequately planned and evolved quickly to require a location move
- Remote working – prior to COVID-19, ICT Department kept low levels of spare Laptops and Keyfobs and couldn't meet the demand quickly due to supply chain demand
- Some pieces ICT equipment taken home by staff without notifying the ICT Department rendered asset register ineffective

Finance

- NIAS received many gifts from the public and other organisations throughout the response phase but the appropriate forms were not always completed. This meant the Central Gift Register was not up to date or reflective
- Retrospective approvals for expenditure should be completed as required
- At times the Finance team felt detached from the NIAS Command Structures and Senior Management

Staffside

- Lack of clarity in regard to the future leave to fulfil these roles
- Certain groups are being disbanded, this makes it more difficult for Unions to engage with the organisation and Senior Management

- Attendance management polices being enforced for incidents, which happened prior to COVID-19. This does not show recognition for staff who worked tirelessly throughout the response

Generalised learning:

What worked well:

- Use of remote working and video conferencing. Staff have reported that these tools helped them to be more productive and greatly reduced travel time etc.
- Cross silo working- staff having the opportunity to work with colleagues from across the organisation
- Shared purpose across the cells and high levels of collective leadership

HR, ICT, Finance & Staffside Second Surge Recommendations:

- *Amplify remote working capabilities and technology availability across the organisation- this should include appropriate equipment for HR staff who are required to work from home e.g. two screens and docking stations*
- *Consideration to be given as to how HR communicate with command structures*
- *HR to be included in daily huddles*
- *HR Cell Lead to be identified*
- *Policies and process should be followed appropriately when receiving gifts, this needs to be communicated regularly*
- *Retrospective approvals for expenditure should be completed as required*
- *Clarification of Command Structures to all staff*

7.0 Risk Management

With regards to risks under the control of NIAS during the pandemic and during the recovery phase, NIAS made every effort to adhere to its Corporate Risk Management Policy and Strategy and to current guidance and best practice (DoH guidance, ISO 31000 Risk Management Principles and Guidelines, Risk Management Standard for Ambulance Services – NHSLA 2013-14, Institute of Risk Management ERM guidance etc.). For a complete list of the current risks associated with COVID-19, please see associated Recovery Co-ordination Group papers, SMT papers or contact the Risk Management Team.

Risks Well Managed:

The Risk Manager shared a range of examples where NIAS staff demonstrated a robust response to risk management in this evolving situation, see table below for examples:

Area / Task	Risk Managed
Projects paused and project staff redeployed to increase remote working capacity.	Trust objectives / performance
Site 5 contingency made ready ahead of initial timescales.	IPC / Social Distancing
Subject experts recorded voiceovers for PowerPoints / videos etc. for training to continue.	Recruitment / front line operations
Operational staff readily took on new roles such as delivering food, testing in Nursing Homes, Testing of staff, antibody	Staff health and wellbeing, Departmental directions

testing etc.	
Headquarters staff immediately adapted working patterns (working weekends, evenings, bank holidays and as part of rotas to reduce risk in heavily populated buildings).	Trust objectives / performance, IPC / Social Distancing
Headquarters, CFR and Training staff abandoned existing roles in order to take on new roles and tasks such as loggists, members of Operational Support Unit, fit testing, arranging accommodation etc.	Pandemic response, IPC, staff health and wellbeing
Estates staff prioritised statutory responsibilities and worked to reduce risk in the procurement of systems to keep staff safe for example, Perspex screens.	Statutory obligations, IPC / Social Distancing
Remote monitoring technology was introduced to enable social distancing across control rooms.	IPC / Social Distancing
Staff have adapted to staggered meal breaks and shift times.	IPC / Social Distancing
Occupational Health support and arrangements have been bolstered.	Staff health and wellbeing
Financial arrangements have been adapted to support line management requirements.	Pandemic response
Communication and information arrangements for staff have been improved with regular bulletins and newsletters being circulated.	Staff health and wellbeing, IPC / Social Distancing
Remote and homeworking processes have been implemented successfully.	Trust objectives / performance
EAC processes have adapted to include floorwalkers and increased clinical input to call taking.	Clinical risk management
Trade Union relationships have improved due to joint working.	Communication
Supervisors removed from front line duties and provided with additional training to provide presence at station level to provide support and guidance to staff.	Communication
Relationships with other organisations have been strengthened, for example partnerships with NIFRS in the event of a loss of fleet expertise and / or resources.	Business continuity

Risk Management Second Surge Recommendations

- *Person dedicated to administration of issue logs / risk registers etc.*
- *Reinforce the importance of timely responses to requests to update risk registers etc.*
- *Absolute clarity on how resources will be allocated in response to risk assessments, e.g. training and upskilling of administrative staff to support operational services, how / when – students in Training will be redeployed, how / when PSNI, NIFRS support is expected, how / when PAS / VAS roles increase?*

8.0. Command Structures

During the COVID-19 response phase the NIAS Major Incident Plan Version 10 (June 2018) was utilised to guide on the setting up of the structures required to manage an incident of this scale. The structures put in place were Strategic (Gold), Tactical (Silver) and Operational (Bronze). Whilst there is an ongoing official debrief of these structures led by the Emergency Planning

Officer there has been some general feedback provided throughout the learning process and is therefore included in this summary of learning.

What worked well:

- The Boardroom functioned well as the accommodation for Silver command
- Bronze officers suggested the daily COVID-19 Huddles worked well. However, it was felt that this Huddle should not replace the formal escalation route up to Silver. Bronze information shared at the Huddle did not appear to formally feed through to Silver.
- Silver had the ability to offer 24/7 cover. This was dialled down when need reduced but could be dialled up again
- There was a review of Gold, Silver and Bronze command structures partway through the response period with a considerable list of recommendations. Some of these were implemented but since surge did not occur, there was not adequate time to move to the proposed amended ways of working.

Challenges:

- Informal reporting between work streams and Directors/Gold resulted in duplication of communication and at times meant the appropriate escalation and communications process through Silver to Gold was not followed
- It was perceived that the Gold Cell made Tactical decisions, which should have been made by Silver. Learning suggests this led to the workload of Silver being reduced
- Several of the Directors who were part of the Gold Cell are new to the organisation and have been unable to access appropriate Strategic Commander Training
- Silver Commander was not included in Gold Cell meetings
- Area Managers felt unappreciated when not included in Silver command rota
- Engagement from Command structures in the debrief process has been limited
- The ongoing nature of COVID-19 mean there has been no definite end to the response

Command Structure Second Surge Recommendations:

- *Commander training for Strategic level should be prioritised*
- *Reduce the volume of informal communication by ensuring that Silver / Tactical Command Room co-ordinate and own all escalation of issues and disseminating of decisions to Bronze and Operational Staff.*
- *Silver Commander to be included in the Gold Cell to improve communication between Gold and Silver*
- *Role of Area managers in Command Structures to be clarified*
- *Business Intelligence / templates / information flow / information management systems to support decision-making need further consideration – what are our triggers to indicate a future surge?*
- *A paper titled "Effectiveness of Management Structures COVID-19" was tabled at SMT on 23rd April 2020 and agreed. This paper includes recommendations that should be fully implemented during any future response to the COVID-19 pandemic.*

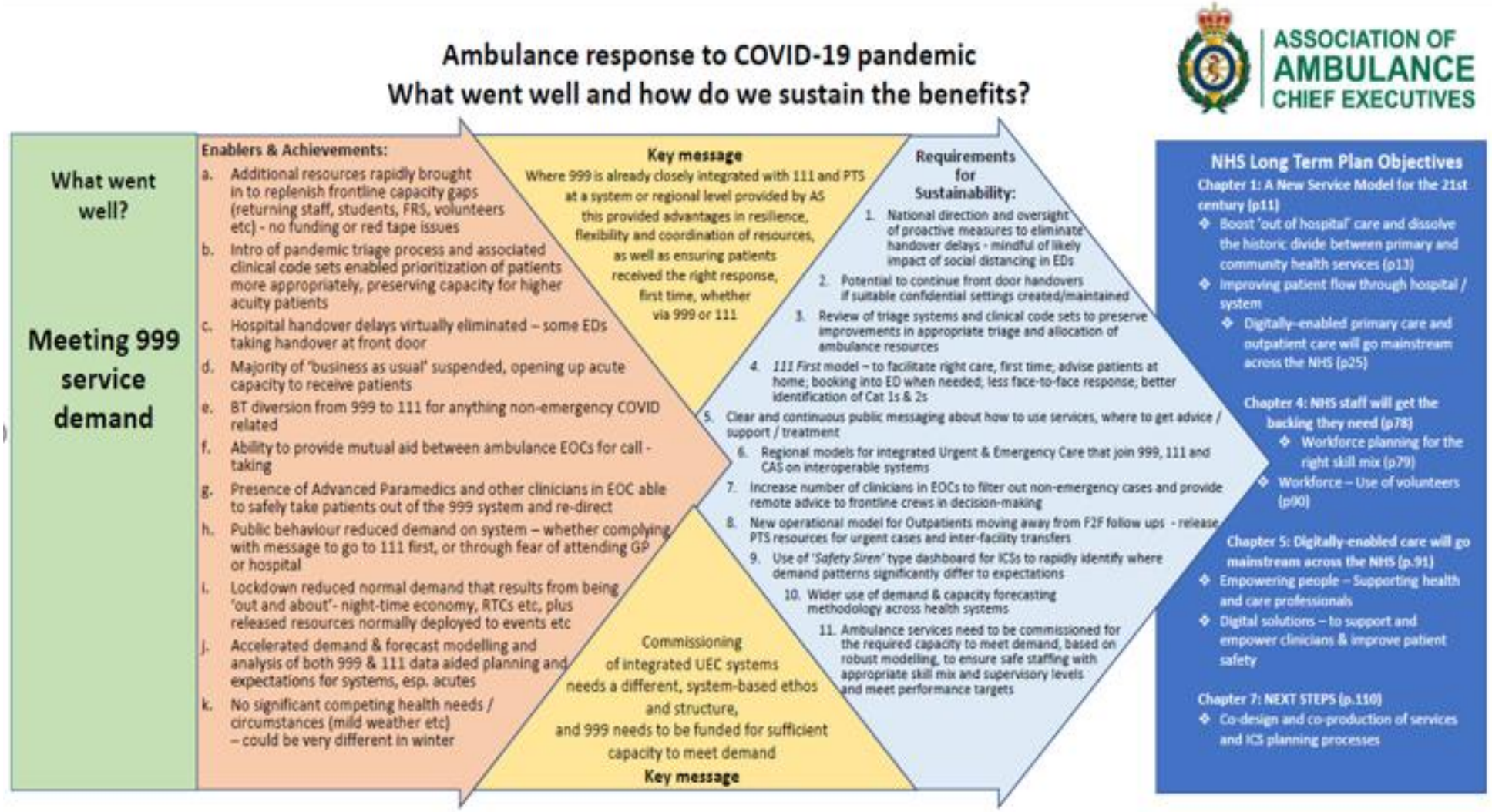
9.0. National Learning

NIAS is involved in meetings and learning opportunities with other ambulance services via Ambulance Association of Chief Executives (AACE) and about to engage in shared learning processes with the National Ambulance Service (NAS) of Ireland. One page from the AACE learning document has been prepared and is attached in Appendix A to illustrate some of the shared learning across UK Ambulance services.

10.0. Conclusion

The response to the COVID-19 pandemic has, without question, been a challenging time for staff and for NIAS as an organisation. The safety of our service users and our staff has been the primary concerns throughout this response and this is why the structures and supports included in this report were developed. This learning exercise indicated that there is a general consensus that NIAS got through the first response. However, many have the opinion that this was achieved by a margin and because we did not reach the surge levels that some had predicted. It is therefore important that the structures and supports that were put in place are improved and refined to ensure NIAS is appropriately prepared and equipped to respond to any future surge. The recommendations formed from analysis of all the information received in the report are summarised for consideration in Appendix B and for progression by the Director responsible.

Appendix A


Ambulance response to COVID-19 pandemic
What went well and how do we sustain the benefits?
ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES
What went well?
Meeting 999 service demand
Enablers & Achievements:
a. Additional resources rapidly brought in to replenish frontline capacity gaps (returning staff, students, FRS, volunteers etc) - no funding or red tape issues
b. Intro of pandemic triage process and associated clinical code sets enabled prioritization of patients more appropriately, preserving capacity for higher acuity patients
c. Hospital handover delays virtually eliminated – some EDs taking handover at front door
d. Majority of 'business as usual' suspended, opening up acute capacity to receive patients
e. BT diversion from 999 to 111 for anything non-emergency COVID related
f. Ability to provide mutual aid between ambulance EOCs for call - taking
g. Presence of Advanced Paramedics and other clinicians in EOC able to safely take patients out of the 999 system and re-direct
h. Public behaviour reduced demand on system – whether complying with message to go to 111 first, or through fear of attending GP or hospital
i. Lockdown reduced normal demand that results from being 'out and about'- night-time economy, RTCs etc, plus released resources normally deployed to events etc
j. Accelerated demand & forecast modelling and analysis of both 999 & 111 data aided planning and expectations for systems, esp. acutes
k. No significant competing health needs / circumstances (mild weather etc) – could be very different in winter
Key message
Where 999 is already closely integrated with 111 and PTS at a system or regional level provided by AS this provided advantages in resilience, flexibility and coordination of resources, as well as ensuring patients received the right response, first time, whether via 999 or 111
Commissioning of integrated UEC systems needs a different, system-based ethos and structure, and 999 needs to be funded for sufficient capacity to meet demand
Key message
Requirements for Sustainability:
1. National direction and oversight of proactive measures to eliminate handover delays - mindful of likely impact of social distancing in EDs
2. Potential to continue front door handovers if suitable confidential settings created/maintained
3. Review of triage systems and clinical code sets to preserve improvements in appropriate triage and allocation of ambulance resources
4. 111 First model – to facilitate right care, first time; advise patients at home; booking into ED when needed; less face-to-face response; better identification of Cat 1s & 2s
5. Clear and continuous public messaging about how to use services, where to get advice / support / treatment
6. Regional models for integrated Urgent & Emergency Care that join 999, 111 and CAS on interoperable systems
7. Increase number of clinicians in EOCs to filter out non-emergency cases and provide remote advice to frontline crews in decision-making
8. New operational model for Outpatients moving away from F2F follow ups - release PTS resources for urgent cases and inter-facility transfers
9. Use of 'Safety Siren' type dashboard for ICSs to rapidly identify where demand patterns significantly differ to expectations
10. Wider use of demand & capacity forecasting methodology across health systems
11. Ambulance services need to be commissioned for the required capacity to meet demand, based on robust modelling, to ensure safe staffing with appropriate skill mix and supervisory levels and meet performance targets
NHS Long Term Plan Objectives
Chapter 1: A New Service Model for the 21st century (p11)
❖ Boost 'out of hospital' care and dissolve the historic divide between primary and community health services (p13)
❖ Improving patient flow through hospital / system
❖ Digitally-enabled primary care and outpatient care will go mainstream across the NHS (p25)
Chapter 4: NHS staff will get the backing they need (p78)
❖ Workforce planning for the right skill mix (p79)
❖ Workforce – Use of volunteers (p90)
Chapter 5: Digitally-enabled care will go mainstream across the NHS (p.91)
❖ Empowering people – Supporting health and care professionals
❖ Digital solutions – to support and empower clinicians & improve patient safety
Chapter 7: NEXT STEPS (p.110)
❖ Co-design and co-production of services and ICS planning processes

Appendix B

Summary of Key Recommendations for action in short and medium term in preparation for future surge

Learning Theme	*Recommendation*	*Lead Director*
PPE:	*Reconvene PPE Cell with the same staff who successfully managed PPE during the first phase of the pandemic*	*Paul Nicholson*
	Ensure the PPE Cell meet on a frequent basis and that decision-making is shared contemporaneously so all stakeholders are aware	
	Re-initiate daily stock checks and request of need	
	Ensure support is identified to courier PPE to Stations	
	Attempt to Identify 1 or 2 masks with BSO colleagues which can be prioritised for NIAS staff	
	Work collaboratively with BSO to procure aprons which are more suitable for professionals working in pre-hospital care	
	If pandemic PPE stock is nearing expiration date or contains already expired items this should be communicated to staff prior to release	
	Actively communicate with staff about the quantities of PPE that have been acquired and used	
Staff Communication:	*Consideration to be given to a COVID-19 specific WhatsApp group that would subsequently be used for only for essential COVID-19 guidance*	*Maxine Paterson*
	Communication cell to be resourced with appropriate levels of staff	*Maxine Paterson*
	NIAS representation at Regional Emergency Care Huddles to identify early issues at local hospitals and communicate this to frontline staff	*Rosie Byrne*
	Include at least one HALO in NIAS daily Huddle, this could be as a watching/listening brief	*Rosie Byrne*
	Ensure REACH project is not delayed. Provision of electronic devices for staff is vitally important	*Dr Nigel Ruddell*
	Continue to issue Operational Guidance Summary document each time (included in last three versions) the Operational Guidance is issued which outlines the changes from the previous document	*Lynne Charlton*
	CSOs to maintain a presence at Station Level to offer support, advice and guidance to staff specifically in regard to the changes made to clinical guidance	*Dr Nigel Ruddell*
Fit Testing	*Firmer guidance to be included in Fit Testing Policies/Procedures regarding need to ensure there is no facial hair interfering in the fitting of the mask*	*Lynne Charlton*

	An SOP for Fit Testing to be circulated (this has been developed)	
	Routine/Scheduled Fit Testing should be a requirement. Staff suggested this be completed at yearly PP Training	
	Dedicated Fit Testing team, not just during the COVID-19 response – should include a coordinator with responsibility for Fit Testing	
	Endeavour Control prioritise standing down staff who need to be Fit Testing	
	Informatics to manage and control centralised Fit Testing Database	
	Robust audit and assurance processes should be in place to ensure Fit Testing is carried out in HSE standard	
IPC	*Continued IPC representation at Health Silver Sub-Group*	*Lynne Charlton*
	Clarification of where and how IPC contribute to command structures	
	IPC Team to be expanded (this is underway)	
	Develop and implement policy on The management of Infection Prevention and Control Incidents and Outbreaks (this is underway)	
	Recognition of cleaning crews through social media or event	
	Consideration to be given to longer term investment in enhanced cleaning crews	
	Clarity regarding levels of PPE which are more consistent across hospital/pre-hospital	
COVID-19 Testing	*Consideration to be given to surveillance testing*	*Lynne Charlton*
	Clear NIAS Track and tracing policies to be widely distributed and enforced	
	Ensure swab testing team structure is agreed prior to any second surge	
	Continue to have the ability to provide this service in the West if and when needed	
Operational Support Unit (OSU)	*OSU team, with appropriate experience and knowledge, to be identified and trained before any future surge so this can be put in place immediately in the case of a second surge*	*Lynne Charlton*
	OSU lead to be identified from the offset	
	Clarity on the role of OSU to be provided and then communicated appropriately to staff across the organisation	

	Daily OSU Huddle to ensure staff maintain contact and awareness of who is included in the team and to check in on guideline changes etc.	
Crisis Accommodation	*CAT to be participate in Ops huddles from the outset of any future surge*	*Roisin O'Hara*
	Consideration to be given to supplying the team with support from Procurement professionals	
	Consideration to be given to CAT participation in command structure i.e. representation on Silver and Bronze	
	Work is in progress to develop a CAT Toolkit which will simplify the re-establishment of the CAT function within the Trust in the event of a subsequent COVID-19 wave, or similar crisis	
Operations Learning	*Catering should be dialled up in the event of a second surge.*	*Rosie Byrne*
	Appropriate support to be provided to Officers to distribute food supply across divisions/stations	
	Include at least one HALO in NIAS daily Huddle, this could be as a watching/listening brief	
	Explore the potential of Station Officer cover as business as usual	
	In the event of a second surge the Daily Ops Huddles should again expand to include COVID-19 response cell leads & HALOs	
	Consideration to be given to further enhancing showering and cleaning facilities across all stations	
	Ensure plans are in place to restart Crisis Accommodation service immediately in the event of a second surge	*Roisin O'Hara*
Emergency Ambulance Control (EAC)	*EAC specific cell or silver sub group to be set up to provide the support of subject matter experts*	*Rosie Byrne*
	Provide on-site welfare support for EAC staff	
	Put systems in place to ensure staff overtime is monitored	
	Data shared should be representative of the whole workload of EAC staff not just 999 call volumes.	
	Appropriate equipment to be procured and supplied to EAC training team to facilitate the promotion of new forms of training	
Clinical Support Desk	*Early identification and training of extra CSD staff resource.*	*Dr Nigel Ruddell*
	Development of a CSD Bank	
	Consider rolling recruitment for CSD	
Patient Care Services (PCS)	*COVID-19 risk assessments to be completed for VCS drivers to ensure this service can continue*	*Rosie Byrne*
	Consideration to be given to providing VCS drivers with protective	

	screens for their cars	
	Consideration should be given to PCS again moving to 24hr rota to support Emergency work	
	Consideration should be given to PCS vehicles being fitted with the appropriate apparatus to secure emergency equipment	
	Expand patient assessment training	
	Consideration to be given to training PCS staff in blue light driving. This would provide a further resource to A&E service	
	Explore ways in which capacity can be increased in PCS vehicles e.g. separation of rear cabin	
Medical Directorate & RATC Learning	*Contingency plans to be regularly communicated with frontline staff*	*Dr Nigel Ruddell*
	Decisions should made to be in line with NIAS context i.e. consideration to be given to geographical situation	
	Training Officers and CSOs to be used in positions that will make fully use their high levels of clinical knowledge and skills	
	Appropriate ICT input regarding hardware and software to be provided to RATC to ensure virtual training needs are met going forward	
	HART identified that should there be a model agreed of support to NIAS from PSNI	
	Ensure REACH project is not delayed. Provision of electronic devices for staff is vitally important	
	CSOs to maintain a presence at Station Level to offer support, advice and guidance to staff specifically in regard to the changes made to clinical guidance	
Corporate Functions (HR, IT, Finance & Staffside)	*Amplify remote working capabilities and technology availability across the organisation- this should include appropriate equipment for HR staff who are required to work from home e.g. two screens and docking stations*	*Maxine Paterson*
	Consideration to be given as to how HR Communicate with command structures	*Michelle Lemon*
	HR to be included in daily huddles	*Michelle Lemon/Rosie Byrne*
	HR Cell Lead to be identified	*Michelle Lemon*
	Policies and process should be followed appropriately when receiving gifts, this needs to be communicated regularly	*Michelle Lemon*
	Retrospective approval of purchases should be a priority	*Michelle Lemon*
	Clarification of Command Structures to all staff	*Dr Nigel Ruddell/Maxine Paterson*

Risk Management	*Person dedicated to administration of issue logs / risk registers etc.*	*Dr Nigel Ruddell*
	Reinforce the importance of timely responses to requests to update risk registers etc.	
	Absolute clarity on how resources will be allocated in response to risk assessments, e.g. training and upskilling of administrative staff to support operational services, how / when – students in Training will be redeployed, how / when PSNI, NIFRS support is expected, how / when PAS / VAS roles increase?	
Command Structure Second Surge Recommendations:	*Commander training for Strategic level should be prioritised*	*Dr Nigel Ruddell*
	Reduce the volume of informal communication by ensuring that Silver / Tactical Command Room co-ordinate and own all escalation of issues and disseminating of decisions to Bronze and Operational Staff	
	Silver Commander to be included in the Gold Cell to improve communication between Gold and Silver	
	Role of Area managers in Command Structures to be clarified	
	Business Intelligence / templates / information flow / information management systems to support decision-making need further consideration – what are our triggers to indicate a future surge?	
	A paper titled "Effectiveness of Management Structures COVID-19" was tabled at SMT on 23rd April 2020 and agreed. This paper includes recommendations that should be fully implemented during any future response to the COVID-19 pandemic	

TB/01/10/2020/05

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	1 October 2020
Title of paper:	Performance Report
Brief summary:	Members are asked to note the Performance Report which has been updated as at 13 September 2020.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	n/a
Prepared and presented by: **Date:**	Alison Vitty, Corporate Manager Rosie Byrne, Director of Operations 24 September 2020

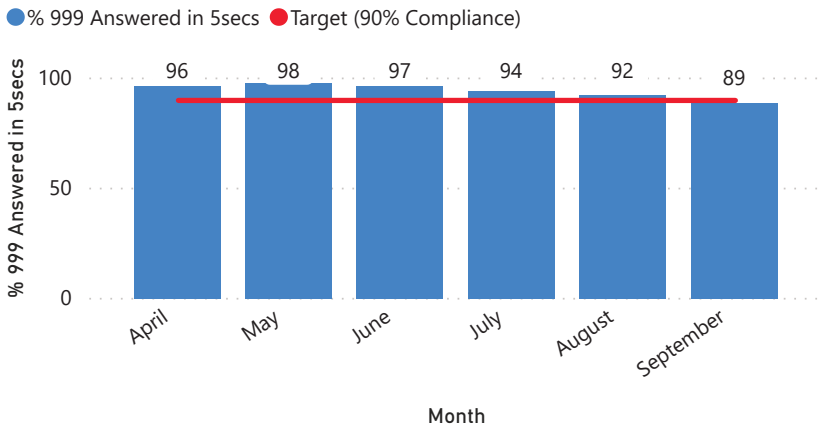
Northern Ireland Ambulance Service
Health and Social Care Trust

TRUSTBOARD REPORT
01/04/2020 TO 13/09/2020

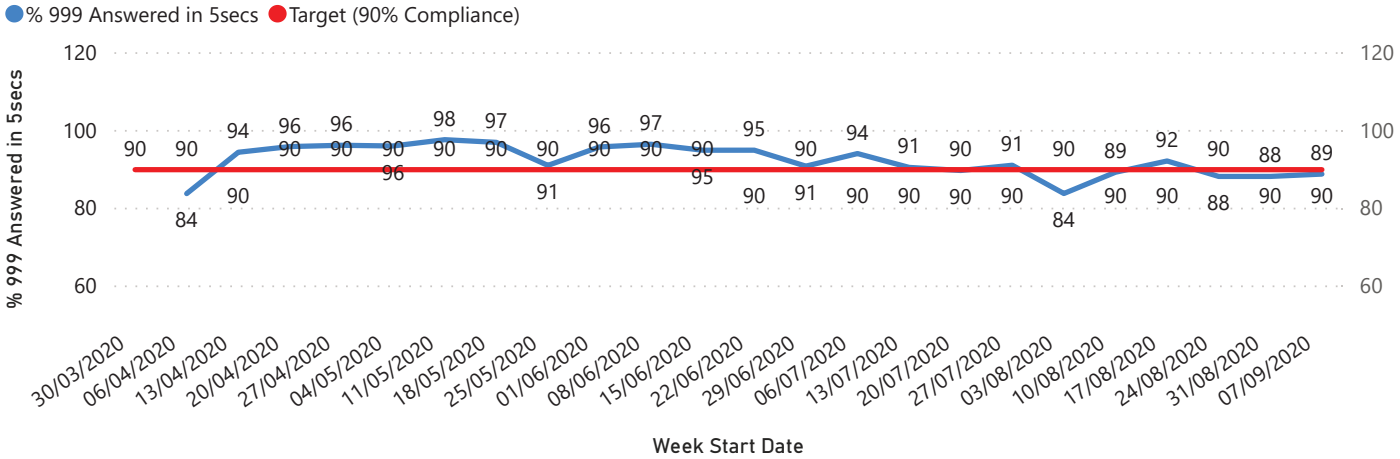
(Please note that data will not be held for the full period in all areas as this was a very fluid position)

1. 999 Primary Line Call Answering Performance - Target Compliance of 90%

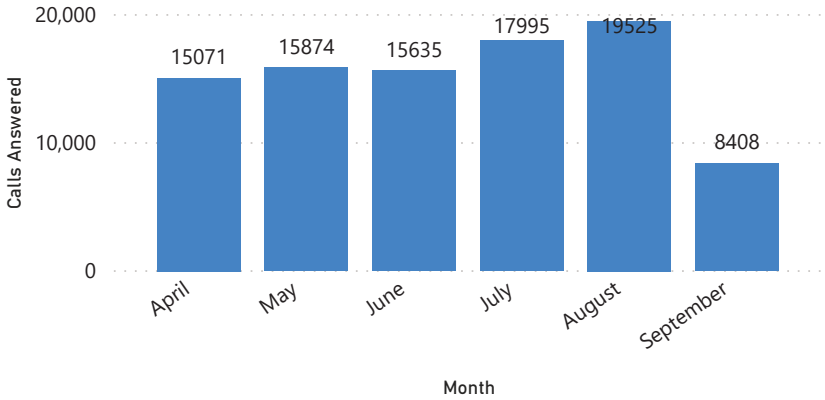
Percentage of 999 Calls Answered in 5 Seconds and Target (90% Compliance)



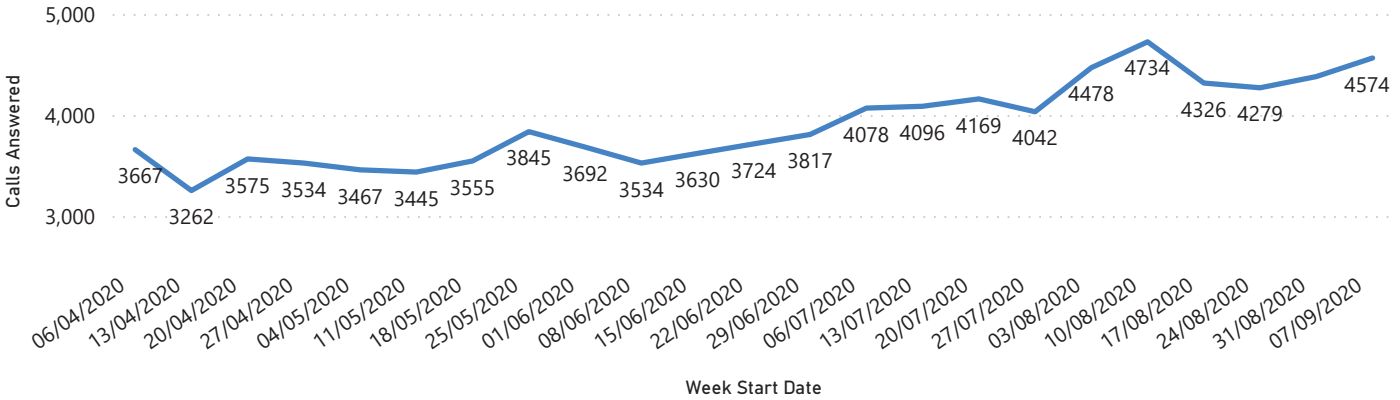
Percentage of 999 Calls Answered in 5 Seconds and Target (90% Compliance)



Total Monthly Calls Answered



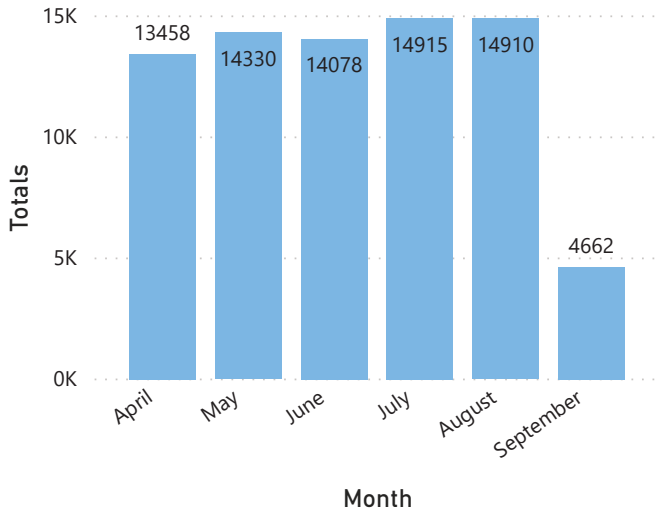
Total Weekly Calls Answered



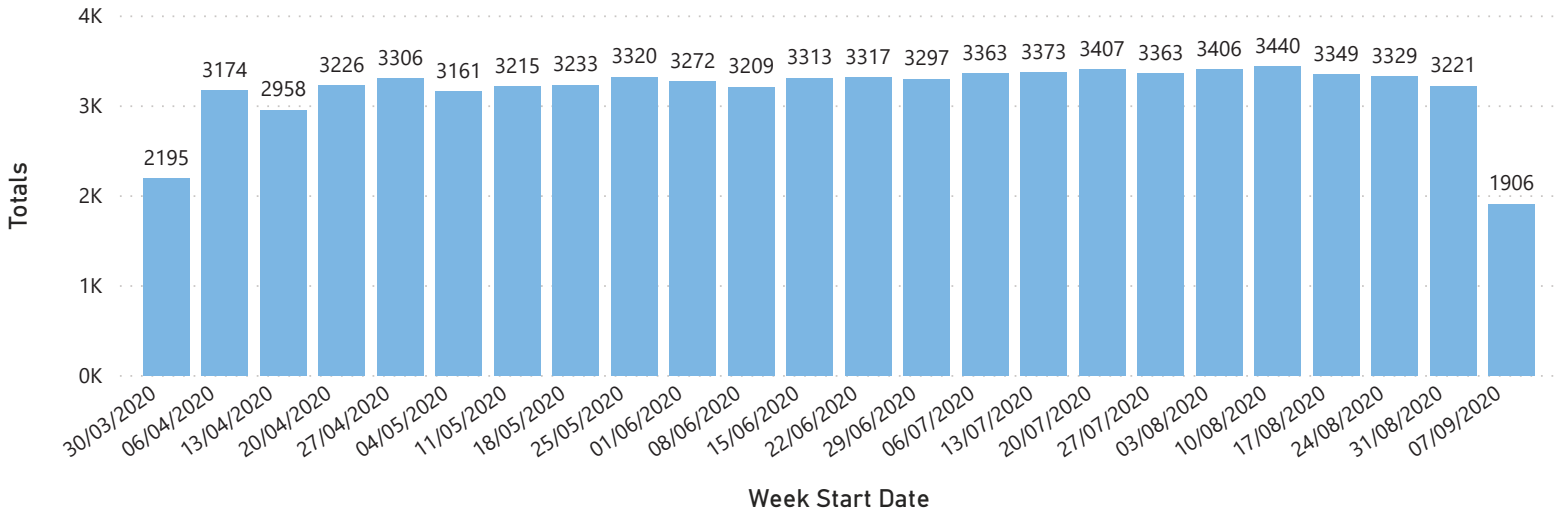
2. The Proportion of Calls by Category (face to face) i.e. Acuity

Card 36 implementation date: 03/04/2020

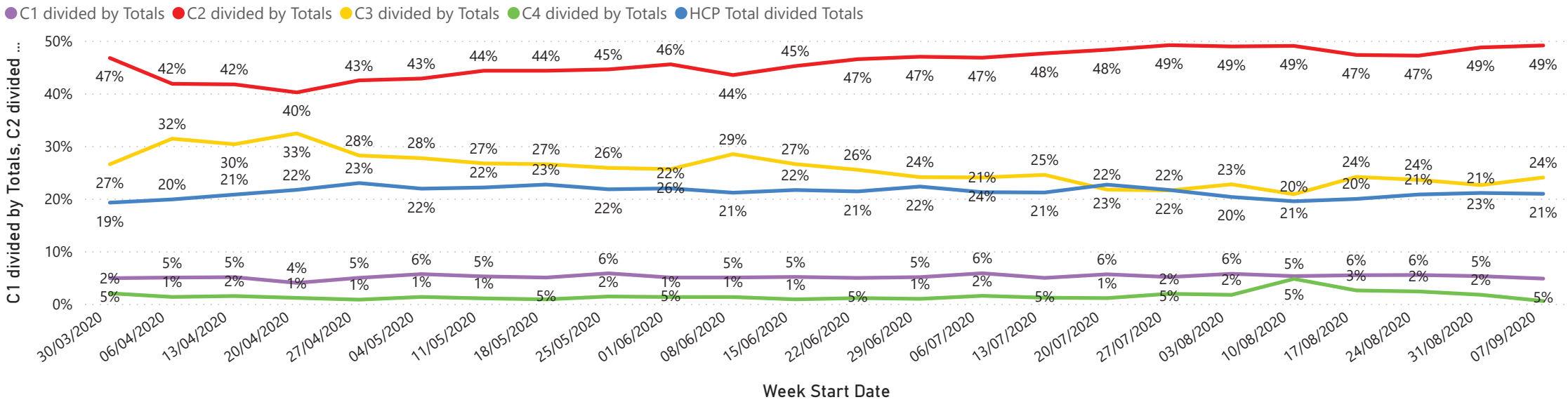
C1, C2, C3, C4 and HCP Total Responses



C1, C2, C3, C4 and HCP Total Responses



Percentage of C1, C2, C3, C4 and HCP Total Responses

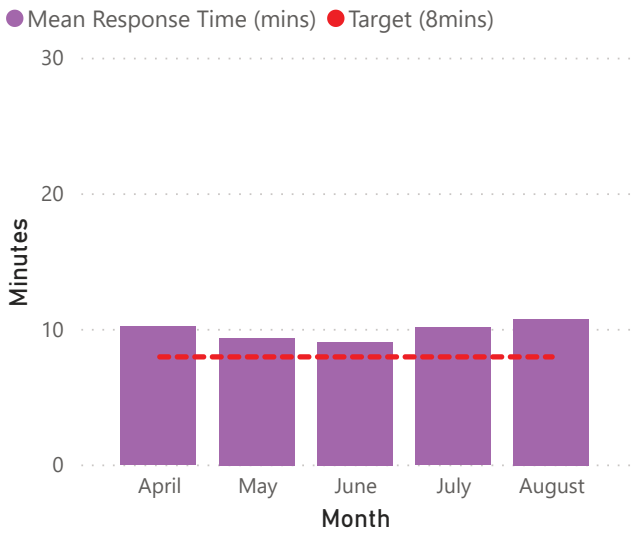


3. EAC NIAS Emergency Activity Performance

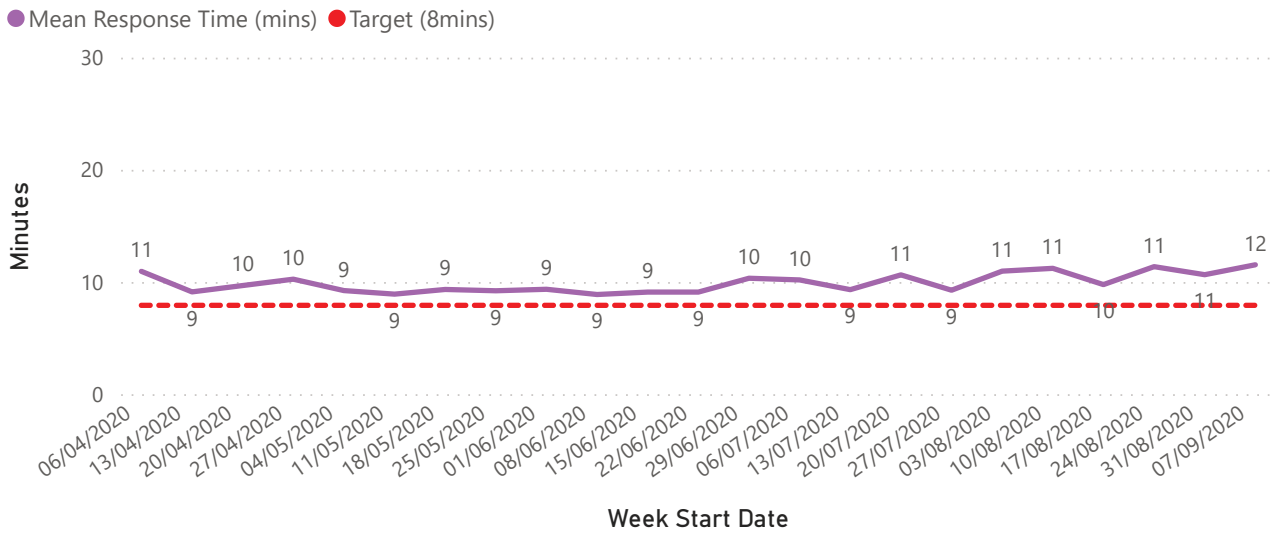
C1 Monthly Performance

Month	Mean Response Time
April	00:10:15
May	00:09:25
June	00:09:07
July	00:10:10
August	00:10:48

C1 Monthly Performance



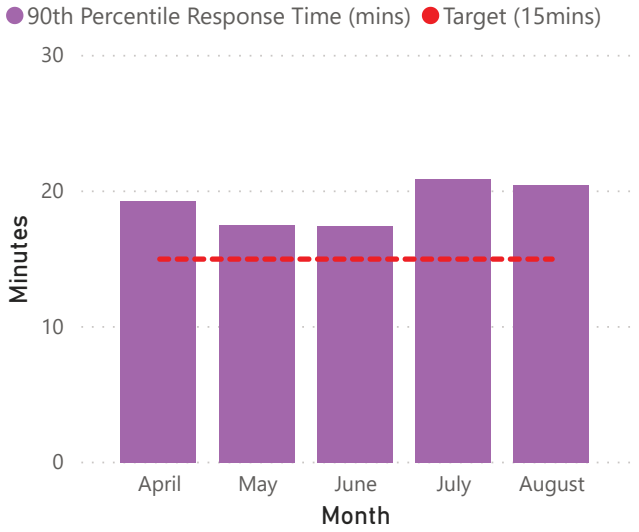
C1 Weekly Performance



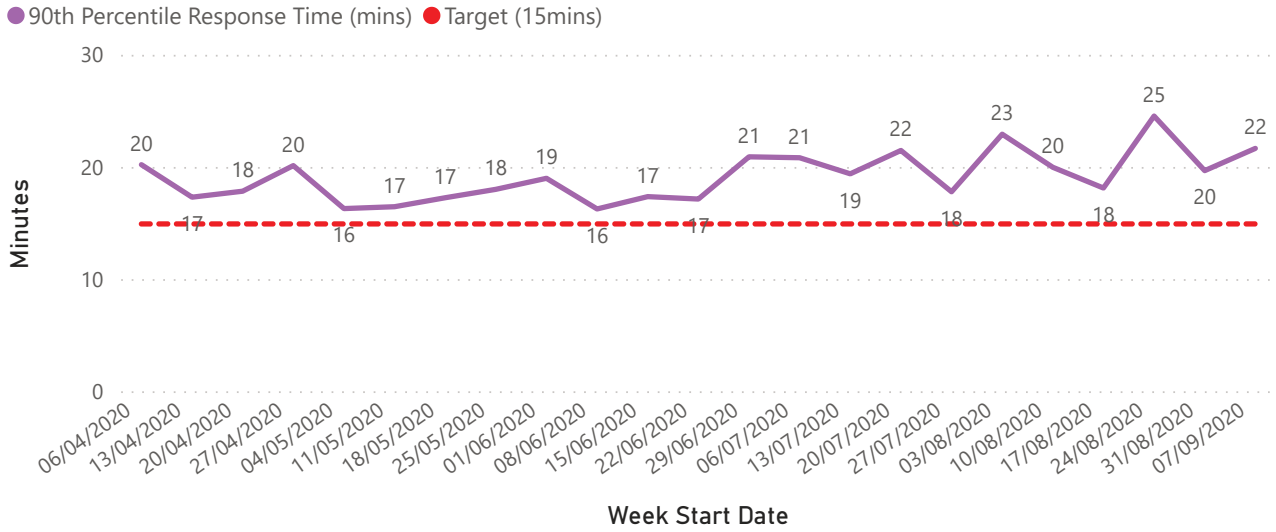
C1 Monthly Performance

Month	90th Percentile Response Time
April	00:19:19
May	00:17:33
June	00:17:26
July	00:20:54
August	00:20:30

C1 Monthly Performance



C1 Weekly Performance

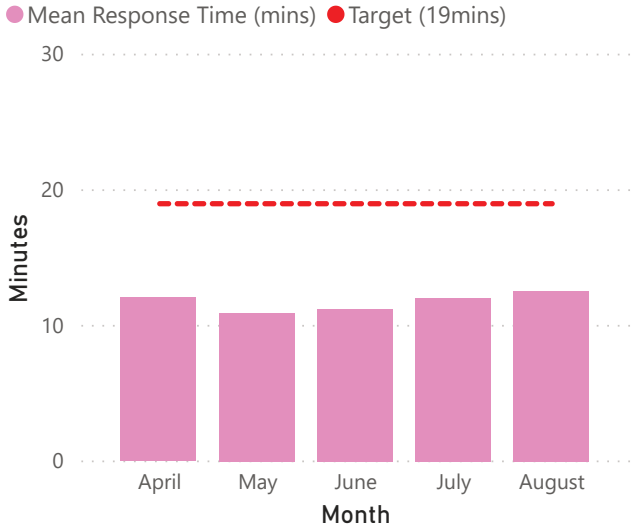


3. EAC NIAS Emergency Activity Performance

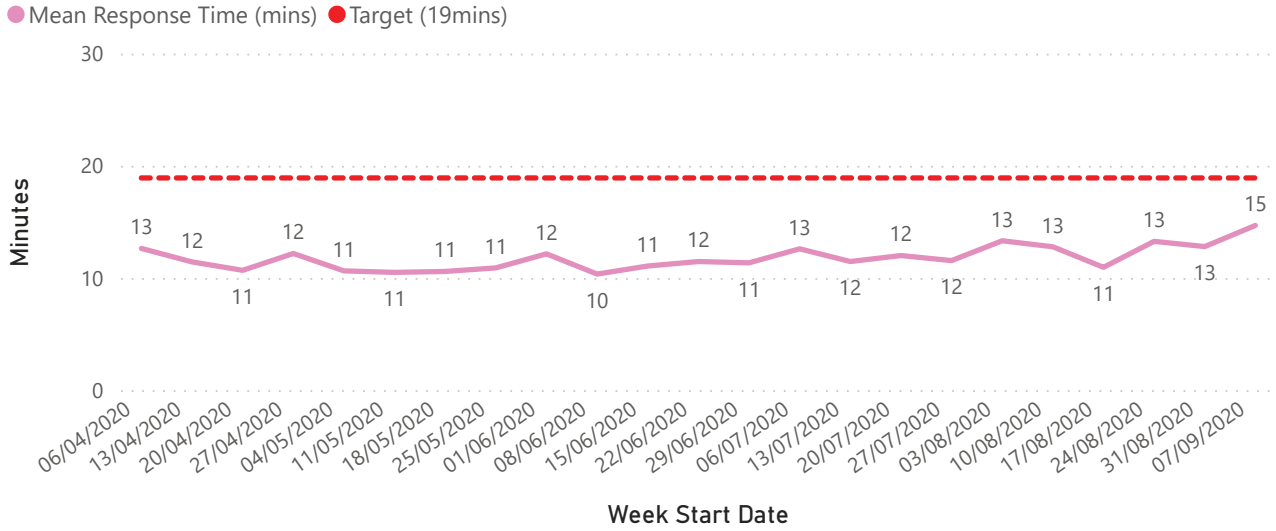
C1T Monthly Performance

Month	Mean Response Time
April	00:12:05
May	00:10:58
June	00:11:13
July	00:12:02
August	00:12:35

C1T Monthly Performance



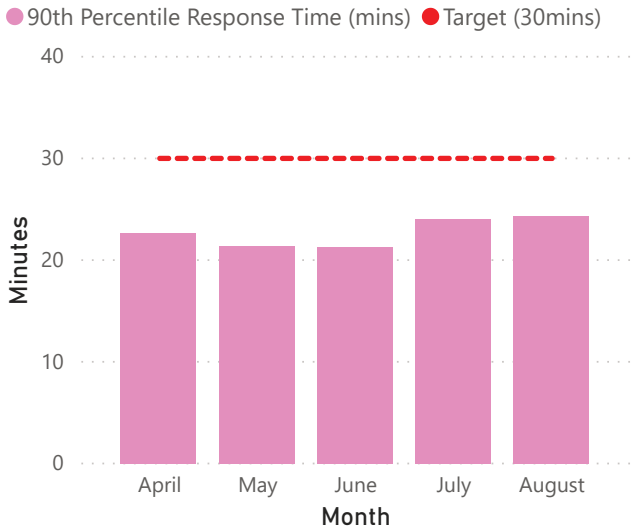
C1T Weekly Performance



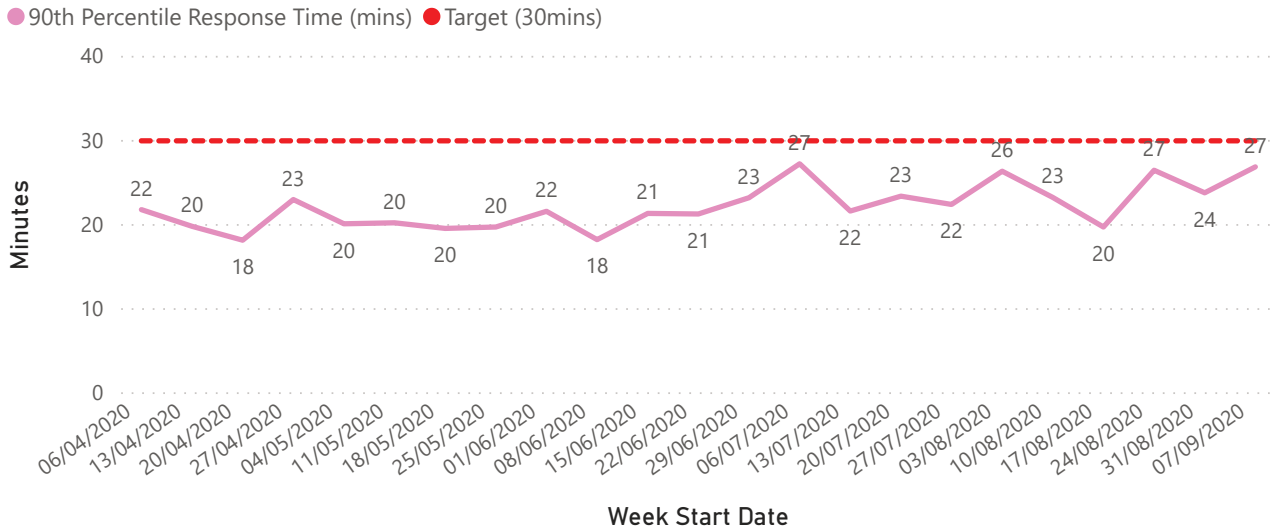
C1T Monthly Performance

Month	90th Percentile Response Time
April	00:22:39
May	00:21:22
June	00:21:18
July	00:24:05
August	00:24:23

C1T Monthly Performance



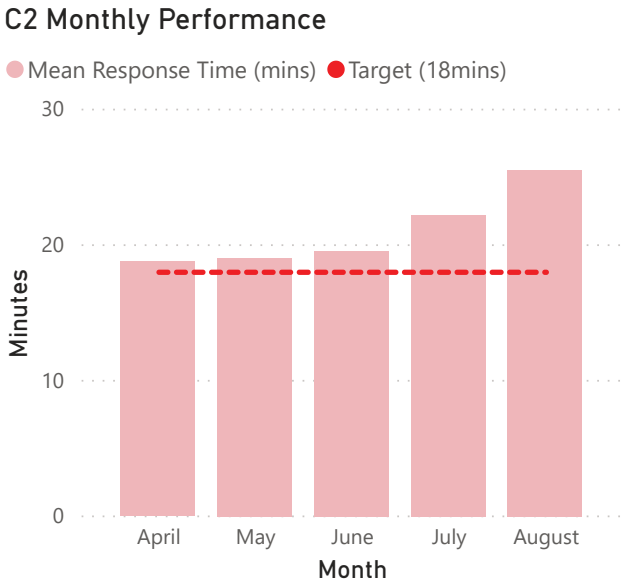
C1T Weekly Performance

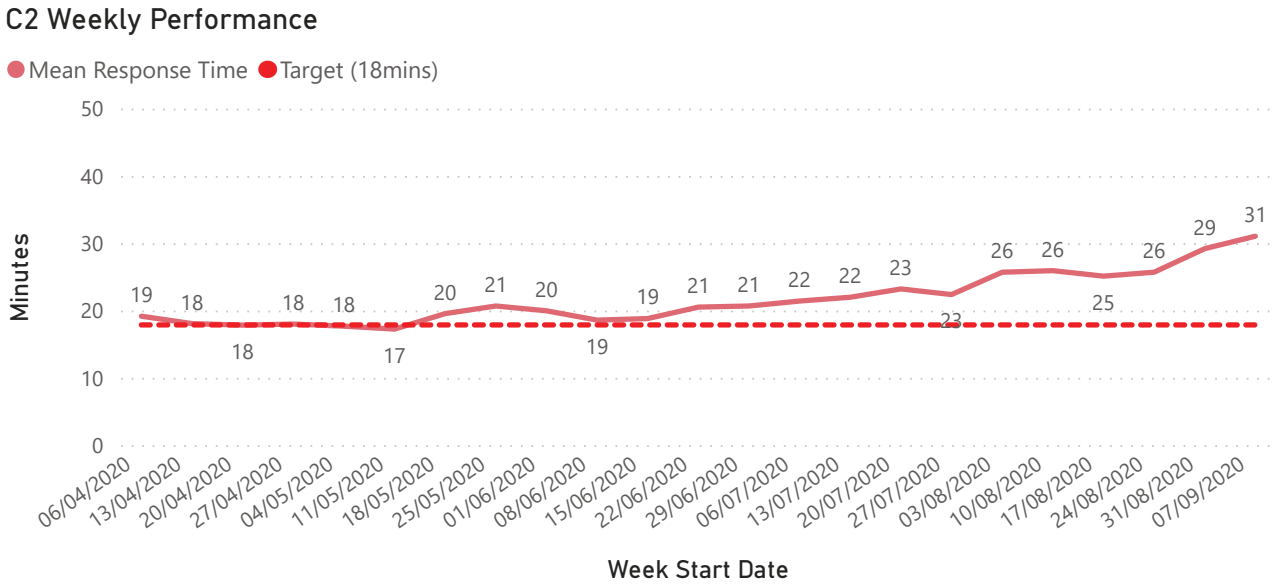


3. EAC NIAS Emergency Activity Performance

C2 Monthly Performance

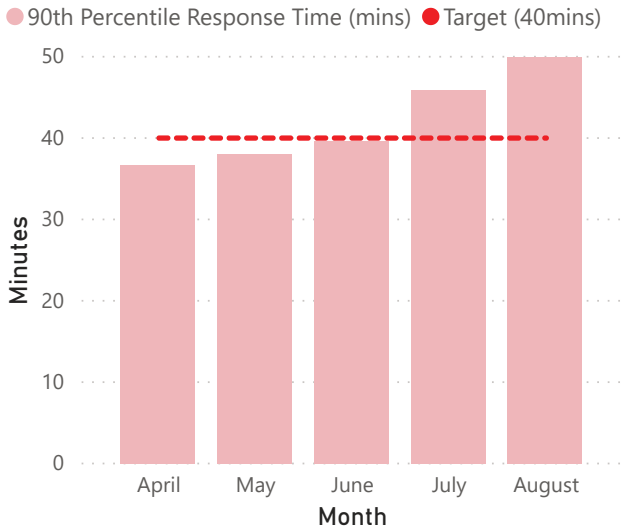
Month	Mean Response Time
April	00:18:48
May	00:19:04
June	00:19:33
July	00:22:14
August	00:25:32

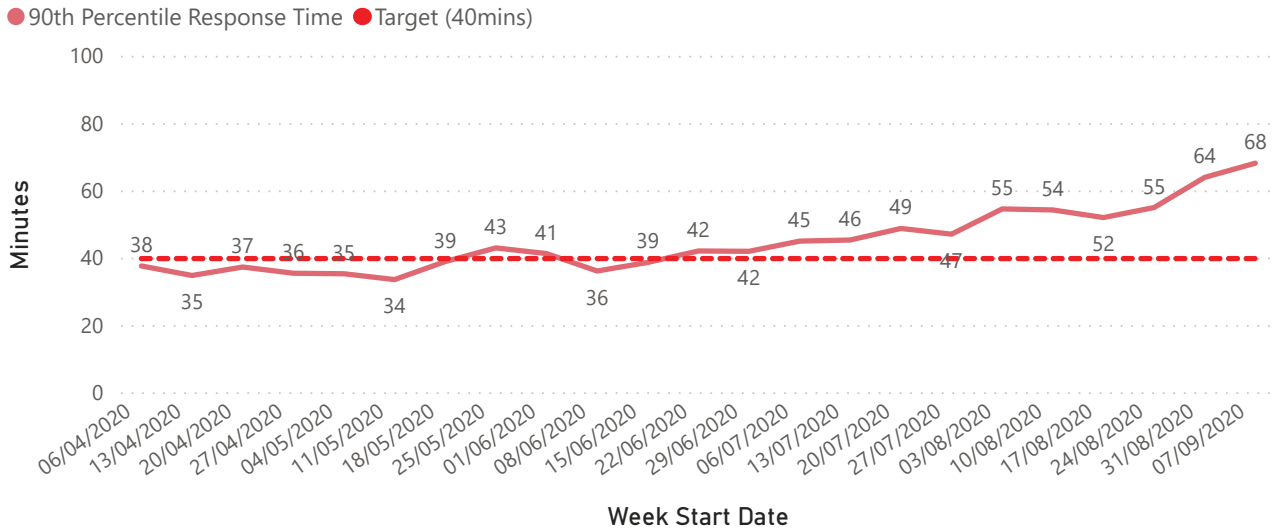




C2 Monthly Performance

Month	90th Percentile Response Time
April	00:36:40
May	00:38:05
June	00:39:40
July	00:45:57
August	00:53:17



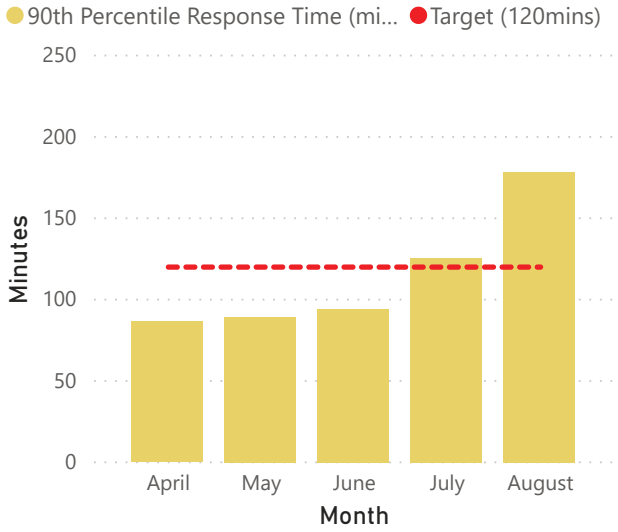


3. EAC NIAS Emergency Activity Performance

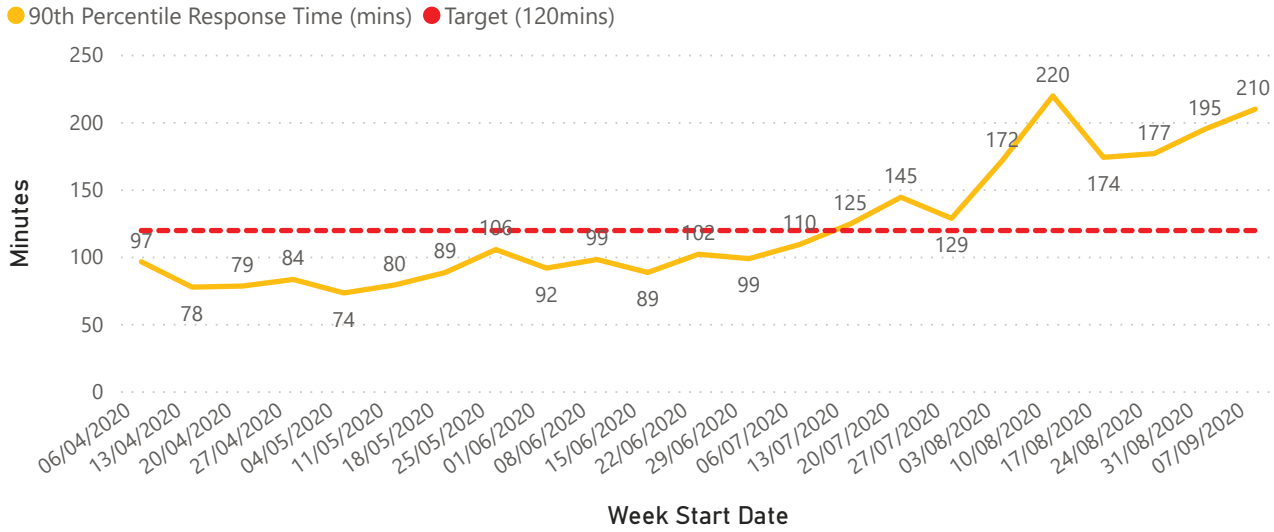
C3 Monthly Performance

Month	90th Percentile Response Time
April	01:26:32
May	01:29:19
June	01:34:24
July	02:05:30
August	02:58:28

C3 Monthly Performance



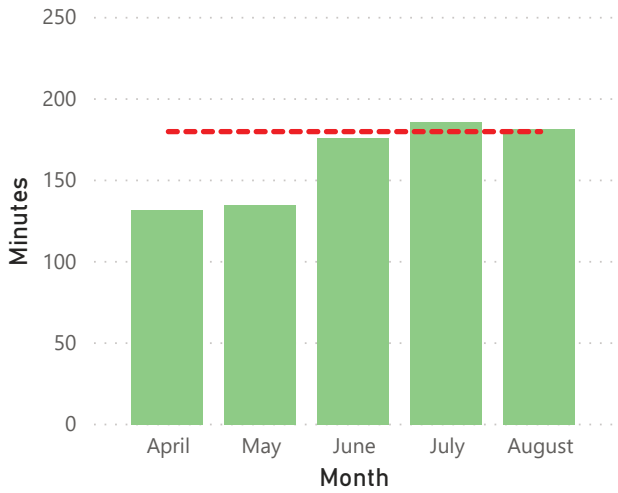
C3 Weekly Performance



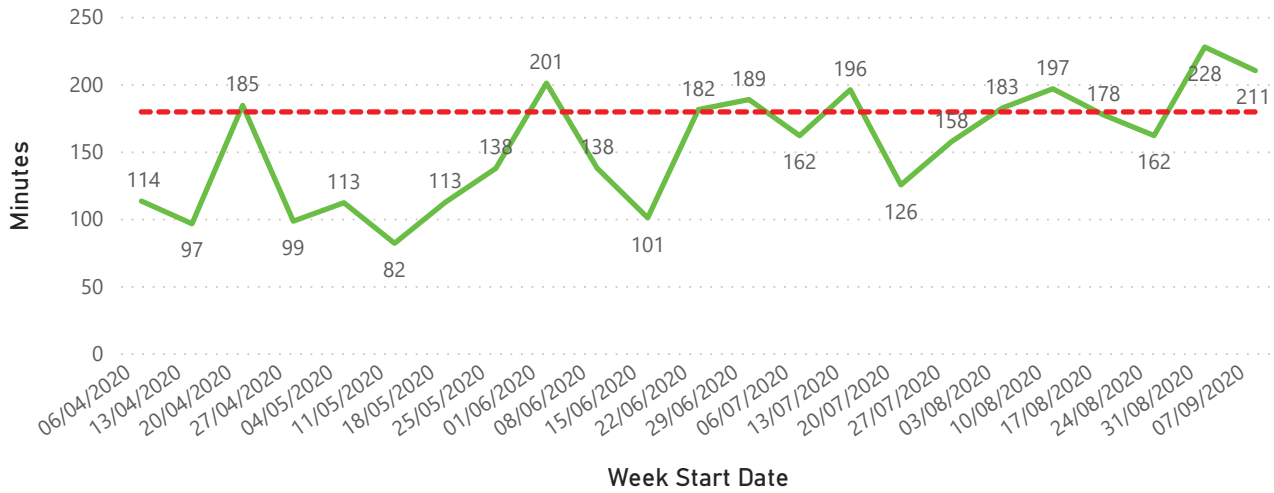
C4 Monthly Performance

Month	90th Percentile Response Time
April	02:11:53
May	02:15:07
June	02:55:51
July	03:05:42
August	03:01:51

C4 Monthly Performance

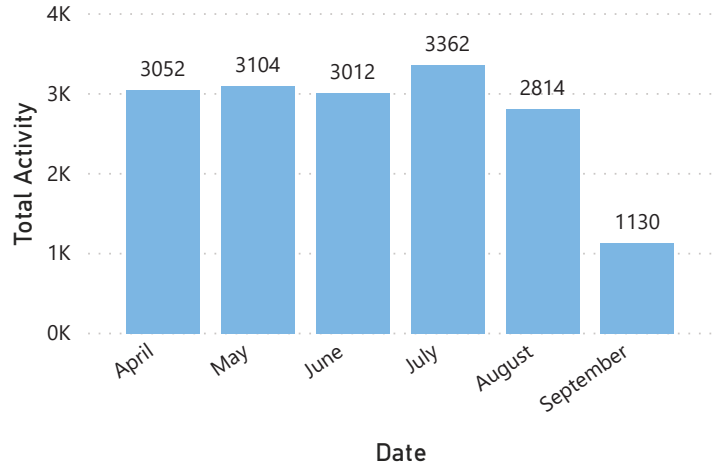


C4 Weekly Performance

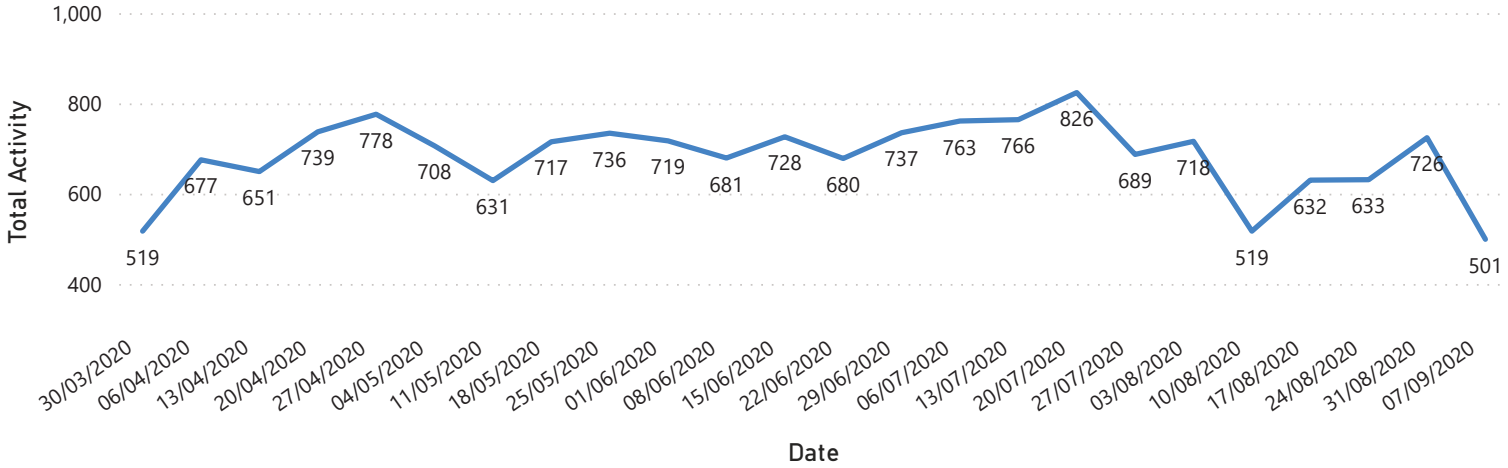


4. Clinical Support Desk (CSD) - Hear & Treat/See & Treat/See & Convey

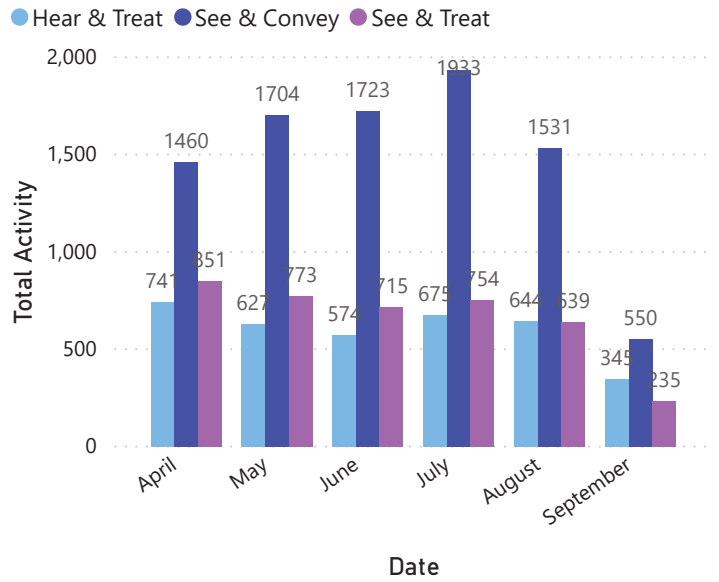
Total CSD Desk Activity



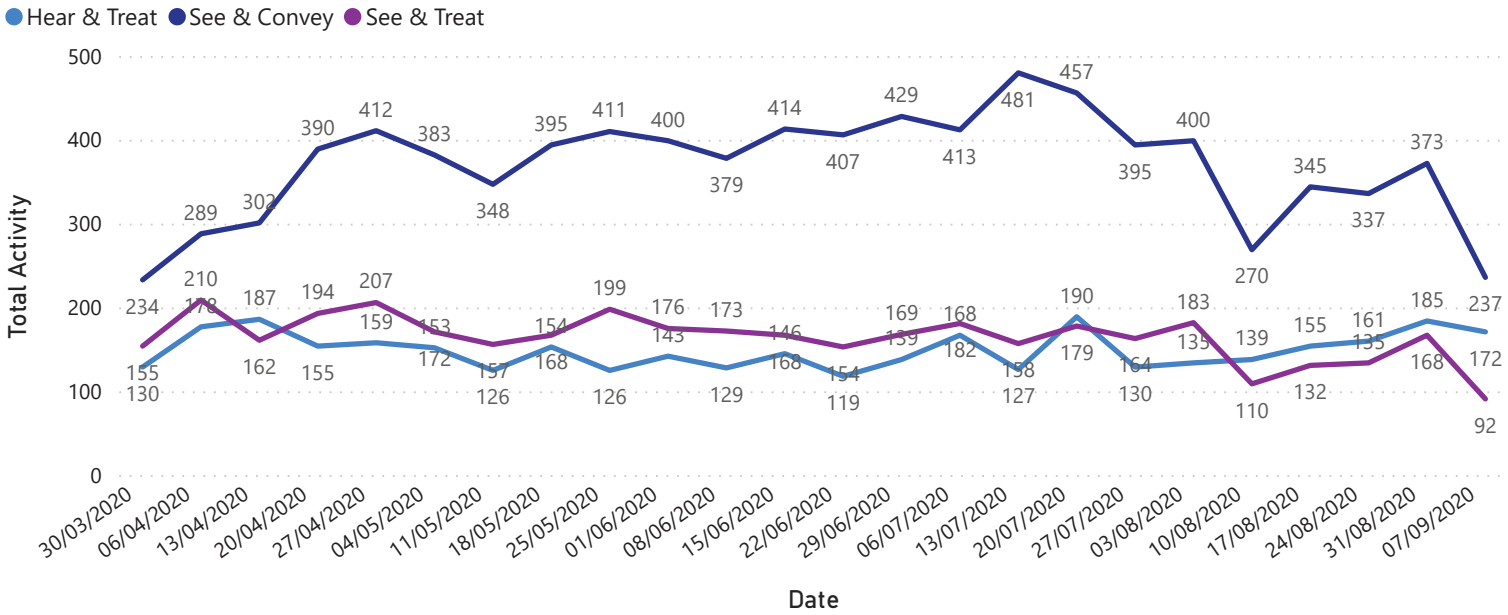
Total CSD Desk Activity



CSD Desk Activity (Hear & Treat/See & Treat/See & Convey)

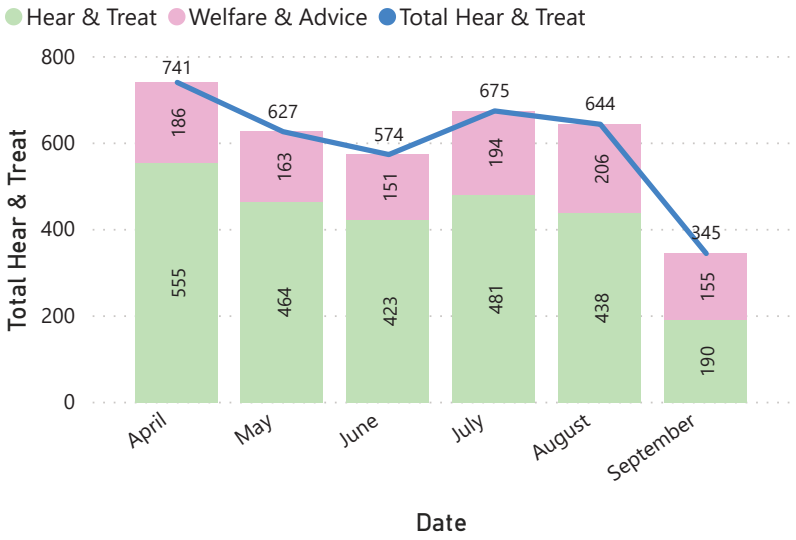


CSD Desk Activity (Hear & Treat/See & Treat/See & Convey)

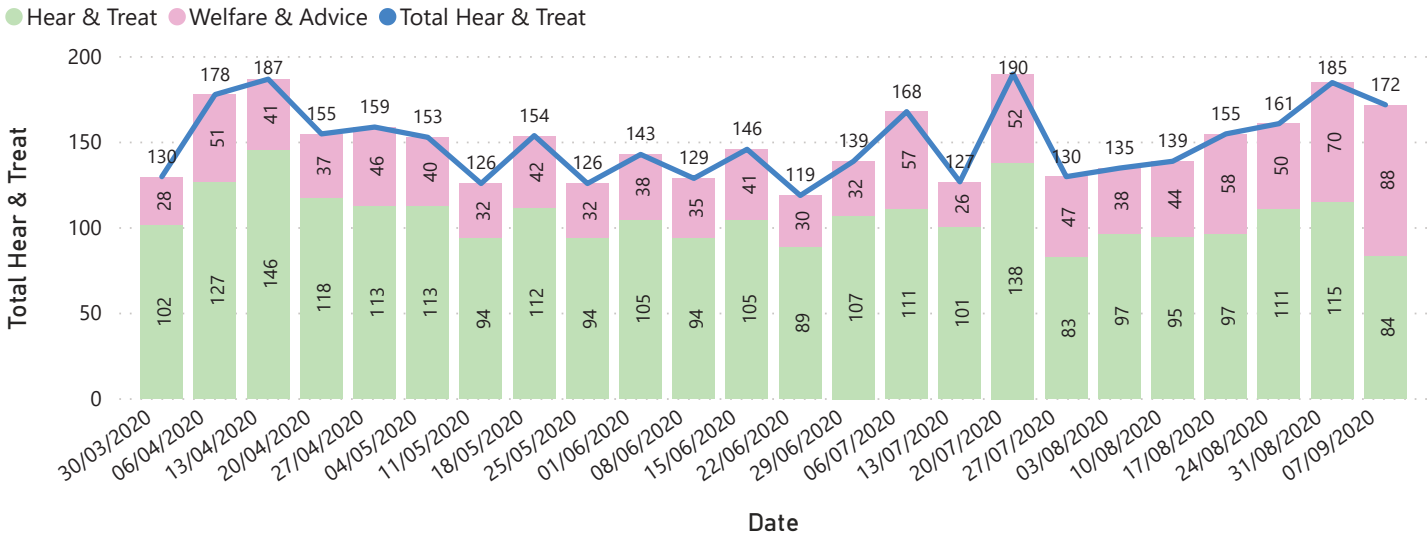


4. Clinical Support Desk (CSD) - Hear & Treat/See & Treat/See & Convey

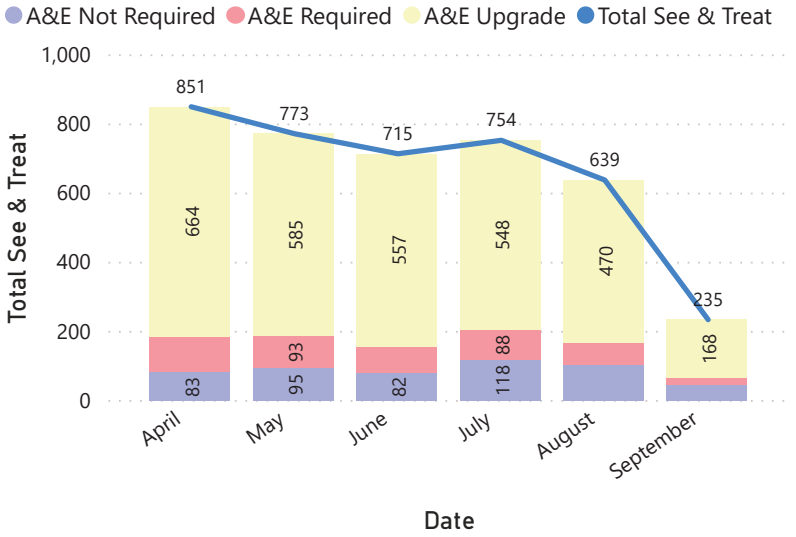
Total CSD Desk Hear & Treat Activity



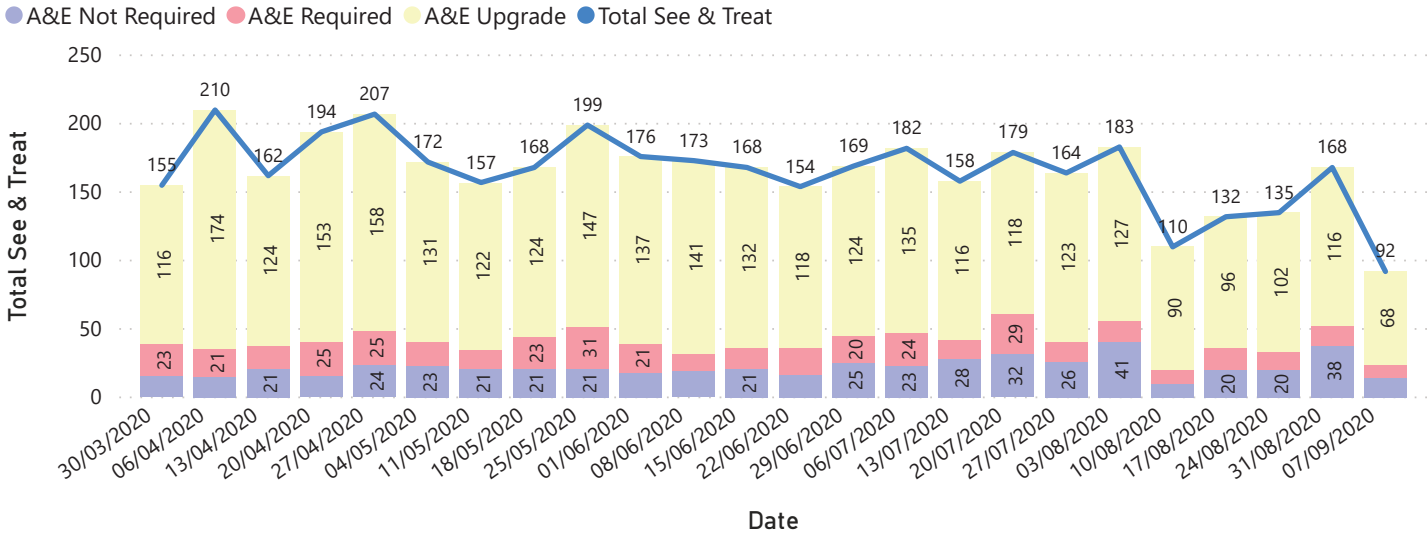
Total CSD Desk Hear & Treat Activity



Total CSD Desk See & Treat

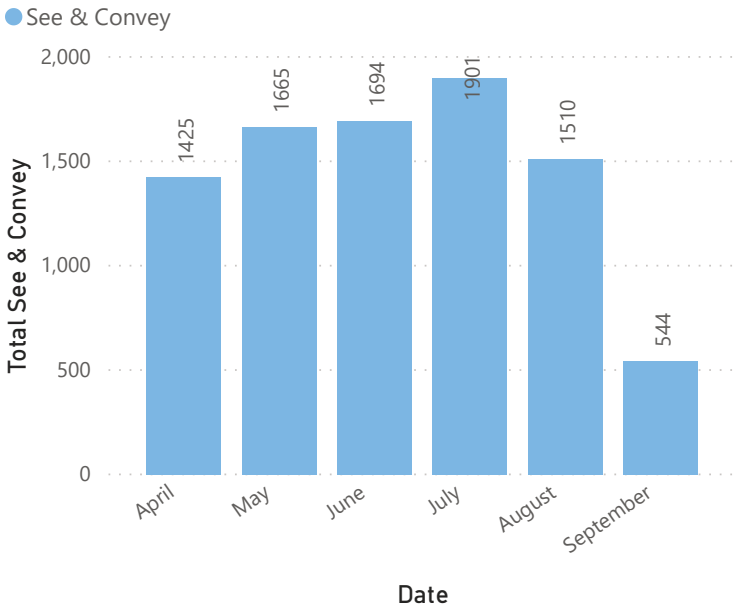


Total CSD Desk See & Treat

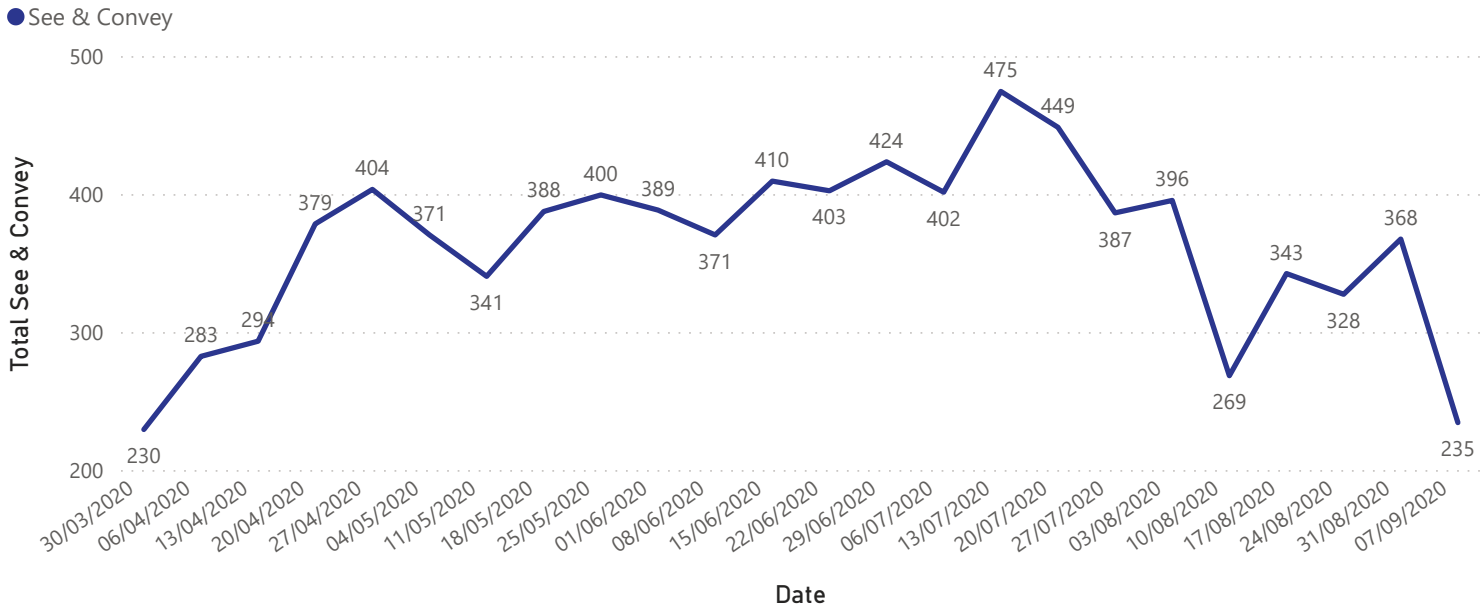


4. Clinical Support Desk (CSD) - Hear & Treat/See & Treat/See & Convey

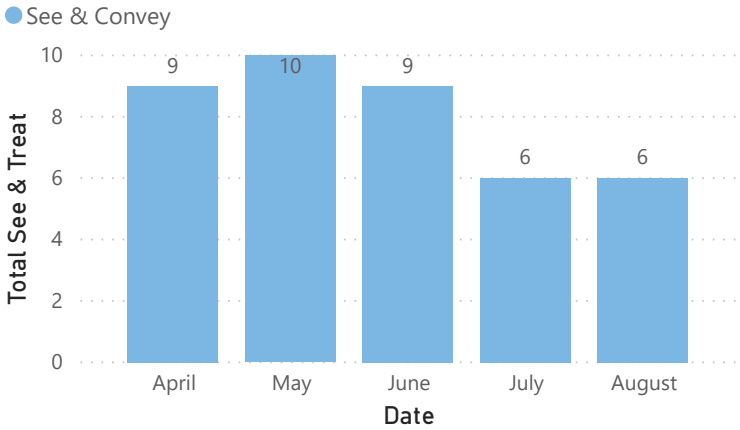
Total CSD Desk See & Convey Activity (Acute Hospitals)



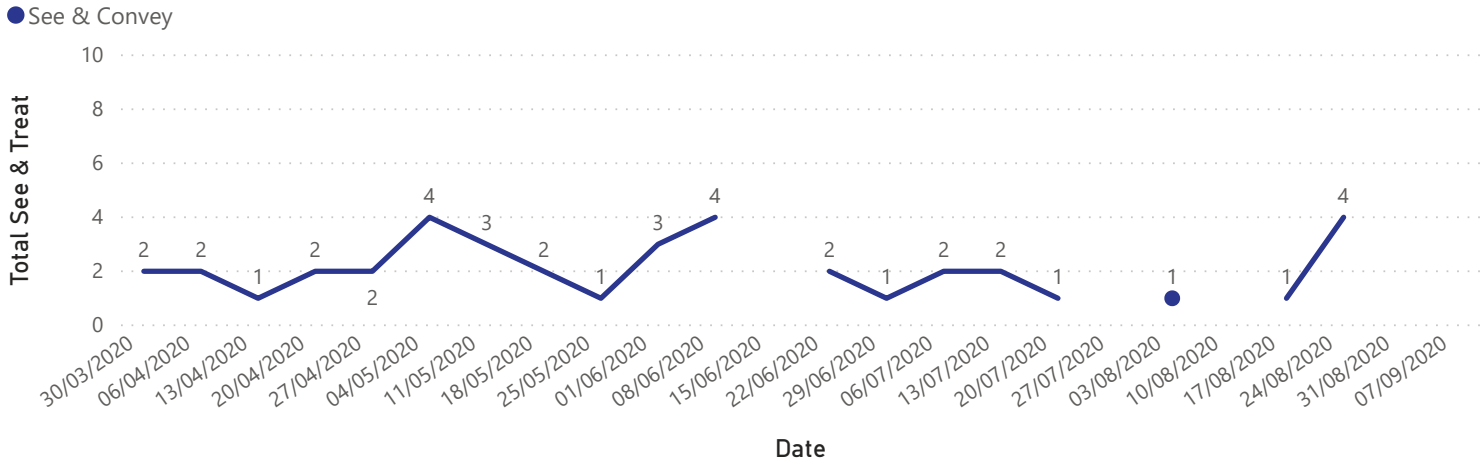
Total CSD Desk See & Convey Activity (Acute Hospitals)



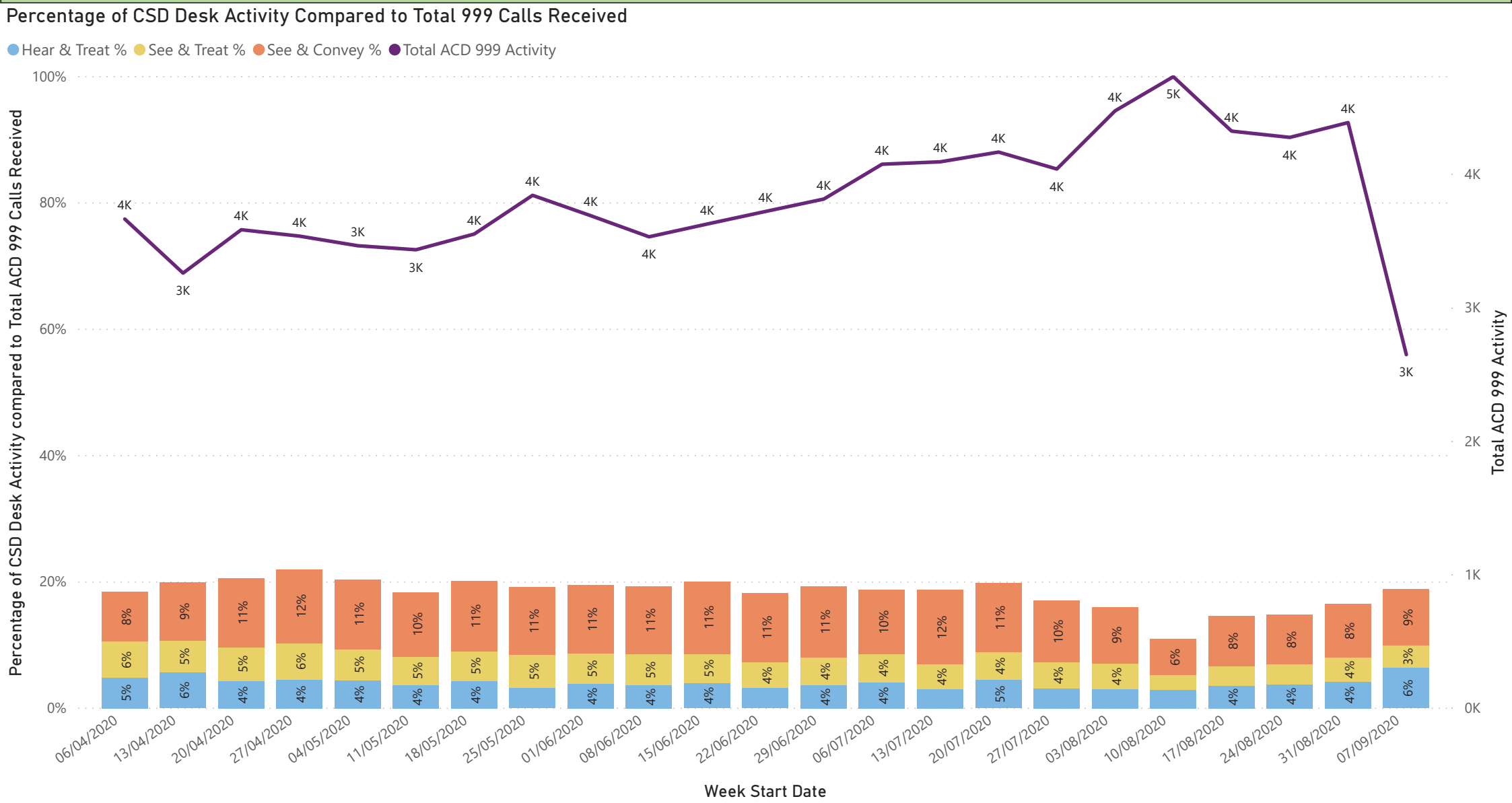
Total CSD Desk See and Convey Activity (Non Acute Hospitals)



Total CSD Desk See and Convey Activity (Non Acute Hospitals)

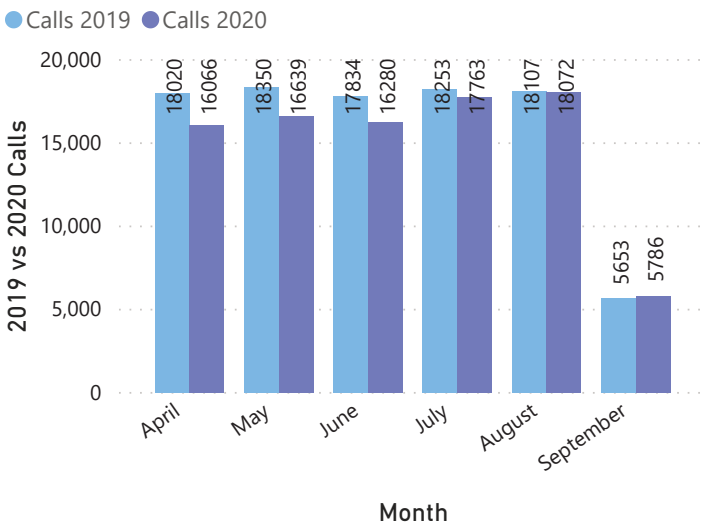


4. Clinical Support Desk (CSD) - Hear & Treat/See & Treat/See & Convey

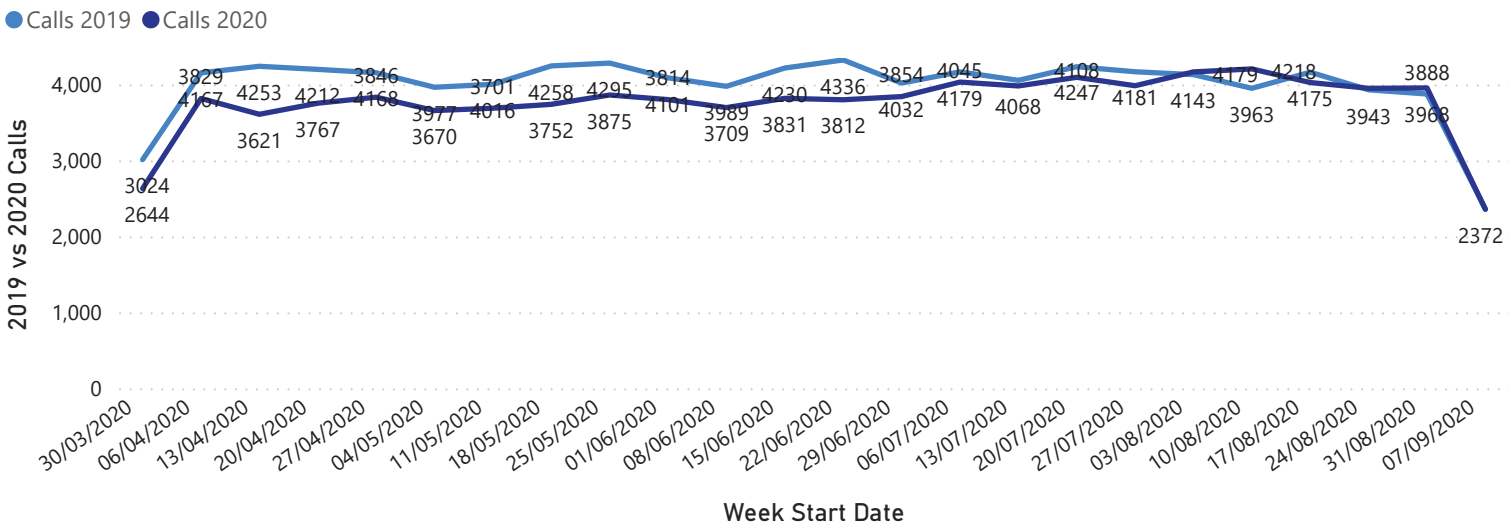


5. Emergency Calls, Responses and Conveyance Rates

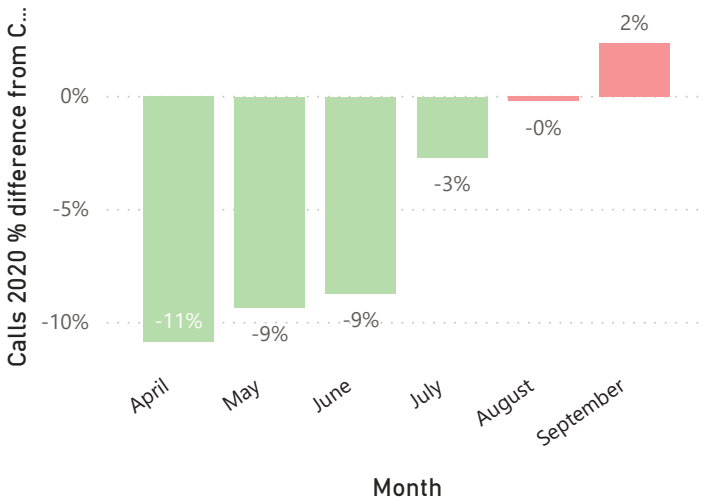
2019 vs 2020 Calls Received



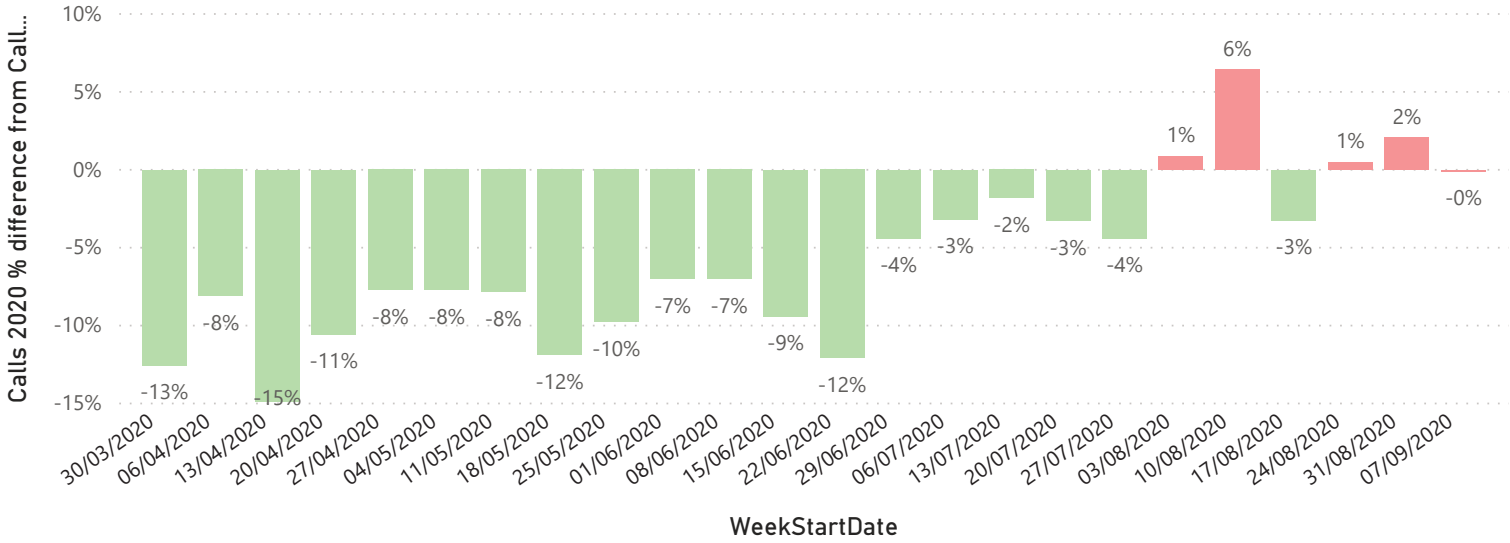
2019 vs 2020 Calls Received



Percentage Difference in Calls Received - 2019 vs 2020

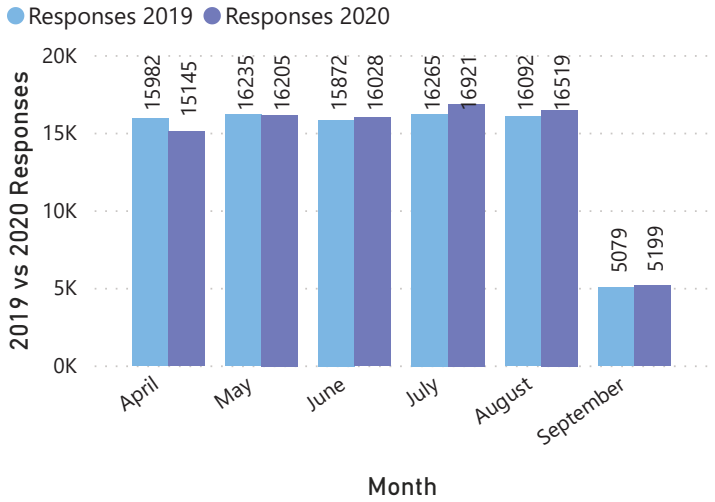


Percentage Difference in Calls Received - 2019 vs 2020

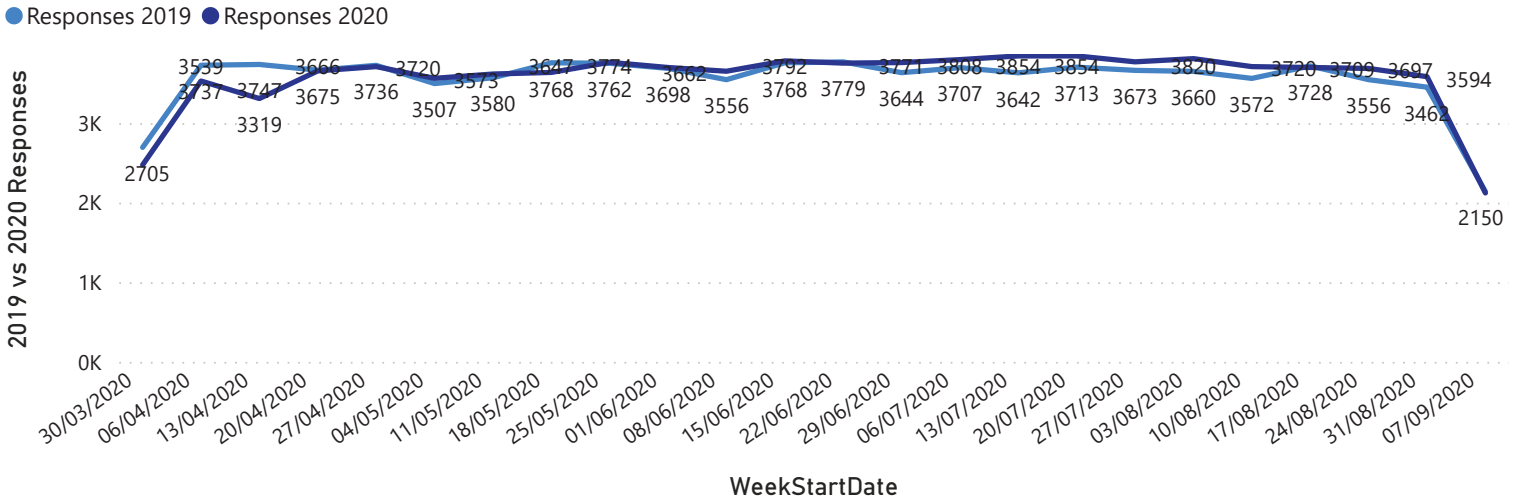


5. Emergency Calls, Responses and Conveyance Rates

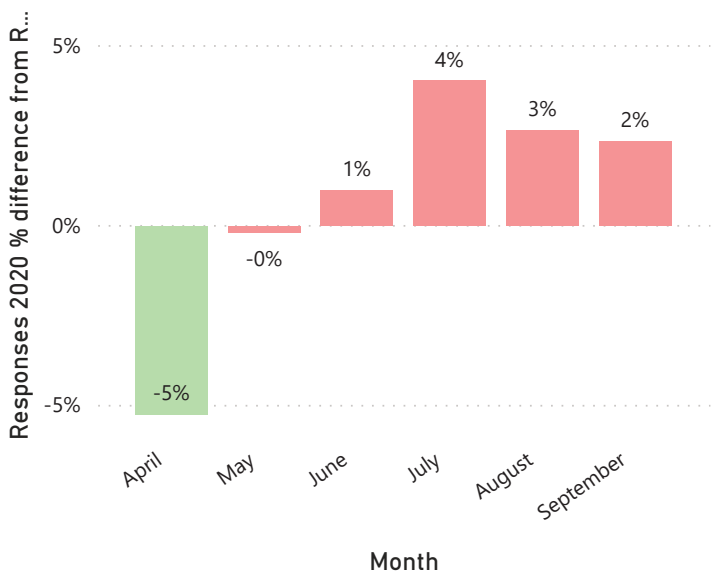
2019 vs 2020 Responses



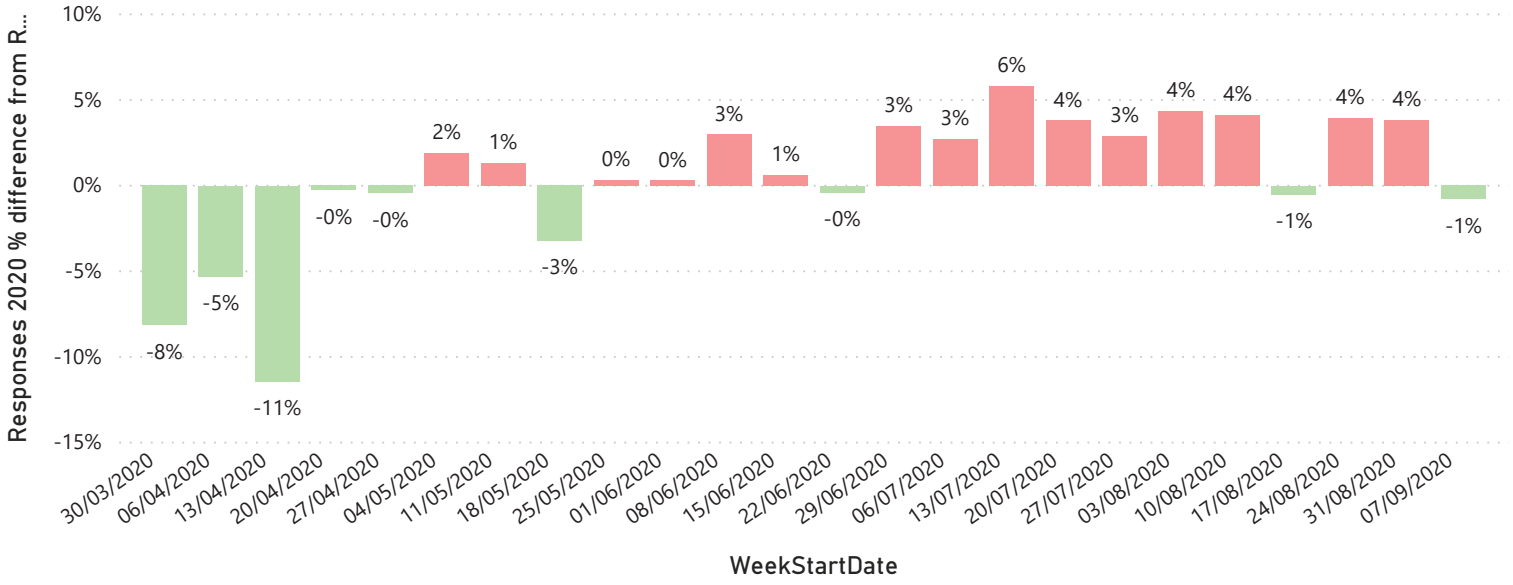
2019 vs 2020 Responses



Percentage Difference in Responses - 2019 vs 2020

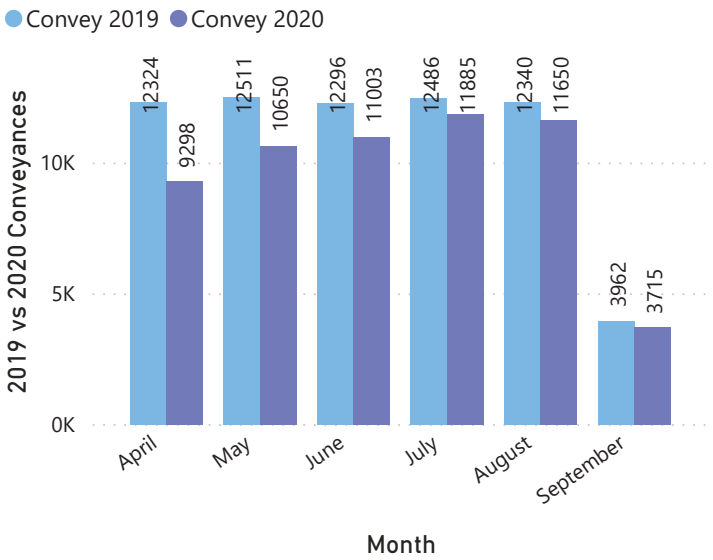


Percentage Difference in Responses - 2019 vs 2020

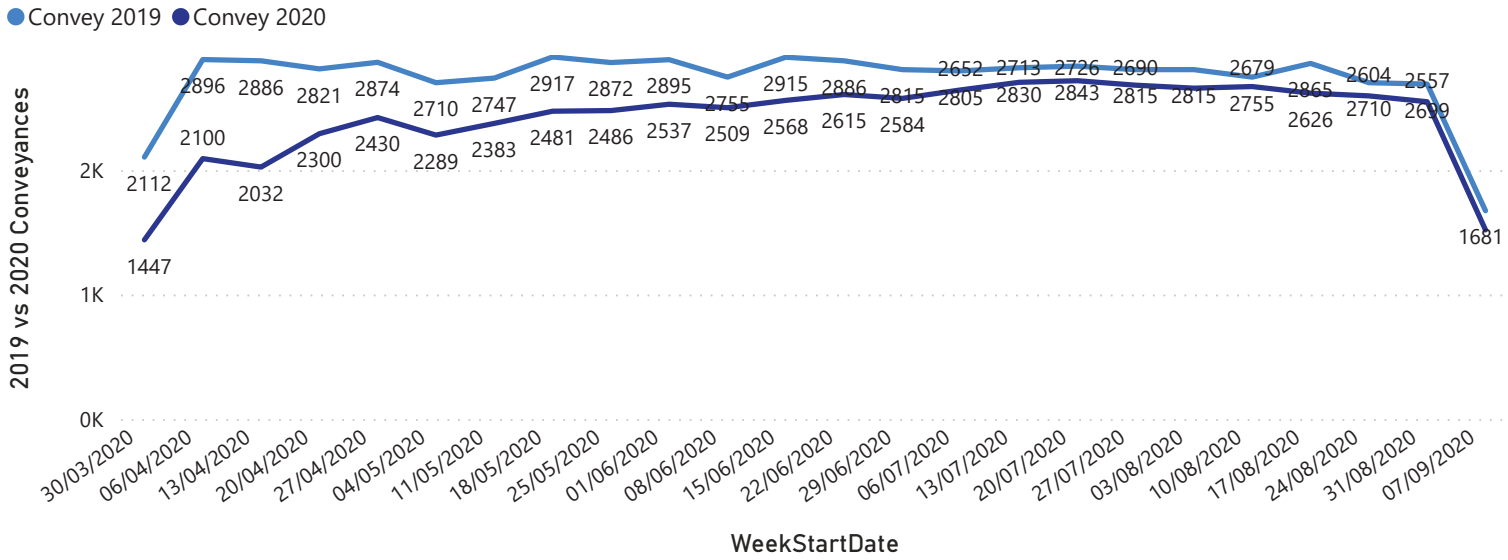


5. Emergency Calls, Responses and Conveyance Rates

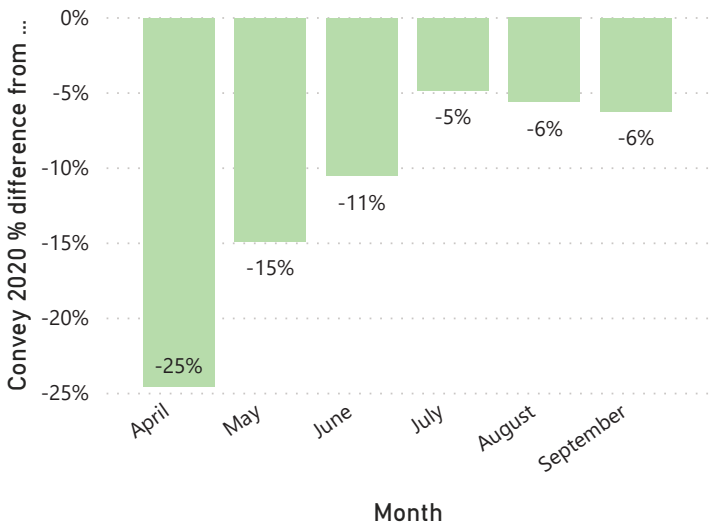
2019 vs 2020 Conveyances



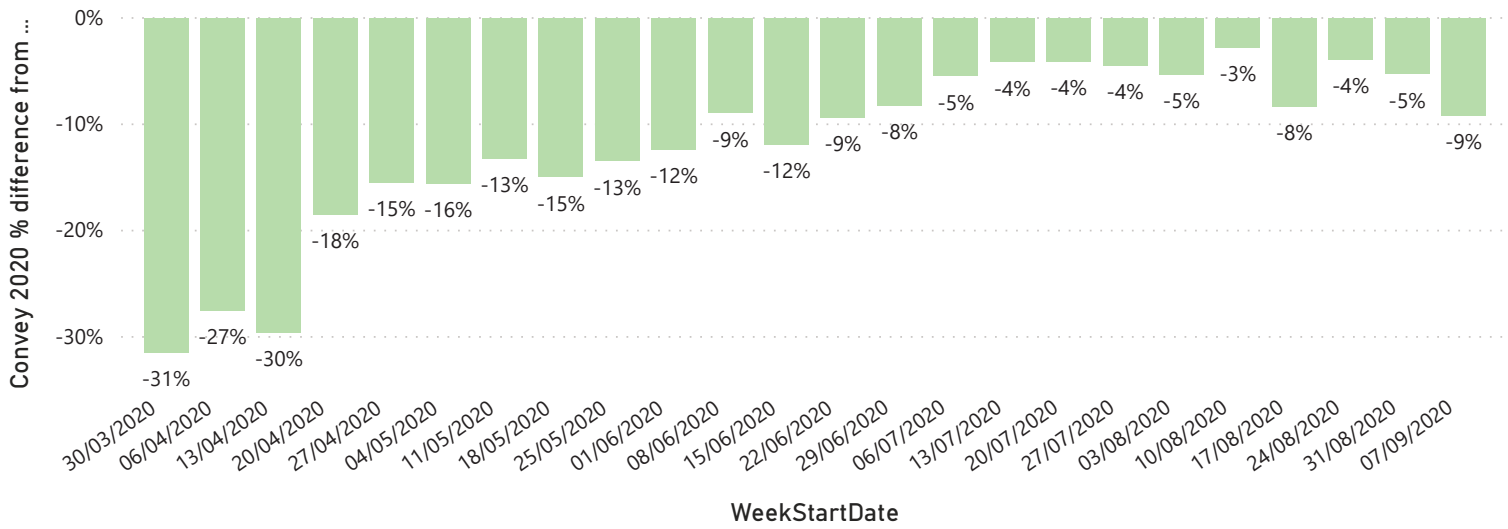
2019 vs 2020 Conveyances



Percentage Difference in Conveyances - 2019 vs 2020



Percentage Difference in Conveyances - 2019 vs 2020



6. Ambulance Turnaround Times - KPI 30 minutes by Acute Hospital Sites

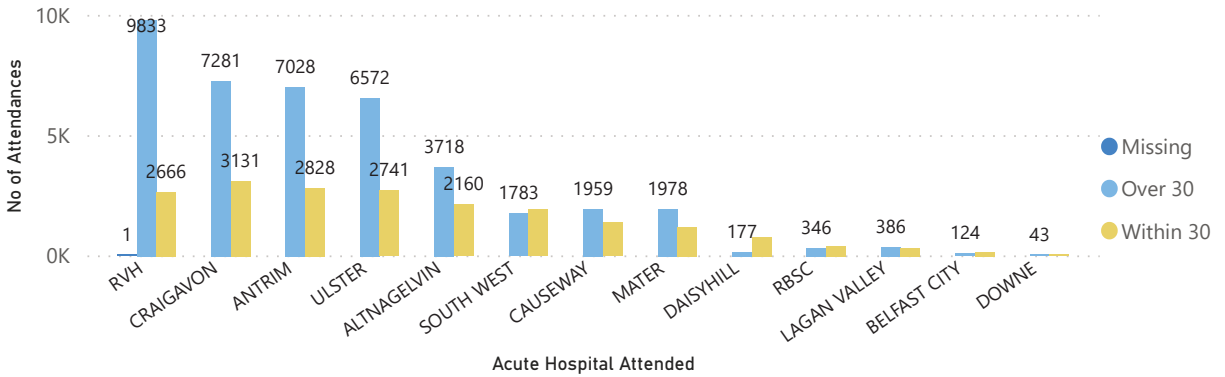
Average Ambulance Turnaround Times (mins)

Hospital	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	**Avg. per Hospital**
ALTNAGELVIN HOSPITAL	35	35	38	40	42	40	**38**
ANTRIM AREA HOSPITAL	38	35	36	37	43	44	**38**
BELFAST CITY HOSPITAL	36	33	29	24	25	31	**30**
CAUSEWAY HOSPITAL	32	33	32	35	39	38	**35**
CRAIGAVON AREA HOSPITAL	41	39	44	46	49	47	**44**
DAISYHILL NEWRY	23	24	20	24	26	24	**23**
DOWNE HOSPITAL	39	32	30	23	24	27	**30**
LAGAN VALLEY LISBURN	34	33	31	32	31	31	**32**
MATER INFIRMORUM	50	37	32	36	37	55	**40**
R/BELF FOR SICK CHILDREN	32	29	31	29	30	38	**31**
ROYAL VICTORIA	45	51	46	46	52	59	**49**
SOUTH WEST ACUTE HOSPITAL	31	30	30	29	33	38	**31**
ULSTER HOSPITAL	41	37	36	41	50	64	**43**
Avg. per Month	**40**	**39**	**39**	**40**	**45**	**49**	**41**

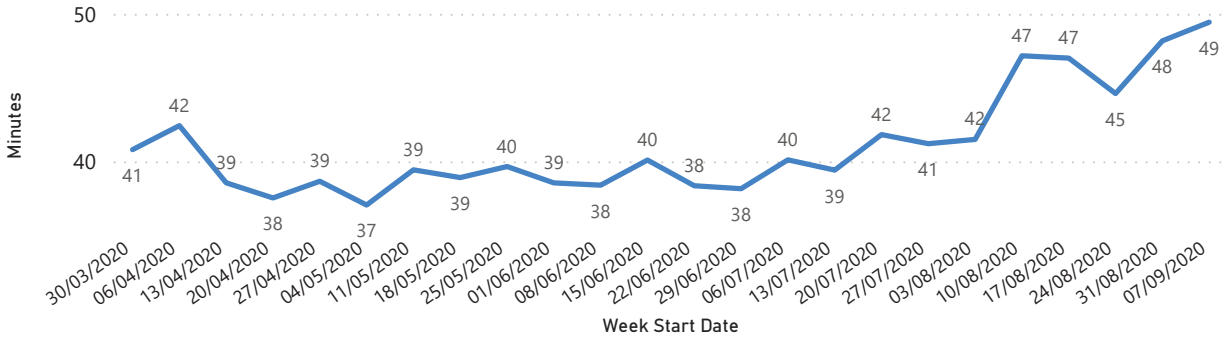
Maximum Ambulance Turnaround TImes (mins)

Hospital	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	**Max. per Hospital**
ALTNAGELVIN HOSPITAL	144	160	166	258	184	198	**258**
ANTRIM AREA HOSPITAL	125	147	166	100	240	188	**240**
BELFAST CITY HOSPITAL	111	99	59	49	76	85	**111**
CAUSEWAY HOSPITAL	101	129	98	153	194	133	**194**
CRAIGAVON AREA HOSPITAL	216	168	285	280	261	283	**285**
DAISYHILL NEWRY	80	174	53	156	92	81	**174**
DOWNE HOSPITAL	76	116	80	45	45	53	**116**
LAGAN VALLEY LISBURN	79	100	232	79	103	71	**232**
MATER INFIRMORUM	133	402	772	253	183	385	**772**
R/BELF FOR SICK CHILDREN	184	148	205	172	170	233	**233**
ROYAL VICTORIA	257	264	286	232	325	275	**325**
SOUTH WEST ACUTE HOSPITAL	142	239	101	111	181	132	**239**
ULSTER HOSPITAL	163	309	276	326	336	392	**392**
Max. per Month	**257**	**402**	**772**	**326**	**336**	**392**	**772**

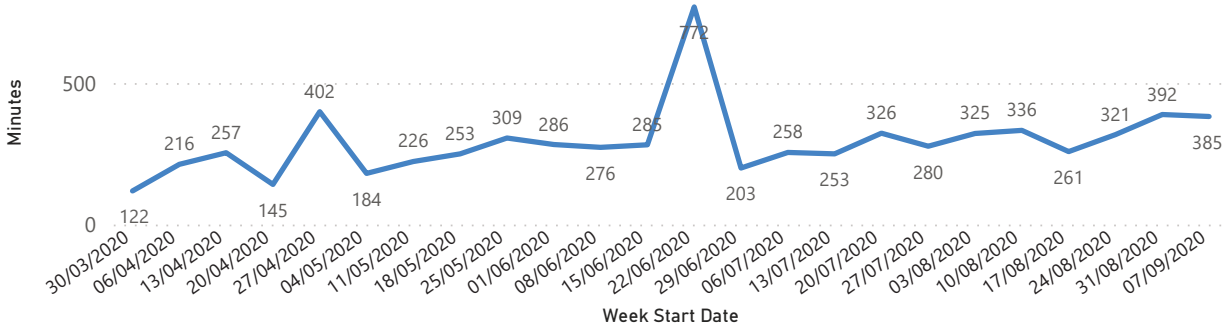
Number of Attendances which met the Ambulance Turnaround Time KPI Target of 30mins



Average Ambulance Turnaround Times (mins)

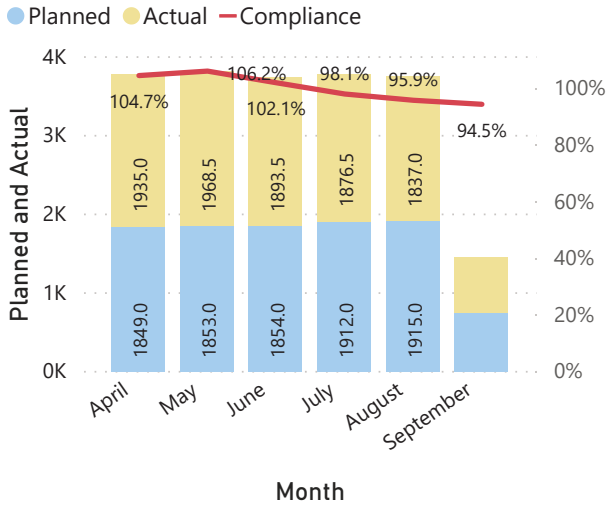


Maximum Ambulance Turnaround TImes (mins)

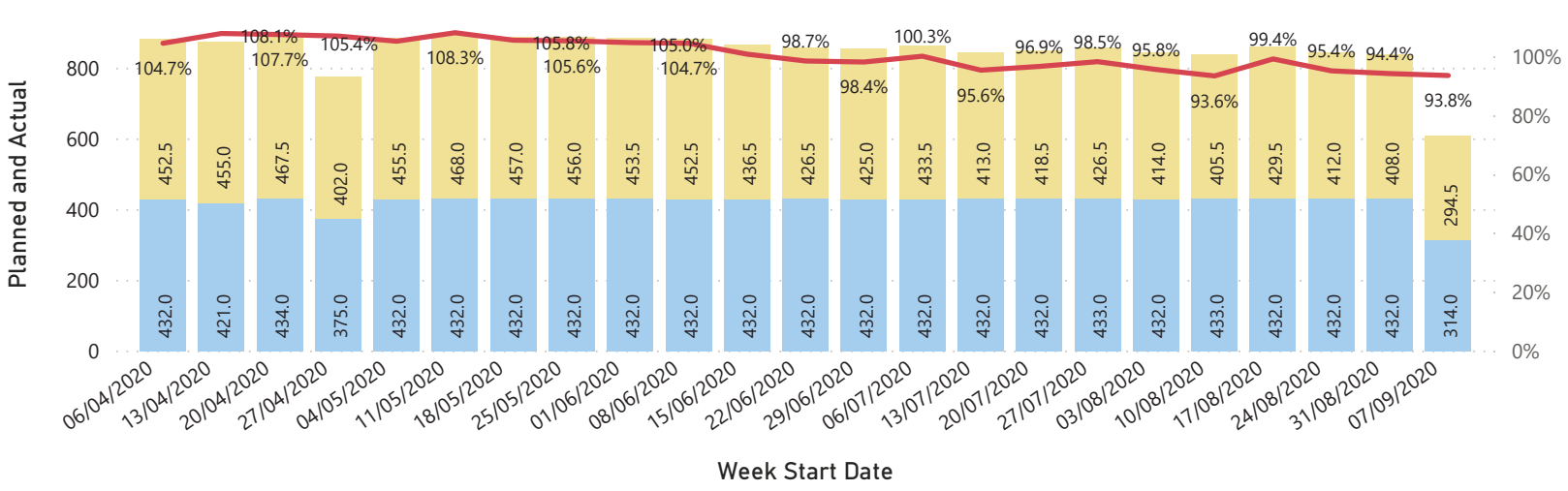


7. Vehicle Resource Levels

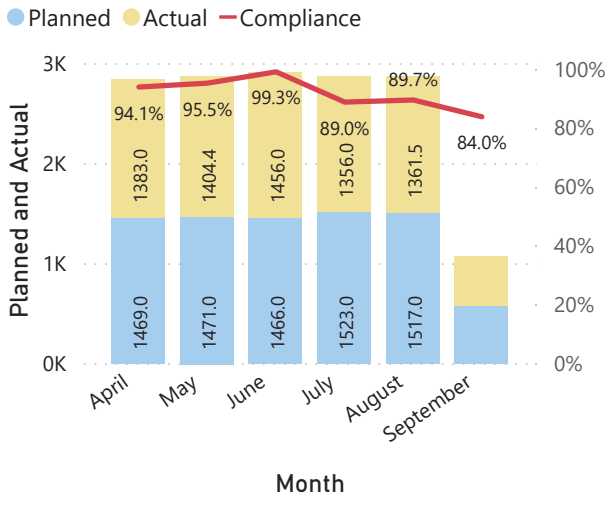
A&E NI Planned vs Actual Compliance by Day Shift



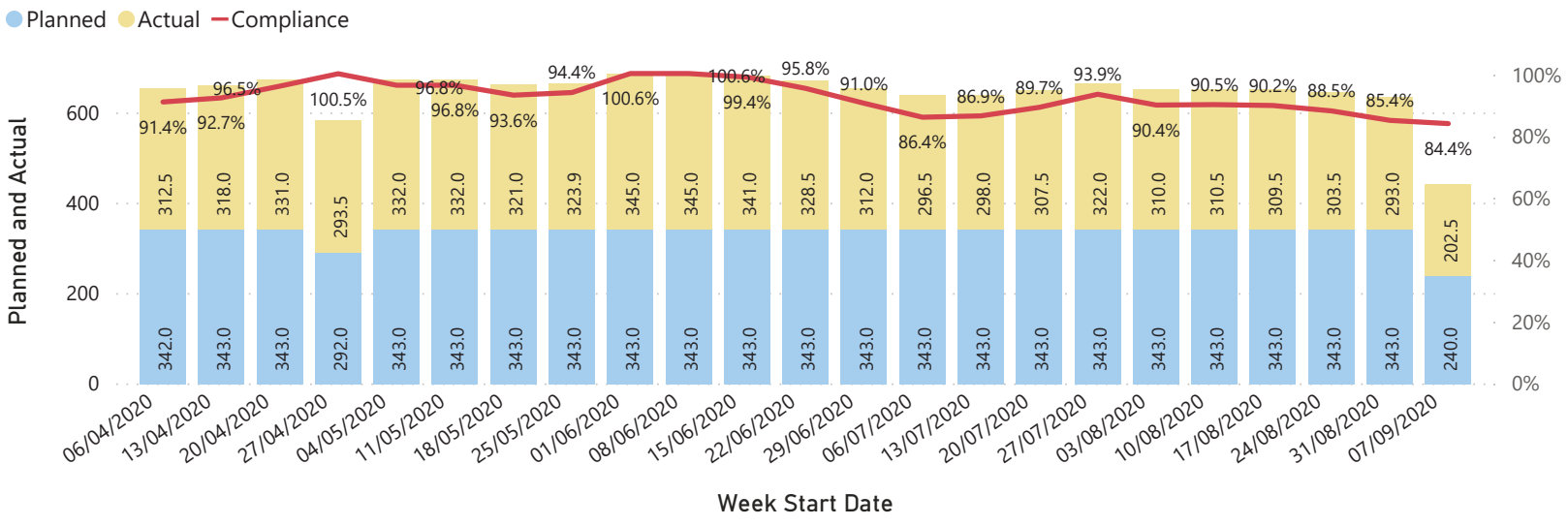
A&E NI Planned vs Actual Compliance by Day Shift



A&E NI Planned vs Actual Compliance by Night Shift

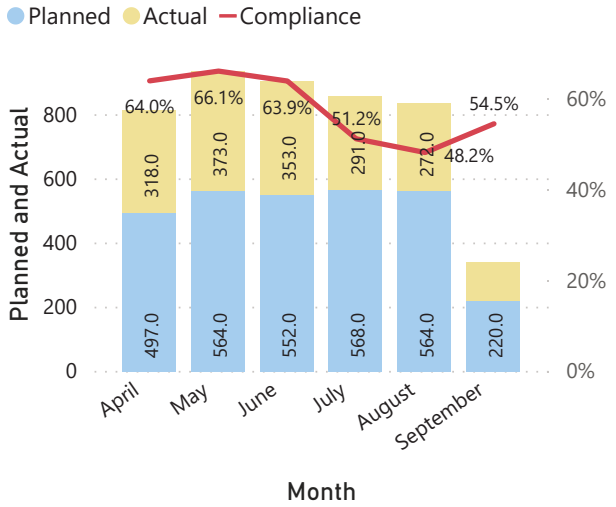


A&E NI Planned vs Actual Compliance by Night Shift

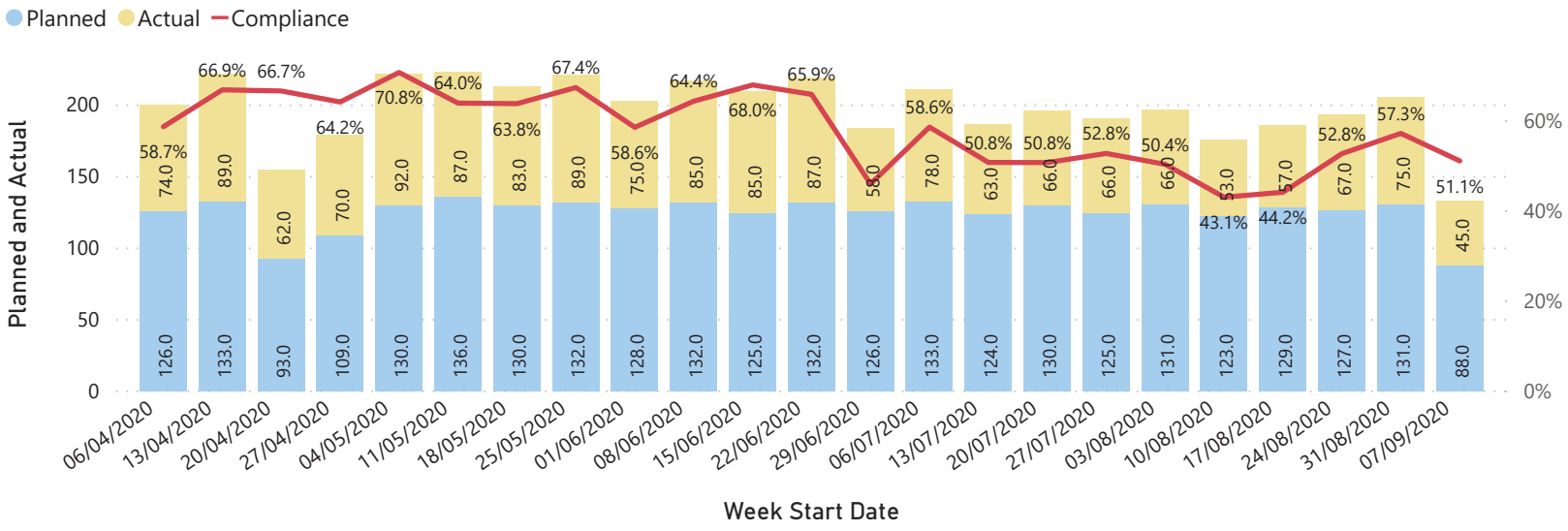


7. Vehicle Resource Levels

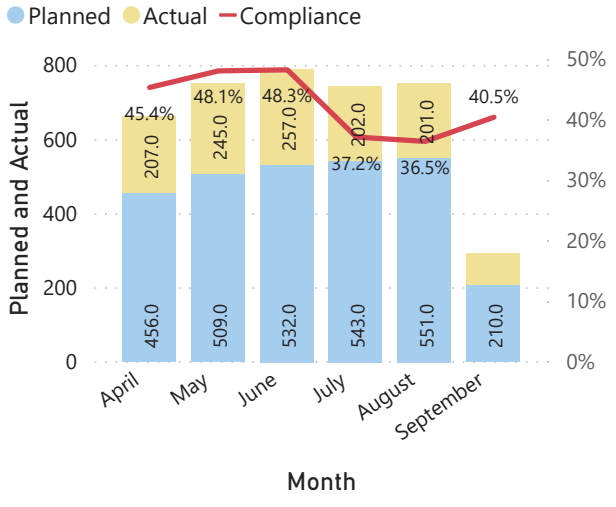
RRV NI Planned vs Actual Compliance by Early Shift



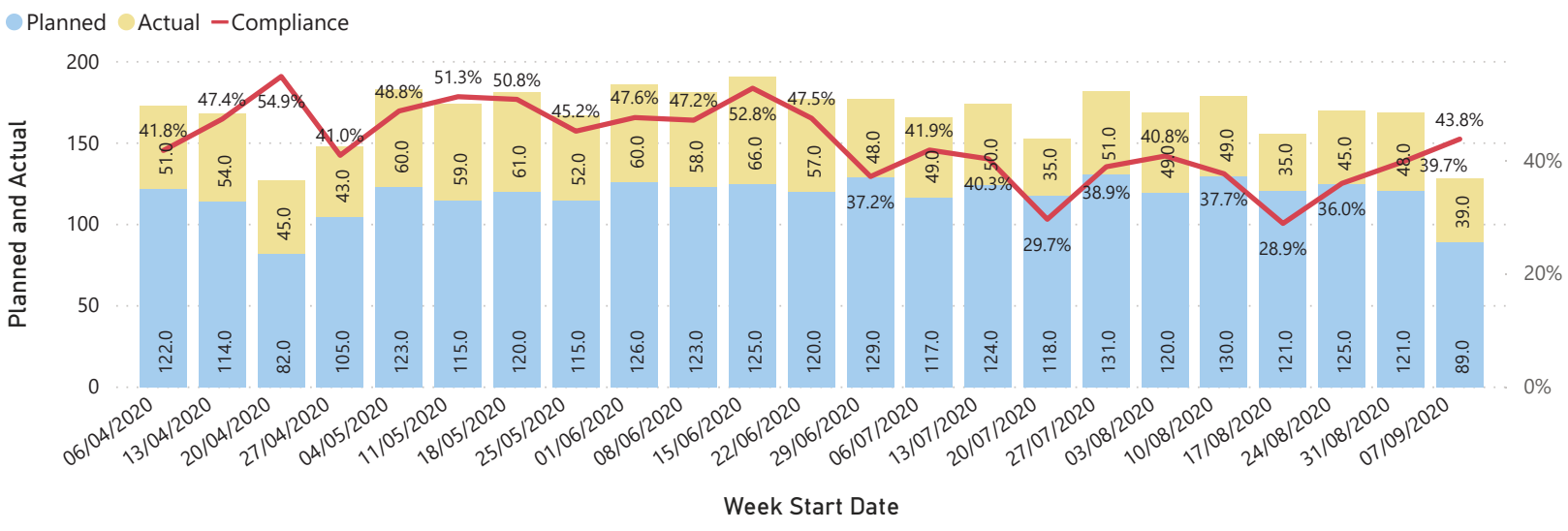
RRV NI Planned vs Actual Compliance by Early Shift



RRV NI Planned vs Actual Compliance by Late Shift

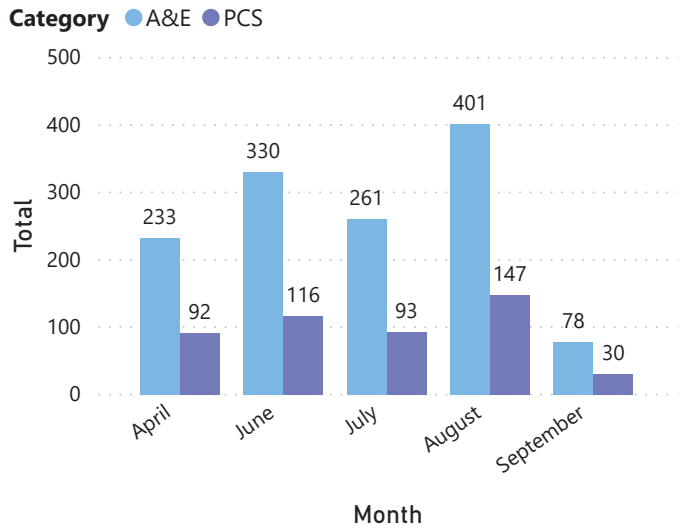


RRV NI Planned vs Actual Compliance by Late Shift

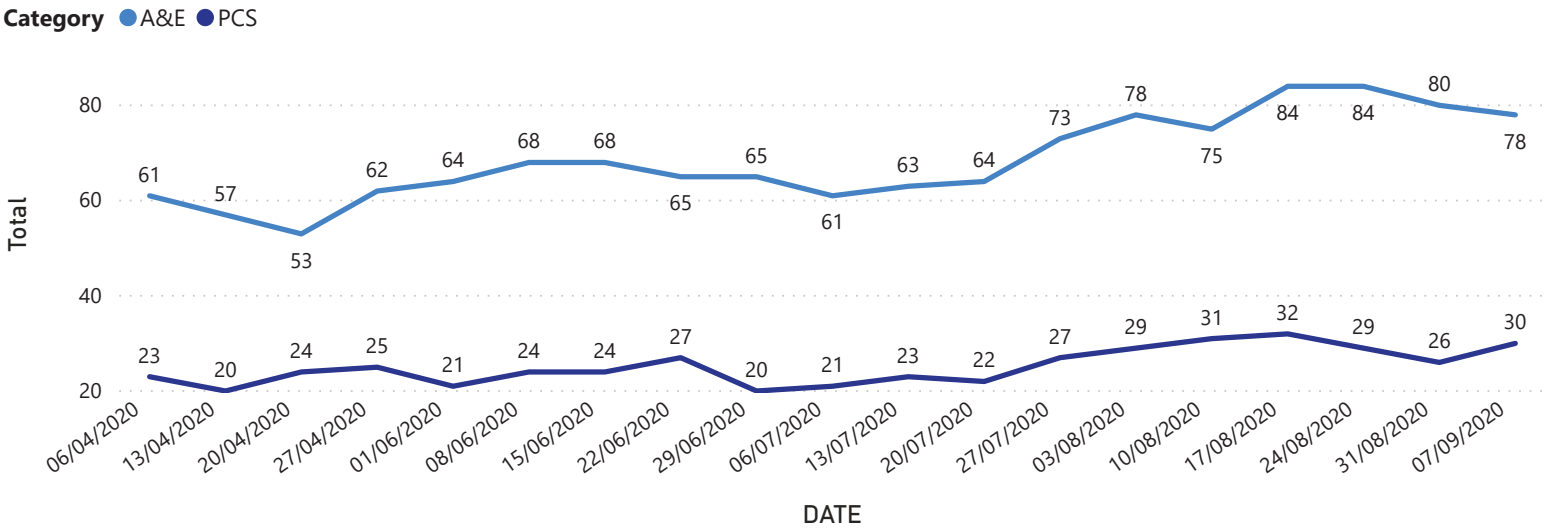


8. Current Staff Sickness Levels (Suspected COVID-19 staff absence is not included in this data)

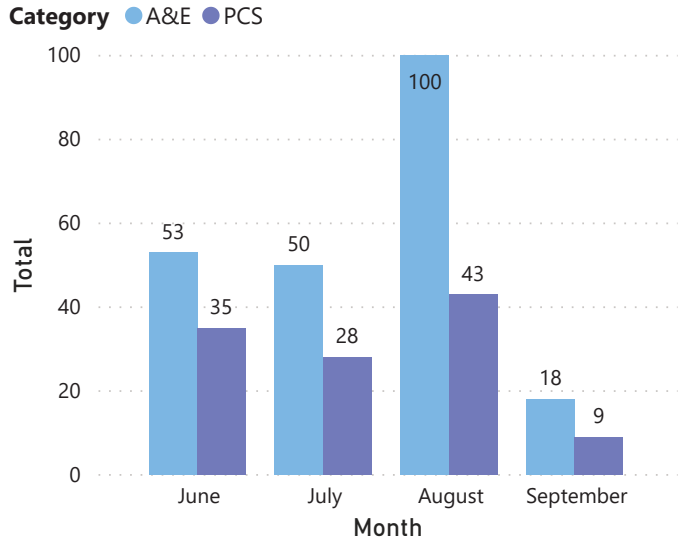
Northern Ireland Staff Sickness Totals



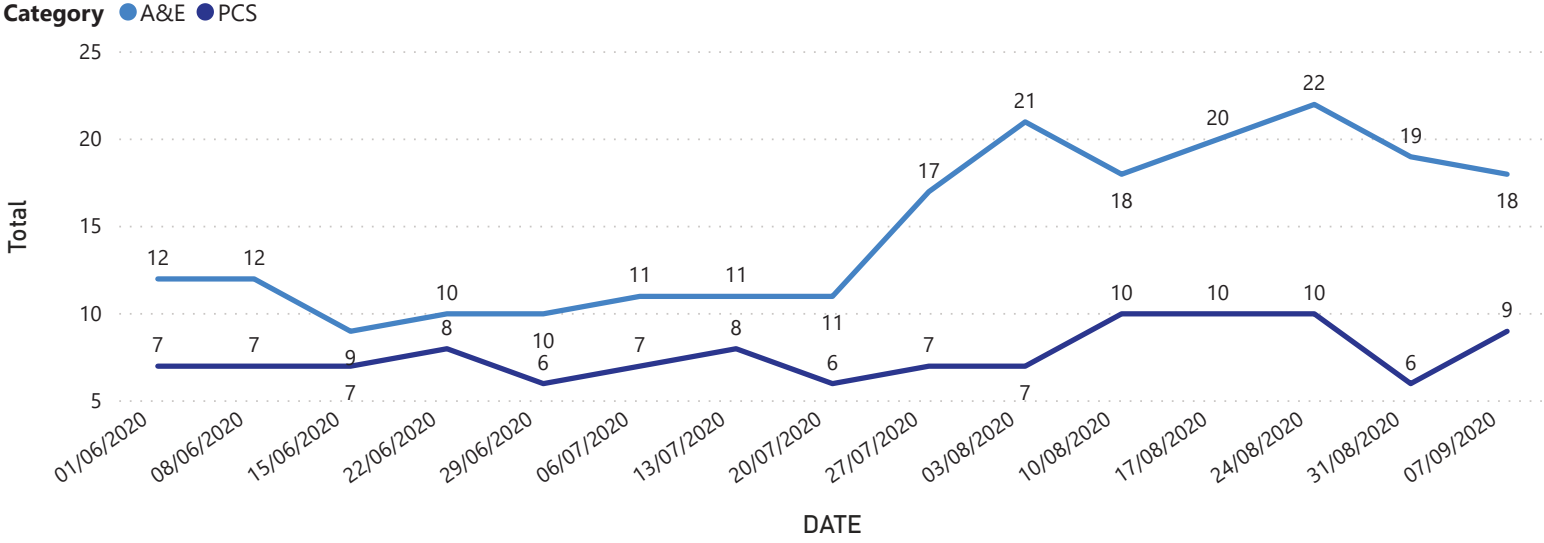
Northern Ireland Staff Sickness Totals



Belfast Division Staff Sickness Totals

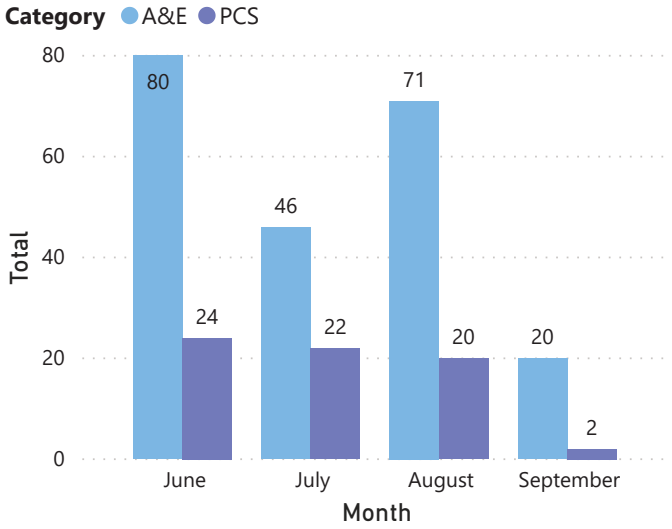


Belfast Division Staff Sickness Totals

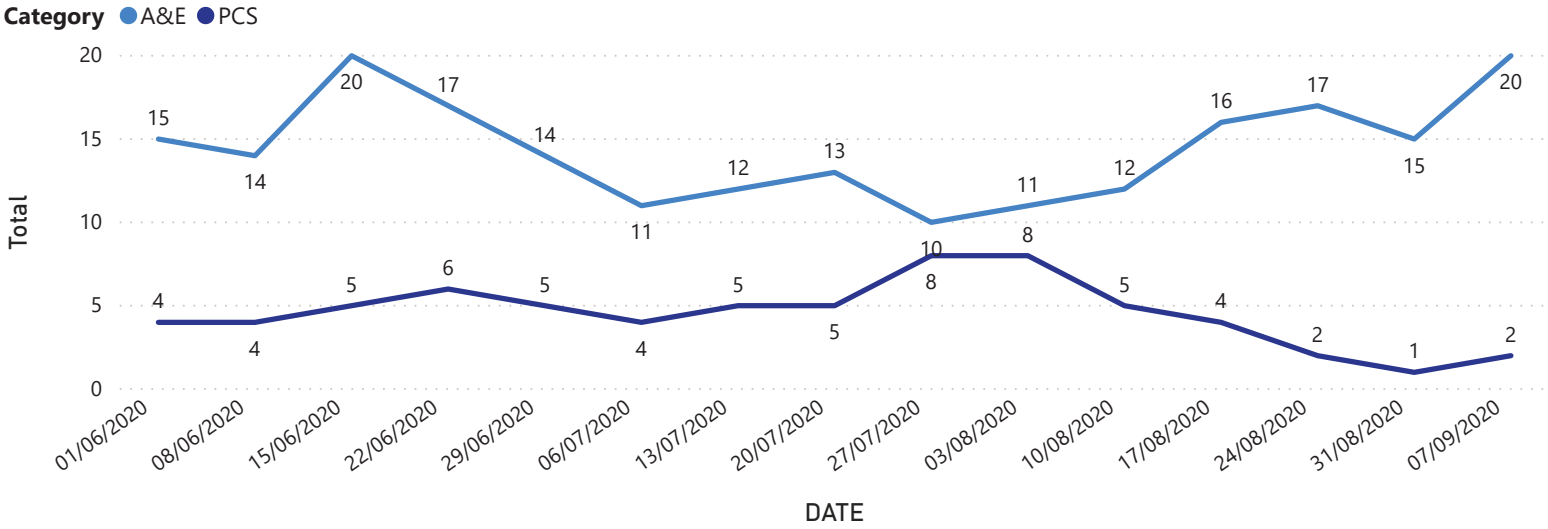


8. Current Staff Sickness Levels (Suspected COVID-19 staff absence is not included in this data)

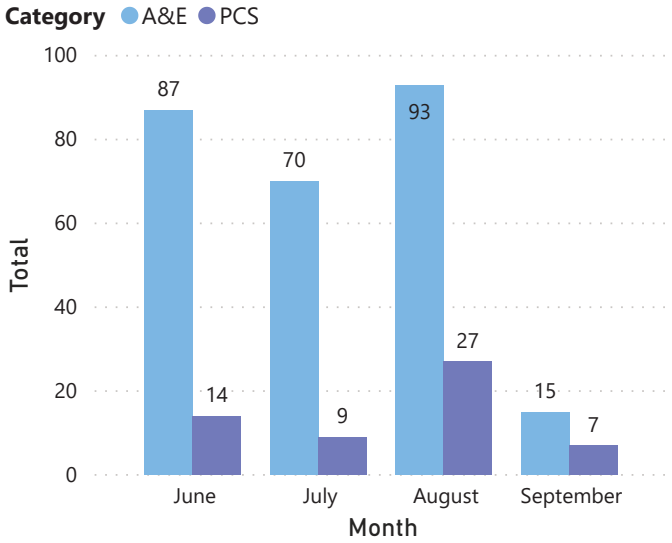
Northern Division Staff Sickness Totals



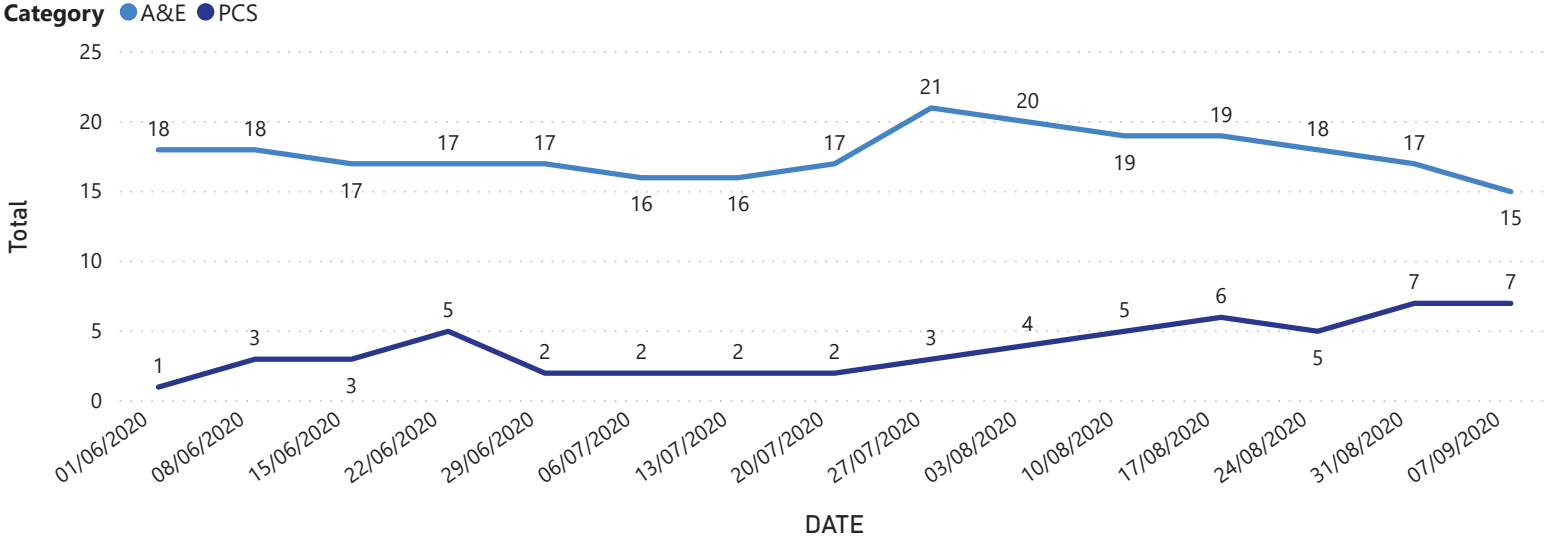
Northern Division Staff Sickness Totals



South Eastern Division Staff Sickness Totals

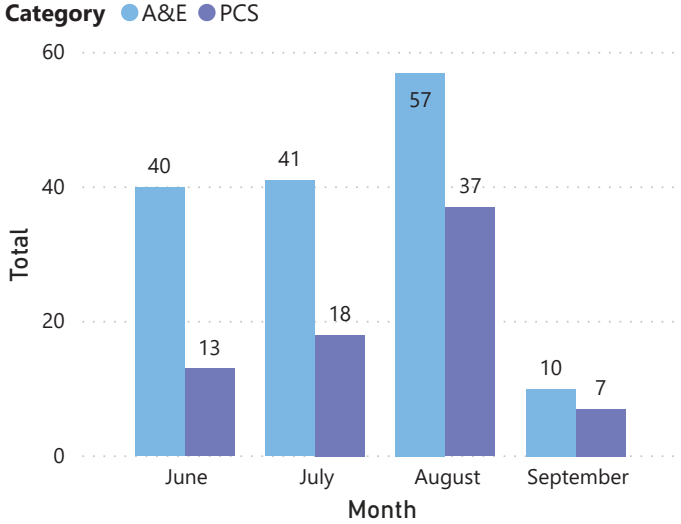


South Eastern Division Staff Sickness Totals

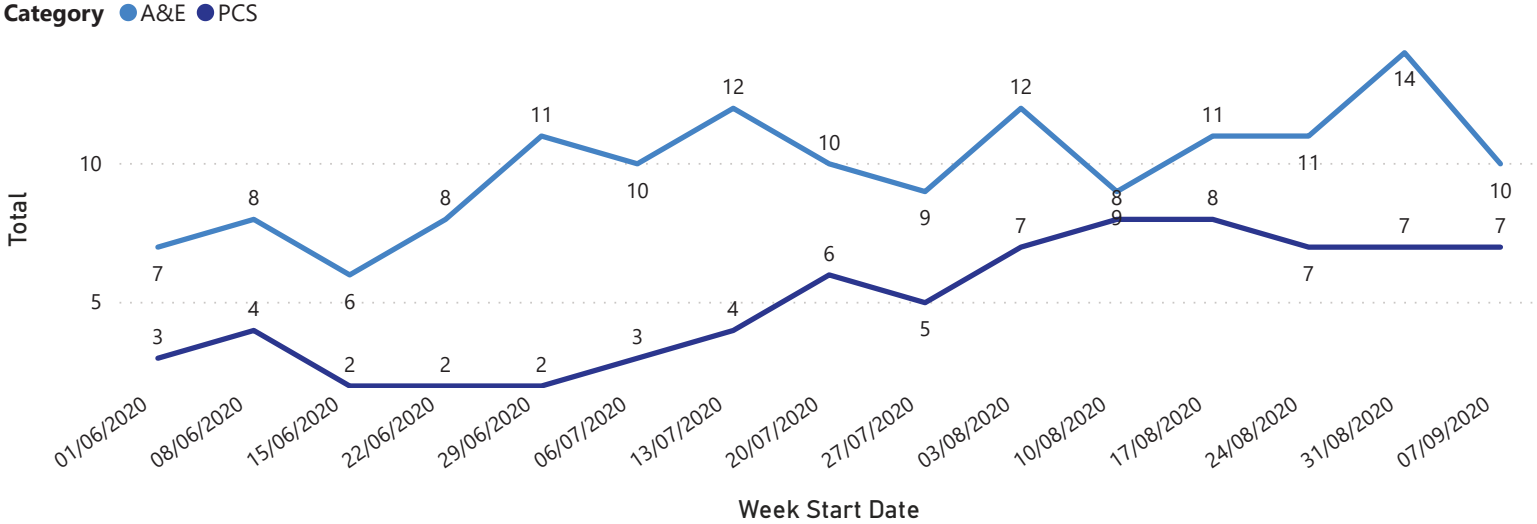


8. Current Staff Sickness Levels (Suspected COVID-19 staff absence is not included in this data)

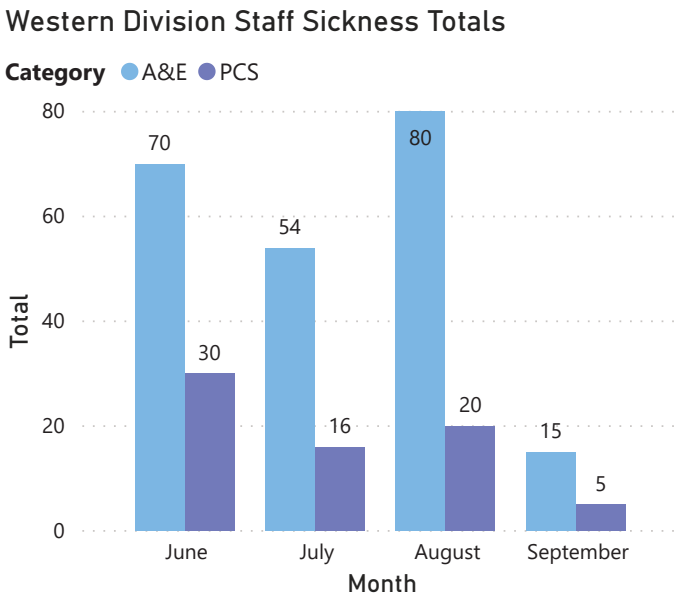
Southern Division Staff Sickness Totals



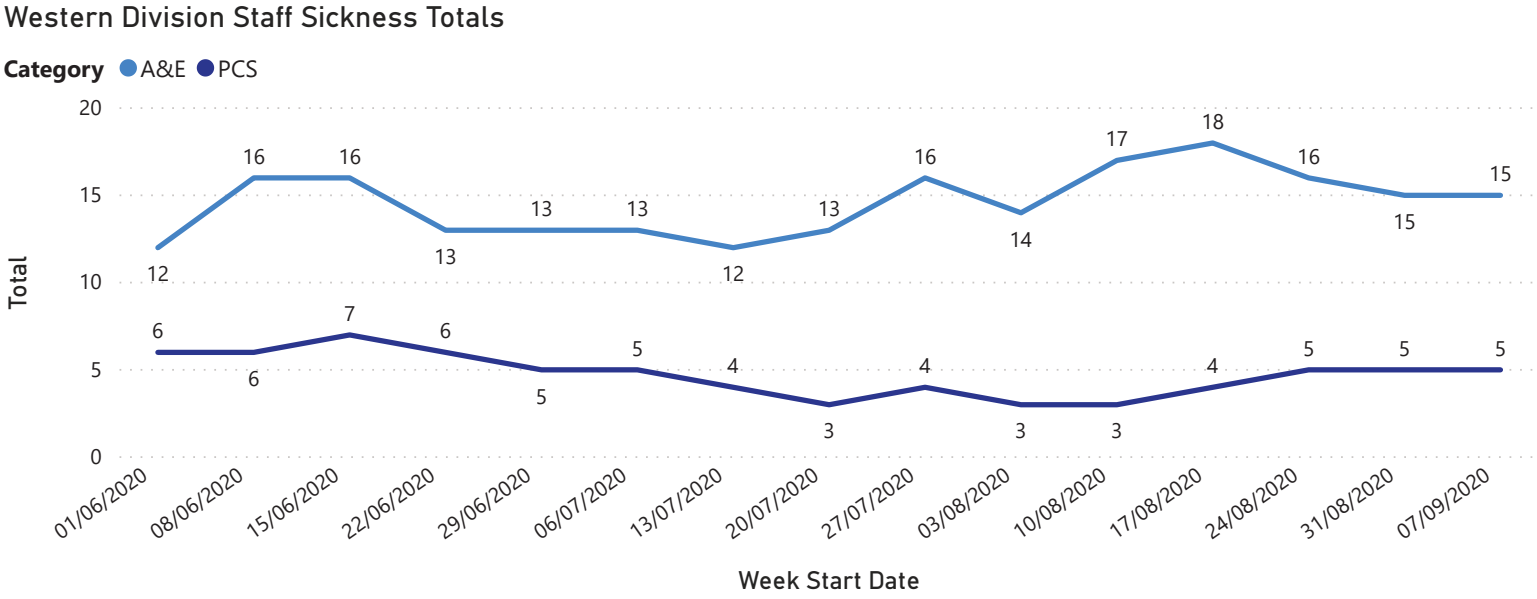
Southern Division Staff Sickness Totals



Western Division Staff Sickness Totals

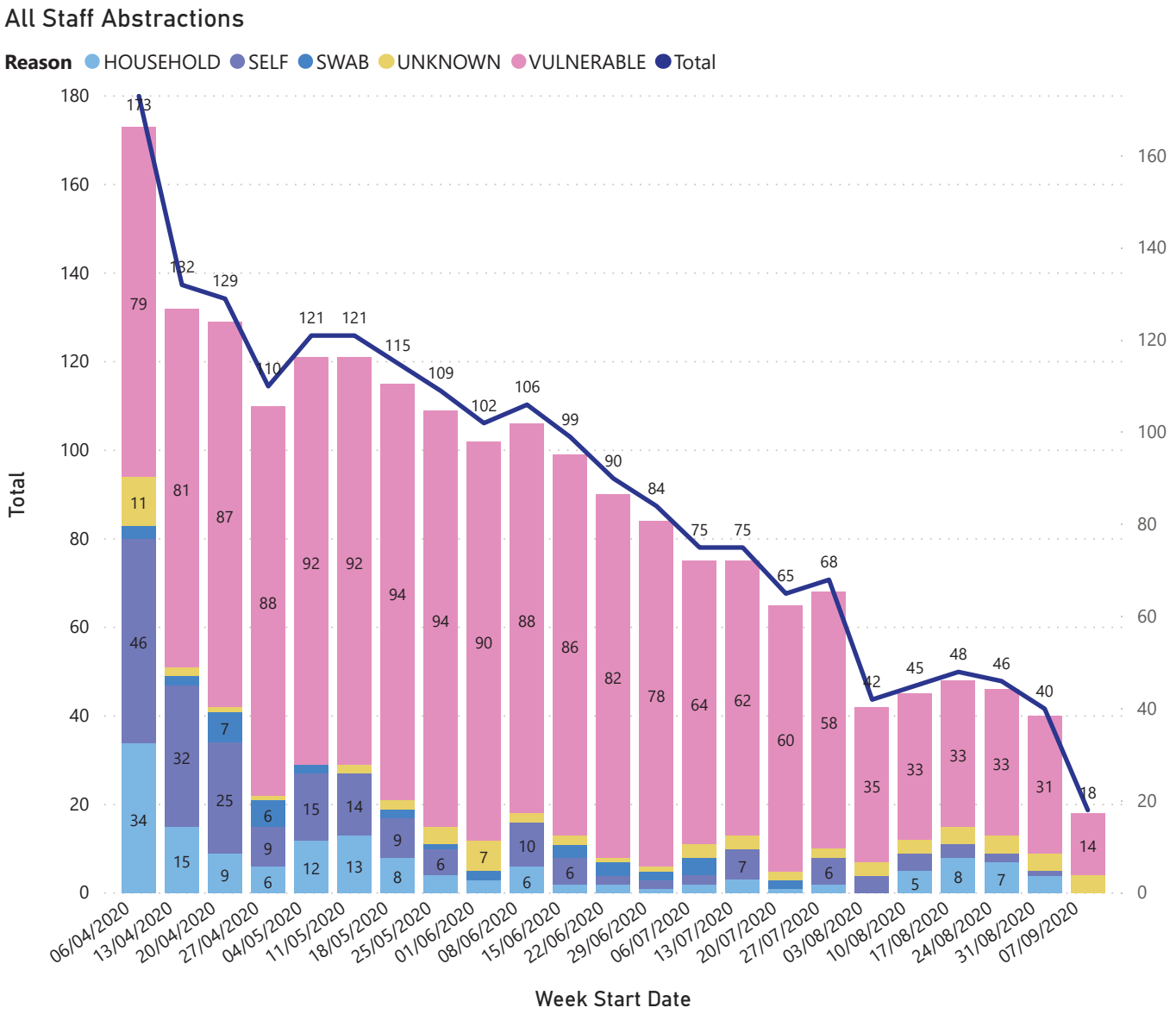


Western Division Staff Sickness Totals



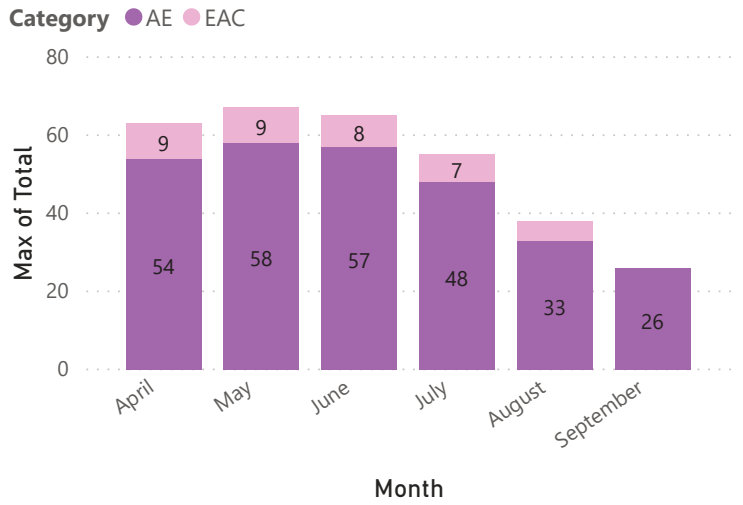
9. NIAS COVID-19 Staff Abstractions by staff grouping

Category	HOUSEHOLD	SELF	SWAB	UNKNOWN	VULNERABLE
AE					
Apr 2020	26	31	4	13	54
May 2020	11	15	3	4	58
Jun 2020	3	6	1	5	57
Jul 2020	2	7	3	3	48
Aug 2020	5	3		4	33
Sep 2020	1			3	26
EAC					
Apr 2020	6	9	2	1	8
May 2020	2	2		2	9
Jun 2020	1	1	2	1	8
Jul 2020	2	2	1	1	7
Aug 2020	1	2			5
NEAC					
Apr 2020		1	1		
May 2020	1				
PCS					
Apr 2020	8	12	2	3	25
May 2020	1	7	1	1	25
Jun 2020	1	4	1	1	23
Jul 2020	1	1	1	1	14
Aug 2020	2	1		1	8
Sep 2020				1	4
SUPPORT					
Apr 2020	2	2			3
May 2020	1		1		2
Jun 2020	1		1		2
Jul 2020					2
Aug 2020		1			2

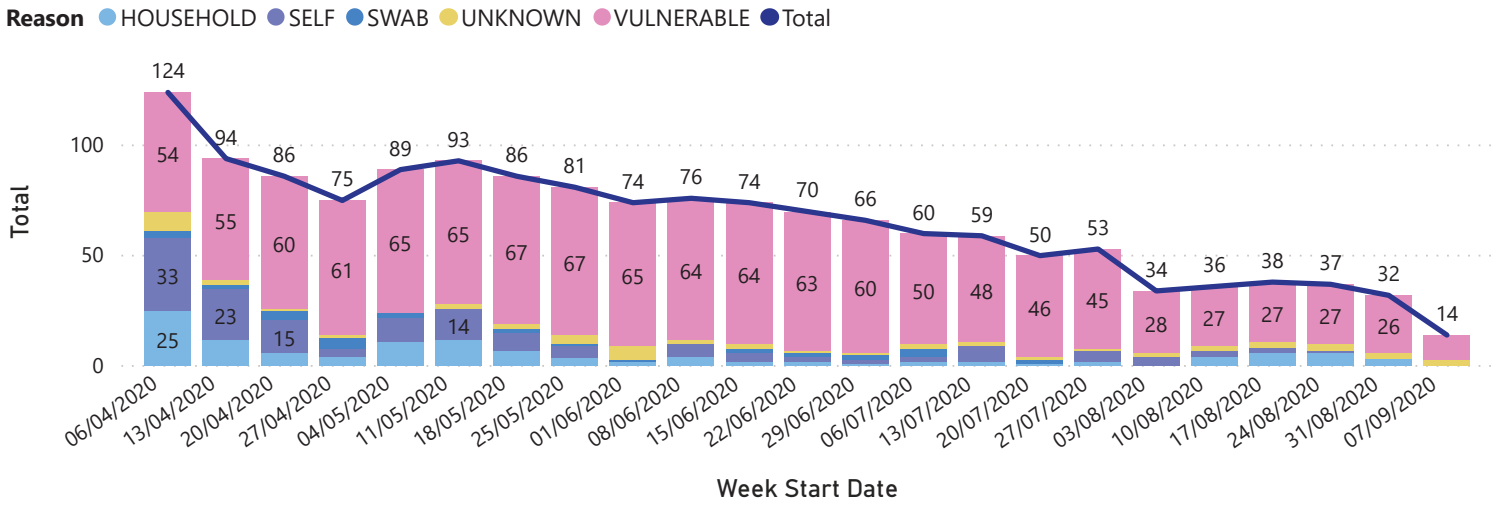


9. NIAS COVID-19 Staff Abstractions by staff grouping

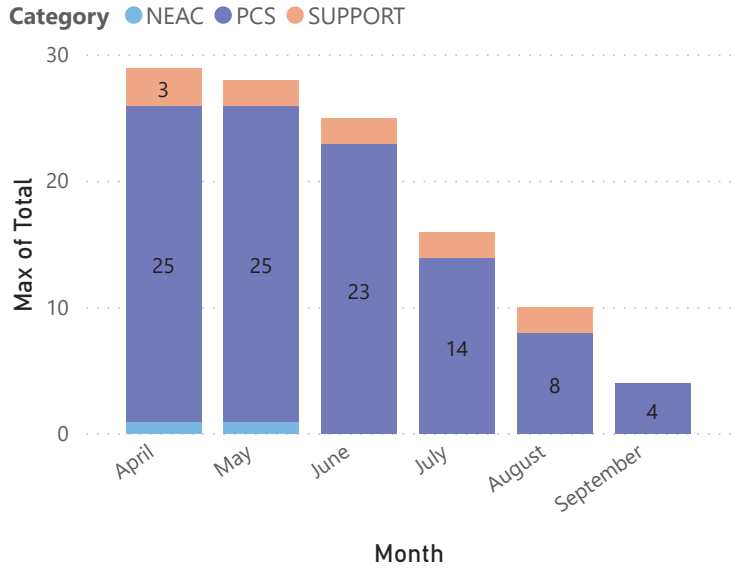
A&E/EAC Staff Abstractions



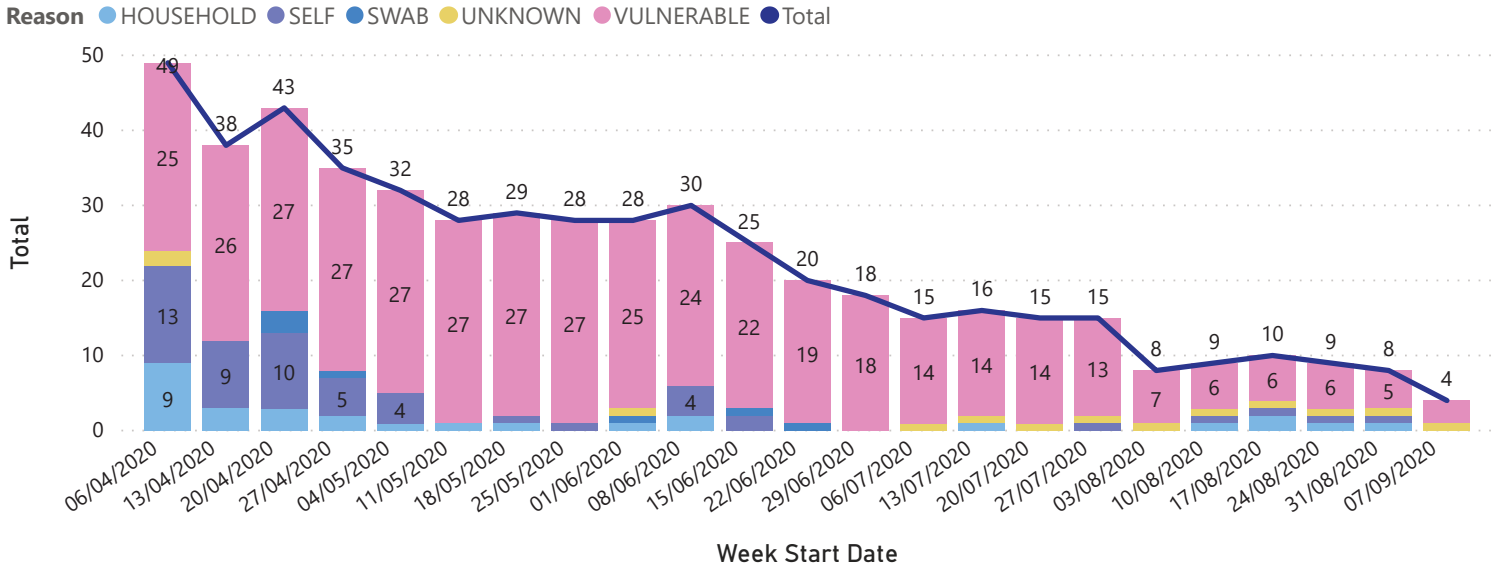
A&E/EAC Staff Abstractions



PCS/NEAC/Support Staff Abstractions

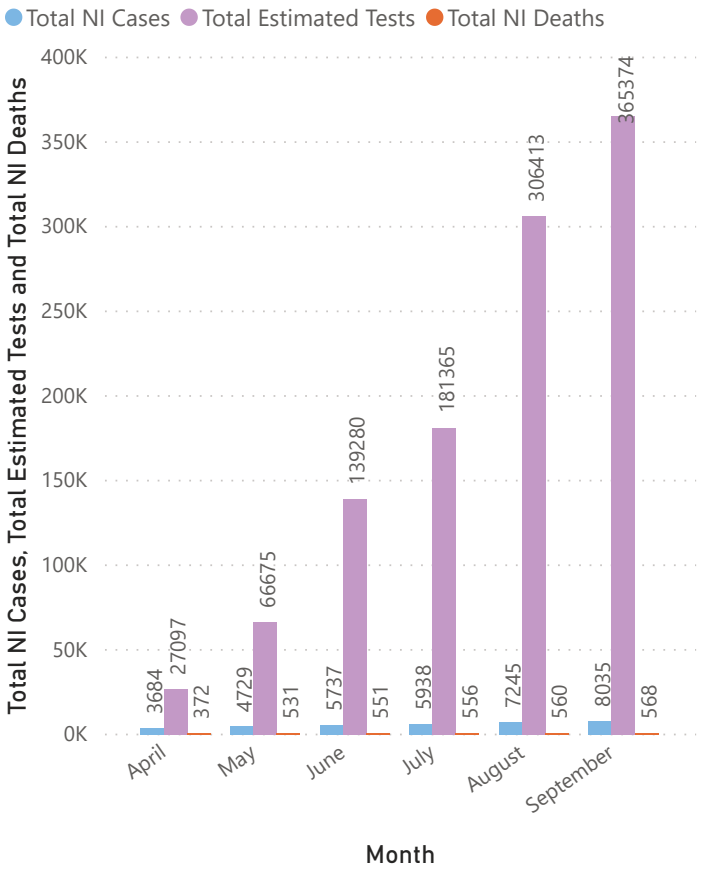


PCS/NEAC/Support Staff Abstractions

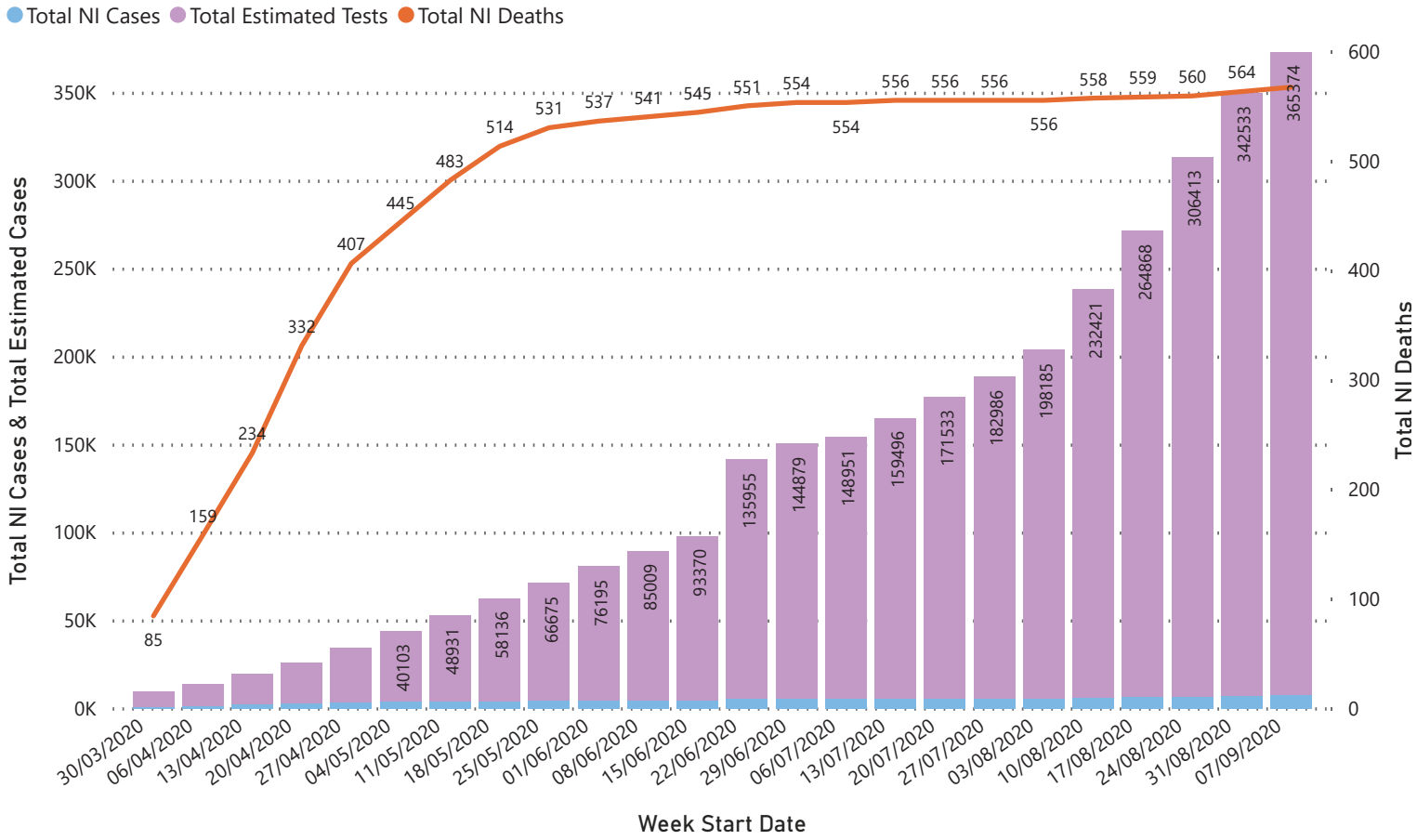


10. Northern Ireland COVID-19 Reports (external source of Public Health Agency/Department of Health)

Cumulative Monthly Totals of NI COVID-19 Cases, Estimated Tests and Deaths

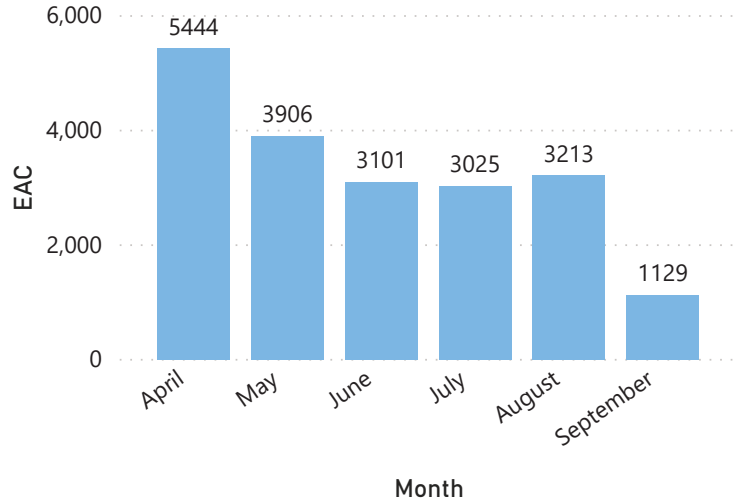


Weekly Totals of NI COVID-19 Cases, Estimated Tests and Deaths

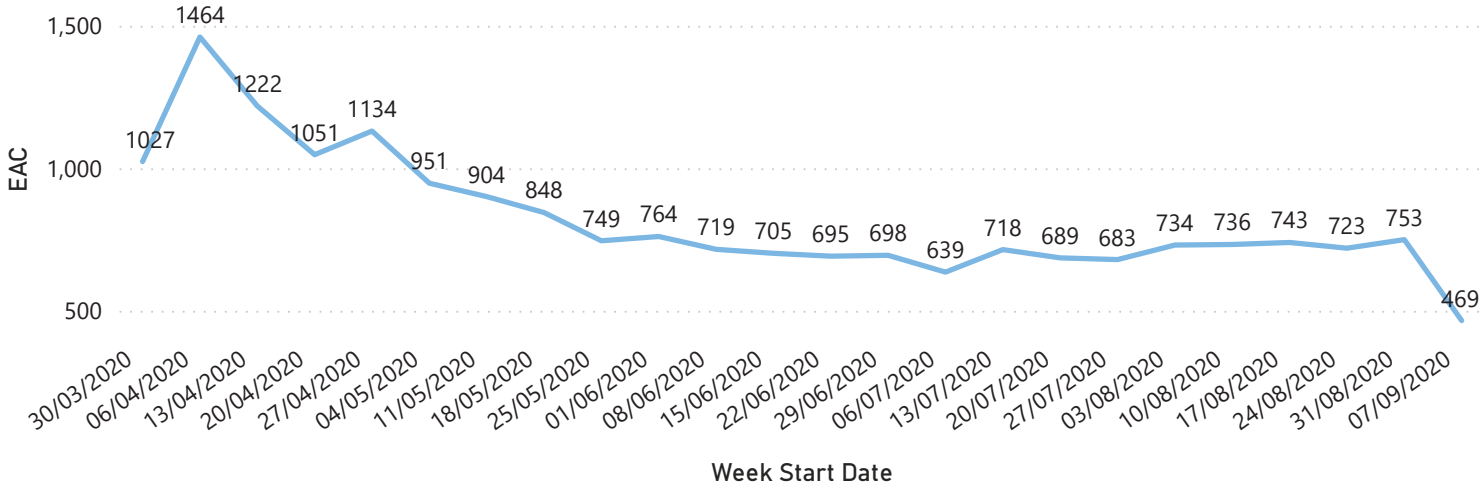


11. NIAS Suspected COVID-19 Related Activity for Emergency Ambulance Control (EAC) (Calls) and Non Emergency Ambulance Control (NEAC) (Journeys)

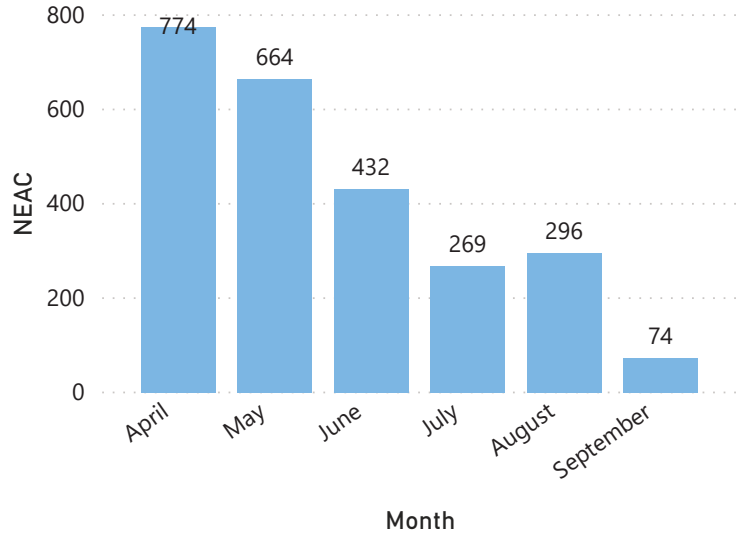
EAC Suspected COVID-19 Related Call Activity



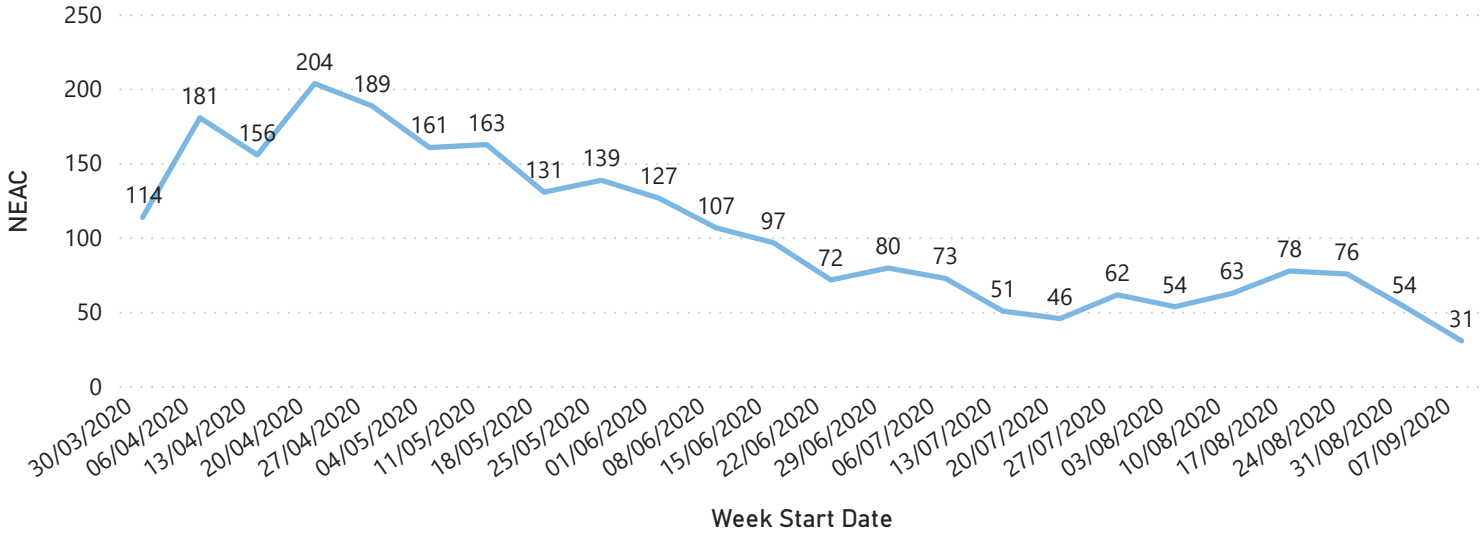
EAC Suspected COVID-19 Related Call Activity



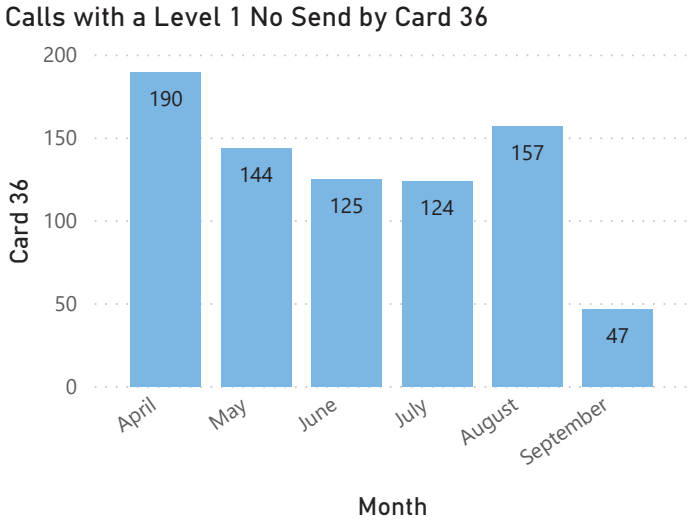
NEAC Suspected COVID-19 Related Call Activity

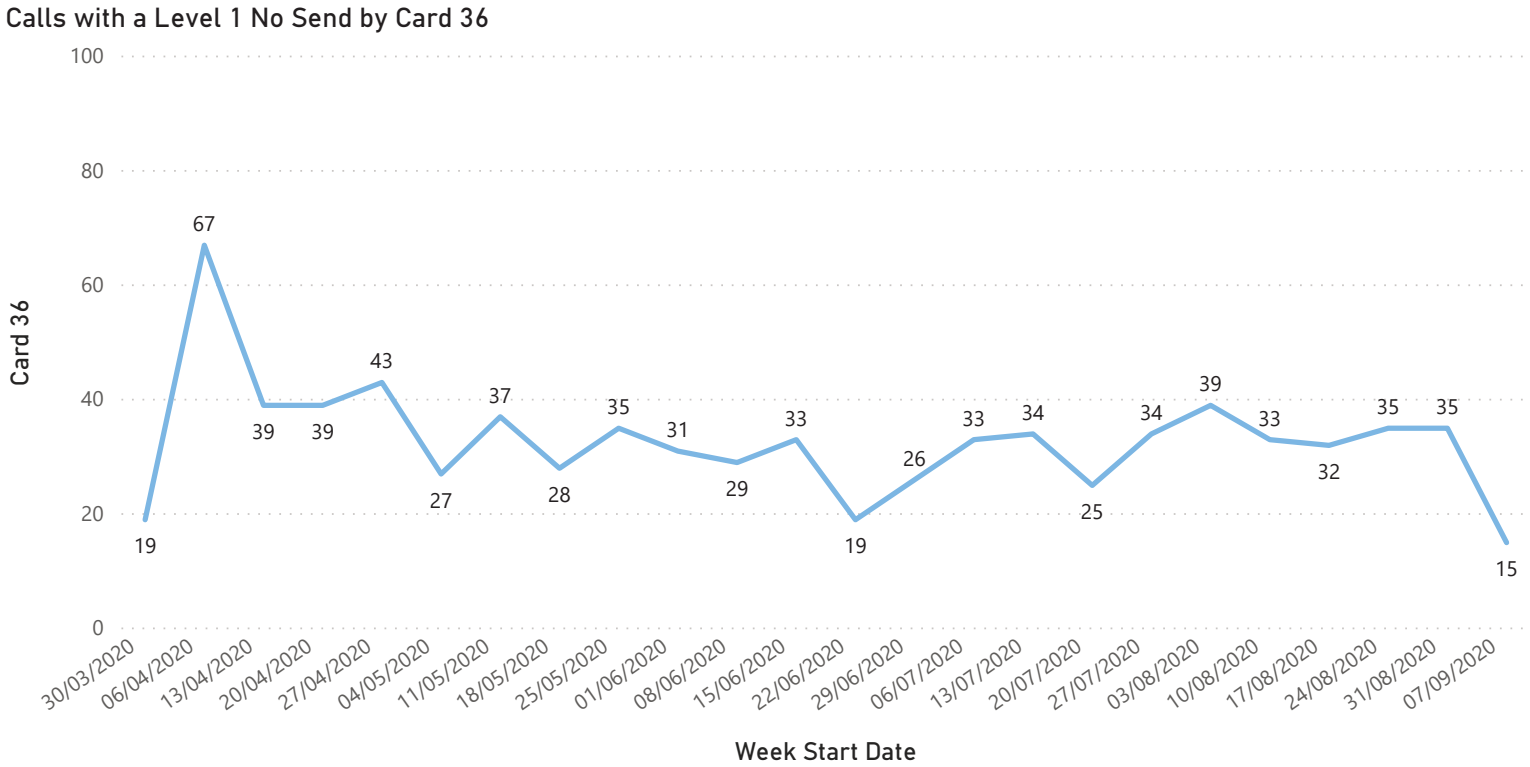


NEAC Suspected COVID-19 Related Journeys



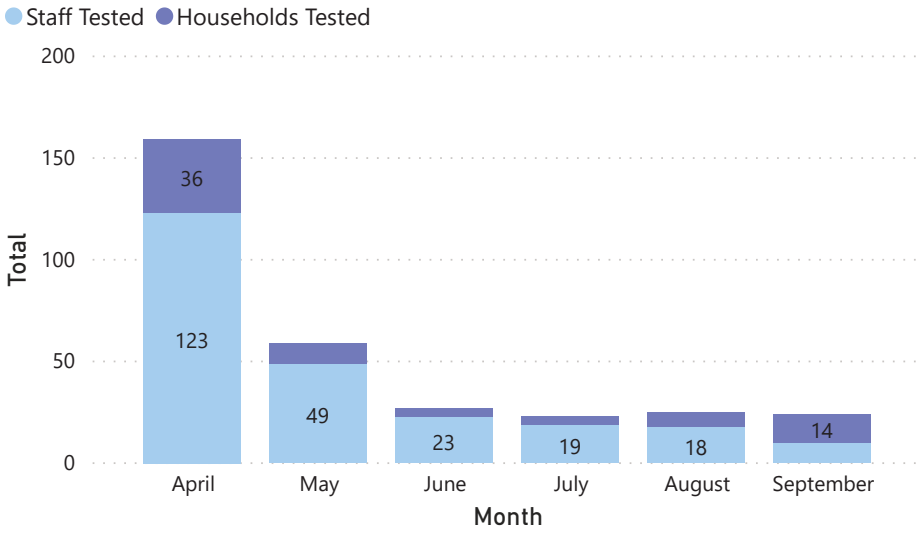
12. EAC Card 36 Suspected COVID-19, Level 1 No Send for Cat 5 Calls (Card 36 was Implemented on 03/04/2020)



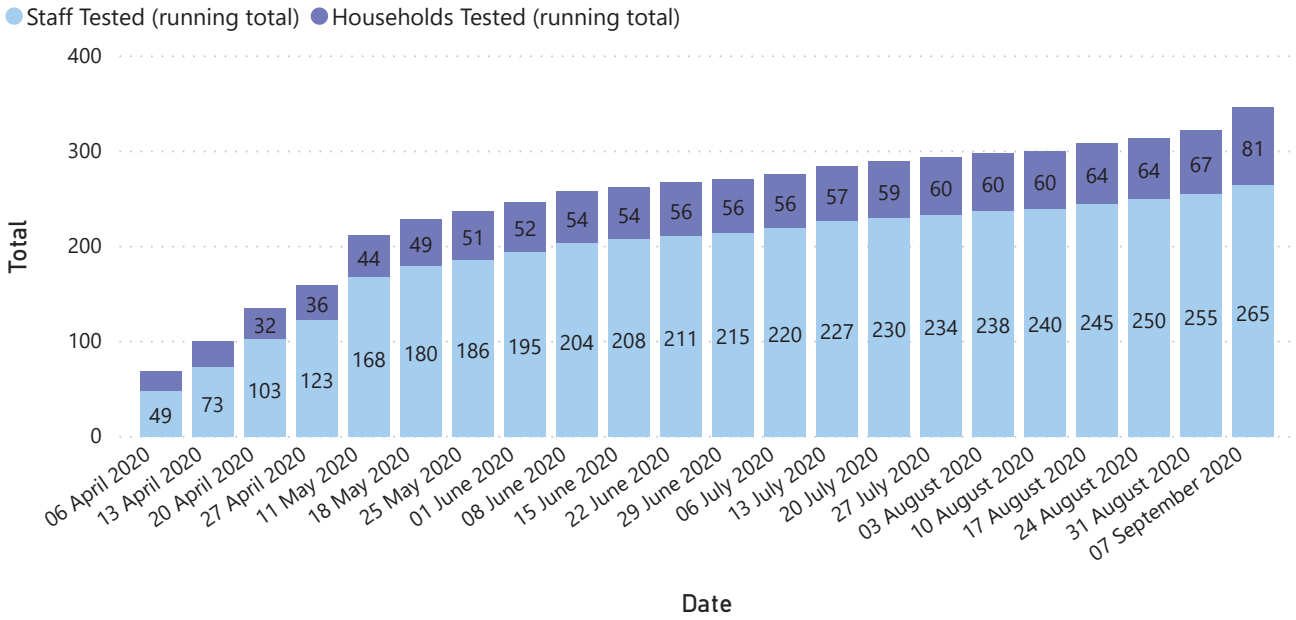


13. NIAS COVID-19 Swab Testing

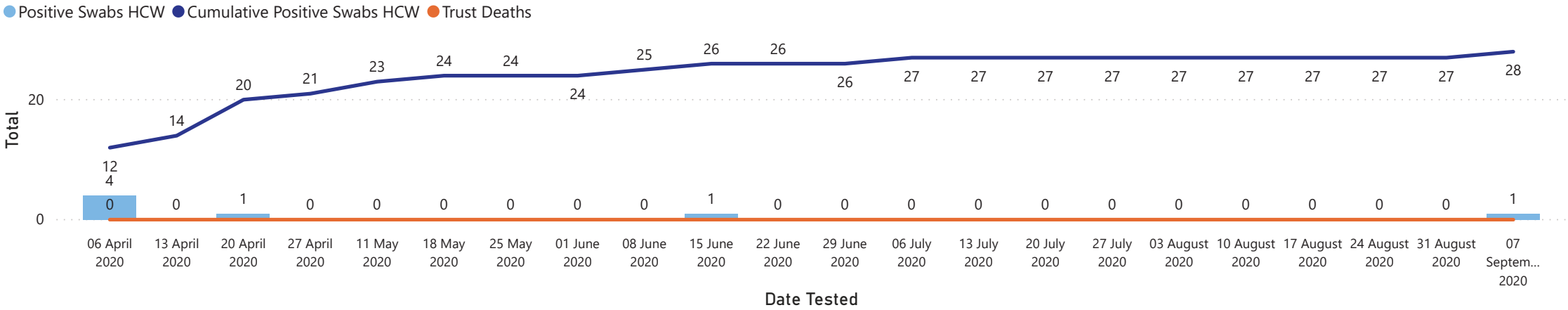
Staff Tested, Households Tested, Monthly Positive Swabs HCW Totals



Staff Tested, Households Tested, Daily & Cumulative Positive Swabs HCW

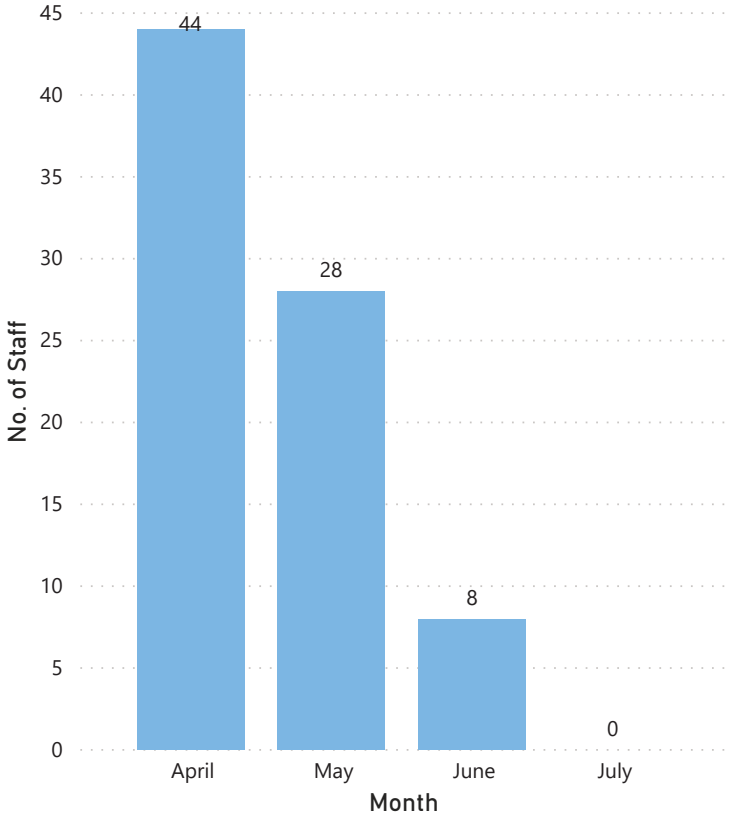


Staff Tested, Households Tested, Daily & Cumulative Positive Swabs HCW

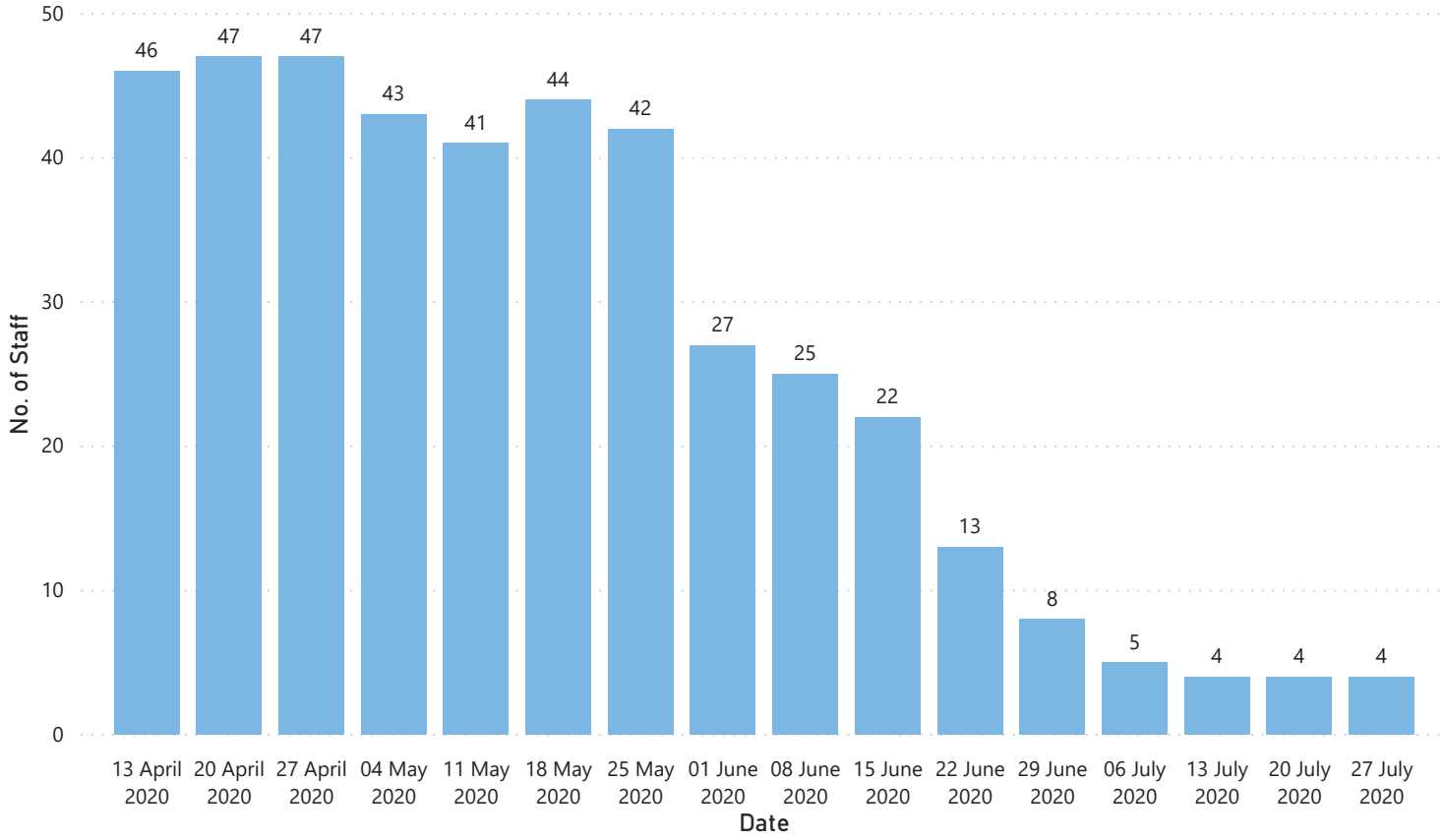


14. Emergency Accommodation Requests

Monthly Total Number of Staff in Accommodation (as per month end date)



Number of Staff in Accommodation (as per the week start date)



TB/01/10/2020/06

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	1 October 2020
Title of paper:	NIAS Future Surge & Winter Resilience Plan 2020/21
Brief summary:	The NIAS Plan outlines initiatives required to help respond to additional demand pressures arising during winter 2020-2021 and/or through any subsequent waves of Covid-19 Pandemic. The plan is structured under the following four areas: • Operational Resilience • Supporting Timely Discharge • Improving Patient Flow Across Trust Boundaries • Hospital Turnaround
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	n/a
Prepared and presented by:	Ms Maxine Paterson Director of Planning, Performance & Corporate Services
Date:	24 September 2020

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust plan to address subsequent Covid-19 Pandemic Surge and Operational Winter Resilience 2020/2021

Northern Ireland Ambulance Service

September 2020

Northern Ireland Ambulance Service
Health and Social Care Trust

Contents

1.0 Executive Summary

The Northern Ireland Ambulance Service Plan outlines initiatives required to help respond to additional demand pressures arising during Winter 2020/2021 and / or through any subsequent waves of Covid-19 Pandemic.

The plan is structured under the following four areas:

- Operational Resilience
- Supporting Timely Discharge
- Improving Patient Flow Across Trust Boundaries
- Hospital Turnaround

2.0 Introduction

The Northern Ireland Ambulance Service (NIAS) experiences significant operational challenges throughout the year due to a range of factors, but primarily the significant increases in demand over recent years which have not been matched with corresponding increases in capacity. This shortfall in capacity was recognised in the Demand and Capacity Review carried out in 2017 which informed the development of the proposed new Clinical Response Model.

The Winter period brings specific challenges and is a particularly busy period for the wider Health and Social Care (HSC) system and NIAS. Increased 999 activity, increased staff absence, handover delays at acute hospitals and reduced services in the wider health economy all affect our ability to respond to patients quickly. Delayed turnarounds at hospital meant that the 30 minute handover standard was only met in 29% of cases in 2019/20. This equates to over 40,701 total operational hours lost, which is an average of 111 operational hours lost per day during 2019/20.

For those reasons outlined above coupled with the impact of COVID-19 on our workforce, overall NIAS staffing levels are below the required level as we enter the winter period, with a subsequent over-reliance on overtime to provide the service. A much-needed

programme to recruit extra staff is on-going, however this in itself presents operational challenges as staff develop and move into posts of a higher grade and thus leave gaps in other parts of the service.

In addition, the COVID-19 pandemic has brought additional pressures with the need to provide adequate Personal Protective Equipment (PPE) for staff, and the impact of social distancing on our services, such as reducing capacity in our Non-Emergency Vehicles which has an impact on our carrying capacity for patients attending Outpatient appointments. There are a range of staff who are not on front-line duties due to underlying conditions and this and the continued spread of the disease with the need for contract tracing are causing further gaps in rotas.

While significant efforts continue on an ongoing basis to provide maximum shift cover across Northern Ireland within available resources, including substantial use of voluntary and private ambulances to supplement capacity, the additional pressures associated with the winter period are not expected to be any less than in previous years given the challenges briefly outlined above. Protecting the 999 response capability must continue to be our primary focus if we are to deliver a safe service as a minimum, over the winter period.

This plan describes the key strategic and operational actions NIAS will take during Winter 2020/21 to maintain safety, quality and performance, and contribute to the wider unscheduled care system. It has been developed taking account of the experience and learning from previous winters and in conjunction with the other HSC Trusts and other partners in healthcare delivery. In addition, the pressure of the COVID-19 pandemic has added new complexity to planning because of the likelihood of a future surge.

3.0 Planning Principles

NIAS has adopted the following principles in preparing this surge plan as outlined in the Regional Covid-19 Pandemic surge planning strategic framework:

- Patient safety remains the overriding priority.

- Safe staffing remains a key priority and Trusts will engage with Trade Union side on safe staffing matters in relation to relevant surge plans.
- Trusts should adopt a flexible approach to ensure that 'business as usual' services can be maintained as far as possible, in line with the Rebuilding HSC services Strategic Framework. This should allow Trusts to adapt swiftly to the prevailing COVID-19 context.
- It is recognised that there will be a fine balance between maintaining elective care services and managing service demand arising from COVID-19 and winter pressures. Addressing COVID-19 and winter pressures will take priority over elective care services, although the regional approaches announced such as day-case elective care centres and orthopaedic hubs will support continuation of elective activity in the event of further COVID-19 surges.
- The HSC system will consider thresholds of hospital COVID-19 care, which may require downturn of elective care services.
- Trusts Surge Plans, whilst focusing on potential further COVID-19 surges, should take account of likely winter pressures.
- Trusts should plan for further COVID-19 surges within the context of the regional initiatives outlined in the Surge Planning Framework.
- Trusts should as far as possible manage COVID-19 pressures within their own capacity first. Should this not be possible, Trusts are required to make use of the regional Emergency Care facility at Belfast City Hospital or the regional 'step down' facility provided at Whiteabbey hospital, as appropriate. Trusts will also consider collectively how they will contribute staff resources to support Nightingale hospitals when necessary.
- The Department, HSCB, PHA and the Trusts will closely monitor COVID-19 infections, hospital admissions and ICU admissions to ensure a planned regional response to further COVID-19 surges. This will support continued service delivery.
- The Department will, if COVID-19 infection rates and other indicators give cause for action, recommend further tightening of social distancing measures to the Executive.

4. Challenges

COVID-19 global pandemic has presented the health and social care system with a number of unique challenges which have dramatically changed the way services were delivered for various reasons and has had significant impact on clinical, patient and staff safety.

The key purpose of our response to the COVID-19 pandemic is to work together to reduce the impact on life preserving services by protecting the following key functions which will remain the focus of the organisation during the period of the pandemic.

- Emergency call handling
- Prioritising emergency calls
- Emergency vehicle dispatch
- Emergency vehicle availability (incl. fleet and resourcing)
- Protection of EAC and adequate staffing in both EAC and front line emergency vehicles is paramount
- Staffing in our Resource Management Centre is essential.

Some of the key challenges in implementing our winter resilience plans and COVID-19 surge plans include:

- **Planning** assumptions for a pandemic outbreak are complex as it is difficult to anticipate how significant the impact will be and external influences are largely unpredictable. In keeping with the UK Coronavirus Action Plan NIAS aims to gather as much information and intelligence as possible to ensure that planning assumptions remain measured and focused. Intelligence is provided by our Informatics Department on a daily basis in relation to predicted call volume and the potential impact of 'calming measures '. A **daily statistical report** is regularly compiled which identifies potential COVID-19 related calls as well as highlighting areas of higher demand and potential future pressures and trends. Whilst demand remains unpredictable we focus on our ability and capacity to respond based on the staff we have available and the other available resources such as Voluntary and Private Ambulance capacity.

- **Service delivery pressures arising as a consequence of normal winter ailments including Seasonal flu prevalence as well as any covid-19 outbreak** will be alleviated through the flu vaccination programme and the population 'buy-in' to the measures to limit Covid-19 spread including downloading the Stop Covid-NI contact tracing app.
- Continuing to **maintain effective Covid-19 social distancing** in line with Infection Prevention and Control advice and guidance, to safely manage contingency spaces for Emergency Ambulance Control (for example).
- Assessing **workforce** pressures including the ability to safely and appropriately staff all services taking into consideration the impact of local cluster outbreaks within staff groups. Also factoring the need for staff to take planned annual leave especially as we approach the autumn and winter period, and flexible working necessary to support childcare and caring commitments. We must also continue to ensure our staff are rested, feel supported and valued, and that we managing the workforce resources required for testing and swabbing to maintain patient and staff safety in respect of spread of infection.
- Our **transport infrastructure** has been assessed for its limitation to support the required social distancing. This presents significant challenges particularly for our Patient Care Service and includes a reduction in carrying capacity and productivity which is increasing reliance on Voluntary and Private Ambulance services.
- Establishing sustainable **new models for 'swabbing' and 'testing'** of health care workers and patients as part of our ongoing response to Covid-19 is essential to being alert to any potential local clusters of Covid-19 outbreaks.
- Attaining and sustaining a **reliable supply of critical PPE** to enable us to safely cope with seasonal demands plus any covid-19 surges. In this plan the Trust has assumed a supply of PPE to meet the anticipated activity levels. The Regional PPE group will inform all Trusts if there are challenges with critical supplies the Trust will be advised and adjustments may be required.
- Enhanced Vehicle **Cleaning** has been arranged in all divisions. In some Divisions this means operating cleaning activities over extended hours and/or bringing in extra cleaning staff. Enhanced Station Cleaning and cleaning of other NIAS Estate including EAC and NEAC has been extended under the leadership of the Facilities Manager.
- We are mindful of our commitment to **engagement and partnership working** and this continues as we prepare to implement for seasonal resilience and emergency decisions that may need to be taken rapidly in event of any future Covid-19 surge.
- Providing continued support to **staff** including those who were and may again be 'shielding', vulnerable people, and people at risk of harm; providing Peer Support and other support services will continue to be important.

- Rebuilding services safely in some areas is anticipated to require **capital and revenue funding consequences** that will be subject to securing DOH approval. This is also the case of the additional services we need to put in place for the anticipated increase in activity during the winter season and any future Covid-19 surge. Approval timelines for additional resources will impact on deliverability.

Impact of Regional Rebuild

There are significant changes being considered across Health and Social Care under the auspices of the Department of Health's Regional Rebuild Management Programme. All of these are heavily reliant on Ambulance Capacity. With additional changes to hospital site reconfiguration or service models, it is imperative that NIAS has the required capacity to respond to calls for emergency transfers between sites and Non-Emergency conveyancing to and from different hospitals.

It is also important that these plans build in the required Ambulance capacity to support transfer of patients to and from sites which may need longer journey times or which may necessitate changes in activity from unscheduled to scheduled. This will require the appropriate staffing resources for the NIAS Patient Care Service.

The Urgent and Emergency Care reconfiguration also aims to reduce footfall in EDs with plans to increase telephone advice and scheduling of onward appointments. In order to maximise the benefit of these pathways, NIAS will continue to develop the telephone triage Clinical Support Desk in Emergency Ambulance Control in line with available funding.

5. Responding to Winter Pressures

NIAS anticipates that seasonal increases in demand especially during Winter will have an impact on service delivery. Any surge in people with Covid-19 needing access to care and hospital admission will add even more pressure to the unscheduled & emergency care system.

In order to respond to this, NIAS has worked with other partners across HSC to create a combined resilience plan to include response to future surges of COVID-19 and winter pressure.

6. Resilience plan actions

The NIAS COVID-19 Surge/Winter Resilience Plan 2020/21 focuses on four themes:

- Operational Resilience
- Supporting Timely Discharge
- Improving Patient Flow Across Trust Boundaries
- Hospital Turnaround

6.1 Operational Resilience

Operational Resilience

Implementation of Demand Management Plan and Resource Escalation plan

NIAS has improved its management of demand pressures with the implementation of a Resource Escalation Action Plan (REAP) adapted from the National REAP document developed in consultation with all UK Ambulance Trusts and the National Ambulance Resilience Unit. This went 'live' in March 2019. A national approach to demand planning enables a consistent approach to patient

safety, risk, system and resilience understanding at times of pressure. It provides system partners and stakeholders with a clear visual representation of the issues faced and actions being considered.

Our capacity and ability to respond is considered weekly by NIAS to assess the expected operating level for the next seven days, with the ability to change this level based on information or intelligence between meetings. REAP is the strategic tool used to mobilise organisational action. Depending on which of the four levels that NIAS is operating on, there are a range of actions which may be taken. In addition, NIAS operates a Demand Management Plan or Surge Plan (DMP) to manage day-to-day variation to demand. These plans operate at a tactical level.

The Operations Directorate also host a daily teleconference 'Huddle' in which senior managers from across the service participate. Since the COVID-19 pandemic started, this Huddle includes a link with the Personal Protective Equipment (PPE) team and other relevant COVID-19 response functions when relevant. Alongside this daily sharing of information, new meeting structures have been implemented that enable the full range of matters to be discussed and responded to, at the appropriate levels and appropriate time. This includes meetings with other Trusts and meetings facilitated by the Health and Social Care board (HSCB).
Demand Management and REAP Actions which we may choose to implement include pausing training, redeploying of officers and training staff onto front-line duties and authorising the additional use of independent and voluntary ambulance services.

Planning of staff leave (Absence)

The NIAS Resource Management Centre (RMC) is responsible for monitoring compliance against commissioned hours for Operations including the Control Centres. All requests for operational staff leave are co-ordinated through the NIAS Resource Management Centre with any shortfalls filled with voluntary and private services where possible. We must manage leave appropriately to ensure staff have much needed rest to build longer-term resilience. We also have to monitor COVID-19 related leave.
EAC are planning to recruit an additional cohort of emergency call takers and they will be operational in time for January 2021 which will further increase resilience during this busy period.

Maximising the uptake of flu vaccination

NIAS successfully introduced a “Peer Vaccination Programme” over the past few years. NIAS Paramedics can administer the Flu Vaccine to eligible staff at their base locations and a small team of Paramedics provide mobile Flu Vaccine clinics to all eligible staff.

This has improved the levels of staff uptake for the flu vaccination from 35% in 2017/19 to over 50% 2018/19 and 62% in 2019/20. NIAS will build on the approach taken in previous years and support the wider HSC in delivery of their Flu Vaccination plans in line with best practice set out by DOH.

Extending Clinical Support Desk

The role of the Clinical Support Desk (CSD) within Ambulance Control will be developed to provide appropriate clinical advice to a greater range of 999 calls. The staffing levels of the CSD will increase to enable longer working hours – aiming for 24 hour cover 7 days a week when practical. Work continues on introducing additional Healthcare Professionals such as Mental Health Professionals and Nurses into the CSD to expand the range and types of 999 calls assessed as suitable for referral to the CSD.

What does this mean for me?

We may change our responses to calls coming into Ambulance Control which may mean that you are asked if you are able to transport yourself or your relative to the Emergency Department if clinically safe to do so. We may signpost you to other Healthcare Services which are considered appropriate for your needs.

6.2 Supporting Timely Discharge

Supporting Timely Discharge

Coordination of hospital non-emergency transport for discharges

In previous winters we have worked closely with other HSC Trusts to add extra discharge capacity with additional resources and co-ordination with our Patient Care Service (PCS).

PCS provide transport to support the discharge of some high-dependency patients home. This is critical to supporting the wider system and patient flow which releases beds for service users. We have established a specific ambulance control function to oversee coordination of increased inter-hospital transfers and discharges to reflect the importance of these functions during times of system pressure. Whilst we have plans to do the same this winter, if we reach certain levels of Emergency Ambulance demand with a shortfall in our resources, for the reasons explored above, this may affect our ability to be responsive to discharge and inter-hospital transfer requests.

What does this mean for me?

Your discharge from hospital by NIAS, may be delayed or you may be carried home by a Voluntary or Private Ambulance

6.3 Improving Patient Flow Across Boundaries

Improving Patient Flow Across Boundaries

Equalise Unscheduled Care Pressures across Emergency Departments

NIAS will continue to coordinate smoothing to equalise unscheduled care pressures across the region through continuous monitoring of ED activity and regular contact with hospitals. This may mean NIAS officers monitoring the flow to different hospitals and making temporary decisions to direct ambulances to a different hospital site than usual.

NIAS will also continue to work with partners to put in place any temporary ambulance diverts agreed between Trusts.

Engagement with Primary Care and maximising NIAS Appropriate Care Pathways

NIAS has a range of Appropriate Care Pathways offering alternatives to the Emergency Department through treatment in the community or providing an alternative destination to address their clinical need. NIAS is increasing its partnership working across the region with other Healthcare Professionals including Trust based Mental Health Professionals, Occupational Therapists, Out of Hours Providers, GPs and the PSNI with the aim of improving out of hospital interventions for a range of conditions and enhance the interventions available for the existing pathways.

We will continue to maximise the opportunities associated with this work to minimise unnecessary ED attendances and support service users to access the service they need more quickly.

In addition, as outlined above, some of the COVID-19 reconfiguration work may mean longer journey times for NIAS and reliance on ambulances to transfer patients between hospitals in an emergency.

What does this mean for me?

If we implement 'smoothing' to help ease demand pressure in one Emergency Department this may mean you are taken to

a different hospital than usual. We may utilise our Appropriate Care Pathways to refer you to a specialist service other than the Emergency Department. You will be advised that if you are concerned or if your situation deteriorates that you should call 999 for further assistance.

6.4 Hospital Turnaround Times

Hospital Turnaround

Improving Ambulance Turnaround times

Delayed turnaround times continue to present a significant challenge. This results in much needed ambulance resources being unavailable to respond to urgent calls in the community leading to increased response times with the associated risks.

In order to mitigate against this, during 2020/21, NIAS will continue to work with EDs to develop local solutions to improve hand over times, based on 4 key principles:

- The patients in the urgent care pathway who are at highest risk of preventable harm are those for whom a high priority 999 emergency call has been received, but no ambulance resource is available for dispatch.
- Acute Trusts should always seek to accept handover of patients within 15 minutes of an ambulance arriving at the ED or other urgent admission facility (e.g. medical/surgical assessment units, ambulatory care etc.).
- Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel is inappropriate.
- The patient is the responsibility of the ED from the moment that the ambulance arrives at the ED.

Hospital Ambulance Liaison Officers (HALOs) in Emergency Departments

The function of HALOs in hospital sites is to liaise with ambulance crews and clinical hospital staff/managers to ensure:

- NIAS hand over patients into the care of hospital staff as safely and quickly as possible, then make ready and clear, protecting NIAS capacity to responds to 999 calls and major incidents.
- Work collaboratively with Trust ED Teams in optimising patient flow within the ED departments.

NIAS has made an additional number of HALO posts permanent and already due to pressure increased HALO hours of operation at the Ulster Hospital. We intend to increase HALO hours over the winter months to support staff.

What does this mean for me?
This means that we will continue to work with Trusts to ensure that ambulance patients do not wait a long time for handover.

7. Wider health and social care impact

It is acknowledged that any future waves of COVID-19 pandemic would have a significant impact on the ability to deliver the Trust phase 3 Rebuild Plan. The Trust will continue to apply the regionally agreed rebuild planning principles to decision making to:

- Ensure equity of access for the treatment of patients across Northern Ireland;
- Minimise the transmission of Covid-19; and
- Protect the most urgent services.

Northern Ireland Ambulance Service
Health and Social Care Trust

TB/01/10/2020/07

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	1 October 2020
Title of paper:	NIAS Rebuilding Services Phase 3
Brief summary:	Phase 1 (covering June 2020) of the Rebuilding HSC Services was noted at the Trust Board meeting on 27 May and Phase 2 (covering July – September 2020) was noted at the August meeting. Phase 3 relating to October 2020 was submitted to the DoH on 18 September and is before Trust Board for information.
Recommendation:	**For Approval** ☐ **For Information** ☒
Previous forum:	n/a
Prepared and presented by: **Date:**	Ms Maxine Paterson Director of Planning, Performance & Corporate Services 24 September 2020

NI AMBULANCE SERVICE- REBUILDING HSC SERVICES PLAN- PHASE 3- OCTOBER 2020

To consistently show compassion, professionalism and respect to the patients we care for.

The Minister of Health, Robin Swann, launched his 'Strategic Framework for Rebuilding Health and Social Care Services' in the Assembly on 9 June 2020. Using the strategic framework, the Northern Ireland Ambulance Service Trust (NIAS) published phase 1 and 2 plans on 10 June and 10 July 2020 respectively. The plans examined the steps, which NIAS would take to assess the first phase of rebuilding our services while charting a way forward, initially, to the end of June. The phase 2 plan covered the period from 1 July to 30 September 2020.

The phase 3 plan presents a number of challenges; whilst we continue to move forward to restore services a number of constraints remain within our environment. We have pressures around our workforce capacity and the impact of safety measures that were implemented to protect staff and patients have limited our resource capacity in our emergency response and non-emergency patient care services.

Plans to fully restore services are also dependent on NIAS' ability to protect staff and patients from a possible second surge of Covid-19, coupled with managing the pressures associated with winter, and the demands this can place on service delivery. The winter period brings specific issues; a busy period for the wider Health and Social Care (HSC) system and NIAS. Increased 999 activity, staff absence, hand-over delays at acute hospitals and reduced services in the wider health system all affect our ability to respond to patients quickly. Understanding the associated risks, NIAS have developed a plan to manage a potential surge and winter pressures and may need to initiate this quickly to manage the safe delivery of our service which will impact on our ability to deliver the rebuilding agenda.

Our staff have been the main reason that we managed the Covid-19 response effectively since March 2020. They will play a key role in managing our future response and protecting them remains our priority. It is important that we recognise that many staff have worked determinedly for months, without rest, and we must protect their health to ensure the resilience of our service during the winter season.

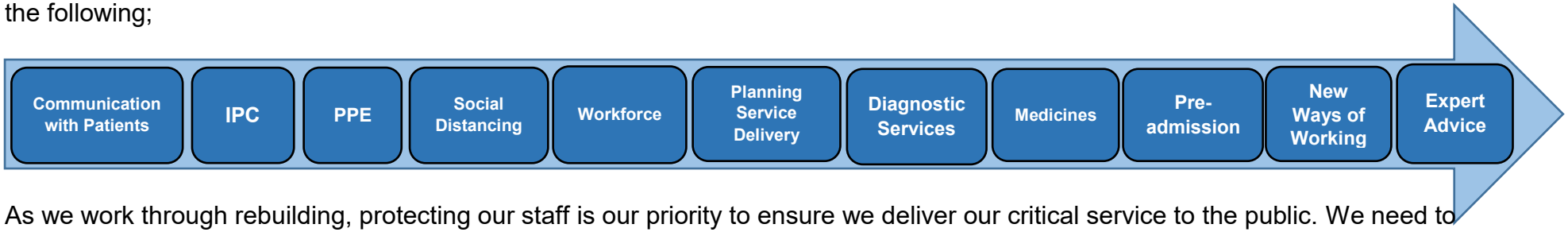
As we move forward to rebuild services we will continue to engage with our patients, service users and staff. We will work together with our partners across Northern Ireland to implement transformation and contribute to the regional areas of focus to support the HSC in delivering our regional rebuilding agenda with an approach which;

- Ensures Equity of Access for the treatment of patients across Northern Ireland;
- Minimises the transmission of Covid-19; and
- Protects the most urgent services.

Our plans consider of a range of factors:

- Ensuring rebuild plans focus on mitigating the highest level of risks to patients and staff;
- Considering safety and risk in respect of ensuring both an effective ongoing response to Covid-19, and the need to rebuild services on an equitable basis for the Northern Ireland population;
- Ongoing internal discussion and agreements to rebuilding plans, delivering on our commitment to co-production and engagement with our HSC partners and other relevant stakeholders to bring informed involvement in key decision-making;
- NIAS' local risks and challenges that include significant infrastructure issues;
- First Responder partner agency plans i.e. NIFRS and PSNI; and
- Issues and evidence that affects the Trust, which include new guidance, policies, legislation and governance arrangements.

We assess our plans against the Department of Health's framework and checklists before and during implementation and integrate the following;



As we work through rebuilding, protecting our staff is our priority to ensure we deliver our critical service to the public. We need to manage key constraints and limit the impact these have on our workforce and patient care;

- Health and Safety requirements, including maintenance of social distancing guidelines and the availability of PPE;
- Enhanced cleaning, clinical and non-clinical areas and infection control as protection to the spread of the virus;
- New models for staff testing and tracing potential outbreaks;
- Workforce availability and flexibility across 7 day service including requirement for staff leave;
- Rebuilding normal service capacity whilst retaining Covid-19 readiness; and
- Physical space to meet safety requirements and the impact on the delivery of our service.

We have adopted an incremental approach to ensure these risks are managed appropriately. As we work to deliver services for those most in need, our absolute priority will be to keep our patients and staff safe.

What will this look like for patients?

- The way services are delivered may look and feel different. Examples of what patients and service users may be able to expect are outlined below and elements of this may form part of our public messaging during Phase 3:
- Members of the public who need an ambulance response should phone 999 as usual;
- We recognise that some of our service users may be concerned about travelling to hospital. We will continue to encourage patients who need to travel to hospital by ambulance to do so;
- Staff will be wearing masks and other protective covering to keep both patients and themselves safe;
- We will use our ambulances in a way that ensures social distancing guidelines are observed. This will mean a reduction in our capacity for non-emergency journeys;
- We may ask patients to wear a mask; and
- The configuration of Emergency Departments in other Trusts may mean patients are taken to a different Emergency Department than they might usually attend.

Looking ahead

In this third phase, we will continue to build on new ways of working and innovations to provide safe and effective care. We have been reflecting on our response to Covid-19 and reflecting on our successes and what we can improve. This learning and sharing of best practice is informing our longer-term operational, strategic and financial planning as well as the wider regional priorities. We will also continue to engage with key partners to ensure that plans are representative of and include the valuable input of those who use our services.

It is important we recognise the funding implications and stress the necessary on-going and additional funding required to achieve our objectives i.e. the Clinical Triage infrastructure and re-instatement of Complex Case support. We have not included detail regarding the finances required to deliver this plan however, it is important to reflect the cost implications of its delivery.

The following table outlines the NIAS' Phase 3 Rebuilding Plan, post October 2020.

Our Services	What did we do during Covid-19 pandemic?	What did we do to rebuild services June 2020? (Phase 1)	What are we planning to do to rebuild services July to September 2020? (Phase 2)	What are we planning to do to rebuild services post October 2020?
Corporate	❖ Communicated with patients to support them with appropriate use of our services.	❖ We have developed a communication plan to encourage the public to continue to use our services appropriately and to reassure the public of our continued efforts to deliver safe services.	❖ Continue to deliver messages to the public and service users to keep them informed.	❖ Continue to deliver messages to the public and service users to keep them informed
	❖ Recruitment to NIAS was modified during this time.	❖ We restarted recruitment processes on a priority basis.	❖ Continue to scale up recruitment processes based on corporate and strategic plans, subject to funding.	❖ Restore all recruitment activity prioritising plans scale up resources as appropriate.
	❖ Supported the HSC with information to direct resources to most vulnerable patients.		❖ Assess the long-term benefits of information analysis commenced during COVID-19 response and its impact to service configuration across the HSC e.g. Nursing Home data.	❖ Continue to deliver strategic information to the HSC to support longer term modelling and future planning.
	❖ Implemented range of front-line peer support mechanisms.		❖ Assess options to sustain peer support for staff to maintain resilience and well-being in the longer term.	❖ Continuity of approach, subject to ongoing review, including ongoing alignment with core work strategy
		❖ Commenced targeted engagement with front-line staff to ensure the incorporation of relevant learning into our delivery model in collaboration with Trade Unions.	❖ Implement the learning and feedback from staff across the organisation to sustain innovative practices begun during COVID-19 response.	❖ Continue to implement learning and feedback from staff across the organisation.
	❖ Engaged with ROI and UK Ambulance partners to ensure		❖ Engage with partners to ensure the adoption of national ambulance	❖ Reflect on the impact of adoption of enhanced

Our Services	What did we do during Covid-19 pandemic?	What did we do to rebuild services June 2020? (Phase 1)	What are we planning to do to rebuild services July to September 2020? (Phase 2)	What are we planning to do to rebuild services post October 2020?
	implementation of national best practice and the sharing of information to support effective response. ❖ Suspended all programmes associated with REACH to re-deploy resources to operational support structures.		service guidance, standards and protocols are adopted to maintain consistent safe and effective care. ❖ Ensure any relevant learning is incorporated into implementation of the new Electronic Patient Record, which will significantly transform clinical practice and NIAS' partnership with the wider HSC.	standards and protocols on patient outcomes. ❖ Continue to progress with the roll out of mobile devices for staff and introduction of electronic patient records
Operations	❖ Preserved front-line ambulance response by maintaining at least 90% staffing levels by re-deploying all staff in training for Paramedic or Associated Ambulance Practitioner courses and making appropriate use of independent and voluntary sector where appropriate.	❖ We re-instated training where appropriate whilst ensuring the maintenance of our emergency response resources.	❖ We will complete training for existing students and start two new trainee AAP cohorts to build our workforce capacity. We will work closely with the Ulster University to recommence FdSc paramedic education.	❖ Plans will continue, with the Paramedic FdSc cohort that recommenced on 1st September Two AAP cohorts that commenced in August will continue to be delivered
	❖ Adapted ambulance response to support the re-configuration of Trust services to meet increasing numbers of COVID-19 patients.	❖ Modified destination protocols have been reviewed and adapted to meet Hospital Trusts planning for re-instatement of services.	❖ Continue to liaise with HSC Trusts regarding impact of longer journey times and associated service changes on NIAS and ensure any resource requirements and/or risks are identified.	❖ Previous actions will continue and in addition Area Managers are represented on Local Implementation Groups with regard to Unscheduled Care Network.
	❖ Extended hours of operations for management support to frontline staff.	❖ We stood down extended managerial support however we monitored activity through twice daily huddles Monday – Friday to assess need to re-establish this support.	❖ The need for additional managerial support will be carefully monitored.	❖ Advertise Station Officer positions and extend Supervisor positions

Our Services	What did we do during Covid-19 pandemic?	What did we do to rebuild services June 2020? (Phase 1)	What are we planning to do to rebuild services July to September 2020? (Phase 2)	What are we planning to do to rebuild services post October 2020?
	❖ Re-deployment of Covid-19 vulnerable staff to non-patient facing roles so they could continue to support infection prevention control and staff welfare functions.	❖ We established processes based on national and regional guidance to assess risks to frontline staff who have been identified as vulnerable to the impact of Covid-19.	❖ We will develop processes to support these staff and their managers in line with the emerging guidance in order to support their safety and enable their contribution to NIAS as appropriate.	❖ In line with national and regionally agreed guidance and protocols, continue to support vulnerable staff to return to patient-facing or non-patient facing roles to enable their continued contribution to NIAS.
Control	❖ Implemented new triage protocols to support resource escalation response.		❖ Evaluating the outcome and benefits of new protocols for telephone triage and thresholds for ambulance dispatch.	❖ Implement a Demand Management Plan within EAC to assist in managing periods of high demand.
	❖ Increased usage of Hear and Treat/See and Treat response to service users.		❖ Investigate how to sustain enhanced Clinical Triage via phone by a larger group of NIAS clinicians.	❖ Complete recruitment and training of additional CSD Paramedics. ❖ Commence recruitment exercise for wider clinical roles to support hear & treat services (i.e. Introduction of mental health nurses)
	❖ Enhanced business continuity infrastructure by implementing contingency control site.		❖ Review benefits of development of multi-site Emergency Ambulance Control provision and implement extended resilience plan.	❖ Ensure benefits of contingency site are implemented.
Patient Care Services	❖ Patient Care Services re-deployed to support Emergency Ambulance Services.	❖ We assessed the level of Non-Emergency resources required in line with Hospital Trusts' requirements.	❖ We will commence the transferring of resources back to Non-Emergency Transport duties on phased basis in line with demand.	❖ Potential further changes to the configuration of PCS in response to winter pressures and any further surge. We continue to use IAS resources on a daily basis to

Our Services	What did we do during Covid-19 pandemic?	What did we do to rebuild services June 2020? (Phase 1)	What are we planning to do to rebuild services July to September 2020? (Phase 2)	What are we planning to do to rebuild services post October 2020?
				supplement resources.
	❖ Voluntary Car Service suspended.	❖ We began to reinstate Voluntary Car Services to undertake outpatient appointments as Trust services i.e. Cancer, Renal and Day Centres scale up with appropriate risk assessment and guidelines in place.	❖ We will continue to carry out risk assessments with Volunteer Drivers to ensure they can return to duties safely, protecting themselves and service users.	❖ We await input and advice from Occupational Health in relation to returning VCS volunteers. It remains our intention to progress as many VCS back to active duty as possible.
	❖ Activity of Voluntary and Private Ambulance services increased to manage additional demand in support of NIAS Emergency Services.	❖ We re-assessed the level of use of Voluntary and Private Ambulances to support A&E Services and began the process of transferring PCS vehicles to Non-Emergency work.	❖ This will be kept under review as demand for non-emergency patient journeys increases in line with hospital and outpatient services is re-configured.	❖ We have returned a significant quantity of PCS to NEAC Control; however a cohort continue to provide additional support to UEC workload. We are recruiting to enhance NEAC management support.
Clinical	❖ Suspension of Community First Responder Schemes.	❖ We reviewed clinical evidence to assess re-instatement of Community First Responder Schemes and determined it should not be re-instated yet.	❖ In line with appropriate guidelines we will continue to risk, assess the potential to re-instate this service with the appropriate guidelines and relevant equipment (e.g., PPE).	❖ Continue to work on the reintroduction of the local schemes through provision and training related to PPE and other issues with intention to return to service during the period indicated.
	❖ Piloted joint plans with PSNI to enhance resilience for first responder services.	❖ Assess impact of the collaboration to consider future opportunities.	❖ Agree framework for collaboration and partnership working to embed learning and knowledge sharing.	❖ Maintain bi-weekly meetings to progress partnership working.
	❖ Stood down Complex Case team for re-deployment in	Team Reinstated	❖ Reinstated team support service users in accessing the most	❖ The team continue to work to support

Our Services	What did we do during Covid-19 pandemic?	What did we do to rebuild services June 2020? (Phase 1)	What are we planning to do to rebuild services July to September 2020? (Phase 2)	What are we planning to do to rebuild services post October 2020?
	response phase.		appropriate care in the community and unlock additional resource capacity.	
	❖ Suspended Helicopter Emergency Medical Service (HEMS) to re-deploy staff to support critical care operations within Hospital Services.	❖ Whilst HEMS was reinstated in April 20, during May and June we delivered a wider response by the HEMS team to non-trauma calls where critical care interventions were required.	❖ We intend to embed the extended role of the HEMs team going forward. Risk assessment will commence regarding reinstatement of the airdesk into Emergency Ambulance Control.	❖ HEMS attending non-trauma calls with pilot in place to review each call. Social distancing in place at MLK and EAC airdesk.

The plan has been developed in conjunction with the multidisciplinary NIAS Recovery Co-ordination Group that includes a wide range of staff and stakeholders. A number of these staff members have liaison roles with the voluntary and private ambulance providers; some represent NIAS on regional and national fora ensuring NIAS' rebuilding plans are in line with the plans of other Trusts, and in line with the emerging evidence base and best practice from across the UK.

NIAS will also contribute to areas of regional focus to support the HSC in the re-configuration of services that meet the needs of the population in the following areas;

- Cancer services:
- Acute Care at home and Care homes
- Planning for further Covid-19 surges
- Rebuilding primary care services & repurposing of Covid-19 centres
- Mental Health and Social Stress
- Screening Services
- Urgent and Emergency Care
- Service Delivery Innovation

We will also continue to engage with key partners to ensure that plans are representative of and include the valuable input of those who use our services. NIAS is committed to its legal duties under Section 75 of the Northern Ireland Act 1998 as detailed in its

approved Equality Scheme and the Rural Needs Act 2016. In terms of assessment of the NIAS Trust Rebuild plan, NIAS will screen for both equality and rurality to identify potential adverse impact

Northern Ireland Ambulance Service Health and Social Care Trust

www.nias.hscni.net