Northern Ireland Ambulance Service
Health and Social Care Trust

A meeting of Trust Board to be held at 10.00am on Thursday 5 March 2020 in the Conference Room, NIAS Northern Divisional Headquarters, 120-130 Antrim Rd, Ballymena BT42 2HD

AGENDA

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1	Welcome & Declarations of Conflict of Interest	
2	Minutes of the previous meeting of the Trust Board held on 30 January 2020 **For Approval**	TB05/03/2020/01
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4	Chair's Update **For Noting**	
5	Chief Executive's Update **For Noting**	
6	Peer Support – presentation **For Noting**	No paper
7	Update on Coronavirus **For Noting**	TB05/03/2020/02
8	Infection Prevention Control – verbal update **For Noting**	TB05/03/2020/03
9	HR Review – verbal update **For Noting**	No paper
10	Directors' Performance Reports (by exception) 10.1 Finance 10.2 Operations 10.3 Medical 10.4 Human Resources/Corporate Services 10.5 CRM Programme - verbal 10.6 Safety & Quality - verbal **For Noting**	TB05/03/2020/04

11 Forum for Questions

12 Date & venue of next meeting: **Thursday 7 May 2020 at 10am in the Boardroom, NIAS HQ**

13 Any Other Business

Standing Orders

This section is designed to provide information extracted from Standing Orders pertinent to the smooth running of the public Board meeting. The full Standing Orders are available for consideration at any time through the Chief Executive's Office or from the website. The excerpts below represent key items relevant to assist with the management of the Public Meeting.

Admission of Public and the Press

3.17 *Admission and Exclusion on Grounds of Confidentiality of business to be transacted*

The public and representatives of the press may attend meetings of the Board, but shall be required to withdraw upon a resolution of the Trust Board as follows:

'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 23(2) of the Local Government Act (NI) 1972'

3.18 *Observers at Board meetings*

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these Terms and Conditions as it deems fit.

PROCEDURE RELATING TO SUBMISSION OF QUESTIONS FROM THE PUBLIC AT NIAS TRUST BOARD MEETINGS

Questions may be put to the Board which relate to items on the Agenda.

Every effort will be made to address the question and provide a response during the meeting at the appropriate point on the Agenda.

If it is not possible to provide a response during the meeting a written response will be provided within seven days.

Questions must be put to the Board in written form and must be passed to the Board Secretary before the item on the Agenda entitled "Forum for Questions".

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

Thursday 5 March 2020 at 10.00am, Conference Room, NIAS Northern Divisional Headquarters, 120-130 Antrim Rd, Ballymena BT42 2HD

TB/05/03/2020/01

Return to Agenda

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 30 January 2020 at 10.00am in the Boardroom, NIAS HQ, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

PRESENT:	Mrs N Lappin	Chair
	Mr T Haslett	Non Executive Director
	Mr W Abraham	Non Executive Director
	Mr D Ashford	Non Executive Director
	Mr A Cardwell	Non Executive Director
	Mr J Dennison	Non Executive Director
	Mr M Bloomfield	Chief Executive
	Ms M Lemon	Interim Director of HR
	Mr P Nicholson	Interim Director of Finance
	Dr N Ruddell	Medical Director
	Mr R Sowney	Interim Director of Operations
IN ATTENDANCE:	Mr B McNeill	Clinical Response Model (CRM) Programme Director
	Ms L Charlton	Director of Safety & Quality Improvement
	Ms S Sellars	Board Apprentice
	Mrs C Mooney	Board Secretary
APOLOGIES:	Ms R O'Hara	Director of HR & Corporate Services

1 **Welcome, Introduction & Apologies**

The Chair welcomed those present to the meeting and advised that apologies had been received from Ms O'Hara.

She welcomed Ms Michelle Lemon, Interim HR Director, who had returned from secondment to the DoH, to cover for Ms O'Hara, and Ms Maxine Paterson who was attending today's meeting to observe business in preparation for taking up post as Director of Planning, Performance and Corporate Services at the beginning of April.

The Chair also welcomed Mrs Mooney, Board Secretary, to her first official meeting.

2 Previous Minutes (TB30/01/2020/01)

The minutes of the previous meeting held on 5 December 2019 were **APPROVED** on a proposal from Mr Sowney and seconded by Mr Ashford subject to the following amendments at Mr Abraham's request:

Page 3, 2nd para – wording to read '… and welcomed the commitment to prevention in the Strategic Plan.'

Page 7, 4th para – Mr McNeill to expand the minute to provide further clarity as to the target, ie the 90th centile.

Page 7, 4th para – Mr Bloomfield to consider wording around NIAS' obligation to transport patients.

Page 11, 8th para – wording to read 'Mr Abraham acknowledged the considerable effort that had gone into this work and welcomed the progress that was now being made.'

Page 17, 4th para – wording to read '… from April onwards.'

3 Matters Arising

3.1 Directors' Performance Reports Human Resources (TB 05/12/2019/07)

Mr Cardwell acknowledged that he had not been present at the December meeting but sought confirmation that, as referred to in the minutes, '… absence levels were back to 2018/19 levels… '.

Ms Lemon undertook to clarify this.

3.2 Action List arising from December Board meeting

The Chair took members through the detail of the action list arising from the December Board meeting.

4 **Chair's Update**

The Chair commenced her update by referring to the Ministerial visit to NIAS HQ which had taken place on Wednesday 29 January. She said that she had been delighted when Minister Swann had accepted NIAS' invitation and added that this had been his first formal visit to a Trust since being appointed Minister.

The Chair said that the Minister had had an opportunity to meet with some paramedic students and had spent some time in the Control Room. She emphasised the benefit of the Minister hearing about the crucial role of NIAS in the transformation agenda and the challenges facing the Trust.

Continuing her update, the Chair advised the meeting that the Board would be joined at lunch by four graduates from the Foundation Degree Programme who had not been able to attend the graduation ceremony on 5 December but who would be presented with their certificates today.

The Chair referred to the emergency planning scenario held after the December Board meeting and said that it was a worthwhile and interesting event.

Concluding her remarks, she mentioned that, since the December meeting, both Mr Bloomfield and Ms Sellars had been on ride-ons with staff and she invited Ms Sellars to comment.

Ms Sellars advised that she had accompanied Stella Simpson in a RRV and said she had welcomed the opportunity to see how strategic decisions made at Trust Board level affected staff operationally. Ms Sellars said the professionalism and respect shown by staff to patients was outstanding while at the same time ensuring patients received the necessary care and treatment.

The Chair's update was **NOTED** by members.

5 **Chief Executive's Update**

Commencing his update, Mr Bloomfield advised that, during December and January, work had continued to address the outstanding Internal Audit recommendations. He added that this

work had culminated in a cross Directorate workshop to examine the outstanding recommendations and believed that progress had been made.

Mr Bloomfield advised that much of December and early January had been taken up with planning for and managing the industrial action. Meetings had continued with Trade Union colleagues as well as with colleagues from the DoH, HSCB and other Trusts to ensure that, on the days of industrial action, the Trust was able to maintain service delivery. He indicated that, as a result of this concerted focus on industrial action, most other meetings and events were postponed. Mr Bloomfield reported that the day of industrial action, ie 18 December 2019, had been managed well and he believed this was a result of good planning and effective working with Trade Union colleagues.

Continuing, Mr Bloomfield said that significant discussions had taken place with Trade Unions in relation to which services would be categorised for derogation. He explained that this in essence meant which services would be exempt from industrial action. Mr Bloomfield said that Trade Union colleagues had agreed that they would respond from the picket lines to Cat 1 and 2 calls and added that the arrangements put in place had worked effectively and allowed staff to respond without delay.

Mr Bloomfield reported that emergency call takers had advised members of the public that, due to industrial action, it would take longer to respond to their call and patients were encouraged to make their own way to hospital if appropriate to do so. He indicated that the public were very responsive to this and that overall the day had passed off satisfactorily.

Mr Bloomfield pointed out that he, the Chair and other Directors had visited staff on a number of picket lines. He said that he would like to place on record the responsible approach taken by staff in ensuring the continuation of services to the most urgent calls while exercising their right to take industrial action. Mr Bloomfield also commended the significant input of staff involved in planning for the day.

Mr Bloomfield said he was pleased that the issues around industrial action now appeared to have been resolved and any further action had been suspended. He said that work had been carried out in

preparation for industrial action on 24 January but action had since been stood down.

Mr Bloomfield said that, at the December Board meeting, it had been agreed to circulate a schedule of pre-Christmas visits to stations to members. He explained that, as a result of preparation for industrial action, these visits had not taken place as planned. However he said that the Chair, he and other Directors had managed to visit most of the stations before the Christmas holidays and meet with staff. He added that these visits had been appreciated by staff.

Continuing his update, Mr Bloomfield reported that normal winter pressures continued through the Christmas and New Year period. However he said that there had been a deterioration this year with regard to turnaround times at EDs which had been particularly challenging around the end of December. Mr Bloomfield said that, on a number of occasions, it had not been possible to transfer patients from ambulances into EDs and he acknowledged that this was not a position which the Trust considered to be acceptable. He advised that a number of meetings had taken place with colleagues from the DoH, the HSCB and other Trusts to try to resolve the situation. He said that, while further work was still needed to resolve this issue, there had been some progress and he added that Mr Sowney would report on this further later in the meeting.

Referring to Ms Sellars' earlier comments about the ride-on she had been on, Mr Bloomfield said such opportunities allowed staff to provide feedback on issues affecting them. Mr Bloomfield said that his recent experience on a RRV had raised a number of issues, for example the time taken for transport to arrive on scene to transport a patient to hospital which had necessitated the paramedic to remain on scene. He said that it would be important to examine how this could be improved.

Further to the Chair's reference to the Minister's visit in her update, Mr Bloomfield said that SMT had advised the Minister of a number of priority issues for the Trust, including the Trust's long-term Strategy which was before the Board today for approval; the Trust's ambition to contribute to the wider transformation agenda; the recent introduction of the new Clinical Response Model and the development of an associated business case for the DoH's consideration; progress towards the paramedic education model

and, based on sufficient funding being made available, the opportunity over the next 18 months to ensure a positive staffing position prior to the introduction of the Degree qualification.

Mr Bloomfield said that he had also taken the opportunity to discuss with the Minister some of the day-to-day operational challenges faced by the Trust, particularly around turnaround times.

Continuing his update, Mr Bloomfield said that Dr Ruddell would provide an update on the Coronavirus later in the meeting. However he advised members that arrangements for Health Silver had been put in place and said that staff were heavily involved in arrangements as well as participating in daily teleconferences with colleagues across the health and social care system.

The Chair thanked Mr Bloomfield for his report and invited members to ask questions.

Mr Abraham commented that, in a meeting in November 2019, Mr Johnston, DoH, had asked for a business case around CRM and he asked if there had been a delay in submitting this to the DoH.

Responding, Mr Bloomfield advised it is hoped to submit the business case to the DoH by the end of February. This is in line with the agreed timescale.

Mr Dennison commended the Chief Executive and Directors on their management of industrial action. He asked whether the Trust's approach had been part of the wider HSC system response.

Mr Bloomfield explained that the Trust has been part of the approach taken by the wider health and social care system. He advised that industrial action had been regularly discussed at the fortnightly meeting of the Transition Implementation Group (TIG) chaired by the Permanent Secretary. Mr Bloomfield pointed out that the impact of the industrial action had been different in different organisations. He said that he had been of the view that it was important to manage the relationship with Trade Unions well and to recognise staff entitlement to take industrial action and for the Trust to facilitate this as much as possible while ensuring continued service delivery.

Ms Lemon echoed Mr Bloomfield's comments and said that a regional approach had been adopted in previous industrial action. However she said that the DoH had made clear that discussions around derogations should take place at a local level with engagement up to the point of action being taken.

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

6 **Volunteering in NIAS - presentation**

The Chair welcomed Ms Stephanie Leckey, Community Resuscitation Lead, and Mr John Wright, Assistant Director Operations, to the meeting to present on Community First Responders Scheme and the Voluntary Care Scheme respectively. She also advised the meeting that Dr Ruddell would present on BASICS doctors.

Commencing his presentation, Dr Ruddell explained that BASICS doctors were affiliated to the British Association for Immediate Care and volunteers who provided a 24/7 and 365 days a year cover, for example, at RTCs, industrial and farming accidents and incidents where there are multiple casualties. He added that a number of BASICS doctors were also very much involved in HEMS.

Dr Ruddell referred to the NI context and said that there was a small team of volunteers within the Province which had been volunteering for over thirty years. He said that the volunteers carried pagers which were linked to the Emergency Control Centre. He advised that their role involved a specialist form of training and said that it had become a recognised specialty within medicine called pre-hospital emergency medicine.

Continuing, Dr Ruddell indicated that the volunteers were self-funding and equipped themselves. He pointed out that there was a governance structure in place and work was ongoing to examine the potential for honorary contracts with NIAS.

Dr Ruddell indicated that a recent audit of care for serious trauma showed that, in NI, an individual's chances of survival following roadside attendance was higher than average and he said that this was as in part a result of the attendance of BASICS doctors.

Dr Ruddell believed that the attendance and interventions of BASICS doctors was much appreciated by NIAS crews. He said that they made a very important contribution to the care, and particularly the trauma care, of the NI population.

Concluding his presentation, Dr Ruddell suggested that the Trust Board may wish to give consideration as to how the Trust could recognise the valuable contribution made by the BASICS team.

In relation to the Volunteer Car Service (VCS), Mr Wright, AD Operations, explained that this regional service was managed through the Non Emergency Ambulance Control at Altnagelvin. He described the background and processes to the service and said that a significant proportion of the work undertaken by the VCS was to transport renal patients.

Continuing, Mr Wright indicated that 85 VCS drivers undertook 75,000 patient journeys with over two million miles being undertaken.

In response to a question from Mr Abraham as to the insurance required by drivers and whether the Trust should make a contribution towards this, Mr Wright indicated that drivers were required to have business insurance and said it was his understanding that there was no additional cost to this. He added that work was being taken forward to examine the potential of VCS drivers being able to access the Occupational Health Service and also receive additional training.

The Chair stressed the importance of volunteers having visibility within the Trust and advised that she was giving consideration to the current Committee structure to determine where the input from volunteers might best sit. She said that, when one considered the significant number of journeys undertaken by the VCS, it would be important to recognise the contribution of this important service which was provided by 85 individuals.

Mr Cardwell asked how volunteers were recruited. Responding, Mr Wright explained that the Trust did not actively recruit volunteers but tended to approach voluntary organisations to determine interest. He indicated that there was funding for VCS for renal patients in the Southern, Western and Northern areas with the Southern area also covering cancer patient transport. He said that currently there was

no funding for transport for renal patients in Belfast but said that this service would be beneficial.

Mr Bloomfield explained that the purpose of today's presentation was to raise awareness of the contribution made by volunteers across the Trust and to examine how best to recognise it. He said that he would share Mr Wright's view that it would be helpful to recruit more VCS drivers thereby reducing the workload on the existing volunteers. However he suggested that this could be examined within the PCS review currently being undertaken and said that members would receive a briefing on this review at the February workshop.

Mr Wright indicated that the Trust's Assurance Committee had expressed concern a number of years previously around the operation of PCS. He said that work had since been undertaken to assure members that close monitoring and scrutiny was now undertaken in relation to VCS mileage to ensure that VCS drivers were not undertaking significant excess mileage.

Mr Bloomfield indicated that the audit of PCS services had not identified the number of journeys undertaken by VCS drivers as an issue.

Mr McNeill welcomed the additional support being given to the management of these services and said that he would like to see the service canvas for volunteers in the South Eastern and Belfast areas.

Ms Leckey suggested that Volunteer Now would be a helpful contact and added that the organisation also carried out vetting checks.

In relation to the Community First Responder scheme, Ms Leckey explained that the schemes were made up of volunteers who lived within a particular community. She said that, in terms of operation, NIAS would alert volunteers to specific 999 emergency calls in their area. She said that the volunteers' aim was to reach a potentially life-threatening emergency in the vital first few minutes before the arrival of an ambulance crew. Ms Leckey said that volunteers were able to provide basic emergency life support and use a defibrillator if required. She indicated that CFRs were alerted in addition to an

ambulance so an ambulance would have already been despatched to respond to a call.

Ms Leckey advised that there were approximately 1,500 out of hospital cardiac arrests in NI year and CFRs could improve the patient's chance of survival by using the skills learned.

She said that, over the past two years, the NIAS Community Resuscitation Team had provided training and awareness to over 67,000 people across NI, including CFRs. Ms Leckey indicated that there were seventeen schemes in NI with 330 volunteers across these seventeen schemes.

Continuing, Ms Leckey said that, while the number of alerts sent to CFRs was known, there was no mechanism within the system to confirm who actually attended the call. She said that work was being taken forward to look at auditing the calls through patient report forms and added that her ultimate aim would be to show the impact of the CFRs on patient outcome.

Ms Leckey referred to the first CFR conference which had been held and which was attended by over 100 volunteers. She said that this had helped the volunteers to feel part of the overall NIAS family and she emphasised that the volunteers were a strong link in the chain of survival.

Mr Ashford noted that the number of calls in the North West, ie Derry City area was three times as much as other geographical areas.

In response, Ms Leckey explained that the Heart of Foyle scheme in the West was in an urban area, therefore there was a higher density of people compared to other more rural schemes. She indicated that, in the West, there was a scheme where taxi drivers were CFRs and carried the necessary equipment in their cars. She said that quite often the taxi drivers were the first on the scene and able to provide an initial response. She also pointed out that the demand and number of alerts was significantly higher than the number of individuals able to respond.

Mr Haslett asked what form the alert sent to CFRs took.

Ms Leckey explained that, at the moment, while alerts to CFRs were sent through a text message, work was ongoing to transfer CFRs to GoodSam. However both text message and GoodSam would run concurrently for a period of time.

Mr McNeill referred to the future development of the scheme and asked whether consideration had been given to CFRs being able to provide oxygen therapy and airway management responses.

Responding, Ms Leckey said that further work was required in this regard. She indicated that it would be important to ensure CFRs were not being alerted to inappropriate calls and said that recently CFRs had responded to a number of violent calls. She said that, with this in mind, consideration was being given to providing conflict resolution training to CFRs to equip them with the necessary skills.

Ms Leckey also said that, in GB, paediatric training had been provided to CFRs. However she believed that it would be important to ensure the effectiveness of the current schemes before encouraging the introduction of any further schemes and expanding the skill base of the current CFRs. She said that, if the CFRs were to carry oxygen, then they would require further training and there also needed to be an appropriate infrastructure to support the CFRs which was not currently in place.

The Chair asked Ms Leckey to give some thought to what the Board could do to support CFRs and said that, while having references to the importance of volunteers within the Strategic Plan was welcome, it would be important to involve those volunteers on the ground and make them feel part of the overall NIAS team.

She thanked Dr Ruddell, Mr Wright and Ms Leckey for their interesting presentations. Mr Wright and Ms Leckey withdrew from the meeting.

7 **Organisational Health and Culture Programme – presentation**

The Chair invited Ms Lemon to present on the Organisational Health and Culture Programme.

Ms Lemon referred to the AACE Benchmarking Report 2019 which had recommended that work be taken forward to look at the Trust's overall Organisational Health and Development needs and

assessing and addressing culture issues. She described in detail the drivers for change and the proposed methodology to take forward the work.

Continuing, Ms Lemon indicated that there were a number of issues which could be achieved early in the process. However she stressed that this work would need to be ongoing.

Ms Sellars emphasised the importance of culture, communication and recognition within an organisation and referred to an e-mail recently sent by the Chief Executive to a member of staff to let them know of positive feedback received. She said that this had been very much appreciated by the member of staff concerned.

Mr Sowney reiterated the point made by Ms Lemon about the long-term nature of this work. He referred to the fact that the Trust received a significant number of compliments in relation to staff and said that it was important that staff received early feedback in relation to these. He also indicated that when staff were subjected to verbal and physical abuse and felt it was important to make contact with the staff concerned as soon as possible to ensure their health and wellbeing needs were being met. Mr Sowney said that small actions such as these were very important and contributed towards staff feeling valued.

In response to a question from Mr Abraham, Ms Lemon explained that the work to take forward the programme would commence in the coming weeks and that today's presentation outlined the approach to be taken.

Mr Abraham welcomed this work and said that he looked forward to updates on its progress and implementation and how the change could be measured.

The Chair enquired as to how the Trust Board could assist in the work.

Responding, Ms Lemon welcomed the Board's support and explained that Board interviews were a component of the established methodology. She commented that it was likely that the work would reach a stage when resources would be required. However she undertook to keep members apprised.

Ms Charlton referred to the 'Being Open' policy recently forwarded by the DoH as well as learning from the IHRD and believed that these were very much in keeping with what had been discussed in respect of organisational culture. She was of the view that NIAS was unique in that it was a mobile workforce and emphasised the importance of Trust Board and senior management interaction with staff on the ground.

The Chair echoed the comments made by Ms Charlton and said that she could not over-emphasise the positive reaction of staff in seeing Board members, both Non Executive and Executive Directors, taking the time to undertake ride-alongs. She said that she had found them extremely insightful and very much appreciated by staff.

Mr Ashford welcomed this work and suggested it would be important for this work to link with the HR review also being undertaken

Ms Lemon advised that she and Mr Bloomfield had discussed this point with AACE and it was clear that resources would also be required to undertake the HR review which would be undertaken with the support of AACE. She added that a terms of reference for the HR review would be drawn up and said that she had taken the opportunity to discuss the review with the HR team to make them aware that they would be involved.

The Chair thanked Ms Lemon for her presentation and said that she looked forward to the regular updates on progress.

8 **Draft NIAS Strategic Plan (TB30/01/2020/02)**

The Chair welcomed Ms Sarah Williamson to the meeting and reminded members that discussion on the draft Plan had taken place at the December In Committee meeting when members had suggested a number of amendments.

She drew members' attention to the final draft of the Plan, which incorporated members' amendments, and said that approval was being sought to this at today's meeting with a view to scheduling a formal launch of the Plan at the end of February.

Mr Bloomfield referred to the Plan and outlined the changes which had been made. He referred in particular to page 35 which set out

priority actions for year one and said that these priorities, which would be monitored throughout the year, would form the basis of the Trust's Corporate Plan for 2020/21. Mr Bloomfield referred to the staff engagement events attended by the Chair and said that it had reinforced to staff that their input to the Plan had been worthwhile and that delivery against these priorities would be closely monitored by the Trust Board. He said that it would be important to demonstrate their achievement at the end of year one and felt that this would help build confidence.

Mr Bloomfield further referred to Appendix A which set out the priority areas for transformation. He said that this would assist the Trust in setting its priorities for the next 5-6 years and provide both assurance and confidence to staff and also stakeholders of the Trust's intentions.

Mr Bloomfield said that he would like to place on record his sincere thanks to Ms Hilary Pilling from AACE for her contribution to the development of the Strategic Plan. He also thanked Ms Sarah Williamson for assuming responsibility for the Plan and also to Ms Sellars who had undertaken to proof read the document. He also conveyed his thanks to Mr McPoland who had assisted in the organisation of the staff engagement events and had provided the photographs for the document.

Mr Ashford alluded to the fact that the NI Executive had reformed and the potential for the Programme for Government to be changed. He asked if this would have any implications for the Plan in terms of its content.

In response, Mr Bloomfield explained that the DoH had been kept apprised and had been aware that the final draft was coming before the Trust Board today for approval and that Ministerial approval would be sought for the final draft. Mr Bloomfield acknowledged that the themes within the Plan fitted with the DoH's 'Delivering Together' strategy.

Mr Haslett alluded to the earlier presentation on organisational culture and suggested that it would be important to refer to culture within the 'Foreword'. He added that this would also reflect the fact that organisational culture was being changed through the Strategic Plan. Mr Haslett also suggested that, from the perspective of a member of staff, it might be helpful to bring forward the

'transformation priority areas' for inclusion in the 'Foreword' so staff could see immediately where the priorities lay.

Mr Dennison believed that, while the Plan distilled a number of key messages for different stakeholders, it would be important to clarify what the various stakeholders wished to know. He said that he would have preferred to have some of the key points of the conclusion brought forward and added that consideration would need to be given to communications.

Responding to a question from the Chair as to whether he was suggesting a leaflet for staff and a separate leaflet for stakeholders, Mr Dennison said that it would be important to clarify what the Trust was pledging to do through its Strategic Plan. He said that such clarification would be helpful to Non Executive Directors when referring to the Plan.

At the Chair's request, members indicated that they would be happy to approve the Strategic Plan 2020-2026 subject to the changes to be made.

Mr Haslett proposed that the Board approve the Plan. This proposal was seconded by Mr Dennison.

The Chair undertook to advise members of the date identified for the launch of the Strategic Plan. Concluding discussion, she thanked Ms Williamson for her contribution to the Plan.

9 **Audit Committee – Terms of Reference (TB30/01/2020/03)**

At the Chair's request, Mr Nicholson introduced this agenda item by advising that it was best practice to review the Committee's Terms of Reference on an annual basis.

Responding to a question from Mr Ashford, Mr Nicholson explained that both Internal and External Audit were in attendance at the Committee and had had input to the discussion around the Terms of Reference.

Mr Ashford referred to the membership of the Committee, in particular the requirement for 'one member of the Committee to have significant, recent and relevant financial experience.' He cited recent Audit Office guidance on Audit Committees which stated that

the Committee should have a member who has the 'ability to interpret a set of financial statements' and he enquired whether this could be used. He undertook to forward the information to Mr Nicholson for his consideration.

Mr Nicholson explained that the membership of the Committee had been drawn up in line with Audit Office guidance but undertook to examine this further. He reminded members that the recruitment and appointment processes for Non Executive Directors were taken forward by the Public Appointments Unit within the DoH and said that the Unit had specified an individual with '… significant, recent and relevant financial experience.'

Mr Abraham indicated that the Terms of Reference had been reviewed by the External Auditor on the Committee but acknowledged that it would be useful to examine this further.

The Chair advised that she would be giving consideration to the Trust Committee structure in the coming months and would keep members apprised.

Mr Abraham proposed the approval of the Audit Committee Terms of Reference. This was seconded by Mr Ashford and **APPROVED** by the Board.

10 **Corporate Risk Register (TB30/01/2020/04)**

Dr Ruddell drew members' attention to the Corporate Risk Register which had been distributed to members in advance of the Board meeting.

Mr Cardwell referred to the recent incident affecting the Trust's IT systems.

Responding, Mr Nicholson explained that the incident had affected HSC external access and log-ins to computer systems and added that he was awaiting the full and definitive incident report. He said that, as a result, the ability for NIAS staff to access systems remotely had been removed for a period of one week while the supplier provided the relevant patches to the system.

Mr Nicholson advised that staff would be examining the NIAS response to the incident and would produce a report accordingly.

He undertook to bring the report to an In Committee meeting of the Trust Board. He indicated that, while this incident was being investigated, another incident had occurred in relation to the functionality of radios. Mr Nicholson pointed out that there was a small team examining both incidents and cautioned that, in the event of multiple incidents, cognisance would have to be taken of the availability of a limited team.

Members **NOTED** the Corporate Risk Register as at 14 January 2020.

11 Directors' Performance Reports

Mr Bloomfield explained that, more recently, Directors had reported on their respective areas of performance by exception. He said that with Director and staff changes, he was proposing the introduction of a single Finance report and an overall performance report which would include key performance issues from each Directorate. He added that this would be the responsibility of Ms Patterson, the new Director of Planning, Performance and Corporate Services. Mr Bloomfield advised that the current arrangement of reporting by exception would continue until the new arrangements came into operation.

The Chair invited the relevant Director to provide an update by exception on their respective area.

11.1 Finance (TB30/01/2020/05)

Mr Nicholson advised that the Trust was reporting a breakeven position at the end of December 2019. He added that income levels had been agreed with commissioners and have been in line with assumptions which were included in the Trust Delivery Plan. Mr Nicholson indicated that, while there were a small number of assumptions, these were significant within the current plan in relation to the breakeven forecast in terms of Income and Expenditure.

Mr Nicholson reported that the Trust had received a Capital Resource Limit of £8.3 million which allowed the Trust to continue with planned cyclical fleet replacement. He indicated that, within this overall allocation, £4.3 million had been earmarked for specific ICT schemes and contingency control room arrangements.

Moving to the prompt payment of invoices, Mr Nicholson advised that the Trust had achieved 95.9% of invoices paid on time against a start of 95% performance.

Mr Nicholson drew members' attention to page 49 of the Board papers which outlined a number of service issues as well as a number of service developments ongoing to refresh and replace the technology infrastructure and platforms.

In terms of Information Governance and informatics, Mr Nicholson pointed out that this section of the report detailed the breadth of information requests received from a range of sources.

Mr Haslett referred to the Trust's breakeven position and acknowledged that he found it difficult to understand how the Trust achieved financial balance month on month. He enquired as to the progress within the capital budget as no detailed supporting information had been provided.

Responding, Mr Nicholson explained that the Trust's financial position was largely based on assumptions around Income and Expenditure and agreed in line with the Trust Delivery Plan. He referred to the forecast position and cited the example of the assumptions around superannuation changes and said that income had been confirmed within that.

Mr Nicholson explained that, within Directors' areas of responsibility, there were areas of financial pressures/underspends which contributed to the overall Trust savings plan. He acknowledged that, while a proportion of the capital expenditure was expended towards the end of the financial year, a significant proportion would be committed within the first nine months of the financial year. However he pointed out that the Trust's breakeven and capital budgets were very much based on a number of financial assumptions. Mr Nicholson pointed out that, in terms of revenue income, this should match the cost of the pay award and said that, should this not be the case, it would be then necessary to bring details to a Trust Board meeting for consideration.

Mr Nicholson further explained that, in relation to Expenditure, there were ambitious programmes for the refurbishment of a number of stations as well as the sluice programme and he added that, within

the capital budget, there were a number of planned schemes within IT.

Mr Nicholson referred to Agenda for Change and described this as one of the biggest financial planning assumptions.

Responding to a question from the Chair in relation to the assumption around the pay award now that the Assembly was operational, Mr Nicholson explained that the 2019/20 pay award and pay parity continued to be a priority.

Mr Abraham acknowledged the financial position and said that, as the Trust dealt with the ebb and flow of finances, it would always adjust spend to a breakeven position.

Referring to Mr Abraham's point, Mr Bloomfield said that, in recent weeks, Mr Nicholson had been asked by the DoH to advise on any areas of where savings could be delivered in order to support the wider health and social care system achieving a breakeven position. He advised that, for a short period of time, the sluice programme had been put on hold. However the DoH had since indicated that the Trust could now proceed with the programme.

The Chair believed that this demonstrated the need for a Trust Finance Committee where such issues could be considered. She indicated that the Audit Committee considered issues concerning the risk of finance whereas a Finance Committee could consider issues showing patterns of reporting.

Mr Haslett said, while he very much appreciated that the Trust's intention was to achieve a breakeven position each year, he acknowledged that he was unsure as to the Trust's financial exposure as this was not covered in the finance report.

Mr Abraham indicated that the Audit Committee and external auditors continually monitored the risk and he advised that issues were fully discussed at Audit Committee when external auditors were present. He acknowledged that members were not having sight of the minutiae around the day-to-day/week-to-week financial management or of how the Trust was on track to achieve a breakeven position.

Mr Nicholson said that he very much accepted the points made by Mr Abraham and referred him to the discussion which had taken place at the December In Committee meeting.

The Chair thanked Mr Nicholson for his report.

11.2 **Operations (TB30/01/2020/06)**

Commencing his report, Mr Sowney advised that the turnaround times discussed at the last Board meeting continued to present a challenge to the Trust. He explained that an ED Handover protocol had been issued by the HSCB in early January and said that this required HSC Trusts and NIAS to escalate issues after one hour if crews were not turned around and released. Mr Sowney said that, while the escalation protocol was to be welcomed, further work was required to resolve what was a complex issue. He said that a significant proportion of the difficulties were related to processes and the interaction/interface between NIAS and EDs.

Mr Sowney said that, as the Chief Executive had referred to earlier in the meeting, it had not been possible to transfer patients from ambulances to EDs on a number of occasions until sufficient space had been identified in ED. He referred the Emergency Divert Protocol which had been agreed by Trust Chief Executives and issued on 6 January to address this issue but acknowledged that this in itself had not fully resolved the issues.

Mr Sowney said that it would be important to ensure crews were released early in order to deal with emergency calls waiting for a response.

Mr Sowney referred to the 'cohorting' of staff and indicated that this was a complex issue as not all Trusts worked to the same definition. He explained that 'cohorting' was an element of the clinical handover and said that a number of Trusts had refused to work with that system. Mr Sowney said that HALOs were embedded within major EDs and he commended the work carried out by Ms Williamson in this area to draw up Standard Operating Procedures to provide clarity on their role. He said that work continued with Trusts to reach agreement around the definition of cohorting and acknowledged that, while beyond the control of NIAS, efforts would continue with Trusts to try to influence how to progress this issue.

Mr Sowney said that, as well as challenges around turnaround times, the Trust was also experiencing challenges around capacity in terms of hours lost while waiting at EDs. However he reassured members that every effort was being made to address such issues.

Continuing, Mr Sowney reported that he and Dr Ruddell had met with colleagues from the Belfast Trust to agree a way forward on a model which worked for all concerned. He said that, should this model prove to be successful, it would then be proposed for roll-out to other areas.

Concluding his report, Mr Sowney referred to the flu vaccination programme and said that he wanted to place on record his appreciation to Ms Laura Coulter, Area Manager, West Division, and her team for the excellent performance around vaccination. He advised that the target for vaccination was 50% and that, through the efforts of Ms Coulter and her team, 60.75% was achieved. He added that NIAS was also assisting other Trusts in this area.

Mr Cardwell referred to an Ambulance Trust in England which had introduced financial penalties for hospitals which had incurred a delay in releasing ambulance crews from EDs and he asked whether introducing a similar scheme would be helpful.

Responding, Mr Sowney said that he did not believe it would be helpful and added that a number of Ambulance Trusts were experiencing similar challenges with regard to turnaround times at EDs.

Mr Bloomfield agreed with Mr Sowney's view and indicated that the mechanism by which to do so did not exist.

The Chair indicated that on occasions it was difficult for Trusts to understand the significant impact delays in releasing ambulance crews had on the services provided by the Trust. She said that, in order to do so, an invitation had been extended to Belfast Trust colleagues to spend some time in the Control Room to hear and see at first hand the difficulties experienced by staff in ensuring ambulance coverage.

Mr Sowney said that, while appreciating the challenges facing EDs, it would be important at the same time to understand the pressures across the whole system. He was of the view that response times

and risks to patients in the community by not being able to send a response was greater than overcrowding in EDs where clinical staff are available should a patient deteriorate rapidly. Mr Sowney added that there was also a need to be mindful that, in relation to turnaround times, NIAS staff were missing meal breaks and finishing shifts late.

Mr McNeill commended Mr Sowney on the work he had done to address this issue and acknowledged that, even with additional resources, it was likely that NIAS staff would continue to be delayed in EDs. Mr McNeill emphasised that achieving a 30-minute handover would be important.

Mr Sowney indicated that there were a number of Ambulance Trusts which would be better resourced than NIAS and which continued to experience difficulties with turnaround times. He said that the risk associated with this should not be underestimated.

Mr Bloomfield advised that this issue was receiving continued focus and said that he had discussed the matter with the Permanent Secretary, the Chief Medical Officer and the Chief Nursing Officer as well as other Trust Chief Executives. Continuing, Mr Bloomfield advised that Mr Sowney had been asked by the DoH to provide his assessment of the impact the new ED Escalation Protocol and he believed that the fact that the DoH was requesting such an assessment so soon after its implementation showed the importance the DoH was attaching to this.

Continuing his update, Mr Sowney reported that, supported by AACE, the Trust had recently commenced a review of the operational management structure. He said that this was timely given the amount of investment needed to ensure the model going forward was fit for purpose and future proof.

Mr Haslett welcomed the improvement in response times and asked whether this momentum would continue.

Mr Bloomfield explained that there had been an improvement in November because the Trust had invested heavily in increasing staff resources to support the introduction of CRM. He reminded members that, in the summer of 2019, staffing levels were between 85-89% of planned capacity being delivered whereas in November, in order to ensure the smooth transition to the new model, the Trust

was regularly at over 100% of planned cover. Mr Bloomfield said that the Trust had also incurred a significant proportion of overtime as well as using voluntary and private ambulances.

The Chair pointed out that the additional resources used at that time gave a clear indication of what could be provided by the Trust if sufficiently resourced. However she indicated that this approach would not be sustainable without additional resources.

The Chair thanked Mr Sowney for his report.

11.3 **Medical (TB30/01/2020/07)**

Dr Ruddell reported that a final inspection of the helipad would take place on 31 January 2020. He commended the team which had been operational now for over 2½ years and said that it was now carrying blood for emergency blood transfusions.

At the Chair's request, Dr Ruddell provided an update in relation to Coronavirus. He reported that 7,783 individuals had been infected with 170 deaths – none of which had occurred outside China – resulting in a mortality rate of between 2-3%. Dr Ruddell confirmed that no cases had been confirmed within the UK and advised that neither a vaccine nor specific treatment were available. He confirmed that the Emergency Planning and Infection Prevention teams were having daily teleconference calls with PHA colleagues.

Dr Ruddell said that a regional approach, in line with the approach adopted by NHS England, had been taken. He confirmed that NIAS staff had the necessary equipment to protect themselves from infection and added that this was standard issue within ambulances. Dr Ruddell advised that FIT testing had also been updated.

Responding to a question from Ms Sellars as to how the Trust communicated with staff on the ground, Dr Ruddell advised that mechanisms were already in place to outline to staff the levels of protection required. He added that processes had been reviewed within the last year and said that CMO advice had been disseminated to staff. Dr Ruddell said that, in addition to the CMO advice, advice from the PHA and NHS England had also been disseminated and made available on the clinical app available to staff.

Ms Charlton advised that there had been learning from colleagues in Ambulance Trusts across the UK and a pragmatic operational plan in use by other Ambulance Trusts had been shared with NIAS covering issues, for example, how to ensure the cleaning of vehicles after use.

The Chair thanked Dr Ruddell for his report.

11.4 **CRM Programme – verbal report**

Referring to Mr Abraham's earlier question on the timescales for completion of the business case, Mr McNeill advised that he was planning to be in a position to submit the Strategic Outline Case to the DoH by the end of February as intended. He indicated that a significant proportion of the work required, including the Fleet Strategy, had already been completed.

Mr McNeill explained that, at the DoH's request, the Trust had been afforded the opportunity to make a submission in relation to its capital needs against the DoH 10-year year capital plan. He said that, in its submission, the Trust had promoted the make-ready concept which had previously been presented to Trust Board as well as the prioritisation of hubs in Belfast and Craigavon and the replacement of the Emergency Control Centre. Mr McNeill advised that the capital plan had subsequently been accepted by the DoH. He also pointed out that discussions were also ongoing with DoH colleagues as to the content and format of the business case.

Continuing, he said that work would now be taken forward with Finance colleagues in terms of the funding profiles. He pointed out that recruitment and training of the paramedic workforce would dictate the pace of developments and explained that the recruitment of additional staff would have an impact on fleet requirements thereby identifying further estates issues which would need to be resolved.

Referring to performance, Mr McNeill said that the DoH representative on the Capacity Review group had been keen to see what the performance trajectory would be with additional resources. He explained that, in order to do this, it had been assumed that the 30-minute handover had been accepted and incorporated into the trajectory as improvements would not be possible unless the issues of handover and the need for additional capacity were addressed.

In response to a question from Mr Haslett as to the availability of funding, Mr McNeill explained that, during the consultation process for the introduction of CRM, the Trust was clear in identifying the number of additional hours cover required to meet the standards and indicators and added that this gave the Trust an objective to work towards. However, he said, should the funding not meet the Trust's requirements, it would be important for the Trust to be clear that it would not be able to meet the targets. Mr McNeill added that additional hours recouped through improved turnaround times would also be helpful.

Mr Bloomfield, agreeing with Mr McNeill's point, emphasised that, in order for the Trust to fully deliver on its objectives, it would require the full funding. He added that there was an acceptance by the DoH that, if effective transformation was to take place across the health and social care system, the ambulance service had an important role to play and therefore needed to be appropriately resourced.

The Chair thanked Mr McNeill for his update.

11.5 **Safety & Quality – verbal report**

Ms Charlton reported that work was being taken forward in relation to the RQIA improvement notice relating to IPC training and education and added that the compliance date was March.

She advised that Ms Ruth Finn, IPC lead, had worked with staff across the Trust to address the actions within the improvement plan. Ms Charlton said that she hoped the plan was on track to achieve the minimum compliance with the aim then of working to strengthen arrangements in the coming months. She indicated that she would be meeting with RQIA representatives at the end of February to discuss the progress made in advance of the compliance date. She said that she would take this opportunity to highlight any concerns. Ms Charlton said that one challenge was the release of staff for face-to-face training. She commended Ms Emma Giddings who had co-ordinated post-proficiency training sessions across the Divisions. Ms Charlton also thanked Operational colleagues who ensured staff were released to undertake this training.

Ms Charlton undertook to provide Trust Board with a briefing following expected unannounced inspections in April.

Continuing her update, Ms Charlton briefed members on the introduction of the Online User Feedback system to be provided through Care Opinion. She explained that this was a DoH led initiative which would be rolled out on a regional basis from April 2020. Ms Charlton referred to the need for transparency and believed that the 'Being Open' policy complemented this initiative.

She assured members that safeguarding and moderating policies were in place within the system and any feedback to and from the Trust would be considered in line with the policies before being made public. She referred to the earlier discussion around culture and welcomed the DoH decision to introduce the initiative. Ms Charlton indicated that the roll-out was being led and supported by PHA colleagues and she advised that the Scottish Ambulance service was using the system.

Ms Charlton referred to the Regional 10,000 Voices initiative and said that feedback to Trusts had largely been positive. She believed that the Online User Feedback would be an excellent vehicle to share with staff how much the service was valued by the public. She acknowledged that inevitably issues of concern would also be identified but believed that these could be used as learning and to improve the services delivered.

She indicated that there was a regional implementation plan and highlighted that additional resources would be required to implement the system across health and social care. Ms Charlton advised that the Chief Executive of Care Opinion would attend SMT on 4 February 2020 to talk about the initiative and she undertook to keep Trust Board members apprised as well as the feedback submitted to Care Opinion. It was agreed that members should receive a further update at the February Trust Board workshop.

Concluding her update, Ms Charlton advised that the Complex Case Team led by Joanna Smylie had recently received the regional HSC QI award for implementing care across boundaries. She commended Ms Sarah Williamson for her significant contribution to quality improvement within the organisation and said that it was a great accolade for the team.

The Chair echoed Ms Charlton's comments and added her congratulations.

11.6 **Human Resources/Corporate Services – verbal report**

Ms Lemon said she would like to highlight that, in terms of absence, there had been a slight reduction in absence rates. She explained that the cumulative absence rate last year was 11.48% and that the DoH target was to reduce this by 5%, resulting in a target of 10.92%. Ms Lemon indicated that, in November, the cumulative figure had been 10.81%. She acknowledged that, while this was positive, challenges remained in this area.

Ms Lemon advised that a Good Attendance workshop had been scheduled for the following week to take stock of the current position in terms of progress made to date and plans for the future.

Mr Bloomfield welcomed the recent recruitment of externally qualified EMTs and paramedics and said that those recruited were a combination of individuals returning to Northern Ireland and individuals from further afield.

The Chair thanked Directors for their reports which were **NOTED** by members.

12 **Committee minutes**

- Audit Committee – 18/6/19

  Mr Abraham referred to Ms McCue's retirement and thanked her for her years of service.

- Assurance Committee – 15/10/19

  Mr Haslett referred to the presentation given by Ms Lemon earlier in the meeting. He said that it was clear that that considerable efforts, including financial investment, were being made to improve attendance and added that this was an issue highlighted at each Board meeting.

  He advised that progress was being made in relation to the IPC report and said that this area would be closely monitored. Mr Haslett referred to the meeting with RQIA with regard to SAIs

and complaints and said that additional resources had been made available to address the backlog.

Ms Charlton indicated that the key elements of the discussion with RQIA related to the importance of service user, family and carer engagement. She added that this was very much in keeping with the regional 'Being Open' policy and work ongoing around IHRD.

Ms Charlton referred to a further regional policy around providing support to staff involved in incidents, complaints, claims and coroners' inquests. She alluded to Ms Lemon's earlier presentation and the importance of culture and said that how the organisation supported its staff was critical.

Mr Bloomfield said that he would like to take this opportunity to commend Ms Charlton on her commitment to improving engagement with service users, families and carers moving forward and that she had engaged directly with families in relation to some very difficult cases.

Ms Charlton acknowledged the challenges associated with progressing SAIs, in particular ensuring timely, sensitive and compassionate engagement with families who could still be grieving for loved ones, and reinforced the need to support staff with an aim to ensuring effective communication.

13 **Forum for Questions**

As no members of the public were present, no questions had been submitted.

14 **Date of next meeting**

The next Trust Board meeting will take place on Thursday 5 March 2020 in the Conference Room, NIAS Northern Divisional Headquarters, 120-130 Antrim Rd, Ballymena BT42 2HD.

15 **Any Other Business**

15.1 MOTs

Mr Dennison sought clarification on whether the difficulties currently being experienced in relation to MOTs would have an impact on the NIAS fleet.

Responding, Mr McNeill advised that, while no issues had been identified as yet, the position could change over time if the backlog increased significantly. He pointed out that, in the short-term, there may be an issue in relation to RRV cars but said that the position would be closely monitored.

SIGNED: _____

DATE: _____

TB/05/03/2020/02

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	5 March 2020
Title of paper:	Update on Coronavirus
Brief summary:	Members will appreciate that this is a rapidly developing situation and are asked to note this update on Coronavirus is as at 27 February 2020.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Prepared and presented by:	Ms Lynne Charlton, Director of Safety and Quality Improvement
Date:	27 February 2020

Trust Board Brief

COVID-19 (Wuhan Novel Coronavirus) position as of 27.02.20

Background

Coronaviruses are a large family of viruses, some of which cause illness in people, ranging from the common cold to more severe diseases. As a group, whilst coronaviruses are common across the world. The 2019-nCoV strain is a strain not previously seen in humans.

On 31 December 2019 Chinese authorities notified the World Health Organisation of an outbreak of viral pneumonia in Wuhan City. On 30 January 2020, the WHO designated the Wuhan Novel Coronavirus (2019-nCoV) outbreak as a Public Health Emergency of International Concern.

In response the UK CMOs advised that governments should raise the risk in the UK from low to moderate in order that all governments could plan for all eventualities.

Typical symptoms of coronavirus include fever and a cough that may progress to a severe pneumonia causing shortness of breath and breathing difficulties. Generally, coronavirus can cause more severe symptoms in people with weakened immune systems, older people, and those with long-term conditions like diabetes, cancer and chronic lung disease.

Global and UK position *(NB *as of 26.02.20)*

36 countries affected, closest seriously affected country Italy, 229, 7 fatalities

- **China** - 77 658 confirmed cases (2 663 deaths)
- **Outside of China** - 2 592 confirmed cases (37 deaths)

- **UK** - 6,795 concluded tests of which 13 were confirmed positive
- **NI** – 52 concluded tests since testing began, of which 52 were confirmed negative.

Case definition for suspected cases

The case definition for suspect cases of Wuhan Novel Coronavirus (CoVID-19) is both epidemiological and clinical. This has changed on a number of occasions to reflect an expanding geography and changes to clinical symptomology.

If COVID-19 is seen in the UK, it is most likely to occur in travellers that have recently returned from an affected country (reflected in the table below). Therefore an accurate travel history is a key part of identifying potential risk. If patients meet the below criteria they can be classified as a suspected case.

In the 14 days before the onset of illness,

- Travelled to China; Macao; Hong Kong; Thailand; Japan; Republic of Korea; Taiwan; Singapore; Malaysia **or**
- Travelled to South Korea; Iran; Northern Italy; Vietnam; Cambodia; Laos; Myanmar *since the 19.02.20* **or**
- Had contact with a confirmed case(s) of COVID-19

And

- Severe acute respiratory infection requiring admission to hospital with clinical or radiological evidence of pneumonia or acute respiratory distress syndrome

Or

- Has symptoms of respiratory illness including cough or shortness of breath with or without fever

Or

- Fever with no other symptoms

Trust Position

A COVID-19 Incident Management Team (IM) has been established with senior representation from all Directorates, to progress necessary related actions and to develop a NIAS COVID-19 Surge Plan. The Trust's surge plan will detail robust arrangements to effectively manage our resources and maximise resilience in the event of a COVID-19 pandemic. The plan will set out strategic and tactical options to enable us to continue to deliver our critical services despite potential disruption to our staffing levels and with an increasing demand on our service.

Personal Protection Equipment (PPE) for staff

When providing care and treatment in such cases crews must wear full appropriate Personal Protective Equipment including Tyvek disposable suit, aprons, FFP3 mask, face shield and gloves.

FFP3 masks

Staff caring for patients with suspected COVID-19 must wear a Filtering Face Piece Class 3 (FFP3 mask). Each member of staff must have a fit test to determine which face piece provides the best fit for their face. The performance of tight-fitting face pieces depends on achieving a good contact between the wearer's skin and the face seal of the face piece. Inadequate fit will significantly reduce the protection provided to the wearer. For this reason there is a number of FFP3 masks in the market. Fit testing is therefore a method for checking that a specific model and size of tight-fitting face piece matches the wearer's facial features and seals adequately to the wearer's face.

Fit testing

The legislation recommends that fit testing should be carried out 'regularly' as the fit of the mask can be affected by:

  - weight loss or gain;
  - substantial dental work;
  - any facial changes (scars, moles, effects of ageing etc) around the face seal area

- The Trust is currently undertaking a scoping exercise to ensure fit testing is up-to-date as well as determining that there is a sufficient supply of those masks for which staff are being fitted.
- Facial hair interferes with the effectiveness of masks and therefore the protection offered. All operational staff who may be required to use face masks must be clean shaven when fit testing takes place and during times when indicated.

Actions

- A baseline position of fit testing across the organisation has been carried out.
- A number of staff currently on light duties have been trained to carry out fit testing alongside a number of Clinical Training Officers.
- A risk assessed fit testing schedule has been developed and we are currently carrying out fit testing across all Divisions/Departments.
- We endeavour to reduce the impact of fit testing on operational response by carrying this out at destinations such as EDs whilst staff are waiting to turnaround etc.
- In order to mitigate against the potential impact on operational response, additional crews are to be secured at times of fit testing.
- A stocktake of available FFP3 masks at station and vehicle level is currently being undertaken to determine level of risk and inform contingency plans.
- NIAS senior representatives sit on Health Silver and Regional PPE group to work together to seek solutions to regional PPE challenges.

Current Pathways

Testing & confirmed cases

In NI PHA guidance is that testing for COVID-19 is currently carried out in Secondary Care. NIAS can be requested to convey a patient for testing at an acute hospital site. If conveyance is required, arrangements are currently overseen by HART paramedics. Currently patients are conveyed in a double crewed ambulance. In line with Public Health England documentation some of the other UK Ambulance Services have developed clinical pathways which avoid the need for transfer to hospital, instead utilising a single ambulance paramedic and suitably equipped response car to transport a hospital healthcare professional to the patient (with all the necessary PPE, disposal equipment and testing kits) in order to undertake the swabs and then return to hospital with them. PHA are currently considering a model of

community testing, NIAS are collaborating with the other Trusts to agree pathways for community testing for consideration.

If a community testing pathway is not introduced within NI, there is a concern regarding the practical difficulties and potential operational impact of expected increasing number of patients requiring conveyance purely for testing for COVID-19. This can result in a double-crewed ambulance for the prolonged period associated with a double journey and the subsequent decontamination process (approx. 3 hours) which all carry a risk to the emergency response to other 999 calls in the community.

Currently numbers of suspected cases requiring conveyance for testing are low (24 calls as of 26.02.20) but have the potential to increase in very near future. Regardless of pathway for testing, this is likely to have an impact on our current operational capacity.

Other points to note

Staff Exposure

In circumstances where staff are exposed to suspect cases in advance of being aware of the need to don appropriate PPE they will be required to be excluded from work until the test result is known (in the case of the negative test this may be up to 24 hours, if the test result is positive this could extend to 14 days). A regional HR group has been convened to consider HR advice (including pay arrangements) in these circumstances.

Effective communication of the evolving clinical guidance and case definition

Due to the changing context and subsequent evolving case definition – there is a need for timely and effective communication to operational staff including control regarding latest guidance. This leads to the need for multiple communications out to staff using memos, JRCALC app and a flowchart for control. There is a risk that the information will not reach all operational frontline staff in a timely way.

PAS/VAS – PPE & Fit testing Requirements

We are currently not knowingly allocating any calls related to suspect cases of COVID-19 to our PAS/VAS providers. We have been advised that some providers have challenges in access to appropriate PPE in particular FFP3 masks. We are currently exploring the specific requirements, their position with fit testing and how we can support them, although options to provide support with provision of FFP3 masks will be limited.

Members will appreciate that this is a rapidly developing situation which the Trust is closely monitoring and working with its partners across the HSC.

TB/05/03/2020/03

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	5 March 2020
Title of paper:	Progress with IPC Improvement Notice
Brief summary:	This paper will provide an update on progress in relation to the NIAS RQIA Improvement Notice and will update the board on the progress meeting held between NIAS and RQIA on the 24.02.20 in relation to same. The improvement plan has been attached for reference. The following 5 areas for improvement had been identified. 1.IPC training programme- All key actions for improvement have been implemented with the exception of IT solutions to facilitate e-learning in all NIAS stations. The role of out of REACH personal electronic devices will facilitate this action point to be achieved. Rollout of REACH devices will commence in April 20. 2.Competency based assessment tools - All key actions for improvement in relation to this have been implemented and associated expected outcomes achieved. 3.Delivery of training and competency based assessment- A review of Clinical Training Officer (CTO) and Clinical Support Officer (CSO) capacity to deliver IPC training and carry out observations of practice in relation to IPC has been undertaken. 6 additional CTOs took up post between Oct and Nov 2019. Recruitment for CSOs has been progressed to appointment stage, with 38 candidates successful at interview. 16 CSOs will be immediately appointed following this tranche of recruitment with a waiting list also being created.

	IPC Lead took up post at the start of November 2019.Job descriptions have been agreed for the posts of IPC Practitioner, IPC Support Worker, Environmental Cleanliness Lead, Vehicle Cleaning Supervisor and Vehicle Cleaning Operatives. These job descriptions have now been forwarded for job evaluation. Education and Training Strategy and associated plan for delivery of IPC education has been agreed and is being implemented. Level 1 and 2 IPC e-learning is available for all staff. Approximately a third of all staff that are required to undertake this training have done so to date. Efforts continue to ensure staff are undertaking this training as required. Face to face IPC training, including competency based assessment of Aseptic Non-Touch Technique (ANTT) commenced in September 2019 and will continue as per frequency outlined in training plan and strategy. 260 staff have been ANTT competency assessed since Sept 2019. Clearly defined systems and processes have been developed and are being implemented for formal sharing of outcomes of hand hygiene audits and ANTT competence assessments with line management staff. All IPC related training records are now recorded on HRPTS which enables contemporaneous access for all line managers. Work continues across the organisation in relation to the implementation of the agreed processes. 4.Key Performance Indicators (KPIs)- KPIs related to IPC training and competency will be reported to Assurance Committee in March 2020 and routinely thereafter. 5.IPC training Strategy- An IPC training Strategy has been developed and is being implemented across the organisation. Hand hygiene auditing has been introduced following development of a NIAS specific hand hygiene auditing tool. All key actions for improvement related to this action are in progress with the aim to demonstrate minimal compliance with same by March end 2020.

Recommendation:	**For Approval** ☐ **For Noting** ☒
Prepared and presented by:	Ms Lynne Charlton, Director of Safety & Quality Improvement
Date:	27 February 2020

February 2020

Northern Ireland Ambulance Service
Health and Social Care Trust

Infection Prevention and Control Training Improvement Plan

Background

In 2017-18 RQIA carried out unannounced inspections and monitoring visits in Infection Prevention and Control (IPC), Hygiene and Cleanliness across NIAS. A number of inspections highlighted serious concerns regarding monitoring and assurance mechanisms for hygiene, cleanliness and (IPC) at station and vehicle level. At organisational level serious concerns were identified regarding governance systems, audit and assurance, education, training and access to expertise in hygiene, cleanliness and IPC.

Six improvement notices were issued between July 2017 and February 2018. Three notices related to Safe & Effective Care – Ensuring Safe Practice and Appropriate Management of Risk, were lifted upon subsequent inspection. Three notices remained requiring improvement in Corporate Leadership and Accountability of the Organisation with a compliance date of October 2018. In November 2018, RQIA carried out follow up inspections to NIAS Headquarters and Craigavon Ambulance Station in addition they also carried out a series of Infection Prevention Control monitoring visits to Broadway, Bangor, Altnagelvin and Ballymena Ambulance Stations. As a result of this work RQIA advised that they considered that sufficient progress and improvement had been made to address their concerns in relation to Corporate Leadership and Accountability of Organisations, Criteria 4.3 (b;i).

However, while they recognised that NIAS had made some progress in taking forward actions outlined in the Improvement Notice relating to staff training and competency based assessment, it was felt that further work was required across the Trust in relation to Corporate Leadership and Accountability of Organisations, Criteria 4.3 (m). They therefore determined to remove the remaining three Improvement Notices to Broadway, Bangor and Craigavon Ambulance Stations and issue one Trust wide Improvement Notice relating to staff training and competency based assessment.

Following consideration of the findings of further unannounced inspections on 29th & 30th July RQIA determined to extend the date for compliance with the current Improvement Notice to 31 March 2020.

This Quality Improvement Pan (QIP) aims to address the areas for improvements necessary to achieve minimum compliance under each of the headings below:

- IPC Training Programme
- Competency Based Assessment
- Delivery of Training & Competency Based Assessment
- Key Performance Indicators
- IPC Training Strategy

Key

G	**Actions fully implemented**
A	**In progress**
R	**No progress made**

Action Ref	Milestone/Deliverable *IPC Training Programme*	Key Actions for Improvement	Expected Outcome	Completion Date	Responsible Person(s)	Executive Lead	Status
1.	Develop a tailored IPC training programme to meet the needs of staff at all levels across the Trust, including Non-Executive Directors of the Trust.	1. Review IPC related content of Trust Statutory & Mandatory Training Policy and make necessary changes based on learning from national guidance to reflect IPC Training requirements.	Updated Trust Statutory & Mandatory Policy	April 19	PHA Secondee AD Education & Learning Clinical Training Manager	Medical Director	**G**
		2. Review and update (where necessary) current IPC content & frequency of training programmes to ensure this is line with national guidance and controls assurance standards. • Corporate Induction • ACA Training • Associate Ambulance Practitioner (AAP) • Post Proficiency Training (PP) • Vehicle Cleaning Operative Training Programme • E learning programme	IPC aspect of all Training Programmes reviewed and updated.	May 19	PHA Secondee Medical Director	Medical Director	**G**

		3. Develop content of NIAS IPC Link Training Programme, including frequency & learning outcomes with NIAS staff and Lead IPC Nurses in N.I.	Agreed content & delivery of IPC Link training	Dec 19	IPC Lead Nurse	Director of Quality Safety & Improvement	G
		4. Deliver content & deliver training programme for Non-Executive Directors.	Agreed content & delivery of NED IPC training	Aug 19	Clinical Training Manager PHA Secondee	Medical Director	G
		5. Work with Leadership Centre to provide Level 2 IPC training on an e-learning platform for NIAS staff	IPC Level 2 e learning programme available to all relevant NIAS staff	May 19	Clinical Training Manager PHA Secondee AD Education & Learning	HR Director	G

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		6. Engage internal IT support to put in place IT solutions which facilitate e-learning within all NIAS stations and HQ.	PCs which support sound and video at station level	June 19	Clinical Training Manager ICT Manager PHA Secondee	Financial Director	**R** Paused as the reach programme will deliver personal devices for all staff

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Action Ref	Milestone/Deliverable *Competency Based Assessment Tools*	Key Actions for Improvement	Expected Outcome	Completion Date	Responsible Person(s)	Executive Lead	Status
2.	Develop Standardised Competency Based Assessment/Observational Audit Tools for: • Hand Hygiene • Aseptic Non Touch Technique (antt) for Clinical Invasive Procedures	1. Engage with IPC Leads from UK Ambulance Services to determine competency based assessment tools in use for hand hygiene and antt.	Gain national perspective on available competency based assessment tools	Jan 19	PHA Secondee	Medical Director	G
		2. Review antt organisation competency based assessment tool for antt for clinical invasive procedures.	Understand content of best practice antt examples	Jan 19	PHA Secondee Clinical Training Manager	Medical Director	G
		3. Review Competency based assessment/audit tools currently in use for hand hygiene and antt to make changes required to standardise with best practice.	Updated standardised competency based assessment tools for ant & hand hygiene	April 19	PHA Secondee	Medical Director	G
		4. Test amended competency based assessment & audit tools with CSO and training staff.	Agreed competency based	May 19	Clinical Training Manager	Medical Director	G

		5. Implement use of competency based assessment tools antt and hand hygiene audits. **Key Actions for**	assessment/audit tools Evidence of use of competency based assessment tools for antt utilised during training sessions and clinical observations. Evidence of use of hand hygiene audit tools within clinical observation system and at station level	Dec 19	Clinical Training Manager IPC Lead CSO (Improvement)	Medical Director Director of Quality Safety & Improvement	G

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Action Ref 3.	Milestone/Deliverable *Delivery of Training & Competency Based Assessment*	Improvement	Expected Outcome	Completion Date	Responsible Person(s)	Executive Lead	Status
	(a) Sufficient designated staff to be made available, to deliver training, carry out competency assessment and audits of practice and support frontline staff.	1. Review current capacity of training officers and clinical support officers to deliver IPC training and carry out observations of practice in relation to IPC. Determine necessary contingency arrangements.	Identify any potential gaps in capacity of clinical support officers to deliver IPC training and carry out observations of practice in relation to IPC.	Dec 19	AD Education & Learning Clinical Training Manager	Medical Director	G
		2. Progress recruitment for additional Training Officers 3. Progress recruitment for IPC Lead Nurse	Agreed contingency arrangements Sufficient compliment of training officers to support post proficiency training, competency based assessments	Feb 20	AD Education & Learning Clinical Training Manager Medical Director	Medical Director	G
		IPC Practitioner Environmental Cleanliness Lead 4. Agree plan for delivery of IPC training to operational		Nov 19	Director of Quality Safety & Improvement IPC Lead Nurse	Medical Director Director of Quality Safety & Improvement	G A

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		staff (including requirements by staff group, frequency and method of delivery, ie face to face/ e learning) with Director of Operations.	Lead IPC post appointed IPC Practitioner & Environmental Cleanliness Lead appointed	Nov 19	IPC Lead AD Education & Learning	Director of Quality Safety & Improvement Medical Director	**G**
		5. Explore options for additional expert external support to deliver IPC training and carry out competency based assessments for antt. 6. Engage with operational management team to ~~agree robust processes~~ and guidance in relation to sharing individual outcomes from training and competency assessment are shared with relevant staff responsible for carrying personal development reviews (PDRs)	Agreed annual training and education plan (including requirements by staff group, frequency and method of delivery, ie face to face/e learning)	Dec 19	Medical Director Clinical Training Manager IPC Lead	Operations Director Medical Director Director of Quality Safety & Improvement	**A** Paused as progressing currently with NIAS staff internally
	(b). Outcomes from staff training and competency assessment should be aligned and used to inform staff appraisal	7. Outcome of formal assessments (using standardised	Availability of bespoke antt training & competency based assessment option delivered by external provider Clearly defined systems and processes in place for formal sharing	Dec 20	Clinical Training Manager Medical Director Operations AD IPC Lead ASAM SO	Medical Director Director of Ops Director of Quality Safety and Improvement	**G**

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		assessment/observational audit tool) of hand hygiene technique along with formal assessment of antt for ambulance staff involved in performing invasive procedures or managing breaches in patient skin integrity to be formally shared with line managers.	outcomes of hand hygiene audits and antt competency based assessments with line management staff.	Feb 20	IPC Lead Clinical Training Manager AD Education & Learning Operational Management Team	Medical Director Director of Quality Safety and Improvement Director of OPs	**A**
		8. Robust systems and process in place for routine sharing of IPC Education & Training Records to be shared formally with line managers.	~~Evidence of effective~~ information sharing & records held at Divisional/station level. Clearly defined systems and processes in place for formal sharing IPC training records. Evidence of training records held locally at Divisional and station level.	Feb 20	IPC Lead Clinical Training Manager AD Education & Learning	Medical Director Director of Quality Safety and Improvement Director of OPs	**A**

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Action Ref	Milestone/Deliverable *Key Performance Indicators*	Key Actions for Improvement	Expected Outcome	Completion Date	Responsible Person(s)	Executive Lead	Status
4.	Agree reporting of Key Performance Indicators (KPIs) related to IPC training and competency assessment.	1. Review current KPIs related to IPC training and competency assessment at IPC Group, agree frequency and number of competency assessments required for hand hygiene and antt.	Approved IPC KPIs	Dec 19	IPC Lead IPC Group	Medical Director Director of Quality, Safety & Improvement	**G**
		2. Review current quarterly reporting of IPC training and competency assessment reporting to Assurance Committee include routine reporting of competency assessment for antt.	Evidence of IPC related KPIs reported to Assurance Committee including hand hygiene and antt	Jan 20	IPC Lead IPC Group	Medical Director Director of Quality, Safety & Improvement	**A**

		.					
Action Ref	**Milestone/Deliverable IPC Strategy**	**Key Actions for Improvement**	**Expected Outcome**	**Completion Date**	**Responsible Person(s)**	**Executive Lead**	**Status**
5.	(a) Develop an IPC Training & Education Strategy.	1. Agree organisational roles & responsibilities in relation to IPC training and competency assessment and describe them within IPC Training Strategy.	Organisational Roles and Responsibilities agreed and outlined within IPC Strategy and approved by IPC Group and Trust Board	Aug 19	Clinical Training Manager AD Education & Learning PHA Secondee	Medical Director	**G**
		2. Review current assurance arrangements relating to IPC training and competency based assessment, identify gaps and describe assurance framework arrangements within IPC Training Strategy	Competency based assessment arrangements and related assurance framework outlined in approved IPC Training and Education Strategy	Aug 19	Clinical Training Manager AD Education & Learning PHA Secondee	Medical Director	**G**

	(b) Implement IPC Training & Education Strategy across the organisation	3. Describe arrangements for delivery of IPC training & education programme within IPC Training Strategy 4. Seek IPC Group approval for IPC Training Strategy	Arrangements for delivery of IPC training & education programme outlined within approved IPC Training & Education Strategy	Aug 19 Aug 19	Clinical Training Manager PHA Secondee Medical Director Medical Director	Medical Director Medical Director	G
		5. Seek Trust Board approval for IPC Training Strategy	IPC Group Approval				G
		6. Deliver IPC Training in line with IPC Education & Training Strategy 7. Carry out Competency Based Assessments of antt in line with PC Education & Training Strategy 8. Carry out hand hygiene audits in line with IPC Education & Training Strategy 9. Share outcomes of IPC training, competency based assessment and hand hygiene audits with line managers to align with and inform PDR.	Trust Board Approval Evidence of delivery of IPC Education & Training Evidence of Competency Based Assessments of antt Evidence of Hand Hygiene Audits	Aug 19 Feb 20	Medical Director AD of Education & Learning Clinical Training Manager IPC Lead Operational Management Team	Medical Director Director of Quality, Safety & Improvement Medical Director Director of Operations	G A

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		10. Monitor and report on IPC KPIs related to IPC Education and Training competency based assessment of antt & hand hygiene	Evidence of records held at station and divisional level. Inclusion of IPC Education and Training KPIs in Assurance Committee Reports.				

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TB/05/03/2020/04

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT
January 2020 (Month 10)

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently reporting a breakeven position for the ten months ending 31 January 2020 (Month 10), subject to key risks and assumptions in respect of Agenda for Change, investment and efficiency savings. In particular, Accident & Emergency staff are currently being paid at Band 4 and Band 5 on account, without prejudice and subject to the outcome of the matching process. The Trust continues with the assumption that the Board will fund the full legitimate costs of Agenda for Change for NIAS.

Financial position at the end of January 2020 (Month 10)

Financial Breakeven Assessment (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Costs		10,042	15,225	20,294	25,593	30,784	35,998	41,343	46,685	51,968		
Other Expenditure		2,410	3,696	5,376	6,953	8,423	9,871	11,860	13,501	15,217		
Expenditure Total		12,452	18,921	25,670	32,546	39,207	45,869	53,203	60,186	67,185		
Income		147	220	299	436	520	576	609	691	737		
Net Expenditure		12,305	18,701	25,371	32,110	38,687	45,293	52,594	59,495	66,448		
Net Resource Outturn		12,305	18,701	25,371	32,110	38,687	45,293	52,594	59,495	66,448		
Revenue Resource Limit (RRL)		12,305	18,701	25,374	32,110	38,687	45,293	52,594	59,495	66,448		
Surplus/(Deficit) against RRL		0	0	3	0	0	0	0	0	0	0	0

Forecast financial position at the end of March 2020

The Trust is also currently forecasting a breakeven position at the end of 2019/20, subject to a number of assumptions particularly in respect of Agenda for Change, investment and efficiency savings. The Trust is required to deliver savings proposals to address a forecast £1.6m savings requirement in 2019/20.

The Trust continues to work with HSCB and other stakeholders to highlight emerging cost pressures and service changes with a view to achieving objectives and maintaining financial balance.

Capital Spend

The Trust has received a Capital Resource Limit (CRL) allocation of £8.345m. This allocation allows the Trust to continue with planned cyclical fleet replacement. Within this allocation, £4.345m has been earmarked for specific ICT schemes and contingency control room arrangements.

Prompt Payment of Invoices

The Trust is required to pay non-HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% (increased from 60%) of invoices within 10 working days (14 calendar days) has also been set.

Performance by number of invoices paid for each of these measures is shown below.

A range of plans are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Total bills paid	2,324	2,686	2,466	2,344	1,783	2,207	2,659	1,948	2,832	2,068			23,317
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,124	2,510	2,254	2,229	1,723	2,033	2,530	1,871	2,715	1,972			21,961
% bills paid on time	91.4%	93.4%	91.4%	95.1%	96.6%	92.1%	95.1%	96.0%	95.9%	95.4%			94.2%
Total bills paid within 10 working days (14 calendar days)	1,509	1,909	1,976	1,790	1,403	1,461	1,978	1,482	1,865	1,476			16,849
% bills paid on time	64.9%	71.1%	80.1%	76.4%	78.7%	66.2%	74.4%	76.1%	65.9%	71.4%			72.3%

Business Services Organisation (BSO) Procurement & Logistics Service (PaLS) Key Performance Indicators (KPI's)

The Business Services Organisation provides a range of services to The Trust, including Procurement and Logistics Services (PaLS), Legal Services, Technology Services and Internal Audit. New reporting arrangements for the Service Level Agreements have identified Key Performance Indicators (KPIs) in respect of Purchasing and Supply. Performance to the end of January 2020 (Month 10) is as follows:

Key Performance Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Average Processing Time Per Requisition Days (Target 5 Days)	3.37	3.21	2.97	3.67	4.21	5.35	3.94	4.31	5.33	4.48		
Percentage of Products Supplied on First Request % (Target 95%)	99.10%	99.90%	99.80%	99.80%	99.20%	100.00%	99.90%	99.62%	99.89%	99.60%		
Number of Lines Issued (Stock and Non Stock Line)	1,456	1,285	1,312	795	1,290	1,236	1,822	1,797	1,609	2,074		
Value of Spend £k (Stock and Non Stock)	675	218	321	296	989	2,817	1,055	1,244	1,149	483		

Information Technology Systems - System Availability

Robust procedures are in place to confirm ongoing availability of Trust systems. Any system failures are reported in this section.

Cyber Incident

On the evening of Wednesday 15 January 2020, NIAS IT were made aware of a security breach on two hardware devices (Citrix NetScaler) which sit outside the firewalls to the NIAS corporate network. These NetScaler's are used to authenticate remote access users (for Citrix and Promis/GRS) and as load balancers for email.

The NIAS IT team took immediate action to attempt to contain the situation. Both NetScaler devices were taken offline, which impacted on remote access services and email. These devices were then wiped and rebuilt from a clean backup by Novosco; after which the latest recommended configuration changes were applied (there was still no software patch available to actually resolve the underlying problem).

Firewall logs were captured and investigated for any signs of intrusion beyond the NetScaler devices. There was no evidence of any intrusion attempts or further compromise. Forescout (Security monitoring software) alerts were checked to ensure that no malicious/unusual activity had been detected on the internal NIAS network.

NIAS took the decision to partially reintroduce the rebuilt NetScaler devices to service on Thursday 16th January in order to enable email – allowing them to be accessible from the internal network, but not from the public internet until a proper certified software patch was made available from Citrix. This decision continued to impact on remote access to NIAS.

Citrix released a certified software patch on Friday 24 January, which was deployed on NIAS's NetScaler devices that same day. NIAS's NetScaler's were then made accessible again via the public internet, restoring full remote access for NIAS staff. As a precautionary measure, staff who used remote access during the period of suspected vulnerability (10-13 January 2020) were asked to change their passwords.

This cyber incident was managed through the HSCNI cyber security incident response action plan as a level 1 (local) incident; and the details of NIAS's suspected NetScaler exploit were reported to the National Cyber Security Centre.

DTR Radio Incident

On the same evening of Wednesday 15 January 2020 and just after NIAS IT had dealt with the cyber incident, EAC staff reported issues with radio communications. Crews could not be contacted on radio via the Integrated Communications Control System (ICCS). EAC despatcher desks were asked to use the contingency Zetron desktop devices or hand held radios while the fault was investigated by the PSNI support team.

The fault proved to be problematic to diagnose and after 3 days of troubleshooting between NIAS IT, ICCS provider (Northgate) and the PSNI the fault was escalated to Motorola who manufacture the radio infrastructure.

Motorola engineers attended the PSNI site hosting the central radio infrastructure on Monday 20 January and after 2 days of testing identified the fault as expired security certificates. New certificates were released by Motorola on Wednesday 22 January and applied to NIAS radio positions by NIAS IT. This action resolved the issue and Motorola accepted full responsibility for the system outage. The PSNI have assured NIAS that procedures will be put in place in future maintenance schedules to ensure this cannot happen again.

Information Technology Systems – Developments

Any system developments are reported in this section

A project to replace the CAD hardware is now at procurement stage. This project will replace hardware which is now seven years old and while in extended manufacturer support is beyond recommended life. An option to host the Disaster Recovery components of the system in the Public Sector Data Centres is currently being explored with the CAD providers (MIS) and BSO. The second stage of implementing the Assured Continuity of Service (known as ACS) module which will support future Disaster Recovery and management arrangements for the CAD will also be completed within this project scope.

The building 'Foyle' adjacent to HQ has now been made IT ready and work has continued on relocation off staff. Wi-Fi installation in the building is now complete and fully operational.

A business case to replace the aging telephony and ICCS (telephony for the control Room) systems has been submitted to the DHCNI team for comment before formal submission to the Department of Health.

The Reach project:

The rollout of the new Mobile Data system to A&E and PCS vehicles is now complete and operational.
The REACH requirements have been reviewed by the project team and prioritised for delivery with early engagement with key stakeholders underway. High level timeline:

- system design configuration Milestone (2) – Complete
- system commissioning by end Feb 2020 – In preparation
- pilot by April 2020, roll out by June 2020
- Project completed by Nov 2020.

Radio replacement project – This project is delayed due to the implementation of CRM and is now due to commence on 2 March 2020.

ICT Help Desk Performance

Key* - Immediate 4 Hours, Urgent 1 Day, High 2 Days, Medium 3 Days, Low 7Days

	January		
Target to Respond to 95%	No of Calls	Within time	Actual
Immediate	8	8	100%
Urgent	35	35	100%
High	8	8	100%
Medium	710	697	98%
Low	631	630	100%
Total	1392		

Information Governance/Informatics – Developments: 01/01/2020 to 31/01/2020

Developments in the provision of Information are reported in this section.

- ***Control Assurance – Information Management: Self-Assessment completed for 2018/19***
- ***Review of Information Asset Owners across the Trust***
- ***Review of IG Policies and Procedures***
- ***Corporate Induction and Specialist IG training for AAP Course***
- ***Supporting the Operations Directorate with the implementation of the Clinical Response Model (CRM). The new model was implemented on 13 November 2019 and the Information Team were integral in the go live process and continue to develop new reports and business intelligence to support the introduction of the new model. All previous data analytic reports are being rebuilt and meetings with external stakeholders including HSCB and Department of Health, Hospital Information Branch have been undertaken. This work remains ongoing***
- ***Supporting Medical Directorate and Transformation Collaborative with Quality Improvement Templates and data analysis. These continue to be developed and monitored. Includes Falls, Hypoglycaemia, Acute Coronary Syndrome, Cardiac Arrest (refer to Medical Directorate section of report for reporting)***
- ***ACP monitoring aspects reviewed. ACP pathways continued to be monitored and reviewed. Ad hoc datasets have been provided to support further initiatives as required ie quality improvement***
- ***Ad hoc data requests to support FOIs and acute service modernisation included hospital turnaround times, winter pressures ie Christmas/New Year, diverts, mental health activity, Dispatch points, independent ambulance activity.***
- ***Supporting work and data streams in Frequent Caller Monitoring and Information Markers including policy/procedures, analytics and business intelligence***
- ***Patient Report Forms and 999 calls to support inter-face incidents, Serious Adverse Incidents, Child Protection Issues, Vulnerable adults etc; PRFs to support quality assurance of Quality Improvement***
- ***AED (Automatic External Defibrillators) Location Interactive Tool being updated on monthly basis***
- ***Interactive tool being updated regularly to support HEMs/Clinical Support Desk***

The Information Team has developed a suite of reports to support performance management which includes daily, weekly, monthly analysis of operational performance; hospital turnaround times; non-emergency transportation etc. These are shown in the Operations section of this Report. Clinical indicators are available in the Medical Directorate's section. Assurance in the area of IG is sought through the Information Governance Steering Group, chaired by DOF&ICT as SIRO with Medical Director as Caldicott Guardian. Minutes are reported to Assurance Committee.

INFORMATION GOVERNANCE SUMMARY OF FREEDOM OF INFORMATION, GENERAL DATA PROTECTION REGULATIONS (SUBJECT ACCESS), PSNI REQUESTS AND SOLCITOR ENQUIRIES PROCESSING LEVELS

Summary 2019/20 requests compared with same period in 2018/19:

	April 2019 to January 2020	April 2018 to January 2019	% Increase / (Decrease)
1 Freedom of Information Requests Received	200	186	+7.5%
1a Freedom of Information Questions Received	498	588	-15.30%
2 General Data Protection Regulations, Subject Access Requests Received	74	49	+51%
3 Police Service of Northern Ireland Requests Received	426	410	+3.90%
4 Solicitor Enquiries Requests Received	754	492	+53.30%
Total (1a) not included in Count	**1456**	**867**	**+68%**

Increase in requests received in all areas for reporting period

1. FREEDOM FOR INFORMATION ACT (2000) – REQUESTS FOR INFORMATION – 01/04/2019 to 31/12/2019

Freedom of Information Act (2000) relates to any information held in an electronic or manual format and can be accessed by anyone who requests it. Exemptions are limited and unless they specifically apply, information must be released. Personal information is accessible using the General Data Protection Regulations (see following):

2019-20 Data

Freedom of information	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 01/04/19 to 31/01/20	Total 01/04/18 to 31/01/19
Number of Requests Received	18	29	27	29	20	17	13	21	6	20			**200**	186
Number of Questions Received	46	68	40	60	64	46	29	54	28	63			**498**	588
Completed Requests processed within 20 days or less	8	20	22	22	14	11	6	13	2	10			**128**	150
Completed Requests exceeding 20 days	10	8	4	6	6	2	3	5	3	0			**47**	21
REQUESTS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	0	3			**3**	
REQUESTS Still being processed (outside 20)	0	0	0	1	0	0	0	2	1	7			**11**	
Stood Down	0	1	1	0	0	4	4	1	0	0			**11**	
Number of Records Fully Disclosed	31	58	34	46	54	26	16	44	26	28			**363**	
Vexatious Requests	0	0	0	0	0	0	0	0	0	0			**0**	
Number of Records for which records not held	9	9	3	6	6	6	0	2	0	0			**41**	
Requests where exemptions wholly/partially applied	6	0	0	0	4	0	0	4	0	0			**14**	
Questions stood down	0	1	3	0	0	14	13	1	0	0			**32**	
QUESTIONS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	0	11			**11**	
QUESTIONS Still Being Processed (outside 20)	0	0	0	8	0	0	0	3	2	24			**37**	
Referrals for Independent Review	0	0	0	0	0	0	0	0	0	0			**0**	
Appeals to the Information Commissioner	0	0	0	0	0	0	0	0	0	0			**0**	
Requestor Type														
Member of Public	5	18	14	12	9	8	4	7	2	7			**86**	
Local Government	0	0	1	0	2	0	0	0	0	1			**4**	
Staff Member	3	4	7	5	1	1	1	2	2	3			**29**	
Media	2	4	0	5	4	4	3	5	0	3			**30**	
Student	0	4	0	1	0	1	0	1	0	0			**7**	
Commercial Company	2	1	2	2	3	1	0	1	1	1			**14**	
Solicitor	1	0	0	1	0	0	1	0	0	0			**3**	
WhatDoTheyKnow.com	2	1	2	4	1	2	4	4	2	5			**27**	
NHS	0	0	0	0	0	0	0	0	0	0			**0**	
Trade Union	0	0	0	0	0	0	0	0	0	0			**0**	

%age completed within 20 working days	
Apr '19 - Jan '20	64.00%
Apr '18 - Jan '19	80.65%

Data will be subject to amendments

2. DATA PROTECTION ACT 1998/GENERAL DATA PROTECTION REGULATION – SUBJECT ACCESS MONITORING

The General Data Protection Regulation/Data Protection Act 1998 allows an individual to have the right to see and/or receive a copy of personal data held about them on both electronic and manual records and to have any incorrect data amended or deleted.

Processing (Subject Access) for the Period 01/01/2020 to 31/01/2020

General Data Protection Regulations/Data Protection Act 2018 – Subject Access	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 – Jan 20	April 18 – Jan 19
Number of Requests Received	7	6	9	4	6	8	18	10	1	5			74	49
Completed Requests processed within 30 days or less	5	2	4	3	4	6	11	6	1	3			44	33
Completed Requests exceeding 30 days	2	3	5	1	1	0	0	0	0	0			9	6
Requests still being processed in line with 30 days	0	0	0	0	0	0	0	0	0	0			0	0
Outstanding Requests exceeding 30 days	0	1	0	0	1	2	6	3	0	2			13	
Request received and action taken but identity not confirmed or requestor stood down the request or requestor has not made further contact	3	0	0	3	0	0	1	1	0	0			8	1
COMPLIANCE RATE – 60%														
Patient	2	1	3	1	1	0	5	3	1	3			20	
NIAS Staff Member	1	1	0	1	2	2	7	2	0	1			17	
External Agency ie Solicitor acting on behalf of patient/staff	2	3	5	0	3	6	6	5	0	0			30	
Relative of Patient	2	1	1	2	0	0	0	0	0	1			7	

- There are a number of subject requests from 2018/19 that remain outstanding relating to staff requests for disciplinary files, HR records etc - these are currently being prioritised
- For requests that have been received but awaiting further information these are not included in count of number of requests received

3. POLICE SERVICE OF NORTHERN IRELAND REQUESTS – Police Acts, Common Law 01/04/2019 to 31/01/2020

Purpose: for the prevention, investigations and detection of crime; for apprehension and prosecution of offenders; or to prepare a file for Coroners Court etc.

Requests include the release of call incident logs, 999 calls, radio transmissions, staff names/shift patterns, Patient Report Form, and staff witness statements in line with legislative requirements to assist with PSNI investigations, for example, investigation of fatal road traffic collisions, murder enquiries, alleged assaults.

Requests will relates and include the release of call incident logs, 999 call, staff names and shift patterns, Patient Report Form, staff witness statements in line with legislative requirements to assist with PSNI investigations for example, investigation of fatal road traffic collisions, murder enquiries, alleged assaults etc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 - Jan 20	Apr 18-Jan 19
Number of Requests Received (based on receipt of correspondence date)	51	41	34	49	42	33	38	46	41	51			426	410

4. SOLICITOR ENQUIRIES 01/04/2019 to 31/01/2020

Requests for Information which fall under the remit of the Data Protection Act 1998/General Data Protection Regulations and/or Access to Health Records (NI) Order 1993

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 – Jan 20	Apr 18-Jan 19
Number of Requests Received (based on receipt of correspondence date)	65	63	77	99	65	66	72	86	64	77			754	492

5. DEPARTMENT OF HEALTH – REQUESTS FOR INFORMATION

Processing for the Period 01/04/2019 TO 31/01/2020

DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 – Jan 20
Assembly Questions (Oral)	0	0	0	0	0	0	0	0	0	0			0
Assembly Questions (Written)	0	0	0	0	0	0	0	0	0	2			2
CORs/SCORs Received	1	2	3	0	2	3	1	0	0	1			13
TOFs Received	0	0	0	0	0	0	0	0	0	0			0
INVs Received	0	0	0	0	0	0	0	0	0	1			0

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Title:	Operations Directorate Performance Report
Purpose:	Up-date Trust Board on Operational Performance, Actions and Activities
Content:	**Emergency Ambulance Control (EAC) Update:** • Call Performance and Activities **Operational Performance Update:** • New Clinical Response Model (CRM) performance (Cat 1-4) • Emergency Department Turnaround Times • Update on Flu Vaccination Campaign
Recommendation:	For Noting: • Increasing numbers of calls • Increased turnaround times
Prepared and Presented by:	Robert Sowney, Interim Director of Operations

Emergency Ambulance Control (EAC) Report

EAC Call Taking Statistics

Emergency Ambulance Control has three designations of call covered by the Automatic Call Distribution (ACD) system which manages all incoming Emergency, Routine and Urgent / HCP calls.

Emergency Call (999) Activity

From April 2019 – January 2020 the number of emergency calls answered was 182,885 averaging approximately 600 emergency calls per day.

As well as taking calls from the general public, NIAS also receives calls from hospitals, GP's and other health care professionals. The average daily calls (i.e. all calls including 999, Routine & HCP) to EAC continues to increase and now stands at approximately 1100 calls per day.

Key Performance Indicator - 999 Call Answer Times

EAC currently aims to answer calls as quickly as possible and has a target of 90% of all emergency calls answered within 5 seconds*. (*it is envisaged that this target will change to a mean target in 2020 in line with other UK Ambulance Services).

Call answer performance up to January 2020 was 76% of 999 calls were answered within 5 secs. The average 999 Call Delay was 14secs.

A number of reasons and risks have been raised in relation to current and forecasted pressures on 999 call answering performance which are as follows:

- Increase in call demand and call surges
- Reduction of frontline operational response capacity leading to an increase of duplicate 999 calls.
- Reduction in Emergency Ambulance Control (EAC) Call Taking staff/capacity
- Absence levels of call taking staff (EMD levels at 11.8% for 2018/19)
- Emergency leave/high staff turnover

- Expected/unexpected call surge
- Increase in ambulance calls due to seasonal variations and significant days.

Key actions & Highlights

In January 2020 Mrs Ruth McNamara took up the role of Assistant Director of Operations (Control & Communications) on a temporary basis.

- Preparation and planning for a new EMD course for March 2020 has commenced to provide additional 999 Call Taking capacity.
- The recruitment process for EMD Supervisors has been completed and a comprehensive training programme has been developed. It is expected that the supervisors will take up post in March 2020.
- Work commenced on the construction of a new Control Training and Quality Improvement facility and is due to be completed by July 2020. This will provide EAC with its first dedicated training facility and will help improve the delivery of training to EAC staff.
- EAC rota re-design. An external specialist company has been engaged to conduct a review of rotas to ensure we have the right skills on duty at the right time to meet the service demand.
- A new EAC Duty Manager, Simon Fell has been taken up position from January 2020.

RESPONSE TIME PERFORMANCE REPORT YEAR END REPORT

Introduction

On 12 November 2019, a new Clinical Response Model (CRM) programme was implemented along with a new set of response categories within Northern Ireland and which the data below is based on. The CRM model will focus on achieving optimal outcomes for patients by providing the right response, in the right place, based on clinical need for every call. This means new, evidence-based categories for presenting conditions and proposed new targets for response times.

Response Time Targets

Call Type	Category	Mean Standard	90th Perpercentile
999 Immediately Life Threatening	**Category 1 (C1)**	**8 min**	**15 min**
	Category 1T (C1T)*	**19 min**	**30 min**
999 Emergency – Potentially Serious Incidents	**Category 2 (C2)**	**18 min**	**40 min**
Urgent Problem	**Category 3 (C3)**	**No standard**	**120 min (02:00:00) hh:mm:ss**
Less Urgent Problem	**Category 4 (C4)**	**No standard**	**180 min (03:00:00) hh:mm:ss**
Non-Urgent Enquiry	**Category 5 (C5)**	**No specified target**	**No specified target**

***C1T – Indictor only**

Summary of Trends and overall comment:

- The first quarter post implementation of the new Clinical response Model (CRM) show encouraging performance, as we continue to meet the Cat 1 transportation target and show improvement in both the mean and 90th percentile for all categories (C1, 2, 3 and 4) in January 2020 compared to the previous month of December 2019. (Ref tables below)

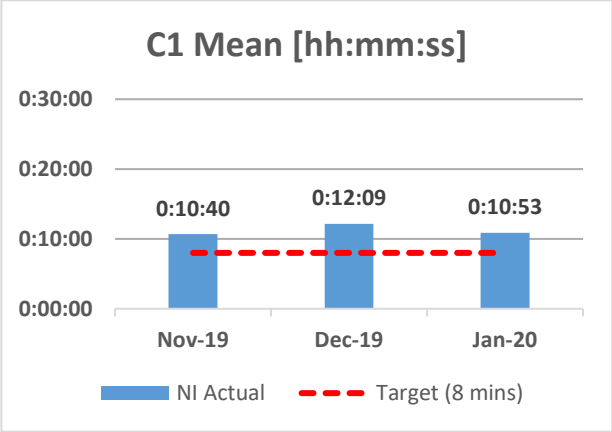
- Trends for ambulance turnaround times greater than the standard (i.e. 30 mins) continue to impact heavily on NIAS response and availability. We continue to work with hospitals and HSCB to improve these.

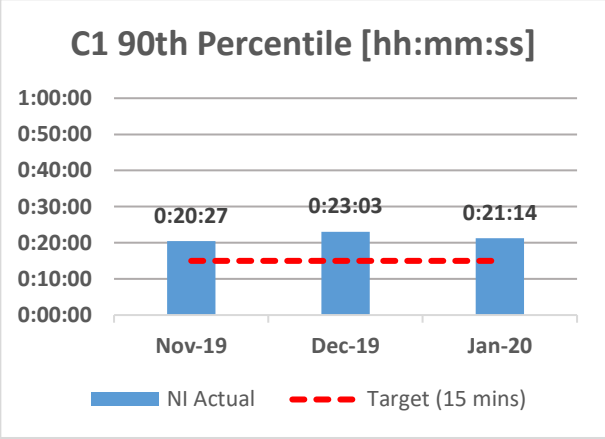
- The potential for further Industrial Action continued to have some impact on Management plans in January. There was however no direct disruption to normal front line service delivery. The result of the Unions ballot regarding future action is pending.

- COVID-19 (Coronavirus): Operations Directorate have been working closely with the Medical Directorate to prepare and plan for the future impact of COVID-19 on NIAS service delivery. Senior staff are engaged in developing procedures e.g. for managing the pathways for transporting suspected patients to and from hospital. In relation to this, Operations staff are currently receiving updated Fit Testing for individual protective wear.

Ambulance Response Programme (ARP) – Response Times Charts (by Month) – Northern Ireland

Category 1 Time Taken for ambulance response to arrive

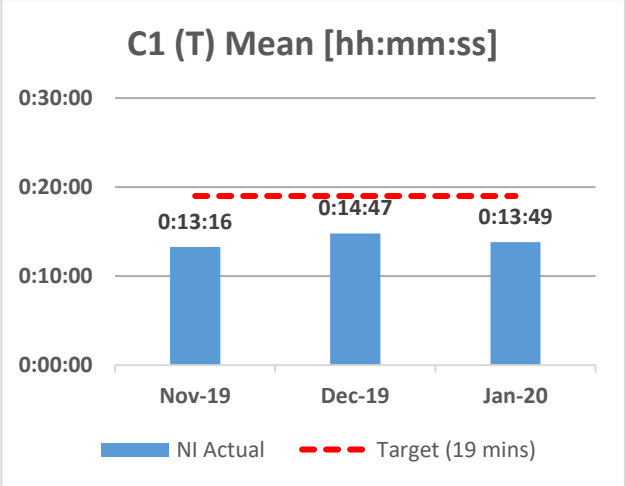


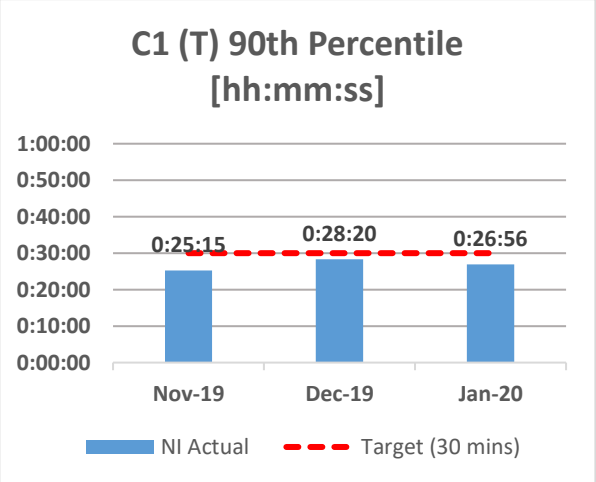


Category 1 average (mean) response time performance for January 2020 was 10min 53 seconds.

Category 1 90th percentile performance for January 2020 was 21min 14seconds.

Time Taken for transporting vehicle (as required) to arrive

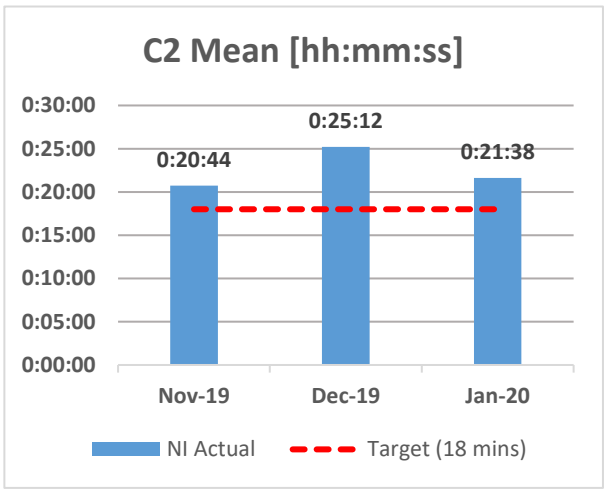


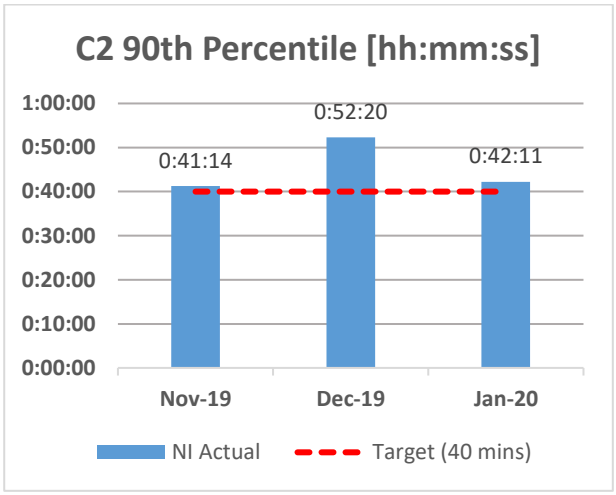


Category 1T average (mean) response time performance for January 2020 was 13min 49 seconds.

Category 1T 90th percentile performance for January 2020 was 26min 56 seconds.

Category 2 Time Taken for ambulance response to arrive

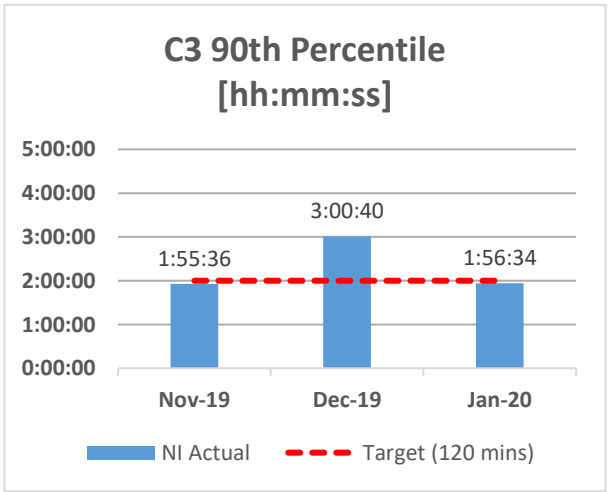


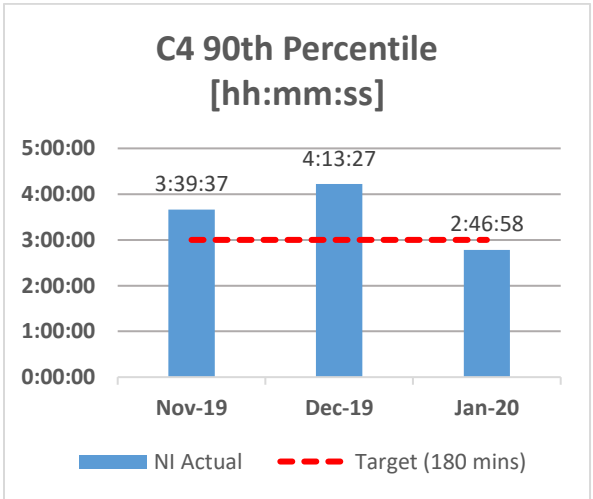


Category 2 average (mean) response time performance for January 2020 was 21min 38 seconds.

Category 2 90th percentile performance for January 2020 was 42min 11 seconds.

Category 3 & 4 Time Taken for ambulance response to arrive





90th percentile performance for January 2020 was 1h 56 min for Category 3 and 2h 47min for Category 4.

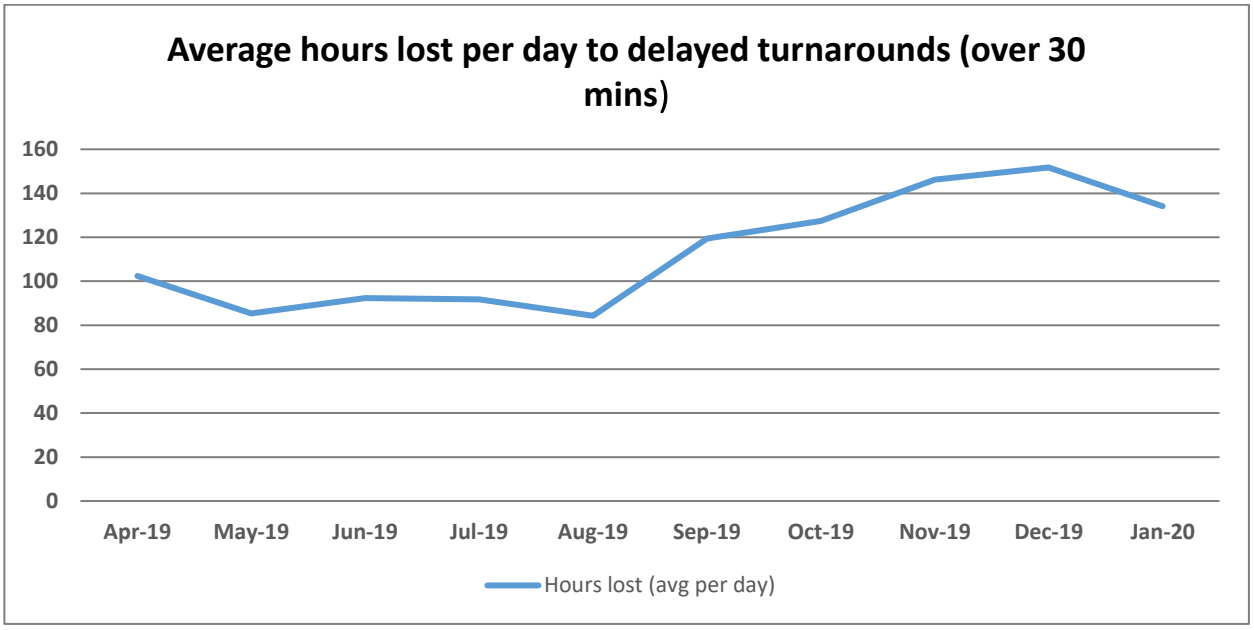
Hospital Turnaround Times

Trends for ambulance turnaround times greater than the standard (i.e. 30 mins) continue to heavily impact on NIAS response and availability.

We continue to work with hospitals and the HSCB to improve the turnaround times**.**

Data is shown below for the current year to date from April 2019; the most recent quarter and graph to show the overall (increasing) trend of average hours lost per day.

Turnaround Delays	YTD	Nov-19	Dec-19	Jan-20
Total Number of Turnaround Times Reported at Acute Hospitals 2019/20	130380	13626	13458	13097
Total Number of Turnaround Times in Excess of 30 minutes 2019/20	91792	10063	10085	9664
% of Turnaround Times in Excess of 30 minutes 2019/20	70.40%	73.85%	74.94%	73.79%
Total Operational Hours Lost to Turnaround Times in Excess of 30 minutes 2019/20	34718	4388	4704	4156
Average Operational Hours Lost to Turnaround Times Delays in Excess of 30 minutes 2019/20 PER DAY	113	146	152	134



Addressing Turnaround times

As reported to Trust Board last month, a number of measures have recently been implemented to address the issues with Turnaround times at Emergency Departments. These include additional HALO capacity and the new Ambulance Handover Escalation Protocol which are reported on below:

Additional HALO capacity

Approval has been given to increase the HALO capacity across all sites: 24hr at Ulster and 16hr at RVH/ CRG/ ALT and AAH. The recruitment process for this has commenced and is expected to be completed within the first quarter of 2020-21.

Ambulance Handover Escalation Protocol

NIAS have been working to support the new ***Regional Ambulance Handover Escalation Protocol*** introduced in January 2020 for planned and emergency diverts between hospitals.

There are some bedding in issues with this new procedure, which have been highlighted to the Department, and we expect to engage further to support further improvement.

NIAS have recently reported to the Department of Health on this comparing data from January 2019 to January 2020, following key points were highlighted:

1. **Planned and Emergency Divert**

The majority of planned diverts are between hospitals within the same Trust.

The South East Trust has predominantly activated Emergency diverts in the first month and the opportunity to improve the procedure and audit trail has been identified by NIAS.

2. **Generally, there was a fall in ambulance arrivals in January 2020**

Regionally, the number of ambulance arrivals to the five main hospitals was greater in January 2019 *(n=9751),* compared to January 2020 *(n=9418)*

3. **Turnaround Times* (within the 30-minute Standard has declined)**

Regionally, the proportion of turnaround times within the 30-minute standard has declined from 34.22% in January 2019, compared to 26.21% in January 2020.

*(*This is the time from arrival at ED until the ambulance crew have clinically handed the patient over and are operational again)*

4. **Clinical Handover Times (within the 15-minute Standard has declined)**

Regionally, the patient clinical handover times within the 15-minute standard has declined from 39.57% in January 2019, compared to 18.00% in January 2020.

*(*This is the time from arrival at ED until the patient is clinically handed over to the ED staff)*

5. Ambulance Clearing Times (within 15-Minute Standard has improved)

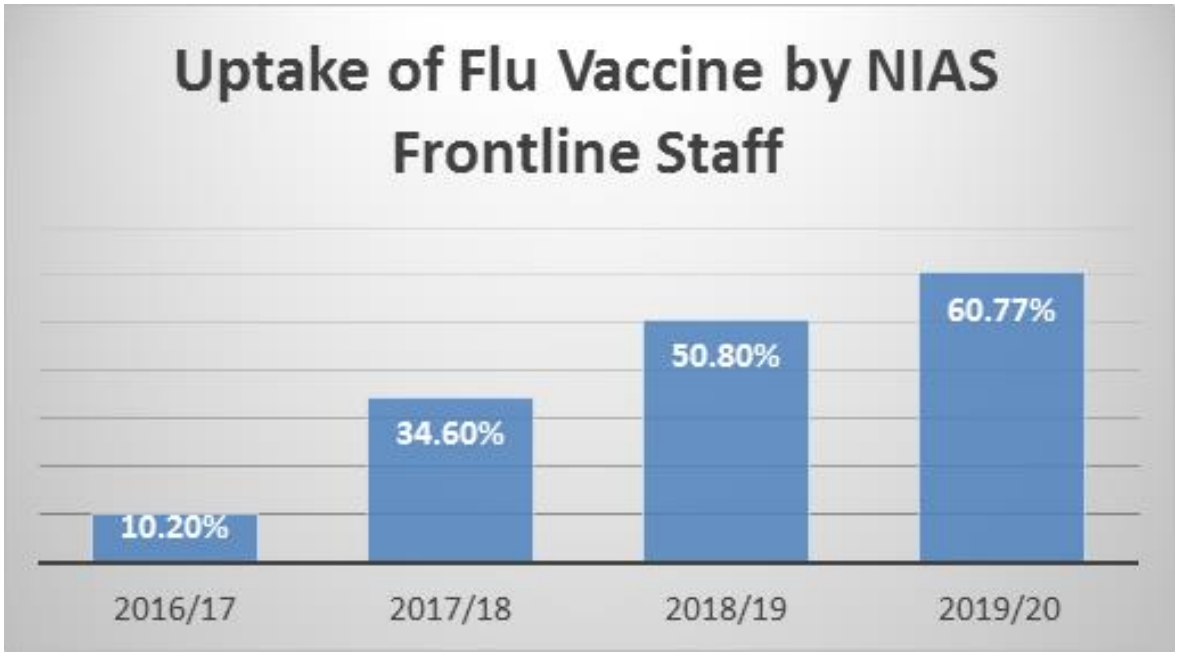
Regionally, the ambulance clearing times within the 15-minute standard has improved from 61.04% in 2019, compared to 77.68% in 2020.

*(*This is the time from when the patient is clinically handed over until the ambulance crew are operational again).*

NIAS flu Vaccination Campaign

The Chief Medical Officer Dr Michael McBride has stated his ambition is for a 100% uptake of medical professionals with direct patient contact to be vaccinated. A minimum uptake target of 50% has been set across all Trusts this year for frontline Health Care workers for 2019/20 flu season.

So far this season, **60.77%** of staff with patient contact have received the flu vaccination (702 which out of a total frontline workforce of 1155) which is more than 10% above the DOH target of 50%. A year on year increase of uptake continues as shown in the table below.



In total 816 employees have been vaccinated: 679 operational and 137 non-operational by NIAS Peer Vaccinators**,** plus an additional 23 operational staff by the Occupational Health department.

We continue to assist other Trusts with their Flu Campaigns and have had positive feedback from the Occupational Health department whom we are working closely with.

Above pictures: Peer Vaccinator Jim Lawlor working with BHSCT to vaccinate their frontline staff

The Flu vehicles, which have been an invaluable addition to the NIAS Flu Campaign this season, have been put to further good use, being used in the current FIT testing.

An end of HSCW Flu Season Evaluation Workshop (2019-20) is due to be held on Friday 24th April 2020 where each Trust will discuss their campaigns and share their plans for next season.

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Medical Director
5 March 2020
(January 2020)

Medical Directorate Performance Report for Trust Board

Emergency Planning & Business Continuity	
	The major focus for the Emergency Planning & Buisness Continuity Team during January 2020 has been work in relation to the potential impact of Covid-19. Significant work has been undertaken alongside the IPC team in refreshing plans for infection outbreak and fit testing of frontline staff. NIAS is represented on daily teleconferences with Health Silver who are leading the Northern Ireland response, and the Medical Director is engaged with counterparts in other UK Services to share learning. The HART Advisors are managing transfer of potential cases individually at this stage.
Risk Management	
Corporate Risk Register	A workshop for a review of the Corporate Risk Register both by individual Directors and collaboratively will be scheduled following the launch of the new NIAS Strategic Plan.
Incident Reporting Procedures	A weekly meeting of the SAI team is now held to jointly review potential cases for notification to the HSCB. Draft criteria have been adopted for the review of cases where delay in response is a key feature and with this proactive approach there is an increased number of cases being reported. Family engagement remains a major challenge for the organisation.
Outcomes from Reports, Alerts, etc.	The Senior Management Team is updated weekly on any new potential SAIs and a formal report on adverse incidents including SAIs involving NIAS are provided to the Assurance Committee. The Medical Director reports on any Coroner's reports, medication and device alerts, NICE guidance and regional learning letters which are applicable to the context of an Ambulance Service. All of these areas are eligible for discussion at the Trust's Learning Outcomes Review Group.
Clinical Care	
Regional Community Resuscitation Strategy	**Community** Community Resuscitation is included within Health and Wellbeing of the Community Plans of the following Councils – Ards & North Down, Lisburn & Castlereagh, Mid-Ulster Council, Antrim & Newtownabbey, Armagh, Banbridge & Craigavon, Derry City & Strabane. Plans are in place to follow up with Belfast, Causeway Coast & Glens, Mid & East Antrim, Fermanagh & Omagh. Plans are now in place between NIAS, Councils and SportNI to provide Heartstart training across five

	Council areas who have Community Resuscitation plans. This will build capacity for approximately 60 trainers to deliver training to sports clubs within the agreed Council areas. **AEDs** Number of AEDs now registered on the NIAS interactive map: 1648. Meetings held with British Heart Foundation regarding the integration of the National Defibrillator Network. Planned to go live on 19th February 2020. **Community First Responders** Review ongoing of all processes and documentation relating to the recruitment, training and support of CFRs. New CFR schemes are on hold until at least June 2021 to provide training in Conflict resolution, moving and handling and safeguarding to existing CFR volunteers (approx. 320). **Schools** Schools teacher training continues as scheduled. **Data** The Central Survey Unit have confirmed a number of CPR/AED questions to be asked to 11-18 year olds as part of the Children and Young Peoples Behaviour and Attitudes survey. This commenced in October 2019. Plans in place to discuss the collection and collation of Out of Hospital Cardiac Arrest statistics.
Regional Electronic Ambulance Communications Hubs (REACH) Project (previously ePRF)	Data centre links with BSO are being managed through the existing structures of Belfast Trust on the Knockbracken site. There is an issue with a physical blocked duct on site impacting on cabling. Belfast Trust are investigating this but as yet there is no resolution. Current plans will proceed with the existing 100Mb link via Belfast City Hospital until the new data links are established. Milestone 2 has now been signed off at the Programme Board in January 2020. The issue of the Active Directory is a wider NIAS issue that needs to be taken forward as part of a shared services project. There is a current resolution in place for the project in order to avoid delays with a view to a longer term option of federating through active directory. Project is currently working towards having the central system commissioned by end of March 2020 – Milestone 3. Live interfaces now established with CAD, HCN and the Corpuls defibrillators.

Appropriate Care Pathways	The Appropriate Care Pathways continue to be used by staff and the non-convey rate is maintained around 24.4%. **Training / Education** Planning is underway for the input of the Clinical Transformation team into next year's training plan. Members of the team have presented at new staff inductions and training courses to promote the use of ACPs and ensure trainees are well versed in the available pathways. Courses have included those for: · AAPs · New direct entry staff The SHSCT and NIAS are working in collaboration to develop ways which is responsive, reduces inappropriate need for a paramedic to attend an uninjured faller and minimises disruption to domiciliary care services. NIAS and the SHSCT have introduced a pilot in the use of a Raizer chair to assist uninjured clients to get up from the floor if they do not have family to assist them or cannot get up using the backward chaining method or have a hoist insitu. The Raizer chairs will be stored by an independent ambulance provider who aim to respond to patients within one hour of receiving the call from NIAS. In the month of January the independent provider has responded on six occasions at the request of NIAS. Work is currently underway to review the SHSCT Enhanced care at Home referrals process similar to the question set for falls referral. **Presentations** The CSO seconded to the Clinical Transformation and Improvement team continues to engage with other relevant stakeholders on behalf of NIAS. In conjunction with the other agencies the team delivered MATT awareness training at the QUB Medical Study Day. **NART Tool Pilot** Four homes continue to participate in this pilot to support Nursing Home staff with access to a triage tool to help with decision-making for patients who may require medical assessment. This is showing significant results to date including a 40% reduction in ED attendances based upon early analysis of the completed NaRT forms. The team continue to support these Nursing Home managers and staff. An evaluation has commenced in association with the Public Health Agency in order to determine next steps regarding this tool. This pilot has also been included in the Urgent and Emergency Care Review

	under the Older Persons strand and an I-stumble tool for the management for patients who have fallen. **Quality Improvement** 14 new staff are undertaking the SQE Quality Improvement Programme this year and there are a very comprehensive and encouraging range of projects from participants who range from front-line, Paramedic, Supervisor, Ambulance Control, Non-Emergency Ambulance Control and support functions. **Clinical Support Desk** The CSD continues to provide telephone based clinical triage (Hear & Treat) for low acuity calls received by Emergency Ambulance Control. The Desk triaged 2430 calls in January. Over the past 6 months the team has achieved a 25% Hear and Treat rate and a further 36% of calls were downgraded to an ICV resource. Discussions with current CSD staff who are temporary have secured 4 out of those 5 for a further 6 months minimum, with only 1 leaving to return to operational A&E duties. A new rota has been introduced from the 1st January 2020 which will introduce improved cover including some 24/7 cover. Full 24/7 will be dependent upon recruitment and retention. A business case for additional and recurrent funding for CSD is currently being finalised for consideration by HSCB Commissioners. **Regional Meetings** The team continue to be involved in a range of new clinical developments and groups such as: Regional Sepsis Work Palliative Care developments Diabetic referral pathway meeting with the NHSCT Lead Dr Kennedy Caring Together: Partnership in Practice with PHA/PSNI/NIAS care home response British Geriatric Society Conference Review and next steps of the MATT Service Pilots regarding Anticipatory Care Frailty developments including Co-chairing the T&F group for Public Health Messages HSCQI and regional Improvement Initiatives Scoping of further ACP together with Trust leads.

	The team continue to provide leadership input to the national Ambulance Q initiative as it develops.
Helicopter Emergency Medical Service (HEMS)	The helipad at the RVH site has now been fully approved and flight testing is due to commence mid-February with live landings likely to start one week later. Landing at this pad will save around 25 minutes per patient journey as well as reducing reliance on an A&E resource to meet the aircraft at Musgrave Park Hospital. The Clinical Team have reviewed the potential of expansion of HEMS to attend medical calls where advanced skills may be of specific benefit. This will require review by the commissioners and the development of clear guidance for the HEMS Dispatch Team, but the greater impact will be on the Charity relating to fuel costs for additional flights. Initially the service was introduced as a response to serious trauma, but there are a limited number of medical emergencies every week which would benefit from the same advanced skill set.
Clinical Education and Training	
	January 2020 saw the second cohort of Foundation Degree student Paramedics begin their training in the Regional Ambulance Training Centre. This group of former NIAS EMTs had successfully completed a bridging programme in late 2019 and began their studies in the classroom ahead of their first placement in February. An addition to the programme was a talk by representatives from the Coroner's Office who advised students on procedures and documentation following unexpected deaths. This practical and informative lecture was well received and will be delivered again to future students. Our Level 4 Associate Ambulance Practitioner students have completed their Certificate in Emergency Ambulance Response Driving as part of their training to become qualified EMTs in May 2020. The AAP students and Training Officers based in Magee Campus recently provided an urgent response when a nursing student became acutely unwell whilst on campus. Due to the quick thinking and professional care received, the student made a good recovery and kindly sent a letter of thanks to the NIAS Chief Executive to share her appreciation of the care she experienced. A group of qualified paramedics and EMTs joined NIAS and completed a 2-week induction programme in January. This ensures that their existing skills are enhanced with knowledge of NIAS policies and procedures and that they are fully competent in using NIAS equipment.

	Post Proficiency training for all A&E staff was completed in several Divisions during January with a few remaining training days planned for February. This training includes elements from the Infection Prevention Control Education & Training Plan developed to support the RQIA's recommendations. Another important aspect of the IPC plan is sufficient Clinical Support Officers in post to provide clinical supervision and audit of IPC processes. A recruitment process for additional CSOs began in late 2019 and successful candidates will be appointed in February.

EMERGENCY PLANNING REPORT FOR JANUARY 2020

KPI No		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2	**No of Potential Major Incidents**	**1**								**1**			
	No of Declared Major Incidents	**1**											
	No of Airport alerts												
	Belfast International Airport	**1**			**1**		**1**			**1**			
	Belfast City Airport			**1**	**2**						**1**		
	City of Derry Airport												
	St Angelo Airport												
	Newtownards Airfield												
	Other airfields												
	Business Continuity	**1**			**1**	**2**	**3**	**1**	**1**	**1**	**2**		
	Hazardous Material Incidents (HART calls)												
	HART pre-planned deployments		**1**		**3**	**1**					**1**		
4	**Training sessions**	**1**	**3**	**2**		**1**	**2**	**3**	**2**	**2**	**3**		
	Emergency Planning	**4**	**4**	**5**	**1**	**2**	**2**	**4**	**5**	**2**	**2**		
	HART	**2**	**1**	**4**	**1**	**1**	**2**	**1**	**1**	**2**	**1**		
	Business Continuity												
5	**Exercises**												
	Live	**1**		**2**			**1**			**1**	**1**		
	Tabletop		**2**	**2**	**1**	**4**	**1**	**2**			**1**		
	Observer		**1**					**1**					
6	**Updates or amendments to MIP**												
	Events	**1**	**5**	**3**	**1**	**2**	**2**	**1**	**1**				
	HART Calls/ deployments	**77**	**73**	**110**	**133**	**121**	**138**	**121**	**136**	**161**	**127**		
	GOLD operational				**2**								

Potential Major Incidents
There were no potential Major Incidents during this period.

Major Incidents
There were no declared Major Incidents during this period.

Airport Alerts
On 7 January 2020 at 0740hrs NIAS received an airport alert to the George Best Belfast City Airport for an aircraft making an emergency landing reporting “smoke in the cabin”. No ETA and no detail of number of passengers on board provided. Dispatched to scene 6 A&E crews, 2 Intermediate Care Vehicles, 2 HART crews, 2 Rapid Response Vehicles, 8 Officers, 1 Doctor and the Emergency Equipment Vehicle and Mobile Control Vehicle.

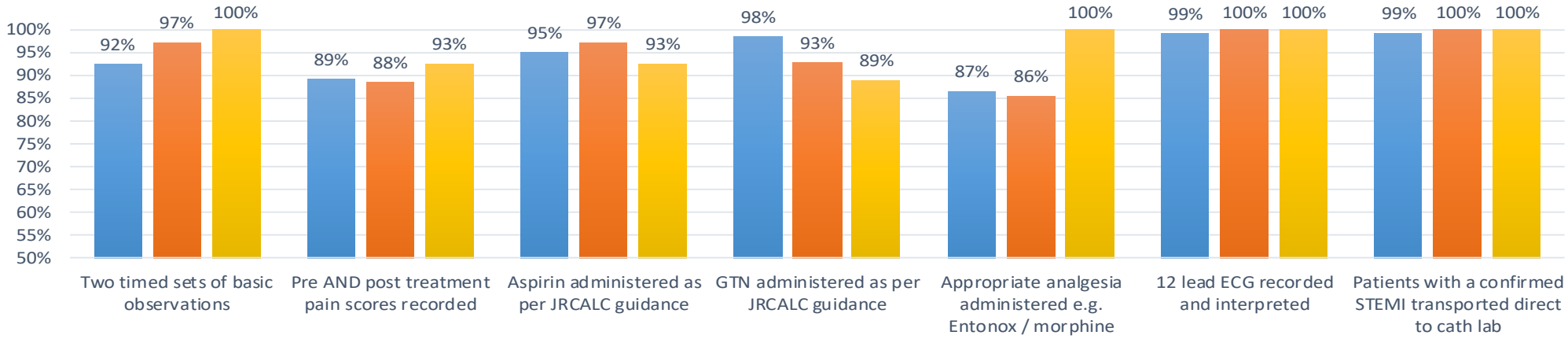
HAZMAT / Hazardous Area Response Team (HART) deployments
54 = Deployments with Breathing Apparatus skills/ HAZMAT deployments
13 = Restricted Space
5 = Inland Water Operations
1 = Special Services Operations
6 = HAZMAT
48 = Assistance to Ops

William Newton
Assistant Director of Emergency Planning

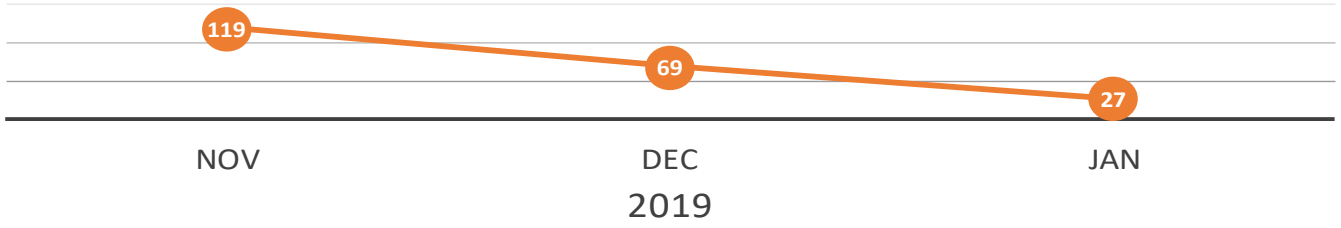
Northern Ireland Ambulance Service
Health and Social Care Trust

ACUTE CORONARY SYNDROME

QUALITY IMPROVEMENT COMPLIANCE



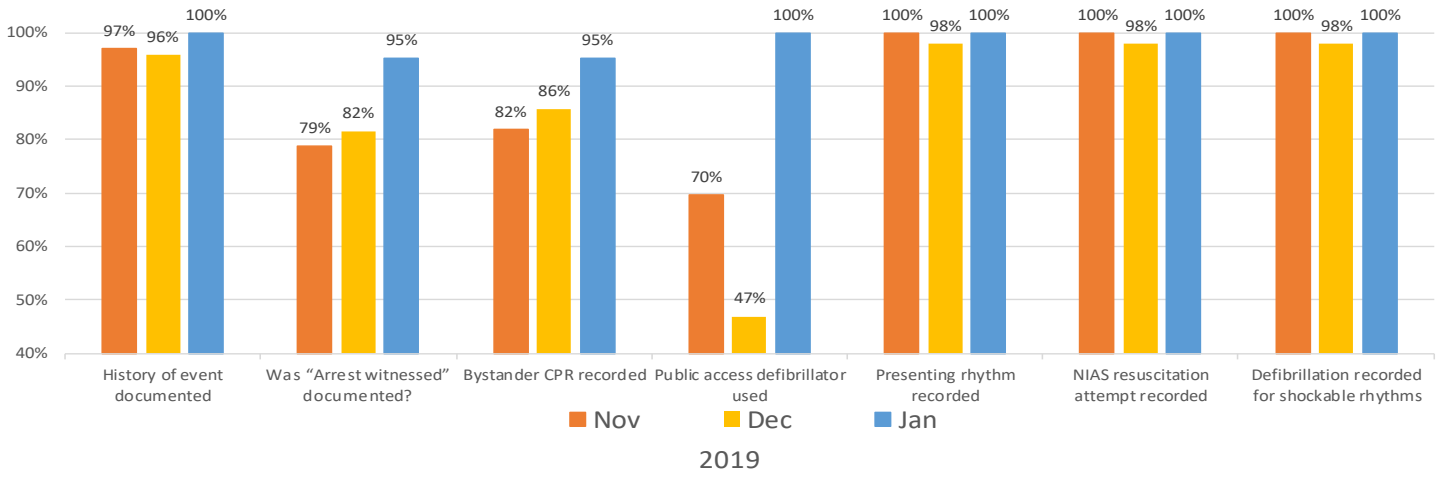
Total PRFs Audited

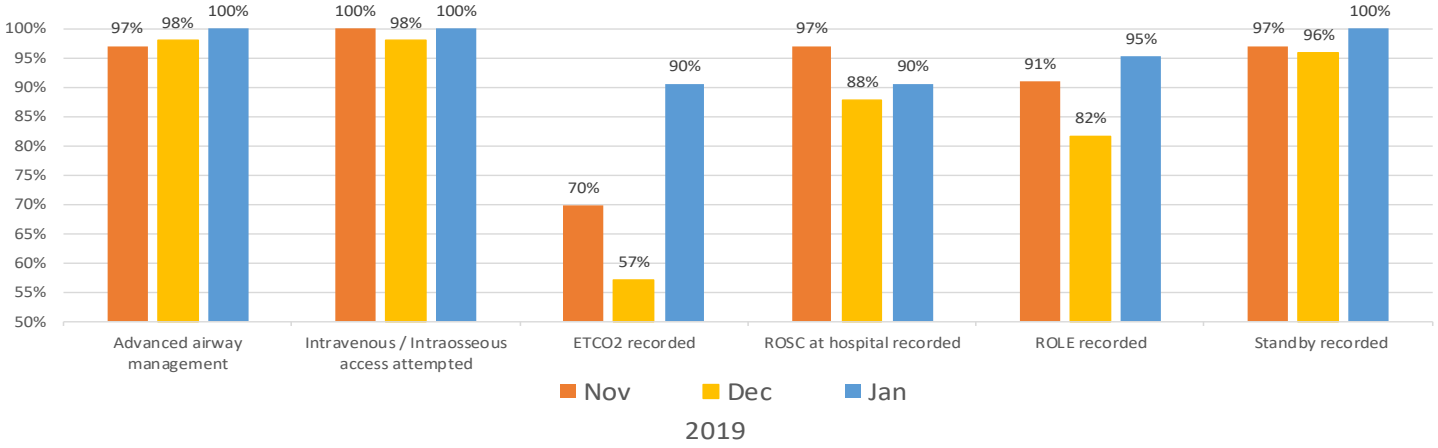


Northern Ireland Ambulance Service
Health and Social Care Trust

CARDIAC ARREST

QUALITY IMPROVEMENT COMPLIANCE





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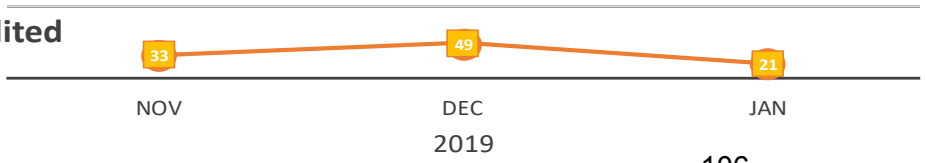
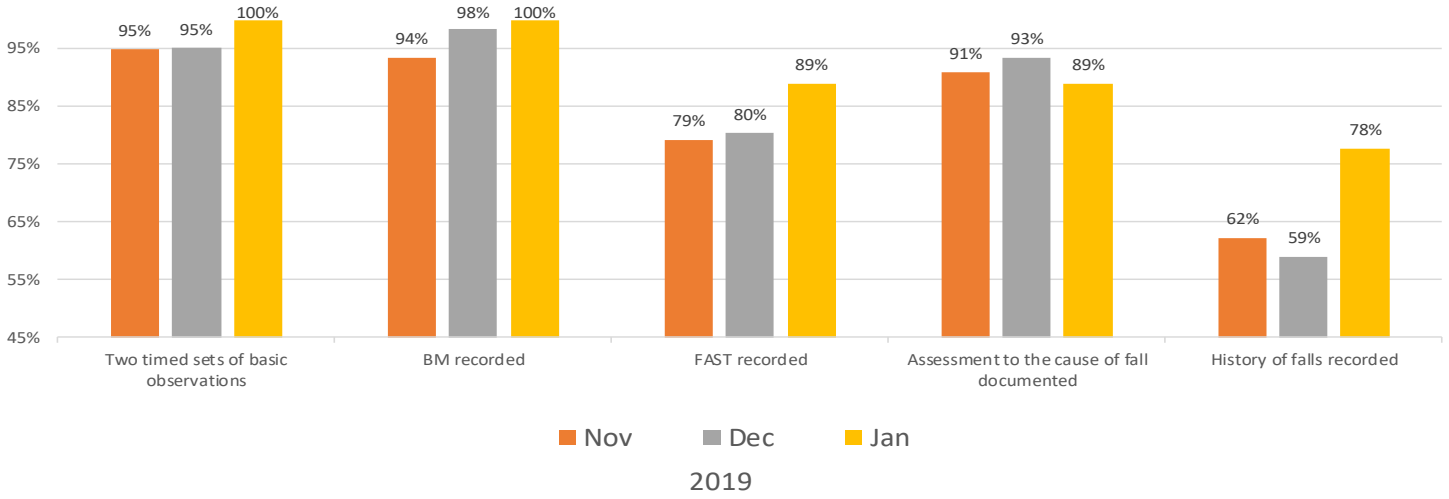
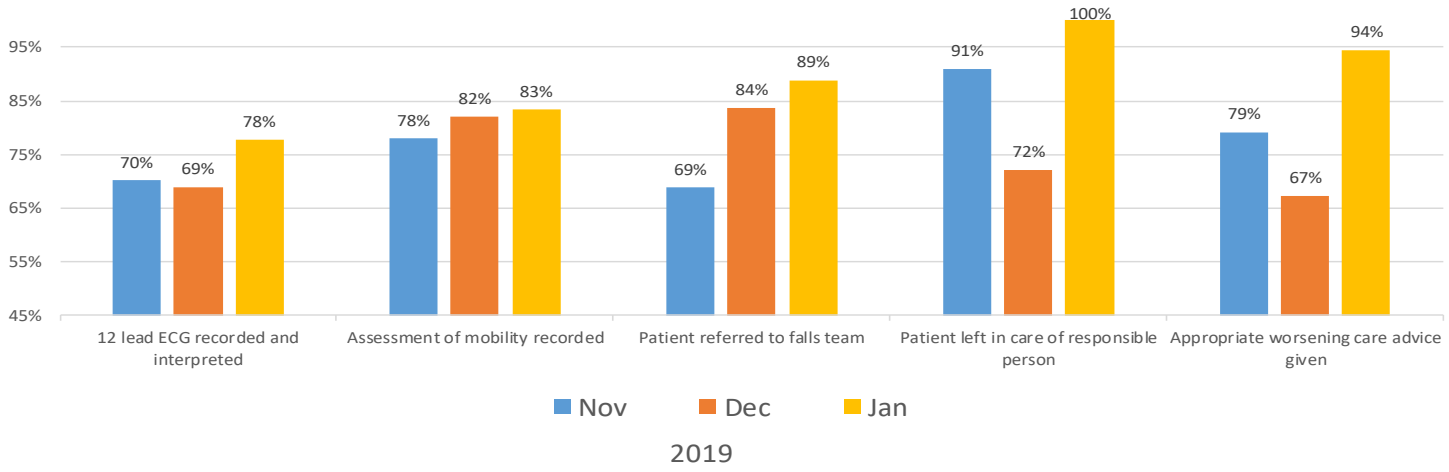


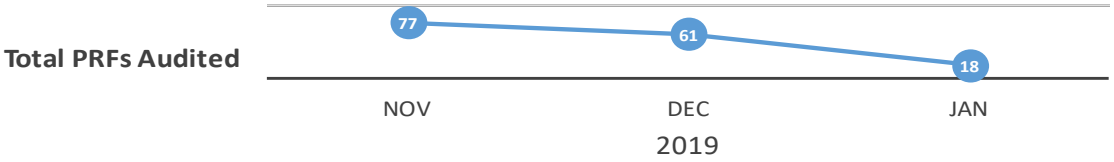
Northern Ireland Ambulance Service
Health and Social Care Trust

FALLS

QUALITY IMPROVEMENT COMPLIANCE



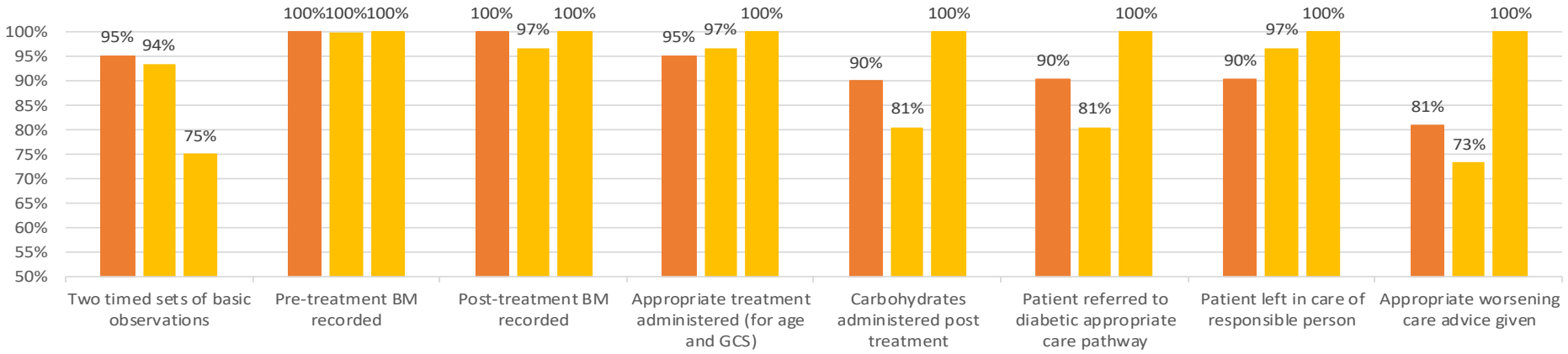


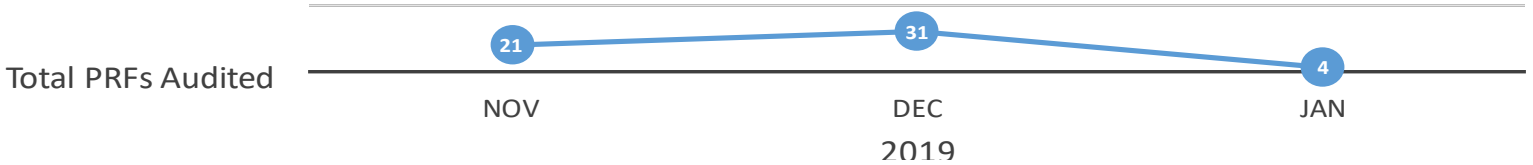


Northern Ireland Ambulance Service
Health and Social Care Trust

HYPOGLYCAEMIA

QUALITY IMPROVEMENT COMPLIANCE

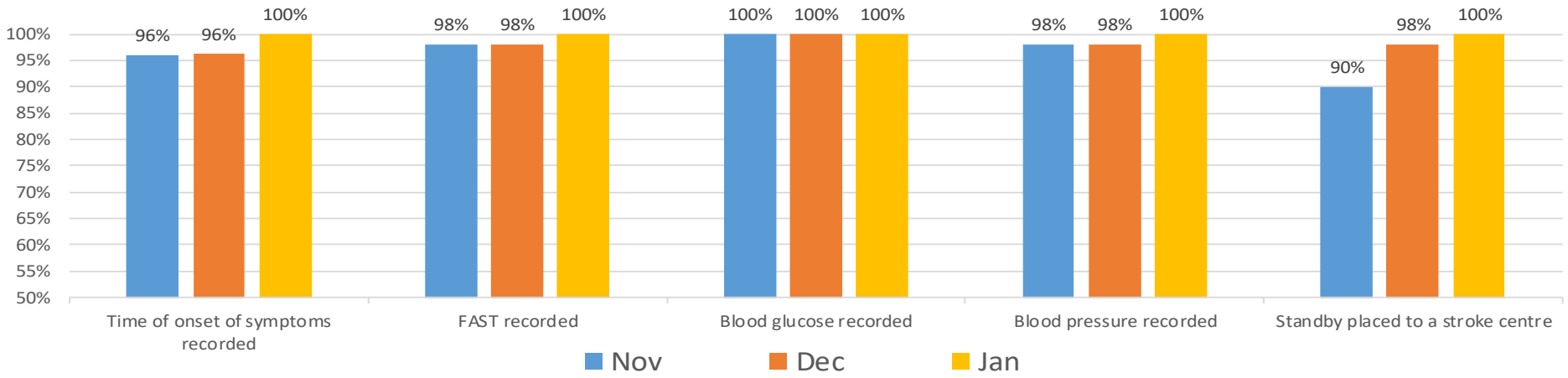


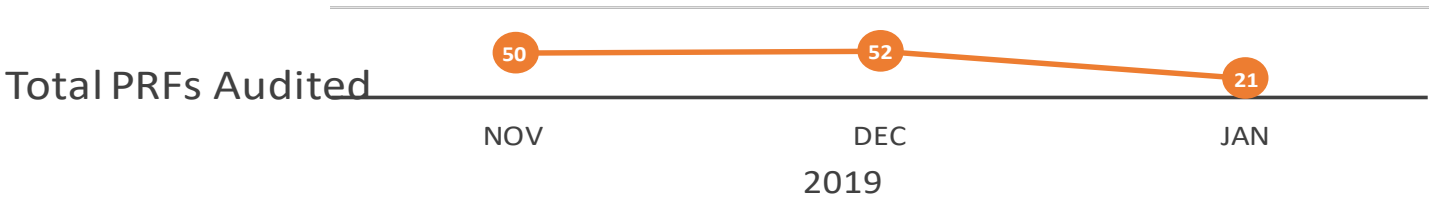


Northern Ireland Ambulance Service
Health and Social Care Trust

STROKE

QUALITY IMPROVEMENT COMPLIANCE





Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

HUMAN RESOURCES AND CORPORATE SERVICES DIRECTORATE

Director of Human Resources and Corporate Services

(As at 31 January 2020)

Section 1: **Human Resources & Corporate Services**

HRCS KPI: **Shaping & Developing Future Workforce (Workforce Information)**

WORKFORCE INFORMATION

Monthly Corporate Workforce Information is published monthly in arrears; consequently the table below reflects the NIAS workforce position as at **31 January 2020**. This information is taken from HRPTS.

JANUARY 2020	TRUST TOTAL	CX / BOARD	PLANNING, PERFORM-ANCE & CS	QUALITY, SAFETY & IMPROVE'T	FINANCE / ICT	HRCS	MEDICAL	OPERA-TIONS
FUNDED (WTE) RECURRENT / (TEMPORARY FUNDING)	1392.28 (71.00)	7.00 (1.00)	1.00 (0.00)	2.00 (0.00)	40.63 (6.00)	31.15 (14.00)	77.00 (14.00)	1233.50 (36.00)
STAFF IN FUNDED POSTS (WTE) PERM STAFF / (TEMP STAFF)	1308.28 (18.33)	2.00 *(3.00)	0.00 (0.00)	2.00 (0.00)	23.43 (2.00)	21.48 (1.73)	76.60 (3.00)	1182.77 (8.60)
OVERALL VACANCY LEVELS (WTE)	**-136.67**	**-3.00**	**-1.00**	**0.00**	**-21.20**	**-21.94**	**-11.40**	**-78.13**

NB: *The above figures do not include individuals who support ELD clinical programmes as required, nor individuals employed on Bank Contracts or engaged through an Employment Agency.*

On the basis of the information above @ **31 January 2020**, the Trust has an overall vacancy level of **136.67** WTE posts.

*Non-Executives employed on a Fixed Term Contract.

Section 1: **Human Resources & Corporate Services**

HRCS KPI: **Shaping & Developing Future Workforce (Workforce Information)**

WORKFORCE INFORMATION

The following table provides a breakdown of frontline vacancies as at **31 January 2020**.

Post	Funded Est WTE	Staff-in-Post WTE	Vacancy WTE	Bank Staff	Recruitment Activity
Station Supervisor	46.00 (inc 15.00 temp)	46.67	0.67	0	None
Paramedic + Student Para	320.40	408.33	87.93	54	Rolling recruitment for Registered HCPC Paramedics ongoing; 43 Student Paramedics commenced FdSc in January 2020.
RRV Paramedic	85.20	52.24	-31.00	0	None
EMT + Trainee EMT	301.40	297.21	-4.19	14	Waiting list established for qualified and trainee EMT's. Next cohort of 48 to commence May 2020.
ACA (inc. PCS Sup.) + Trainee ACA	269.50	250.17	-19.33	4	Waiting list established for trainee ACA's. Next cohort of 24 to commence May 2020.

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Staff To Achieve High Quality Performance (Attendance Management)

CORPORATE ABSENCE REPORT (@ 31 JANUARY 2020)

The Trust's sickness absence target for the current Reporting Year (2019/20) has not yet been advised by the Department of Health. Working on last year's Department of Health target to deliver 5% improvement on the previous year's absence levels NIAS target for 2019/20 would be 10.92%. This target is however subject to review.

2019/20 Monthly Sickness Absence including Comparators to Previous Reporting Year (2018/19)												
MONTH	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
NIAS ABSENCE TARGET (2018/19)	**REDUCE SICKNESS ABSENCE RATES BY 5% ON 2018/19 PERFORMANCE TO 10.92%**											
NIAS cumulative % hrs lost (18/19)	**9.73%**	**9.88%**	**10.92%**	**11.33%**	**11.36%**	**11.52%**	**11.44%**	**11.25%**	**11.35%**	**11.39%**	**11.41%**	**11.48%**
NIAS monthly % hrs lost (18/19)	**9.73%**	**10.02%**	**13.09%**	**12.57%**	**11.50%**	**12.32%**	**11.05%**	**9.98%**	**12.09%**	**11.78%**	**11.57%**	**12.21%**
NIAS cumulative % hrs lost (19/20)	**10.77**	**10.62%**	**11.17%**	**11.40%**	**11.26%**	**11.05%**	**10.94%**	**10.81%**	**10.85%**	**10.74%**		
NIAS monthly % hrs lost (19/20)	**10.77**	**10.47%**	**12.41%**	**12.06%**	**10.70%**	**9.96%**	**10.35%**	**9.89%**	**11.11%**	**9.8%**		
Monthly % hrs lost (S/T)	2.15	2.00%	2.36%	2.37%	2.20%	2.40%	2.50%	2.67%	3.08%	2.02%		
Monthly % hrs lost (L/T)	8.62	8.48%	10.05%	9.69%	8.50%	7.57%	7.85%	7.22%	8.04%	7.78%		
Av. days lost (7.5 hrs) per Employee per Mth	2.29	2.34	2.42	2.70	2.28	1.99	2.28	2.01	2.21	2.09		
Av.NIAS estimated costs (£'000)	£424	£411	£493	£485	£431	£385	£408	£402	£467	£408		
NIAS CUMULATIVE % HRS LOST:	**(2018/19) 11.48%**				**(2019/20 @ 31 JAN 2020) 10.74%**					**ON TARGET**		

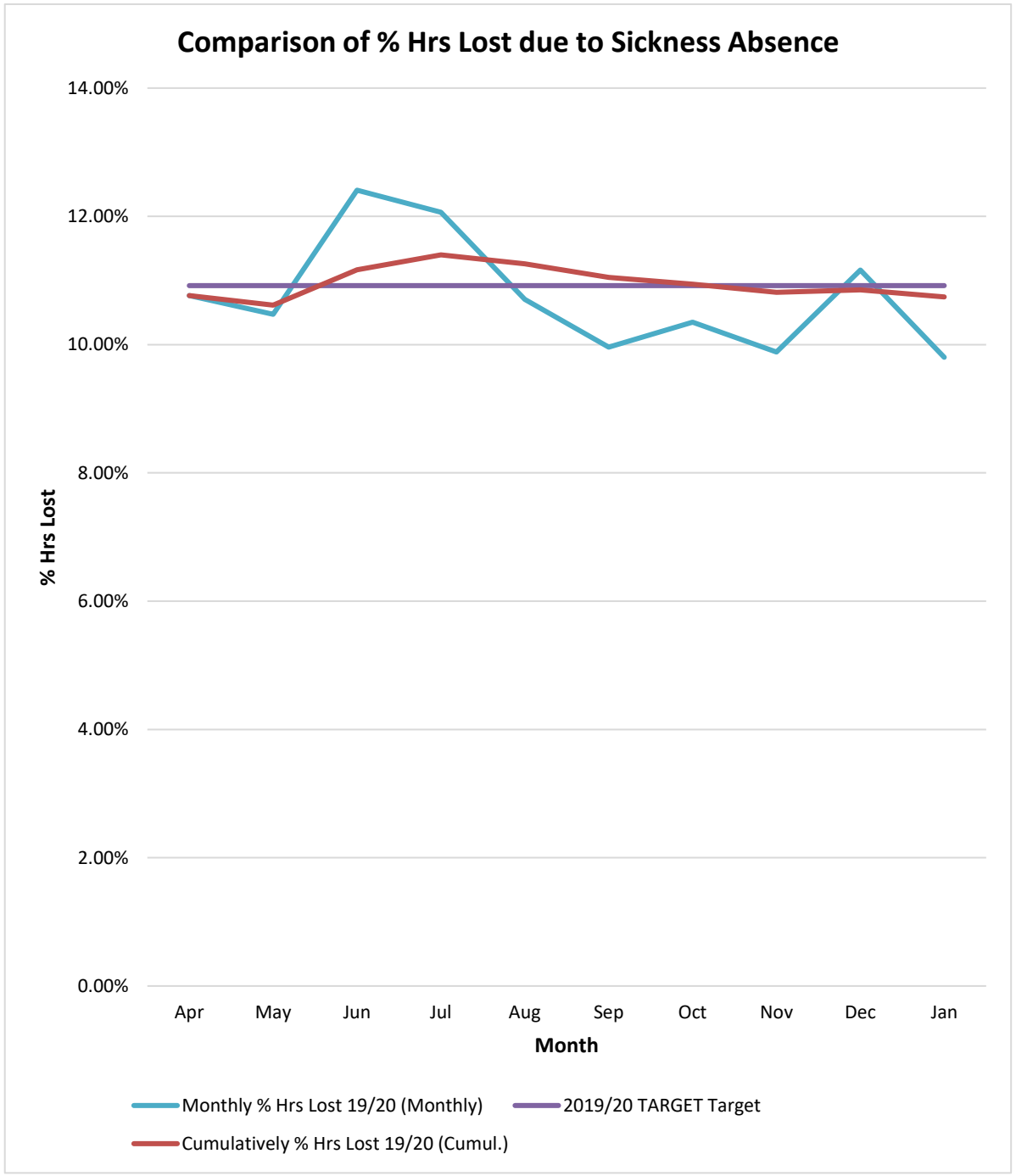
NB:(1) The Figures exclude Bank Staff and the Non-Executive Team; (2) The information is reported from HRPTS and, in line with HSC regional reporting, is in % hours lost; (3) In respect of average days lost it should be noted that, whilst the majority of NIAS staff are shift workers (approx 88%), who mostly work 12 hour shifts, the HRPTS calculation automatically divides working days over a standard 5-day week (Monday – Friday, based on a 7.5 hr day).

THE POSITION AT JAN 20 DEMONSTRATED A MONTHLY REDUCTION OF 1.98% AND A CUMULATIVE REDUCTION OF 0.65% AGAINST JAN 19

The Trust continues to take the following measures to address current levels of absence:

- AACE associates have now completed their Review of Attendance Management within NIAS. The findings and recommendations of their Report have been accepted and a Good Attendance Programme structure has been developed to implement the recommendations;
- HR MANAGER (AM) recruited to and commenced appointment wef 1 October 2019.
- OPS PERFORMANCE MANAGER (AM) recruited to and commenced appointment wef 4 November 2019.
- GA ADMINISTRATOR appointed and commenced wef July 2019.
- Temporary Senior HR Advisers (GA) (x5) appointed to each Division, during September, October and November 2019 alongside existing Senior HR Adviser (EAC/NEAC), to support operational managers in managing attendance. Temporary funding secured to support this pilot until 31 March 2020.

- BSO Internal Audit have completed their audit of compliance with the current Attendance Management Policy/Procedure and an action plan to take forward their recommendations has been finalised;
- Collaborative working is ongoing within regional HSC on Attendance Management work-streams;
- Work-streams under the Health & Well-Being Programme ongoing including: Unison Partnership Project; Peer Support Project; Health & Wellbeing workshops for staff.



ABSENCE CATEGORIES / REASONS WITH MORE THAN 1% ABSENCES (APR 19 – JAN 20) INCLUDE:

Mental Health	20.94%
Other Reasons*	34.22%
Back problems + Injury / Fracture + Other Musculosketal problems	19.98%
Accident / Untoward Incidents at work	6.22%
Gastrointestinal problems	7.01%
Asthma, Chest, Resp.	1.21%
Heart, Cardiac & Circulatory Problems	3.34%
Influenza	1.15%
Pregnancy Related	1.06%
Ear, Nose, Throat (ENT)	1.34%
TOTAL	**96.47%**

ABSENCE CATEGORIES WITH LESS THAN 1% ABSENCES (APR 19 – JAN 20) (3.53%) INCLUDE:-

Blood Disorders; Burns/Poisoning/Frostbite/Hypothermia; Dental/Oral Problems; Endocrine/Glandular Problems; Eye Problems; Genitourinary & Gynaecological Conditions; Headache/migraine; Infectious Diseases; Nervous System Disorders; Skin Condition; Substance Abuse; Tumours and Cancers; Viral Illness.

*** ABSENCE REASONS RECORDED WITHIN "OTHER REASONS" CATEGORY (APR 19 – JAN 20) INCLUDE:**

Chronic Fatigue	1.52%
General Debility	72.15%
Hospital Investigation	17.64%
Post-Surgery Debility	8.69%

Section 1: **Human Resources & Corporate Services**

HRCS KPI: Supporting Staff to Achieve High Quality Performance (to promote a culture of performance management, developing sound systems for managing performance and underperformance issues effectively and constructively)

England Ambulance Services	**April 2019**	**May 2019**	**June 2019**	**July 2019**	**Aug 2019**	**Sept 2019**	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb 2020**	**Mar 2020**
							Not available at time of print	Not available at time of print	Not available at time of print			
East Midlands Ambulance Service NHS Trust	5.33%	5.21%	5.20%	5.51%	5.45%	5.65%						
East of England Ambulance Service NHS Trust	5.91%	5.90%	6.14%	6.75%	6.27%	6.12%						
Yorkshire Ambulance Service NHS Trust	6.26%	6.05	5.78%	5.75%	6.21%	6.00%						
South Central Ambulance Service NHS Foundation Trust	6.57%	6.34%	6.07%	6.13%	6.25%	6.22%						
London Ambulance Service NHS Trust	4.94%	4.91%	4.94%	5.04%	5.74%	5.74%						
S/East Coast Ambulance Service NHS Foundation Trust	5.35%	5.65%	5.58%	5.91%	5.83%	5.30%						
North East Ambulance Service NHS Foundation Trust	6.03%	6.57%	6.28%	6.88%	6.64%	6.11%						
North West Ambulance Service NHS Trust	5.77%	5.81%	5.93%	6.12%	6.03%	6.10%						
West Midlands Ambulance Service NHS Foundation Trust	3.39%	3.46%	3.29%	3.34%	3.43%	3.59%						
South Western Ambulance Service NHS Foundation Trust	5.68%	5.63%	5.81%	5.88%	5.93%	5.66%						
By Staff Group - Ambulance												
By Organisation Type - Ambulance												
	2017	**2018**	**2019**	**2020**								
Scottish Ambulance Service	7.58%	7.67%	7.80%	Not av								
	Apr-Jun 17	**Jul-Sep 17**	**Oct-Dec 17**	**2017**	**Jan-Mar 18**	**Apr-Jun 18**	**Jul-Sep 18**	**Oct-Dec 18**	**Jan-19**	**Feb-Dec 19**	**2020**	
Welsh Ambulance Service	6.30%	6.90%	7.40%	6.80%	8.10%	7.50%	7.60%	7.90%	7.89%	Not availabl e	Not availa ble	
Information Source:												
1. NHS Digital (www.digital.nhs.uk)												
2. ISD Scotland (www.isdscotland.org)												
3. Stats Wales (www.statswales.gov.wales)												

Section 1: **Human Resources & Corporate Services**

HRCS KPI: Supporting Staff to Achieve High Quality Performance (to promote a culture of performance management, developing sound systems for managing performance and underperformance issues effectively and constructively)

GOOD ATTENDANCE PROGRAMME

This report provides an update of actions taken against key deliverables of the Good Attendance Programme, as reported to the Good Attendance Programme Board.

Trust Board are advised that there were initial delays in delivering key actions due to capacity/resource issues for HR and Operational Management.

Attendance Management Policy & Related Procedures

- GOOD ATTENDANCE (GA) WORKSHOP held with key stakeholders on 7 August 2019 to review the Attendance Management Policy & Procedure (AMP&P) and agree rollout, implementation, training needs and a communications plan. FOCUS GROUPS held in September and detailed work completed on review/refresh.
- 1 November 2019 launch date of refreshed AMP&P postponed due to further consultation request by TUs. Dates for further consultation now being arranged following cessation of Industrial Action.
- Consultation with Trade Unions on ANNUAL LEAVE POLICY ongoing.
- LIGHTER DUTIES POLICY under review using SQE methodology. Mapping exercise held with relevant stakeholders 6 February 2020.

Management Support/Capacity

- HR MANAGER (AM) recruited to and commenced appointment wef 1 October 2019.
- OPS PERFORMANCE MANAGER (AM) recruited to and commenced appointment wef 4 November 2019.
- Temporary Senior HR Advisers (GA) (x5) appointed to each Division, during September, October and November 2019 alongside existing Senior HR Adviser (EAC/NEAC), to support operational managers in managing attendance. Temporary funding secured to support this pilot until 31 March 2020.
- GA ADMINISTRATOR appointed and commenced wef July 2019.
- Weekly OPS/HR COLLABORATIVE MEETINGS established to manage complex cases.
- Suite of standard AM REPORTS available to managers with effect from 1 April 2019.
- AM TOOLKIT has been constructed and will be launched with the AMP&P refresh.
- TRAINING on implementation of the AMP&P available via real-time support of HR Advisers. A classroom based AM Training programme has also been developed and will be launched in conjunction with the AMP&P refresh.
- TEMPLATE DOCUMENTATION available to managers.
- Suite of Metrics developed at both HR Adviser/HR Manager level and HRM/AD/Good Attendance Programme Board level. These will be further refined and quantified going forward

Occupational Health Improvements

- OH workshop held on 11 September 2019 with key stakeholders, facilitated by AACE, the purpose of which was to undertake an initial review of existing NIAS OH arrangements together with a GAP analysis against 'text book' OH services and benchmarking undertaken of other NHS Ambulance Trust OH SLAs.
- Proposal for use of alterative OH service providers presented and agreed by GA Programme Board on 1 October 2019 to supplement existing OH capacity. Five Independent providers have been established across the region and use of these commenced 18 November 2019.
- Monitoring systems have been established to monitor the efficiency and effectiveness of Occupational Health Services.
- Monitoring Systems have demonstrated significant improvement in the timeliness, accessibility and quality of Occupational Health advice.

Health & Wellbeing Initiatives

- HEALTH AND WELLBEING ANNUAL WORKPLAN in place.
- Work on JOINT PARTNERSHIP HEALTH & WELL BEING PRIORITIES continues.
- PEER SUPPORT COORDINATORS (x2) commenced in August 2019.
- Work continues around Peer Support including H&WB Peer Support Workshops 1st Nov & 4th Nov.
- HEALTH AND WELLBEING Proposal date of completion 20th Dec. Proposed date not achieved due to other commitments.
- Good Attendance Programme Board informed of plan for 'Best in Blue Light Services' changes within two years.

Northern Ireland Ambulance Service Health and Social Care Trust

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