Northern Ireland Ambulance Service
Health and Social Care Trust

A meeting of Trust Board to be held at 10.00am
Thursday 30 January 2020 in the Boardroom, NIAS Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

1	Welcome & Declarations of Conflict of Interest	***Click on links to navigate:***
2	Minutes of the previous meeting of the Trust Board held on 5 December 2019 **For Approval**	TB30/01/2020/01
3	Matters Arising	
4	Chair's Update **For Noting**	
5	Chief Executive's Update **For Noting**	
6	Volunteering in NIAS – presentation by Ms S Leckey, Community Resuscitation Lead **For Noting**	No paper
7	Organisational Health and Culture Programme – presentation by Ms M Lemon, Interim Director of HR **For Noting**	No paper
8	Draft NIAS Strategic Plan **For Approval**	TB30/01/2020/02
9	Audit Committee - Terms of Reference **For Approval**	TB30/01/2020/03
10	Corporate Risk Register **For Noting**	TB30/01/2020/04
11	Directors' Performance Reports (by exception)	
	11.1 Finance	TB30/01/2020/05
	11.2 Operations	TB30/01/2020/06
	11.3 Medical	TB30/01/2020/07
	11.4 CRM Programme – verbal report	No paper

11.5	Safety & Quality - verbal report	No paper
11.6	Human Resources/Corporate Services - verbal report	No paper

For Noting

12 Committee minutes

-	Audit Committee – 18/6/19	TB30/01/2020/08
-	Assurance Committee – 15/10/19	TB30/01/2020/09

For Information

13 Forum for Questions

14 Date & venue of next meeting

15 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 30 January 2020 at 10.00am, Boardroom, NIAS Headquarters, Site 30 Knockbracken Healthcare Park, Belfast, BT8 8SG

TB/30/01/2020/01

Return to Agenda

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 5 December 2019 at 10.00am in the Belfast Harbour Commissioner's Office, Corporation Square, Belfast BT1 3AL

PRESENT:	Mrs N Lappin	Chair
	Mr T Haslett	Non Executive Director
	Mr W Abraham	Non Executive Director
	Mr D Ashford	Non Executive Director
	Mr M Bloomfield	Chief Executive
	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 L Gardner	Assistant Director of HR
	Ms S Sellars	Board Apprentice
APOLOGIES:	Mr J Dennison	Non Executive Director
	Mr A Cardwell	Non Executive Director
	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 Mr Dennison, Mr Cardwell and Ms O'Hara.

Continuing the Chair reminded members that, later that afternoon, they would join an Emergency Scenario exercise scheduled to take place at the Odyssey Arena involving members of the emergency services. Following this, members would then travel to Jordanstown to attend the Paramedic Graduation Ceremony.

Concluding her remarks, the Chair congratulated Ms Lynne Charlton on her recent appointment as NIAS Director of Safety & Quality Improvement and said that she looked forward to working with her.

2. Previous Minutes

The minutes of the previous meeting held on 3 October 2019 were **APPROVED** on a proposal from Mr Haslett and seconded by Dr Ruddell.

3. Matters Arising

11.0 Equality Staff Return

Mr Bloomfield referred to the query raised by Mr Cardwell in relation to the approval process for the annual return to the Equality Commission. He confirmed that Trust Board approval would now be sought to the annual return prior to submission.

4. Chair's Update

Commencing her update, the Chair advised that, following discussion at the previous Board meeting on turnaround times, she had requested information from NIAS officers and had had preliminary discussions with a number of other Chairs.

The Chair indicated that she had received correspondence from Strictly Boardroom regarding the Board Apprenticeship scheme enquiring whether NIAS would be willing to host an apprentice in the next round. It was noted that each apprentice would spend 12-months with the host organisation and that Ms Sellars would remain with NIAS until August. Members agreed that the Trust would host an apprentice in the next round and the Chair undertook to respond accordingly.

The Chair advised that she had met with Mr Jackie Johnston, Department of Health (DoH), for her annual appraisal and added that, following the successful implementation of the Clinical Response Model (CRM) on 12 November 2019, Mr Johnston had noted that the DoH was awaiting a business case in respect of the

CRM setting out the resources required and had been keen for the business case to be submitted as soon as possible. The Chair commented that she had discussed this briefly with Mr McNeill and had emphasised the importance of ensuring the business case was robust and fully supported by the Trust Board.

The Chair advised that she had also spent a night shift with Kenny McCausland and Paddy Adams, NIAS staff, in Ardoyne Station and invited Mr Ashford to share his experience of a Rapid Response Vehicle (RRV) shift.

Mr Ashford indicated that he had spent at 12-hour shift with Billy Carlisle. He said that he had found it interesting to see at first hand the challenge with hospital turnaround times. He also welcomed the commitment to prevention in the Strategic Plan. He noted that, of the calls responded to, only one could not have been prevented by an upstream intervention.

Thanking Mr Ashford for his comments, the Chair encouraged other members to consider ride-alongs and said that these were much appreciated by staff. She was of the view that, as staff were asked to undertake 12-hour shifts, she felt that there was merit in spending the full shift with staff. The Chair noted that Ms Sellars had indicated an interest in undertaking a ride-along in the near future.

Mr Sowney echoed the Chair's comments and said that he would encourage members to spend time with NIAS crews.

Mr Bloomfield said that it would also be important to consider spending some time with the Patient Care Service (PCS) vehicles and added that the level and skill shown by staff was outstanding.

The Chair encouraged both Executive and Non Executive members to call into stations in the approach to the Christmas holidays and undertook to circulate a schedule.

The Chair also undertook to circulate information on the AACE conference in March as well as information on a meeting with Mr K Donnelly, Comptroller and Auditor General, which was scheduled to take place the following week.

Concluding her remarks, the Chair mentioned that her Mother had recently been taken to hospital by Adrian Hawkins and Dwayne

Funston and she commended them on the care and attention shown to her Mother.

Mr Ashford referred to the development of the business case and asked whether it would be helpful for members to have sight of various sections of the business case before submission to the DoH. Responding, Mr McNeill indicated that it had recently been suggested by DoH colleagues that a Strategic Outline Case (SOC) was now required in advance of the business case. He undertook to keep members apprised.

5. **Chief Executive's Update**

Commencing his update, Mr Bloomfield advised that the Clinical Response Model went live on 12 November 2019 and said Mr McNeill would provide a detailed update later in the meeting. He said that its introduction had been successful and conveyed his thanks to all involved, in particular Mr McNeill.

Mr Bloomfield referred to the ongoing industrial action and advised that an Industrial Action Management Team had been established. He said that this forum had met several times and added that weekly meetings were also taking place with Trade Union colleagues to effectively manage the industrial action and ensure core services were maintained. He pointed out that, to date, the only specific action was a 24-hour overtime ban at the end of November but arrangements had been put in place to prepare for this. Mr Bloomfield said that an incident team had been in place during the ban and added that there had been limited impact on service users. He indicated that, while no formal notification had been received of future action, he did expect further action to take place and said that seven days' notice was required from Trade Unions. He pointed out that ambulance services had been impacted upon by industrial action taking place across Trusts with delays in EDs and potential for longer turnaround times.

Continuing, Mr Bloomfield welcomed the progress which had been made on recruitment issues with the appointment of Ms Charlton as Director of Quality & Safety Improvement and Mrs Carol Mooney as NIAS Board Secretary. He indicated that Dr Russell McLaughlin, an ED Consultant at Belfast Trust, had been appointed as Assistant Medical Director on a part-time basis and would provide support to Dr Ruddell. Mr Bloomfield also advised that Ms Maxine Patterson,

currently Head of Shared Services, Business Services Organisation, had been appointed as Director of Planning, Performance and Corporate Services and would take up post in March. He indicated that recruitment to a number of Assistant Director posts was ongoing and undertook to keep members updated.

Mr Bloomfield reported that the flu vaccination programme was progressing well and added that the target was for all health organisations to vaccinate 50% of their workforce. He pointed out that NIAS had been the only Trust to achieve this target last year and said that the target had already been exceeded this year with the Trust close to having 60% of its workforce vaccinated. He commended Ms Laura Coulter, Western Division Manager, for her leadership in relation to the vaccination programme.

Mr Bloomfield reported that, at the start of November, he had attended a meeting with Trust Chief Executives, DoH and HSCB colleagues to discuss winter plans and provide assurance to the Permanent Secretary that robust plans were in place within available funding to manage the usual seasonal pressures. One significant issue highlighted during the discussions was that of turnaround times. Mr Bloomfield said that he took the opportunity to highlight the fact that whatever actions were taken to address other pressures, tackling turnaround times would have significant benefit. He indicated that progress was being made and said that Mr Sowney would update members later in the meeting.

Mr Bloomfield reminded the meeting that 10 November 2019 had been designated World Mental Health Day and said that NIAS staff had arranged an event in Omagh at which a range of groups and organisations had displayed information highlighting support available to staff. In addition to this, he said, staff had received a presentation on how they could recognise and manage Post Traumatic Stress Disorder (PTSD). Mr Bloomfield acknowledged that one could see how the circumstances of the work in which NIAS staff were involved could potentially lead to PTSD. He said that he had accompanied the Chair and other Directors to the event and he commended all involved in its organisation and said that he was keen to support staff in rolling out similar events to other divisions.

Continuing, Mr Bloomfield advised that, in October, he had also attended the graduation of the latest cohort of Emergency Medical

Technicians (EMTs) from Belfast and the North West. He pointed out that these EMTs had become operational from the start of November.

Mr Bloomfield commented that he and Mr Sowney had visited the Director of the National Ambulance Service in the Republic of Ireland at the end of October to hear further about their work and to continue to support joint working.

He advised that he had recently had an introductory meeting with the PSNI Chief Constable who was keen to explore areas for possible collaborative working to meet patients' needs.

Mr Bloomfield reported that he had attended an AACE meeting in Birmingham on 20 November when attendees had received a range of presentations, including one demonstrating the stresses and fatigue felt by staff as a result of 12--hour shifts. He said that there was a need to examine this further.

Concluding his report, Mr Bloomfield advised that he had also attended a number of TIG and Chief Executive Forum meetings and added that preparations for industrial actions had undoubtedly become the main issue facing health and social care.

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

6. **Clinical Response Model Update**

Mr McNeill confirmed that the new code set had been successfully introduced to the service. He said that the work involved should not be underestimated and he commended all involved. He indicated that the 'go live' was implemented by the management team within the control room. Mr McNeill advised that additional cover was provided for the night of the changeover and for the week thereafter. He pointed out that the success of the 'go live' was in no small way as a result of the significant input by the IT team with the successful implementation of the new software. He explained that a decision had been taken to implement the changeover in the middle of the night as it was less busy then with the shift working extremely hard to clear as many calls as they could to make the changeover more manageable.

Mr McNeill indicated that the new system appeared to be much better for patients in terms of managing and prioritising calls. He added that the new system had also been accepted by staff.

Turning to performance in the first 24 hours of the new code set, Mr McNeill advised that the service had been able to delivery on Cat 1 performance. He acknowledged that further work would be taken forward in the New Year in respect of HCP calls in order to better manage performance against HCP calls from GPs/primary care. He explained that the new model had been designed to ensure better performance than from the existing system. He added that the system had already been introduced in England and said that it would be helpful to learn from their experience.

Mr Ashford commented that there were four categories of degrees of urgency within HCP calls.

Responding to a query from Mr Haslett, Mr McNeill confirmed that both the mean (average) and the 90th centile (nine out of ten calls) within Cat 1 were new standards replacing the previous target which was responding to 72.5% of Cat A calls in less than 8 minutes and 67% by LCG area. He explained that these new standards would be more easily understood, enable the service to ensure a more equitable performance and not focus on areas where it is easier to improve performance, ie responding to calls within an urban area as opposed to a rural setting. He reminded the meeting that NIAS' responsibility is to appropriately transport patients to ED and once patients crossed the threshold of ED, they come under the care and responsibility of the ED.

Mr Bloomfield referred to the 18 Cat 1 calls received in the first 24-hours of implementation of the new code set and said that it would be important to determine the reasons behind the those few calls outside the 8-minutes response time.

Members were advised that the dashboard was designed by the NIAS IT team and Mr McNeill pointed out that further refinements were continually being made to ensure that the system provided the necessary information.

Continuing, Mr McNeill advised that, as well as additional staff in the control room, additional field staff had also been deployed to mitigate against any risks which may have arisen. He further

pointed out that the deployment of additional field staff also demonstrated the results, which could be achieved with the investment required, in terms of cover to provide the code set in combination with the required amount of hours.

Mr McNeill explained that the purpose of the transport target was to avoid circumstances, on occasions, whereby a paramedic could be with a patient for a considerable time. He indicated that the guidance governing transporting patients was rigorous.

Mr McNeill acknowledged that, as a result of going beyond the time allowed for GP urgent calls, some changes had been made to how Cat 4 calls were managed and moved to Cat 3. He added that a protocol had subsequently been developed and approved by the Assistant Medical Director as being clinically appropriate. Mr McNeill indicated that the protocol would apply until the new system became operational.

Continuing, Mr McNeill pointed out that reports to the HSCB and DoH had now resumed.

In terms of next steps, Mr McNeill believed that a business intelligence solution would be key in relation to exporting data from CAD to the data warehouse. He said that it would then be necessary to develop methodologies to interrogate the data and be in a position to prepare performance reports as required. Mr McNeill added that this would be taken forward through the CRM programme.

Mr McNeill said that it would be important to promote and instil a culture of performance improvement throughout the organisation and added that it was clear that staff wished to see the continuation of the successful implementation of the new code set. He indicated that Ms Charlton was keen to commence work on clinical performance indicators and believed that the results of this would be clearly evident.

Mr McNeill reiterated his thanks to those involved and believed that the result would be better for patients, in particular Cat 1 patients. He said that staff were happy to see the Trust moving to address important issues such as meal breaks and finishing times. Mr McNeill acknowledged that this was only the start of the journey and believed that, while it would take a number of weeks before the new

process for call taking would be fully embedded, it would take longer to get to where the Trust needed to be in terms of the sophistication of information reports.

On behalf of the Trust Board, the Chair conveyed her thanks to all concerned and welcomed the success of the implementation of the new code set. She commented that Mr Bloomfield and she had attended a meeting of AACE shortly after the set had gone live and colleagues had been very complimentary about its implementation.

Mr Bloomfield said that he would like to add his thanks to those of the Chair and Mr McNeill. He said that Mr McNeill had been released from his substantive role to oversee the CRM implementation and said that this had clearly been the correct decision. He paid tribute to Mr McNeil's significant role in leading this work.

Mr Bloomfield reminded the meeting that, during the consultation on the CRM, individuals had expressed concern in relation to Cat 2 performance and pointed out that Cat 2 calls accounted for approximately half of the overall calls received. He referred to the point made earlier by Mr McNeill that additional staff had been deployed but emphasised that this had been the correct approach to adopt as it demonstrated what could be achieved with additional investment. Mr Bloomfield advised that he would be writing to the DoH to update them on the implementation.

Mr Abraham commented that the Board had discussed the introduction of the CRM for a considerable time and he welcomed its successful implementation.

Mr Ashford echoed Mr Abraham's points and said that it would now be important for resources to be made available to enable full implementation of the CRM.

7. **ORH Demand & Capacity Refresh (TB05/12/2019/02**

Commencing his presentation, Mr McNeill explained that this was the culmination of work which had commenced in May 2018 and provided members with a high level overview of the work undertaken. He reminded the meeting that the review objective had been to 'determine the underlying capacity required to deliver the

Ambulance resource time targets under the new clinical response model (CRM) by 2022/23.'

Mr McNeill reminded members that he had initially presented the outcome of the capacity review exercise to the Board in August 2017. He said that this exercise had been helpful and had allowed the Trust to begin the process towards the CRM by determining what was required in terms of resources.

Referring to the timescale of 2022/23, Mr McNeill explained that capacity reviews would normally be undertaken on three-year cycles. He indicated that there were some issues with regard to funding streams and to take forward the CRM would involve a much longer timescale, hence 2022/23.

Mr McNeill described in detail the overall approach adopted to take forward the demand and capacity review and highlighted the three key issues as being: Pre-Triage Sieve; Turnaround Times and Unit Hour Production.

Responding to a question from Mr Abraham, Mr McNeill explained that an element of the business case would examine potential locations and added that it was intended to use some of the existing or retained facilities used by the NIFRS.

In terms of staffing, Mr McNeill indicated that 325 new staff would be needed and said that work would continue in terms of estates solutions to locate these staff. He drew members' attention to the profiling of staff requirements, ambulance fleet and locations.

Mr McNeill said that meetings had been held with all local managers to take them through the findings of the exercise. He added that the opportunity was also taken to discuss whether adjustments could be made to existing facilities to accommodate new staff or whether, in working with DoH colleagues, there were opportunities to accelerate the ten-year capital plan.

Mr Abraham referred to the complexity of the work to be undertaken while Mr Haslett referred to the significant funding required.

Mr McNeill acknowledged that the funding required would be significant and said that initial estimates were approximately £30 million to take account of the 325 new staff needed; the changes to

the management structure; changes to support staff recommended through the AACE benchmarking report.

Mr Bloomfield said that this figure was known by the DoH and had been factored into their financial planning.

The Chair commented that Mr Johnston had impressed upon her the need for the Trust to provide a range of options to allow a phased approach over a number of years.

Agreeing with the Chair's comments, Mr Bloomfield indicated that the current working assumption was profiling over a five-year period and said that this timescale was reasonable to allow for the recruitment of staff.

Mr McNeill described the next steps to be taken and said that these included workforce planning; fleet capital planning; estate capital planning and business intelligence systems and tools. He indicated that he hoped to be in a position to bring a Retained Fleet Strategy and the business case to a future Board meeting.

Mr Haslett thanked Mr McNeill for the significant contribution he had made in progressing this work. He acknowledged the fact that call operators now had 90 seconds in which to determine the Category to be attributed to the call.

Mr Ashford commended the work undertaken and said that he had now a better understanding of the detail.

Responding to a question from Mr Ashford in relation to Cat 1 calls, Mr McNeill explained that PCS vehicles would be used to respond to Cat 1 calls if passing the location of the call. He added that PCS would target HCP calls only if appropriate and said that PCS would be asked to support HCP calls.

Mr Abraham acknowledged the considerable effort that had gone into this work and welcomed the progress that was now being made.

The Chair referred to point 4 of the Executive Summary and the need for the Trust to reduce its sickness down to at least 10% and suggested that this was a working assumption with the Trust's intentions being to reduce as much as possible.

Mr McNeill explained that, following today's meeting, the report would be confirmed as final.

Mr Bloomfield noted that members were not being asked to approve the methodology which had been used to determine the numbers of new staff required. He said that the report would be finalised and included as part of the business case submission to the DoH.

The Chair thanked members for their comments.

8. **Fire Safety Policy/Procedure (TB05/12/2019/03)**

Mr McNeill drew members' attention to the documents before them and commended Ms Keating, Risk Manager, and Mr Snoddy, AD Operations (Performance) on the significant work involved in updating the Fire Safety Policy/Procedures.

The Chair confirmed that the Policy/Procedures were in line with the Standing Orders and described it as a very comprehensive document.

Mr Ashford, agreeing with the Chair's description, commended the document. However he noted that he could not see a reference to 'shared premises' or a 'shared means of escape' and stressed the importance of taking account of others' risk assessments.

Mr McNeill referred Mr Ashford to paragraph 9.1 'Shared Premises' on page 10 of the Fire Safety Procedure which covered the need for consultation on the development of any procedure.

The Fire Safety Policy/Procedure was **APPROVED** on a proposal from Mr Abraham and seconded by Mr Haslett.

9. **Standing Financial Instructions (TB05/12/2018/04)**

Mr Nicholson explained that Audit Committee had considered the Standing Financial Instructions (SFIs) and recommended them to the Board for approval. He pointed out that the SFIs had been benchmarked against three other Trusts and he noted that the changes made had been minor, eg DHSSPS to be replaced by DoH. Mr Nicholson explained that a further change focussed on the demise of cheques and cash.

Continuing Mr Nicholson pointed out that a 'Key Points' section had been added at the start of each section and said he hoped members and employees would find this helpful. He added that, subject to approval by the Trust Board, the document would be disseminated to all staff.

The Standing Financial Instructions were **APPROVED** on a proposal from Mr Sowney and seconded by Mr Haslett.

10. Directors' Performance Reports

The Chair invited the relevant Director to provide an update on their respective area and invited Ms Charlton to provide a verbal update.

10.1 Operations (TB05/12/2019/05)

Mr Sowney advised that the HSCB had expressed concern in relation to turnaround times on a number of sites, in particular the Ulster, Craigavon and Royal Victoria Hospitals, and added that he and the Chief Executive had had discussions with the HSCB and Trust colleagues around this issue. He confirmed that the Trust had found it necessary to issue a number of Early Alerts and said that, as a result of these discussions, the DoH and HSCB had signed off on an escalation protocol which he undertook to circulate to members.

He explained that the protocol encouraged Trusts to work to 15 minute turnaround times with escalation steps being introduced once the maximum time of one hour had been reached. Mr Sowney acknowledged that there was still further work to do in terms of determining how best to monitor the turnaround times.

Mr Sowney said that he continued to meet with Trusts to discuss how best to address the issue and had expressed concern as to the fact that NIAS crews were not being released because the clinical handover had not yet taken place.

Mr Sowney said that, while Trusts would refer to capacity and lack of space as the main challenges facing them, the

most significant issue for him was discharge delays. He added that, in his discussions with South Eastern Trust colleagues, he had suggested that Trust and NIAS staff should meet to map processes and procedures to determine ways in which turnaround times might be improved. Mr Sowney added that he would be meeting with Southern Trust colleagues in the coming days to discuss similar issues.

Mr Abraham asked whether there was a point at which the Trust Chief Executive would be required to forward a letter of explanation as to why NIAS crews had been detained at an ED. He believed that it would be important to identify additional ways in which pressure on Trusts could be maintained to ensure a swift turnaround time.

Mr McNeill expressed his concern at the amount of time spent by NIAS crews in EDs in normal working hours and believed that this was a collective challenge. However, he said detaining crews in ED became more problematic after crews' contracted working hours in the context of industrial action.

Mr Bloomfield advised that, in discussions with Trade Unions, the Unions confirmed that staff would not walk away from patients during an overtime ban.

Mr Abraham said that he had called for the introduction of an escalation protocol at the previous Board meeting and asked how the protocol would be measured effectively with Trusts.

Responding, Mr Bloomfield explained that the Early Alert had been declared on an evening when there had been one ambulance across four divisions. He welcomed the introduction of the protocol which would come into effect at the start of January but cautioned it would take some time to deliver sustainable improvement.

The Chair suggested that it would be timely for members to receive an update on the implementation of the protocol at a future meeting.

10.2 **Medical (TB05/12/2019/06)**

Dr Ruddell welcomed the appointment of Dr Russell McLaughlin as Assistant Medical Director on a part-time basis. He reported that the SAI Lead, as well as a Lead for Infection Prevention & Control, had also recently been appointed. Dr Ruddell advised that the latter would work within Ms Charlton's Directorate. He added that the recruitment exercise for the Assistant Clinical Director with a paramedic background was being progressed.

10.3 **Human Resources (TB05/12/2019/07)**

Ms Gardner referred to the comments which had been made by the Chief Executive earlier in the meeting regarding industrial action and said that the focus over the last number of weeks had been on managing the impact on patients and services. She added that it was anticipated that increased action would be taken during December.

Continuing, Ms Gardner advised that progress had been made on the recruitment to a number of Executive and senior level posts. She explained that, while recruitment was generally progressed through BSO Shared Services, recruitment exercises for such senior posts had been conducted internally.

Ms Gardner acknowledged that addressing absence levels remained a challenge and said that the Good Attendance Programme Board was now meeting on a monthly basis. She explained that the DoH had set a target of 10.94% in respect absence and said that the Trust was currently at 10.92%. She acknowledged that this was not an acceptable level of absence and said that work would be taken forward by the Programme Board. Ms Gardner added that she hoped by the next meeting to have established targets.

Ms Gardner advised that there had been a number of appointments to the Good Attendance project, most notably the appointment of the Operational Manager in November. She indicated that work would be taken forward to focus on attendance management and said that there was a good

structure in place with six advisers at Divisional level. She welcomed the fact that absence levels were back to 2018/19 levels and said that work would continue to improve on this.

Turning to the complaints backlog, Ms Gardner reported that not much progress had been made since June with only 24% of complaints having been closed. She said that she hoped to be able to report an improved position by February.

Welcoming the improvement in the cumulative absence figure, the Chair commented that Mr Dennison had been unable to attend the last Programme Board meeting.

Ms Sellars sought clarification in relation to the reference to 'best in blue light' on page 178 of the report. In response, Ms Gardner explained that this related to the 'gold star standard' of a health and wellbeing model.

Mr Abraham said that he would be interesting in hearing more about the anticipated impact of the Good Attendance programme. Mr Bloomfield advised that it was intended to report progress mainly through the Assurance Committee.

10.4 **Finance (TB05/12/2019/08)**

Commencing the finance section of the Performance Report, Mr Nicholson reported that the Trust was currently reporting a breakeven position for the seven months ending October 2019.

He indicated that there were ongoing issues in relation to Agenda for Change (AfC) and said that it was assumed that the Board would fund the full legitimate costs of the AfC for NIAS.

Mr Nicholson advised that the Trust had received an increased Capital Resource Limit (CRL) of £8.3 million, thereby allowing the Trust to continue with planned fleet replacement. He added that, within this allocation, £4.3 million had been earmarked for specific ICT schemes and contingency control room arrangements.

He pointed out that the successful implementation of the CRM and the impact on operational, control room, IT and Information Governance colleagues should not be underestimated both in terms of the project itself and when it was fully embedded.

10.5 **Safety & Quality Improvement**

Ms Charlton reported that there had been a focus on priorities informed by the draft NIAS Strategic Direction and the Duty of Quality across a number of themes. She alluded to work being taken forward in relation to the AHP Professional Assurance Framework; National Quality Indicators; Safeguarding and reporting processes and the quality of PAS/VAS services.

Ms Charlton advised that discussions were being held with PHA colleagues around professional assurances for AHPs and she added that the Trust would be required to report on this on a bi-annual basis.

Continuing, Ms Charlton emphasised the importance of learning from practices already in place and building capacity and capability for staff around improvement methodologies. She added that some progress had already been made in relation to the latter.

Ms Charlton suggested that it would be important for the Trust Board to receive regular reports on the regional online user feedback system and added that work was being taken forward to provide this from April onwards.

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

11. **Any Other Business**

11.1 Meeting dates 2020

The Chair advised that she had requested that Board meetings were scheduled between April – March and said that the schedule would be taken forward by the Board Secretary upon taking up post.

11.2 Thanks

Mr Haslett said that he had been asked by the Captain of the Portadown Golf Club to convey their thanks to the NIAS crew who attended an incident at the Club at the end of November.

Mr Haslett advised that he had accompanied Dr Ruddell and Ms Charlton to a meeting with RQIA representatives on 27 November. He said that a number of issues were raised, including the concept of family engagement and a patient advocate role.

12. **Date of next meeting**

The next meeting will be held at 10am on Thursday 30 January 2020. Venue to be confirmed.

SIGNED: _____

DATE: _____

TB/30/01/2020/02

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	Thursday 30 January 2020
Title of paper:	Draft NIAS Strategic Plan 2020 - 2026
Brief summary:	NIAS has a central role to play in the implementation of the Department of Health's 'Health and Wellbeing 2026 – Delivering Together' strategy and can contribute to addressing many of the priorities within it. In order to maximise this contribution, an ambitious, long-term Strategic Plan is required. Our draft Plan – '*Caring Today, Planning for Tomorrow*', sets out how NIAS can address the current challenges and how we intend to develop the service to deliver benefits to patients, staff and communities over the coming years. Trust Board considered an earlier draft of the Plan at their December 2019 meeting and comments have been incorporated into the final draft. Subject to Trust Board approval, the Plan will be launched in February and widely shared with staff and other stakeholders and partner organisations.
Recommendation:	Trust Board is asked to approve the Draft NIAS

	Strategic Plan 2020 – 2026 **For Approval** ☒ **For Noting** ☐
Previous forum:	Trust Board – 5 December 2019 SMT – 21 January 2020
Prepared and presented by: **Date:**	Sarah Williamson, TYC Manager Michael Bloomfield, Chief Executive 23 January 2020

TB/30/01/2020/03

Northern Ireland Ambulance Service
Health and Social Care Trust

Caring today, planning for tomorrow - Our Strategy to Transform: 2020-2026

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

Contents

Foreword

The Northern Ireland Ambulance Service has a central role to play in the implementation of the Department of Health's *'Health and wellbeing 2026 – delivering together'* strategy and can contribute to addressing many of the priorities within it. To ensure we maximise this contribution we need an ambitious, long-term strategy that sets out how we can address the current challenges and how investment in our service will enable us to transform and bring tangible benefits to patients, staff and communities over the coming decade.

If we are to work efficiently and effectively and embrace innovation and integration in a sustainable way, we need to commit ourselves to an achievable vision, re-think some of our ways of working and, rightly, justify the investment we are seeking.

This strategy document provides a comprehensive picture of our organisation – who we are, what we do, our role in the health and social care system and some of the challenges we are working to overcome. Most importantly it describes our long term goals within our vision for 2026, and how and why we need to transform our service to be able to achieve these.

Some elements of this strategy are already underway, but over the course of the next six years we are aiming for a step-change in some priority areas that will determine who we are, what we do and how we perform within the health and social care system. We will manage these changes through a transformation programme, delivering annual plans of phased activity and monitoring progress through a transparent process of governance.

The NIAS trust board recognises their role in leading this transformation and values the input and experiences of our staff and patients in influencing change and improvement.

We look forward to working with our staff, our volunteers and *all* of our partners in taking NIAS forward, to transform our services and deliver excellence in meeting the needs of our patients over the coming years.

Michael Bloomfield, CEO
and Nicole Lappin, Chair
Northern Ireland Ambulance Service

About NIAS

NIAS provides high quality urgent & emergency care and treatment as well as scheduled, non-emergency patient transport services for the all the population of Northern Ireland.

NIAS Facts and Figures

In 2018-2019

We received **218,000 calls**
of which **195,000** resulted in an
ambulance arriving on scene

59,000 calls were for immediately life-threatening conditions **(Category A)**
89,000 calls were for serious but not immediately life-threatening conditions **(Category B)**
47,000 calls were for not immediately life-threatening or serious conditions **(Category C)**

We made **200,000 non-emergency journeys**, taking people to and from hospital appointments or for routine treatment

We currently have:
Circa 1,400 staff supported by **250 volunteer first responders** and almost **100 volunteer car service drivers**
116 frontline, double-crewed emergency ambulances
43 rapid response ambulance cars and **115 non-emergency vehicles**

coordinated by **one Emergency Control Room** and **one Non-Emergency Control Room**, across **five operating divisions** and out of **59 ambulance stations or deployment points**

NIAS has an annual operating
budget of circa £80m

Our partners

The services provided by NIAS are commissioned by the Health and Social Care (HSC) board, we work closely with colleagues in the five other trusts across Northern Ireland: Belfast HSC Trust; Northern HSC Trust; South Eastern HSC Trust; Southern HSC Trust and Western HSC Trust. We collaborate with our partners in other response agencies and provide mutual support across the border areas with the National Ambulance Service in the Republic of Ireland. We also work with independent ambulance services in order to meet the demands for transport services across HSC.

Our mission

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

Our values & behaviours

Our values, and the behaviours they instil, form the foundations for the culture and ethos for the whole organisation.

The HSC Leadership Strategy indicates that collective leadership offers a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. NIAS is committed to adopting this strategy and to creating a related programme of work to mainstream this vision within our organisational culture. The Trust has already adopted the new HSC Values and related expected behaviours developed as part of this framework and will work to mainstream and embed these across the Trust:

What does this mean?

Working together

We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibilty of all.

Excellence

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.

Openness & Honesty

We are open and honest with each other and act with integrity and candour.

Compassion

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

In order to achieve these outcomes a new Organisational Culture Programme will be established. This work will focus on listening to the results of the staff survey and other feedback in order to understand the culture of the organisation and to model a vision for a new culture of collective and compassionate leadership. At the heart of this work will be a commitment to tangible action to ensure we fully involve and value our people. The programme will link to other key work streams such as health and wellbeing, communications and appraisal processes in order to ensure a consistent approach and delivery of outcomes.

Where we are now

Since our formation as a regional Trust in 1995, NIAS has grown significantly. From fleet changes, technological advances, developments in clinical training and scope of practice, our service looks very different to how it did at its inception and over time we have necessarily developed our operational responses to meet the changing healthcare needs of the population of Northern Ireland.

Our core services cover a range of responses to deal with emergency, life-threatening calls and major incidents, as well as urgent unscheduled care and planned, non-emergency patient transport services.

Demand on these services, especially for urgent care which forms the bulk of our activity, has continued to increase year on year. At the same time, the profile of health conditions we are treating has changed as our population lives longer, medicine progresses and national and global societal developments and competing political agendas influence many of the factors that impact on our health and well-being. We now have a larger proportion of our population living with a complex mix of clinical conditions, which demands a different system for managing health and social care on a day-today basis.

- To meet these changing healthcare needs, the recent advances in our clinical response models have seen the introduction of a new, evidence-based way of categorising the 999 calls we receive, so that we can target our resources appropriately and get to those in life-threatened situations the fastest.

- Working closely with colleagues in other parts of the HSC, we have developed new Appropriate Care Pathways (ACPs) for many clinical conditions, so that patients get the right care from the point that they contact us, reducing the number of interactions they need to make before they get to the clinical specialty they need and we can, where possible avoid the need to route their care through the hospital emergency department (ED).

- These aims have also been supported by a pilot scheme deploying community paramedics in a Co-operation And Working Together (CAWT) funded programme, to support partnership working with the primary care sector in managing patients in some of our more rural areas.

- Our new electronic patient record will mean we can access important information regarding patients and also share details with the relevant clinicians across the system more quickly and easily, not only facilitating the treatment patients receive and their experience of their care, but also supporting the way we monitor and learn from individual cases and outcomes.

- In recent years, we have significantly increased our specialist capabilities for responding to major incidents and being able to treat patients in hazardous environments with our Hazardous Area Response Team (HART) and our Helicopter Emergency Medical Services (HEMS).

- Our team of volunteers has grown significantly, with our Community First Responders (CFRs) playing a vital role in getting life-saving skills to patients as quickly as possible when needed, and our volunteer car drivers caring for our non-emergency patients taking them to their appointments and healthcare facilities when their own transport options are limited.

Our range of responses include:

Double-crewed emergency ambulance

Rapid response paramedic cars

Helicopter Emergency Medical Services (HEMS) – for major trauma incidents

Clinical Support Desk (CSD) – providing clinical advice, and referral when needed, over the phone (Hear & Treat)

Appropriate Care Pathways (ACPs) and direct referral routes avoiding hospital emergency departments e.g. for falls, COPD, heart failure, palliative care and diabetes

Community paramedics – commissioned in specified rural areas to support the provision of primary care services for patients with long-term conditions and the assessment and treatment of minor illnesses and injuries, while maintaining the ability to provide an emergency response in life-threatening situations.

Community First Responders (CFRs) – volunteers trained in vital life-saving skills for those experiencing or at risk of cardiac arrest

Specialised intervention for our frequent callers to identify underlying needs and engage with social, community or secondary care services on their behalf

Multi-agency mental health triage team for those in mental health crisis

Emergency preparedness and specialist resources for major incidents, complex or hazardous environments and mass casualty events

Northern Ireland Specialist Transfer and Retrieval team (NISTAR) – dedicated service for children and babies requiring urgent transfer between hospitals

New Clinical Response Model

Our new Clinical Response Model (CRM) came into operation in November 2019 and defines how we deliver our core service for Urgent & Emergency Care (UEC). It focuses on achieving optimal outcomes for patients by providing the right response, in the right place, based on clinical need, for every call. The model uses evidence-based prioritisation of categories for presenting conditions when someone calls 999, and new response targets aligned to these categories.

Introducing this CRM forms part of a wider framework of ongoing efficiency led reforms, including; review of systems, processes and structure within our Emergency Ambulance Control (EAC); the ongoing implementation of alternative pathways, where patients are assisted to get more appropriate health services for non-emergency conditions; along with our community resuscitation and defibrillator strategy across NI (including our local CFRs).

Ambulances are dispatched in response to 999 emergency calls based on the clinical need of the patient. The calls are prioritised according to the seriousness of the patient's condition which will be assigned to one of 5 call categories.

NIAS, like many ambulance services in the UK and internationally, uses the prioritisation Advanced Medical Priority Dispatch System (AMPDS). This is a clinical triage system that accounts for a variety of risk factors in presentation of illness, pain and injury.

Our new CRM includes an enhanced call taking process based on a set of Pre-Triage Sieve (PTS) questions and identification of the Nature of Call (NOC). When receiving 999 calls, specially trained, ambulance call-takers will utilise these processes prior to opening the full AMPDS triage software to identify at the earliest opportunity those patients with an immediately life threatening condition i.e. Category 1 patients.

Earlier activation of ambulance resources to Category 1 incidents has the potential to realise significant benefits for all patients. Our aim is to match appropriate ambulance resources to the needs of the patient. Category 1 calls are the most critical and demand a response based on the level of clinical intervention required. Calls in Categories 2, 3, and 4, whilst they may still be urgent in nature do not require a similar response as Category 1.

Not every patient needs to be taken to hospital. Not every patient needs immediate paramedic intervention. Ensuring that an ambulance is appropriately dispatched for a patient who needs to be taken to hospital – and not sending a paramedic in a car – will mean many of the patients whose condition is known to require specific clinical destinations will reach that definitive place of care quicker than they do at present.

Some people who call the ambulance service, may not require an ambulance attendance at all. In those cases, we will provide effective clinical advice by telephone, where their condition or complaint can be managed through telephone advice or arrange referral to an appropriate service without the need for the attendance of an ambulance clinician. Provision of clinical telephone advice is a benefit of our newly established paramedic-led Clinical Support Desk (CSD) within the EAC team. As part of our **Strategy to Transform**, we will be expanding this element of our service to include a range of clinical specialties who can provide advice to patients over the phone, or in the future via technology devices, and support clinical decision-making for frontline staff on scene.

New Ambulance Quality Indicators (AQIs) being developed will evidence the quality of our patient care across a range of clinical indicators. While speed of response is still an important consideration, especially for those patients in Category 1, it is vital that the care we give is appropriate and effective for the patient. The quality of our care will be monitored for all categories of call and our Quality Improvement strategy ensure we enhance our responses through continuous learning.


CCTV
in operation
in this area
AMBULANCE

Current challenges

Whilst making significant positive advances to meet the changing needs of our society, over time, other elements of our organisational develoment have struggled to keep up. Investment in NIAS has inevitably had to compete with other demands on public finances and our resources have become increasingly stretched, making it difficult to keep up with technological advances and address workforce capacity gaps.

In looking to the future, working with the Department of Health (DoH), we recognise that in order for patients across the HSC system to benefit from the opportunities of a transforming health and social care service, NIAS needs to be at the heart of regional plans and the investment required to address current challenges and deliver our **Strategy to Transform** will be crucial. We are therefore taking significant steps to review every aspect of our organisation so that we can deliver the necessary changes over the next few years and justify the support and investment made available to us.

Whilst our **Strategy To Transform** presents opportunities to drive improvement in our service, there are also challenges and risks which will require effective and robust planning, strong leadership and resilience to ensure we move forward at pace. Key challenges include:

- Increased demand resulting in operational pressures and increased response times.
- Increasing public expectations.
- Balancing transformation programmes with existing pressures and demands.
- Availability of the appropriate professional disciplines, and support services staffing.
- Underlying financial position.
- Rapid pace of reform required.
- No confirmed recurrent funding after 2019/2020 for some programmes.

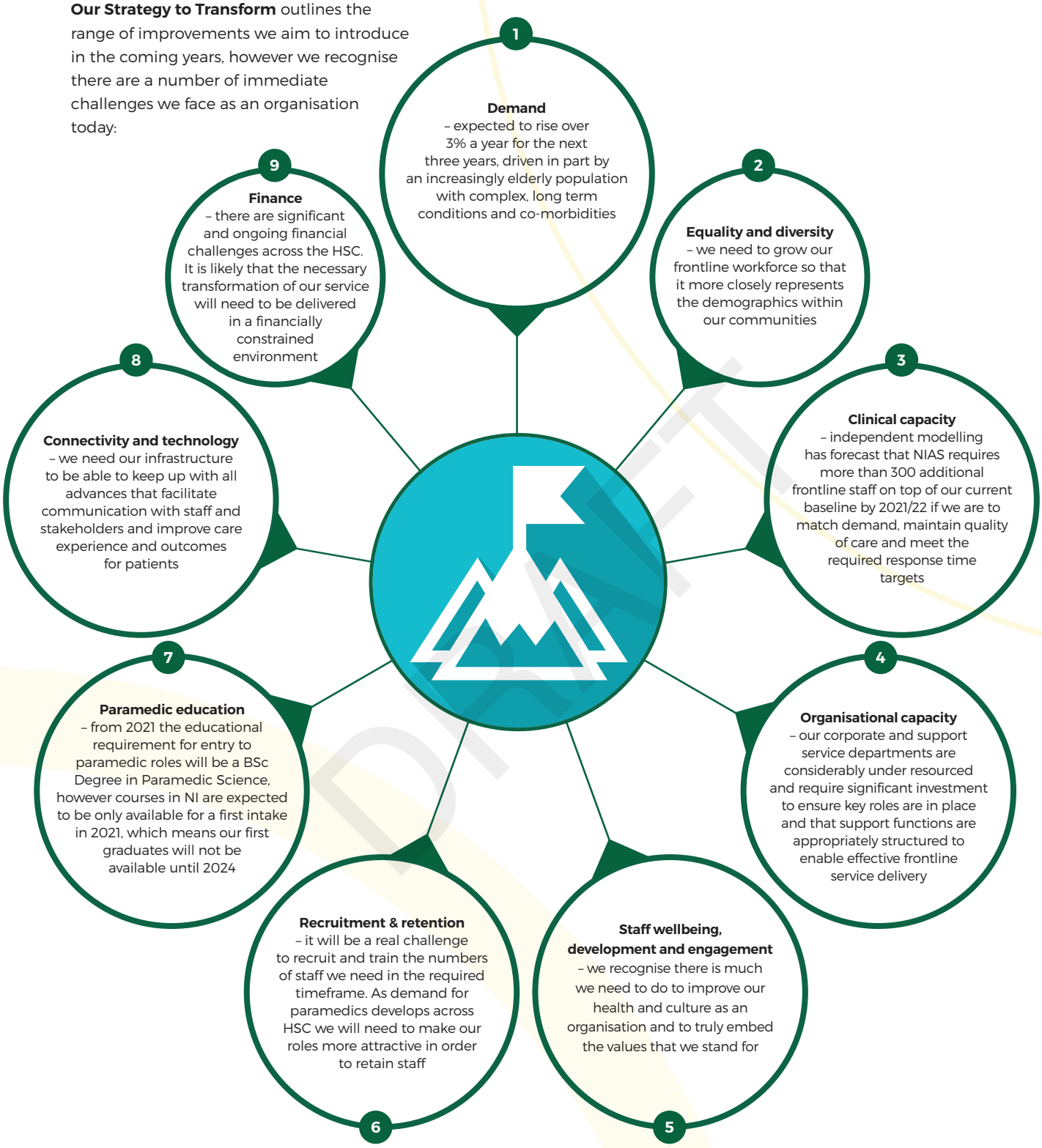
NIAS will ensure challenges and risks are acknowledged and planned for by senior management and relevant partners at each stage of programme development. We will continue to engage with regional partners and key planning and governance structures such as Transformation Implementation Group (TIG), Transformation Operational Group (TOG) and DOH Workforce structures to ensure all necessary measures and steps are taken to ensure success and avoid the risks of project failure or the destabilising of current services.

Whilst the volume, breadth and pace of these programmes present a significant challenge, we will continue to instil a commitment to quality and innovation into all transformation programmes, seeking to ensure that services are safe, high quality and provide a positive experience for service users.

Additionally, the trust's commitment to development of our performance framework with a link to demonstrable outcomes will underpin and support the planning, monitoring and evaluation of key workstreams and transformation deliverables.

Challenges we face

Our Strategy to Transform outlines the range of improvements we aim to introduce in the coming years, however we recognise there are a number of immediate challenges we face as an organisation today:



"It is only by listening to all of our staff, by engaging with them in a meaningful way and by working together in the genuine spirit of co-production and collective leadership, will we be able to resolve the many challenges we face and realise the benefits from the undoubted opportunities that lie ahead." ***Michael Bloomfield, CEO NIAS***

Our goals

Our patients will feel professionally cared for; always with compassion and respect

Our staff will feel positive and proud to work for NIAS

Our stakeholders and partners will have confidence in us as a reliable provider at the centre of urgent and emergency care

Our communities will continue to value and trust us

In delivering these goals, we will be contributing to the DoH 'Delivering Together' strategy for 2026 by:

- Demonstrating a shift in the balance of care away from hospitals by taking more care to the patient and signposting patients to appropriate alternatives to the ED
- Expanding our workforce and enhancing skill sets to manage more urgent care in primary and community settings and encourage prevention of ill health
- Focusing on improving and maintaining the health and wellbeing of our staff
- Collaborating proactively with partner providers, blue light partners and volunteers to co-produce effective models of care and improve our responses to patients
- Embracing new technologies to improve our connectivity with our workforce, patients and partners
- Targeting investment in the transformation of our service, to ensure the delivery of effective and sustainable services for the benefit of patients and the wider HSC

Our **Strategy to Transform** describes the goals we will be working towards, to realise our vision for NIAS by 2026, whilst recognising and addressing the real issues impacting on the service and staff at the current time

Health and social care of the future

The world of healthcare is forever developing, and the changes anticipated over the next decade and beyond are set to transform how our health, ill-health, wellbeing and social care needs are managed.

As more of us live longer thanks to medical, economic and social advances, improvements in developing technologies, public health education and new integrated ways of working will be focussed on enabling us to do so well, remaining independent for as long as possible and receiving care out of hospital whenever other more appropriate options are available.

The Northern Ireland Programme for Government (2016-2021) contains strategic outcomes which touch on every aspect of government, including the attainment of good health and education, economic success and confident and peaceful communities.

Making Life Better 2012-2023 aims to create the conditions for individuals and communities to take control of their own lives and achieve their full health and wellbeing potential. The framework has been structured around six key themes: Giving Every Child the Best Start; Equipped Throughout Life; Empowering Healthy Living; Creating the Conditions; Empowering Communities and Developing Collaboration.

Quality 2020 has driven the agenda for safety, effectiveness and person centred services and many of the principles and activities which evolved from that strategy inform our own **Strategy to Transform.**

Recent reviews of Northern Ireland HSC have included **The Right Time, The Right Place** (Donaldson Report) 2014 and following this, the **Systems not Structures** (Bengoa Report) in 2016. This international expert panel led by Professor Rafael Bengoa proposed: "by agreement, and without the need for structural reform - the provider sector to take collective responsibility for all health and social care for a given population and with a joint capitated budget linked to population based outcomes…". The expert panel's recommendations were addressed in the Minister of Health's proposals, **Health and Wellbeing 2026: Delivering Together**, subsequently being taken forward by the DoH TIG.

Key themes in the **Delivering Together** strategy describe how the health and social care systems in Northern Ireland will aim to "move beyond simply managing illness and instead ensure that our health service supports people to stay well: physically, mentally and emotionally". Providers across the HSC system are increasingly working together as a single system, alongside partners in local authorities, other agencies and the voluntary sector, with the emphasis on person-centred care, ill-health prevention, social wellbeing and providing more diagnostics, treatment and care in the community and home settings.

The way we design and deliver services will be focussed on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

NIAS role in Delivering Together

NIAS has an important central role in delivering the necessary reforms set out in Delivering Together and ambitious aspirations in our Strategy to Transform, to ensure provision of high-quality care is maintained in a progressive and sustainable way.

Tremendous strides have been taken over the last couple of decades in moving the ambulance sector from being a service that primarily transported patients to hospital, to being healthcare providers at the centre of urgent and emergency care, with highly skilled clinicians delivering treatment at scene and over the phone - often avoiding the need for a patient to be brought to the ED, or even for an ambulance to be dispatched. The recognition, in August 2018, of paramedics as Allied Health Professionals (AHPs) in NI has been a significant development which will offer many opportunities for development of the role and career pathways.

The years ahead hold equally exciting developments in healthcare, especially with the expected level of technological advancements and the increasing ability to integrate care seamlessly across disciplines. NIAS is on a mission to transform the organisation and the way out-of-hospital care is delivered, in line with the transforming health and social care system across Northern Ireland and the rest of the United Kingdom.

- Supporting patient flow through the system, especially through avoiding unnecessary conveyance to hospital and in supporting hospital discharges and interfacility transfers
- Improving access to care and advice for patients, especially out of hours
- Coordinating multidisciplinary telephone and video clinical assessment services
- Having access to the single NI electronic care record (NIECR) being designed through the Encompass programme, so that our patient records interface with all others in the HSC system
- Supporting health promotion and the prevention agenda through our daily interactions with patients, by having simple conversations and signposting to support when appropriate
- Sharing of population health data within the system to support research and planning processes
- Increasing efficiency and reducing unwarranted variation wherever possible
- Providing a country-wide oversight of the impacts of reconfigurations and gaps in services, to support ongoing strategic level discussions in respect of transformation
- Developing our workforce and infrastructure to deliver a wider range of skills to achieve the best outcomes for our patients from our new clinical response model and new ways of working
- Developing integrated working through co-design and co-production of new services and alternative pathways with partner providers
- Participating in multidisciplinary teams in the primary care setting
- Being a connected partner with interoperable platforms and the ability to access and share patient records and care plans in a timely way
- Implementing wider rollout of community paramedicine and rotating roles
- Making use of advances in technology to improve access for patients to clinical advice (e.g. video assessments; wearable devices)
- Engaging our staff and patients in building a collective understanding of the need for, and benefits of, transformation of health and care services
- Providing a clear career structure and development opportunities for both clinical and non-clinical staff, creating collaborative system leaders
- Providing a supportive and progressive environment where our staff feel valued and engaged in the advances we wish to take as an organisation

Our vision to 2026

Over the coming years, NIAS is committed to transforming our service and the way we deliver care, in line with the DoH strategy Delivering Together. We have ambitious aspirations and believe these are needed if we are to continue to provide high quality care in a progressive and sustainable way. We are seeking support from the DoH, our commissioners, other partner providers and our staff to enable us to realise these aims, through our Strategy to Transform, to bring real benefits to our patients, the health and social care system, our workforce and the population we serve.

Our vision to 2026: For our patients

1. We will provide the highest standards of quality care for patients, consistently meeting or exceeding the full range of response time targets set out in our Clinical Response Model and clinical quality indicators, as well as other assurance measures
2. We will ensure our patients receive the most appropriate response for their needs - the right response, in the right place, every time
3. We will work with other providers so that patients will benefit from a wide range of evidence-based responses and care pathways, particularly in respect of conditions identified nationally as a priority for service improvement (e.g. mental health, diabetes, coronary and respiratory diseases)
4. We will provide more patients with the treatment they require at home, either discharging on scene or referring directly into other care services, and only conveying them to EDs when clinically required or where there is no appropriate alternative
5. We will focus on quality improvement through benchmarking with other ambulance services on clinical performance, learning from experience and research, as well as sharing best practice across the UK
6. We will maximise the use of technology developments to facilitate integrated care - joining up the patient experience across providers. Other technology advances will also provide ways for patients to interact digitally with NIAS in their assessment and care should they wish
7. We will ensure patients will have access to reliable, timely and the most appropriate non-emergency Patient Care Service (PCS) for transportation to scheduled care and inter-facility transfers based on their needs
8. We will respond swiftly and effectively in the event of any major incident or mass casualty event, or to patients in challenging or hazardous environments, with specialist capabilities when needed – whether the cause is accidental, deliberate or an act of nature
9. We will proactively seek feedback and input from our patients and partners, so we can take their views into account in developing our services

GOAL

Our patients will feel professionally cared for; always with compassion and respect

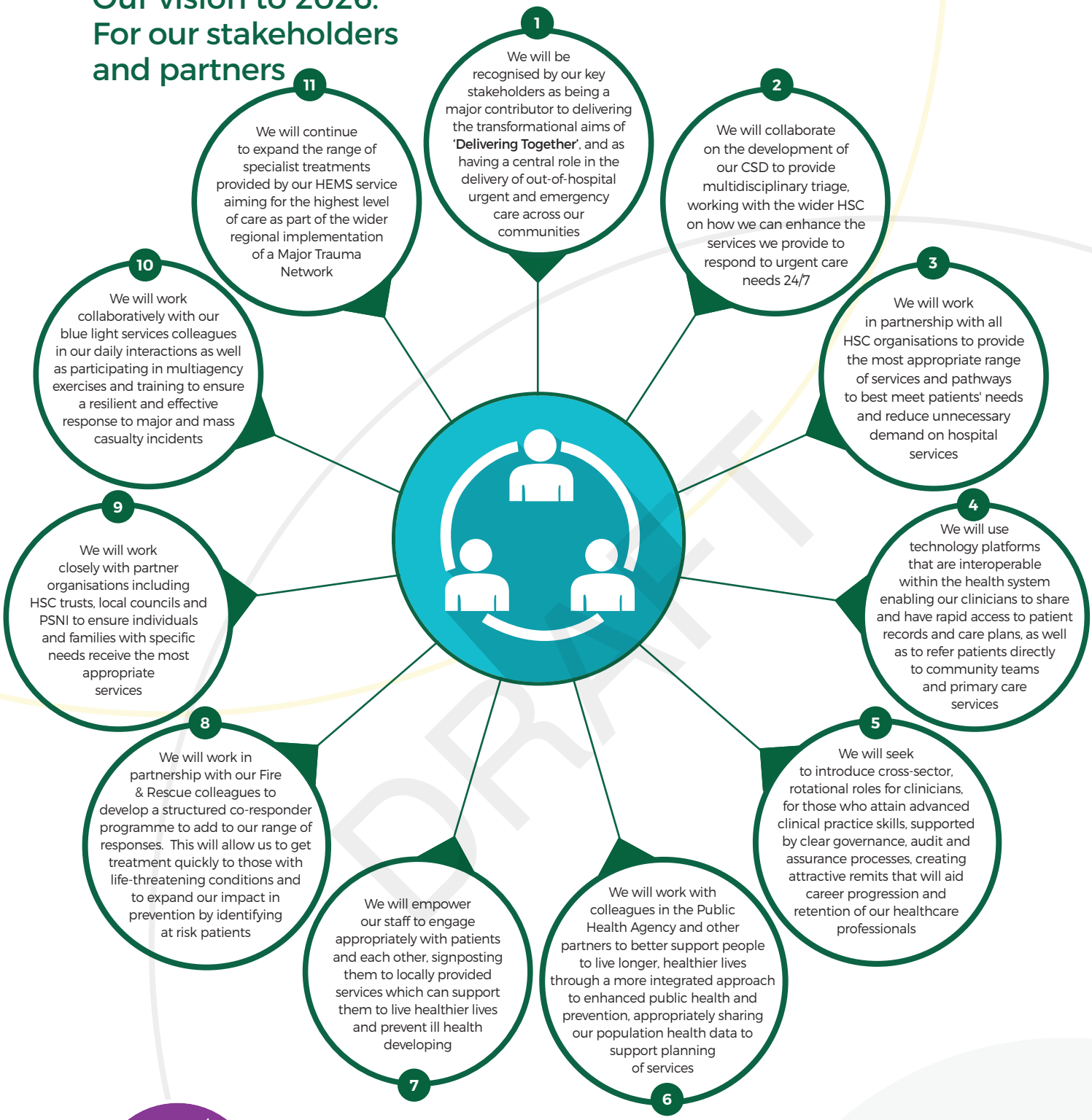
Our vision to 2026: For our workforce

1. We will be an employer of choice offering a wide range of roles, clear clinical career pathways and organisational development frameworks, with all staff feeling supported to achieve their full potential
2. We will develop the necessary education and training programmes to ensure we recruit staff with the right skill sets, facilitate continuing professional development and continue to meet our statutory obligations
3. We will place a strong emphasis on staff wellbeing and safety, providing a broad range of support functions to assist them when they are in need, particularly following an injury, traumatic or adverse events
4. We will have technology solutions in place providing mobile connectivity so that our dispersed staff can rapidly access advice and remote support and receive clinical updates and general communications from the organisation in a timely way
5. We will embrace a collective leadership approach, with staff feeling empowered to initiate improvements and collaborate in the design of new ways of working. Our culture will encourage innovation and creativity, with a focus on learning should things go wrong
6. We will introduce a robust quality improvement framework to provide opportunities for staff to initiate and be involved in improving patient care and outcomes
7. We will provide meaningful & constructive feedback through structured appraisal and development conversations so that staff feel valued and included in the organisation's vision. Success will be celebrated, and poor performance will be managed constructively
8. We will build our corporate and clinical capacity to meet the demands on our services and develop the range of skillsets required to meet the needs of our patients and new models of care
9. We will focus on creating an inclusive workforce and a culture that celebrates diversity and empowers and values all staff equally
10. We will ensure staff feel able to speak up without fear of retribution when they have concerns about patient care, their role or their work environment, and will provide safe mechanisms for them to do so. Staff will feel confident that their ideas, opinions and comments will be heard, contributing to a culture of openness and honesty
11. We will ensure the organisation's infrastructure – estate, technology, vehicles and equipment - are fit for purpose in facilitating staff to undertake their role as effectively and efficiently as possible
12. We will have constructive relationships with our trade unions, working together through our Partnership Forum to continually improve our services and working arrangements with our staff
13. We will develop partnership arrangements with other UK ambulance trusts to create exchange programmes to encourage sharing of best practice and individual development

GOAL

Our staff will feel positive and proud to work for NIAS

Our vision to 2026: For our stakeholders and partners



GOAL

Our stakeholders and partners will have confidence in us as a reliable provider at the centre of urgent and emergency care

Our vision to 2026: For our communities

1. We will commit to work with our communities and partner providers in HSC in the design and development of our services, using the principles of co-production
2. We will continue to be highly valued by the population we serve as an essential organisation that can be trusted to be there when people need us
3. We will be increasingly recognised as a mobile treatment service that provides care closer to home as well as a coordinator of access to the most appropriate healthcare and advice
4. We will continue to embrace the contribution of volunteers who support our service and expand our Community First Responder schemes, making best use of their time and skills to enhance the care provided to patients
5. We will participate in UK-wide public health surveillance as these systems develop, to support our Public Health colleagues in providing early warnings of disease activity and to provide reassurance and situational awareness on an ongoing basis. This information can be used, along with other sources, to identify potential public health threats and the need for action to mitigate these
6. We will aim to reduce the number of patients who request the assistance of the ambulance service on a frequent basis through working in partnership with such patients to find better solutions for long term or complex physical, mental health and social problems
7. We will seek to support rural communities by providing an equitable emergency response across Northern Ireland while, at the same time, developing our Community Paramedic models of care where they can undertake a dual role with primary care teams and whilst maintaining emergency response in rural areas
8. We will be considered as a compassionate, caring organisation playing a key role in transforming the way urgent and emergency care is delivered, shifting the balance of care away from hospitals and improving the future sustainability of the Health and Social Care system across Northern Ireland
9. We will commit to reducing our carbon footprint and ensuring environmental impact assessments are undertaken and acted upon across all of our functions
10. We will welcome diversity in our workforce, reflecting the communities we serve and respecting individual needs and values of our patients as we care for them

GOAL

Our communities will continue to value and trust us

Delivering our strategy to transform

Our Mission

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

Our Values

- Working together
- Excellence
- Openness & Honesty
- Compassion

Goals

- Our patients will be professionally cared for; always with compassion and respect
- Our staff will feel positive and proud to work for NIAS
- Our stakeholders and partners will have confidence in us as a reliable provider at the centre of UEC
- Our communities will continue to value and trust us

Priority Areas for Transformation

- Delivering care
- Our workforce
- Organisational health
- Quality improvement
- Digital enablers
- Our infrastructure
- Communication and engagement

Corporate Plan and Transformation Programme

Enabling Strategies

- UEC
- PCS
- Quality & Safety
- Digital
- Workforce
- Organisational Development
- Communications & Engagement
- Estates & Fleet
- Finance

Points of Focus

Governance and assurance framework

Governance and assurance framework


AMBULANCE

Enabling transformation

To deliver our strategy so that we transform our services between now and 2026 involves elements of change and innovation across every aspect of the organisation, whilst delivering our business as usual. We have seven areas of priority for transformation:

Our transformation priority areas are:

1. Delivering care
2. Our workforce
3. Organisational health
4. Quality improvement
5. Digital enablers
6. Our infrastructure
7. Communication and engagement

Each of these priority areas will contain specific supporting strategies, encompassing a range of specific projects and reviews which in turn will focus on implementing key actions for change. This includes our need to address the current challenges, outlined earlier, as well as implement further advances and new ways of working in the way we deliver our services and integrate care across the system.

All of these will be brought together within our Corporate Plan and Transformation Programme which will be underpinned by our governance and assurance frameworks.

We will have key performance indicators and milestones covering the next six years, by which progress against our transformation can be measured and monitored at local, departmental and board level as well as being shared with our stakeholders. Some projects and reviews will be phased over the course of those six years. Some will start immediately, whilst others will begin further into the programme.

We recognise that we will continually need to adapt to changing circumstances and manage risks and obstacles along the way. Our plans will therefore need to be dynamic and iterative as we learn and improve – always with our vision and goals in mind and our mission which is ***to consistently show compassion, professionalism and respect to the patients we care for.***

1. Delivering Care

- Delivery of UEC is our core business, at the heart of out-of-hospital healthcare provision. From our initial phone triage, to delivering treatment on scene, or providing advice over the phone, we have a central role to play in integrating care across the health and social care system, coordinating access for patients to the right services and reducing pressures on hospital EDs.

- Our new CRM introduced in November 2019 will continue to be embedded as we are able to introduce the assets and resources needed to meet the standards set within it. The primary aim is to identify and get treatment to patients with a life-threatening issue fastest, and for all other patients ensure we provide the most appropriate response for their clinical needs. This involves developing our capacity, capabilities and relationships with other providers to offer a wider range of appropriate responses and pathways.

- Increasingly our ambulance clinicians will be providing patients with the treatment they require on scene or in their home rather than going to hospital, and we will work with our partner providers to develop more ACPs and specific response models, such as the Mental Health Triage team (provided in partnership with PSNI and Belfast and SE Trusts), so that patients can access the right care, in the right place, every time.

- Through our see & treat (S&T) and hear & treat (H&T) models of care, and supported by new technologies, patients may be either safely discharged or referred directly to other services within the community setting, again, reducing the need for attendance at hospital EDs. We will continue to campaign for regional consistency in terms of the services offered over extended hours where we can demonstrate this will benefit patients.

- We will continue to work with hospitals to improve the process for handing over patients in their EDs. When hospital treatment is indicated, where possible patients will be conveyed to specialised destinations (eg to Primary Percutaneous Coronary Intervention (pPCI) units) and will only be taken to emergency departments when clinically needed or where alternatives are not available.

- As well as developing our responses for those with UEC needs, we will be looking at ways we can improve our non- emergency, Patient Care Service (PCS) for scheduled appointments, with a view to providing more reliable and timely transport services. We will also be reviewing these capabilities to align them alongside the UEC system, so that we can contribute to patient flow across providers. With their daily interactions with patients, our PCS workforce can also play a significant role in our public health activities, helping to improve health and wellbeing across our communities.

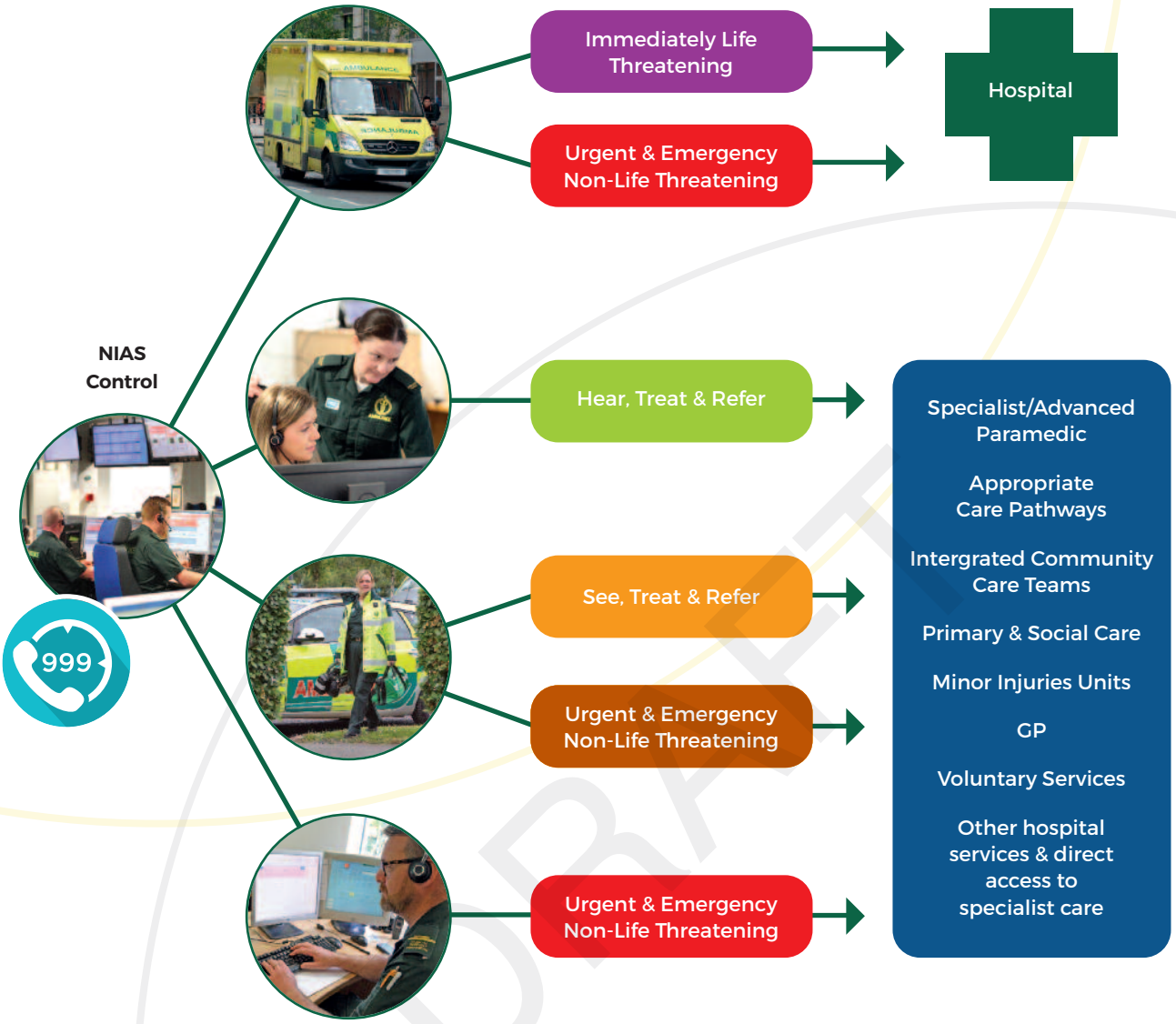
- Our response capabilities for major incidents and hazardous environments will continue to be enhanced to meet national risk and threat assessments, so that we can safely get life-saving treatment quickly to those involved in such events, whether a consequence of terrorist activity, civil disorder, accidents or natural disasters such as flooding.

- Our HEMS teams provide critical assessment and treatment on scene at serious trauma incidents, and in support of the major trauma network we will seek to develop and enhance this service and the clinical interventions it offers in order to continue to improve outcomes for these patients.

- We will be working with the NI Fire & Rescue Service to consider how we might structure co-responding schemes to ensure patients in life-threatening situations, particularly in rural areas, receive the necessary treatment as quickly as possible and join forces in identifying vulnerable, at risk persons, taking steps to prevent ill health or injury where we can.

- We will continue to work in partnership across statutory, business, community and voluntary sectors to build a Community of Lifesavers across Northern Ireland. We will do this to grow our number of volunteer Community First Responders. Our resuscitation training programmes, and defibrillator registration will continue to expand so that effective, emergency life-support can be provided to patients in need, ahead of ambulance clinicians arriving on scene.

Urgent & Emergency Models of Care



APPROPRIATE CARE PATHWAYS - CASE STUDY

An elderly patient with diabetes required frequent emergency responses due to critically low blood sugars, with each call resulting in a trip to the local emergency department. Using our diabetic referral ACP, the patient was successfully treated at home and referred for rapid follow-up by the Community Diabetic care team to stabilise their regular diabetic medication, meaning no further life-threatening episodes, no further 999 calls for low blood sugars and reduced attendances at the local hospital. A referral by NIAS can improve the long-term condition of patients as well as reducing pressures on an already-busy health system.

2. Our Workforce

- All of our people work incredibly hard in often very challenging circumstances. We recognise the value their individual experiences can bring to making improvements in our services and the way we run our organisation. We will create a workforce strategy that is focussed on engaging, developing, empowering and supporting our staff.

- Our staff are our most important asset and the health and wellbeing of every single employee needs to be a top priority for us. Our health & wellbeing programme of work is instrumental to helping us focus on how we can be more proactive in anticipating support needs and preventing ill or deteriorating health among our staff, as well as encouraging participation in activities that promote good health. This will also help to ensure that we are an employer of choice

- Recent advances have included the developing UNISON/NIAS Health and Wellbeing Partnership, the Health and Wellbeing Project, and the Peer Support project. We intend to accelerate this agenda, with new staff, resources, integrated planning and external partnerships, as part of a strategy. Our ambition is to help all staff to lead healthy lives, at home and in work, in the knowledge that the Trust has the best possible support structures to deal with health and wellbeing – whether proactively or reactively.

- Staff safety is paramount, and the trust takes a zero tolerance approach to violence and aggression towards any member of staff whilst they are carrying out their role. We will continue to work with staff to understand the risks, review untoward incidents and revise the measures we take, where we can, to do all that is reasonably possible to protect our staff from these kinds of behaviours and actions.

- Transforming our service relies on transforming our workforce and the resources that enable them to perform their roles efficiently and effectively. As our UEC delivery models develop, so will our workforce, requiring investment in new roles and enhanced skill sets and flexible working models.

- Independent demand and capacity modelling reviews have demonstrated that NIAS will require over 300 additional frontline clinicians to deliver our new CRM in a sustainable and effective way. Recruitment to these posts will require investment over several years, and this forms part of our workforce planning within our CRM implementation programme.

- With a growing workforce and the need to restructure our operational functions to accommodate this, there is a need to also revise our model for provision of human resources support across the trust to ensure there is ready access to the necessary knowledge and expertise when recruiting and managing, and supporting a dispersed workforce operating 24/7.

- We will develop a model of clinical education which drives clinical excellence. This will include innovative teaching and learning techniques for all of our frontline staff, including use of new technological advances.

- NIAS is committed to embedding a clear career framework for our clinicians, whether starting out with us as Ambulance Care Assistants (ACAs) or Emergency Medical Technicians (EMTs) or joining as a graduate paramedic. We will aim to achieve consistency with other ambulance services in the UK when developing skill-sets, and ensure we have the appropriate mix to support our range of responses.

- The continuing professionalisation of the paramedic role, and the requirement for graduate entry by 2021, creates many opportunities for individuals. We will adopt the career framework and nomenclatures developed by the College of Paramedics (CoP) (Figure 1) and will endeavour to support all staff who aspire to progress their career this way. Adopting this framework will enable us to better align our clinicians with other registered healthcare professionals such as nurses and other AHPs, so there is clearer understanding of scopes of practice as we increasingly work alongside each other and in multidisciplinary teams.

- Over time we will seek to develop a larger cohort of specialist and advanced paramedics, supporting paramedics wishing to undertake postgraduate studies. These clinicians with extended skills will play an important part

in managing patients, primarily with long-term conditions, in their home setting. They will also be able to provide clinical decision support to paramedic and emergency medical technician colleagues either on scene or through our clinical support hub.

- Our clinical workforce is supported by our non-clinical staff providing corporate services. We will introduce a clear framework of personal development opportunities for our non-clinical workforce enabling them to progress their careers within NIAS and the wider health system.
- Unplanned absence can significantly affect our ability to ensure we have the right level and skill mix of resources to meet our patients' needs from one day to the next. In recognising the links between a healthy culture, staff wellbeing and attendance, we are revising our attendance management policy and absence procedures to be able to target support and intervention more appropriately, as well as improving our workforce information and analysis processes and staff rostering system.
- Partnership arrangements and improving working relationships with our unions and staff representatives is as important as ever. In implementing a programme of significant growth and change across the organisation, it is imperative that we progress in a constructive way, respecting any impacts on our staff, ensuring they have a voice and input to the way we develop.

College of Paramedics Career Framework 2018

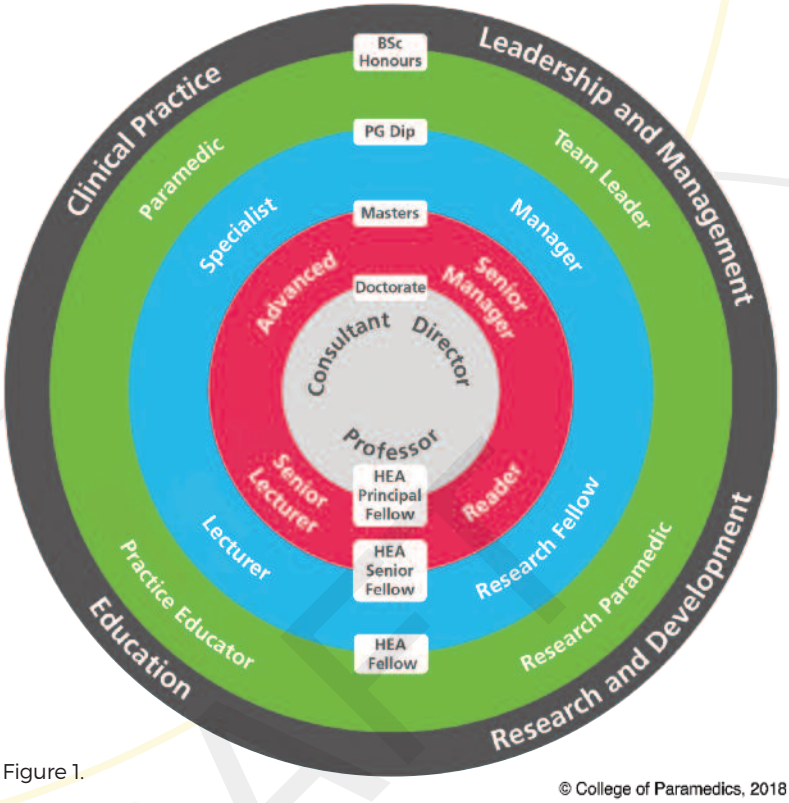


Figure 1.

Caring today, planning for tomorrow - **Our Strategy to Transform: 2020-2026**

Working together · Excellence · Openness & Honesty · Compassion

HSC Collective Leadership Approach

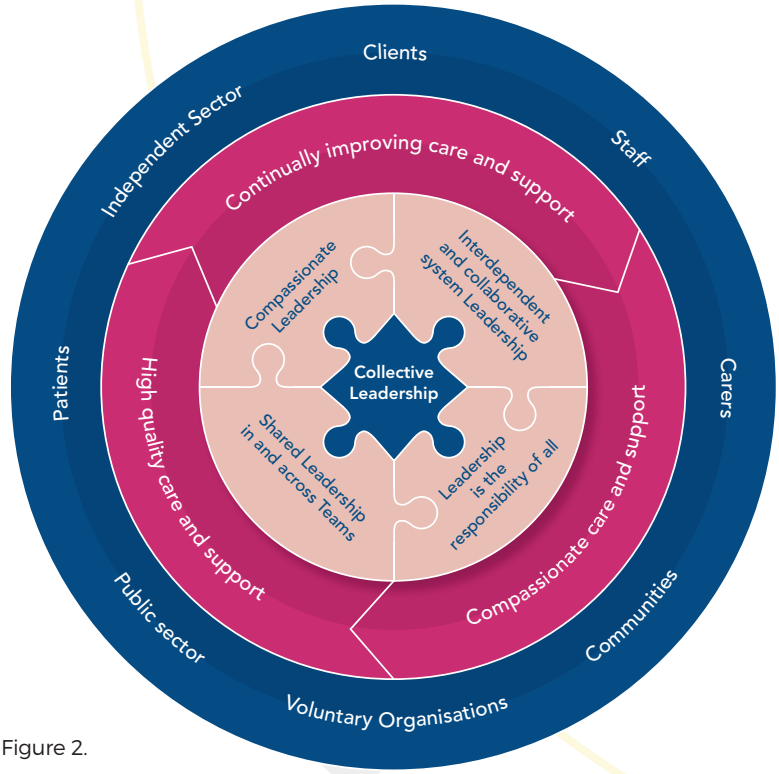


Figure 2.

3. Organisational Health

- Transforming NIAS means more than just changing some of our systems and processes. We welcome the investment that will support some of the major changes we are making in implementing our new CRM, including the recruitment of almost a third again of our frontline workforce – more than 300 extra clinicians. This alone will have wide ranging impact on how the organisation operates, and our corporate services and infrastructure will necessarily expand to accommodate these changes. All of this will take time and will inevitably change the shape of our organisation.

- We recognise that our staff are our most valuable asset and we can only achieve the vision we have laid out through their involvement, engagement and empowerment; embracing diversity and innovation. We therefore equally recognise that we need to have a supportive, inclusive and innovative culture so that we can be as healthy as possible as an organisation, and as individuals, be proud and committed to working for NIAS.

- We are strongly committed to our statutory and policy obligations around promoting equality, non-discrimination and human rights. This work is not just about procedures. It is fundamentally about bringing strong values into the heart of all our decision-making and actions.

- Our visionary strategy will need demonstrable leadership, not just from the trust board and executive team, but throughout the organisation, with everyone enthused to making the required transformation in a coordinated and sustainable way.

- For many years, NIAS has operated with a very small executive team and limited capacity within our corporate services. This will need to change if we are to have effective structures, processes and systems in place to support accountability and governance in delivering our strategy and associated plans.

- By laying out our clear vision the trust board aims to inspire everyone working in or alongside NIAS to contribute towards delivery of our common goals. These goals will be embedded through the organisation in departmental, team and individual objectives. We will strengthen our corporate governance framework and introduce a new system of appraisal that will link these with our organisational plans.

- We will demonstrate progress against delivery of our goals through regular monitoring of meaningful measures and make necessary adjustments through processes of quality improvement, risk management and continuous learning.

- In adopting the HSC approach to collective and compassionate leadership (Figure 2), NIAS will encourage the personal development and empowerment of all members of staff to lead in their areas, with a focus on continuous improvement across the service. We will develop a leadership framework that will support and enhance team working within NIAS and across the system.

- We will actively look for aspiring leaders and champions within our trust to lead by example at all levels and encourage adherence to our values and behaviours in delivering our services and developing the necessary changes to achieve our vision.

- Providing excellence for our patients will always be the primary focus for everything we do and of any changes we make.

4. Quality Improvement

- A new quality strategy bringing together all our activities aimed at improving care and safety, will detail how we will achieve our mission to excel in all that we do for the patients we care for.
- By introducing a robust quality improvement (QI) methodology and increasing our QI capabilities we will target areas where there may be a need to see most progress in achieving better outcomes and experience for both patients and staff. This methodology will enable us to manage change in an evidence-based and controlled way and allow input from staff and our range of stakeholders, including patients and carers.
- We wish to be recognised as a learning organisation and we will be reviewing our approach to investigation of serious incidents and complaints as well as boosting our clinical audit and research functions.
- Northern Ireland has historically been the home of many medical advances, and in future NIAS will seek to cater for research in topics specific to out-of-hospital urgent & emergency care. We are already contributing to national audit of patients with heart disease and acute stroke, and in the past year have begun providing information to the Trauma Audit and Research Network (TARN) database, to develop better understanding of the care of patients with serious trauma.
- To allow for in-house research projects, we have established a research group and have developed a relationship with the Southern Health & Social Care Trust to provide a research governance and ethics framework to support research work by ambulance practitioners.

RESEARCH PIECE: ACUTE SEIZURE MANAGEMENT

Neurologists from the Belfast Trust and the NIAS Clinical Service Improvement Lead published an article in the Epilepsy and Behaviour Journal titled "Brief Communication: Attitudes and Perceptions of Paramedic Staff Towards Acute Seizure Management in Northern Ireland. This research involved asking paramedics to complete questionnaires regarding their confidence in assessing / treating epilepsy; the level of training they had received, and any barriers to effective management. There was a 75% questionnaire return rate. The research concluded that there is work needed to increase confidence in paramedic decision-making regarding 'non-conveyance' of a patient following a seizure. This now provides a focus for ongoing training and decision-making support mechanisms.

5. Digital Enablers

- Our digital strategy will be business led and enabled by technology and business intelligence functions. Where required, it will be underpinned by HR policies and processes. Digital transformation represents a significant challenge but promises to create many opportunities to advance the way we operate and deliver care. Our digital enablers will drive our use of future technologies to better connect our workforce, patients and key stakeholders.

- Information will be considered and managed as a strategic asset. The aim will be to input information once and re-use it many times; access will be limited to business need, and not technical or organisational limitations.

- Ensuring our systems and platforms are interoperable with our partner providers will be key to integrating with other services allowing us to act as a gateway to the wider healthcare system, signposting the most appropriate services for patient needs.

- The public are increasingly expecting new ways of accessing and interacting with healthcare services through use of digital channels. We need to be open to new technologies as they emerge and become reliable (e.g. use of video capture on scene, artificial intelligence, wearable devices) to determine if they can further our overall vision. In time, access will inevitably develop using technology and we will listen to our patients, providing e-services they trust and value, so they can confidently interact digitally and virtually with our clinicians.

- Our clinicians will also be able to take advantage of being able to share information from scene with other clinical experts and specialists, to get remote decision making support when needed, to ensure the best treatment and outcomes

- We have a workforce dispersed right across the country and our frontline staff are on the move most of their working day or night. We therefore have a strong need to provide seamless connectivity and an ability to be able to communicate with every individual member of staff no matter where they are working.

- Personal issue devices will support our clinicians having rapid and real-time access to patient records and care plans and clinical updates, to enable them to work more safely and effectively, improving the patient experience and outcome.

- Cyber-security and secure data management are essential aspects where we cannot afford to compromise. Cyber-security will be designed 'in' as an enabling function for all new systems and services. We will ensure that best-practice is consistently applied to ensure high levels of resilience and security for critical infrastructure services

- The wealth of data we hold can support continuous improvement through appropriate, robust analysis, enhancing levels of safety and effectiveness in our processes. We will develop our business intelligence in order to support managers and staff with the information they need to lead and manage services appropriately.

- We will also be working closely with our commissioners and partner providers, to contribute knowledge gained through the data we collect, to support a population health management approach to planning and design of healthcare services.

- Developments in digital technology will assist us in providing a sustainable service in the face of increasing demand, enabling new approaches to predicting demand, and to the way we triage and respond to calls.

- To deliver our digital strategy we will build a fit for purpose digital support team comprising of inhouse teams and strategic partnerships with supplier organisations.

- Given the speed of development in the world of technology, our digital strategy will remain dynamic and will be refreshed at least every 3 years, or more frequently as required.

Electronic Patient Records

Digitisation of healthcare records began roll-out in 2019/20 and is due to be fully implemented in 2020/21. This will enable all frontline staff to rapidly transmit patient details from mobile devices on scene to any receiving hospital or clinical team, make direct referrals to other care providers and provide real-time reporting on clinical performance. These mobile devices will also be used for staff to receive safety-critical information, support educational development and provide clinical resources to aid decision-making.

6. Our Infrastructure

- An expanding workforce and new ways of working will rely heavily on our infrastructure and key assets being fit for purpose to support effective and efficient operations.
- Our programmes for the development of our estates and our vehicles are based on the premise of future-proofing these assets as change takes place and on efficient sustainability, whilst reducing our impact on the environment.
- Our estate strategy aims to rationalise much of our old estate, which is no longer fit for purpose, and provide effective maintenance for existing accommodation that is. Over time we will move to a new model of hub & spoke locations to support the introduction of 'Make Ready' systems (see box insert below).
- Our estate provision for Ambulance Control and Resource Management requires significant investment to become fit for purpose in terms of space, digital enablement and resilience.
- Through our regular fleet replacement programme, 99% of our emergency ambulances and 92% of its non-emergency ambulances are now less than 5 years old. As we embed our new CRM and plans for our urgent & emergency care provision, the need to ensure the fleet has the right profile is paramount.
- Operating a large fleet of this type has obvious environmental impacts. Much has been achieved achieved through technological advances to mitigate the impact of the base vehicles. Wherever practicable NIAS continues to explore the opportunity to adopt more environmental practices.
- We will endeavor to reduce the trust's carbon footprint by adopting new technologies such as electric and hybrid vehicles as these become viable options.
- We will also seek out greener energies for our vehicle system power, such as hydrogen fuel cells and solar power, and for our estate.
- By utilising vehicle management information supplied by telemetry systems we will aim to improve vehicle and driver performance to improve efficiency and reduce environmental impact.
- NIAS is committed where possible to work with other ambulance services, emergency and other healthcare providers to leverage combined purchasing power through centralised procurement.

MAKE READY

The 'Make Ready' System is a quality assured vehicle preparation programme, designed to minimise cross infection and maximise patient safety, whilst eliminating the hours of service associated with the cleaning and stocking of vehicles. All of the vehicle preparation is undertaken by specially trained, non-clinical staff, allowing ambulance clinicians to focus on the delivery of high quality patient care.

Key benefits of a Make Ready Scheme

1. **Improvement in standards of cleanliness.**
2. **A significant reduction in lost hours of ambulance availability.**
3. **A reduction in stock consumption measurable with procurement and financial data**
4. **Improved vehicle reliability**
5. **An improvement in patient safety measurable in reduction of adverse incidents**
6. **Enables effective asset management**
7. **Savings made on consumables and drugs stocks with no out of date items being wasted**

7. Communications & Engagement

- A vital aspect of ongoing delivery of our vision and strategy is the engagement of our stakeholders in developing it, monitoring progress and providing feedback. Our staff, patients, partner providers, commissioners and regulators all have a part to play in shaping our future.

- We will be innovative in improving our internal communication with staff, and in how to gain their input and involvement in our transformation projects.

- NIAS will not be able to deliver this **Strategy To Transform** in isolation. Neither will the full potential of the HSC **Delivering Together** strategy be realised without the inclusion of NIAS in these discussions. Co-production and co-design of new ways of working and the integration of new models of care across the system is essential and we will be seeking to engage wholeheartedly in these processes.

- To excel in all that we do for the patients we care for, NIAS will work collaboratively across the HSC to facilitate the sharing of best practice and learning. Successful outcomes for patients require efficient use of resources and we can achieve more by working together than we can separately. There are also many opportunities to extend these relationships to our colleagues in other ambulance services in the rest of the UK, Ireland and more widely afield.

- The patient and public voice is important in reminding us why we do what we do and how we can do better. We will be developing our Personal and Public Involvement (PPI) processes and opportunities into a more comprehensive Co-production model to ensure we are taking the views and experiences of our patients into account in all that we do.

- NIAS will always strive to meet our commitments in ensuring equality of opportunity:

  - Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
  - Between men and women generally;
  - Between persons with a disability and persons without;
  - Between persons with dependants and persons without.

  and promoting good relations between persons of different religious belief, political persuasion or racial group. These will be key aims within our Communications and Engagement Strategy, reflecting the diverse population we both serve and employ.

- Communication is made so much easier these days with personal devices, social media and online channels. NIAS will continue to develop our means of engagement using these avenues, to share information about our services and to work with Public Health NI in their public messaging campaigns to improve health and wellbeing.

Conclusion

This strategy outlines an ambitious programme of work for the next six years, agreed with DoH and our other stakeholders. It will require tangible investment in NIAS over time as a key partner within the Health and Social Care system, so that we can unlock new efficiencies as we change the way healthcare is delivered. Our transformation programme will require careful oversight as we implement a concurrent series of enabling strategies and plans for each of our key functions. The trust board will monitor milestones and performance indicators through regular highlight reports so that we can adapt to changing circumstances and manage risks along the way.

Appendix A outlines our Points of Focus for each of the Priority Areas which directly link to achieving our vision and goals. In addition, it is important that we prioritise some of the key objectives for the first twelve months and our priority actions for 2020/21 are outlined here:

Priority Actions – Year One

1.	We will secure wide-ranging support for our Strategy and develop a supporting business case to secure funding in order to improve our service to patients through increased workforce and supporting infrastructure.
2.	We will develop a comprehensive workforce plan for the whole organisation designed to support our strategy and will continue to train additional Paramedics, EMTs and ACAs with appropriate investment in support services.
3.	We will develop an Improvement Plan to deliver the best possible response times to patients within existing resources.
4.	We will develop a suite of supporting infrastructure strategies for Estates and Fleet ensuring that the most pressing issues are addressed in year one.
5.	We will review our Human Resources model with a view to establishing a revised model to better meet organisational and workforce needs.
6.	We will initiate a new Organisational Culture Programme to take focused action to develop a culture of collective and compassionate leadership.
7.	We will develop a new Quality and Safety Strategy which focuses on how we continually improve, measure and evidence the quality of our services for our patients.
8.	We will continue to work with HSCB and Primary Care to develop a model for training Specialist Paramedics to work on a rotational basis in Primary Care.
9.	We will commence a Patient Care Service Improvement Programme to improve the quality of our service for this important group of service users.
10.	We will open a new training and administration facility for Emergency Ambulance Control.
11.	We will implement a new approach to personal development reviews to inspire and motivate staff to be the best that they can be and to provide the best possible care to patients.
12.	We will undertake a review of our Operational Management Structure to provide more effective support for staff, including on a 24/7 basis.
13.	We will consolidate and refresh our technology infrastructure to maintain service and improve resilience.
14.	We will begin roll-out of our new Electronic Patient Report Form with links to wider HSC systems enabling our clinical staff to access and share records enhancing the care we offer.
15.	We will establish arrangements to improve business intelligence through data warehousing, business intelligence tools and best practice.

Appendix A

Points of focus within our transformation priority areas

In order to achieve our vision for NIAS and meet the goals we have set ourselves over the next six years, we will be focussed on some specific points within each of our priority areas for transformation. As we do so, there will be many overlaps and interdependencies both within our trust and across the rest of the health system. As described in our diagram on page 21, these will be brought together within an integrated Corporate Plan and Transformation Programme, which will be underpinned by our governance and assurance frameworks.

Priority Areas for Transformation

DELIVERING CARE

Points of Focus 2020 - 2026

1 Operational Delivery

- Developing UEC strategy
- Reviewing operational structures
- Implementing CRM
- Implementing our DMP
- Developing our CAD capabilities including auto-dispatch
- Improving hospital handovers
- Introducing HCP/IFT framework
- Building our CFR schemes
- Developing Co-responding schemes

2 Integrating Urgent & Emergency Care

- Standardising more ACPs
- Increasing S&T and H&T
- Expanding community paramedicine
- Introduce cross-sector, rotational paramedic roles
- Enhancing our CSD
- Developing access to 24/7 non-emergency advice
- Supporting nursing & care home triage

3 Re-designing Patient Care Services

- PCS strategy
- Improving reliability of our scheduled care transport
- Expanding the non-emergency remit
- Aligning with UEC to support patient flow
- Enhancing the PCS role in public health
- Review communication devices for private providers

4 Improving public health / preventing ill-health

- Developing frequent-caller support hubs
- Embedding the principles of MECC
- Signposting for Third Sector support
- Expanding our community resuscitation programme
- Contributing to national syndromic surveillance systems

5 Emergency preparedness & resilience

- Developing HART capabilities
- Improving business continuity and disaster recovery arrangements
- Developing JESIP and MI capabilities
- Multi-agency planning & exercising programme
- Implementation of learning from exercises, major incidents enquiries relating to NIAS and elsewhere

For our patients

For our workforce

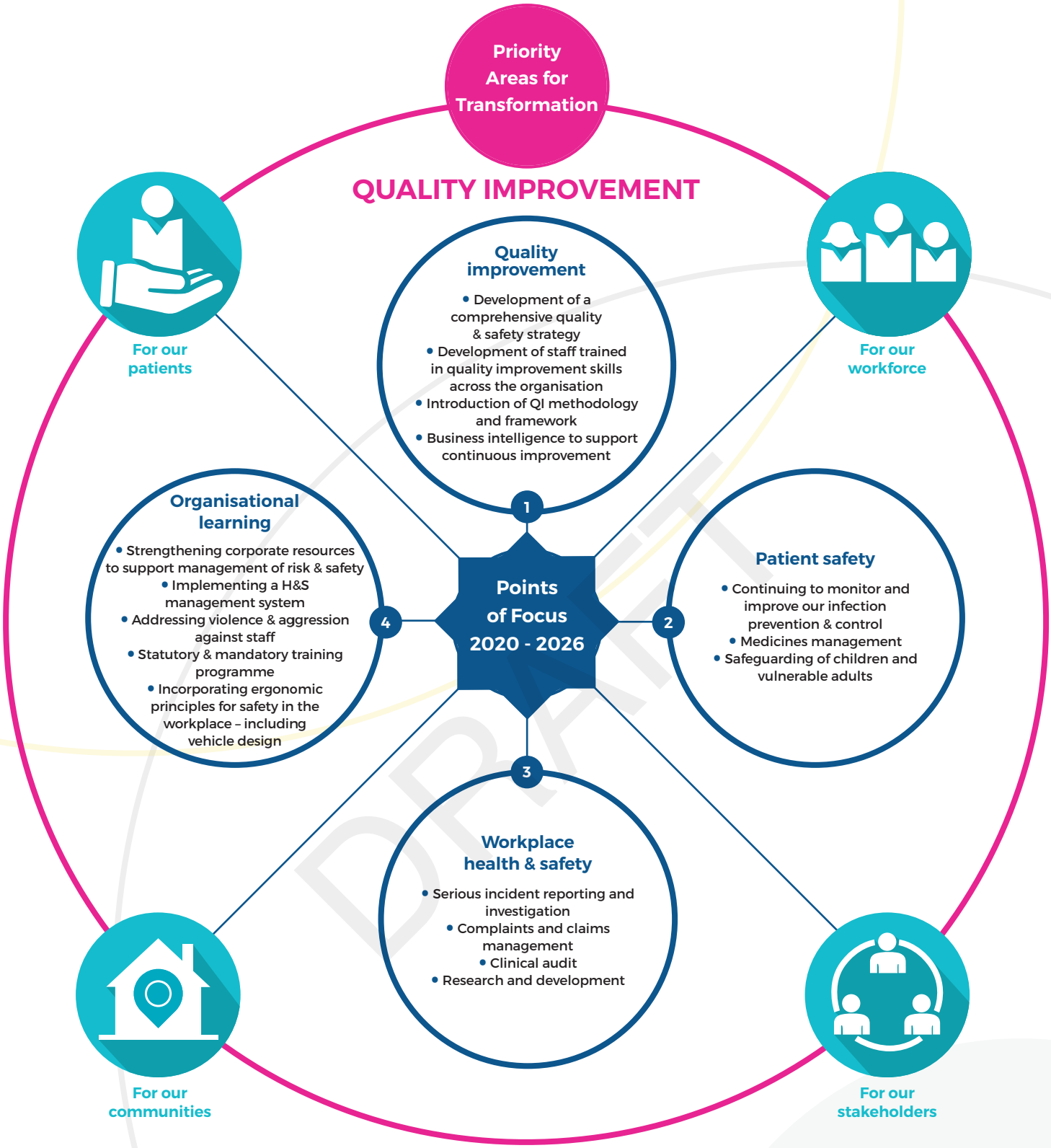
For our communities

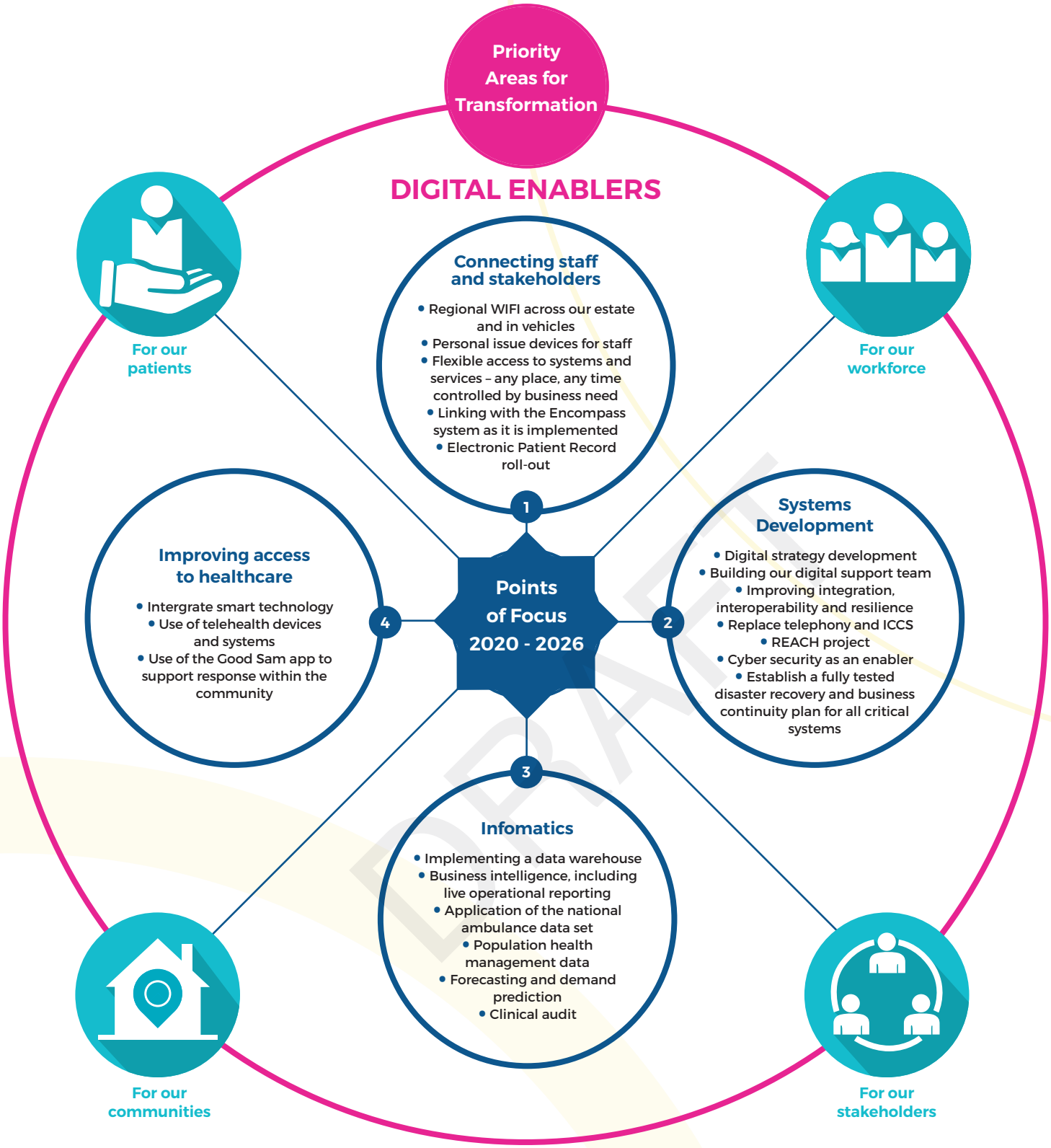
For our stakeholders

Caring today, planning for tomorrow - **Our Strategy to Transform: 2020-2026**

Working together · Excellence · Openness & Honesty · Compassion


Priority Areas for Transformation
OUR WORKFORCE
Points of Focus 2020 - 2026
1
Operational Delivery
• Development of a workforce strategy to engage, develop, empower and support all staff
• Design and implementation of revised HR delivery model
• Workforce information analysis and forecasting systems
• Workforce planning and recruitment schedule
• Review of processes to improve local management of recruitment activity delivered by Shared Business Services
• Application of improved attendance management practices
• Revised appraisal process and personal development plans
• Expansion of multidisciplinary roles
• Introduction of cross-sector rotational paramedic models
• Improving partnership working mechanisms with our trade unions
• Supporting and expanding our volunteer workforce
2
Education, Learning & Development
• Adoption of clinical career framework and pathways for all frontline roles
• Non-clinical training and development framework
• Development of mentoring support & supervision processes
• Continue partnerships with universities and higher education institutions
3
Corporate governance
• Board and senior management development
• Corporate governance framework review
• Performance management systems
4
Health & Wellbeing
• Rollout of a comprehensive health & wellbeing programme
• Review of scope and delivery of occupational health services (internal and external)
• Embedding our peer support network
• Reducing and responding to violence & abuse against staff
• Promoting healthy lifestyles & resilience
• Preventing physical or mental ill health or work-related injury
5
Corporate support services
• Expansion of support functions and structural review to support CRM
6
Organisational health
• Culture survey and review
• Staff engagement processes
• Collective leadership development
• Embedding of values and behaviours
• Talent management / identifying future leaders
• Inclusive and supportive approaches to organisational change
For our patients
For our workforce
For our communities
For our stakeholders


Priority Areas for Transformation
QUALITY IMPROVEMENT
For our patients
For our workforce
Quality improvement
• Development of a comprehensive quality & safety strategy
• Development of staff trained in quality improvement skills across the organisation
• Introduction of QI methodology and framework
• Business intelligence to support continuous improvement
1
Organisational learning
• Strengthening corporate resources to support management of risk & safety
• Implementing a H&S management system
• Addressing violence & aggression against staff
• Statutory & mandatory training programme
• Incorporating ergonomic principles for safety in the workplace – including vehicle design
4
Points of Focus 2020 - 2026
2
Patient safety
• Continuing to monitor and improve our infection prevention & control
• Medicines management
• Safeguarding of children and vulnerable adults
3
Workplace health & safety
• Serious incident reporting and investigation
• Complaints and claims management
• Clinical audit
• Research and development
For our communities
For our stakeholders


Priority Areas for Transformation
DIGITAL ENABLERS
For our patients
For our workforce
Connecting staff and stakeholders
• Regional WIFI across our estate and in vehicles
• Personal issue devices for staff
• Flexible access to systems and services – any place, any time controlled by business need
• Linking with the Encompass system as it is implemented
• Electronic Patient Record roll-out
1
Improving access to healthcare
• Intergrate smart technology
• Use of telehealth devices and systems
• Use of the Good Sam app to support response within the community
4
Points of Focus 2020 - 2026
2
Systems Development
• Digital strategy development
• Building our digital support team
• Improving integration, interoperability and resilience
• Replace telephony and ICCS
• REACH project
• Cyber security as an enabler
• Establish a fully tested disaster recovery and business continuity plan for all critical systems
3
Infomatics
• Implementing a data warehouse
• Business intelligence, including live operational reporting
• Application of the national ambulance data set
• Population health management data
• Forecasting and demand prediction
• Clinical audit
For our communities
For our stakeholders

Priority Areas for Transformation

INFRASTRUCTURE

For our patients

For our workforce

Our fleet

- Vehicle design - the right type of vehicles to support the range of responses we provide
- Vehicle replacement and procurement planning
- Maintenance and support systems
- Access to technology to operate a modern fleet

1

Environment and Sustainability

- Developing environmental impact assessment process
- Developing our strategy for reducing our carbon footprint
- Introduce sustainable and efficient procurement practices

4

Points of Focus 2020 - 2026

2

Our estate

- Estates strategy to support our expanding workforce and CRM
- Reconfiguration and Hub & Spoke plans
- Relocation of our EAC
- Review and testing of fallback EAC arrangements
- Estates maintenance programme

3

Asset management

- Option appraisal for introduction of Make Ready system
- Recruitment and training for vehicle preparation workforce
- Embed IP & C policies and procedures
- Review asset management system

For our communities

For our stakeholders

Priority Areas for Transformation

COMMUNICATIONS & ENGAGEMENT

For our patients

For our workforce

Stakeholder engagement

- Communication & engagement strategy
- Strengthen Personal and Public Involvement processes
- Engage with partners in the UEC system to gain awareness and participation in our long term objectives
- Co-production strategy – working with our partners
- Community engagement events programme

1

Public Health

- Work with the Public Health Agency (PHA) on public health messaging and campaigns
- Participate in the National Ambulance Syndromic Surveilance System

4

Points of Focus 2020 - 2026

2

Internal Communications

- Staff engagement plan
- Identify priorities to improve functionality and communication within the trust
- Development of our intranet
- Use of technology to comminicate in real-time with staff

3

Media Management

- Redesign of our website
- Development of social media strategy
- Working with the media to positively promote our service

For our communities

For our stakeholders

Glossary

ACA	Ambulance Care Assistant
ACP	Appropriate Care Pathway
AHP	Allied Health Professional
AMPDS	Advanced Medical Dispatch System
CAD	Computer Aided Dispatch
CAWT	Cooperation and Working Together
CEO	Chief Operating Officer
CFR	Community First Responder
CoP	College of Paramedics
COPD	Chronic Obstructive Pulmonary Disease
CRM	Clinical Response Model
CSD	Clinical Support Desk
DMP	Demand Management Programme
DoH	Department of Health
EAC	Emergency Ambulance Control
ED	Emergency Department
EMT	Emergency Medical Technician
GP	General Practitioner
H&S	Health and Safety
H&T	Hear and Treat
HART	Hazardous Area Response Team
HCP	Healthcare Professional
HEMS	Helicopter Emergency Medical Service
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICCS	Integrated Communications Control System
IFT	Inter-Facility Transfer
IP&C	Infection Prevention and Control
JESIP	Joint Emergency Services Interoperability Principles
MECC	Making Every Contact Count
MI	Major Incident
NIAS	Northern Ireland Ambulance Service Health and Social Care Trust
NIECR	Northern Irelance Electronic Care Record
NISTAR	Northern Ireland Specialist Transfer and Retrieval Team
PCS	Patient Care Service
PHA	Public Health Agency
pPCI	Primary Percutaneous Coronory Intervention
PSNI	Police Service of Northern Ireland
PTS	Pre-Triage Sieve
QI	Quality Improvement
REACH	Regional Electronic Ambulance Communication Hubs
S&T	See and Treat
TARN	Trauma Audit and Research Database
TIC	Transformation Implementation Group
TOG	Transformation Operational Group
UEC	Urgent & Emergency Care

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service
Ambulance Headquarters
Site 30, Knockbracken Healthcare Park
Saintfield Road, Belfast, BT8 8SG

Tel: 028 9040 0999
Fax: 028 9040 0900
Textphone: 028 9040 0871
Web: www.nias.hscni.net

Working together Excellence Openness & Honesty Compassion

January 2020

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	Thursday 30 January 2020
Title of paper:	Audit Committee – Terms of Reference
Brief summary:	The Terms of Reference have been reviewed and updated to take account of changes to the Standing Orders regarding membership of the Committee. Moving forward, the updating of Committees' Terms of Reference will be taken forward through the annual review of Standing Orders and Standing Financial Instructions. If approved, the Terms of Reference will be incorporated into the Standing Orders and distributed as appropriate.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	Audit Committee – 15 October 2019 SMT – 21 January 2020
Prepared and presented by:	Paul Nicholson, Interim Director of Finance & ICT
Date:	23 January 2020

Northern Ireland Ambulance Service
Health and Social Care Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

Audit Committee Terms of Reference

Recommended at Audit Committee: 15 October 2019 (previously 16 March 2018)

Approved at Trust Board: (previously 12 April 2018)

CONTENTS

1. CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee).

1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.3 All procedural matters in respect of the conduct of the meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2. MEMBERSHIP OF THE COMMITTEE

2.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members.

2.2 One of the members of the Committee will be appointed Chair of the Committee by the Board.

2.3 The Chair of the Board shall not be a member of the Committee.

2.4 One member of the Committee shall be the Chair of the Assurance Committee.

2.5 One member of the Committee must have significant, recent and relevant financial experience.

2.6 A quorum shall be two members.

3. ATTENDANCE

3.1 The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the External and Internal Auditors.

3.2 The Chairman, Chief Executive, Executive Directors and other Officers of the Trust may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director or Officer.

3.3 The Chief Executive should be invited to attend at least twice annually, to discuss with the Committee the process for assurance that supports the Mid-Year Assurance Statement and the Governance Statement.

3.4 A representative from the Sponsor Department (Department of Health) will be invited and may attend meetings of the Committee as an observer.

3.5 The Assistant Director of Finance shall attend to take the Minutes of the meeting and provide appropriate support to the Chairman and Committee members.

4. FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year. The Chair of the Committee may convene additional meetings as is deemed necessary. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1 The Audit Committee's primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice as and when necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

6.1 The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

6.2 In particular the Committee will review:

- The adequacy of all risk and control related disclosure statements (in particular the Mid-Year Assurance Statement and the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions;
- The adequacy of the policies and procedures for all work related to fraud and corruption as required by the Department of Health (DoH) and the Business Services Organisation's (BSO) Counter Fraud and Probity Service (CFPS);
- The annual schedule of losses and compensation payments and will make recommendations to the Board regarding their approval;
- The register of Single Tender Actions (Direct Award Contracts).

6.3 In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions.

6.4 The Committee will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

6.6 The Committee shall seek to ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- Consideration of the Head of Internal Audit's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- Annual review of the effectiveness of internal audit.

External Audit

6.7 The Committee shall review the work and findings of the External Auditor appointed by the Northern Ireland Audit Office and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the performance of the External Auditor;
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Strategy;
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust;
- Review of all External Audit reports, including consideration of the annual Report to Those Charged with Governance before submission to the Board and any work carried out outside the Annual Audit Strategy, together with the appropriateness of management responses.

Other Assurance Functions

6.8 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.9 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

Financial Reporting

6.10 The Audit Committee shall review the Trust's Annual Report and the Financial Statements before submission to the Board, focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements;
- Major judgemental areas;
- Significant adjustments resulting from the audit;
- The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

Value for Money

6.11 The Audit Committee shall oversee the adequacy of the Trust's arrangements for ensuring that Value for Money (VFM) is obtained in the expenditure of all public funds entrusted to its care. This will include a review of the findings from, and management's response to, all value for money audit reports issued to the Trust as part of the regional VFM programme sponsored by DoH.

7. REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

8. OTHER MATTERS

8.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

TB/30/01/2020/04

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	Thursday 30 January 2020
Title of paper:	Risk Register
Brief summary:	The Risk Register has been updated to take account of discussion at SMT on 14 January 2020. However members should note that the Register is currently being reviewed to take account of a number of further risks which have been identified. This will then be considered by the Assurance Committee at its next meeting.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 14 January 2020
Prepared and presented by: **Date:**	Katrina Keating, Risk Manager Dr Ruddell, Medical Director 23 January 2020

Northern Ireland Ambulance Service
Health and Social Care Trust

Corporate Risk Register			
Date of last review:	14th January 2020	**Tabled at SMT:**	14th January 2020

ID	Description	Opened	Resp.	Level
1	As a result of vacancies, sickness, abstractions, increased turnaround times at EDs and increased time at scene due to adoption of care pathway assessments, there is a significant risk that harm will occur if response times are delayed. (369).	03/10/18	Robert Sowney	**Extreme**
2	If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals (311).	09/08/17	Paul Nicholson	**Extreme**
3	If NIAS staff fully withdraw their labour due to industrial action, this will result in a loss of services, which would present a risk to patient safety (449).	25/10/19	Michelle Lemon	**High**
4	Trust telephony system is end of manufacturer support/currently supported on extended break fix only. The system contains legacy components which are end of life/hosted on unsupported operating systems. Patient safety & cyber security risk (419)	19/07/19	Paul Nicholson	**High**
5	If the Trust does not make suitable arrangements to adequately maintain and improve the overall condition of its estate, this may result in breaches of statutory duty and put staff at risk. There is the potential for closures of sites (262).	31/12/14	Brian McNeill	**High**
6	The current operational management arrangements (nine to five) present a risk to effective service delivery and in the necessary support to staff (372).	03/10/18	Robert Sowney	**High**
7	If the management of sickness absence is not improved this may impact on service delivery and improvement as well as resulting in an inability to achieve financial balance. This could further exacerbate the potential for detrimental impact upon service (403).	13/08/19	Michelle Lemon	**High**
8	If the Trust overspends against core budget due to savings plans, overspending against core budget, cost pressures and/or service changes or any changes to terms and conditions, the Trust may breach its statutory duty to break even (420).	05/08/19	Paul Nicholson	**High**
9	There is a risk that should the trust not develop and implement an holistic, detailed and fit-for-purpose response to acts of aggression towards NIAS employees, there is potential for such aggression to continue to rise. This will adversely affect the health and well-being of staff (395).	17/12/18	Sowney, Robert	**High**
10	There is a risk to staff and potentially service delivery if the Trust does not improve and sustain arrangements to support staff health and wellbeing (301).	03/10/18	Michelle Lemon	**High**
11	There is a potential risk to patient and staff safety, as well as organisational reputation, as current Trust hygiene, cleanliness and infection prevention control arrangements do not comply with regional standards (309).	24/07/17	Lynne Charlton	**High**
12	Accommodation in Emergency Ambulance Control (EAC) is not fit for purpose and has been maximised. Telephony slots are also at capacity. This presents a risk to service improvement (halting of recruitment / expansion) which will lead to an inability to meet increasing demand (353).	08/05/18	Sowney, Robert	**High**
13	If adequate business continuity arrangements are not in place for Emergency Ambulance Control (EAC), there is a risk that calls may not be answered and patient care will be compromised (300).	26/10/16	Robert Sowney	**High**
14	There is a risk that the implications of the EU Exit may affect the provision of service by NIAS through interruption to supply chains for equipment and medicines, delay in responding to cross-border emergencies, delay in mutual aid from NAS in the event of a major incident, and difficulties for staff who are resident in ROI. Cross-border journeys may also be affected (367).	03/10/18	Dr Nigel Ruddell	**High**

TB/30/01/2020/05

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT
December 2019 (Month 9)

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently reporting a breakeven position for the nine months ending 31 December 2019 (Month 9), 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 December 2019 (Month 9)

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			
Other Expenditure		2,410	3,696	5,376	6,953	8,423	9,871	11,860	13,501			
Expenditure Total		12,452	18,921	25,670	32,546	39,207	45,869	53,203	60,186			
Income		147	220	299	436	520	576	609	691			
Net Expenditure		12,305	18,701	25,371	32,110	38,687	45,293	52,594	59,495			
Net Resource Outturn		12,305	18,701	25,371	32,110	38,687	45,293	52,594	59,495			
Revenue Resource Limit (RRL)		12,305	18,701	25,374	32,110	38,687	45,293	52,594	59,495			
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				21,249
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				19,989
% bills paid on time	91.4%	93.4%	91.4%	95.1%	96.6%	92.1%	95.1%	96.0%	95.9%				94.1%
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				15,373
% bills paid on time	64.9%	71.1%	80.1%	76.4%	78.7%	66.2%	74.4%	76.1%	65.9%				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 December 2019 (Month 9) is as follows:

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			
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%			
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			
Value of Spend £k (Stock and Non Stock)	675	218	321	296	989	2,817	1,055	1,244	1,149			

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.

Nov – Dec Service Issues

On 26th November a CAD system failure was reported to IT out of hours. On-call technician attended site and restarted the system which worked for a while before failing again. The system continued to work for a period then fail and the issue was escalated to the supplier who diagnosed a fault on the disk of the primary server. NIAS IT switched users to the secondary server and C3 system was restarted successfully. The faulty disk on the primary server was replaced the next working day and there have been no further outages.

There was an issue on 13th December at the NEAC caused by a Cisco data switch memory leak. This resulted in a degradation of service to users for a period of up to 2 hours. The issue was resolved by a switch reboot but will require a firmware update to apply a permanent fix. This work is scheduled for January 2020.

Information Technology Systems - Developments

Any system developments are reported in this section

CRM went live on 12 November and has been embedded in business as usual support processes with no technical issues in this reporting period.

To support future Disaster Recovery and management arrangements for the CAD, the Trust are in the process of implementing the Assured Continuity of Service (known as ACS) module. This will simplify and speed up processes that are necessary in a DR scenario as well as some standard upgrades. The first stage of implementing ACS was completed whilst the main system was off line during the Microsoft upgrade work. The second stage was planned for February but following a planning review by the IT Change Advisory Board (CAB) it was agreed that further scoping of the expected benefits was required and that the merits of delaying implementation until the CAD hardware replacement project were explored.

The building ‘Foyle’ adjacent to HQ has now been made IT ready and work has commenced on relocation off staff. To date the CRM support team, Estates and HR Absence Management team have been relocated. The next proposed step is for architects to survey the offices within the Foyle building to make effective use of all office space areas and then develop a move plan before any further staff are relocated. A building survey to support the implementation of WiFi has been completed and contractors will commence installation in February.

Work is underway to develop a business case to replace the aging telephony and ICCS (telephony for the control room) systems. The requirement will also support the plans for Site 5 and enhanced disaster recovery arrangements. NIAS engaged Deloitte to write the business case for submission to DOH by end December 2019. This target date has not been met by Deloitte and an extension to end January 2020 has been agreed.

The Reach project: The rollout of the new Mobile Data system to A&E vehicles is now complete and operational. The rollout to the Non-emergency fleet commenced on 30 September and completed in mid-October 2019. There are an additional 6 new PCS vehicles require fitting with the new system hardware with a target completion date of 31 January 2020.

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 by end Nov 2019 – This Milestone (2) was due to be signed off in November 2019 however there are issues that need to be resolved in terms of the high level technical design. This relates to user authentication and has the potential to impact on the timely delivery of the following milestones:
    - o system commissioning by end Feb 2020
    - o pilot by April 2020, roll out by June 2020
    - o completed by Nov 2020

Radio replacement project – work delayed due to implementation of CRM. Work on ICCS rescheduled for w/c 20 Jan 2020. Roll out of radios dependant on reconfiguration in control.

ICT Help Desk Performance

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

	Nov			Dec		
Target to Respond to 95%	No of Calls	Within time	Actual	No of Calls	Within time	Actual
Immediate	4	4	100%	7	6	86%
Urgent	38	38	100%	42	42	100%
High	22	22	100%	12	11	92%
Medium	577	562	97%	597	574	96%
Low	550	550	100%	479	477	100%
Total	1191			1137		

***Information Governance/Informatics* – Developments: 01/11/2019 to 31/12/2019**

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.***
- ***Appointment of new permanent Information Analysts to support BI are now in place.***
- ***Supporting Medical Directorate and Transformation Collaborative with Quality Improvement Templates and data analysis. These continue to be developed and monitored. Includes Falls, Hypoglycemia, 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 drug/alcohol, independent ambulance providers, hospital turnaround times.***
- ***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 December 2019	April 2018 to December 2018	% Increase / (Decrease)
1 Freedom of Information Requests Received	180	163	+10.4%
1a Freedom of Information Questions Received	434	528	-17.8%
2 General Data Protection Regulations, Subject Access Requests Received	69	49	+40%
3 Police Service of Northern Ireland Requests Received	375	350	+7.1%
4 Solicitor Enquiries Requests Received	677	485	+39.5%
Total (1a) not included in Count	**1301**	**1047**	**+24.2%**

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 31/12/19	Total 01/04/18 to 31/12/18
Number of Requests Received	18	29	27	29	20	17	13	21	6				**180**	163
Number of Questions Received	46	68	40	60	64	46	29	53	28				**434**	528
Completed Requests processed within 20 days or less	8	20	22	22	14	11	6	13	1				**117**	133
Completed Requests exceeding 20 days	9	7	4	6	6	2	3	4	0				**41**	18
REQUESTS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	4				**4**	
REQUESTS Still being processed (outside 20)	1	1	0	1	0	0	0	3	1				**7**	
Stood Down	0	1	1	0	0	4	4	1	0				**11**	
Number of Records Fully Disclosed	27	55	34	46	54	26	16	42	1				**301**	
Vexatious Requests	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				**41**	
Requests where exemptions wholly/partially applied	6	0	0	0	4	0	0	3	0				**13**	
Questions stood down	0	1	3	0	0	14	13	1	0				**32**	
QUESTIONS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	14				**14**	
QUESTIONS Still Being Processed (outside 20)	4	3	0	8	0	0	0	5	13				**33**	
Referrals for Independent Review	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**	
Requestor Type														
Member of Public	5	18	14	12	9	8	4	7	2				**79**	
Local Government	0	0	1	0	2	0	0	0	0				**3**	
Staff Member	3	4	7	5	1	1	1	2	2				**26**	
Media	2	4	0	5	4	4	3	5	0				**27**	
Student	0	4	0	1	0	1	0	1	0				**7**	
Commercial Company	2	1	2	2	3	1	0	1	1				**13**	
Solicitor	1	0	0	1	0	0	1	0	0				**3**	
WhatDoTheyKnow.com	2	1	2	4	1	2	4	4	2				**22**	
NHS	0	0	0	0	0	0	0	0	0				**0**	
Trade Union	0	0	0	0	0	0	0	0	0				**0**	

%age completed within 20 working days	
Apr '19 - Dec '19	65.00%
Apr '18 - Dec '18	81.60%

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 01/04/2019 to 31/12/2019

General Data Protection Regulations/Data Protection Act 2018 – Subject Access	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 – Dec 19	April 18 – Dec 18
Number of Requests Received	7	6	9	4	6	8	18	10	1				69	49
Completed Requests processed within 30 days or less	5	2	4	3	4	6	11	6	1				42	33
Completed Requests exceeding 30 days	2	3	5	1	1	0	0	0	0				11	6
Requests still being processed in line with 30 days	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				10	
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				8	1
COMPLIANCE RATE – 61%														
Patient	2	1	3	1	1	0	5	3	1				17	
NIAS Staff Member	1	1	0	1	2	2	7	2	0				16	
External Agency ie Solicitor acting on behalf of patient/staff	2	3	5	0	3	6	6	5	0				30	
Relative of Patient	2	1	1	2	0	0	0	0	0				6	

- 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 31/12/2019

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 - Dec 19	Apr 18-Dec 18
Number of Requests Received (based on receipt of correspondence date)	51	41	34	49	42	33	38	46	41				375	350

4. SOLICITOR ENQUIRIES 01/04/2019 to 31/12/2019

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 – Dec 19	Apr 18-Dec 18
Number of Requests Received (based on receipt of correspondence date)	65	63	77	99	65	66	72	86	64				677	485

Processing for the Period 01/04/2019 TO 31/12/2019

5. DEPARTMENT OF HEALTH – REQUESTS FOR INFORMATION DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 – Dec 19
Assembly Questions (Oral)	0	0	0	0	0	0	0	0	0				0
Assembly Questions (Written)	0	0	0	0	0	0	0	0	0				0
CORs/SCORs Received	1	2	3	0	2	3	1	0	0				12
TOFs Received	0	0	0	0	0	0	0	0	0				0
INVs Received	0	0	0	0	0	0	0	0	0				0

TB/30/01/2020/06

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING 30 JANUARY 2020

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) • Turnaround Time • Update on Flu Vaccination Campaign
Recommendation:	For Noting: • New Clinical Response Model (CRM) in operation from November 2019 • Increasing numbers of calls • Increased turnaround times
Previous Forum:	
Date of SMT Approval:	
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 – December 2019 the number of emergency calls answered was 164,699, 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 1159 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 November 2019 was 75% of 999 calls were answered within 5 secs. 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
- 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 from September – December 2019

- EAC staff received CRM training in preparation of "go live" date in November.
- New Clinical Response Model codeset was successfully introduced within EAC on 12 November 2019.
- In September 2019 two of our EMDs, Lynsey Perry and Sarah Brunton where nominated for the UK Dispatcher of the Year Award for the high quality of their call taking skills. While they did not win the overall award, for NIAS to have 2 EMDs nominated is further evidence of the high standard of our EMDs.
- An EMD training course consisting of 8 new staff was completed by December 2019.

- The recruitment and selection process for new EMD Supervisors posts has been completed and training is now underway. EMD Supervisors will give greater oversight of the function allowing real time performance monitoring.
- 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 has been appointed and takes up position in January 2020.

EMD (999 Call Takers) Compliance & Award Scheme

An ongoing call audit process is a vital part of how we quality assure 999 call-taking. The latest audit figures from October to December 2019 shows NIAS meeting the required standards throughout the 3 month period.

This is a significant achievement in the journey towards re-accreditation and displays the excellent work by EMDs within the EAC and the audit team.

EAC continues meet the IAED Accredited Centre of Excellence standards thus providing clinical assurance that 999 calls are being prioritised appropriately. NIAS is one of only four other national services that have achieved this accreditation.

Emergency Ambulance Control continues to operate an EMD award scheme. Certificates and badges continue to be awarded for randomly selected calls with overall “High Compliance” and for calls with exemplary (100%) Customer Service. Other awards are for Baby Born, Cardiac Life Saver & Non-Cardiac Life Saver. In order to attain these specific awards the call must be reviewed as meeting the standards of “Compliant” or “High Compliance”.

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.

Note: The data included in this report for November is not for the full month, rather the two weeks post implementation. All other months are reported on wholly.

Response Time Targets

Call Type	Category	Mean Standard	90th Percentile
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:

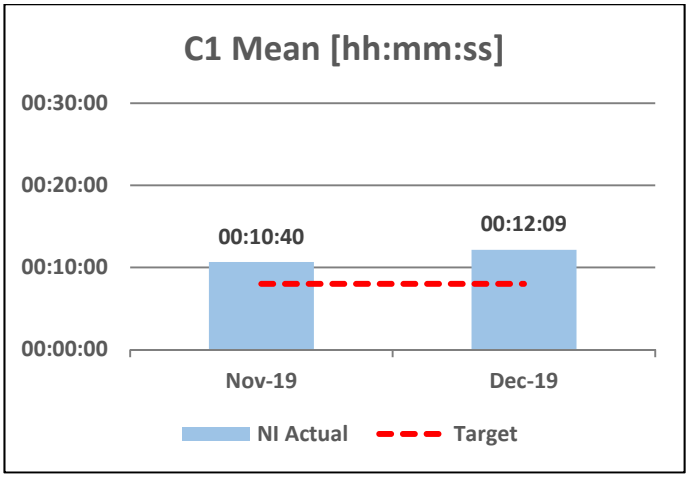
- November and December were challenging months for NIAS and other HSC Trusts due to Industrial Action which disrupted normal service delivery - most significantly for NIAS the action taken on November 30th and December 18th as this included NIAS staff. Other Industrial action days throughout the wider HSC system also impacted on NIAS service delivery.

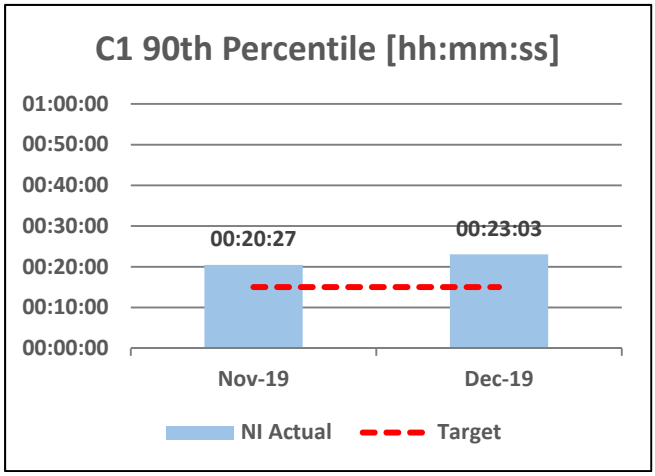
- Trends for ambulance turnaround times greater than the standard (i.e. 30 mins) continue to increase which impacts heavily on NIAS response and availability. We continue to work with hospitals and HSCB to improve these.

- The first six weeks post implementation of the new Clinical response Model (CRM) show encouraging performance, as we are meeting the Cat 1 transportation target and are within reasonable reach of Cat 1 & 2 targets.

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

Category 1 Time Taken for ambulance response to arrive

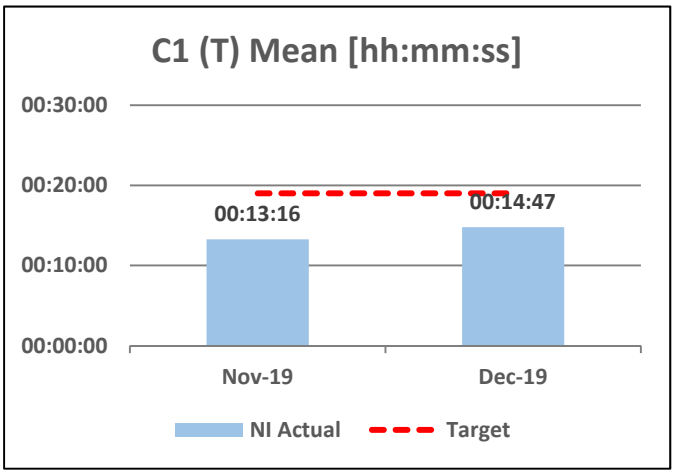


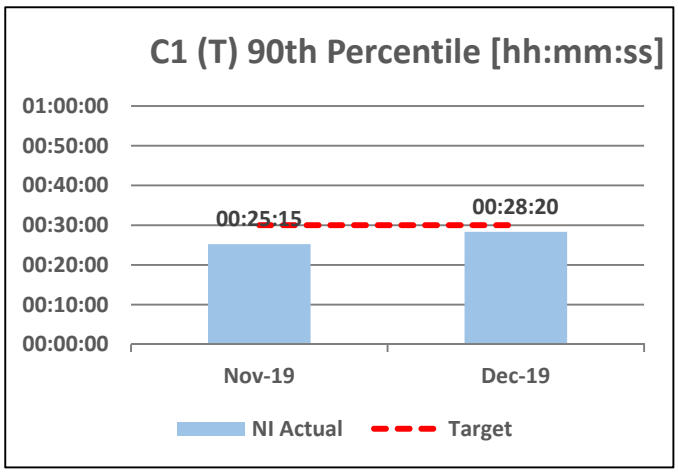


Category 1 average (mean) response time performance for November 2019 was 10min 40 seconds and for December 2019 was 12min 09 seconds.

Category 1 90th centile performance for November 2019 was 20min 27seconds and for December 2019 was 23min 03 seconds.

Time Taken for transporting vehicle (as required) to arrive

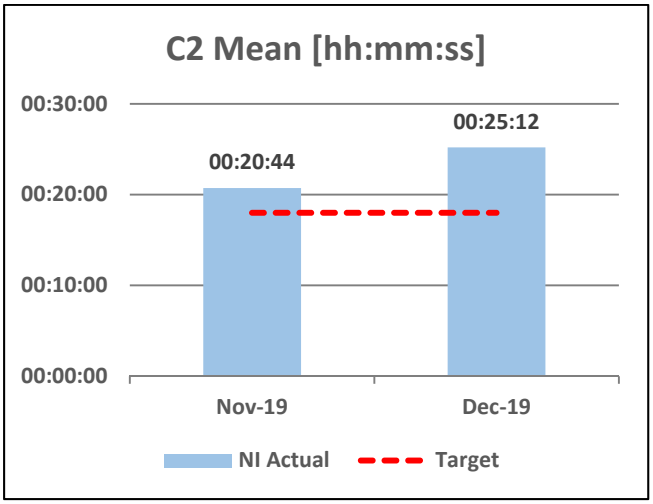


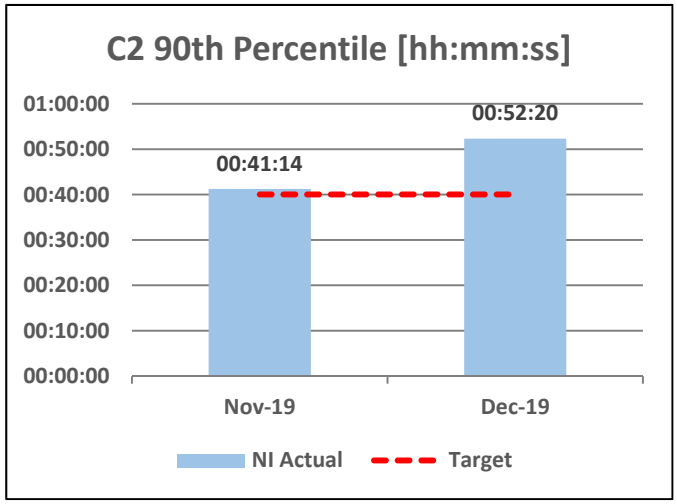


Category 1T average (mean) response time performance for November 2019 was 13min 16 seconds and for December 2019 was 14min 47 seconds.

Category 1T 90th centile performance for November 2019 was 25min 15 seconds and for December 2019 was 28min 20 seconds.

Category 2 Time Taken for ambulance response to arrive

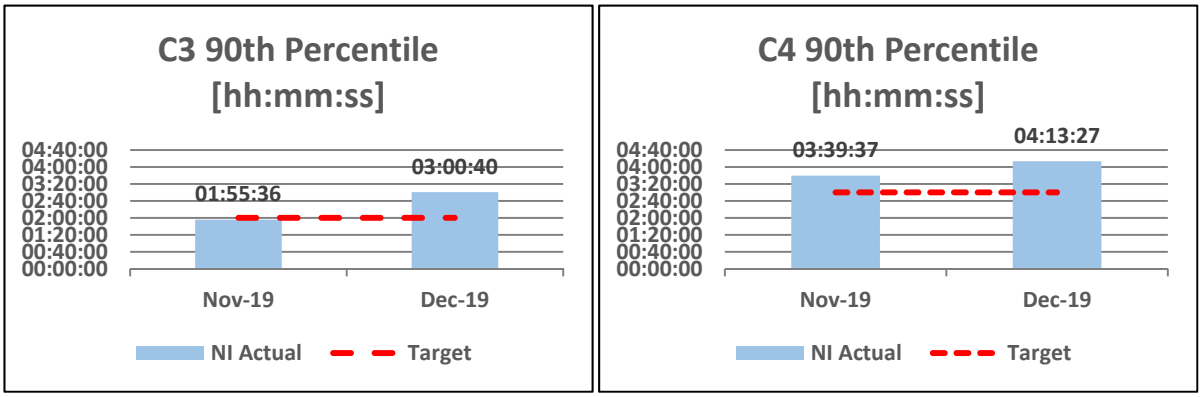




Category 2 average (mean) response time performance for November 2019 was 20min 44 seconds and for December 2019 was 25min 12 seconds

Category 2 90th centile performance for November 2019 was 41min 14 seconds and for December 2019 was 52min 20 seconds

Category 3 & 4 Time Taken for ambulance response to arrive



Category 3 90th centile performance for November 2019 was 1h55 min and for December 2019 was 3hr 00 mins.

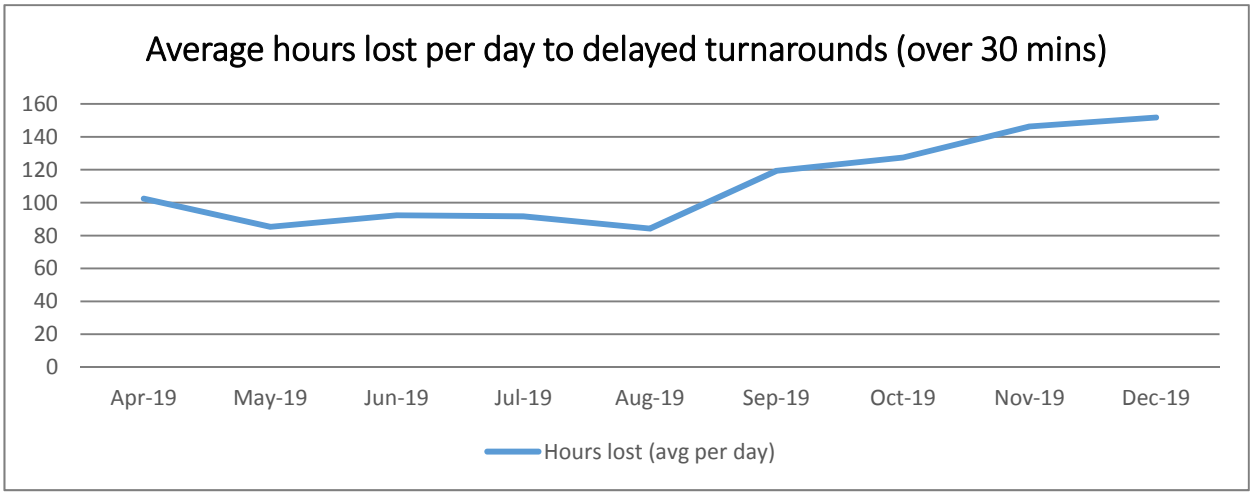
Hospital Turnaround Times

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

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	Oct 19	Nov 19	Dec 19
Total Number of Turnaround Times Reported at Acute Hospitals 2019/20	117283	13549	13626	13458
Total Number of Turnaround Times in Excess of 30 minutes 2019/20	82128	9751	10063	10085
% of Turnaround Times in Excess of 30 minutes 2019/20	70.03%	71.97%	73.85%	74.94%
Total Operational Hours Lost to Turnaround Times in Excess of 30 minutes 2019/20	30562	3950	4388	4704
Average Operational Hours Lost to Turnaround Times Delays in Excess of 30 minutes 2019/20 PER DAY	111	127	146	152

Disclaimer - Please note that missing values are excluded in Patient handover Times as not all resources have the capability to return the timestamps or data not returned. For the reporting period this relates to over 23,000 missing values



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

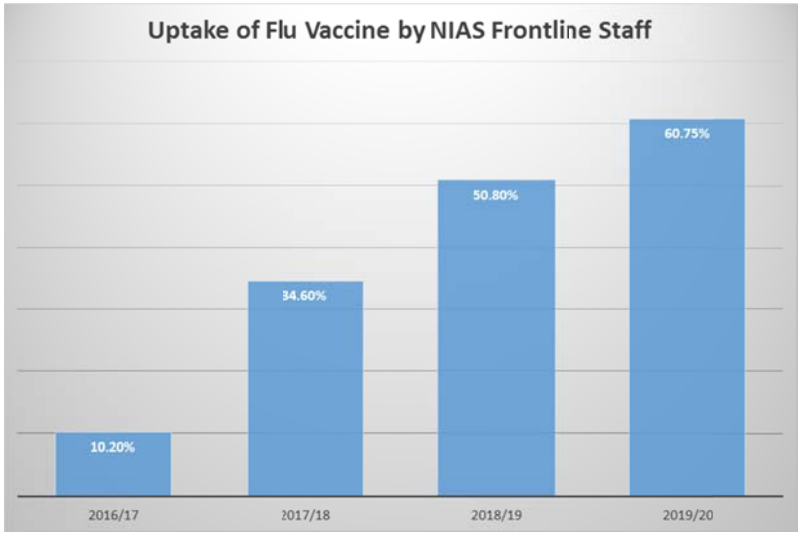
Some of the actions since the last Trust Board to improve the position on ambulance turnaround times at Emergency Departments include:

- A regional escalation plan was issued by the HSCB early January 2020.
- An emergency divert protocol was agreed by all Trust Chief Executives and issued on 6 January 2020. This is to ensure that every effort is made to avoid a patient being delayed in an ambulance, where the crew are unable to gain access to the Emergency Department, due to over-crowding and capacity issues.
- A memo was issued to all operational staff by the Director of Operations on 2 January 2020, to provide clarity around 'cohorting'. This is an escalation, in order to release crews to respond to calls and assist with rest periods / meal breaks / late finishes.
- A Standard Operating Procedure for the HALO role was produced by the HALOs in collaboration with Senior Managers, to provide standardisation of the role and improve ambulance turnaround times.

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 805 employees have been vaccinated by NIAS Peer Vaccinators**, 669** operational and 136 non-operational. In addition 23 staff have been vaccinated by the Occupational Health department bringing the total of staff with patient contact who have been vaccinated to 692 which is **60.75%** - exceeding the DOH target of 50%- and continues the year on year increase of uptake as shown in the table below.



Peer Vaccinators are still available and are at present assisting other Trusts with their campaign. It is hoped that by using the NIAS liveried flu vehicles we can encourage frontline workers in other Trusts to have the Flu Jab.

The most recent figures available from other Trusts are:

Belfast HSCT **39.1%** South Eastern HSCT **40.8%** Northern HSCT **39.5%**

Southern HSCT **35.9%** Western HSCT **25.1%**

We are receiving frequent requests for assistance from the other Trusts and have accommodated several clinics in a variety of locations.

TB/30/01/2020/07

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Medical Director
30 January 2020
(Nov-Dec 2019)

Medical Directorate Performance Report for Trust Board

Emergency Planning & Business Continuity	
	Significant work was undertaken by the Emergency Planning Department including the NIAS Business Continuity Lead in order to prepare for industrial action on 18 December 2019. An Incident Management Team and Incident Control Team were formed and involved regular meeting with staffside representatives in order to manage the risk of delayed response to patients. Focus was maintained on Cat 1 and Cat 2 responses by NIAS crews, with Cat 3, 4 and 5 able to be managed by PAS and VAS. An incident log was matained throughout the 24 hours of action in order to facilitate learning for future incidents. An EU Exit now appears likely in 2020 following the recent Westminster election. NIAS continues to cooperate with the Department's co-ordinating group and will be required to provide daily sitreps in the lead up to any EU Exit.
Risk Management	
Corporate Risk Register	A workshop is scheduled for a review of the Corporate Risk Register both by individual Directors and collaboratively in early 2020.
Incident Reporting Procedures	An SAI Lead has been appointed and will take up post on 1 January 2020. The new Director of Quality, Safety & Improvement has also taken up post and is working alongside other Directors to assist with the review of incident and SAI management. An increased number of SAIs have been noted relating to a delay in response to patients ranging from high priority emergencies to non-critical healthcare professional admissions. Many of these reflect increased pressure of demand, although the issue of hospital turnarounds has also been a factor in releasing crews to respond.
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. Further partnership working is ongoing with 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: 1614. Meetings held with British Heart Foundation regarding the integration of the National Defibrillator Network. Planned to go live in February 2020. **Community First Responders** Review ongoing of all processes and documentation relating to the recruitment, training and support of CFRs. **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 it is having a delay impact. There has been good clinical feedback on the software reflecting NIAS needs and this is now being configured by Ortivus for delivery to NIAS early January 2020.

	Milestone 2 was due to be signed off in November 2019 however there are some issues that need to be resolved in terms of the high level technical design. This relates to user authentication and active directory in the regional data centres. At the minute NIAS is not federated across to BSO and there are duplicate IP address ranges. This means that Mobimed (ePCR) software cannot access the Active Directory to authenticate users via the servers in the regional data centres. NIAS/BSO/Ortivus are working on a viable solution due early January 2020 which will allow M2 to be signed off pending successful testing. Issue with Active Directory will still need resolved however whilst it is highlighted by the REACH programme, it is a wider NIAS issue which will need resolution in preparation for shared services and is outside of scope for this project. Meeting has taken place with Clinical teams at SETrust and they are very happy to be part of phase 1 roll out. Teleconference has taken place with ehealth lead for GPs to begin to look at exchange of clinical information and GP pathways for conditions whereby patients are left at home. Follow up meeting led by Medication Director to take place early 2020.
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** The CEC continue to offer a range of short courses to promote the use of pathways. During the reporting period, a meeting was held with the CEC to formalise the arrangements in place for a service level agreement and to agree courses for the next year. 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 Ambulance Care Attendants 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. Two Raizer Chairs purchased by NIAS will be available for use within the whole of the Southern Trust area between the hours of 0730-2200. The Raizer Chairs will be stored by an independent ambulance provider who aim to respond to patients within 1 hour of receiving the call from NIAS.

Presentations

The CSO seconded to the Clinical Transformation and Improvement team delivered the following presentations as part of our work to support Nursing Home providers to safely manage appropriate patients within the Home rather than unnecessary conveyances to the Emergency Department.

- Independent Sector Care Home Nursing Managers (RCN)
- Care Home Nursing Support Team (CHNST) Belfast – The identification of the Deteriorating patient

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.

Urgent and Emergency Care Review

Members of the team continue to represent NIAS on a range of the Urgent and Emergency care sub groups. Furthermore, two members of the team co-chair the regional navigation sub group and their workstream met to finalise an initial paper to scope the introduction of a single point of

	contact for urgent care out of hours. Another member of the team is now Co-chair of the Frailty Task and Finish Group. **Clinical Support Desk** The CSD continues to provide telephone based clinical triage (Hear & Treat) for low acuity calls received by Emergency Ambulance Control. With the introduction of the CRM Code-set in November 2019 the CSD will primarily undertake triage of Category 5 calls. During this reporting period CSD has appointed 2 new Clinical Hub Mangers, 1 in post, 1 awaiting job offer from BSO. 3 new Paramedics have been successful and have accepted posts for CSD. Training to due to commence in January 2020. 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. The CSD continues to experience capacity issues in relation to staffing levels which will result in significant numbers of shifts being left uncovered but relief staffing are being deployed to provide as much cover and support as possible. 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 Review and next steps of the MATT Service Pilots regarding Anticipatory Care Frailty developments HSCQI and regional Improvement Initiatives The team continue to provide leadership input to the national Ambulance Q initiative as it develops.
Helicopter Emergency Medical Service (HEMS)	HEMS has now commenced carrying blood products for the management of patients with severe trauma.

	The helipad on top of the Critical Care building at the Royal Victoria Hospital has now been certified as functional by the Civil Aviation Authority following a successful test of the fire fighting apparatus. However issues remain with the function of some of the equipment and as a result final sign-off has not been received from NIFRS. Once these issues are resolved, test flights and training can commence within a matter of days. The Clinical Team are scoping the 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.
Clinical Education and Training	
	In 2020 the Regional Ambulance Training Centre will deliver an extensive programme of education and training courses following the team's busy schedule in 2019. Due to the increased volume of courses being delivered by the RATC, additional accommodation has been acquired in Foyle Villa providing additional training rooms and office space for the team. The first cohort of students on the Foundation Degree (FdSc) in Paramedic Practice celebrated the completion of their studies with a graduation ceremony at Ulster University in December 2019. The 39 successful students have obtained HCPC Registration and have taken up paramedic posts with NIAS. A second cohort of existing NIAS EMTs have successfully completed the bridging programme and will commence the FdSc in Paramedic Practice in January 2020. Two Associate Ambulance Practitioner (AAP) courses with 37 students finished the classroom training and are now completing 750 practice hours as EMTs. To support the Trust's aim to train large numbers of clinical staff for workforce stabilisation and to enable backfill of EMTs who have stepped into student paramedic roles, two further AAP courses commenced in October 2019 at Foyle Villa and Magee Campus. New Ambulance Care Attendances completed their training in December, this training included additional observational skills, and they have taken up ACA positions in stations across NIAS. Post proficiency training, including an Infection Prevention Control component, is currently being delivered to Operational staff and will conclude in March 2020. Further continuing professional development opportunities for clinical staff are being provided in conjunction with the HSC Clinical Education Centre. The CEC are providing a programme of short courses for EMTs and

	paramedics to strengthen their skills and knowledge and support the wider NIAS Education, Learning & Development strategy.

EMERGENCY PLANNING REPORT FOR NOV-DEC 2019

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**								
	City of Derry Airport												
	St Angelo Airport												
	Newtownards Airfield												
	Other airfields												
	Business Continuity	**1**			**1**	**2**	**3**	**1**	**1**	**1**			
	Hazardous Material Incidents (HART calls)												
	HART pre-planned deployments		**1**		**3**	**1**							
4	**Training sessions**	**1**	**3**	**2**		**1**	**2**	**3**	**2**	**2**			
	Emergency Planning	**4**	**4**	**5**	**1**	**2**	**2**	**4**	**5**	**2**			
	HART	**2**	**1**	**4**	**1**	**1**	**2**	**1**	**1**	**2**			
	Business Continuity												
5	**Exercises**												
	Live	**1**		**2**			**1**			**1**			
	Tabletop		**2**	**2**	**1**	**4**	**1**	**2**					
	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**			
	GOLD operational				**2**								

Potential Major Incident

On 27 December 2019 @ 00.11 NIAS received an emergency call to a nightclub in Belfast for “a possible crush and several people finding it hard to breathe”. This call was upgraded to a potential Major Incident. Despatched to the scene 1 A&E, 1 Intermediate Care Vehicle, HART, 3 Officers, 1 Doctor. First crew arrived on scene at 00.20hrs. Two Trusts were alerted to the potential MI. Delta 2 arrived on scene and at 00.43 issued a stand down stating possibly a hoax call.

Major Incidents

There were no declared Major Incidents during this period

Airport Alerts

On 23 December 2019 @13.42 NIAS received a call to the Belfast International Airport for a light aircraft making an emergency landing with possible issue with undercarriage. Tasked to the scene 2 A&E vehicles, 1 RRV, 3 HART, 2 Officers. The plane made a safe landing and the incident was stood down by air traffic control @13.52. No NIAS vehicles arrived on scene prior to stand down.

HAZMAT / Hazardous Area Response Team (HART) deployments

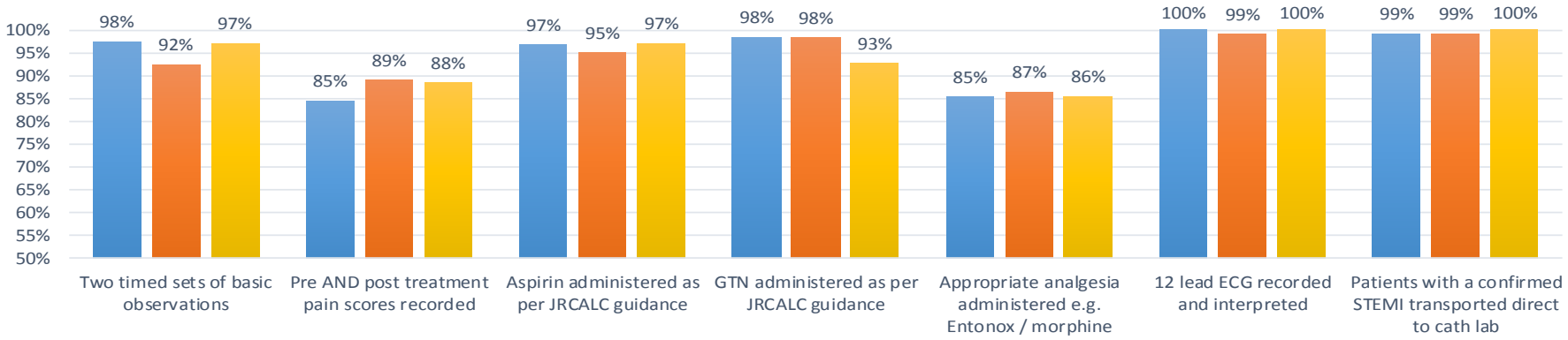
122 = Deployments with Breathing Apparatus skills/ HAZMAT deployments
37 = Restricted space
24 = In-land Water Operations
6 = Special Services Operations
8 = HAZMAT
100 = Assistance to Ops

William Newton
Assistant Director of Emergency Planning

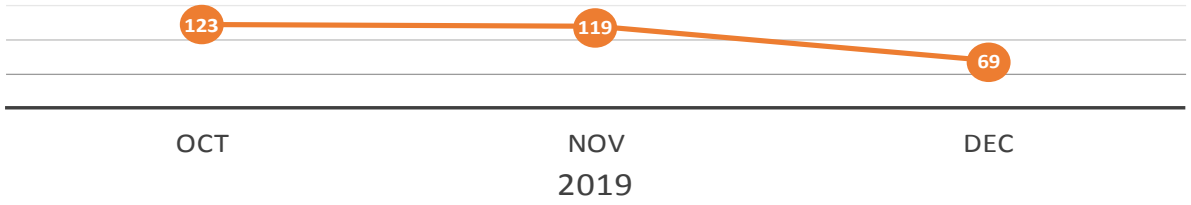
Northern Ireland Ambulance Service
Health and Social Care Trust

ACUTE CORONARY SYNDROME

QUALITY IMPROVEMENT COMPLIANCE



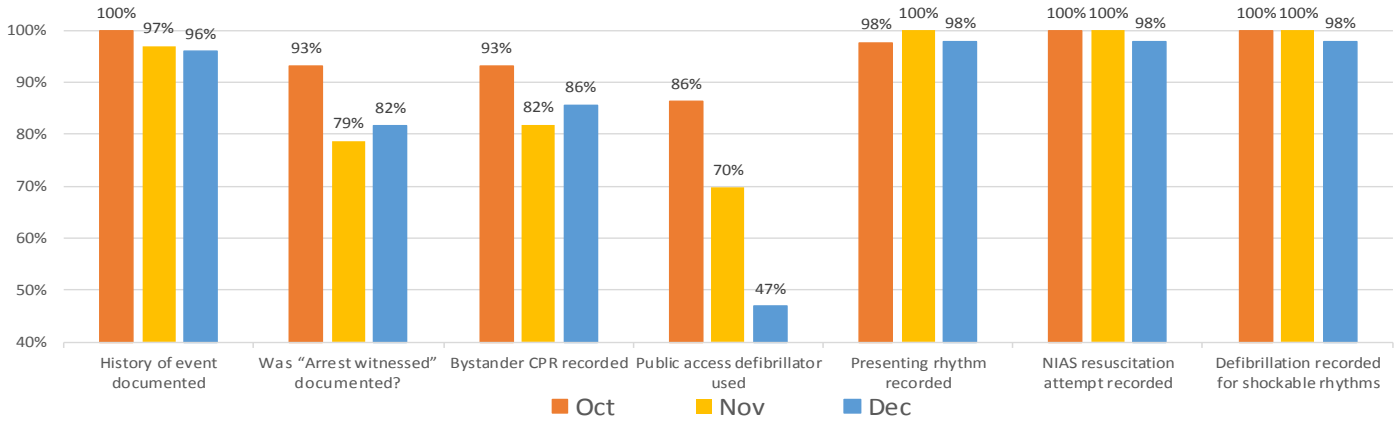
Total PRFs Audited

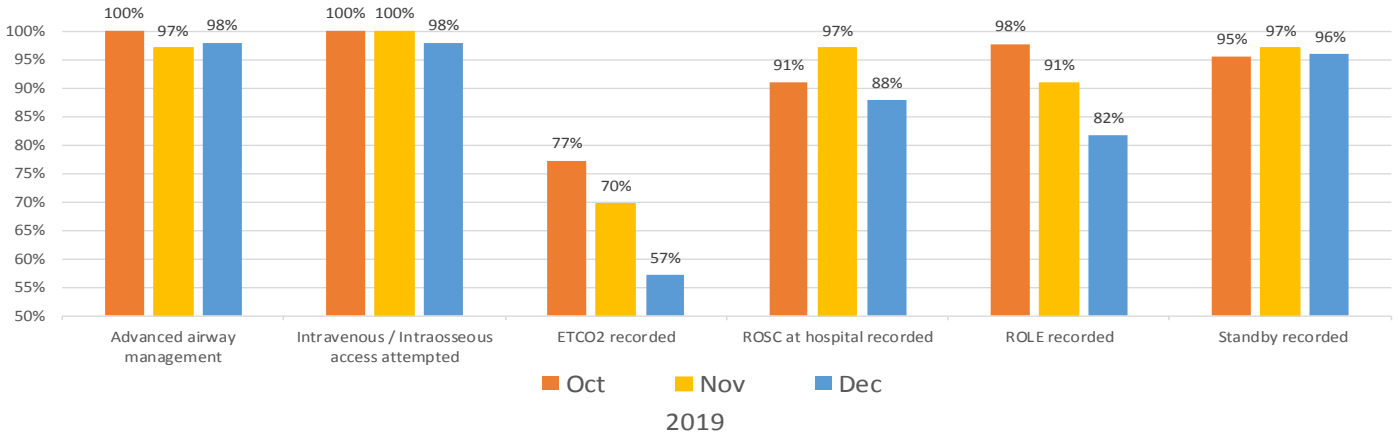


Northern Ireland Ambulance Service
Health and Social Care Trust

CARDIAC ARREST

QUALITY IMPROVEMENT COMPLIANCE

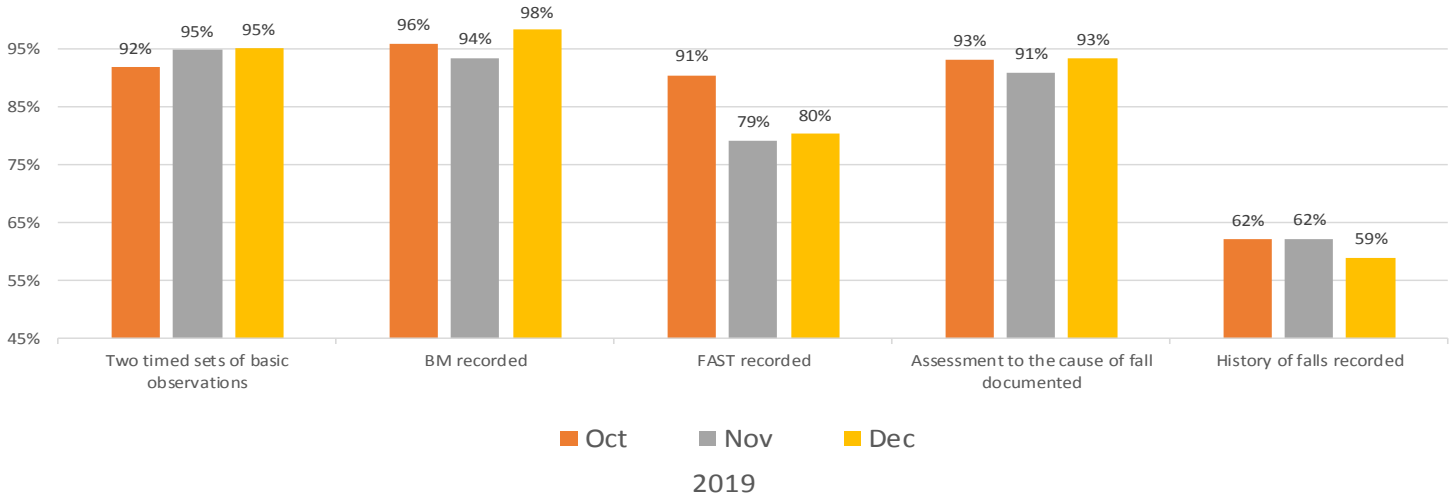


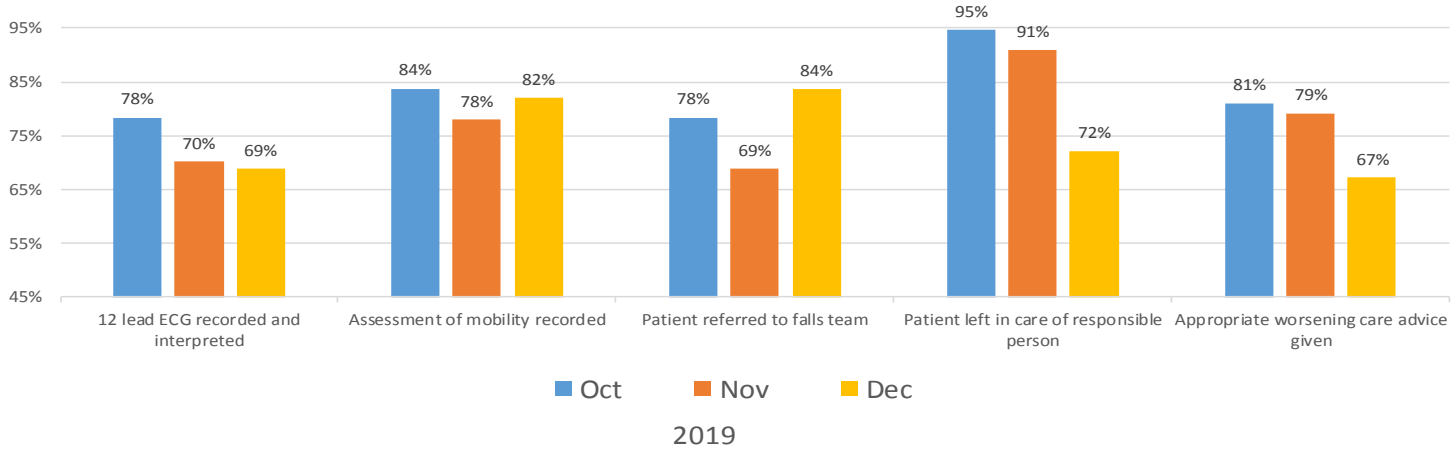


Northern Ireland Ambulance Service
Health and Social Care Trust

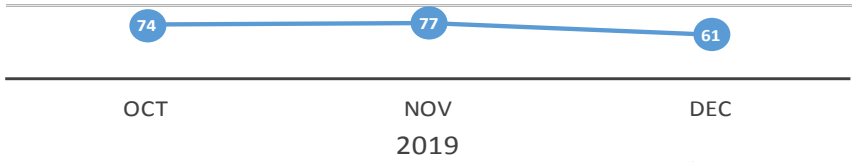
FALLS

QUALITY IMPROVEMENT COMPLIANCE





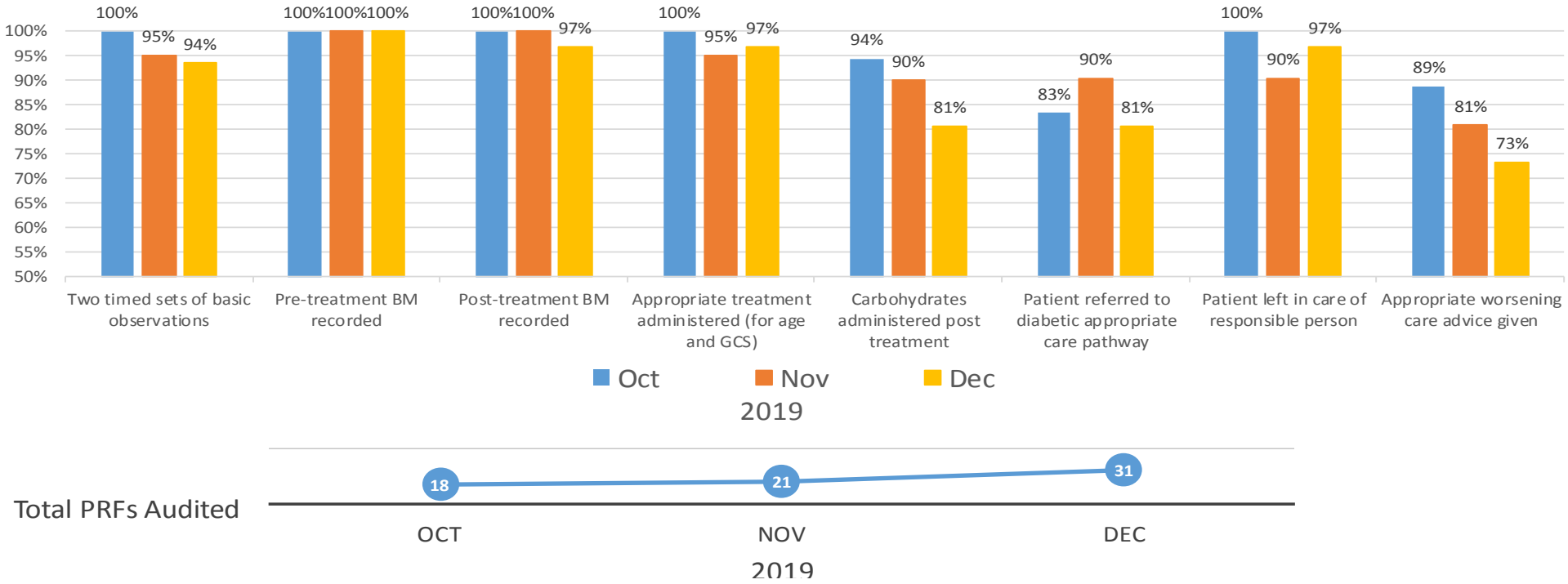
Total PRFs Audited



Northern Ireland Ambulance Service
Health and Social Care Trust

HYPOGLYCAEMIA

QUALITY IMPROVEMENT COMPLIANCE

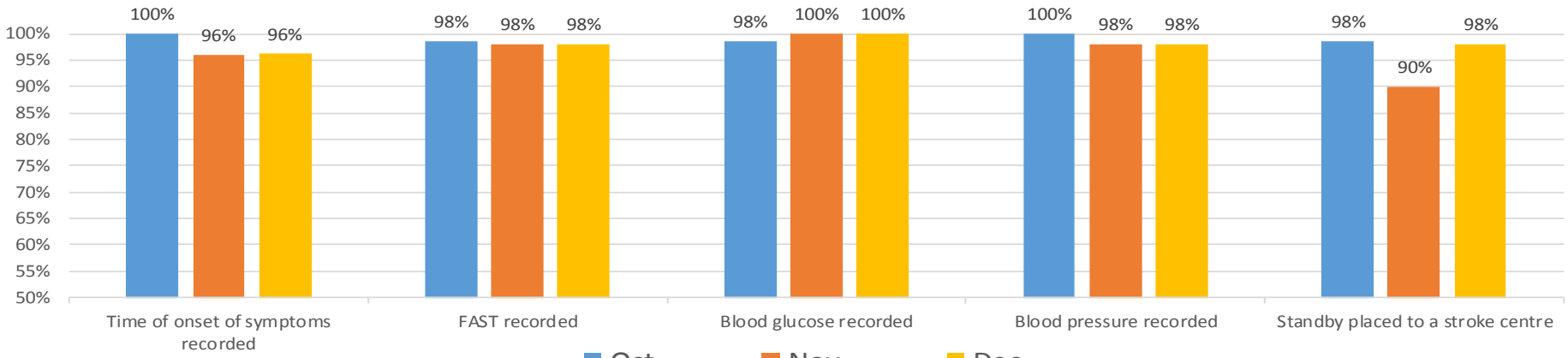


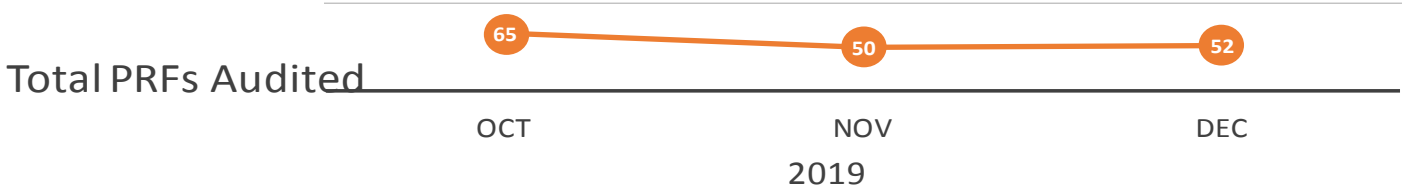
Total PRFs Audited

Northern Ireland Ambulance Service
Health and Social Care Trust

STROKE

QUALITY IMPROVEMENT COMPLIANCE





TB/30/01/2020/08

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a meeting of the Audit Committee held on Tuesday, 18th June 2019 at 9.30am in the Boardroom, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT:	Mr W Abraham	Non-Executive Director (Chair)
	Mr D Ashford	Non-Executive Director
	Mr T Haslett	Non-Executive Director
IN ATTENDANCE:	Mrs S McCue	Director of Finance & ICT
	Mr A Phillips	Assistant Director of Finance
	Mrs T Steele	Financial Accounts Manager
	Mr D Lynn	NI Audit Office
	Mr B Clerkin	ASM
	Mr D Charles	BSO Internal Audit
	Mr M Bloomfield	Chief Executive
Minute Taker	Mrs S McMullan	Senior Secretary

Welcome and Introduction to Meeting

Mr Abraham welcomed everyone to the meeting of the Audit Committee and thanked all members for their attendance.

1.0 Apologies

No apologies noted.

2.0 Declaration of Potential Conflict of Interest and Confirmation of Quorum

No conflicts of interest were declared and the meeting was confirmed as quorate.

3.0 Minutes of the previous meeting of Audit Committee

The minutes of the previous Audit Committee meeting held on Tuesday, 21st May 2019 subject to a number of small amendments were approved.

4.0 Matters Arising

4.1 Outstanding Internal Audit Recommendations

Mr Phillips advised that prior to the Mid-Year Follow Up Review by Internal Audit, he would circulate in July 2019 the outstanding list to the relevant directors and managers asking for updates on progress.

4.2 Extensions of Non-Executive Directors

Mr Phillips advised that to date, NIAS had not received any formal notification of extensions for any Non-Executive Director. Whenever notification is received and time permitting, the extensions would be noted in the Annual Report.

5.0 Chairman's Business

5.1 Audit Committee Annual Report

Mr Abraham presented the Annual Report and Mrs McCue noted that this document had been circulated internally to the Chair, Chief Executive and the Audit Committee members for comment. Mr Haslett advised that he was also a member of the Remuneration Committee. Mr Phillips agreed to amend the Remuneration Report to reflect this.

5.2 Audit Committee Self-Assessment

Mr Abraham presented the assessment. Mr Lynn advised that the response to question 33 should be changed to 'Yes', as appropriate levels of communication are held. Mr Abraham agreed to amend that answer.

6.0 Internal Audit

6.1 Internal Audit General Annual Report 2018-19

Mr Charles presented this report and advised that the report is a snapshot of the work completed over the 2017-18 and 2018-19 periods for the whole of the HSC. He highlighted that Internal Audit delivered 230 audit reports annually, providing 5,200 audit days. He highlighted the overall performance against its Key Performance Indicators, noting that 100% of the agreed audit assignments were completed, and that there has been a continued improvement towards the KPIs for first draft reports and reports being finalised.

Mr Charles advised that 58% of the whole audit assurance provided was satisfactory. He noted that new audit areas tended to have a lower level of assurance and that the number of non-assurance assignments was increasing. Mr Charles discussed the performance of the follow up reviews of the outstanding audit recommendations and noted that whilst the majority related to the 2017-18 and 2018-19 years, a significant amount related to older years.

Mr Bloomfield noted the improvement and the small number of historic audit recommendations for NIAS. He commented on some duplication of audit recommendations over the years and asked if the context of a finding and or recommendation changed, could this be reviewed? Mr Charles advised that the Audit Committee could approve the removal of a recommendation.

7.0 External Audit

7.1 External Audit Draft Report to those Charged with Governance 2018-19

Mr Phillips circulated copies of the draft 2018-19 Report to those Charged with Governance to the Committee.

Mr Lynn advised that this report summarises the key issues for the 2018-19 audit and that the audit work was sub-contracted to ASM. Mr Clerkin expressed his gratitude to Mrs McCue and her team for their assistance throughout the audit process. Mr Clerkin then proceeded to present the report in detail.

In the Key Message section, Mr Clerkin highlighted:

- the proposal that the Comptroller and Auditor General certify the 2018-19 financial statements for both Public Funds and Charitable Trust Funds with unqualified audit opinions;
- Four misstatements were identified which required adjustment; and
- Two priority one recommendations were identified, one in relation to an Agenda for Change contingent liability / accruals and one in relation to Confidence and Supply funding.

In the Significant Risks section, Mr Clerkin provided an overview of significant risks and other risk factors. Mr Clerkin noted that in March 2019, the Audit Strategy was presented to the Audit Committee highlighting one significant risk in relation to Agenda for Change. He continued that this risk has been ongoing for a long period of time and is becoming more difficult to sustain. Mr Clerkin highlighted that this issue does need to be resolved (and links to another finding).

In the Audit Findings section, Mr Clerkin highlighted:

- on one occasion a Direct Award Contract was awarded prior to approval;
- a fruitless payment was incorrectly classed as a compensation payment;
- a Priority 1 finding related to two accruals were included in the financial statements relating to Agenda for Change. The first related to £1,490k regarding the regrading of paramedics from band 5 to band 6. The second was a new accrual of £1,770k relating to the regrading of Emergency Medical Technicians from band 4 to band 5. Mr Clerkin advised that there needed to be a liability at the end of the year and continued that he felt that this should be a provision rather than an accrual. Mr Bloomfield advised that he felt the Trust will reach a resolution this year in regards to the regrading, that NIAS had seconded a manager to DoH to work on a resolution to the banding issue and informed the Committee that he is due to meet with the Permanent Secretary tomorrow to discuss a paper on this issue. Mr Lynn noted that this accrual was higher than the materiality threshold of £1m and the issue was the timing of the departmental decision. It was agreed that evidence was required to support the final view and that tomorrow's meeting would provide this.
- a Priority 1 finding related to Confidence and Supply Funding and the HSCB not having approved the business case for hospital receivers. Mr Bloomfield advised that this was a timing issue;
- Two Priority 2 findings, one relating to a number of POP and general accruals and the second relating to an overpayment of salary due to a late notification of a leaver;
- Two Priority 3 findings were also noted relating to a DAC award being awarded prior to approval and the failure to meet the prompt payment target for the year;

- Five audit adjustments were noted, one of which related to the already discussed Agenda for Change banding issue and the correct status as either an accrual or provision; and
- Two unadjusted misstatements were noted, which were not material in nature.

In the Appendices, Mr Clerkin discussed the letter of representations, the unqualified opinions of the audit certificates and progress against the implementation of prior year recommendations.

8.0 Annual Reports & Accounts

8.1 Draft, Audited, Uncertified, Annual Report & Accounts for the Year Ended 31 March 2019

Mrs McCue noted that a draft version of this report was presented to the Audit Committee in May 2019 and input was received from a number of different parties. Mr Phillips advised that the Governance Statement had four additional internal governance divergences, and that the Remuneration Report would be amended to reflect Mr Haslett's membership of the Remuneration Committee. Mr Bloomfield advised that a sentence should be added to the conclusion of the Governance Statement.

8.2 Resolution to Trust Board for the approval and signature of the Annual Report & Accounts

The Committee confirmed they were content to approve the Annual Report to Trust Board subject to the Agenda for Change accruals versus provisions issue being clarified based on the outcome of Wednesday's meeting with the Permanent Secretary, and the accounts to be adjusted accordingly.

8.3 Draft, Audited, Uncertified, Charitable Trust Funds Trustee's Annual Report for the Year Ended 31 March 2019

Mr Phillips advised that there had been only minor changes to the Trustee's Annual Report since the draft version of this report was presented to the Audit Committee in May 2019.

8.4 Resolution to the Trust Board for the approval and signature of the Charitable Trust Funds Trustee's Annual Report

The Committee confirmed they were content to approve the Trustee's Annual Report to Trust Board

9.0 Closed Meeting

Mr Bloomfield, Mrs McCue, Mr Phillips, Mrs Steele and Mrs McMullan were excused from the meeting for a short period of time to allow the Audit Committee to meet independently with the Internal and External Auditors. On their return, Mr Abraham advised that there were no matters arising or actions required as a result of the closed meeting.

10.0 Any Other Business

10.1 Standing Orders and Scheme of Reservation and Delegation

Mr Phillips distributed the above draft document along with a summary of the review and apologised that it was not included in the original set of papers. Mrs McCue noted that normally this document should be reviewed annually; however, it had last been reviewed a number of years ago. Mr Phillips advised that the Standing Orders had been benchmarked against 4 other Trusts who had recently reviewed their own. Mr Phillips drew the Committees attention to a number of sections were the NIAS version was different to the other Trusts regarding membership of the Audit and Assurance Committees.

The Committee agreed to recommend the draft Standing Orders to Trust Board for approval.

Mrs McCue advised that following on from the Trust Board Workshop, the Chair would review the Boards committee structures and the Standing Orders would likely require further amendment following that review.

10.2 Standing Financial Instructions

This item was deferred to the next meeting.

10.3 Note of Thanks

Mr Abraham expressed his gratitude to Mrs McCue for her contribution to the Audit Committee and Trust Board as well as to the Ambulance Service and extended his best wishes to her on her retirement.

Mrs McCue thanked Mr Abraham for his kind words and added that she had appreciated her time at Audit Committee throughout her 17 years with the Ambulance Service.

11.0 Date, Time and Venue of Next Meetings

Next meeting is scheduled for Tuesday, 15 October 2019, 2.00pm in the Boardroom, NIAS Headquarters.

Signed: William Abraham Date: …15 October 2019……

TB/30/01/2020/09

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee
Tuesday 15 October 2019 11am
Board Room, NIAS, Knockbracken Healthcare Park, Belfast

PRESENT	Mr T Haslett	Non-Executive Director (Chair)
	Mr W Abraham	Non-Executive Director
	Mr A Cardwell	Non-Executive Director
	Mr D Ashford	Non-Executive Director
IN ATTENDANCE	Mr M Bloomfield	Chief Executive
	Mrs N Lappin	Trust Chair
	Dr Nigel Ruddell	Medical Director
	Mr P Nicholson	Interim Director of Finance & ICT
	Ms R O'Hara	Director of HR & Corporate Services
	Mr R Sowney	Interim Director of Operations
	Ms L Charlton	Director of Safety, Quality & Improvement
	Mrs K Keating	Risk Manager
	Ms L Gardner	Employee Relations Manager
	Ms S Sellars	Board Room Apprentice
	Mrs J McSwiggan	Minute-taker

1.0 Welcome and Apologies

The Chair and Committee welcomed the following attendees:

- Sarah Sellars, Board Room Apprentice, to her first Assurance Committee meeting.
- Paul Nicholson, attending as Interim Director of Finance & ICT.
- Lynne Charlton, newly appointed Director of Safety, Quality & Improvement.

No apologies had been received.

2.0 Procedure

2.1 Declaration of Potential Conflicts of Interest

No potential conflicts of interest were declared.

2.2 Quorum

The Committee was confirmed as quorate.

2.3 Confidentiality of Information

The Chair reminded those present that some information, such as that relating to specific patients, requires confidentiality, and that meetings should otherwise be open and transparent.

3.0 Minutes of the Assurance Committee Meeting held on 21 May 2019

The Minutes were presented for noting, having previously been circulated, agreed and signed by the Committee Chair.

4.0 Matters Arising

Matters arising are covered within the Agenda.

4.1 Action Points

Progress against action points arising in the previous meeting was noted.

5.0 Internal Audit Report on Complaints, Litigation, Incidents and Serious Adverse Incidents

The Committee noted the progress reflected within the Complaints & Claims action plan and the SAIs & Incidents action plan, and acknowledged the efforts made to date on both.

There was discussion on the temporary redeployment of staff on light duties. This was noted to be a time-limited and complicated process, and a planned review was welcomed.

The Committee noted the ongoing challenge of reporting incidents in a timely manner, although the introduction of the daily operational huddle and the recruitment of a permanent SAI Lead were both noted as beneficial to the process.

Action: R O'Hara to update forecast end dates within action plan.

6.0 Attendance Management

L Gardner as Project Manager for the Good Attendance Programme presented to the Committee, highlighting the following progress:

- Project Administrator appointed July 2019.
- Good Attendance Manager for HR commenced September 2019.
- Good Attendance Manager for Operations due to commence November 2019.
- Approval to recruit six Business Advisors.

It was noted that the revised implementation date for the refreshed Policy & Procedure is 1 December 2019. The role of KPIs in measuring changes in practice and the positive impact on sickness absence was highlighted. Analysis on absence linked to denied leave was requested.

Action: R O'Hara / L Gardner to present summary to Trust Board.

The Committee acknowledged the progress being made to address this important area, and it was agreed that attendance will remain a challenge while the service continues to experience the current operational pressures.

Mark Cochrane (Area Manager) joined the meeting to brief the Committee on the Occupational Health Project, highlighting the actions being undertaken to reduce the wait time for appointments. It was noted that the Association of Ambulance Chief Executives (AACE) are supporting NIAS in revising the specification for occupational health provision.

7.0 Corporate Risk Register

Noted. Four news risks were highlighted, and one risk has been de-escalated as it duplicates other current risks.

With regards the risk summary included within the papers, the difference between an issue and risk was clarified.
Action: Risk Manager and Chief Executive to review wording and amend to avoid ambiguity.

It was noted that the risk to NIAS from turnaround times is already included within the Operations Directorate register.

8.0 IPC Progress Update

L Charlton referred to IPC Key Performance Indicators paper and highlighted progress made and areas for continued improvement.

With regards the compliance target for vehicles/estate, it was noted that regional compliance levels are in keeping with those in RQIA's audit tool and with those used by other UK ambulance services, and whilst continuous improvements are required to achieve and sustain compliance, the Trust believes these are appropriate standards to work towards.

9.0 Serious Adverse Incidents Report

The Committee noted that NIAS is bound by HSCB regional procedures on the targets of 72 hours for notification of an incident and 8 weeks for completion of report. It was clarified that the 72 hour deadline is from awareness of an incident to notification of the incident. It was suggested that the heading "Reporting within 72 hours" should be changed to "Notification with 72 hours" to provide clarity.

Action: K Keating to update column heading.

10.0 Complaints / Litigation Report

Nothing to be tabled at this meeting.

11.0 Assurance Framework (Operations)

It was noted that this document is in draft form and will be developed following further work with the Operations Team. Several workshops have already been undertaken, and there is widespread awareness of these complex issues. It was suggested that for a deeper understanding by Board Members, a workshop be held for more in-depth exploration of the framework, with the Directorate frameworks possibly being scrutinized on a rotating basis.

Action: Board Workshop to consider the Assurance Framework to be arranged (K Keating).

12.0 Local Risk Register Review (Operations)

With regards risk 408, it was noted that plans to replace the telephone system in EAC are underway. Immediate steps have been taken to stabilise the existing systems as much as possible, with medium-term mitigation and long-term plans in place. It was noted that this is part of a planned replacement cycle.

13.0 Whistle-blowing Register

It was noted that the first investigation has now been completed and learning from it, including factors delaying its conclusion, will be brought to the Learning Outcomes Review Group.

The second investigation will be closed following final comments from Internal Audit, who have been assessing the culture within the control room, which ties in with broader work being undertaken on culture across the organisation.

14.0 NICE Guidelines and Departmental Advisory Notices

Noted. It was highlighted that all are reviewed and the vast majority are not relevant to NIAS. These are reported to the Committee by exception.

15.0 Clinical ELD Plan and Mid-Year Update

The Committee welcomed Emma Giddings back to the role of Clinical Training Manager following her secondment to the Major Trauma Network.

The update and plan were noted.

It was noted that the first Paramedic Graduation Ceremony will take place after Trust Board on Thursday 5 December at University of Ulster Jordanstown. The Committee suggested that the Trust Board meeting also take place at Jordanstown.

16.0 Mandatory Training Compliance Report

Noted.

17.0 Clinical Support Desk (CSD) Evaluation

David Marshall (CSD Manager) presented a review of the work of CSD, including headline findings and recommendations from the Advanced Life Support Group (ALSG) review of the service.

Clarification was provided on how the KPIs relate to the anticipated expansion and continued provision of a safe service.

18.0 Reports from Groups and Committees

18.1 Learning Outcomes Review Group

Noted.

18.2 **Health & Safety Committee**
No briefing included.

18.3 **Fire Compliance Group**
Noted.

18.4 **Facilities Support Group**
Noted.

18.5 **Information Governance Steering Group**
Group has not met during this reporting period.

18.6 **Medical Equipment Group Meeting**
Noted.

18.7 **Infection Prevention & Control Group**
Noted.

18.8 **Emergency Preparedness & Business Continuity Group**
Group has not met during this reporting period.

18.9 **Joint PSNI/NIAS Clinical Care Working Group**
Group has not met during this reporting period.

18.10 **Community Resuscitation Strategy Implementation Group**
Noted.

It was noted that defibs are currently registered on the NIAS database within twenty days including confirmation to the registrant that it can now be accessed.

18.11 **Frequent Callers Group**
Noted.

19.0 **Any Other Business**

The Committee Chair asked that in future the length of presentations be restricted to fifteen minutes.

Date of Next Meeting

Dates of 2020 Trust Board and Committee meetings to be agreed.

Signed: _____ **Date:** 4 November 2019
(Trevor Haslett, Chairman)

Northern Ireland Ambulance Service Health and Social Care Trust

www.nias.hscni.net