Northern Ireland Ambulance Service
Health and Social Care Trust

A Meeting of Trust Board to be held at 10.00am
Thursday, 1 August 2019 at Northern Divisional Headquarters, Ballymena.

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1.0	**Welcome, Introductions and Apologies**	
2.0	**Procedure:** Declaration of potential Conflict of Interest: Quorum:	
3.0	**Minutes of the previous meeting of the Trust Board held 18 June 2019** *(for approval and signature)*	**TB01/08/2019/01**
4.0	**Matters Arising**	
5.0	**Chair's Update**	
6.0	**Chief Executive's Update**	
7.0	**Update on proposed new Clinical Response Model** *(Mr B McNeill)*	**PRESENTATION**
8.0	**Final Accounts 2018-19 Mr P Nicholson** *(for noting)*	**TB01/08/2019/02**
9.0	**Update on Incidents and Complaints Report – Dr N Ruddell / Ms R O'Hara** *(for noting)*	**TB01/08/2019/03**
10.0	**Recruitment Update – Ms O'Hara** *(for noting)*	**TB01/08/2019/04**
11.0	**Concerns, Complaints and Compliments - Policy and Procedure – Ms R O'Hara** *(for approval)*	**TB01/08/2019/05**

12.0 **Good Attendance Management update - _ Ms R O'Hara** **TB01/08/2019/06**
(for noting)

13.0 **Claims Management - Policy and Procedure – Ms R O'Hara** *(for approval)* **TB01/08/2019/07**

14.0 **Infection Prevention & Control Education & Training Strategy - Ms L Charlton** *(for approval)* **TB01/08/2019/08**

15.0 **Items for Noting**
15.1 Assurance Committee Minutes 21 May 2019 **TB01/08/2019/09**

16.0 **Performance Reports as at March 2019**

Highlight Reports by each Director:

16.1 Medical **TB01/08/2019/10**

16.2 Human Resource **TB01/08/2019/11**

16.3 Finance **TB01/08/2019/12**

16.4 Operations **TB01/08/2019/13**

17.0 **Application of Trust Seal**

18.0 **Any Other Business**

Next meeting of Trust Board will be held on Thursday 3 October 2019, Location to be confirmed.

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 Senior Secretary before the item on the Agenda entitled "Forum for Questions".

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

Thursday 1 August 2019 at 10.00am, Meeting Room, Ballymena Ambulance Station, 120-130 Antrim Road, Ballymena, BT42 2HD

TB/01/08/2019/01

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of Trust Board
Tuesday 18 June 2019, 11.30am, Boardroom, NIAS Headquarters, Site 30
Knockbracken Healthcare Park, Belfast, BT8 8SG

Present:

Mrs N Lappin	Chair
Mr W Abraham	Non-Executive Director
Mr A Cardwell	Non-Executive Director
Mr J Dennison	Non-Executive Director
Mr D Ashford	Non-Executive Director
Mr T Haslett	Non-Executive Director
Mr M Bloomfield	Chief Executive
Mrs S McCue	Director of Finance & ICT
Mr R Sowney	Interim Director of Operations
Mrs R O'Hara	Director of HR & Corporate Services
Dr N Ruddell	Medical Director

In Attendance:

Mrs J McSwiggan	Senior Secretary

The Board welcomed Mr R Sowney, Interim Director of Operations, to his first Trust Board meeting.

1.0 Apologies

No apologies were noted.

2.0 Procedure: Declaration of potential Conflict of Interest / Pecuniary Interest / Quorum

No potential conflicts of interest/pecuniary interest were declared. The Board was confirmed as quorate.

3.0 Minutes of the previous meeting of Trust Board held on 4 April 2019

It was noted that a name has been omitted under Agenda Item 10.0 (The Ambulance Service Charity).
Action: Chief Secretary to add name to Minutes.

Subject to this change the Minutes were approved on the proposal of A Cardwell, seconded by T Haslett.

4.0 Matters Arising

Under Agenda Item 8.0 (HSC Conflict, Bullying and Harassment in the Workplace), R O'Hara advised that at the April meeting of the HR Directors' Forum, the other Trusts confirmed that regionally developed policies are presented to their Boards for noting as opposed to approval.

All other matters arising are covered within the Agenda.

5.0 Chair's Business

5.1 Chair's Update

The Chair gave an outline of her activities and meetings attended since her last report, highlighting the following:

- Thanks to all who had organised and contributed to the very successful NIAS Leadership Conference (11 April 2019).
- The NICON Conference had been well attended (16-17 May 2019).
- With regards the Duty of Candour session at NICON, J Dennison advised that P McBride (Chair of IHRD Duty of Candour Workstream) had been invited to present to his organisation.
- **Action: J Dennison to provide feedback on the Duty of Candour presentation to his organisation.**
- Thanks to the other Non-Executive Directors who joined the Chair on a very interesting visit to HEMS (10 June 2019).
- The potential value of the Programme for Government to NIAS was highlighted.

6.0 Chief Executive's Business

6.1 Chief Executive's Update

The Chief Executive outlined his activities and meetings attended since the last Trust Board, highlighting the following:

- With regards recent media reports, the Board noted that these are being taken seriously, and immediate and longer term action is being undertaken to resolve issues raised. The Chief Executive had written to staff twice immediately following the media reports on staff stress to remind them of the range of support available. It was noted that many staff do not have access to corporate communications, so on this occasion Station Officers had been asked to print and distribute a copy to each individual. It was agreed that consulting staff on how best to communicate with them would be essential, and that considering the work of other Trusts and organisations in this area would be beneficial. The value of face-to-face communication was also noted.
- The CRM proposal has now been submitted formally to the Department of Health for consideration, and appropriate preparation work is being taken forward by Mr B McNeill.
- The Chief Executive added his welcome to Mr R Sowney, who has been in post as Interim Director of Operations since May.
- Recruitment for senior staff posts is ongoing.
- The Chief Executive added his thanks for the Leadership Conference.

- The contribution of Glenn O'Rorke (HEMS Operational Lead), Stephanie Leckey (Community Resuscitation Lead), Jonny McMullan (Control Quality Assurance Auditor) and Frank Orr (Assistant Director of Education, Learning & Development) at the NICON Conference was acknowledged.
- Forty-eight EMTs graduated on 20 May and are now on operational duties. A further cohort of 48 has started.
- A regular meeting with NIFRS to discuss areas of possible collaboration was held on 24 May 2019.
- Work by AACE on the long-term strategic direction for NIAS is nearing conclusion, and a series of engagement sessions with staff are planned for the summer, with an invitation to Non-Executive Directors to attend.
- Congratulations to Jackie O'Hara (Paramedic Supervisor), the deserving recipient of the Queen's Ambulance Medal in the Queen's Birthday Honours.
- Jackie was also one of eight NIAS staff who graduated from Limerick University last week, congratulations to them all for embarking on this study in their own time. The Board will consider how it can support future students.
- Congratulations also to Stephanie Lecky (Community Resuscitation Lead), on being runner up at RCN Nurse of the Year 2019.

7.0 Transformation Initiatives

The Chief Executive welcomed Sarah Williamson on her return to work and introduced members of staff who presented a number of transformation projects. It was noted that these projects had recently been presented to the Department of Health's review of urgent and emergency care and had been positively received.

The Board thanked the team for an excellent presentation and agreed to encourage more visibility of this work at Committee and Board level to provide support to the team. It was noted that the role of this work is in parallel to and complements the CRM programme and is an integral part of the longer term strategic development of the Trust.

8.0 Draft NIAS Corporate Plan 2019/20

The draft Corporate Plan for 2019/20 was considered, with the major change being the current year's key objectives. With regards the AACE recommendations for good attendance, it was noted that following the Trust Board Workshop in March 2019, a Good Attendance Programme has been established to implement the recommendations.

The Plan was approved on the proposal of A Cardwell, seconded by W Abraham.

9.0 Items for Approval

9.1 Revised Corporate Risk Management Policy / Interim Corporate Risk Management Strategy

Within the Policy, clarification was required on page 41 that the specific opportunities referred to are for organisational learning to be embedded

across the organisation.
Action: K Keating, Risk Manager, to reword.

Subject to the requested clarification, the Policy and Strategy were approved on the proposal of D Ashford, seconded by T Haslett.

9.2 Revised Policy & Procedures for Management of Medicines

It was noted that this is a scheduled review, and no substantial changes have been made to the document – changes include an extended range of drugs, and EMTs being permitted to administer a range of drugs.

The Board asked that in future a cover sheet be provided to clarify what changes have been made in the course of a document review. It was noted that the new Board Secretary will ensure consistency of presentation.

The logistics of procuring medicines from the Belfast Trust's Pharmacy were clarified.

Assurance was provided that the level of detail contained within the Policy is appropriate for the public domain.

Action: References to DHSSPS should be replaced with DoH.

Subject to these amendments, the document was approved on the proposal of D Ashford, seconded by A Cardwell.

9.3 Assurance Committee Minutes 12 March 2019

It was noted that the timescale for concluding the two open whistle-blowing cases remains on target for end June 2019.

J Dennison proposed that the Board enter into reserved session, seconded by W Abraham, in order to discuss the details of these cases.

Following discussions, W Abraham proposed that the Board return to public business, seconded by Dr Ruddell.

9.4 Assurance Committee Minutes 4 April 2019

It was noted that actions arising from the Internal Audit Report on Complaints, Litigation, Incidents and Serious Adverse Incidents were now contained within the Annual Report. The steps taken by the Trust to address the backlog of outstanding investigations were commended.

The reference to formal updates and standing agenda items was highlighted.

10.0 <u>Performance Reports as at 31 March 2019</u>

The Directors were asked to report by exception.

Medical
Dr N Ruddell, Medical Director, confirmed that NIAS has a Business Continuity Strategy and Policy, as well as a schedule of exercise. Plans for all facilities are now in place.

Corporate Risk Register
The Corporate Risk Register was presented to Trust Board, as part of the scheduled quarterly reviews.

Human Resources & Corporate Services
R O'Hara, Director of HR & Corporate Services, highlighted the following:

- Page 161 (Complaints Report) – it was noted that as of 3 June the Complaints Manager will now focus solely on clearing a backlog of open complaints. The Complaints Policy and Procedure is out to consultation until 28 June.
- It was clarified that "local resolution" is a Datix term referring to NIAS (i.e. Complaints or other Manager).
- **Action: A RAG rating for projects within the Good Attendance Programme will be included to give the Board a better indication of progress.**
- It was agreed that Assurance Committee is the best forum for a detailed review of the Good Attendance Programme, with the Board retaining oversight through this report.

Finance & ICT
S McCue, Director of Finance & ICT, highlighted the financial position at the end of March 2019, having discussed this in detail at Audit Committee this morning.

The challenges faced by the small Information Team in light of the rising number of information requests were highlighted.

Operations
R Sowney, Interim Director of Operations, highlighted the following:

- Performance remains a challenge, particularly at weekends and in the evening. While steps are being taken to sustain staff numbers over the summer, it was noted that the long term answer lies in recruitment.
- Effective communication with staff is key at all levels to improve staff morale, actions to address this are:
  - More improved verbal communication between control and crews.
  - Face-to-face meetings with staff during station visits to provide an opportunity for management to express their support and listen to concerns.
  - Written communication in hard copy format to all staff who have poor access to email.
- In the longer term, standardisation of station management is required to enable sharing of best practice across stations.
- Turnaround times at ED remain a challenge, and while hospital receivers free up resources, this is a short term solution only.

11.0 Application of Trust Seal

The Trust Seal was not applied.

12.0 Any Other Business

12.1 Standing Orders

S McCue circulated the revised Standing Orders, with the changes highlighted. The document has been revised to meet Internal Audit recommendations, and to provide more clarity to arrangements within the Trust. The following points were highlighted:

- ***3.17.1 (Reserved Sections) and 3.17.3 (Business proposed to be transacted when the press and public have been excluded from a meeting).***
  The Board is content for the Chair to draw the public meeting to a close and declare the start of the reserved meeting, with separate Minutes taken for both parts. Clarification on the wording around In Reserve / In Committee is required.

- ***4.8.1 – Audit Committee***
  It was agreed to remove the wording around membership of the Remuneration Committee to align with other Trusts, proposed by the Chair, seconded by R Sowney.

- ***4.8.3 – Assurance Committee***
  The requirement for one member to have "recent and relevant clinical experience" was discussed. It was suggested that the provision of clinical input be co-opted rather than stated explicitly in the Standing Orders. The removal of this wording was proposed by R Sowney, seconded by J Dennison, with a more in depth review of this proposed for the Board Secretary upon appointment.

- It was noted that the approval of policies at Trust Board is not referenced within the Standing Orders.

The Standing Orders will be reviewed, including all of the issues raised here, by the Board Secretary following appointment.

12.2 S McCue's Retirement

The Board paid tribute to S McCue's contribution to NIAS over her 17 years as Finance Director and Board Member. The Board expressed its thanks and wished her well in her retirement. The Chief Executive added his personal thanks for her support and her contribution to the organisation.

Date, Time and Venue of Next Meeting

The next Trust Board meeting will be held on Thursday 1 August 2019.

Signed: _____ **Dated:** _____
(Chair)

TB/01/08/2019/02


Northern Ireland
Ambulance Service
Health and Social Care Trust
Annual Report and Accounts
for Year Ended 31 March 2019

Northern Ireland Ambulance Service Health and Social Care Trust

Annual Report and Accounts for the year ended 31 March 2019

Laid before the Northern Ireland Assembly under Article 90(5) of the Health and Personal Social Services (NI) Order 1972 (as amended by the Audit and Accountability Order 2003) by the Department of Health on 8 July 2019

Any enquiries regarding this document should be addressed to the Director of Finance at the following address:

Northern Ireland Ambulance Service HSC Trust, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG.

This publication is also available for download from our website at www.nias.hscni.net.

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Chair's Preface

Having been appointed as Chair of the Northern Ireland Ambulance Service (NIAS) Board in July 2018, it is a privilege for me to prepare a preface to the 2018-19 Annual Report. In doing so I want to express gratitude to my predecessor, Paul Archer, who served NIAS for almost ten years before his retirement. His sage advice and assistance on taking up the role led to a seamless transition and allowed me to hit the ground running. This was much appreciated by me.

For the first time this document includes a report from the Non-Executive Directors (see page 36). Therefore, I do not intend to repeat much of what is already included there. Instead, I wish to record my personal thanks to all NIAS staff who ensure that the public continue to receive excellent care on a day and daily basis. I count it as an honour to serve the organisation and the people who work for it. Having joined a crew for a ride along in Enniskillen and viewing first hand the work which our committed frontline staff do, this further increased the respect which I already have for them.

At this point it would be remiss of me not to acknowledge that NIAS employees face many challenges. Workforce pressures, difficult working environments, physical and verbal abuse from a small minority of the public, current organisational structures and the increasing demands of an ageing population with increased chronic illnesses are just some of those difficulties. While NIAS hopes to embark on a period of significant service transformation, in order for it to be successful, these difficulties must be addressed. As Chair, I am satisfied that under the leadership of our Chief Executive, Michael Bloomfield and the senior management team, these challenges will be met and overcome.

NIAS does not exist in a vacuum. I want to thank other colleagues who assist in the delivery of our ambulance services. In particular, NIAS could not do what it does without the considerable support given to it by the Department of Health and the HSC Board. Also, working alongside many others across the HSC sector ensures that the public is cared for and treated in the most appropriate way.

Finally, I want to thank my colleagues on the Board for their dedication to NIAS. Challenges present opportunities and I am looking forward to tackling these with you in the months and years ahead.

Mrs Nicole Lappin

NIAS Chair

18 June 2019

Performance Report

Performance Overview

Chief Executive Overview of Performance

I am pleased to be able to provide this overview of performance at the end of my first full year as Chief Executive of the Northern Ireland Ambulance Service (NIAS). As I wrote in last year's Annual Report only a few weeks after having been appointed, it is a privilege to lead this organisation and to support all of our staff in the outstanding work that they do. Having met many of them during the past year and seen at first hand the amazing work they do, I cannot overstate how impressed I am by the commitment, professionalism and compassion our staff provide every day in delivering high quality care to patients and their families, often in very challenging circumstances.

Considerable progress has been made across a range of important areas over the past year. Many of those are outlined in more detail elsewhere in this report and I will touch on some of them. But it is also important to acknowledge the challenges that exist.

2018-19 has seen the deteriorating trend in recent years in Category A response times continue. Only 37% of Category A calls were responded to within 8 minutes against a target of 72.5%, and compared to 45% in 2017-18. There are many reasons for this, including continued increases in demand, our current levels of vacancies and sick absence, and the ongoing challenge of delays in handing over patients to Emergency Departments. In addition to increasing response times for patients, these issues can also lead to difficulties for our staff as their shifts regularly over-run and rest periods are often late or disturbed.

A number of actions have been taken over the past year to address the staffing challenges we face, in particular the commencement of a Foundation Degree in Science in Paramedic Practice programme in January 2019 being delivered by NIAS in partnership with Ulster University. This is the first Paramedic training programme to be delivered locally in four years and I look forward to the 47 students who have commenced this programme qualifying later this year. We hope to commence a second cohort of Paramedic Students later in the year.

In addition, a first group of 45 Emergency Medical Technicians (EMTs) completed their training and became operational in May 2019, and a further two EMT training courses are planned for this year

providing an additional 48 staff. Similarly, 78 new Patient Care Service (PCS) staff have been recruited over the last year and plans are in place to recruit and train a further 48 during 2019-20.

We have also increased staffing levels in the Emergency Control Room through the appointment of an additional 16 Emergency Medical Despatchers (EMDs) in recent months who will provide much needed support for that important function.

Another main reason for our current unsatisfactory Category A response times is that we are currently categorising around 30% of all calls as immediately life-threatening, requiring an 8 minute response. This model is outdated and studies across the UK have demonstrated that a more appropriate percentage of immediately life threatening calls is around 7%. During 2018-19 we carried out an extensive public consultation on a proposed new Clinical Response Model (CRM) which aims to better meet the needs of those who call our service by ensuring those with the most serious life-threatening conditions get the most immediate response, while ensuring those which are less serious receive a response appropriate to their needs.

Feedback from a wide range of stakeholders and individuals during the consultation was broadly positive. We have refined our proposals in light of the consultation exercise and these will be submitted to the Department of Health for approval.

Implementing the proposed changes in the new CRM will require considerable work and we will therefore be establishing a CRM Programme Team to commence preparatory work for the implementation, subject to Departmental approval.

Good progress has been made during the past year on Infection Prevention and Control (IPC) – an issue which presented a major challenge in the previous year and resulted in three Improvement Notices being issued by the Regulation and Quality Improvement Authority (RQIA). In December 2018 the RQIA acknowledged the significant progress and improvement in IPC across a range of practices, resulting in the removal of those Improvement Notices. While further work is required, the improvements achieved are as a result of genuine team working across the organisation and are an example of what can be achieved when capable, committed and enthusiastic staff are empowered and supported to lead on the changes necessary to deliver positive outcomes.

The past year saw an important step forward in the acknowledgement of the valuable role our staff play in the overall delivery of safe, high quality and effective healthcare by recognition of Paramedics as Allied Health Professionals (AHPs) by the Department of Health, bringing NIAS Paramedics into line with colleagues across the UK. This is another element in the continued professionalisation of our service and we look forward to the further development opportunities and benefits that AHP status will bring.

The health and wellbeing of our staff is a top priority for me, my senior team and the Trust Board, and I am pleased that further progress has been made over the past year in this regard. A pilot Peer Support Programme commenced in November 2018 following the training of a first cohort of highly committed volunteer staff who are now providing much needed support to staff after traumatic calls and experiences. Many staff have already availed of this service and we will be seeking to extend it during 2019-20.

We are also continuing to take forward a range of actions under our Health and Wellbeing Partnership with Unison to further promote and support the wellbeing of our staff.

An important part of protecting the health of our staff as well as their families and the patients they come into contact with is to be vaccinated against flu. Building on our peer vaccination programme introduced last year, our staff vaccination level increased from 35% in 2017-18 to 51% in 2018-19 - the highest level in any of the Northern Ireland Health and Social Care Trusts. This is an excellent achievement and demonstrates how importantly staff across the organisation take their responsibility to protect themselves and the many elderly and vulnerable patients they meet every day from flu.

Other areas where there has been good progress over the last year include:

- We successfully completed a procurement exercise to introduce an electronic patient records solution as part of our digital transformation programme. Ortivus have been appointed as the provider and we look forward to taking forward the detailed design and implementation phases in the year ahead;
- The continued development and expansion of Appropriate Care Pathways and the Clinical Support Desk have enabled us to improve our service by providing more appropriate responses for people who call 999. This means that the number of people who do not need an ambulance to be sent or who do not need to be taken to an Emergency Department (ED) has continued to increase – better meeting the needs of patients and supporting the wider HSC sector; and
- The Helicopter Emergency Medical Service (HEMS) which commenced in July 2017 has completed its first full year in service. The Doctor-Paramedic team working in partnership with the Air Ambulance NI charity has been tasked to 492 incidents during the past year bringing their advanced life-saving skills to patients who are in imminent danger.

Looking forward, it will be important to ensure momentum is maintained in these and other areas as we continue on a process of reform and to fully realise the contribution the Ambulance Service has to make to the wider transformation of the HSC sector. Tremendous strides have been taken over the past 10 years in moving the Ambulance Service from one that primarily transported patients to hospital, to one that provides much higher levels of care and treatment at the scene and over the

phone - often avoiding the need for a patient to be brought to an ED, or even for an ambulance to be dispatched.

During the next year we will be developing a long-term Strategic Direction for NIAS setting out how we can build on these recent developments to continue to better meet the needs of patients and support the rest of the system by providing more care in the community with less reliance on hospitals - as envisaged in Health and Wellbeing 2026: Delivering Together.

In conclusion, we continue to face many challenges as a service, but good progress is also being made across a number of important areas as outlined above. Considerable opportunities lie ahead and I believe that with the continued dedication and commitment of our staff to providing the highest standards of care to those in our community who rely on our service at the most anxious times in their lives, and working with our partners in the HSC sector and beyond, that we will take an increasingly important and central role in delivering the necessary reforms to ensure that services are sustainable for the future and that they meet the changing needs and expectations of future generations.

Purpose and Activities of the Trust

Purpose …

The Northern Ireland Ambulance Service is highly valued by the people of Northern Ireland. It exists to improve their health and well-being, and applies the highest levels of human knowledge and skill to preserve life, prevent deterioration and promote recovery.

Our Vision is:

To provide an excellent quality of care, experience and outcomes for the patients we serve.

This vision is underpinned by our core values that will help us to deliver the highest levels of care and services.

Our Core Values are:

- Compassion;
- Respect;
- Integrity; and
- Learning and Improvement.

During 2018-19, NIAS participated in the development of a new set of HSC-wide Values and associated behaviours and will be adopting these in 2019-20.

NIAS has identified six key themes from which the Corporate Objectives and annual priorities are developed. They provide clarity for the general public and our staff who deliver our services and ensure consistency between strategy and delivery.

Our 6 Key Themes are:

- **Motivated and Engaged Workforce:** the Trust will explore how we can fully achieve this for staff, at all levels. We will find opportunities for staff involvement and engagement in developing and modernising how we deliver our services. We will collaboratively develop and deliver modernisation and improvement, and encourage staff to have a greater understanding of their impact on service delivery and outcomes for patients. We will enable staff to be part of learning activities that are adapted and appropriate for them;

- **Right Resources to Patients Quickly:** the Trust will develop sustainable, innovative workforce and systems solutions building on the recommendations of the NIAS Demand and Capacity Review (2017). We will aim to have the right number of staff with the right skills to ensure our quality of service meets agreed standards in terms of time and clinical quality. We will develop highly skilled staff equipped to deliver safe patient care with a focus on the delivery of clinical excellence and appropriate pathways. Through this we will ensure we deploy the right resources, skills and response that is appropriate to clinical need;

- **Improving Experience and Outcomes for Patients:** The Trust will ensure that we listen to, and learn from, patients and others in the planning and delivery of services. We will promote meaningful engagement and involvement in service developments. We will use a range of standards, measures and indicators to offer assurance that our service is operating effectively, safely and in the best interest of patients;

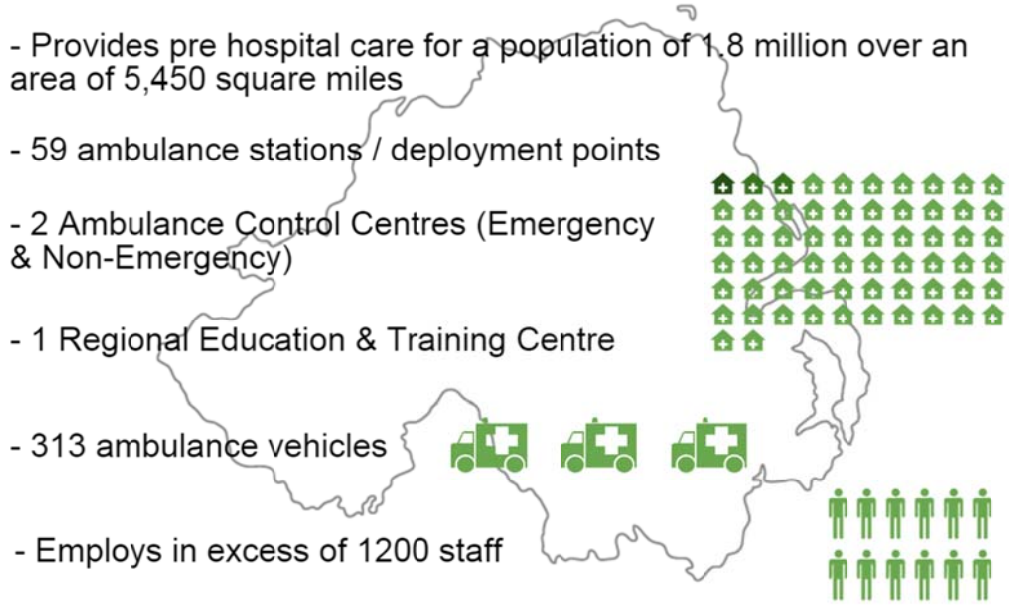
- **Clinical Excellence at Our Heart:** we will ensure the best outcomes for our patients through working to the highest standards of care and developing, leading and sharing best clinical practice. We will ensure clinicians receive the highest standards of education, learning and development to perform effectively and safely. Clinical staff will be equipped to carry out their role supported by advancements in technology, medical equipment, clinical practice and clinical audit. NIAS will develop and implement clinical supervision for regulated professionals. We will involve our staff and others to identify and develop the best models of clinical practice and appropriate systems and processes for measuring outcomes;

- **Recognised for Innovation:** the Trust will continue to work collaboratively on innovations and transformations that deliver on our priorities. We will position NIAS as an integral part of the whole HSC system and influence and shape services to ensure improvements to the patient experience and outcome. We will develop and embed a quality improvement methodology within the Trust and celebrate related successes. NIAS has a vital role to play in the delivery of urgent and emergency care, providing a range of clinical responses to patients in their homes and community settings and can potentially integrate seamlessly across the spectrum of providers in health and social care. We can increasingly shift the balance of care away from hospitals, reduce demand on emergency departments and take the pressure off general practice. There are real benefits to be gained for patients by investing in NIAS services to improve the future sustainability and performance of the health system overall. NIAS will identify the impact of those changes in an open and evidenced manner using clear, validated and timely data; and

- **Effective, Ethical, Collective Leadership:** the Trust will develop an Organisational Development Framework and Annual Delivery Plan that will provide a focus on promoting the right culture and supporting behaviours to drive improvements and transformations. We will ensure there are leadership development opportunities to develop the skills and confidence of our leaders to support the Trust priorities, as outlined in the Corporate Plan.

About the Northern Ireland Ambulance Service HSC Trust

The Northern Ireland Ambulance Service (NIAS) was established by the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995 as amended by the Health and Social Services Trusts (Establishment) (Amendment) Order (Northern Ireland) 2008 and Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.



The principal ambulance services we provide are:

- Emergency response to patients with sudden illness and injury;
- Non-emergency patient care and transportation;
- Specialised health transport services; and
- Co-ordination of planning for major events and response to mass casualty incidents and disasters.

Performance Analysis

Overview of Organisational Performance

The Northern Ireland Ambulance Service (NIAS) exists to provide a high quality ambulance service which delivers the best clinical outcomes for those patients who make use of our services. We seek to do this by having in place the necessary resources in terms of staff, fleet and estates. However, we cannot deliver this service in isolation and we are committed to participating fully in the development and delivery of responsive integrated health and social care services through close collaboration with partners throughout the Health and Social Care system. Engagement with local communities and their representatives in addressing issues which affect their health is also key to the future development of our services.

This annual report examines NIAS performance during 2018-19 in terms of delivering our service, and identifies the challenges that NIAS has faced in doing so. The report also outlines the measures that NIAS has taken in facing these challenges. The report will also review the way in which we have managed our budget in the context of these challenges during the year.

Performance against Ministerial Target – Category A Response

NIAS is required under the Commissioning Direction Plan to formally report to the Health and Social Care Board (HSCB) on performance indicators for Category A performance and turnaround times at Emergency Departments.

Commissioning Direction Plan Key Performance Indicator: 72.5% of all Category A (life threatening calls) should be responded to within eight minutes, 67.5% in each Local Commissioning Group (LCG) area. Since 2012-13 NIAS performance against this target has been falling steadily and, regrettably, continued to fall in 2018-19 to the point where NIAS responded to 37.2% of Category A calls within the required 8 minutes.

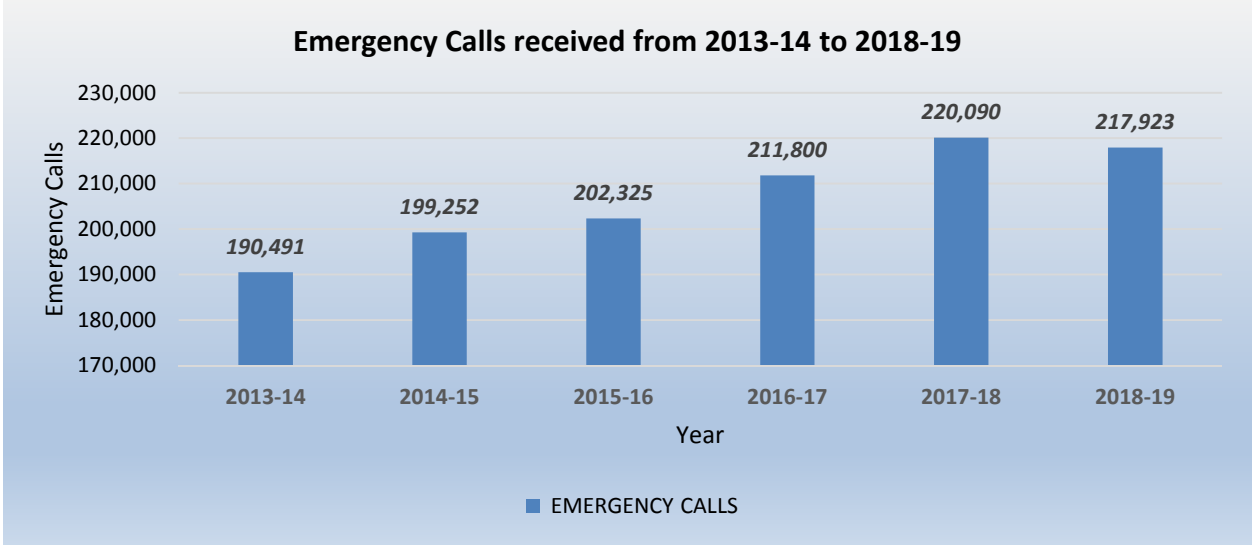
The following table outlines the performance against this Key Performance Indicator for the year 2018-19:

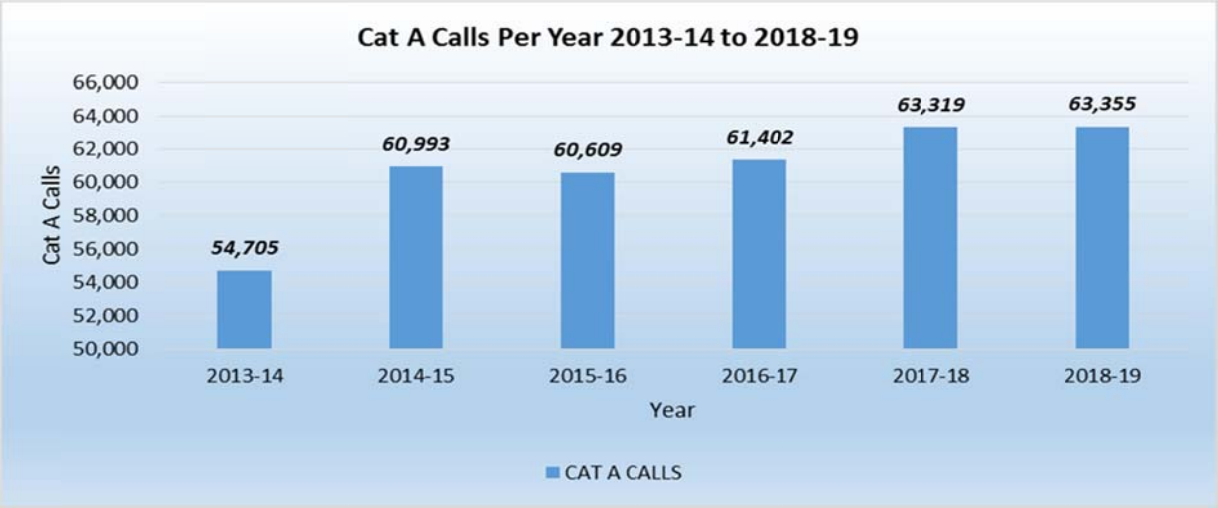
Category A "potentially immediately life-threatening" 999 calls with a sub-8 minute response		
Location	**2018-19**	
	Target	**Actual**
N Ireland	72.50%	37.2%
Belfast	67.50%	45.6%
North	67.50%	32.0%
South East	67.50%	31.0%
South	67.50%	32.6%
West	67.50%	42.9%

This continues to be a matter of concern for the Trust. As had been reported in previous Annual Reports, increasing category 'A' demand for our Service, compared to the available capacity has regrettably, inevitably led to a deterioration in response times. There are a number of specific issues, which have contributed to this deterioration, such as demand pressures and extended hospital turnaround times.

Demand pressures

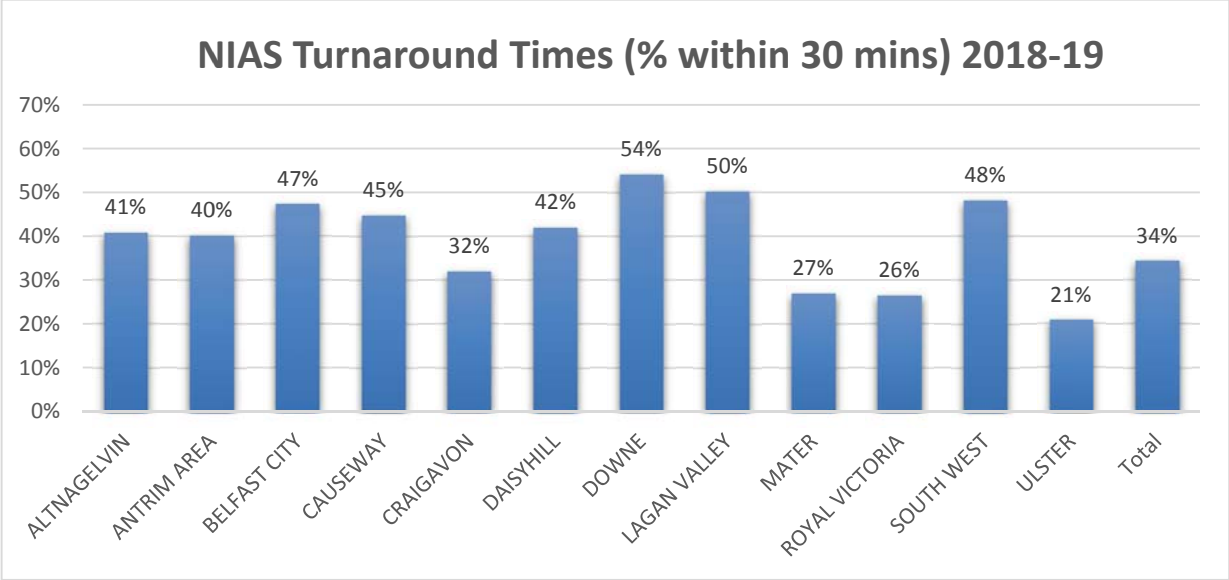
While the number of emergency and healthcare professional calls reduced slightly during 2018-19 compared with 2017-18, the increasing trend in category 'A' calls has continued, as shown in the following tables:





Hospital Turnaround Times

In 2017-18, 39.1% of all ambulance arrivals at hospitals resulted in ambulance turnaround times within the standard 30 minutes. During 2018-19, this reduced further to 34%, as shown below.



NIAS continues to work with the other HSC Trusts to improve ambulance turnaround times. In particular, during 2018-19 we have fully participated in the HSCB/PHA led regional initiative, being supported by the Patient Safety Forum, to improve turnaround times and look forward to seeing the impact of this during 2019-20.

Hospital Ambulance Liaison Officers (HALOs) continue to work closely between Ambulance and Emergency Department staff at four hospitals to support improved patient flow and ambulance turnaround times. During the winter period, NIAS increased the hours of operations of the HALOs at weekends and evenings using additional winter pressures funding allocated by HSCB Commissioners.

As a further measure to address patient handover delays at Emergency Departments (EDs) over the winter period, NIAS worked in partnership with other HSC Trusts to introduce Hospital Receivers in a number of EDs with the longest turnaround times. These qualified healthcare professional staff provide appropriate care and monitoring to suitable patients, until they can be handed over to ED staff, allowing Ambulance staff to respond to other calls. Early indications are that this initiative has had a positive impact on reducing patient handover delays, in particular the very long delays experienced on regular occasions during the previous winter.

Corporate Challenges

Infection Prevention and Control

Infection prevention and control has been a significant challenge to the Trust during 2018-19. An update on this is provided within the Governance Statement on page 56.

Information Governance

A key challenge during 2018-19 was embedding the strengthened requirements of the General Data Protection Regulations (GDPR) which came into force on 25th May 2018. This has been a focus for NIAS during the year and we continue to embed GDPR requirements into relevant policies and procedures with the development of stronger privacy notices and earlier identification of data protection issues in contract arrangements. Data breaches and cyber related incidents continue to be a focus for the Trust as we recognise the serious implications for patients, staff and the organisation.

There has been an increase in the level of information requests of over 11% in 2018-19 compared with the previous year (2019: 1,430 requests, 2018: 1,294 requests). This includes a 180% increase in subject access requests (2019: 84 requests, 2018: 30 requests). As anticipated and due to GDPR there has been a growth in direct requests from patients and third parties in relation to requesting their information that the Trust may hold about them as in some cases no fee is applied.

Cyber Security

With the ongoing risk in relation to cyber security, NIAS continues to collaborate with other HSC organisations through the Regional Cyber Security Forum to develop and maintain a shared cyber security approach and to take forward Information Security Management best-practice aligned to the International ISO27001 standard. Please refer to the Governance Statement on pages 44 and 59 for further information.

Service Developments – Improving Services for Our Patients

Work continued during 2018-19 to develop and expand initiatives to reform the way we deliver services and ensure the people who call our service receive the most clinically appropriate response.

Clinical Response Model

NIAS has experienced significant growth in demand for emergency 999 response calls over recent years. The service is undergoing significant reform and improvement and as part of this wider transformation agenda, we are proposing to introduce a revised Clinical Response Model (CRM), similar to those introduced in recent years elsewhere in the UK. This is designed to provide a more clinically appropriate ambulance response than the current model, which was introduced over forty years ago, by better targeting the right resources (clinical skills and vehicle type) to the right patients. This proposal represents a significant change in the way that NIAS provides its services.

From September 2018 to January 2019, NIAS engaged in a consultation process with key stakeholders, including service users, political representatives, Trade Unions and our workforce to fully consider all of the perspectives and potential impacts of introducing a new Clinical Response Model (CRM) for NIAS. The Consultation was promoted through a range of actions, including: direct email contact with over 450 stakeholders; individual meetings; attendance at Local Commissioning Group meetings; interaction with the Patient Client Council; and, the use of both mainstream media and social media. Feedback from the consultation was broadly supportive as reflected in a published document which includes the final policy proposals for the CRM changes and final Equality Impact Assessment (EQIA) that looks at the potential impact of the proposed changes in line with the Trust's responsibilities under Section 75 of the Northern Ireland Act 1998. It also summarises the views of stakeholders who responded to the CRM consultation, including the NIAS responses to those issues that are directly relevant to the development of a new CRM. This CRM EQIA document, which details our proposals and is supported by the HSCB, was forwarded in May 2019 to the Department of Health for approval.

Paramedic Clinical Support Desk

In October 2017 a Paramedic Clinical Support Desk (CSD) was established within Emergency Ambulance Control undertaking telephone triage of 999 calls and using their clinical expertise to provide self-care advice or refer patients to appropriate care pathways to ensure the right treatment, in the right place at the right time. The team use the Manchester Triage System to ensure that clinical decisions are safe and appropriate.

The role of the CSD Paramedics is to provide:

- Telephone based 'hear & treat' services ensuring that patients receive the most appropriate clinical care;
- Clinical advice/support to clinical staff which will complement existing clinical support mechanisms;
- Advice and support in relation to the use of NIAS Appropriate Care Pathways; and
- Real time clinical advice to enable the deployment of the right resource, first time to patients.

The team initially consisted of 5 Paramedics who received additional training and education in patient assessment and remote triage. Further recruitment took place during 2018 with an additional 6 Paramedics joining the team. The team now operates from two sites - the Emergency Ambulance Control room in NIAS HQ, Belfast and the Non-Emergency Ambulance Control room in Altnagelvin.

From April 2018 to March 2019 the CSD triaged 18,142 "999" calls. 48% of these calls required an emergency 'blue light' ambulance response. The remaining 52% had a range of outcomes including:

- Self-care advice with no response required (21%);
- Non-emergency ambulance transport to Emergency Departments (22%); and
- Patient welfare calls and / or advice to operational crews (9%).

The CSD team are practicing Paramedics and regularly undertake frontline operational shifts in order to consolidate their skills and provide frontline clinical leadership. In addition, during 2018-19, the team were involved in a number of small pilots including the joint response of a CSD Paramedic and BHSCT consultant geriatrician to patients presenting with frailty related conditions.

Helicopter Emergency Medical Service

The Helicopter Emergency Medical Service (HEMS) went live at the end of July 2017. The service is delivered through a partnership involving the Northern Ireland Ambulance Service (NIAS) and the charity, Air Ambulance Northern Ireland (AANI). Both parties have signed up to an agreed Memorandum of Understanding (MoU) setting out their various roles and responsibilities with the Health and Social Care Board as an interested party.

The purpose of HEMS is to provide advanced clinical interventions at the scene of an incident which previously would not have been delivered until a patient arrived in hospital. In essence a critical care Consultant and a critical care trained Paramedic can reach an incident anywhere in Northern Ireland within thirty minutes in order to supplement the initial treatment of a patient provided by NIAS crews. The HEMS team is dispatched by the airdesk Paramedic only to cases of serious trauma. The airdesk

Paramedic, who is an operational HEMS Paramedic, actively and passively interrogates the initial 999 call to determine if the HEMS team is required. If there is limited information from the scene, the airdesk Paramedic can wait for updates from ambulance crews who subsequently arrive and then request assistance from the HEMS team. After assessment and any critical care interventions have been carried out, the team will then decide on the most appropriate destination for the patient which may include flying them directly to the Royal Victoria Hospital (RVH) for specialist treatment.

The HEMS team were tasked to 492 calls in 2018-19 with an average of 41 calls per month. The primary reason for activation was to road traffic collisions (45%) with falls being the second main reason (21%). The HEMS team were mobile within 10 minutes in 96% of all calls. This time frame is from the decision of the airdesk Paramedic to activate the team to the team being airborne. The HEMS team were tasked to all council areas in 2018-19 with Saturday being the busiest day of the week.

In 2018-19 HEMS began several clinical projects to ensure a gold standard of pre-hospital critical care is continually delivered. These included the carrying of blood products, the use of pre-filled syringes when delivering a pre-hospital anaesthetic and the establishment of clinical performance indicators. HEMS has continued to support the implementation of the RVH helipad.

Community Paramedics

We are now in the second year of the Community Paramedic Project which aims to improve the availability of alternative options to Emergency Department attendance ensuring that timely and appropriate interventions are undertaken to facilitate treatment for those living in remote and rural areas. The current project is part financed by the European Union's European Regional Development Fund through the INTERREG VA Cross - border programme managed by the Special EU Programmes Body (SEUPB) (2019: £97k, 2018: £115k).

Community Paramedics collaborate with other healthcare providers in a variety of settings utilizing their extended Paramedic skills and availability to integrate into their local community resulting in a patient centred, safe experience with high quality outcomes. The new model continues to develop new ways of working in order to deliver better quality care and where possible, will ensure more patients are treated in their own homes and communities without the need for hospital treatment.

With the success of the pilot in the Castlederg and Fintona areas it is intended that NIAS further develop the role, embed it in the current operational structure and improve rural medical services in other areas throughout Northern Ireland.

Community Resuscitation

NIAS, as lead agency for the implementation of the DoH Community Resuscitation Strategy, introduced a Community Resuscitation Team whose role is to promote awareness and practice of bystander CPR and the use of a defibrillator for people who suffer an out of hospital cardiac arrest. The work of the team is across 4 Themes – Education, Community (including councils), Automated External Defibrillators and Community First Responders. Extensive work across all of these themes is already underway and a 5 year implementation plan is being finalised. In the first year the team provided training/awareness to over 12,000 people across NI, hosted the First Community First Responder Conference where over 100 volunteers attended to network, share best practice and learn practical skills related to their role. There are now almost 250 Community First Responder volunteers across 14 schemes who have given around 30,000 hours to help save lives in their local communities.

Restart a Heart week marked the launch of the NIAS Automated External Defibrillator (AED) interactive map and over 7,000 members of the public received CPR awareness or training during that week. The Balmoral Show in May 2018, provided the opportunity to engage with over 3,000 people and over 1,500 people took the opportunity to have 'hands on' experience of CPR and the use of an AED.

Team leader Stephanie Leckey took the opportunity at the first Community Resuscitation Conference to announce the introduction of the GoodSAM mobile phone app across Northern Ireland later in 2019, allowing for earlier notification of trained responders to a collapsed patient in the neighbourhood.

Fleet and Estate

Fleet

A key NIAS objective is to provide a safe and reliable ambulance fleet which supports the operational model for service delivery. The following table shows the fleet profile in 2018-19:

Vehicle Type	% less than 5 years old
Emergency Ambulances	99%
Non-Emergency Ambulance	93%
Rapid Response Vehicles	79%
Support Vehicles	68%

During 2018-19 in accordance with the NIAS Fleet Strategy, NIAS continued with the 5 year fleet replacement cycle for the operational fleet and replaced the following vehicles:

- 23 Accident and Emergency (A&E) vehicles;
- 26 Patient Care Service (PCS) vehicles including specialist bariatric vehicles;
- 15 Response Vehicles including Rapid Response (RRV) and support type vehicles; and
- 1 Northern Ireland Specialist Transport and Retrieval vehicle (NISTAR).

The Trust continues to look at reducing its carbon footprint by procuring more environmentally friendly vehicles such as electric vehicles and the fitment of solar panels to our new A&E ambulances.

Estate

The newly constructed Enniskillen Ambulance Station became operational on 4 December 2017 and was officially opened on 17 October 2018 by the Permanent Secretary of the Department of Health, Mr Richard Pengelly.

During 2018-19, NIAS commenced a sluice replacement programme throughout the service in line with RQIA recommendations into Infection Prevention and Control (IPC). See also Internal Governance Divergences within the Governance Statement in relation to building leases (section 11, page 57).

Workforce

Key to the delivery of our services is a high performing, appropriately skilled and educated workforce which is suitably equipped and fit for the purpose of delivering safe and high-quality ambulance services. In recognizing our staff as our most valuable asset, NIAS continually seeks to develop staff and care for their physical and mental well-being through structured initiatives, designed to deliver this development and care.

Supporting Our Staff

NIAS has increasingly placed a strong focus on staff engagement, and Health and Wellbeing outcomes for staff. This agenda is a core element of our transformation work.

The UNISON / NIAS Health and Wellbeing Partnership surveyed, analysed and reported on staff issues related to wellbeing and welfare. High-level outcomes with recommendations for action were shared with all staff through Trust-wide communications.

The peer support pilot project continued to involve substantial staff engagement, project development work, and external partnering with public sector colleagues, to benchmark and build on best practice for NIAS in relation to systems of peer support, stress management and trauma response. The first tranche of peer support volunteers were trained and the project commenced in pilot mode in November 2018. Further project development, including staff training, will take place during 2019-20 in seeking to mainstream the project.

In addition, during the year NIAS appointed a Health and Wellbeing Project Manager.

Clinical Education

The field of clinical training has now moved to reside within the Medical Directorate of NIAS. During 2018, the Trust gained approval for the introduction of a Foundation Degree in Science in Paramedic Practice in partnership with Ulster University.

Our first cohort of staff entered the programme in January 2019 and the students are expected to graduate in the Autumn of 2019. During the course, students are embedded with Allied Healthcare Professional colleagues in a variety of clinical settings, as well as gaining vital experience “on the road”.

In the longer term, new Paramedics will be required to undertake a BSc Honours course from 2021 onwards in line with practice across the rest of the UK, and the Department of Health is already scoping the implications of this requirement with a view to commissioning the higher level degree.

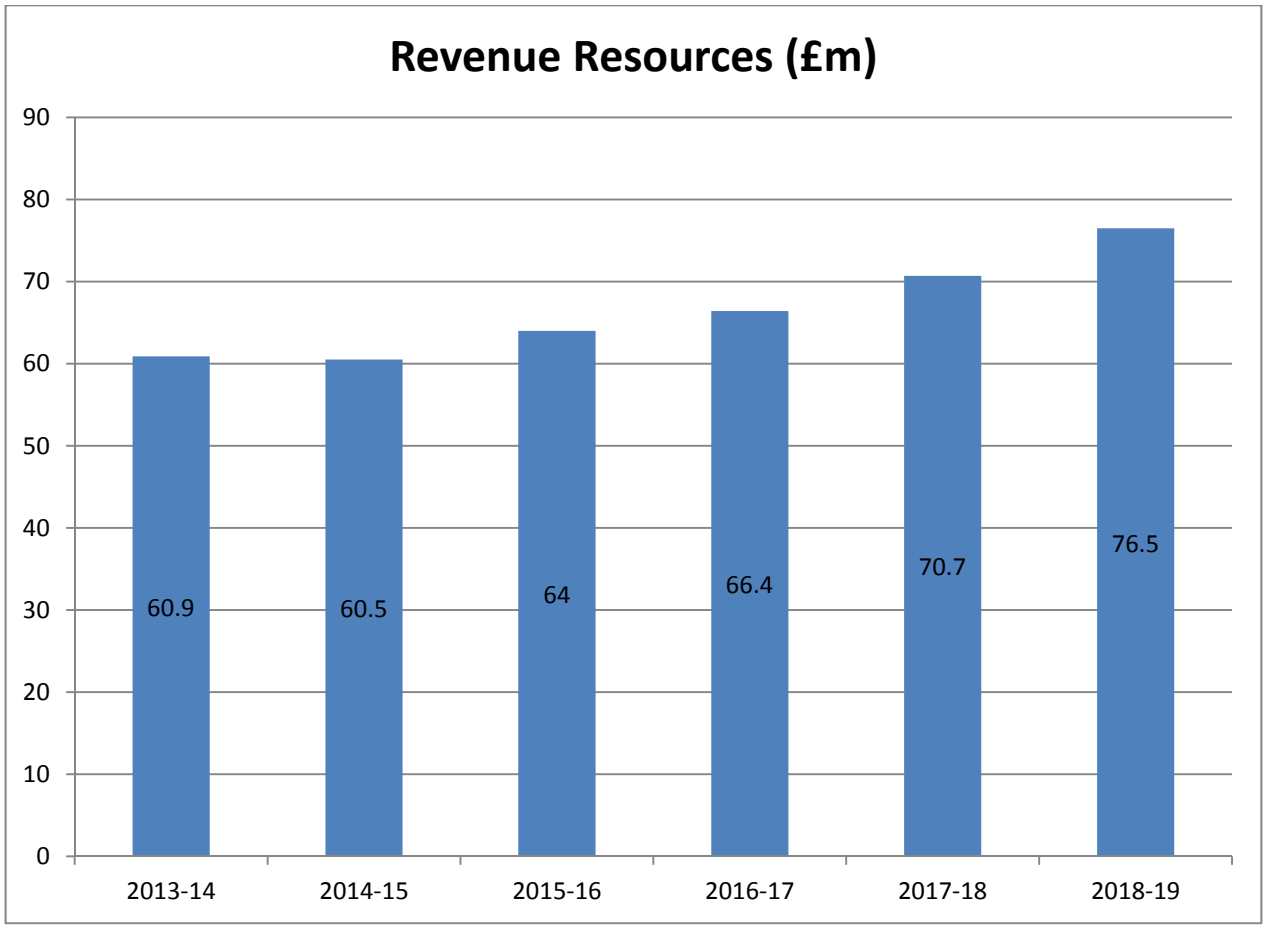
Good Attendance Programme

Sickness levels within NIAS remain unacceptably high (cumulative absence level for 2018-19 was 11.48%), which has the potential to diminish levels of operational cover and affects the ability to respond in a timely manner. On this basis, NIAS has developed a Good Attendance Programme, which is described in further detail in the Health and Wellbeing and the Attendance Management sections within the Governance Statement on pages 55 to 56.

Financial Resources and Performance

Revenue Resources

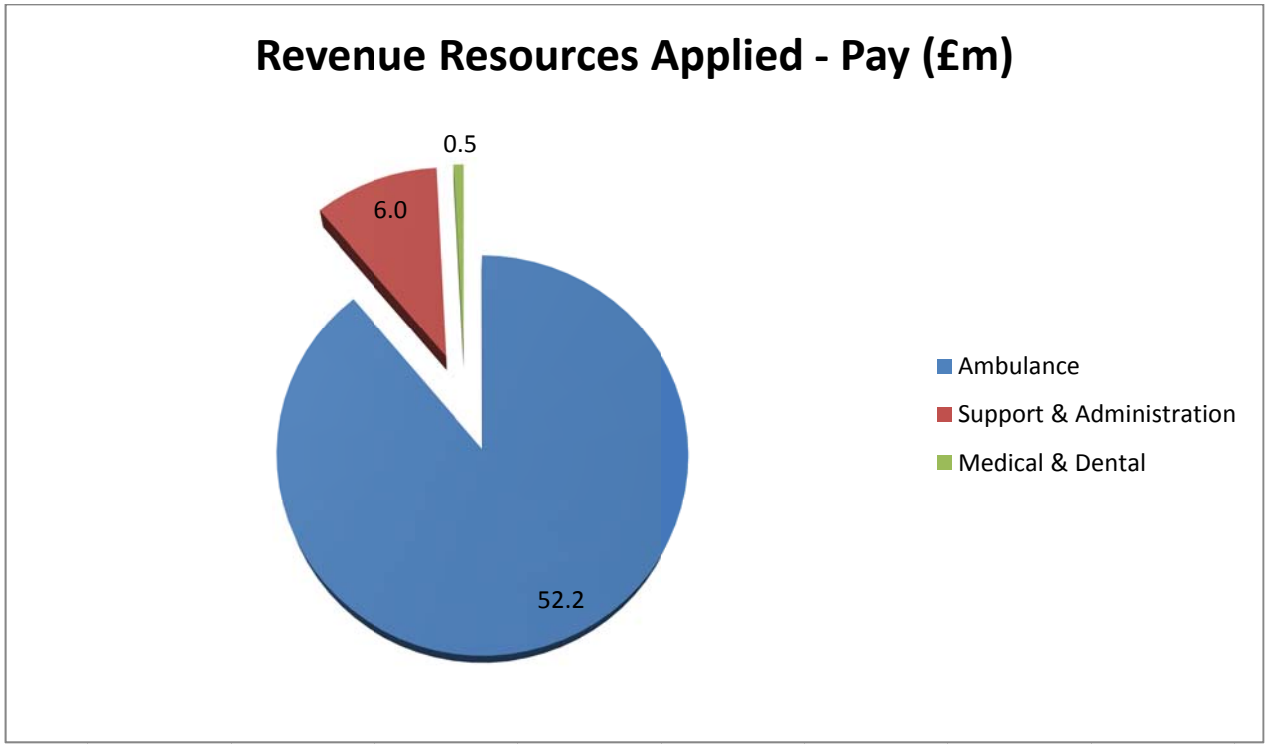
The Health and Social Care Board (HSCB) provide the majority of the revenue resources available to the Trust through the Service and Budget Agreement. This sets the service activity and outcomes to be delivered within the Revenue Resource Limit that is made available to meet the Health and Social Care needs of the population. The total revenue resources available to the Trust for the last six years are shown below.

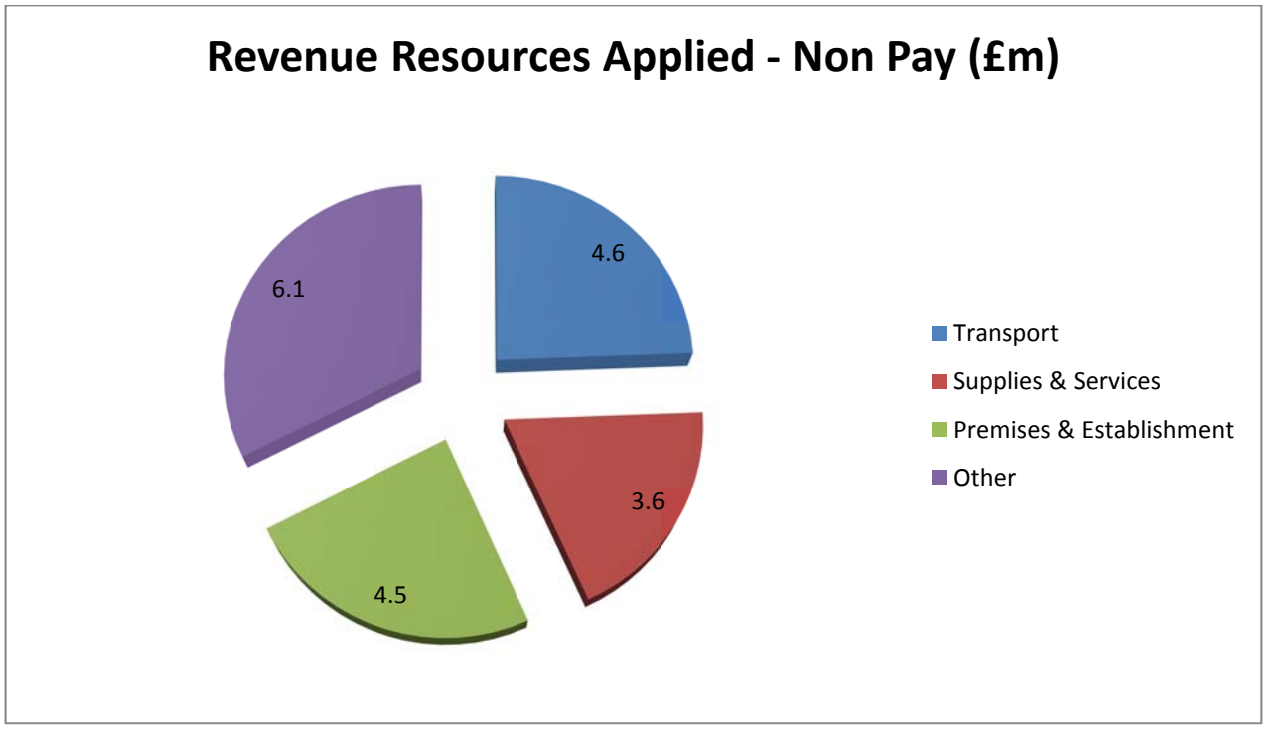


The resources available each year can vary due to a number of factors, for example supported developments, support for unavoidable costs pressures and the level of cash releasing efficiency savings required. The increase in 2018-19 is due to a number of supported developments, for example investment in the implementation of a foundation degree programme for Paramedics and training of significant numbers of Emergency Medical Technicians and Ambulance Care Assistants. This year also included additional allocations to support the Helicopter Emergency Medical Service (HEMS).

Revenue Expenditure

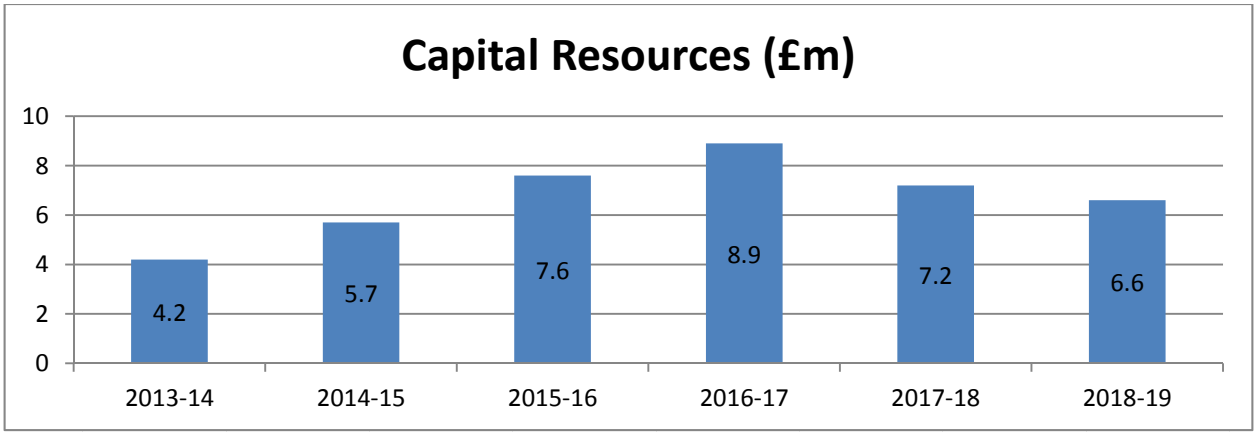
These resources are applied to provide the full range of services provided by NIAS. £58.6m (69%) of total expenditure in the Ambulance Service is on staff costs and the vast majority of this expenditure is on front line Ambulance Service provision. Non pay expenditure of £18.8m is largely made up of the costs of running the ambulance fleet, clinical and non-clinical services and supplies and premises and establishment costs. The breakdown of expenditure between these areas in 2018-19 is shown in the following tables.





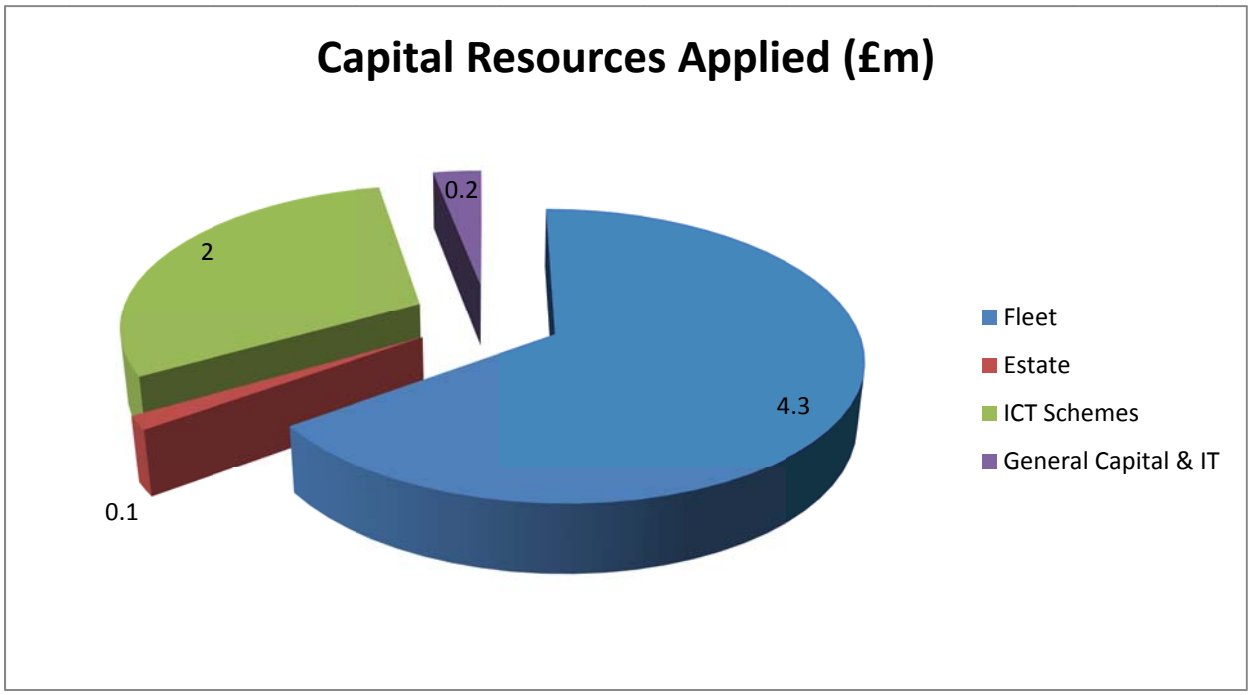
Capital Resources

The Department of Health (DoH) provide capital resources to the Trust through the Capital Resource Limit. This is based upon a number of factors, including overall resources available and the prioritisation of schemes across all Health and Social Care bodies. The total capital allocations made to the Trust for the last six years are shown in the following table.



Capital Expenditure

These resources are applied broadly across the areas of Fleet, Estate, General Capital and IT and Information Communications and Technology. A breakdown of the £6.6m expenditure in 2018-19 between these areas is shown below. Significant schemes during the year included the replacement of the Digital Trunk Radio Infrastructure and also the commencement of the replacement of the Fleet Mobile Data System. The Trust has also been able to maintain investment in replacing the Ambulance fleet in a managed cycle.



Prompt Payment of Invoices

The Trust is required to pay non-Health and Social Care 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% of invoices within 10 working days (14 calendar days) is also in place. The Trust has implemented and maintained a range of plans to improve and maintain performance in this area which has resulted in sustained improvements over recent years, however the cumulative targets for the year were narrowly missed. The cumulative performance for the year was 93.2% of invoices by volume and 94.9% of invoices by value were paid on time within 30 calendar days (see Note 14 of the Annual Accounts). The Trust will continue with efforts to maintain and improve performance in 2019-20.

Long Term Expenditure Trends and Plans

In common with the rest of the Public Sector and with the Health and Social Care system, 2018-19 has been another year of challenge. The Trust has delivered against a range of statutory and regulatory financial duties during the year. Overall, expenditure levels were over £84 million (including non-cash items – see Note 3 of the Annual Accounts). This was against a backdrop of financial savings. Cumulative savings of an additional £0.827 million were required from NIAS for the 2018-19 financial year. This savings target was achieved through a range of non-recurrent measures. The Trust will continue to work with all stakeholders to achieve required savings while maintaining safe and effective care to patients.

With the support of the HSCB, the Trust also delivered a significant investment plan mostly in response to changes in service delivery both in NIAS and in the wider Health and Social Care system. Overall, the Trust delivered a small surplus of £47k.

The Trust also benefited from £6.6 million of capital investment. This included the replacement of ambulance vehicles and investment in information and communications technology that is more and more an integral part of modern healthcare delivery.

Looking ahead, the Trust faces a range of financial pressures. The current political and economic environment locally, nationally and internationally has the potential to significantly add to these pressures.

The introduction and consolidation of a range of developments, for example within the Emergency Ambulance Control environment, the Helicopter Emergency Medical Service and also changes and improvements in the approach to hygiene, cleanliness and infection prevention and control, will have

financial implications for the Trust. There will be further requirements to deliver cash releasing efficiency savings in 2019-20 and additionally, some resources provided non-recurrently during 2018-19 will need to be reviewed in 2019-20. Levels of capital investment will also need to be maintained in order to maintain fleet, estate and technology to appropriate standards.

The Trust is grateful for the support of the HSCB and DoH in securing the levels of investment in the ambulance service in 2018-19 and previous years. The Trust will continue to work with all HSC partners to build on this and continue to provide safe, effective and quality care within available resources.

NIAS, in common with other HSC Trusts, draws down cash directly from the DoH to cover both revenue and capital expenditure. Cash deposits held by the Trusts are minimal and any interest earned is repaid to the DoH. As such, there are no effects of interest costs on outturn and no potential impact of interest rate changes.

Accounts Direction

NIAS accounts have been prepared in a form determined by the Department of Health based on guidance from the Department of Finance Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

Accounting Policies

The accounting policies follow International Financial Reporting Standards to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the HSC Trust for the purpose of giving a true and fair view has been selected. The HSC Trust's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts. There have been no significant changes to accounting policies in the year.

Principal Risks and Uncertainties

The Trust continues to manage the principal risks relating to corporate performance in line with our Corporate Risk Management Policy, Strategy and governance structures. NIAS complies with DoH guidance and assurance processes regarding the identification and management of risks. This is delivered through the Audit Committee and the Assurance Committee and subsequent reporting to the NIAS Trust Board. The Trust's Board Assurance Framework template has been reviewed and continues to reflect levels of assurance linked to the delivery of the NIAS strategic objectives. The Trust continues to develop compliance measures to ensure that appropriate risk management processes are adopted at all levels in all activities and supports initiative and innovation whilst learning from mistakes and taking responsibility.

The Trust is committed to the further development of a culture where people are encouraged to challenge and expect to be challenged about how and why they do things in the interest of their patients, staff, the Trust and the public. The Trust is committed to the proportionate management of risk that ensures the Trust discharges its duty of care to our patients, staff and those who may be affected by our activities. The Trust makes every effort to comply with the regional Serious Adverse Incident Reporting and Follow-up Procedures and the Risk Manager participates in regional reviews as Trust Governance Lead. NIAS continues to support the other HSC Trusts in relation to the investigation and reporting of their Serious Adverse Incidents; these are reported to the Assurance Committee as a standing agenda item as inter Trust and interface incidents.

The Senior Executive Management Team has signaled its concern in regard to the risks captured within the Corporate Risk Register which Trust Board continue to monitor. See Internal Governance Divergences within the Governance Statement (section 11, page 51 to 61).

Mr Michael Bloomfield

Chief Executive

18 June 2019

ACCOUNTABILITY REPORT

Corporate Governance Report

Directors Report

The Trust Board is made up of five Executive Directors, and six Non-Executive Directors including a Chair. The Trust Board normally meets bi-monthly in venues across Northern Ireland. Arrangements for public meetings are published in the local press and the Trust website to encourage public attendance and the agenda is widely circulated. Non-Executive Directors form the membership of the three Trust Board Committees: the Remuneration Committee, the Audit Committee and the Assurance Committee.

The Remuneration Committee provides advice and assurance to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives. The Audit Committee provides assurance of effective internal financial controls including the management of associated risks. The Assurance Committee provides assurance of effective controls in non-financial matters including the management of associated risks.

Membership of Trust Board and Committees and Record of Attendance of Members:

Member	Designation	Trust Board	Audit Committee	Assurance Committee	Remuneration Committee
Mr Paul Archer	Chair (To 30 June 2018)	2 out of 2	-	0 out of 1*	1 out of 1
Mrs Nicole Lappin	Chair (From 1 July 2018)	4 out of 4	1 out of 3*	2 out of 3*	1 out of 1
Mr Dale Ashford	Non-Executive Director (From 16 April 2018)	5 out of 5	5 out of 5	4 out of 4*	-
Dr Jim Livingstone	Non-Executive Director (To 28 February 2019)	5 out of 6	-	0 out of 3	-
Mr William Abraham	Non-Executive Director	4 out of 6	5 out of 5	4 out of 4*	
Mr Trevor Haslett	Non-Executive Director	5 out of 6	3 out of 5	4 out of 4	2 out of 2
Mr Alan Cardwell	Non-Executive Director	6 out of 6	1 out of 1	3 out of 4*	2 out of 2
Mr Jim Dennison	Non-Executive Director (From 1 March 2019)	1 out of 1	-	-	-
Mr Michael Bloomfield	Chief Executive	6 out of 6	3 out of 5*	4 out of 4*	2 out of 2*
Mr Brian McNeill	Director of Operations	6 out of 6	-	3 out of 4*	
Mrs Sharon McCue	Director of Finance and Information Communications Technology	6 out of 6	5 out of 5*	3 out of 4*	-
Ms Roisin O'Hara	Director of Human Resources and Corporate Services	3 out of 3	-	3 out of 3*	1 out of 1*
Ms Michelle Lemon	Acting Director of Human Resources and Corporate Services (up until 31 August 2018)	3 out of 3	-	1 out of 1*	1 out of 1*
Dr Nigel Ruddell	Medical Director (From 1 November 2018) Interim Medical Director (From 1 July 2017 to 31 October 2018)	6 out of 6	-	4 out of 4*	-
*Not a Committee member.					

Interests Held by Board Members

A declaration of board members interests has been completed and is available at www.nias.hscni.net or on request from the Chief Executive's Office, Northern Ireland Ambulance Service, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG.

Personal Data Related Incidents

The Trust is not aware of any reportable data breaches or any significant personal data related incidents in 2018-19.

Statement of Disclosure to Auditors

All directors have confirmed that, to the best of their knowledge, there is no relevant audit information of which the Trust's auditors are unaware. They have confirmed that they have taken steps as directors in order to make themselves aware of any relevant audit information and to ensure that auditors are aware of that information. They confirm that the annual report and accounts as a whole are fair, balanced and understandable and that they take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Fees Paid to Northern Ireland Audit Office

The responsibility for the audit of the Trust rests with the Northern Ireland Audit Office (NIAO). The accounts include a non-cash charge of £28,000 (2018: £24,600) for the statutory audit of the 2018-19 annual accounts (Public and Charitable Funds). In addition to this amount, during the year the Trust received services from the Northern Ireland Audit Office to the value of £1k (2018: nil) in respect of the National Fraud Initiative 2018-19 exercise. No other audit or non-audit services were provided by NIAO to the Trust during the financial year (2018: nil).

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health has directed the Northern Ireland Ambulance Service HSC Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Northern Ireland Ambulance Service HSC Trust, of its income and expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (FREM) and in particular to:

- Observe the Accounts Direction issued by the Department of Health including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in FREM have been followed, and disclose and explain any material departures in the financial statements;
- Prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Northern Ireland Ambulance Service HSC Trust will continue in operation;
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Northern Ireland Ambulance Service HSC Trust; and
- Pursue and demonstrate value for money in the services the Northern Ireland Ambulance Service HSC Trust provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Mr Michael Bloomfield as the Accounting Officer for the Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Northern Ireland Ambulance Service HSC Trusts assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health.

Non-Executive Directors' Report

During the 2018-19 year the Board of NIAS has seen a number of changes. First, the Chair, Mr Paul Archer, who had served NIAS for nearly ten years, left and was replaced by Mrs Nicole Lappin at the beginning of July 2018. Mr Dale Ashford joined the Board at the beginning of the 2018-19 year and Dr Jim Livingstone was replaced by Mr Jim Dennison at the end of the year. We thank Paul and Jim for their dedicated service to NIAS and contribution to the Board over many years. This means that the Board is currently serviced by a full complement of Non-Executive Directors who serve alongside their Executive colleagues.

The past year has presented a number of operational challenges for NIAS in the context of increasing demand, but it has also seen good progress being made in a range of important areas that will contribute to the delivery of improved services for patients and support for our staff. These are described in more details elsewhere in this report and therefore not covered here.

From the beginning of April 2018 the Board steered the organisation through a number of significant issues. First, various Board members assisted with the delivery of the proposed new CRM consultation by meeting with stakeholders, including political representatives, individuals and groups on the need for, and content of, the proposed changes to service delivery. This was an exciting opportunity to discuss the need for service transformation and to raise the organisation's profile in general and was a positive and rewarding experience for those who took part. The Board was kept fully appraised of the progress of the consultation and will consider the consultation outcomes early in the 2019-20 year.

Secondly, the Board continued to give oversight to the Infection Prevention and Control (IPC) issue which was identified by RQIA through a number of ambulance station inspections. The Board monitored the actions taken by the organisation in response to the three improvement notices which had been put in place by RQIA and was kept informed of the progress of steps taken to address the concerns raised by RQIA. To this end RQIA spoke directly to the Chair and Chair of the Assurance Committee to form a view as to the Board's involvement and awareness of the IPC issue. Shortly after this the Board learnt that RQIA lifted the three improvement notices replacing these with a single notice relating to training. The Board recognised that the end goal was not merely the lifting of the improvement notices but that IPC needs to be embedded within NIAS culture. The Board is confident that, with the steps already taken and the actions planned for the immediate future, NIAS will ensure IPC is given the priority it requires.

Thirdly, Non-Executives are keenly aware of the need for the organisation to continue to develop. Along with the Chief Executive, the Chair attended meetings with the Association of Ambulance Chief Executives (AACE) and was delighted to welcome assistance provided by AACE to address a number of important issues. For example, AACE provided a review of Attendance Management in order to assist the organisation understanding where the key challenges are and to provide guidance as to how to overcome these. The Board noted that this has provided a structure for work to be taken forward to manage attendance in a more effective manner. It is through AACE that NIAS raised the issue of appropriate staff uniforms and the Board was advised that the organisation has now been asked to lead nationally on a piece of work to address all issues in this area. Finally, the Board has begun a process to develop a long term strategic plan which will outline how NIAS can fully contribute to, and align its work with, the Department's Delivering Together Strategy.

Non-Executives are acutely aware of the challenges facing the organisation. Some of these have been mentioned above but others include the urgent need for the development of a University Degree level qualification for Paramedics. The Board is satisfied that steps are being taken by the organisation to address this, including the secondment of an Assistant Director of Human Resources to the Department to support the work of the Department in this particular issue. The Board is also acutely aware of the need to tackle the ongoing problem of verbal abuse and physical assaults on staff, and to ensure we have effective mechansims to support staff after such incidents.

Also, if CRM is to be the direction of travel, Non-Executives recognise that, in order for this to be successful, there will need to a commensurate investment in resources in order to ensure that any new targets set by the Department can be met. It is potentially an exciting time for NIAS, not least because Paramedics received AHP recognition during the year, but if CRM is pursued, then NIAS will be well placed to play a central role in supporting true service transformation across the HSC. As the service which NIAS delivers is transformed to meet the needs of a changing demographic with increasing chronic illnesses, this will have a positive impact by providing the most appropriate care to patients in the right place. This will have the effect of reducing reliance on admissions to acute hospitals in many cases. There is a real opportunity to deliver positive outcomes for patients and the HSC sector through CRM, in tandem with Appropriate Care Pathways and the further development of the NIAS Clinical Support Desk.

With the assistance of Internal Audit the Board is taking stock of its governance arrangements and support and this led to a full-day workshop in January 2019 to identify where change is needed to ensure that the Board can continue to deliver for the organisation at a high level. This ongoing work will deliver results in the 2019-20 year enabling the Board to work in a more efficient and better

focused manner, with continued good engagement between Non-Executive Directors and the Executive team.

Non-Executives welcomed the official opening of the new Enniskillen Station during the year and hope to see further improvements in our estate including new stations being delivered in line with an Estates Strategy which is currently being developed, as this will be key to the successful service delivery change envisaged.

Finally, looking forward, Non-Executives will explore different ways to engage with the organisation and its staff and we look forward with anticipation to the consideration of the outcomes of the CRM consultation. Given the recent launch of the *Code of Good Practice for Partnerships between Departments and Arm's Length Bodies*, NIAS Non-Executives welcome opportunities to work closely with Departmental colleagues to deliver a world-class ambulance service for the people of Northern Ireland.

Governance Statement 2018-19

1. Introduction and Scope of Responsibility

The Board of the Northern Ireland Ambulance Service HSC Trust (NIAS) is accountable for internal control. As Accounting Officer and Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health (DoH). In essence, the role of Accounting Officer is to see that the Trust carries out the following functions in a way that ensures the proper stewardship of public money and assets:

- To enter into and fulfil Service Level Agreements with Health and Social Care Commissioners;
- To meet statutory financial duties; and
- To maintain and develop relationships with patients, the local community, Commissioners, other HSC bodies and suppliers.

The Trust is directly accountable to the DoH for the performance of these functions.

The Trust works in partnership with the DoH, the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and also works closely with other partner organisations such as other Health and Social Care (HSC) Trusts and the Regulation and Quality Improvement Authority (RQIA) through the establishment of and representation, on various working groups, all with a view to improving the quality, safety, effectiveness and efficiency of services. These arrangements continue to be reviewed and updated in response to changes in the structure of Health and Social Care across Northern Ireland.

2. Compliance with Corporate Governance Best Practice

The Board of NIAS applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Board of NIAS does this by undertaking continuous assessment of its compliance with Corporate Governance best practice and applying such principles and processes where applicable.

The Trust Board is engaged in an ongoing process of self-assessment against the Board Governance Self-Assessment Tool issued by DoH. The assessment covers four key areas: Board composition and commitment; Board evaluation, development and learning; Board insight and foresight; and Board engagement and involvement. This builds on the work carried out at the last self-assessment

carried out in 2017-18. Plans are in place to complete a self-assessment with all Board members in early 2019-20.

The Trust's Audit Committee annually reviews its effectiveness and application of good practice through the Audit Committee Self-Assessment checklist, issued by the National Audit Office. Areas of improvement are highlighted for consideration through this process.

3. Governance Framework

The Board exercises strategic control over the operation of the organisation through a system of corporate governance which includes:

- A schedule of matters reserved for Board decisions;
- A Scheme of Delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers; and
- Standing Orders and Standing Financial Instructions, including the establishment of an Audit Committee, an Assurance Committee and a Remuneration Committee.

The Audit Committee is chaired by a Non-Executive Director and membership is comprised only of Non-Executive Directors. The Audit Committee meets not less than three times per year in line with its Terms of Reference and during the year met on five occasions. Its primary role is to independently contribute to the Trust Board's overall process for ensuring that an effective internal financial control system is maintained.

The Audit Committee completes the National Audit Office Audit Committee Self-Assessment Checklist on an annual basis as part of the assessment of its effectiveness and an action plan was developed to address areas for improvement identified. No significant performance related issues were identified during this review. Additionally, each year the Chair of the Audit Committee provides the Trust Board with an Audit Committee Annual Report. The Audit Committee fulfilled the requirements of its terms of reference during 2018-19.

The Assurance Committee is chaired by a Non-Executive Director and membership is comprised only of Non-Executive Directors. The Assurance Committee met on four occasions during the year. The Assurance Committee is responsible for assuring the Trust Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board. The Assurance Committee fulfilled the requirements of its terms of reference during 2018-19.

The Remuneration Committee is chaired by the Chair of the Trust Board and membership is comprised of Non-Executive Directors only. The Remuneration Committee met on two occasions during the year. The Remuneration Committee's primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors employed by the Trust. The Remuneration Committee fulfilled the requirements of its terms of reference during 2018-19.

Membership of the Trust Board and Committees and also the record of attendance of members are shown on page 33 of the Accountability Report. During the year, the appraisal processes in place did not identify any significant performance related issues of members of Trust Board or Committees. The Chair has ongoing discussions with each of the Non-Executive Directors in terms of their contribution to their respective committees and to give them an opportunity to highlight any specific concerns or issues.

4. Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and Ministerial priorities are properly reflected in the management of business at all levels within NIAS.

The Board identifies the strategic and corporate aims, objectives and risks and monitors the achievement of these in the public interest. It has established a framework of prudent and effective controls to manage these risks, underpinned by a recently reviewed assurance framework. Decisions are taken by the Board within a framework of good governance to build a successful organisation, which is always striving to achieve excellence.

Business Planning

The Trust's Delivery Plan and Corporate Plan highlight the organisation's plans for the incoming year in line with the stated purpose, mission and vision of the organisation, aligned to the relevant principles and values, which direct action consistent with Ministerial priorities. The NIAS Trust Delivery Plan, which is subject to approval by the HSCB, takes account of available resources and outlines Trust priorities in terms of actions and activity to secure objectives for the year.

The Trust has been working to develop a new strategy which looks to the future and considers our aspirations for a transformed ambulance service for 2026. This will be closely aligned to the DoH's "Health and Wellbeing 2026 – Delivering Together" document. This highlights the value of working as an integrated HSC system alongside a range of 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. A number of workshops are planned for 2019-20 to engage Trust Board and senior managers in its formulation.

During 2018-19, NIAS has been actively engaged with other ambulance services across the UK and Ireland in the development of this strategy, building on the developments of recent years and setting out how NIAS can further improve the service we provide to the public, and support the wider HSC sector.

Risk Management

The Trust Board has established an Assurance Committee, which is a committee of the Board, and is responsible for overseeing all aspects of risk management across the organisation. The Assurance Committee meets at least three times a year and reviews incidents (including Serious Adverse Incidents), Risk Registers and compliance with the replacement arrangements for Controls Assurance Standards, as standing items, as well as other health and safety and risk management issues as they arise. The meetings are recorded and the minutes are reported to the Trust Board. The Trust's Medical Director has been given delegated responsibility for the oversight of risk management and is supported in this regard by a Risk Manager.

The Trust Board continues to review the arrangements in place with reference to best practice and DoH guidance in order to strengthen the arrangements for Risk Management. The Trust's Corporate Risk Management Policy and Strategy is undergoing a scheduled review and will be presented to Trust Board in 2019. The Policy and Strategy specifies ways in which risk can be identified; the means of identification include, although not exclusively, incident reporting, Serious Adverse Incident (SAI) reporting, complaints management, risk assessment, horizon-scanning at Trust Board level, claims management, assurance, benchmarking and consultation with staff and service users. The Strategy also places upon all Trust employees the responsibility to be aware of and to report any and all risks to which they or the Trust are exposed.

This process enables identified risks to be recorded on the Risk Register, evaluated and, if necessary, re-evaluated in line with the regional guidance and best practice. In accordance with the Trust's Risk Management Strategy, this takes into account the likelihood and potential impact on the Trust's patients, employees, environment, reputation and resources. This evaluation then prompts the development of individual risk treatment plans against which progress is monitored through the Trust's Risk Register.

Corporate Risks are those that impact on the organisation as a whole or which cannot be resolved immediately or adequately reduced by treatment at a local level. They are recorded on the Corporate Risk Register which is reviewed on a monthly basis by the Senior Executive Management Team

(SEMT). Risks escalated to the Corporate Risk Register in 2018-19 include: delivering commissioned hours; increasing commissioned hours; voluntary overtime; operational management arrangements; staff health and wellbeing; and EU Exit. Local Risks are those which have a localised impact and which can be reduced to an acceptable level by treatment at a local level. These are recorded on the Local Risk Register and are the responsibility of the Trust's line management. Local Risk Register updates are forwarded to the relevant Directors for distribution and review at local level on a regular basis. The Trust has further developed the mechanisms for the review of Local Risk Registers by ensuring they are formally reviewed by Assurance Committee and Trust Board on a rotational basis. The Trust will be reviewing and updating its risk appetite statement which defines the amount of risk the organisation is willing to accept as part of the scheduled review of the Corporate Risk Management Policy and Strategy. In accordance with the Statutory Mandatory Training Policy, Risk management training is to be completed every two years and a Risk Management e-learning package is under development for 2019-20. Annual workshops are held with all risk owners and risk and governance training is included in the corporate induction provided to all new staff.

The Trust has been included in the RQIA schedule of unannounced visits and continues to develop policies, processes and audit functions in relation to Infection Prevention and Control (IPC). The Trust's IPC Group oversees activities in this area and reports to the Assurance Committee and the Trust Board.

5. Information Governance

In NIAS, information governance is the framework of legislation and best practice guidance including the new General Data Protection Regulations (GDPR), the Freedom of Information Act 2000, Duty of Confidentiality etc. that regulates the manner and way in which the Trust collects, obtains, handles, uses, shares and discloses information. The introduction of GDPR occurred on 25 May 2018 and the Trust implemented governance changes into Trust policies and processes including the appointment of a Data Protection Officer and strengthening Privacy Notices for staff and the public. The Trust holds and processes information obtained from our patients, clients, suppliers, other Trusts, Coroner Service for NI, the Police Service of Northern Ireland, the Police Ombudsman, Solicitors, Coroners, and other stakeholders, as well as from our staff. The Trust uses this information to provide assurance on the level of care and service provision we deliver to our patients and for planning and business continuity. Good quality information forms the basis of high quality care.

The Trust recognises fully that information is required every day across the Trust to discharge our duties. The Trust understands that a large majority of the information we hold is of a personal nature. The Trust uses this information in many ways e.g. to respond effectively to emergencies, to ensure

that non-emergency patients are taken to Hospital appointments, to ensure the continuity of care of a patient we are treating and to support clinical research etc.

During 2018-19 we have continued to embed an information governance framework within the Trust and update staff on GDPR. We have completed information asset registers and identified data flows i.e. all manual and electronic records across the Trust to identify any information governance risks. The Trust's Information Governance Steering Group reviews the management of all information risks and information governance arrangements within the Trust and reports to the Assurance Committee.

Data loss or mismanagement does occasionally happen and while these breaches are relatively minor in nature, nevertheless the Trust continues to use the learning from such incidents to inform and develop good practice. There have been no significant information related breaches brought to the attention of the SIRO during 2018-19.

Cyber Security remains a clear focus of attention for all HSC organisations. The number of incidents of malicious cyber-attacks of computer systems supported by political regimes and / or individuals is expected to grow and all organisations are encouraged to remain vigilant. NIAS undertook a programme of work with Internal Audit to measure its compliance with the National Cyber Security Centre (NCSC) Ten Steps to Cyber Security in 2017 and continues to work on a regional basis to enhance its resilience in this area. A further programme of work supported by the HSCNI Cyber Security Programme Board in 2018 assessed each Trust against ISO 27001 Information Security Standard. The challenge for NIAS and the HSC as a whole is to be prepared to minimise the impact of such an attack on delivery of our service and to be able to restore services as soon as possible. The Trust is working to develop appropriately tested contingency arrangements and to ensure that all users recognise and embed NIAS guidance on password and security of systems.

The Trust has taken steps to advise staff of the need to be vigilant in the areas of data protection and cyber security in line with regional initiatives.

6. Fraud

In line with good practice, NIAS takes a zero tolerance approach to fraud in order to protect and support our key public services. We have put in place an Anti-Fraud Policy and Fraud Response Plan to outline our approach to tackling fraud, define staff responsibilities and the actions to be taken in the event of suspected or perpetrated fraud, whether originating internally or externally to the organisation. Our Fraud Liaison Officer (FLO) promotes fraud awareness, co-ordinates investigations in conjunction with the BSO Counter Fraud and Probity Services team and provides advice to personnel on fraud reporting arrangements. All staff are provided with mandatory fraud awareness

training in support of the Anti-Fraud Policy and Fraud Response plan, which are kept under review and updated as appropriate every five years.

7. Public Stakeholder Involvement

The Trust aims to ensure that those who use our services and their representatives have an opportunity to influence and shape policy and service delivery decisions. Our Personal and Public Involvement Strategy outlines our commitment to involving key stakeholders and their representatives in the development of our services. Service user engagement and involvement is mainstreamed into key policy development processes. Personal and Public Involvement was included as part of the mandatory training programme for all staff during the year.

A key priority remained a programme of engagement on Transformation and Modernisation and related Appropriate Care Pathways. Engagement with a range of stakeholders has been key to ensuring that these pathways remain safe and appropriate. During 2018-19 stakeholders engaged included: NI Fire and Rescue Service; Police Service of NI; RQIA; Patient Safety Forum; other HSC Trusts; PHA and HSCB. In relation to frailty pathways, NIAS has taken part in the British Geriatrics Society's frailty network which has service user input. Staff engagement has also been vital and the Transformation and Modernisation team regularly present at staff inductions and to cohorts undertaking the university programme.

The Trust sought to ensure maximum public involvement in relation to the Clinical Response Model (CRM) consultation and developed an engagement and communications plan that had enough flexibility to respond to user feedback in real time in order to improve the consultation process. It included pre-consultation engagement with key stakeholders, extensive information and awareness raising, innovative approaches to outreach, a responsive attitude to suggestions for improvement, and an extension of the consultation period – from twelve weeks to sixteen weeks - to provide stakeholders with maximum opportunities for involvement. A rolling reporting process of the stakeholder consultation was overseen by SEMT on a weekly basis, and informal and formal engagements were also conducted by members of the Trust Board. This process is being taken forward under the CRM Programme with the establishment of a NIAS Stakeholder Forum to provide effective and meaningful opportunities for ongoing public involvement in policy development.

The Trust has continued to gather and analyse patient experience stories as part of the regional 10,000 Voices project. Further work will be undertaken to use 10,000 Voices as a learning and engagement tool for the Transformation and Modernisation Programme.

The Trust takes into account the views of the public in relation to identifying and managing risks through, for example, the analysis of learning outcomes, complaints and untoward incident reports (UIRs) (including, if appropriate, contact with the service user(s) and/or other related stakeholders such as public sector partners). Risk identification, assessment and management is also considered if it arises from stakeholder feedback provided during the broader policy development processes and is then referred to the relevant NIAS department as appropriate.

8. Assurance

The Trust has an Assurance Framework based on DoH guidance 'An Assurance Framework: A Practical Guide for Boards of Arm's Length Bodies'. This framework is regularly updated and submitted to the Assurance Committee for approval. This identifies the assurances provided to NIAS by its governance structure and highlights any gaps in assurance. This supports improvements in the level of assurance and underpins the challenge function of the Trust Board.

A further important source of assurance is provided by Internal Audit whose audit plans are based on key risks and systems within the organisation. As part of the annual audit programme Internal Audit carried out a review of Risk Management (Including Management of Assurances) and provided a satisfactory level of assurance.

The Trust endeavours to continually improve its structures and processes of assurance through self-assessment exercises and resultant improvement plans. The Trust Board has been engaged in an ongoing process of self-assessment using the Board Governance Self- Assessment Tool issued by DoH. Similarly the Audit Committee annually tests its application of good practice using a Self-Assessment checklist, issued by the National Audit Office.

The Trust also contributes to both Mid-Year and Year End Accountability Meetings with DoH and HSCB which are designed to provide assurances on the Trust's systems of internal control.

These structures and processes and the sources of independent assurance outlined in this statement provide an appropriate and acceptable quality of assurance to Trust Board.

Replacement of Controls Assurance Standards Process

On 30 March 2018, the Permanent Secretary and HSC Chief Executive, Mr Pengelly, wrote to HSC Trusts in respect of the review of Controls Assurance Standards. He reminded Trusts that he had written to all organisations in August 2017 setting out the rationale for ceasing Controls Assurance Standards with effect from 1 April 2018, with a view to providing a more comprehensive and proportionate assurance to the Department.

The Trust is working with Departmental Policy Leads and other HSC organisations to ensure that suitable and proportionate assurance arrangements are in place for each of the standard areas from 2018-19. Until replacement arrangements have been agreed in each area, the previous evidence lists will continue to be used for providing assurance. The Trust recognises that this is a transitional year and will monitor progress and update as and when required.

With regards to Infection Control, NIAS has not yet reached an appropriate level of assurance and this largely relates to the development of an Infection Prevention Control (IPC) Annual Report and Annual Programme, IPC personnel structure, education and training. It is important to note however:

- An IPC Annual Programme will be produced for 2019-20;
- An IPC Annual Report will be produced reflecting 2018-19; and
- Commissioner support has been sought in support of an IPC Business Case to enhance IPC personnel structure.

Work continues on the implementation of an overarching Quality Improvement Plan (QIP). The Trust also continues to progress actions to develop and implement controls assurance in relation to environmental cleanliness. Further details are set out below (section 11) on Infection Prevention and Control.

The Trust continues to develop systems and processes to deliver increased assurance. Action plans will be developed as appropriate and progress against the plan will be monitored throughout the year.

9. Sources of Independent Assurance

NIAS obtains Independent Assurance from the following sources:

- Internal Audit;
- Business Services Organisation (BSO);
- Regulation and Quality Improvement Authority (RQIA); and
- External Audit.

The Trust also relies on other significant assurance functions, both internal and external to the organisation, and considers the implications of any relevant findings for the governance of the organisation. 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 Medicines Regulatory Group and other professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Care Professions Council (HCPC), Royal Colleges and other accreditation bodies).

Internal Audit

The Trust utilises an internal audit function (commissioned from the BSO), which operates to defined standards and whose work is informed by an analysis of risk to which the Trust is exposed and annual audit plans which are based on this analysis. In 2018-19 Internal Audit reviewed the systems as outlined below:

Audit Assignment	Level of Assurance
Financial Review	Satisfactory - Non Pay Expenditure; Asset Management; and General Ledger Limited – Payments to Staff (Four Significant Findings)
NIAS' Compliance with Permanent Secretary's Instructions Regarding Travel	Satisfactory (No Significant Findings)
Patient Flow	Satisfactory (No Significant Findings)
Absence Management	Limited (One Significant Finding)
Board Effectiveness	Limited (Two Significant Findings)
Risk Management	Satisfactory (No Significant Findings)
Management of Complaints, Claims and Incidents	Limited - Claims Management (One Significant Finding) Unacceptable – Complaints and Incident Management including Serious Adverse Incidents (Three Significant Findings)
Assurance Process Post Controls Assurance Standards	No level of assurance provided in this assignment. Processes adopted by the Trust are adequate.
Stock Taking	Satisfactory (No Significant Findings)

Definition of Levels of Assurance	
Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Overall for the year ended 31 March 2019, the Head of Internal Audit has provided limited assurance on the adequacy and effectiveness of NIAS' framework of governance, risk management and control.

In the Financial Review, while Satisfactory assurance was provided in relation to non-pay expenditure, asset management and the general ledger, Limited assurance was provided in relation to payments to staff. Four Significant findings were identified and relate to: the need to strengthen control over the key user roles in the payroll system; the need to ensure payroll control accounts are reconciled and that action is taken on a timely basis; the need for managers to take action on a timely

basis to reduce the occurrence of overpayments; and the need to work with the BSO Payroll Service Centre (PSC) to address issues with the Pension Band Review exercises. The Trust is liaising with the PSC and action will be taken to strengthen controls in this area.

Limited assurance was provided in the Absence Management audit. One Significant finding was identified and related to the following issues: the initial contact of operational staff with the Resource Management Centre; the operational management support structure not being available 24 hours a day, 7 days a week in line with the operational service; issues with the completion of return to work interviews; and issues with occupational health referrals. Action is being taken to review and revise procedures under a newly established Good Attendance Programme Board.

Limited assurance was provided in the Board effectiveness audit. Two significant findings were identified and related to the following issues: the Trust Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions requiring review; the use of Board In-committee meetings; the volume of agenda items and Board papers; Board minutes are not sufficiently detailed; and sub-committees submit verbal updates rather than formal reports. An action plan has been developed to take forward the audit recommendations in this area.

Limited assurance was provided in relation to Claims Management and Unacceptable assurance was provided in relation to Complaints and Incident Management including Serious Adverse Incidents. Four Significant findings were identified: the Complaints procedure requiring review, the timeliness and investigation process of Complaints and related learning; the timeliness of the investigation of Serious Adverse Incidents; delays in the Incident Management Process, the use of incident reporting, and procedures requiring review; and the lack of an operational Claims Management policy and procedures within the Trust. Action will be taken to address all issues highlighted and recommendations made in this audit assignment.

Recommendations to address all control weaknesses have been considered by the Audit Committee and have been, or are currently being, implemented. Progress on implementation will continue to be monitored by SEMT; reviewed by Internal Audit; and considered by the Audit Committee. Whilst the Head of Internal Audit has provided an overall limited assurance, she acknowledges that the leadership team in NIAS were aware of these issues and are taking action to address them.

Follow-up on previous Recommendations

A review of the implementation of previous internal audit recommendations was carried out at mid-year and again at year-end. Progress has been made and 111 (74%) of the 151 recommendations examined have been fully implemented, a further 39 (26%) were partially implemented and 1 (less than 1%) was not yet implemented.

The partially implemented internal audit recommendations relate in particular to: the controls in place in the Payroll Service Centre (PSC) to identify overpayments to staff; the development of procedures for the management of unsocial hours and related allowances; and the development of a formalised regional IT Incident management protocol.

In relation to overpayments, management has taken steps to mitigate against the risk of overpayments occurring and actions to address issues are discussed with the PSC at NIAS specific operational meetings and at the Regional Payroll Customer Forum. Significant work within the Trust and regionally continues to improve controls around the verification and approval processes.

In relation to unsocial hours, management are reviewing the area with a view to strengthening the monitoring effectiveness of relief hours.

In relation to the regional IT Incident management protocol, the HSC Cyber Security Programme Board has developed and formalised a regional IT Incident management protocol. This will be formally approved once testing has been completed.

A significant amount of work has been completed during the year to progress all audit recommendations and plans are in place to consolidate this progress in 2019-20. All audit recommendations include an implementation date and a responsible officer.

BSO Shared Services Audits

A number of audits (summarised below) have been conducted in BSO Shared Services, as part of the BSO Internal Audit Plan. The recommendations in these Shared Service audit reports are the responsibility of BSO Management to take forward and the reports have been presented to the BSO Governance & Audit Committee. BSO have advised that all accepted recommendations in the 2018-19 internal audit reports have been implemented or are being progressed by management.

Audit Assignment	Level of Assurance
Payroll Service Centre – Substantive Audit (March 2019)	Limited (Seven Significant Findings)
Accounts Payable Shared Service	Satisfactory
Recruitment Shared Services	Satisfactory
Business Services Team	Satisfactory

A limited level of assurance continues to be provided in respect of the Payroll Service Centre (PSC). Significant issues still remain which impact on the assurance level provided, and these relate to: significant outstanding audit recommendations remain partially implemented; high levels of manual

input by PSC staff; high levels of manual intervention required by PSC staff; issues with the detection, calculation and processing of overpayments; uncertainty whether data transferred automatically from the payroll system reconciles with HMRC data; inadequate customer relationship management processes; and the payroll system error causing an underpayment of employers superannuation contributions.

Regulation and Quality Improvement Authority (RQIA)

Recommendations are covered in detail in section 11 below under the heading 'Infection Prevention and Control / RQIA'.

External Audit

External Audit provides an independent opinion on the financial statements to the Northern Ireland Assembly. Any control weaknesses or added value issues that are identified in the course of conducting the external audit, are communicated to the Audit Committee in the Report to Those Charged with Governance.

10. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of the effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the internal auditors and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee and Assurance Committee. A plan to address weaknesses and ensure continuous improvement to the system is in place.

11. Internal Governance Divergences

Update on prior year control issues which have now been resolved and are no longer considered to be control issues

Financial Position 2018-19

The Trust continues to operate in an increasingly difficult financial environment. In the 2018-19 financial year the Trust achieved a breakeven position with a small surplus of income over expenditure. Cumulative savings of an additional £0.8 million were implemented through a range of

non-recurrent measures. In addition, the Trust delivered a capital programme in excess of £6.5 million, which was within the Capital Resource Limit (CRL) set by the DoH.

The Trust received significant non recurrent allocations to support specific projects during the year. These included Confidence and Supply allocations for Paramedic training, including the associated backfill of staff at other ambulance grades. The completion of this training and associated costs will extend into 2019-20.

Regional Electronic Ambulance Communication Hub (REACH) formerly e-PRF

NIAS has concluded an OJEU procurement for a solution for electronic patient records and personal issue devices for all front line staff. A full business case was produced based on final costs and submitted for approval to the HSCB Commissioners as agreed, before NIAS could commit to enter into a contract. Following approval in February 2019, a letter of offer had been issued by the BSO Procurement and Logistics Service (PaLS) to Ortivus Ltd as the preferred supplier. NIAS began the process of finalising contracts with the official contract start date of 6 June 2019. The first supplier meeting took place in April 2019.

A Programme Board is firmly established made up of the NIAS SEMT, HSCB E-health, BSO and the HSCB Commissioner to oversee the implementation of REACH and related projects including replacement of mobile data systems and installation of Wi-Fi hubs in vehicles, the upgrade and replacement of radio infrastructure in vehicles and at stations and the use of Wi-Fi for transmission of ECGs.

Paramedic Education

The Trust's in-house Paramedic-in-Training programme, which was approved by the Health and Care Professions Council (HCPC) and largely based on Institute of Healthcare Development (IHCD) ambulance training modules, was formally closed during 2016-17 as a direct result of the withdrawal of IHCD modules. This had the potential impact of not being able to maintain or add to the requisite number of Paramedics in the NIAS workforce in line with service delivery.

With no other route open to train new Paramedics in Northern Ireland, NIAS established a formal Paramedic Education Project to source an interim pre-registration Paramedic programme to meet the short term needs of the Trust and the development of a longer term Paramedic education solution that will meet the future needs. In Quarter 3 of 2017-18, as a result of a tender exercise, the Trust entered into a partnership with Ulster University (UU) to develop a Level 5 Foundation Degree in Science in Paramedic Practice. Members of the Trust's Education and Training Team formed a Curriculum Development Team to develop the FdSc programme.

The programme documentation was formally submitted to the HCPC in Quarter 4 of 2017-18 and a joint UU / HCPC approvals visit took place in May 2018. Both UU and HCPC agreed they would approve the programme, subject to a number of conditions, including a recommendation that the proposed commencement would be moved from September 2018 to January 2019. Revised and additional documentation to address the conditions was submitted to UU and HCPC. In September 2018 UU confirmed it was satisfied that the programme met all of its conditions. Another HCPC approvals visit was held in October 2018, following which, full approval with no conditions was awarded. Following the recruitment and selection of applications from NIAS Emergency Medical Technicians, the first programme, with a cohort of 47 Paramedic students, commenced in January 2019.

This FdSc (level 5) programme will be an interim solution for pre-registration Paramedic education. The HCPC has announced a change to the minimum educational threshold for future Paramedic registration, which will rise to BSc (level 6) for all new students commencing programmes from 1st September 2021. For future Paramedic education, the DoH has stated its intention to commission a BSc and has set up a Paramedic Education and Training subgroup to take forward this process.

Update on prior year control issues which continue to be considered control issues

Agenda for Change

Job Evaluations for Paramedics, RRV Paramedics and EMT posts within NIAS remain ongoing. In 2013, following exhaustion of internal Partnership processes, these three Job Evaluations were passed to the HSC Regional Management and Trade Union Leads, who in partnership referred the posts to the Regional Quality Assurance (RQA) team to consider further under the NHS Job Evaluation Scheme. The RQA is a partnership group comprising Trade Union and Management. The process sits out with NIAS Trust authority and NIAS is not represented in the RQA Team.

In December 2015, NIAS received Partnership correspondence from the Regional Quality Assurance (RQA) team advising that the RQA team had reached a conclusion “that the current banding levels i.e. EMT (Band 4); Paramedic (Band 5) and RRV Paramedic (Band 5) remain unchanged”. This outcome requires to be validated by the RQA team through the production of a Job Evaluation Report, which remains outstanding from the RQA team. All affected staff were advised of the conclusion of the RQA team in December 2015 and will be formally notified of the outcome of their job evaluation process following completion of the Job Evaluation Report. Thereafter in line with due process they will have the right to request a review of the outcome.

From December 2015, the Trust has engaged with Regional leads and DoH colleagues to endeavour to bring this process to a conclusion through due process. The Trust remains committed to the job evaluation process and resolving outstanding issues as a matter of priority and continues to meet with the Departmental Workforce Policy Directorate to attempt to conclude this process. A temporary workforce lead role has been established in the DoH to address NIAS-specific issues. This role is currently engaging with stakeholders in progressing key workforce issues, including the outstanding job evaluation processes.

The Trust recognises the potential for significant non recurrent and recurrent costs in relation to Agenda for Change and will continue to work through due process with Commissioners and DoH to address any potential cost issues with future reviews or job evaluations if they arise.

Business Services Transformation Programme and Shared Services

The Business Services Transformation Programme (BSTP) replaced aged Finance and Human Resources systems and the programme also introduced HSC wide Shared Services for all HSC organisations in Northern Ireland.

Internal Audit reviews of shared services for: Accounts Receivables; Accounts Payables; Recruitment; and Business Services have all been issued with satisfactory levels of assurance and are deemed to be stable.

Whilst significant progress continues to be made in many areas, the Payroll Service Centre (PSC) continues to have significant control issues (see Section 9, page 50 for further detail). The Trust continues to work with BSO Shared Services to make improvements and to realise the expected benefits of the new systems and structures. In the interim, the Trust continues to retain an element of processing in relation to payroll and travel and expenses within NIAS and has put additional controls in place to mitigate and minimise any effect of these weaknesses.

Category A Response Performance

Category A response targets have not been achieved in 2018-19 and continue to present a significant challenge for the immediate future. NIAS achieved 37.2% (8 percentage points lower than last year) against the 72.5% target. Efforts will continue, and be increased, to maximise the use of existing resources to improve Category A response times without compromising our overall commitment to respond promptly and appropriately to all 999 and non 999 requests for ambulance assistance. Performance has also been impacted by increasing hospital turnaround times as a result of pressures in the wider unscheduled care system. In 2018-19 the average turnaround time was 38 minutes 41 seconds at all Acute Hospitals compared to 37 minutes 12 seconds for the previous year. During

2018-19, only 34% of turnarounds took place within the 30 minute target. As a winter contingency, NIAS placed Ambulance Receivers in hospital EDs. Their role was to take the patient from the ambulance crew, reducing ambulance delays at hospital and letting the crew return to service ready for their next call. NIAS is also participating fully in a regional initiative to address this issue being led by the HSCB and PHA.

The main reason for the deteriorating Category A performance is the disparity between demand and capacity. NIAS went through a formal consultation process on the new Clinical Response Model and received favourable feedback. In addition to more accurately targeting the most clinically urgent calls, the proposal also identifies the need for significant additional staff resources. The model will be reviewed in light of the consultation and submitted to HSCB and the DoH for approval in 2019-20.

Health and Wellbeing

NIAS has increasingly placed a strong focus on staff engagement, and Health and Wellbeing outcomes for staff. This agenda is a core element of NIAS' organisational development agenda.

For example, NIAS has established a Health and Wellbeing Partnership with UNISON. This has involved a joint union/NIAS staff survey, which was developed in partnership and is administered with union colleagues. The survey results have been used to ascertain and analyse detailed information from staff about issues related to wellbeing and welfare. Seven NIAS pilot locations throughout Northern Ireland saw participation of around 200 completed surveys. This process took place over three months from December 2017 – February 2018, having been launched jointly by the then Chief Executive of NIAS and the Regional Secretary of UNISON. This was publicised by NIAS social media and internal communications. Trade union officials conducted the circulation of the survey, with communications / awareness support being provided by NIAS HR. A joint Steering Group has considered the detailed analysis of the results to help inform future actions. Since quarter three in 2018-19, a range of action points have been agreed under the Partnership, which are focussed on training, empowerment, communications, and health and wellbeing initiatives. These have been communicated to staff and a work-plan has been agreed.

A peer support pilot project has been developed which has involved substantial staff engagement, project development work, and external partnering with public sector colleagues, to benchmark and build on best practice for NIAS in relation to systems of peer support, stress management and trauma response. A number of large and intensive staff engagement workshops took place in 2017 and 2018 to inform, discuss and encourage involvement in the forthcoming Pilot project. These have been supplemented by communiques, social media and internal communications. A first cohort of peer support volunteers were trained in October 2018. This team have been facilitating support to

significant numbers of staff colleagues following a ‘soft launch’ in November 2018. It is intended that further resources and training will be invested in the peer support project in 2019-20, in order to embed its beneficial impact.

These specific initiatives are in addition to wider ongoing work around health and wellbeing in NIAS. A full project plan for the development of mainstream health and wellbeing will be developed under a new Health and Wellbeing Project Manager who has been recruited and will commence work in quarter one of 2019-20. In addition, this core work will form part of the wider Good Attendance Programme, with a standalone project therein on health and wellbeing.

Attendance Management

Sickness levels within NIAS remain unacceptable, which has the potential to diminish levels of operational cover and affects the ability to respond in a timely manner.

NIAS' sickness absence target for 2018-19, as agreed with the DoH, is to 'improve sick absence rates by 5% on 2017-18 levels'. The cumulative absence rate during 2017 -18 was 10.5%. The requirement in 2018-19 was to achieve an absence rate of 9.97%, however, the cumulative absence level at March 2019 was 11.48%.

In recognition of the higher than average levels of sickness absence across the HSC and NHS Trusts, in November 2018, the Trust invited the Association of Ambulance Chief Executives (AACE) to assist and review its management of attendance (with a particular focus on operational front-line and control room staff).

In February 2019 the Trust Board considered and accepted the AACE findings and recommendations for improving attendance levels within NIAS. A Programme Board and related structures have now been established to take forward priority work streams identified from AACE recommendations, together with recommendations made by Internal Audit following their review of NIAS Absence Management in October / November 2018 which provided only limited assurance to the Trust. These measures are in addition to those identified as part of the Demand and Capacity Review and associated Performance Improvement Plan.

Infection Prevention and Control / RQIA

Following an invitation from NIAS, RQIA has carried out a number of unannounced inspections for Infection Prevention and Control (IPC) across the region since 2017. A number of inspections highlighted concerns regarding monitoring and assurance mechanisms for hygiene, cleanliness and IPC at station and vehicle level. At organisational level concerns were identified regarding governance systems, audit and assurance, education and training and access to expertise in

hygiene, cleanliness and IPC across NIAS. A number of improvement notices were issued between July 2017 and February 2018 and RQIA recommended the implementation of a special measure including the provision of Trust lead for IPC.

It is testament to the hard work of all staff that RQIA have noted a significant improvement regionally in the standard of IPC knowledge and practice across NIAS, as well as recognising much better systems of governance and assurance to maintain this progress. The RQIA has now removed all the previous improvement notices and replaced them with a single notice relating to the further embedding of training and governance across the organisation.

NIAS has submitted a business case to underpin all of this progress which has required the employment of staff dedicated to vehicle cleaning (this having previously been performed by operational staff), upgrading of facilities across stations and further training across the organisation and the employment of a full time organisation lead for IPC matters.

Building Leases

The Trust was previously not compliant with current policies and guidance relating to the acquisition, renewal and disposal of leased property assets including PEL 98/1 and PEL (11) 01 and the DoF DAO letter. Strategic Outline Case's (SOC) and Outline Business Cases (OBC) were not completed nor were Land and Property Services (LPS) requested to perform scoping exercises prior to the renewal of leases for ambulance stations.

The Trust has currently thirteen Commercial leases and is now compliant with current policies and guidance relating to the acquisition, renewal and disposal of leased property assets (including PEL 98/1 and PEL (11) 01) in twelve cases with the remaining one Strategic Outline Case (SOC) still in process with the Landlord. All submitted SOCs, were completed with appropriate input from LPS and BSO's Directorate of Legal Services (DLS) to ensure value for money and compliance.

The Trust has processes in place to actively manage the critical lease dates in compliance with current lease policy, particularly in relation to SOC, OBC, Termination, Renewals, Break Points and interacting with other statutory bodies as required. The Trust has created a series of warnings and events on the 3i Estate Terrier property management system to give notice that action will be required, covering all of the critical lease points above for all commercially leased properties.

EU Exit

In light of the potential for no-deal EU exit, NIAS has worked with the DoH to put in place any required mitigation against issues such as possible delay in supply chains for medicines and equipment and disruption in cross-border travel. Trust representatives will continue to monitor the situation and have

already met with counterparts in the National Ambulance Service of Ireland to ensure that Memoranda of Understanding for cross border emergency and contingency work are in place.

The Community Paramedic project is part financed by the European Union's European Regional Development Fund through the INTERREG VA Cross - border programme managed by the Special EU Programmes Body (SEUPB) (2019: £97k, 2018: £115k).

Identification of new issues in the current year and anticipated future issues

Financial Position 2019-20

In the continuing absence of an Executive and a sitting Assembly the Northern Ireland Budget Act 2018 was progressed through Westminster, receiving Royal Assent on 20th July 2018, followed by the Northern Ireland Budget (Anticipation and Adjustments) Act 2019 which received Royal Assent on 15th March 2019. The authorisations, appropriations and limits in these Acts provide the authority for the 2018-19 financial year and a vote on account for the early months of the 2019-20 financial year as if they were Acts of the Northern Ireland Assembly.

There are a range of challenges expected in 2019-20 and achieving savings and delivering financial balance is an increasing challenge.

While the Trust achieved a breakeven financial position in the year to 31 March 2019, it is important to note that this was achieved following the receipt of significant non-recurring funding, one off contingency measures, expenditure reductions and planned in year slippage on investment. As a result the Trust is aware of the underlying recurrent deficit position it faces, which, coupled with further in-year emergent pressures, ensure that the significant budgetary challenges continue into 2019-20.

The outlook for 2019-20 is indicating the financial year's resources will also be increasingly constrained, both from a capital and revenue perspective.

Given the level of the significant and ongoing financial challenges currently faced across HSC, extensive budget planning work is therefore on-going between the Trust, HSCB and DoH in order to achieve a 2019-20 financial plan. It is anticipated that when the overall Financial Position of the Trust is brought together, the Trust will still carry a significant recurrent and in year 2019-20 deficit, however the Trust remains committed to working with the DoH and HSCB in seeking to find solutions to enable it to live within its budget.

Emergency Ambulance Control Telephone Contingency

Ambulance Services experience occasional mismatch between the number of incoming calls and the number of available call-takers and NIAS has arrangements to manage this situation. The arrangements are coordinated by the BT Emergency Operators. When calls are queuing to be answered by NIAS Emergency Ambulance Control, the BT Operators can divert them to our buddy service, the Scottish Ambulance Service who answer them for us and then electronically pass the resulting call details onto our Computer Aided Dispatch (CAD) system.

It was identified internally that 999 callers were being put through to a telephone queue rather than to our buddy service as part of an internal BT-driven demand management process which kept the BT Operators from being available due to holding 999 ambulance calls. The effect of being placed into a telephone queue was to disable our buddy back-up system with the Scottish Ambulance Service. Callers in this queue waited for considerably longer than we anticipated. We reviewed this situation with BT and while they retain their demand management process for times of significant pressure, it cannot be implemented for lengthy periods of time or without consultation with Control Management.

Cyber Security

Cyber security remains a key focus for NIAS and the wider HSC given threats to systems such as the 'Wannacry' cyber-attack, which had a major impact worldwide most notably with the NHS UK in May 2017. A work programme has been developed in conjunction with regional frameworks to examine Trusts, readiness to respond to such events. This will identify ways to enhance the security of key clinical systems and associated information.

Workforce Pressures - Potential recruitment of NIAS Paramedics to Primary Care

In order to address capacity pressures in Primary Care there is an increasing potential for NIAS to lose experienced Paramedics to GP Federations, GP Practices and Out-of-Hours providers. Given the current staffing position within NIAS and the challenges to maintain safe levels of cover, discussions are ongoing with HSCB to ensure a planned approach to the development of appropriate Paramedic roles to support Primary Care. This needs to be managed in a way that will stabilise the NIAS workforce and associated clinical skill mix to protect emergency response capacity for those patients who require it. We will continue to work collaboratively with Primary Care to identify any potential opportunities to work collaboratively to resolve the issue.

Organisational Capacity

There is increasing recognition of the central role that NIAS and its staff have to contribute to the wider transformation agenda, in particular to manage demand within the community with

less reliance on secondary care. Recent developments and pilot initiatives such as the introduction of Appropriate Care Pathways, Clinical Support Desk, work to provide a more appropriate response to frequent callers and the Multi-Agency Triage Team (MATT) to more effectively respond to patients with mental health needs have all demonstrated the potential opportunities.

There is currently insufficient management capacity in the Trust for NIAS to fully maximise the opportunities these and other initiatives present, as well as being able to effectively manage the implementation of the proposed new Clinical Response Model. The recent approval by DoH of two additional Senior Executive posts will help to address this. To establish the extent of additional management capacity required to effectively take forward these opportunities, AACE has been commissioned to undertake a review to benchmark NIAS management and support staffing levels with comparable UK ambulance services. The findings of this review will be considered by the Trust Board, and discussed as required with HSCB and DoH colleagues.

Condition of Estate

The Northern Ireland Ambulance Service operates from a total of 62 Sites throughout Northern Ireland. There are 58 Operational facilities including 34 Ambulance Stations, 22 Deployment Points and 2 Control Centres. The majority of the NIAS Estate is in overall poor condition, as highlighted in the DoH State of the Estate Report with functional suitability, capacity and compliance issues recorded at most sites. During 2019-20, NIAS plans to develop a revised estates strategy to address not only the condition of the estate, but also the new service delivery model (Clinical Response Model) and to introduce the concept of “Make Ready” to improve operational efficiency.

Confidence and Supply

A condition of the confidence and supply funding to the Trust was approval of each business case by the Trust Senior Management Team and then HSCB approval by 31 March 2019. Of the total two NIAS specific schemes (total value £2.1m), only one (value £1.7m) had been approved by both the Trust Senior Management Team and HSCB by 31 March 2019. The remaining NIAS specific scheme (value £0.4m) had not had the business case formally approved by the Trust Senior Management Team or HSCB by 31 March 2019. The Trust expects both its Senior Management Team and HSCB to approve the outstanding business case in 2019-20. In addition, during the year the Trust benefitted from confidence and supply funding for a further four projects (value £0.1m). These initiatives involved multiple

organisations and the approval of business cases was coordinated regionally with funds allocated to individual organisations.

Incident Management (including Serious Adverse Incidents)

The Trust is currently unable to comply with the regional Serious Adverse Incident (SAI) procedure, particularly in terms of timescales for reporting and final review of incidents and for family engagement. These issues were highlighted during a recent internal audit into the management of complaints, litigation and incidents which also identified the lack of resources within the Trust's Medical Directorate and an increase in the reporting of SAIs. The Trust is taking steps to address these issues including: a Station Officer now providing support one day a week; support from the HSC Leadership Centre; a SAI lead to be in post in September 2019; and a recruitment process for an Assistant Medical Director to be completed in 2019-20.

Complaints Management

The Trust has received an unacceptable level of assurance in relation to its complaints management process. One significant finding and three priority 1 audit recommendations were identified in relation to: timeliness; the investigation process; and related learning. To address these issues, NIAS has developed an action plan and has engaged 2 additional temporary staff to ensure capacity to deliver related actions. The Trust's revised policy & procedure is currently out for consultation and will be tabled at the Trust Board meeting in August 2019 and rolled out thereafter. The policy, procedure and related guidance will address most of the priority 1 findings. The backlog of open complaints has been prioritised and a plan of action has been agreed to deliver this. Open complaints reporting will be enhanced by the August 2019 Trust Board meeting to reflect the new policy and procedures and agreed key performance indicators. The learning from incidents policy will be expanded to include learning from complaints to supplement and enhance current practice. NIAS are in the process of establishing a Patient Safety Directorate that will provide further focus on this area of business. The Trust participates in the HSC Regional complaints arrangements and have highlighted the requirement to review related training packages as part of its action plan. NIAS will ensure complaints awareness and related investigation training is prioritised within its mandatory training programme.

12. Conclusion

The Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money Northern Ireland (MPMNI).

Further to considering the accountability framework within the Trust, I have taken into consideration the limited assurance provided by the Head of Internal Audit. I have sought assurance from the Senior Executive Management Team (SEMT), that where significant findings have identified weaknesses in established controls, that appropriate mitigations and actions plans are in place to address audit recommendations and improve internal controls. In addition, the Trust is taking pro-active steps to identify any other potential control issues and will address these and strengthen the organisations accountability framework. On that basis, I am content that NIAS has operated a sound system of internal governance during the period 2018-19.

Mr Michael Bloomfield
Chief Executive
18 June 2019

Remuneration and Staff Report

Remuneration Report for the Year Ended 31 March 2019

Section 421 of The Companies Act 2006, as interpreted for the public sector, requires HSC bodies to prepare a Remuneration Report containing information about directors' remuneration. The Remuneration Report summarises the remuneration policy of the Northern Ireland Ambulance Service Health and Social Care Trust and particularly its application in connection with senior managers. The report must also describe how the Trust applies principles of good corporate governance in relation to senior managers remuneration.

Senior managers include the Chief Executive and the Executive Directors who operate at Board level and are listed overleaf and on page 33 of the Director's Report.

Remuneration Committee

The membership the Remuneration Committee is comprised exclusively of Non-Executive Directors and the Committee is chaired by the Chair of the Trust Board. Executive Director attendance is restricted to the Chief Executive and the Director of Human Resources and Corporate Services who absent themselves at appropriate points in the meeting to prevent any issues such as an actual or perceived conflict of interest arising.

It is recognised as best practice and is detailed within the Trust Standing Orders and the Audit Committee Terms of Reference that members of the Remuneration Committee should not also be members of the Audit Committee. Due to Non-Executive Director vacancies, the Trust had to place Mr A Cardwell, Non-Executive Director on the Audit Committee from March 2018 to May 2018 and Mr T Haslett, CBE on both the Audit Committee and Remuneration Committee from June 2018.

Remuneration Policy

The policy on the Remuneration of Directors and Senior Managers for current and future periods is governed and administered on the basis of the DoH Departmental Directives and Circulars on HSC Senior Executive Salaries. NIAS applies the Senior Executive Performance Management Scheme as set out within Departmental Circular HSS(SM) 1/2003. The circular sets out the following

requirements which are applied within the Trust:

- The Board determines the strategic and operational corporate objectives of the Trust for the year ahead taking into account the parameters established by the Department and incorporating them within the Trust Delivery Plan;
- The Chair agrees the Chief Executive's performance objectives, undertakes a review of performance and objectives, and completes a final report on the Chief Executive's performance each year;
- The Chief Executive agrees the individual performance objectives of Executive Directors, undertakes a review of performance and objectives, and completes a final report on Executive Director's performance each year;
- Senior Executives agree performance objectives with the Chief Executive, participate in reviews and take responsibility for personal development;
- Performance objectives are linked to Trust Delivery Plans and Strategic Plans. Performance objectives are clearly defined and measurable;
- Each Director's performance is reviewed by the Chief Executive on an annual basis. The approach adopted is based on an assessment of the Executive Director's contribution towards the achievement of agreed objectives aligned to the Trust's Strategic and Trust Delivery Plan. A similar approach is used by the Chair for the Chief Executive. Performance pay would be considered within the total pay limit determined by the DoH;
- The Remuneration Committee encourages effective appraisal of staff and scrutinises objectives for consistency, robustness and alignment with priorities. The Committee also ensures that a robust process has taken place and monitors for consistency of assessment before recommending overall banding and award for senior executives;
- The Remuneration Committee recommendations are presented to Trust Board for consideration and approval; and
- The Remuneration Committee awaits conformation from DoH in relation to outstanding executive pay awards for 2016-17, 2017-18 and 2018-19.

Service Contracts

The Trust Medical Director is employed under a contract issued in accordance with HSC Medical Consultant Terms and Conditions of Service (Northern Ireland) 2004. Three of the other Senior Executives in the year 2018-19 were employed on the pre 23 December 2008 Senior Executive Contract. Both the Chief Executive and the Acting Director of Human Resources and Corporate Services employed during the year were employed on the post 2008 Senior Executives Contract. The contractual provisions applied are those detailed and contained within Circular HSS (SM) 2/2001.

Directors

Non-Executive Directors

Mr Paul Archer, Chair, appointed on 16 October 2008 for a period of four years (extended from 16 October 2012 to 15 October 2016 with final extension to 30 June 2018).

Mrs Nicole Lappin, Chair, appointed on 1 July 2018 for a period of four years.

Mr Dale Ashford, Non-Executive Director, appointed on 16 April 2018 for a period of four years.

Dr Jim Livingstone, Non-Executive Director, appointed on 1 November 2012 for a period of four years (extended from 1 November 2014 to 30 October 2020). – Dr Livingstone stood down from this position on 28 February 2019.

Mr William Abraham, Non-Executive Director, appointed on 18 May 2015 for a period of four years.

Mr Trevor Haslett CBE, Non-Executive Director, appointed on 18 May 2015 for a period of four years.

Mr Alan Cardwell, Non-Executive Director, appointed on 1 August 2015 for a period of four years.

Mr Jim Dennison, Non-Executive Director, appointed on 1 March 2019 for a period of four years.

The terms and conditions applicable to Non- Executive Directors are issued by the DoH.

Executive Directors

Mr Michael Bloomfield, Chief Executive, appointed on 19 March 2018.

Mr Brian McNeill, Director of Operations, appointed 1 June 2005.

Dr Nigel Ruddell, interim Medical Director from 1 July 2017 and was appointed **Medical Director** 1 November 2018.

Mrs Sharon McCue, Director of Finance and Information Communications Technology, appointed 4 March 2002.

Ms Roisin O'Hara, Director of Human Resources & Corporate Services, appointed 1 March 2002.

Ms Michelle Lemon, Acting Director of Human Resources & Corporate Services, appointed from 20 September 2017 to 31 August 2018.

Duration of Contract

All Senior Executives are on permanent Contracts of Employment with continuation subject to satisfactory performance.

Notice Periods

A three-month' notice period is to be provided by either party except in the event of summary dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

Termination Payments (Audited)

Statutory provisions only as detailed in contract. There were no payments made to directors in respect of either compensation for loss of office or early retirement during 2018-19.

Senior Employees' Remuneration (Audited)

The salary, pension entitlements and the value of any taxable benefits in kind of the most senior members of the Trust were as follows:

	2018-19					2017-18				
Name	**Salary £000**	**Bonus / Performance pay £000**	**Benefits in Kind (Rounded to nearest £100)**	**Pensions Benefit (rounded to nearest £1,000)**	**Total £000**	**Salary £000**	**Bonus / Performance pay £000**	**Benefits in Kind (Rounded to nearest £100)**	**Pensions Benefit (rounded to nearest £1,000)**	**Total £000**
Non-Executive Members										
Paul Archer (left 30 Jun 2018)	5 - 10 (25 - 30*)	-	100***	-	0 - 5	25 - 30	-	100***	-	25 - 30
Nicole Lappin (from 1 Jul 2018)	15 - 20 (25 - 30*)	-	100***	-	15 - 20	-	-	-	-	-
Norman McKinley (to 7 Apr 2017)	-	-	-	-	-	0 - 5 (5-10*)	-	-	-	0 - 5
James Livingstone (to 28 Feb 2019)	5 - 10 (5-10*)	-	-	-	0 - 5 (5-10*)	5 - 10	-	-	-	5 - 10
Jim Dennison (from 1 Mar 2019)	0 - 5 (5-10*)	-	-	-	0 - 5 (5-10*)	-	-	-	-	-
William Abraham	5 - 10	-	-	-	5 - 10	5 - 10	-	100***	-	5 - 10
Trevor Haslett, CBE	5 - 10	-	100***	-	5 - 10	5 - 10	-	-	-	5 - 10
Dale Ashford (from 16 Apr 2018)	5 - 10	-	-	-	5 - 10	-	-	-	-	-
Alan Cardwell	5 - 10	-	100***	-	5 - 10	5 - 10	-	100***	-	5 - 10
Executive Members **										
Michael Bloomfield (from 19 Mar 2018)	90 - 95	0-5	300***	(54)	35 - 40	0 - 5 (90 - 95*)	0 - 5	-	-	0 - 5
Shane Devlin (to 18 Mar 2018)	-	-	-	-	-	70 - 75 (70 - 75*)	0 - 5	4600***	34	110 - 115
Sharon McCue	65 - 70 **** (70 - 75*)	0-5	100***	-	70 - 75	70 - 75	0 - 5	-	-	70 - 75
Roisin O'Hara	70 - 75	0-5	-	3	70 - 75	70 - 75	0 - 5	-	(20)	50 - 55
David McManus (to 31 May 2017)	-	-	-	-	-	15 - 20 (100 - 105*)	-	-	-	15 - 20
Brian McNeill	70 - 75	0-5	-	2	70 - 75	70 - 75	0 - 5	500***	-	70 - 75
Michelle Lemon (from 20 Sep 2017 to 31 August 2018)	20 - 25 (65 - 70*)	0-5	-	(2)	20 - 25	60 - 65 (60 - 65*)	0 - 5	-	14	70 - 75
Dr Nigel Ruddell (from 1 Jul 2017)	110 - 115	-	-	30	140 - 145	105 - 110 (110 - 115*)	-	-	43	145 - 150

Please note that the salary bandings for each board member within the remuneration table are reflective of estimated salary increases for the Senior Executive pay award payable from 1 April 2018. Approval in respect of the senior executive pay award for 2016-17, 2017-18 or 2018-19 was not received by the date of the accounts being prepared and as such the CETV values noted overleaf have been calculated using pre adjustment salary figures.

Bonuses relate to the performance in the year in which they become payable to the individual. The bonuses reported in 2018-19 relate to performance in 2017-18 and the comparative bonuses reported for 2017-18 relate to performance in 2016-17.

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increases or decreases due to a transfer of pension rights.

The single total figure of remuneration includes salary, bonus / performance pay, benefits in kind as well as pension benefits.

* denotes full-year equivalent salary.
** During the financial year there were a number of additions to the Executive membership of the Board as set out above and on page 65. The remuneration information disclosed above reflects the relevant directors' salaries on a pro-rata basis.
*** The monetary value of benefits in kind covers any benefits provided by the employer and treated by HM Revenue and Customs as a taxable emolument. These include for example, travel and cycle to work scheme.
**** Reduced hours from 1 January 2018.

Senior Employees' Pension (Audited)

	2018-19				
Name	Real Increase in Pension and Related Lump Sum at Age 60 £000s	Total Accrued Pension at Age 60 and Related Lump Sum £000s	CETV at 31/03/18 £000s	CETV at 31/03/19 £000s	Real Increase in CETV £000s
Executive Members					
Michael Bloomfield	(2.5 - 5) + lump sum of (10 - 15)	35 - 40 + lump sum of 95 - 100	707	744	(68)
Roisin O'Hara	0 - 2.5 + lump sum of (0 - 2.5)	25 - 30 + lump sum of 75 - 80	512	585	4
Brian McNeill	0 - 2.5 + lump sum of (0 - 2.5)	30 - 35 + lump sum of 90 - 95	660	751	12
Michelle Lemon	0 - 2.5 + lump sum of (0 - 2.5)	15 - 20 + lump sum of 30 - 35	199	246	12
Nigel Ruddell	0 - 2.5 + lump sum of 0 - 2.5	35 - 40 + lump sum of 90 - 95	576	695	29

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. In addition, no entries are provided in respect of pensions for Executive members who either leave the Trust's employment or reach the applicable pensionable age during the financial year.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2015 and do not take account of any actual or potential benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. However, the real increase calculation uses common actuarial factors at the start and end of the period so that it disregards the effect of any changes in factors and focuses only on the increase that is funded by the employer.

Negative Results

In some cases, the real increase in CETV and the pension benefits accrued for the single total figure of remuneration can be negative – that is, there can be a real decrease. This is particularly likely to happen during periods of pay restraint and/or where inflation is higher than pay increases.

The final salary pension of a person in employment is calculated by reference to their pay and length of service. The pension will increase from one year to the next by virtue of them having an extra year's service and by virtue of any pay rise during the year. Where there is no pay rise, the increase in pension due to extra service may not be sufficient to offset the inflation increase – that is, in real terms, the pension value can reduce, hence the negative values.

Fair Pay Disclosure (Audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

In accordance with Circular Reference: HSC(F) 23-2013 Amendment on Disclosure of Highest Paid Director and Median Remuneration, (Hutton Fair Pay review Disclosure) staff pay in March (excluding severance payments) should be annualised, and the salary of the highest paid Director is taken at the mid-point of the remuneration band as disclosed in the Senior Employees' Remuneration table. Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The table below outlines this relationship:

	2018-19	2017-18
Band of Highest Paid Directors Remuneration	£110k - £115k	£105k - £110k
Median Total Remuneration	£31,682	£33,345
Ratio	**3.55**	**3.22**

The midpoint of the remuneration band of the highest paid Director in the Northern Ireland Ambulance Service HSC Trust during the financial year was £112,500 (2018: £107,500). This was 3.55 times (2018: 3.22) the median remuneration of the workforce, which was £31,682 (2018: £33,345).

There is a small increase from 3.22 in 2017-18 to 3.55 in 2018-19 due to an increase in the banding of the highest paid director.

Remuneration ranged from £16,943 to £113,840 (2017-18, £14,948 to £105,633).

Staff Report

Number of Senior Staff by Band and Gender

	Executive Director		Non-Executive Director		Senior Staff*		Other Staff		TOTAL	
	No	As %age	No	As %age	No	As %age	No	As %age	No	As %age
Male	3	60.0%	5	83.3%	8	66.7%	941	70.2%	957	70.1%
Female	2	40.0%	1	16.7%	4	33.3%	400	29.8%	407	29.9%
TOTAL	**5**		**6**		**12**		**1,341**		**1,364**	

* Senior staff are considered to be those operating at Assistant Director level (Band 8b and above) and excludes those operating at Senior Manager level (Band 8a and below).

The information in the above table is taken from the Human Resources, Payroll & Travel System (HRPTS) and reflects the position of staff in post on 31 March 2019. The above figures reflect substantive posts and do not include dual employments.

Staff Policies Applied During 2018-19

NIAS is fully committed to complying with its responsibilities to promote Equality of Opportunity in line with employment law and best practice. Employment policies operate in line with the Trust's Equality of Opportunity and Equality Scheme.

During the reporting period 2018-19, a total of 81 applications were received from applicants who declared a disability. In this regard NIAS continued to meet its statutory responsibilities under the Disability Discrimination Act (NI) 1997 (DDA) by making reasonable adjustments both to the selection process itself and the appointment process.

NIAS also continues to support students attending training at the Regional Ambulance Training Centre (RATC) in respect of disabilities declared and makes appropriate reasonable adjustments to both learning and examination requirements.

During the same period NIAS continued to engage with employees where necessary to agree the provision of reasonable adjustments to their post/employment circumstances, under DDA, enabling their continued employment with the Trust.

Staff Costs (Audited)

Staff costs comprise:	2019 Permanently employed staff £000s	2019 Others £000s	2019 Total £000s	2018 Total £000s
Wages and salaries	45,401	2,124	47,525	44,994
Social security costs	4,718	0	4,718	4,623
Other pension costs	6,337	0	6,337	5,706
Sub-Total	**56,456**	**2,124**	**58,580**	**55,323**
Capitalised staff costs	0	0	0	(35)
Total staff costs reported in Statement of Comprehensive Net Expenditure	**56,456**	**2,124**	**58,580**	**55,288**
Less recoveries in respect of outward secondments			0	(34)
Total Net Costs			**58,580**	**55,254**

Staff costs include £nil (2018: £nil) relating to the Charitable Trust Funds.

There were no staff costs charged to capital projects during the year (2018: £35k).

The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension Scheme has been updated to reflect current financial conditions and (a change in financial assumption methodology) will be used in 2018-19 accounts.

Average Number of Persons Employed (Audited)

The average number of whole time equivalent persons employed during the year was as follows:	2019 Permanently employed staff No.	2019 Others No.	2019 Total No.	2018 Total No.
Medical and dental	2	0	2	1
Nursing and midwifery	1	0	1	0
Professions allied to medicine	0	0	0	0
Ancillaries	3	37	40	2
Administrative & clerical	83	33	116	113
Ambulance staff	1,131	10	1,141	1,102
Works	0	0	0	3
Other professional and technical	0	0	0	0
Social services	0	0	0	0
Other	0	0	0	0
Total Average Number of Persons Employed	**1,220**	**80**	**1,300**	**1,221**
Less average staff number relating to capitalised staff costs	0	0	0	(1)
Less average staff number in respect of outward secondments	0	0	0	(1)
Total Net Average Number of Persons Employed	**1,220**	**80**	**1,300**	**1,219**

The number of persons employed include £nil (2018: £nil) relating to the Charitable Trust Funds.

Off Payroll Engagements

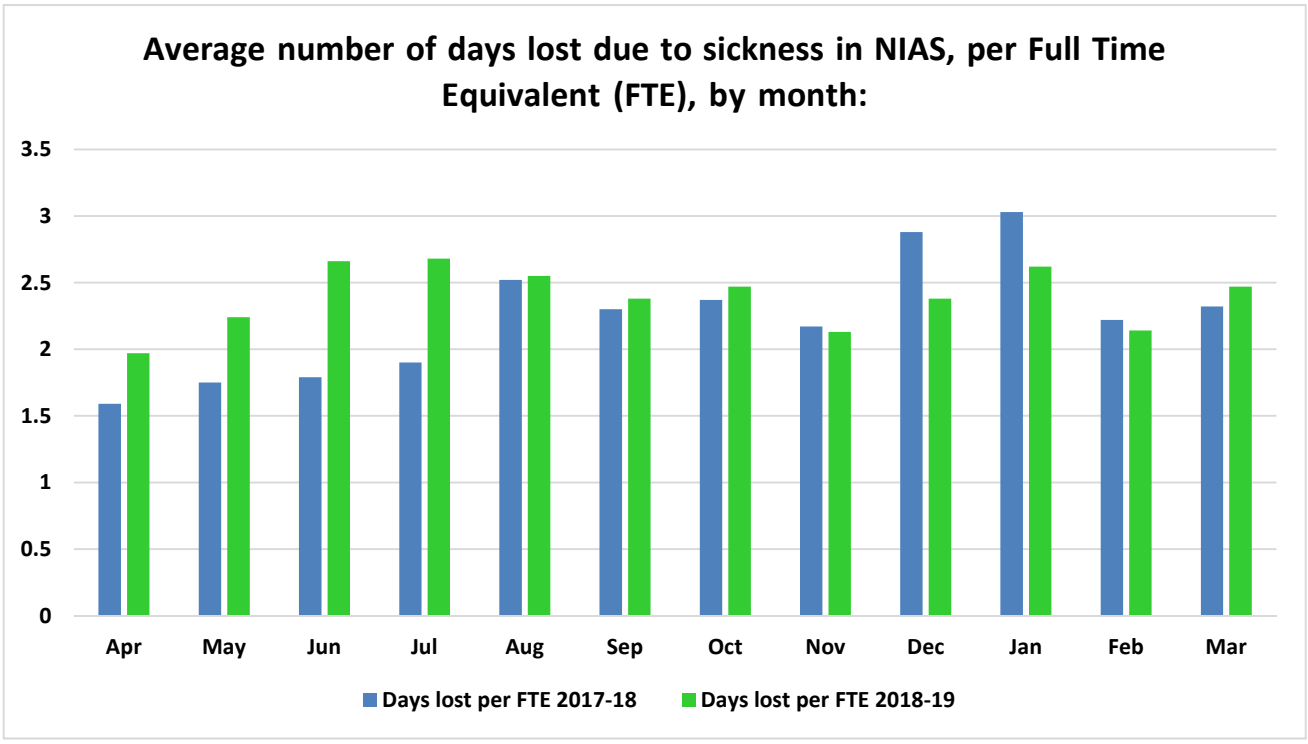
There were no 'off-payroll' engagements at a cost of over £58,200 per annum in place during the financial year (2018: nil).

Expenditure on Consultancy

The Trust spent £15,000 on consultancy during the financial year (2018: £20,197).

Sickness Absence Data

Attendance management continues to present a challenge to NIAS. NIAS sickness absence target for 2018-19, as established by the Department of Health (DoH), was "a 5% improvement on the 2017-18 performance". The sickness absence target for NIAS for 2018-19 was 9.97%. The monthly percentage absence recorded for March 2019 was 12.21%. Cumulatively at 31 March 2019, absence levels within NIAS were totalling 11.48%. Accordingly, the Trust did not achieve the 2018-19 target. However significant work has been undertaken within the Trust to address this which will continue to have a prioritised focus.



Reporting of Early Retirement and Other Compensation Scheme - Exit Packages (Audited)

During the financial year ending 31 March 2019, there were no compulsory redundancies, or other departures where the Trust agreed an exit package (2018: nil).

Redundancy and other departure costs are paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation Act 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at Note 3. Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The Northern Ireland Ambulance Service HSC Trust paid £nil staff benefits in 2019 (2018: £nil).

Trust Management Costs

	2019 £000s	2018 £000s
Trust management costs	5,293	4,782
Income:		
RRL	83,684	76,257
Income per Note 4	993	890
Non cash RRL for movement in clinical negligence provision	(177)	(46)
Less interest receivable	0	0
	84,500	77,101
Less adjustments as detailed in HSS (THR) 2/99	(585)	(32)
Total Income	**83,915**	**77,069**
% of total income	**6.31%**	**6.20%**

The above information is based on the Audit Commission's definition “M2” Trust management costs, as detailed in HSS (THR) 2/99. The adjustments above are exceptional items which may distort the management costs, for example, income from independent ambulance provider recharges to other Trusts and non-recurrent funding for projects undertaken.

Retirements due to Ill-health

During 2018-19 there was 7 early retirements from the Trust, agreed on the grounds of ill-health (2018: 1). The estimated additional pension liabilities of these ill-health retirements will be £22k (2018: £2k). These costs are borne by the HSC Pension Scheme.

ACCOUNTABILITY AND AUDIT REPORT

Funding Report

Regularity of Expenditure (Audited)

The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Northern Ireland Ambulance Service HSC Trust's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health.

The Chief Executive discharges these responsibilities through a governance framework that is tested regularly and on which annual independent assurances are obtained. This framework and the assurances obtained are set out in the Governance Statement for 2018-19 on pages 39 to 62.

The Comptroller and Auditor General provides an annual opinion to the Northern Ireland Assembly which includes an opinion on regularity. The full Certificate and Report of the Comptroller and Auditor General is set out on pages 77 to 79.

Fees and Charges (Audited)

The Northern Ireland Ambulance Service HSC Trust had no income generated from fees or charges during the year (2018: £nil).

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37, the Northern Ireland Ambulance Service HSC Trust also reports liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of a contingent liability. This is where it is not currently possible to quantify the potential impact or liabilities. See Note 21 on page 117 of the Annual Accounts for further information.

Losses and Special Payments (Audited)

Type of loss and special payment	2018-19		2017-18
	Number of Cases	£	£
Cash losses			
Cash Losses - Theft, fraud etc	0	0	0
Cash Losses - Overpayments of salaries, wages and allowances	0	0	0
Cash Losses - Other causes	0	0	0
	0	**0**	**0**
Claims abandoned			
Waived or abandoned claims	0	0	0
	0	**0**	**0**
Administrative write-offs			
Bad debts	0	0	0
Other	0	0	0
	0	**0**	**0**
Fruitless payments			
Late Payment of Commercial Debt	0	0	0
Other fruitless payments and constructive losses	1	24,905	750
	1	**24,905**	**750**
Stores losses			
Losses of accountable stores through any deliberate act	0	0	0
Other stores losses	0	0	0
	0	**0**	**0**
Special Payments			
Compensation payments			
- Clinical Negligence	1	5,437	18,031
- Public Liability	1	5,500	27,500
- Employers Liability	2	8,464	40,601
- Other	0	0	5,750
	4	**19,401**	**91,882**
Ex-gratia payments	**4**	**2,145**	**379**
Extra contractual	**0**	**0**	**0**
Special severance payments	**0**	**0**	**0**
TOTAL	**9**	**46,451**	**93,011**

Losses and Special Payments over £250,000 (Audited)

The Northern Ireland Ambulance Service HSC Trust did not make any individual payments for losses and special payments over £250k during the year (2018: £nil).

Special Payments (Audited)

The Northern Ireland Ambulance Service HSC Trust did not make any special payments or gifts during the year (2018: £nil).

Other Payments (Audited)

The Northern Ireland Ambulance Service HSC Trust did not make any other payments during the year (2018: £nil).

Mr Michael Bloomfield

Chief Executive

18 June 2019

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

NORTHERN IRELAND AMBULANCE SERVICE HEALTH AND SOCIAL CARE TRUST

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

Opinion on financial statements

I certify that I have audited the financial statements of the Northern Ireland Ambulance Service Health and Social Care Trust for the year ended 31 March 2019 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise: the Group and Parent Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes including significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of the group's and of the Northern Ireland Ambulance Service Health and Social Care Trust's affairs as at 31 March 2019 and of the group's and the Northern Ireland Ambulance Service Health and Social Care Trust's net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of this certificate. My staff and I are independent of the Northern Ireland Ambulance Service Health and Social Care Trust in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2016, and have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Other Information

The Trust and the Accounting Officer are responsible for the other information included in the annual report. The other information comprises the information included in the annual report other than the financial statements, the parts of the Accountability Report described in the report as having been audited, and my audit certificate and report. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Responsibilities of the Trust and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Trust and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

My objectives are to obtain evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the parts of the Accountability Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with the Department of Finance's guidance.

Report

I have no observations to make on these financial statements.

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

3 July 2019

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

FINANCIAL STATEMENTS

Consolidated Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

This account summarises the income generated and expenditure consumed on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

		2019 £000s		2018 £000s	
	NOTE	Trust	Consolidated	Trust	Consolidated
Income**					
Revenue from contracts with customers	4.1	744	744	638	638
Other operating income*	4.2	249	535	252	256
Total Operating Income		**993**	**1,279**	**890**	**894**
Expenditure					
Staff costs		(58,580)	(58,580)	(55,288)	(55,288)
Purchase of goods and services	3.1	(7,442)	(7,442)	(5,756)	(5,756)
Depreciation, amortisation and impairment charges	3.1	(6,536)	(6,536)	(6,282)	(6,282)
Provision expense	3.1	(652)	(652)	(228)	(228)
Other expenditures	3.1	(11,420)	(11,423)	(9,533)	(9,537)
Total Operating Expenditure		**(84,630)**	**(84,633)**	**(77,087)**	**(77,091)**
Net Operating Expenditure		**(83,637)**	**(83,354)**	**(76,197)**	**(76,197)**
Finance income	4.2	0	0	0	0
Finance expense	3.1	0	0	0	0
Net Expenditure for the Year		**(83,637)**	**(83,354)**	**(76,197)**	**(76,197)**
Revenue Resource Limit (RRL) and capital grants	24.1	83,684	83,684	76,258	76,258
Add back charitable trust fund net expenditure*		0	(283)	0	0
Surplus / (Deficit) against RRL		**47**	**47**	**61**	**61**

OTHER COMPREHENSIVE EXPENDITURE		2019		2018	
	NOTE	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Items that will not be reclassified to net operating costs:					
Net gain / (loss) on revaluation of property, plant and equipment	5.1-2 / 8.1	1,260	1,260	1,535	1,535
Net gain / (loss) on revaluation of intangibles	6.1-2 / 8.1	0	0	0	0
Net gain / (loss) on revaluation of charitable assets		0	3	0	0
Items that may be reclassified to net operating costs:					
Net gain / (loss) on revaluation of investments		0	0	0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March		**(82,377)**	**(82,091)**	**(74,662)**	**(74,662)**

The notes on pages 84 to 120 form part of these accounts.

* All donated funds have been used by Northern Ireland Ambulance Service Health and Social Care Trust as intended by the benefactor. The Trust Board as corporate trustee has delegated responsibility to the Director of Finance and ICT to manage internal disbursements. The Director of Finance and ICT ensures that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.
** Due to the implementation of IFRS 15, income for 2017-18 has been reclassified for comparative purposes. See Note 4 for further information.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Consolidated Statement of Financial Position as at 31 March 2019

This statement presents the financial position of the Trust. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

		2019		2018	
	NOTE	Trust	Consolidated	Trust	Consolidated
Non Current Assets		£000s	£000s	£000s	£000s
Property, plant and equipment	5.1-2	38,322	38,322	36,847	36,847
Intangible assets	6.1-2	364	364	573	573
Financial assets	7.1	0	297	0	11
Non current trade and other receivables	12.1	0	0	0	0
Other current assets	12.1	0	0	0	0
Total Non Current Assets		**38,686**	**38,983**	**37,420**	**37,431**
Current Assets					
Assets classified as held for sale	9.1	0	0	0	0
Inventories	10.1	101	101	106	106
Trade and other receivables	12.1	1,504	1,504	1,147	1,147
Other current assets	12.1	846	846	1,013	1,013
Current Intangible assets	12.1	0	0	0	0
Current Financial assets	7.1	0	0	0	0
Cash and cash equivalents	11.1	165	165	91	91
Total Current Assets		**2,616**	**2,616**	**2,357**	**2,357**
Total Assets		**41,302**	**41,599**	**39,777**	**39,788**
Current Liabilities					
Trade and other payables	13.1	(16,790)	(16,790)	(15,573)	(15,573)
Other liabilities	13.1	0	0	(2,261)	(2,261)
Intangible current liabilities	13.1	0	0	0	0
Provisions	15.1-5	(987)	(987)	(812)	(812)
Total Current Liabilities		**(17,777)**	**(17,777)**	**(18,646)**	**(18,646)**
Total Assets Less Current Liabilities		**23,525**	**23,822**	**21,131**	**21,142**
Non Current Liabilities					
Provisions	15.1	(2,981)	(2,981)	(2,684)	(2,684)
Other payables	13.1	0	0	0	0
Financial liabilities	7.1	0	0	0	0
Total Non Current Liabilities		**(2,981)**	**(2,981)**	**(2,684)**	**(2,684)**
Total Assets Less Total Liabilities		**20,544**	**20,841**	**18,447**	**18,458**
Taxpayers' Equity and Other Reserves					
Revaluation reserve		9,295	9,295	8,035	8,035
SoCNE reserve		11,249	11,249	10,412	10,412
Other reserves - charitable fund		0	297	0	11
Total Equity		**20,544**	**20,841**	**18,447**	**18,458**

The notes on pages 84 to 120 form part of these accounts.

The financial statements on pages 80 to 83 were approved by the Board on 18 June 2019 and were signed on its behalf by:

Ms Nicole Lappin
Chair
18 June 2019

Mr M Bloomfield
Chief Executive
18 June 2019

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Consolidated Statement of Cash Flows for the year ended 31 March 2019

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Trust during the reporting period. The statement shows how the Trust generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the Trust. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the Trust's future public service delivery.

	NOTE	2019 £000s	2018 £000s
Cash Flows from Operating Activities			
Net surplus after interest / Net operating expenditure		(83,354)	(76,197)
Adjustments for non cash costs		7,151	6,405
(Increase) / decrease in trade and other receivables		(190)	(1,444)
Less movements in receivables relating to items not passing through the Net Expenditure Account			
Movements in receivables relating to the sale of property, plant and equipment		0	0
Movements in receivables relating to the sale of intangibles		0	0
Movements in receivables relating to finance leases		0	0
Movements in receivables relating to PFI and other service concession arrangement contracts		0	0
(Increase) / decrease in inventories		5	(16)
Increase / (decrease) in trade payables		1,217	1,119
Less movements in payables relating to items not passing through the Net Expenditure Account			
Movements in payables relating to the purchase of property, plant and equipment		(733)	2,315
Movements in payables relating to the purchase of intangibles		0	0
Movements in payables relating to finance leases		0	0
Movements in payables relating to PFI and other service concession arrangement contracts		0	0
Use of provisions	15.1-5	(180)	(259)
Net Cash Inflow / Outflow from Operating Activities		**(76,084)**	**(68,077)**
Cash Flows from Investing Activities			
(Purchase of property, plant & equipment)	5.1	(5,792)	(9,212)
(Purchase of intangible assets)	6.1	(17)	(373)
Proceeds of disposal of property, plant & equipment		65	113
Proceeds on disposal of intangibles		0	0
Proceeds on disposal of assets held for resale		0	17
Drawdown from investment fund		(283)	0
Share of income reinvested		0	0
Net Cash Outflow from Investing Activities		**(6,027)**	**(9,455)**
Cash Flows from Financing Activities			
Grant in aid		82,185	77,505
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		0	0
Net Financing		**82,185**	**77,505**
Net Increase / (Decrease) in Cash & Cash Equivalents in the Period		**74**	**(27)**
Cash & Cash Equivalents at the Beginning of the Period	11.1	**91**	**118**
Cash & Cash Equivalents at the End of the Period	11.1	**165**	**91**

The notes on pages 84 to 120 form part of these accounts.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

This statement shows the movement in the year on the different reserves held by the Trust, analysed into the SoCNE Reserve (which reflects a contribution from the Department of Health). The SoCNE Reserve represents the total assets less liabilities of the Trust, to the extent that the total is not represented by other reserves and financing items. The Revaluation Reserve reflects the change in asset values that have not been recognised as income or expenditure. The Charitable Fund Reserve reflects the total value of charitable donations received by the Trust which have yet to be utilised.

	NOTE	SoCNE Reserve £000s	Revaluation Reserve £000s	Charitable Fund £000s	Total £000s
Balance at 31 March 2017		**8,595**	**6,819**	**11**	**15,425**
Changes in Taxpayers Equity 2017-18					
Grant from DoH		77,505	0	0	77,505
Other reserves movements including transfers		319	(319)	0	0
Actuarial gain / (loss)		0	0	0	0
(Comprehensive expenditure for the year)		(76,197)	1,535	0	(74,662)
Transfer of asset ownership		165	0	0	165
Non cash charges - auditors remuneration	3.1	25	0	0	25
Movement - other		0	0	0	0
Balance at 31 March 2018		**10,412**	**8,035**	**11**	**18,458**
Changes in Taxpayers Equity 2018-19					
Grant from DoH		82,185	0	0	82,185
Other reserves movements including transfers	13.2	2,261	0	0	2,261
Actuarial gain / (loss)		0	0	0	0
(Comprehensive expenditure for the year)		(83,637)	1,260	286	(82,091)
Transfer of asset ownership		0	0	0	0
Non cash charges - auditors remuneration	3.1	28	0	0	28
Balance at 31 March 2019		**11,249**	**9,295**	**297**	**20,841**

The notes on pages 84 to 120 form part of these accounts.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1. Authority

These financial statements have been prepared in a form determined by the Department of Health based on guidance from the Department of Finance's Financial Reporting manual (FReM) and in accordance with the requirements of Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the HSC Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. The have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assests and inventories.

1.2 Currency and Rounding

These accounts are presented in UK pounds sterling and rounded in thousands.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise: Land, Buildings, Dwellings, Transport Equipment, Plant & Machinery, Information Technology, Furniture and Fittings, and Assets under Construction.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £1,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or station, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as "under construction" are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (Statement of Asset Valuation Practice) Appraisal and Valuation Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance (DoF). The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Land and non-specialised buildings – open market value for existing use;
- Specialised buildings – depreciated replacement cost; and
- Properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to noncurrent assets.

Modern Equivalent Asset

DoF has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. LPS have included this requirement within the latest valuation.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

Assets Under Construction (AUC)

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Short Life Assets

Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where estimated life of fixtures and equipment exceed 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve

An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land, since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of “non-current assets held for sale” are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

The following asset lives have been used:

Asset Type	Asset Life
Freehold Buildings	15 - 70 years
Leasehold Property	Remaining period of lease
IT Assets	3 - 10 years
Intangible Assets	3 - 10 years
Other Equipment	3 - 15 years

1.5 Impairment Loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the Revaluation Reserve.

1.6 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure, which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the Trust's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible Assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, patents, goodwill and intangible assets under construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current Assets Held for Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land which is a non depreciating asset is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed necessary in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to determine whether the 5 essential criteria within the scope of IFRS 15 are met in order to define income as a contract. Income relates directly to the activities of the Trust and is recognised when, and to the extent that a performance obligation is satisfied in a manner that depicts the transfer to the customer of the goods or services promised. Where the criteria to determine whether a contract is in existence is not met, income is classified as Other Operating Income within the Statement of Comprehensive Net Expenditure and is recognised when the right to receive payment is established.

Grant in Aid

Funding received from other entities, including the Department and the Health and Social Care Board are accounted for as grant in aid and are reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The Northern Ireland Ambulance Service HSC Trust does not have any investments.

The Charitable Trust Funds are invested on behalf of the Northern Ireland Ambulance Service HSC Trust by the NIHPSS Common Investment Fund (see Note 1.26).

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1.12 Research and Development Expenditure

Following the introduction of the 2010 European System of Accounts (ESA10), from 2016-17 there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure.

The Northern Ireland Ambulance Service HSC Trust's expenditure on research and development during the year was £nil.

1.13 Other Expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.14 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus / deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

The Trust as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.16 Private Finance Initiative (PFI) Transactions

The Northern Ireland Ambulance Service HSC Trust has had no PFI transactions during the year.

1.17 Financial Instruments

- Financial Assets

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. IFRS 9 introduces the requirement to consider the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the HSC Body's assessment at the end of each reporting period as to whether the financial instrument's credit risk has increased significantly since initial recognition, based on reasonable and supportable information that is available, without undue cost or effort to obtain. The amount of expected credit loss recognised is measured on the basis of the probability weighted present value of anticipated cash shortfalls over the life of the instrument.

- Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

- Financial Risk Management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities.

Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

- Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

- Interest Rate Risk

The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

- Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

- Liquidity Risk

Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is therefore not exposed to significant liquidity risks.

1.18 Provisions

In accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using DoF-issued discount rates as at 31 March 2019 of:

Rate	**Time period**	**Real rate**
Nominal	Short term (0 – 5 years)	0.76%
	Medium term (5 – 10 years)	1.14%
	Long term (10 - 40 years)	1.99%
	Very long term (40+ years)	1.99%
Inflationary	Year 1	2.00%
	Year 2	2.00%
	Into perpetuity	2.10%

The discount rate to be applied for employee early departure obligations is +0.29% with effect from 31 March 2019.

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the affect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1.19 Contingent liabilities/assets

In addition to contingent liabilities disclosed in accordance with IAS 37, the Trust discloses for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly.

Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.20 Employee Benefits

Short-term Employee Benefits

Under the requirements of IAS 19 Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave (including untaken flexi leave) that has been earned at the year end. This cost has been calculated using actual staff numbers and costs applied to the actual untaken leave balance as at 31 March 2019. It is not anticipated that the level of untaken leave will vary significantly from year to year.

Retirement Benefit Costs

The Trust participates in the HSC Pension Schemes. Under these multi-employer defined benefit schemes both the Trust and employees pay specified percentages of pay into the schemes and the liability to pay benefit falls to the DoH. The Trust is unable to identify its share of the underlying assets and liabilities in the schemes on a consistent and reliable basis. Further information regarding the HSC Pension Schemes can be found in the HSC Pension Schemes Statement in the Departmental Resource Account for the Department of Health.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension scheme has been updated to reflect current financial conditions and (a change in financial assumption methodology) will be used in 2018-19 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

Charitable Fund Reserve

The Charitable Fund Reserve reflects the total value of charitable donations received by the Trust which have yet to be utilised.

1.22 Value Added Tax

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.23 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 23 to the accounts.

1.24 Government Grants

The note to the financial statements distinguishes between grants from the UK government entities and grants from the European Union.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1.25 Losses and Special Payments

Losses and special payments are items that the Northern Ireland Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments in the Assembly Accountability section of the Annual Report is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.26 Charitable Trust Account Consolidation

The Government's Financial Reporting Manual (FReM) consolidation accounting policy requires the Trust's financial statements to consolidate the accounts of controlled charitable organisations and funds held on trust. As a result the financial performance and funds have been consolidated. The Trust has accounted for these transfers using merger accounting as required by the FReM.

It is important to note however the distinction between public funding and the other monies donated by private individuals still exists.

The Board of the Northern Ireland Ambulance Service HSC Trust as corporate trustee has delegated responsibility to manage the internal disbursements of Charitable Trust Funds to the Director of Finance & ICT. The director ensures that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

All such funds are allocated to the area specified by the benefactor and are not used for any other purpose than that intended by the benefactor.

1.27 Accounting Standards that have been Issued but have not yet been Adopted

Under IAS 8 there is a requirement to disclose those standards which have been issued but not yet adopted.

The IASB issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards were effective with EU adoption from 1 January 2014.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A similar review in Northern Ireland, which will bring Northern Ireland Departments under the same adaptation, has been carried out and the resulting recommendations were agreed by the Executive in December 2016. With effect from 2020-21, the accounting boundary for Departments will change and there will also be an impact on Departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may change as a result of the new Standards.

IFRS 16 Leases replaces IAS 17 Leases and is effective with EU adoption from 1 January 2019. In line with the requirements of the FReM, IFRS 16 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2020.

Management consider that any other new accounting policies issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

NOTE 2 SEGMENTAL ANALYSIS

2.1 Analysis of Net Expenditure by Segment

For operational purposes, the services provided by the Northern Ireland Ambulance Service are broadly divided into emergency and non-emergency services. The Executive Directors along with Non Executive Directors, Chairman and Chief Executive form the Trust Board which co-ordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. As the Trust Board of the Northern Ireland Ambulance Service in its capacity as the 'Chief Operating Decision Maker' receives financial information for the Trust as a whole and makes decisions based on the provision of an ambulance service for the whole of Northern Ireland, it is appropriate that the Trust reports on a one operational segment basis.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

NOTE 3 STAFF COSTS AND OPERATING EXPENSES

3.1 Staff Costs and Operating Expenses

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Staff costs[1]:				
Wages and salaries	47,525	47,525	44,966	44,966
Social security costs	4,718	4,718	4,621	4,621
Other pension costs	6,337	6,337	5,701	5,701
Purchase of care from non-HSC bodies	3,267	3,267	2,638	2,638
Revenue grants to voluntary organisations	1,962	1,962	1,444	1,444
Capital grants to voluntary organisations	0	0	0	0
Personal social services	0	0	0	0
Recharges from other HSC organisations	829	829	828	828
Supplies and services - Clinical	2,347	2,347	1,456	1,456
Supplies and services - General	468	468	371	371
Establishment	1,924	1,924	1,527	1,527
Transport	4,361	4,361	4,334	4,334
Premises	2,388	2,388	1,694	1,694
Bad debts	0	0	0	0
Rentals under operating leases	142	142	142	142
Rentals under finance leases	0	0	0	0
Finance cost of finance leases	0	0	0	0
Interest charges	0	0	0	0
PFI and other service concession arrangements service charges	0	0	0	0
Research & development expenditure	0	0	0	0
Clinical negligence - other expenditure	0	0	0	0
BSO services	400	400	320	320
Training	458	458	304	304
Professional fees	131	131	144	144
Patients travelling expenses	0	0	0	0
Costs of exit packages not provided for	0	0	0	0
Elective care	0	0	0	0
Other charitable expenditure	0	3	0	4
Miscellaneous expenditure	222	222	193	193
Non Cash Items				
Depreciation	6,038	6,038	6,140	6,140
Amortisation	226	226	141	141
Impairments	272	272	1	1
(Profit) on disposal of property, plant & equipment (excluding profit on land)	(65)	(65)	(130)	(130)
(Profit) on disposal of intangibles	0	0	0	0
Loss on disposal of property, plant & equipment (including land)	0	0	0	0
Loss on disposal of intangibles	0	0	0	0
Increase / Decrease in provisions (provision provided for in year less any release)	660	660	257	257
Cost of borrowing of provisions (unwinding of discount on provisions)	(8)	(8)	(29)	(29)
Auditors remuneration	28	28	25	25
Add back of notional charitable expenditure	0	0	0	0
Total	**84,630**	**84,633**	**77,088**	**77,092**

[1] Further detailed analysis of staff costs is located in the Staff Report on page 71 within the Accountability Report.

In addition to the notional auditors remuneration above, during the year the Trust received services from its External Auditor (the Northern Ireland Audit Office) to the value of £1k (2018: nil) in respect of fees for the National Fraud Initiative 2018-19 exercise.

NOTE 4 INCOME

The implementation of IFRS 15 includes a 5 stage model for the recognition of revenue from contracts with customers. As a result of this the income for 2017-18 has been reclassified for comparative purposes.

4.1 Revenue from contracts with customers

	2019		Restated 2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
GB / Republic of Ireland Health Authorities	0	0	0	0
HSC Trusts	440	440	303	303
Non-HSC:- Private patients	0	0	0	0
Non-HSC:- Other	304	304	335	335
Clients contributions	0	0	0	0
Total	**744**	**744**	**638**	**638**

4.2 Other Operating Income

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Other income from non-patient services	249	249	167	167
Seconded staff	0	0	34	34
Charitable and other contributions to expenditure by core trust	0	0	0	0
Donations / Government grant / Lottery funding for non current assets	0	0	51	51
Charitable income received by charitable trust fund	0	286	0	4
Investment income	0	0	0	0
Research and development	0	0	0	0
Profit on disposal of land	0	0	0	0
Interest receivable	0	0	0	0
Total	**249**	**535**	**252**	**256**
TOTAL INCOME	**993**	**1,279**	**890**	**894**

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

NOTE 5 CONSOLIDATED PROPERTY, PLANT & EQUIPMENT

5.1 Consolidated Property, Plant & Equipment - Year Ended 31 March 2019

	Land £000s	Buildings (excluding dwellings) £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation								
At 1 April 2018	1,950	17,421	1,441	9,317	27,255	3,398	281	61,063
Indexation	762	492	0	104	516	0	2	1,876
Additions	0	0	3,113	35	2,862	515	0	6,525
Donations / Government grant / Lottery funding	0	0	0	0	0	0	0	0
Reclassifications	0	0	(1,394)	54	1,246	94	0	0
Transfers	0	0	0	0	(42)	0	0	(42)
Revaluation	85	0	0	0	0	0	0	85
Impairment charged to the SoCNE	0	(283)	0	0	0	0	0	(283)
Impairment charged to the revaluation reserve	0	(236)	0	0	0	0	0	(236)
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,627)	(42)	0	(1,669)
At 31 March 2019	**2,797**	**17,394**	**3,160**	**9,510**	**30,210**	**3,965**	**283**	**67,319**
Depreciation								
At 1 April 2018	0	1,295	0	5,997	15,041	1,811	72	24,216
Indexation	0	47	0	72	345	0	1	465
Reclassifications	0	0	0	0	0	0	0	0
Transfers	0	0	0	0	(42)	0	0	(42)
Revaluation	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	(11)	0	0	0	0	0	(11)
Impairment charged to the revaluation reserve	0	0	0	0	0	0	0	0
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,627)	(42)	0	(1,669)
Provided during the year	0	436	0	645	4,408	527	22	6,038
At 31 March 2019	**0**	**1,767**	**0**	**6,714**	**18,125**	**2,296**	**95**	**28,997**
Carrying Amount								
At 31 March 2019	**2,797**	**15,627**	**3,160**	**2,796**	**12,085**	**1,669**	**188**	**38,322**
At 31 March 2018	**1,950**	**16,126**	**1,441**	**3,320**	**12,214**	**1,587**	**209**	**36,847**
Asset Financing								
Owned	2,797	15,627	3,160	2,796	12,085	1,669	188	38,322
Finance leased	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0	0	0
Carrying Amount At 31 March 2019	**2,797**	**15,627**	**3,160**	**2,796**	**12,085**	**1,669**	**188**	**38,322**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £nil (2018: £nil).

During the year the Trust had assets funded from government grants to the value of £nil (2018: £51k), and no assets funded from donations (2018: £nil) or lottery funding (2018: £nil).

The carrying amount as at 31 March 2019 includes £nil (2018: £nil and 2017: £nil) relating to the Charitable Trust Funds.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

NOTE 5 CONSOLIDATED PROPERTY, PLANT & EQUIPMENT

5.2 Consolidated Property, Plant & Equipment - Year Ended 31 March 2018

	Land £000s	Buildings (excluding dwellings) £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation								
At 1 April 2017	1,785	12,798	5,696	5,744	25,399	3,239	234	54,895
Indexation	0	1,217	0	167	932	6	0	2,322
Additions	0	313	3,138	266	2,688	391	50	6,846
Donations / Government grant / Lottery funding	0	0	0	18	32	1	0	51
Reclassifications	0	3,093	(7,393)	3,122	1,178	0	0	0
Transfers	165	0	0	0	(456)	0	0	(291)
Revaluation	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	(1)	(1)
Impairment charged to the revaluation reserve	0	0	0	0	0	0	(2)	(2)
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(2,518)	(239)	0	(2,757)
At 31 March 2018	**1,950**	**17,421**	**1,441**	**9,317**	**27,255**	**3,398**	**281**	**61,063**
Depreciation								
At 1 April 2017	0	844	0	5,370	12,840	1,520	57	20,631
Indexation	0	84	0	109	587	6	0	786
Reclassifications	0	0	0	0	0	0	0	0
Transfers	0	0	0	0	(583)	0	0	(583)
Revaluation	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0	(1)	(1)
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(2,518)	(239)	0	(2,757)
Provided during the year	0	367	0	518	4,715	524	16	6,140
At 31 March 2018	**0**	**1,295**	**0**	**5,997**	**15,041**	**1,811**	**72**	**24,216**
Carrying Amount								
At 31 March 2018	**1,950**	**16,126**	**1,441**	**3,320**	**12,214**	**1,587**	**209**	**36,847**
At 1 April 2017	**1,785**	**11,954**	**5,696**	**374**	**12,559**	**1,719**	**177**	**34,264**
Asset Financing								
Owned	1,950	16,126	1,441	3,320	12,214	1,587	209	36,847
Finance leased	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0	0	0
Carrying Amount At 31 March 2018	**1,950**	**16,126**	**1,441**	**3,320**	**12,214**	**1,587**	**209**	**36,847**
Asset financing								
Owned	1,785	11,954	5,696	374	12,559	1,719	177	34,264
Finance leased	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0	0	0
Carrying Amount At 1 April 2017	**1,785**	**11,954**	**5,696**	**374**	**12,559**	**1,719**	**177**	**34,264**

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

NOTE 6 CONSOLIDATED INTANGIBLE ASSETS

6.1 Consolidated Intangible Assets - Year Ended 31 March 2019

	Software Licenses £000s	Information Technology £000s	Websites £000s	Development Expenditure £000s	Payments on Account & Assets under Construction £000s	Total £000s
Cost or Valuation						
At 1 April 2018	1,040	0	30	0	0	1,070
Indexation	0	0	0	0	0	0
Additions	17	0	0	0	0	17
Donations / Government grant / Lottery funding	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	(14)	0	0	0	0	(14)
At 31 March 2019	**1,043**	**0**	**30**	**0**	**0**	**1,073**
Amortisation						
At 1 April 2018	467	0	30	0	0	497
Indexation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	(14)	0	0	0	0	(14)
Provided during the year	226	0	0	0	0	226
At 31 March 2019	**679**	**0**	**30**	**0**	**0**	**709**
Carrying Amount						
At 31 March 2019	**364**	**0**	**0**	**0**	**0**	**364**
At 31 March 2018	**573**	**0**	**0**	**0**	**0**	**573**
Asset Financing						
Owned	364	0	0	0	0	364
Finance leased	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0
Carrying Amount At 31 March 2019	**364**	**0**	**0**	**0**	**0**	**364**

Any fall in value through negative indexation or revaluation is shown as an impairment.

During the year the Trust had no assets funded from donations, government grants or lottery funding.

The carrying amount as at 31 March 2019 includes £nil (2018: £nil and 2017: £nil) relating to the Charitable Trust Funds.

NOTE 6 CONSOLIDATED INTANGIBLE ASSETS

6.2 Consolidated Intangible Assets - Year Ended 31 March 2018

	Software Licenses £000s	Information Technology £000s	Websites £000s	Development Expenditure £000s	Payments on Account & Assets under Construction £000s	Total £000s
Cost or Valuation						
At 1 April 2017	668	0	30	0	0	698
Indexation	0	0	0	0	0	0
Additions	373	0	0	0	0	373
Donations / Government grant / Lottery funding	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	(1)	0	0	0	0	(1)
At 31 March 2018	**1,040**	**0**	**30**	**0**	**0**	**1,070**
Amortisation						
At 1 April 2017	327	0	30	0	0	357
Indexation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	(1)	0	0	0	0	(1)
Provided during the year	141	0	0	0	0	141
At 31 March 2018	**467**	**0**	**30**	**0**	**0**	**497**
Carrying Amount						
At 31 March 2018	**573**	**0**	**0**	**0**	**0**	**573**
At 1 April 2017	**341**	**0**	**0**	**0**	**0**	**341**
Asset Financing						
Owned	573	0	0	0	0	573
Finance leased	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0
Carrying Amount At 31 March 2018	**573**	**0**	**0**	**0**	**0**	**573**
Asset Financing						
Owned	341	0	0	0	0	341
Finance leased	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0
Carrying Amount At 1 April 2017	**341**	**0**	**0**	**0**	**0**	**341**

NOTE 7 FINANCIAL INSTRUMENTS

7.1 Financial Instruments

As the cash requirements of the Northern Ireland Ambulance Service HSC Trust are met through Grant-in-Aid provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the Trust's expected purchase and usage requirements and the Trust is therefore exposed to little credit, liquidity or market risk.

The Trust did not have any financial instruments as at 31 March 2019 (2018: £nil).

The Charitable Trust Funds has a share in the NIHPSS Common Investment Fund.

	Investments	
	2019 £000s	2018 £000s
Balance at 1 April	11	11
Additions	283	4
Disposals	0	(4)
Revaluations	3	0
Balance at 31 March	**297**	**11**
Trust	0	0
Charitable trust fund	297	11
	297	**11**

7.2 Market Value of Investments as at 31 March 2019

	Held in UK £000s	Held outside UK £000s	2019 Total £000s	2018 Total £000s
Investment properties	0	0	0	0
Investments listed on Stock Exchange	0	0	0	0
Investments in CIF	297	0	297	11
Investments in a Common Deposit Fund or Investment Fund	0	0	0	0
Unlisted securities	0	0	0	0
Cash held as part of the investment portfolio	0	0	0	0
Investments in connected bodies	0	0	0	0
Other investments	0	0	0	0
Total Market Value of Fixed Asset Investments	**297**	**0**	**297**	**11**

NOTE 8 IMPAIRMENTS

8.1 Impairments

	2019		
	Property, plant & equipment £000s	Intangibles £000s	Total £000s
Total value of impairments for the period	508	0	508
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	(236)	0	(236)
Impairments Charged / (Credited) to Statement of Comprehensive Net Expenditure	**272**	**0**	**272**

	2018		
	Property, plant & equipment £000s	Intangibles £000s	Total £000s
Total value of impairments for the period	2	0	2
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	(1)	0	(1)
Impairments Charged / (Credited) to Statement of Comprehensive Net Expenditure	**1**	**0**	**1**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2019

NOTE 9 ASSETS CLASSIFIED AS HELD FOR SALE

9.1 Assets Classified as Held for Sale

	Transport	
	2019 £000s	2018 £000s
Cost		
At 1 April	738	509
Transfers in	42	734
Transfers out	0	(278)
(Disposals)	(734)	(227)
Impairment	0	0
At 31 March	**46**	**738**
Depreciation		
At 1 April	738	382
Transfers in	42	734
Transfers out	0	(151)
(Disposals)	(734)	(227)
Impairment	0	0
At 31 March	**46**	**738**
Carrying Amount at 31 March	**0**	**0**

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

At 31 March 2019 non current assets held for resale comprise A&E Ambulances and other support vehicles.

Due to the specification of ambulance vehicles, their age and high mileage, the resale market is uncertain and most vehicles are sold through an auction house.

During the year ended 31 March 2019, vehicles with a fair value (less costs to sell) of £nil (2018: £nil) were sold.

The assets are valued at the lower of their carrying value (representing net book value) and fair value (less costs to sell).

NOTE 10 INVENTORIES

10.1 Inventories

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Pharmacy supplies	0	0	0	0
Theatre equipment	0	0	0	0
Building & engineering supplies	0	0	0	0
Fuel	26	26	20	20
Community care appliances	0	0	0	0
Laboratory materials	0	0	0	0
Stationery	14	14	14	14
Laundry	0	0	0	0
X-Ray	0	0	0	0
Stock held for resale	0	0	0	0
Orthopaedic equipment	0	0	0	0
Heat, light and power	0	0	0	0
Medical & surgical equipment	61	61	68	68
Other	0	0	4	4
Total	**101**	**101**	**106**	**106**

NOTE 11 CASH AND CASH EQUIVALENTS

11.1 Cash and Cash Equivalents

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Balance at 1st April	91	91	118	118
Net change in cash and cash equivalents	74	74	(27)	(27)
Balance at 31st March	**165**	**165**	**91**	**91**

The following balances at 31 March were held at:

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Commercial banks and cash in hand	165	165	91	91
Balance at 31st March	**165**	**165**	**91**	**91**

NOTE 12 TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

12.1 Trade Receivables, Financial and Other Assets

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Amounts Falling Due Within One Year				
Trade receivables	0	0	0	0
Deposits and advances	0	0	0	0
VAT receivable	875	875	828	828
Other receivables - not relating to fixed assets	578	578	251	251
Other receivables - relating to property plant and equipment	51	51	68	68
Other receivables - relating to intangibles	0	0	0	0
Trade and Other Receivables	**1,504**	**1,504**	**1,147**	**1,147**
Prepayments	846	846	1,013	1,013
Accrued income	0	0	0	0
Current part of PFI and other service concession arrangements prepayment	0	0	0	0
Other Current Assets	**846**	**846**	**1,013**	**1,013**
Carbon reduction commitment	0	0	0	0
Intangible Current Assets	**0**	**0**	**0**	**0**
Amounts Falling Due After More Than One Year				
Trade receivables	0	0	0	0
Deposits and advances	0	0	0	0
Other receivables	0	0	0	0
Trade and Other Receivables	**0**	**0**	**0**	**0**
Prepayments and accrued income	0	0	0	0
Other Current Assets Falling Due After More Than One Year	**0**	**0**	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**1,504**	**1,504**	**1,147**	**1,147**
TOTAL OTHER CURRENT ASSETS	**846**	**846**	**1,013**	**1,013**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**2,350**	**2,350**	**2,160**	**2,160**

The balances are net of a provision for bad debts of £nil (2018: £nil).

NOTE 13 TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

13.1 Trade Payables and Other Current Liabilities

	2019		2018	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Amounts Falling Due Within One Year				
Other taxation and social security	1,150	1,150	1,132	1,132
VAT payable	0	0	0	0
Bank overdraft	0	0	0	0
Trade capital payables - property, plant and equipment	4,493	4,493	3,760	3,760
Trade capital payables - intangibles	0	0	0	0
Trade revenue payables	2,657	2,657	2,373	2,373
Payroll payables	6,133	6,133	4,547	4,547
VER payables	0	0	0	0
BSO payables	23	23	1,749	1,749
Other payables	979	979	725	725
Accruals	1,355	1,355	1,287	1,287
Accruals - relating to property, plant and equipment	0	0	0	0
Accruals - relating to intangibles	0	0	0	0
Deferred income	0	0	0	0
Trade and Other Payables	**16,790**	**16,790**	**15,573**	**15,573**
Current part of finance leases	0	0	0	0
Current part of long term loans	0	0	2,261	2,261
Current part of imputed finance lease element of PFI contracts and other service concession arrangements	0	0	0	0
Other Current Liabilities	**0**	**0**	**2,261**	**2,261**
Carbon reduction commitment	0	0	0	0
Intangible Current Liabilities	**0**	**0**	**0**	**0**
Total Payables Falling Due Within One Year	**16,790**	**16,790**	**17,834**	**17,834**
Amounts Falling Due After More Than One Year				
Other payables, accruals and deferred income	0	0	0	0
Trade and other payables	0	0	0	0
Clinical negligence payables	0	0	0	0
Finance leases	0	0	0	0
Imputed finance lease element of PFI contracts and other service concession arrangements	0	0	0	0
Long term loans	0	0	0	0
Total Non Current Other Payables	**0**	**0**	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**16,790**	**16,790**	**17,834**	**17,834**

NOTE 13 TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

13.2 Loans

When the Trust was established in 1995 it was funded by originating capital, known as Public Dividend Capital (PDC) and also by a loan known as Interest Bearing Debt (IBD). After a change in the way the Trusts were financed in 2007-08 the PDC Reserve and the Income and Expenditure Reserve were replaced by what is now known as the Statement of Comprehensive Net Expenditure Reserve (SoCNE). The IBD balance for NIAS was retained / frozen as at 31 March 2007 with no further payments of interest or principle required.

In order to resolve this outstanding issue, the remaining loan balance has been cleared through the SoCNE Reserves in 2018-19. The Department of Health advised that as the loan has been frozen for a significant period of time, with no requirement to repay, this accounting treatment is appropriate.

	Government Loans	
	2019	2018
Amounts Falling Due:	£000s	£000s
In 1 year or less	0	2,261
Between 1 and 2 years	0	0
Between 2 and 5 years	0	0
In 5 years or more	0	0
Total	**0**	**2,261**

	2019	2018
	£000s	£000s
Wholly repayable within 5 years	0	2,261
Wholly repayable after 5 years, not by instalments	0	0
Wholly or partially repayable after 5 years by instalments	0	0
Total	**0**	**2,261**

Total repayable after 5 years by instalments	**0**	**0**
Loans wholly or partially repayable after 5 years:	**0**	**0**

Terms of Payment	Interest Rate
Originating Capital Debt	8.75%

NOTE 14 PROMPT PAYMENT POLICY

14.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that Trusts pay their non HSC trade payables in accordance with applicable terms and appropriate Government Accounting guidance. The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2019 Number	2019 Value £000s	2018 Number	2018 Value £000s
Total bills paid	22,662	57,625	18,712	51,952
Total bills paid within 30 days of receipt of an undisputed invoice*	21,132	54,674	17,493	49,398
% of bills paid within 30 days of receipt of an undisputed invoice	**93.2%**	**94.9%**	**93.5%**	**95.1%**
Total bills paid within 10 day target	14,909	47,767	12,442	41,247
% of bills paid within 10 day target	**65.8%**	**82.9%**	**66.5%**	**79.4%**

* New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

From 1 April 2015 the scope of the prompt payment compliance measurement increased to take account of all categories of supplier payments made by Trusts, with the only exception being payments made to other organisations within the broader HSCNI.

14.2 The Late Payment of Commercial Debts Regulations 2002

The Northern Ireland Ambulance Service HSC Trust paid no compensation or interest as a result of payments being paid late during the financial year (2018: £nil).

NOTE 15 PROVISIONS FOR LIABILITIES AND CHARGES

15.1 Provisions for Liabilities and Charges - 2019

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2019 £000s
Balance at 1 April 2018	0	0	103	3,393	3,496
Provided in year	0	0	185	500	685
(Provisions not required written back)	0	0	(1)	(24)	(25)
(Provisions utilised in the year)	0	0	(7)	(173)	(180)
Cost of borrowing (unwinding of discount)	0	0	(7)	(1)	(8)
At 31 March 2019	**0**	**0**	**273**	**3,695**	**3,968**

Provisions have been made for three types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, and Injury Benefit. The provision for Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Superannuation Branch. For Clinical Negligence, and Employer's and Occupier's claims, the Trust has estimated an appropriate level of provision based on professional legal advice.

The Trust has no provisions relating to either the Review of Public Administration or the Comprehensive Spending Review.

15.2 Comprehensive Net Expenditure Account Charges

	2019 £000s	2018 £'000
Arising during the year	685	297
Reversed unused	(25)	(40)
Cost of borrowing (unwinding of discount)	(8)	(29)
Total Charge within Operating Expenses	**652**	**228**

15.3 Analysis of Expected Timing of Discounted Flows - 2019

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2019 £000s
Not later than 1 year	0	0	205	782	987
Later than 1 year and not later than 5 years	0	0	21	674	695
Later than 5 years	0	0	47	2,239	2,286
At 31 March 2019	**0**	**0**	**273**	**3,695**	**3,968**

The provision in respect of other liabilities and charges comprises: £734k for Employer's and Occupier's Liability; and £2,961k for Injury Benefit.

NOTE 15 PROVISIONS FOR LIABILITIES AND CHARGES

15.4 Provisions for Liabilities and Charges - 2018

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2018 £000s
Balance at 1 April 2017	0	0	83	3,444	3,527
Provided in year	0	0	57	240	297
(Provisions not required written back)	0	0	0	(40)	(40)
(Provisions utilised in the year)	0	0	(26)	(233)	(259)
Cost of borrowing (unwinding of discount)	0	0	(11)	(18)	(29)
At 31 March 2018	**0**	**0**	**103**	**3,393**	**3,496**

Provisions have been made for four types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Injury Benefit and Industrial Tribunal. The provision for Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims, as well as Industrial Tribunal claims the Trust has estimated an appropriate level of provision based on professional legal advice.

15.5 Analysis of Expected Timing of Discounted Flows - 2018

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2018 £000s
Not later than 1 year	0	0	39	773	812
Later than 1 year and not later than 5 years	0	0	18	564	582
Later than 5 years	0	0	46	2,056	2,102
At 31 March 2018	**0**	**0**	**103**	**3,393**	**3,496**

The provision in respect of other liabilities and charges comprises: £734k for Employer's and Occupier's Liability; and £2,659k for Injury Benefit.

NOTE 16 CAPITAL COMMITMENTS

16.1 Contracted Capital Commitments at 31 March not otherwise included in these Financial Statements

	2019 £000s	2018 £000s
Property, plant & equipment	1,084	58
Intangible assets	125	0
	1,209	**58**

These contracted capital commitments largely relate to partially completed capital schemes recorded as assets under construction at 31 March 2019. £1,071k relates to the replacement of hardware infrastructure for Mobile Data Terminals and associated software and communications technology used within the ambulance fleet. £125k relates to ICT and £13k to Fleet and Estate. The Trust's fleet replacement strategy aims to replace 20% of the ambulance fleet annually. This involves the purchase of a base vehicle and subsequent conversion to a fully operational ambulance vehicle. The Trust purchased just under £1.2m of vehicle chassis in the 2018-19 financial year that will be converted into fully operational vehicles in 2019-20. There is no contractual commitment to this expenditure at 31 March 2019, however the Trust plans to complete the conversion of these vehicles in 2019-20 at an estimated cost of £2.3m.

NOTE 17 COMMITMENTS UNDER LEASES

17.1 Finance Leases

The Northern Ireland Ambulance Service HSC Trust has not entered into any finance leases as at either 31 March 2019 or 31 March 2018.

17.2 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise:	2019 £000s	2018 £000s
Land		
Not later than 1 year	0	0
Later than 1 year and not later than 5 years	0	0
Later than 5 years	0	0
	0	**0**
Buildings		
Not later than 1 year	148	135
Later than 1 year and not later than 5 years	195	282
Later than 5 years	0	9
	343	**426**
Other		
Not later than 1 year	0	0
Later than 1 year and not later than 5 years	0	0
Later than 5 years	0	0
	0	**0**

Obligations under operating leases for Ambulance Stations are recorded fully under Buildings, as the leases do not split the lease cost between land and buildings.

17.3 Operating Leases - Lessor Agreements

The Northern Ireland Ambulance Service HSC Trust has not entered into any lessor agreements as at either 31 March 2019 or 31 March 2018.

NOTE 18 COMMITMENTS UNDER PFI CONTRACTS AND OTHER SERVICE CONCESSION ARRANGEMENTS

18.1 PFI Contracts

The Northern Ireland Ambulance Service HSC Trust has not entered into any PFI contracts as at either 31 March 2019 or 31 March 2018.

NOTE 19 OTHER FINANCIAL COMMITMENTS

19.1 Other Financial Commitments

The Northern Ireland Ambulance Service HSC Trust has not entered into any non cancellable contracts (which are not leases or PFI and other service concession arrangements contracts) as at either 31 March 2019 or 31 March 2018.

NOTE 20 FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

20.1 Financial Guarantees, Indemnities and Letters of Comfort

The Trust has not entered into any of the following: quantifiable guarantees, indemnities or provided letters of comfort as at 31 March 2019 or 31 March 2018.

NOTE 21 CONTINGENT LIABILITIES

21.1 Contingent Liabilities

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

	2019 £000s	2018 £000s
Clinical negligence	55	40
Public liability	10	8
Employers' liability	47	33
Accrued leave	0	0
Injury benefit	0	0
Other	0	0
Total	**112**	**81**

The Trust continues with the agreed process in respect of Agenda for Change in partnership with Trade Unions. However, at this stage, there remain uncertainties over the outcome of the process and the Trust cannot establish the extent to which claims that could be made, nor can it make a reliable estimate of any potential claims under employment legislation that may arise. The current position in respect of Agenda for Change is outlined in more detail in the Governance Statement.

The discount rate which courts in England and Wales must take into account when awarding compensation for future financial losses in a lump sum in personal injury cases changed to (0.75)% in March 2017. The Government subsequently legislated to change how the rate in England and Wales is set and the first review of the rate in that jurisdiction under the new legal framework introduced by the Civil Liability Act 2018 is being carried out. The Department of Justice has power to prescribe the discount rate for Northern Ireland (in consultation with the Government Actuary and the Department of Finance). Secondary legislation to change the discount rate for Northern Ireland under the current legal framework has not been taken forward in the absence of a Minister, although the Department of Justice is keeping the rate under review in the context of the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018 and having regard to ongoing legislative developments in the rest of the UK. In these circumstances, it has not been possible at this time to quantify the potential impact on the Trust of any change in the discount rate. Changing the legal framework for setting the rate in Northern Ireland would require primary legislation.

The Trust is aware of a number of legal cases and appeals across the UK which are testing employment issues, for example payment of allowances or enhancements while on sick or annual leave. The Trust is working regionally with the Department of Health and Trade Union representatives to ascertain the impacts which these cases may have but are not in a position at this stage to quantify the liability and will keep the outcomes of these cases and their appeals under close review.

NOTE 21 CONTINGENT LIABILITIES

21.1 Contingent Liabilities (continued)

On 17th June 2019, the Court of Appeal ruled in respect of the Northern Ireland Industrial Tribunal's November 2018 decision on cases taken against the PSNI on backdated Holiday Pay. It is recognised that the final detail remains to be determined by the Industrial Tribunal who will be guided by the Court of Appeal's Judgement.

This is an extremely rare and complex case with a significant number of issues that still need to be resolved, including further legal advice with regards to the Judgement; the scope; timescales; process of appeals and engagement with Trade Unions. The legal issues arising from this judgment and the implications for the Northern Ireland Civil Service (NICS) and wider public sector will need further consideration. The Department of Finance (DoF) is leading a piece of work across the NICS, reviewing the implications for each of the major staffing groups across the public sector.

Until there is further clarity when this work has concluded, and based on the inherent uncertainties in the final decision that will be made, a reliable estimate cannot be provided at this stage.

NOTE 22 RELATED PARTY TRANSACTIONS

22.1 Related Party Transactions

The Trust is required to disclose details of transactions with individuals who are regarded as related parties consistent with the requirements of IAS24 - Related Party Transactions. This disclosure is recorded in the Trust's Register of Interests which is maintained by the Office of the Director of Finance and ICT and is available for inspection by members of the public.

The previous Chairman, Mr Paul Archer, who left on the 30 June 2018, holds a position as a Trustee of St Johns Ambulance (from 1 November 2017). During the year the Trust had transactions with St Johns Ambulance to the value of £45,915 (2018: £41,591) for the provision of non emergency patient transport to NIAS during periods of exceptional demand.

During the year, none of the other board members, members of the key management staff or other related parties has undertaken any material transactions with the Northern Ireland Ambulance Service HSC Trust.

The Northern Ireland Ambulance Service HSC Trust is an arms length body of the Department of Health and as such the Department is a related party and the ultimate controlling parent with which the Trust has had various material transactions during the year. During the year the Northern Ireland Ambulance Service HSC Trust has had a number of material transactions with other entities for which the Department is regarded as the ultimate controlling parent. These entities include the Health and Social Care Board, the other five HSC Trusts, the Regulation and Quality Improvement Authority and the Business Services Organisation.

NOTE 23 THIRD PARTY ASSETS

23.1 Third Party Assets

The Trust held £nil cash at bank and in hand at 31 March 2019 which relates to monies held by the Trust on behalf of patients (2018: £nil). The Trust does not hold any monies on behalf of patients due to the nature of the service provided.

NOTE 24 FINANCIAL PERFORMANCE TARGETS

24.1 Revenue Resource Limit

The Trust is given a Revenue Resource Limit which it is not permitted to overspend.

The Revenue Resource Limit (RRL) for the Northern Ireland Ambulance Service HSC Trust is calculated as follows:

	2019 £000s	2018 £000s
HSCB	76,448	69,904
PHA	85	0
SUMDE & NIMDTA	0	0
DoH (excludes non cash)	0	0
Other Government Departments	0	0
Non cash RRL (from DoH)	7,151	6,405
Total agreed RRL	**83,684**	**76,309**
Adjustment for income received re Donations / Government grant / Lottery funding for non current assets	0	(51)
Adjustment for Research and Development under ESA10	0	0
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	**83,684**	**76,258**

24.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2019 £000s	2018 £000s
Gross capital expenditure	6,542	7,219
Less charitable trust fund capital expenditure	0	0
(Receipts from sales of fixed assets)	0	0
Net Capital Expenditure	**6,542**	**7,219**
Capital Resource Limit	6,566	7,224
Adjustment for Research and Development under ESA10	0	0
Overspend / (Underspend) against CRL	**(24)**	**(5)**

NOTE 24 FINANCIAL PERFORMANCE TARGETS

24.3 Cumulative Break Even Performance

The Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25% of RRL limits.

	2019 £000s	2018 £000s
Net Expenditure	(83,637)	(76,197)
RRL	83,684	76,258
Surplus / (Deficit) against RRL	47	61
Break Even cumulative position (opening)	852	791
Break Even cumulative position (closing)	899	852

Materiality Test:

	2019 %	2018 %
Break Even in year position as % of RRL	0.06%	0.08%
Break Even cumulative position as % of RRL	1.07%	1.12%

The Department recognises a material surplus or deficit as 0.25% of RRL. The in year break even position is therefore not considered material for any of the last 5 years. The cumulative position at 31 March 2019 is £899k (1.07% of total revenue), which is considered material. This amount is the cumulative effect of non material surpluses building each year since the inception of the Trust.

NOTE 25 POST BALANCE SHEET EVENTS

25.1 Post Balance Sheet Events

There are no post balance sheet events having a material effect on the accounts.

Date Authorised for Issue

The Accounting Officer authorised these financial statements for issue on 3 July 2019.

Northern Ireland Ambulance Service HSC Trust

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TB/01/08/2019/03

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NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

Thursday 1 August 2019

Title:	Update on Actions to Address IA Findings on Incidents, Complaints and Litigation.
Purpose:	For noting (Public)
Content:	Updated Action Plan.
Recommendation:	
Previous Forum:	Assurance Committee
Prepared by:	Medical Director / Director of HR & CS
Presented by:	Medical Director / Director of HR & CS

1. INTRODUCTION & CONTEXT:

This report outlines the actions NIAS have taken and are planning to take to address the findings of the Internal Audit Report into:

1. Complaints
2. Incidents
3. Claims.

The Trust have given this the highest priority and detailed action plans in response to the Audit Report findings were developed immediately by the Medical Director and Director of Human Resources who currently have lead responsibility for SAIs and Complaints and Claims respectively. Progress is on track for many of the actions and this outlined below. Other actions, in particular addressing the backlog of complaints and SAI investigations, will require a longer timeframe although some progress is already evident and reflected in performance reports.

The report was considered at the Trust Assurance Committee and also at the Audit Committee on 12 March 2019. Subsequently a decision was made to hold an extraordinary meeting of the Assurance Committee on 4 April 2019 with a single item agenda to review the immediate actions being taken in response to the Audit Report. The Assurance Committee reviewed progress against the action plans again on 21 May 2019. This item will remain as a standing item on the Trust's Assurance Committee until such time as we are able to meet the recommendations of the Internal Audit findings, and provide assurance to the Department that we have effective arrangements in place to manage incidents and complaints, and to ensure learning is identified in a timely way and appropriate action taken to ensure the provision of safe, high quality care to our service users.

A detailed action plan in response to the Audit Report findings was developed immediately by the Medical Director and Director of Human Resources and Corporate Services, who currently have lead responsibility for SAIs and Complaints respectively. Progress is planned on a number of the actions and reflected in Section 2 of this update.

The Trust recognises the importance of learning from complaints, incidents and litigation and details of each are standing items on the agenda of the Assurance Committee. New SAIs are reported weekly at NIAS Senior Management Meeting and the Learning Outcomes Review Meeting will facilitate enhanced consideration in regard to these Internal Audit findings. It is proposed in the revised policy and procedures, to establish a related Review Group that will consider learning from Complaints, Concerns, Compliments and Claims, in advance of consideration at the Learning Outcomes Review Meetings.

One of the key findings of the Internal Audit Report is the delay in investigating both complaints and SAIs. The Trust recognises the importance of timely action, and the identification and implementation of learning across the organisation to reduce the likelihood of reoccurrence. One of the challenges we face in the timeliness of review of incidents and complaints is the need for input from operational managers in the context of many competing demands on their time as they address a wide range of operational issues. A significant proportion of incidents and complaints relate to specific recurring themes, in particular delayed response due to operational pressures, missed or late staff meal breaks and late shift finishes. These, along with the issue of verbal and physical abuse against staff, are already being reviewed through dedicated work streams within NIAS. This thematic approach will facilitate a focus to be applied to incidents that may occur in much smaller numbers, but which require direct and timely attention.

An external review of demand and capacity has commenced and early indications are that there is a shortfall in capacity in the areas of Governance and Complaints, the Trust will work to secure the funding required in this regard and will plan the resultant recruitment campaign, once approved. Trust Board are advised that action is being taken in the interim:-

- Additional staff were engaged through internal secondment and via agency recruitment or from the Leadership Centre to assist with delivering on the Internal Audit recommendations.
- Backfill arrangements have been put in place to facilitate the Complaints Manager being released from other duties for six months to focus on addressing the backlog of open complaints, transfer of learning and the roll out of Datix Web.
- Arrangements are being finalised to recruit an Assistant Medical Director and also an Assistant Clinical Director (from a paramedic background).
- The Trust have secured Departmental approval to appoint an additional Director post with specific responsibility for safety, quality, patient experience and improvement and arrangements are being finalised to enable recruitment.
- Training is being arranged for senior and middle managers in relation to the review of incidents, including identification and implementation of learning.

2. PROGRESS AGAINST ACTION PLAN AS AT JULY 2019:

1. Complaints:

PRIORITY	AUDIT RECOMMENDATION	PROGRESS AT JULY 2019	RAG
1	Management should urgently review and strengthen the complaints management process and ensure complaints are investigated promptly, consistently and competently.	Review completed, revised policy and procedure developed to address Internal Audit recommendations and to reflect DoH revised Guidance in relation to the Health & Social Care Complaints Procedure (1st April 2019). Related policy and procedure approved by SMT 16/7/19 and tabled for Trust Board approval 1/8/19.	On track
	• Address the issues with the central email system for receiving complaints	Protocol developed and implemented with effect from mid-June 2019.	Actioned
	• Reporting performance of the timeliness of all open complaints	Trust Board report has been enhanced to report on KPI for regional target timescales. Revised Escalation Plan included within Procedure.	On track
	• Taking urgent action to clear the backlog of open complaints focusing on the oldest first	Complaints Manager to focus on progressing current backlog of open complaints through to completion. An action plan has been developed in relation to the backlog and progress monitored accordingly. Some delays were experienced in recruiting a manager to enable the Complaints Manager to focus solely on this work, however, this commenced in June and progress on the action is reflected in the Trust Board Report. Time frame for clearing backlog revised to 31/10/19 due to delays in commencing and competing pressures.	On track
	• Reinforcing with relevant staff the importance of responding to complaints appropriately and in a timely manner	KPIs included in the procedure and will be further reinforced in the Mandatory Complaints Awareness training and Complaints Investigation training.	On track
	• Ensuring there is effective and timely communication with complainants	This is clearly detailed within the Procedure in terms of the roles & responsibilities of the Complaints Manager, Investigation Managers and Investigation Officers. Procedure tabled for Trust Board approval 1/8/19	On track
	• Providing relevant staff with appropriate training	A review of the appropriate training has been actioned and Complaints awareness and investigation training is reflected on the mandatory training matrix and will be reflected in the related L&D Plan 2019-2021. (The L&D plan is scheduled for approval at SMT on 23/7/19). This will be delivered and reported on through the agreed mechanisms, these include an Assurance Committee report. The current training packages have been reviewed in relation to the revised HSC Guidance. NIAS are also developing related e-learning package.	On track
	• Reviewing and updating the relevant procedure to ensure it is fit for purpose	Revised Policy & Procedure developed consulted on, agreed by SMT on 16/7/19 and tabled for approval at Trust Board meeting 1/8/19.	On track

PRIORITY	AUDIT RECOMMENDATION	PROGRESS AT JULY 2019	RAG
1	Management should review the adequacy of resources currently devoted to Complaints Management, Incidents Management and Claims Management	The Association of Ambulance Chief Executives (AACE) were asked to benchmark the NIAS corporate support functions against other comparable ambulance services nationally to identify areas that need to be further strengthened, including within our governance and complaints teams. While it will take time to put in place additional permanent posts to support the complaints management and SAI processes, we have taken a number of immediate actions to address the findings in the Internal Audit Report. This includes engaging 2 Agency staff to support the work attached to the Internal Audit findings. Engaging a consultant from the Leadership Centre to support the work in developing a Claims Policy and Procedure. As part of the development of the revised Concerns, Complaints and Compliments policy and procedures some bench marking was undertaken and related suggestions were provided to SMT on 16/07/19. The pending restructuring should inform the governance reporting lines more fully. The risk register reflects the related current capacity issues.	On track
1	Management should take action to strengthen learning in respect of complaints, incidents and claims particularly to enhance assurances that learning that has been identified has actually been taken forward and embedded in the organisation	The revised procedures, tabled for Trust Board approval 1/8/19 have included the setting up of a Concerns, Complaints, Compliments and Claims Review Group/s. SMT have been asked for nominations for the review group/s and subject to Trust Board approval this will be formalised to reflect appropriate membership and scheduled accordingly. The Learning Outcomes Review Group to be further developed to ensure specific sections are included on complaints, litigation, claims and patient experience work. Reporting to be expanded to include open and closed complaints and litigation cases in order to identify trends, related learning and actions. SMT agreed on 16/7/19 that the related Learning from Incidents Policy should be amended to reflected this enhancement.	On target
2	Management should ensure that DATIX-WEB is fully rolled out across all NIAS Directorates for complaints	Action plan developed to roll out DATIX-WEB by October 2019. Training has commenced with further sessions planned for week commencing 22/7/19.	On track

2. Incidents:

PRIORITY	AUDIT RECOMMENDATION	PROGRESS AT JULY 2019	RAG
	Address the backlog of overdue incident investigations.	A Station Officer is assisting with Serious Incident Investigations one day per week.	Actioned
	Work to address the timeliness of serious adverse incident investigations.	A consultant from the Leadership Centre is assisting for a period of 10 days (I have arranged for the individual to spend time in EAC and go out with a crew this month).	Actioned
	Trust to improve resourcing available for investigation and management of incidents.	The Job description for the Serious Incident Investigation Lead was forwarded to HR in October 2018 for AfC banding and has been agreed July 2019. Recruitment is now progressing through HRPTS.	In progress
		Appointment of Assistant Medical Director (part-time) progressing through recruitment following approval by Department.	In progress
		Appointment of Assistant Director, Paramedicine awaiting outcome of banding but recruitment agreed in principle by Department.	In progress
		Appointment of a Director of Quality, Patient Safety and Improvement has been approved in principle by Department.	In progress
	Trust-wide SAI procedure to be agreed and distributed.	SAI Procedure has now been agreed and implemented (May 2019).	Actioned
	SAI training for SEMT & NEDS to be provided	Leadership Centre has been engaged and confirmed dates for training awaited.	In progress
	SAI training to be provided for staff involved in investigation of incidents.	SAI Training for 69 members of staff took place in 2018. Further cohorts are planned.	Recurring

3. Claims:

PRIORITY	AUDIT RECOMMENDATION	PROGRESS AT JULY 2019	RAG
2	NIAS should review and strengthen their processes for managing claims.	Revised Claims Management Policy and Procedure has been developed, consulted on, approved at SEMT and tabled for approval at Trust Board 1/8/19. This reviews NIAS practice in relation to best practice and strengthens the process to address all related Internal Audit findings.	On track
	The approval of delegated authorisation limits for negotiating settlements.	Included in revised Policy and Procedure.	On track
	Developing the format, file structure and checklists of claims files.	Included in revised Policy and Procedure.	On track
	The process for regularly following up with BSO in respect of live cases.	Included in revised Policy and Procedure.	On track
	Ensure there is corporate visibility and reporting in respect of claims.	Included in revised Policy and Procedure.	On track
	Develop claims management policy and procedure	Included in revised Policy and Procedure.	On track

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NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING 1 AUGUST 2019

PRESENTATION OF PAPER

Title:	FRONTLINE OPERATIONAL RECRUITMENT ACTIVITY REPORT AS AT 24/7/19
Purpose:	TO ILLUSTRATE CURRENT PROGRESS IN RECRUITMENT OF STAFF TO FRONTLINE OPERATIONAL POSTS.
Content:	CURRENT STATUS OF RELEVANT RECRUITMENT EXERCISES INCLUDING RECRUITMENT STAGES, RELEVANT DATES AND NUMBERS.
Recommendation:	FOR NOTING.
Previous Forum:	N/A
Date of SEMT Approval:	N/A
Prepared and Presented by:	ROISIN O'HARA, EXECUTIVE DIRECTOR OF HR & CORPORATE SERVICES

FRONTLINE OPERATIONAL RECRUITMENT ACTIVITY REPORT AS AT 24/7/19

	Advertise	Close	Shortlist	Interview	Waiting List	Driving Assessment	Requisitions Submitted to RSSC	Conditional Offers Accepted	Pre-Employment Checks Outstanding				Final Offers Accepted	Training Start Date
									Candidate Documentation	Access NI	Pre-Employment Health Assessment	Issues Raised with Recruiting Manager		
ACA Trainee 1					Exp 19/07/19		3	2	0	0	0	1	1	05/08/2019
ACA Trainee 2					461 Exp 13/03/20	27-28/04/19	21	20	0	0	0	1	19	05/08/2019
ACA Qualified 1					7	N/A	6	4					1	N/A
ACA Qualified 2				6 20/07/2019		N/A								N/A
EMT Trainee 1					1 Exp 28/07/19		5	4						21/10/2019
EMT Trainee 2					21 Exp 07/03/20		20	20						21/10/2019
EMT Trainee 3					219 Exp 06/07/20	28 20-21/7/19								18/11/2019
EMT Qualified				27 10-11/7/19	15 Exp 11/07/20	N/A								N/A
Student Paramedic		117 15/07/2019	82 18/07/2019	82 13-29/08/19		N/A								30/09/2019 (Bridging) 06/01/2020 (FdSc)
Paramedic Qualified 1					2	N/A	19	17	1	2	1	0	14	12/08/2019 (2 unable to attend)
Paramedic Qualified/Pending Qualification 1					21 (19 UQ)	N/A	6	4	3	2	2	0	1	12/08/2019
Paramedic Qualified/Pending Qualification 2		23/08/2019	N/A			N/A								

= Information is not due/not available from RSSC

= Historic information which is no longer relevant

Please Note:

This information relates only to recruitment of frontline operational staff ie ACA's, EMT's and Paramedics.

Information is valid as at 24/07/19 only.

Information is currently manually collated through discussion with BSO Recruitment Shared Services Centre and relevant Recruiting Managers; regional work is ongoing to improve visibility of processes for client organisations via a system dashboard

Highlights:

466 applicants were invited to attend for interview for Trainee EMT in July 2019.

All activity is currently on track to meet training dates.

All candidates on EMT Trainee 1 and EMT Trainee 2 have been advised to pursue the attainment of their C1 driving licence to enable them to commence the relevant course.

Large waiting lists have been established duration to support ACA / EMT training courses planned for the next 9-12 months.

TB/01/08/2019/05

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Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Concerns, Complaints & Compliments Policy**		
Author:	Linda Rafferty, Programme Manager		
Ownership:	Michael Bloomfield, Chief Executive		
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28/05/19	V0.1	L Rafferty	Initial draft – circulated to SEMT and Complaints Manager
03/06/19	V0.2	L Rafferty	2nd draft – circulated to those listed in Consultation section

It should be noted that pending NIAS restructuring of Directorate roles and responsibilities that the following Trust Board accountabilities currently exist:	
Medical Director	Learning outcomes from Concerns, Complaints and Compliments
Director of Human Resources & Corporate Services	Complaints management system, policy and procedure
All Directors	Local performance management

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1.0 INTRODUCTION

The Northern Ireland Ambulance Service HSC Trust (hereinafter referred to as the Trust) recognises the need to have an effective process for managing concerns, complaints and compliments about any aspect of care or treatment provided across the organisation.

A high standard of concerns, complaints and compliments management will ensure that lessons are learned and shared, and improvements made to enhance the patient experience and quality of services provided.

In our patient-centred environment, patients, patient relatives, carers, advocates and other service users are encouraged to express their views about the treatment and services that they receive.

It is essential that all concerns and complaints are received positively, investigated promptly and thoroughly, and responded to sympathetically. Timely and effective action should be taken where appropriate to prevent recurrence when services provided have fallen below acceptable standards.

In addition to welcoming and valuing complaints and the resultant learning, the Trust values all compliments and places an emphasis on learning from the positive feedback received to further enhance our performance, the patient experience and the quality of services we provide.

1.1 Background:

Each Health and Social Care organisation in Northern Ireland has a legal duty to operate a complaints procedure which includes monitoring the effectiveness of the procedure and publicising arrangements for dealing with complaints.

Effective service user and public involvement is an important aspect of our governance arrangements, and as such helps us to improve the quality of the services we offer and safeguard high standards of care and treatment. This is why all complaints are encouraged, will be taken seriously and viewed as a positive opportunity for learning and improving services.

We recognise that complaints relating to our services represent only a small proportion of the total number of contacts between our staff and the public and that our staff continually strive to provide the highest possible standard of health and social care. Since our service users see our services from a different perspective, their views can provide a valuable insight for an organisation committed to continuous quality improvement.

This policy and supporting Concerns, Complaints and Compliments Procedure detail the Trust's arrangements for dealing with concerns, complaints and compliments received about any aspect of the services provided by or on behalf of the Trust.

1.2 Purpose:

The purpose of this policy and supporting procedure is to ensure that:

- robust complaint management and accountability arrangements are in place in accordance with the Trust's governance arrangements and the Department of Health's (DoH) "Guidance in Relation to the Health and Social Care Complaints Procedure" revised 01 April 2019[1];
- complaint management processes comply with the Parliamentary and Health Service Ombudsman's "Principles of Good Complaint Handling and Good Administration" February 2009[2] and the Health & Social Care (HSC) "Complaints Procedure Directions (NI)" 01 April 2009[3];
- complaints are handled in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame;
- staff are provided with a greater understanding and guidance on complaint management procedures within NIAS to ensure complaints are managed in a positive manner and that learning takes place;
- staff are provided with a greater awareness of the value the Trust places on acknowledging compliments and the importance of using the positive feedback we receive to further enhance the patient experience and quality of services provided.

1.3 Objectives:

The objectives of this policy and supporting procedure are to:

- ensure patients, patient relatives, carers, advocates and other service users are encouraged to provide feedback about their experiences of treatment and services – to tell us what is working well, help identify any potential service improvements, and help identify problems and risk – and that individuals will not be treated differently as a result of making a complaint;
- provide ease of access to those wishing to make a complaint;
- ensure the process for dealing with complaints is simple and straightforward;
- promote local, prompt resolution with involvement of the complainant at the core of the process, and encourages continuous learning and identification of improvements in the quality and safety of services

[1] DoH Guidance in Relation to the Health and Social Care Complaints Procedure revised 01 April 2019 https://www.health-ni.gov.uk/publications/hsc-complaints-standards-and-guidelines

[2] Parliamentary & Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration February 2009 https://www.ombudsman.org.uk/about-us/our-principles

[3] HSC Complaints Procedure Directions (NI) 01 April 2009 https://www.health-ni.gov.uk/publications/hsc-complaints-directions

throughout the Trust.

- ensure staff are aware of their roles and responsibilities in good customer care and complaints handling, including responding positively to concerns or complaints, actively listening, acknowledging, assessing, resolving and investigating concerns or complaints as quickly as possible;
- ensure responses to complaints are timely whilst being comprehensive, accurate and open with an emphasis on early resolution of the complaint;
- ensure complainants receive open, honest and proportionate responses to their concerns or complaints where mistakes are acknowledged, explanations are provided for what went wrong and appropriate and proportionate measures are considered to put things right;
- ensure staff and complainants are treated with the same open and fair approach;
- ensure complaints are used positively to support learning, continuously improve the services we provide and where possible to prevent a recurrence;
- promote a culture of openness, honesty and fairness when investigating all concerns and complaints;
- ensure compliments are appropriately recorded and acknowledged and positive feedback is used effectively to learn from good practice and continuously improve the quality of our services.

1.4 Definitions:

A **concern** is usually where an individual remarks, expresses an opinion or makes an observation about a patient's treatment/care that can be defined as a matter of interest, importance or anxiety.

A **complaint** is an expression of dissatisfaction that requires a response. Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

A **compliment** is an expression of praise, commendation or admiration.

2.0 SCOPE OF THE POLICY

This policy and supporting procedure are applicable to all staff providing services within and on behalf of NIAS. This includes NIAS employees, agency staff, interns, volunteers and others commissioned to provide services on behalf of the Trust.

This policy and supporting procedure apply specifically to concerns, complaints and compliments about **care or treatment, or about issues relating to the provision of health and social care** made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

The procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[4] as an alternative to making an application to the courts.

3.0 ROLES & RESPONSIBILITIES

3.1 <u>All Staff:</u>

The management of concerns, complaints and compliments is the responsibility of all staff providing services within and on behalf of the Trust regardless of level, role or location. It is essential that everyone takes relevant responsibility for managing complaints and compliments in order to improve the service users' experience and to support continuous improvement.

Sections 3.2 to 3.5 below describe the key requirements of the Chief Executive, Trust Board, the designated Director and the Complaints Manager in respect of the Trust's complaint management and accountability arrangements. The supporting Concerns, Complaints and Compliments Procedure contains greater detail regarding all corporate level roles and responsibilities.

3.2 <u>Chief Executive</u>:

As Accountable Officer, the Chief Executive has overall accountability for ensuring compliance with statutory and legal requirements and with relevant complaint guidance.

The Chief Executive will:

[4] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

i. ensure the Trust has clear accountability structures in place for the effective and efficient management of complaints;

ii. ensure complaints handling is included within the Trust's performance management framework and corporate objectives;

iii. ensure that complaints are integrated into the Trust's clinical and organisational governance and risk management arrangements;

iv. ensure a framework is in place whereby learning from complaints and compliments is incorporated into the Trust's clinical and organisational governance arrangements and that lessons from complaints and compliments are taken on board, shared and followed up appropriately in order to improve services and performance;

v. designate a Director to ensure compliance with the relevant Complaints Directions and to ensure that action is taken in light of the outcome of any investigation; and

vi. ensure the appointment of a Complaints Manager with the appropriate authority, standing and support to co-ordinate the local complaints arrangements and manage the process.

3.3 Trust Board:

The Trust Board has a monitoring and assurance role to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

i. ensure that the organisation arrangements contained within the policy and supporting procedure are implemented;

ii. monitor and review the overall reporting performance and receive regular reports;

iii. ensure complaints management is integrated within the Trust's Performance and Assurance Framework.

3.4 Designated Director with Responsibility for Complaints:

The Director of xxx (or their deputy) is the lead Director on behalf of the Trust Board and Senior Management Executive Team for the management of complaints and responsiveness locally and will:

i. take responsibility for the local complaints procedure, ensuring compliance with the regulations and suitable organisational arrangements for the management of complaints;

ii. ensure identification of key issues and actions regarding the management of complaints through the Complaints Review Group for progression via the Learning Outcomes Review Group and onward reporting to the Assurance Committee;

iii. develop and maintain systems to ensure effective monitoring and dissemination of learning from complaints and compliments across the organisation;

iv. put systems in place to ensure robust and accurate reporting of complaints to external agencies as required e.g. Department of Health (DoH), Regulation, Quality and Improvement Authority (RQIA) and the Health & Social Care Board (HSCB);

v. ensure that action is taken in light of the outcome of any investigation;

vi. ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

3.5 Role of the Complaints Manager:

The role of the Complaints Manager is to co-ordinate the local complaints arrangements and manage the process. Whilst the Complaints Manager will be required to carry out the full duties of their role as an employee of the Trust and as detailed in their job description, the HSC Complaints Procedure sets out the following key requirements.

The Complaints Manager is required to:

i. be readily accessible to both the public and members of staff;

ii. deal with complaints referred by staff;

iii. be easily identifiable to service users;

iv. be available to complainants who do not wish to raise their concerns with those directly involved in their care;

v. provide advice and support to vulnerable adults;

vi. consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;

vii. provide support to staff to respond to complaints;

viii. be aware of and advise on the role of the Medical Defence Organisations (MDOs)[5] to assist staff requiring professional indemnity[6];

ix. have access to all relevant records (including personal medical records);

x. take account of all evidence available relating to the complaint e.g. witness to a particular event;

xi. identify training needs associated with the complaints procedure and ensure those needs are met;

xii. ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;

xiii. compile a summary of complaints received, actions taken and lessons learnt;

xiv. maintain and appropriately store records;

xv. Assist the Director in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement;

xvi. Assist the Director in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

The Complaints Manager in required to involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant will be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager will assess what further action might best resolve the complaint and at each stage keep the complainant informed.

4.0 KEY POLICY PRINCIPLES

This policy and its supporting procedure has been developed and set within the Legal Framework for Complaints Management with Health and Social Care.

NIAS is committed to providing safe, effective and high quality services and welcomes feedback from patients/relatives/carers and other service users about their experience of care in order to improve quality. This policy provides the opportunity to put things right for service users as well as improving services.

[5] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).

[6] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

It is recognised that there may be times when treatment and/or services do not meet expectations particularly when something has gone wrong or fallen below standard. By listening to people about their experience of healthcare, the Trust can learn new ways to improve the quality and safety of services and prevent problems happening in the future. By making sure that lessons from complaints are taken on board, shared and followed up appropriately, services and performance can be greatly improved for the future.

Learning from concerns, complaints and compliments can only take place when they are managed in a positive and open manner. It is the Trust's wish to promote an open, honest, just and fair culture, where all staff can learn from complaints.

Patients, relatives, carers and other service users can bring comments, concerns and compliments to the attention of any member of staff. This policy promotes local, prompt resolution with involvement of the complainant at the core of the process, and encourages continuous learning and identification of improvements in the quality and safety of the services we provide.

Wherever possible, staff at a local level will actively seek to resolve dissatisfaction in a sensitive manner at the earliest opportunity. In circumstances where such informal or 'on the spot' resolution is not possible, this policy and its supporting procedure outlines the process to ensure complaints are handled in an efficient and effective manner.

The Trust will strive to ensure that complaints are handled in a speedy and efficient manner, that is open, accessible fair, flexible, conciliatory and without blame.

All complaints will be treated in confidence with openness, honesty and respect being paramount at all times.

Effective communication is essential in good complaint handling. Complainants must be involved in deciding how the issues they have raised are handled and, where appropriate, advised of what will be done as a result of their feedback.

It is essential that all concerns and complaints are received positively, investigated promptly and thoroughly and responded to sympathetically. Timely and effective action should be taken where appropriate to prevent recurrence when services provided have fallen below acceptable standards.

Complaints provide a rich source of information and form a vital part of the Trust's performance management systems. Positive action will be taken as a result of complaints, and learning from complaints will be embedded in the Trust's governance and risk management arrangements. Where something has gone wrong or fallen below standard the Trust will take the opportunity to improve and avoid a recurrence.

Each concern or complaint will be assessed and graded individually in

accordance with the Risk Matrix as set out in the Trust's Risk Management Policy and Procedure in order to decide which level of investigation is appropriate.

The Trust's approach to managing concerns and complaints is designed to encourage and promote learning and continual improvement, and not to increase workload for Investigation Officers by creating unnecessary paper trails.

The Trust values all compliments and places an emphasis on learning from the positive feedback we receive to further enhance our performance, the patient experience and the quality of services we provide.

Through the implementation of this policy and supporting procedure, so far as is reasonably practicable, the Trust will ensure:

- a consistent, timely, high standard of concerns, complaints and compliments management in compliance with NIAS policy, procedures and training;
- timely and accurate reporting through internal assurance processes (Trust Board, Assurance Committee, Committees/Groups etc.);
- all regional and applicable national guidance and best practice is adhered to and all statutory obligations are met, i.e. timely and accurate reporting to external bodies such as RQIA, DoH, HSCB, the Ombudsman etc;
- adequate policies, procedures and templates are available in order to support the complaint management process;
- DATIXweb is fully developed, rolled out and implemented across the Trust to make best use of its functionality in order to enhance the management of complaints and compliments;
- relevant staff and managers are provided with the training necessary to ensure the effective use of the DATIXweb system;
- effective remedial action is taken and lessons are learned, at both an individual and organisational level where appropriate, to reduce the risk of recurrence; and where necessary, learning is embedded into existing policy, procedures, processes, templates, training etc;
- effective sharing of lessons learned, both within the organisation and, where applicable, with other Trusts and Ambulance Services;
- further development of the Complaints Review Group and Learning Outcomes Review Group in order to link recommendations from concerns, complaints and compliments etc. to ensure continual improvement;
- appropriate management of concerns and complaints and continual improvement in complaints management and therefore the quality of care;

- improvement in arrangements to support staff wellbeing;
- adequate arrangements are in place to ensure staff can avail of time off for interview, to make statements etc;
- suitable support is available for Investigation Officers in order to properly investigate concerns and complaints, i.e. training and management support. Staff will have suitable training to help them make balanced judgements on complaint investigation;
- management are empowered to improve culture through the modernisation of the concerns, complaints and compliments reporting system, including the development of adequate mechanisms for feedback;
- improvement in liaison with service users, family members and carers;
- roles and responsibilities are defined and everyone is accountable and responsible for their actions;
- further development of a just (fair), open and positive culture;
- arrangements are in place to manage risks highlighted by complaints (Risk Management Policy and Procedure);
- effective and efficient assurance processes are in place;
- NIAS assets and reputation are safeguarded.

5.0 ADVICE AND INFORMATION FOR SERVICE USERS

5.1 The Trust will produce information for our service users on how to provide feedback on our services which will be well published, simple, clear and easy to complete.

5.2 Information materials pertaining to service user feedback including how to make a complaint or a compliment will be provided free of charge and will be available in various formats and languages. Other arrangements will be made as necessary to meet the specific needs of those wishing to comment on our services, including the provision of interpreting services and translation of information into additional languages, as required.

5.3 Service users who wish to provide feedback on our services may contact the Complaints Manager (or their deputy) for advice and assistance at:

Northern Ireland Ambulance Service HSC Trust Headquarters
Site 30
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8SG
Tel: 02890 400999

Textphone: 02890 400871
Email: complaints@nias.hscni.net
Visit Contact Us http://www.nias.hscni.net/contact-us to find out more

Complaints staff will enclose information about our complaints procedure when acknowledging formal complaints. Queries or requests for additional information should be directed to the Complaints Manager.

5.4 Information materials will include contact details of the Patient and Client Council (PCC) who can provide independent confidential support and advice to service users should they wish to make a complaint or refer their complaint to the Northern Ireland Public Services Ombudsman (NIPSO)[7]:

Patient Client Council
The Patient Client Council Headquarters
1st Floor, Lesley House
25-27 Wellington Place
Belfast
BT1 6GQ
Tel: Freephone 0800 917 0222
Email: complaints.pcc@hscni.net
Website: www.patientclientcouncil.hscni.net

5.5 The Northern Ireland Public Service Ombudsman (NIPSO) can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. The Complaints Manager will ensure information on the role of the NIPSO and their contact details are enclosed in all complaint response letters.

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN
Freepost: Freepost NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk
Website: www.nipso.org.uk

5.6 Other independent advocacy and specialist advocacy services are available for service users who wish to provide feedback. Further information is available from the Complaints Manager (or their deputy).

[7] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

6.0 IMPLEMENTATION OF THE POLICY

6.1 Dissemination:

This policy and supporting procedure are applicable to all staff providing services within and on behalf of NIAS. This includes NIAS employees, agency staff, interns, volunteers and others commissioned to provide services on behalf of the Trust.

The policy and procedure will be available on the Trust's internet and intranet sites and will be circulated by email to all Directors for cascading to their relevant areas of responsibility.

6.2 Resources:

A programme of complaints awareness, investigation and management training will be ongoing throughout the Trust to ensure that this policy and its supporting procedure are followed and that staff encourage service users to provide feedback about their treatment and care experiences.

Complaints awareness training is part of the mandatory induction programme for all new NIAS employees.

6.3 Exceptions:

In certain circumstances, concerns and complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of this policy, for example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board
- requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR)
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAI's)
- Whistleblowing[8]

Any complaints received by the Trust that appear to indicate the need for

[8] Public Interest Disclosure (Northern Ireland) Order 1998

referral under any of the processes outlined above should be immediately transferred to the Complaints Manager for onward transmission to the appropriate department.

Annex 1 provides further detail in this regard.

7.0 MONITORING, REPORTING, REVIEW & INFORMATION GOVERNANCE

7.1 Monitoring and Learning:

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally.

The Trust must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

Complaints are viewed as a significant source of learning and are an integral aspect of our patient/client safety and quality of service ethos. Complaints will help the Trust to continue to improve the quality of our services and safeguard high standards of care and treatment. The Trust must manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services.

The Trust has designated groups in place with operational responsibility for the oversight and monitoring of the complaints process within the Trust Assurance Framework, including the Complaints Review Group, the Learning Outcomes Review Group and the Assurance Committee, a standing Committee of Trust Board.

The Complaints Review Group meet quarterly to review the number of ongoing complaints, the number and outcome of Ombudsman cases the number of re-visited complaints, identify trends, discuss cases of specific concern and identify shared learning for onward progression to the Learning Outcomes Review Group.

Any identified areas of non-compliance or gaps in assurance arising from the monitoring of this procedure will result in recommendations and proposals for change to address areas of non-compliance and/or to embed learning.

7.2 Recording and Reporting:

All complaints and compliments will be recorded on DATIXweb. The system will be used to generate reports.

The Complaints Manager has responsibility for ensuring DATIXweb is fully developed, rolled out and implemented across the Trust to make best use of its functionality and enhance the management of complaints and compliments. He/she will ensure relevant staff and managers are provided with the training necessary to ensure the effective use of the system.

Monthly Reports will be generated for sharing with relevant Directors, Assistant Directors and Investigation Managers.

Quarterly Reports will be generated for Trust Board, the Complaints Review Group and the Learning Outcomes Review Group.

The report will:

- outline the number and types of complaints received;
- the investigation undertaken;
- action as a result; and
- summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints;
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement; and
- monitor performance via analysis of Key Performance Indicators.

The report will include an analysis of compliments received in order to learn from good practice.

Quarterly Statistical Returns will be made to the DoH in accordance with the requirements of the HSC Complaints Procedure.

An Annual Concerns, Complaints and Compliments Report will be generated and reported through the Trust Assurance Framework structures and published on the Trust website as required by statutory regulation. The report, which details the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints will be made available to the HSCB, PCC, RQIA, the Ombudsman and the DoH.

7.3 Review:

This policy and its supporting procedure will be reviewed annually. Feedback from stakeholders will be taken into consideration, along with a review of systems/processes and ongoing analysis of the actual management of complaints via the assurance structure. Audit findings will be taken into consideration and any new legislation, best practice or guidance will be taken into account.

7.4 Information Governance:

The Concerns, Complaints and Compliments Procedure will be managed in accordance with Trust policy and procedure regarding Information Governance.

Formal records of complaints will be stored securely by the Complaints Department in accordance with the Trust's Retention & Disposal Policy and Schedule or to meet the requirements of any formal Inquiry that may be established.

The Complaints Manager will ensure that care is taken during the production of all reports relating to complaints to ensure the protection of patient/client confidentiality.

8.0 EVIDENCE BASE/REFERENCES

- DoH Guidance in Relation to the Health and Social Care Complaints Procedure 01 April 2019
- The HSC Complaints Procedure Directions 01 April 2009
- Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration February 2009
- NIAS Risk Management Policy and Procedure
- NIAS Learning Outcomes Review Group Terms of Reference September 2018

9.0 CONSULTATION PROCESS

The following individuals and groups of staff were consulted with during the development of this policy:

- Administration & Complaints Manager
- Risk Manager
- Corporate Manager
- HR Manager
- Investigation Officers
- Investigation Managers
- Assistant Directors
- Trade Union Representatives
- Senior Management Executive Team
- Trust Board

10.0 APPENDICES/ATTACHMENTS

Listed in Contents.

11.0 EQUALITY STATEMENT

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

The outcome of the screening exercise for this policy is:

Major impact ☐
Minor impact ☐
No impact. ☒

12.0 SIGNATORIES

Linda Rafferty	2019
Linda Rafferty, Lead Author	**Date**
	2019
Michael Bloomfield, Chief Executive	**Date**

Annex 1

What the HSC Complaints Procedure does not cover

This policy has been developed in accordance with the requirements of the DoH Guidance in Relation to the Health and Social Care Complaints Procedure 01 April 2019. The following is an extract from the guidance in relation to **What the HSC Complaints Procedure does not cover**:

Complaints about private care and treatment or service; which includes private dental care[9] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HS organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board
- requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR)
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[10]

Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints Manager for onward transmission to the appropriate department. Where a complaint

[9] The Dental Complaints Services deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/

[10] Public Interest Disclosure (Northern Ireland) Order 1998

is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances – HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure – disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body. The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

The Chief Executive (or designated senior person[11]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body – a similar approach to that outlined above should be adopted in a case referred to a professional regulatory body. The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation nay need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the HSC Board – complaints about the HSC Board's commissioning decisions regarding purchasing of services may be made by, on or on behalf of any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints

[11] A designated Senior Person should be a Director

about the merits of a decision where the HSC Board has acted properly and within its legal responsibilities. Where general concerns about commissioning issues are raised with the HSC Board a full explanation of the HSC Board's policy should be provided. These issues should not, however, be dealt with under the HSC Complaints Procedure.

Requests for Information/Access to Records – although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[12] and requests for access to health or social care records under the General Data Protection Regulation (GDPR)[13].

Independent Inquiries and Criminal Investigations – where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints Procedure.

Children Order Representations and Complaints Procedure – arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 15 of the guidance. The HSC Board and HC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[14].

Adult Safeguarding – where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[15]) and the associated '*Protocol for Joint Investigation of Adult Safeguarding Cases*' (August 2016[16]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[17]. The HSC Complaints Procedure should be suspended pending the outcome

[12] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[13] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr
[14] Children (NI) Order 1995: https://www.legislation.gov.uk/nisi/1995/755/contents
[15] Adult Safeguarding Operational Procedures: http://www.hscboard.hscn.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Adult-Safeguarding-Operational-Procedures.pdf
[16] Protocol for Joint Investigation of Adult Safeguarding Cases: https://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Protocol-for-joint-investigation-of-adult-safeguarding-cases.pdf

[17] Information about and contact details for HSC Trusts can be accessed at the following link: https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse=exploitation-or-neglect

of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures – any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

Coroners Cases – with the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroners investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroners investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action – even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

If the complainant has either instigated formal legal action or advised that he or she intends to do so the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI) – complaints may indicate the need for a Serious Adverse Incident (SAI) investigation. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI investigation is under way. They must also indicate to all concerned that the HSC Complaints Procedure may

still continue during the SAI investigation. However, only those aspects of the complaint not falling within the scope of the SAI investigation will continue via the HSC Complaints Procedure.

The overall consideration must be to ensure that when the investigation is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Concerns, Complaints & Compliments Procedure**		
Author(s)	Linda Rafferty, Programme Manager		
Ownership:	Michael Bloomfield, Chief Executive		
Date of SMT Approval:	16/07/2019	**Date of Trust Board Approval:**	
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Other Relevant Policies:	• DoH Guidance in Relation to the Health and Social Care Complaints Procedure 01 April 2019 • The HSC Complaints Procedure Directions 01 April 2009 • Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling and Good Administration February 2009 • NIAS Risk Management Policy and Procedure • NIAS Learning Outcomes Review Group Terms of Reference September 2018		

Version Control for Drafts:			
Date	**Version**	**Author**	**Comments**
28/05/19	V0.1	L Rafferty	Initial draft – circulated to SEMT and Complaints Manager
03/06/19	V0.2	L Rafferty	2nd draft – circulated to those listed in Consultation section

It should be noted that pending NIAS restructuring of Directorate roles and responsibilities that the following Trust Board accountabilities currently exist:	
Medical Director	Learning outcomes from Concerns, Complaints and Compliments
Director of Human Resources & Corporate Services	Complaints management system, policy and procedure
All Directors	Local performance management

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Annexes

1.0 INTRODUCTION

This procedure supports the Trust's Concerns, Complaints and Compliments Policy, V3.0 dated xxx. The procedure has been developed in accordance with the revised Northern Ireland Health & Social Care (HSC) Complaints Procedure which was published on 1st April 2019. It supports the development and implementation of an up to date, effective system for the management of concerns, complaints and compliments throughout the Northern Ireland Ambulance Service HSC Trust (hereinafter referred to as the Trust). The document sets out the procedure to be adhered to by all staff providing services within and on behalf of the Trust. This includes NIAS employees, agency staff, interns, volunteers and others commissioned to provide services on behalf of the Trust.

In our patient-centred environment, patients, patient relatives, carers, advocates and other service users are encouraged to express their views about the treatment and services that they receive.

We believe that our patients and clients have the right to expect services of the highest quality. It is recognised that there may be times when treatment and/or services do not meet expectations particularly when something has gone wrong or fallen below standard. By listening to people about their experience of healthcare, the Trust can learn new ways to improve the quality and safety of services and prevent problems happening in the future. By making sure that lessons from complaints are taken on board, shared and followed up appropriately, services and performance can be greatly improved for the future.

This procedure promotes local, prompt resolution of complaints with involvement of the complainant at the core of the process, and encourages continuous learning and identification of improvements in the quality and safety of the services we provide.

In addition to welcoming and valuing complaints and the resultant learning, the Trust values all compliments received and places an emphasis on learning from the positive feedback to further enhance our performance, the patient experience and the quality of services we provide.

1.1 Key Principles:

The NIAS Concerns, Complaints & Compliments Procedure is based on the 4 key principles of the HSC Complaints Procedure which are:

i. openness and accessibility – flexible options for pursuing a complaint and effective support for those wishing to do so;

ii. responsiveness – providing an appropriate and proportionate response;

iii. fairness and independence – emphasising early resolution in order to minimise strain and distress for all; and

iv. learning and improvement – ensuring complaints are viewed as a positive opportunity to learn and improve services

1.2 Standards for Complaints Handling:

The Trust will ensure it operates within the HSC Complaints Procedure Standards for Complaints Handling which are:

Standard 1:	Accountability
Standard 2:	Accessibility
Standard 3:	Receiving complaints
Standard 4:	Supporting complainants and staff
Standard 5:	Investigation of complaints
Standard 6:	Responding to complaints
Standard 7:	Monitoring
Standard 8:	Learning

Annex 1 provides further detail on each of the Standards.

2.0 MAKING A COMPLAINT

2.1 What is a complaint?

A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

2.2 Promoting access:

The Trust will ensure service users are made aware of their rights to complain and are given the opportunity to understand all possible options for pursuing a complaint. Complainants will be provided with the support they needs to articulate their concerns and to successfully navigate the system. They will be advised on the types of help available, for example through frontline staff, the Complaints Manager and the Patient and Client Council (PCC). The Trust will ensure it promotes and encourages more open and flexible access to the Complaints Procedure and other less formal avenues in an effort to address barriers to access.

The Trust will ensure that:

- arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the organisation;
- arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
- flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and

- all staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

2.3 Who can complain?

Any person can complain about any matter connected with the **provision of care or treatment**, or about issues relating to the **provision of health and social care**. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

This procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[1] as an alternative to making an application to the courts.

2.4 What the Procedure does not cover:

Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of this procedure. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board
- requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR)
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[2]

Any complaints received by the Trust that appear to indicate the need for

[1] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.
[2] Public Interest Disclosure (Northern Ireland) Order 1998

referral under any of the processes outlined above should be immediately forwarded to the Complaints Manager. In these circumstances, investigation of other aspects of the complaint will only be taken forward if they do not, or will not, compromise or prejudice the matter under investigation.

Annex 2 provides further detail in this regard.

2.5 Consent:

Complaints by a third party may be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

- individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- individual is incapable (for example, rendered unconscious due to an accident; judgement impaired as a result of a learning disability, mental illness, brain injury or serious communication problems);
- subject of the complaint is deceased; and
- delay in the provision of consent may result in a delay in the resolution of the complaint.

Where a person is unable to act for him/herself, his/her consent shall not be required.

The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the third party complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or their deputy) will provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the Northern Ireland Department of Health's (DoH) good practice in consent guidance[3].

Third party complainants who wish to pursue their own concerns can bring these to the Trust without compromising the identity of the patient/client. The Trust will consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

The Trust will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised.

Consent forms are attached at Annex 3(A), 3(B) and 3(C).

2.6 Confidentiality:

[3] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

All HSC staff have a legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the General Data Protection Regulations (GDPR)[4] which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled Code of Practice on Protecting the Confidentiality of Service User Information[5] published January 2012.

It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigator(s), but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

2.7 Third Party Confidence:

The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only information which is relevant to the complaint should be considered for disclosure, and then only to those within the HSC who have a demonstrable 'need to know' in connection with the complaint investigation.

Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

[4] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

[5] DoH Code of Practice: https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

2.8 Use of Anonymised Information:

Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so. Annex 4 provides information regarding record keeping.

2.9 Anonymous complaints:

Anonymous complaints (verbal or written) will be investigated in the same manner as those from identified persons provided that sufficient information is supplied suggesting that there is some validity in the complaint or enquiry made. Although no written reply can be made an investigation should be undertaken and findings recorded and remedial action taken as necessary.

2.10 How can complaints be made?

Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service that may enhance the communication of the complaint to the Trust. Service users must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint.

Complaints may be made verbally or in writing and should also be accepted via any method, for example, by telephone, email or the Trust's website. The Trust will be mindful of technological advances and ensure local arrangements are in place to ensure there is no breach of patient/client/staff confidentiality.

Complaints may be made at any time to any member of staff, i.e. any NIAS employee, agency staff, intern, volunteer or others commissioned to provide services on behalf of the Trust, and directly to the Complaints Manager.

Some complainants may prefer to make their initial complaint to someone within the Trust who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive.

It is essential that all staff are aware of their roles and responsibilities when dealing with complaints. This will enable them to respond positively, and where possible, resolve the complaint at local level.

2.11 What information should be included in the complaint?

A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – for example an apology, an explanation or a change to our services.

2.12 Timescales for making a complaint:

A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

In any case where the Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

2.13 Advice and information for service users:

The Trust will produce information for our service users on how to provide feedback on our services which will be well published, simple, clear and easy to complete.

Information materials pertaining to service user feedback including how to make a complaint or a compliment will be provided free of charge and will be available in various formats and languages. Other arrangements will be made as necessary to meet the specific needs of those wishing to comment on our services, including the provision of interpreting services and translation of information into additional languages, as required.

The Trust's Complaints Manager (or their deputy) will be available to assist anyone wishing to make a complaint and will offer help and advice

when requested to do so.

The Complaints Manager contact details are as follows:

Northern Ireland Ambulance Service HSC Trust Headquarters
Site 30
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8SG
Tel: 02890 400999
Textphone: 02890 400871
Email: complaints@nias.hscni.net
Visit Contact Us http://www.nias.hscni.net/contact-us to find out more

Complaints staff will enclose information about our complaints procedure when acknowledging formal complaints. Queries or requests for additional information should be directed to the Complaints Manager.

Information on external support/contacts is attached at Annex 5.

2.14 Unreasonable or abusive complainants:

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. The Trust does not view behaviour as unacceptable just because a complainant is forceful or determined. In fact it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the Trust or unreasonable behaviour towards our staff to be unacceptable.

Regional guidance on dealing with unacceptable actions by a complainant is outlined in Annex 6. The guidance should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

3.0 HANDLING COMPLAINTS

3.1 Guidance:

Guidance on good practice principles for dealing with complaints is outlined in Annex 7; an overview of the complaints investigation process is attached at Annex 8; a flowchart detailing the key step required when handling a complaint is attached at Annex 9; and a flowchart detailing time limits and performance targets is attached at Annex 10.

3.2 Accountability:

All HSC organisations must ensure that there are clear lines of accountability for the handling and consideration of complaints. As a HSC Trust, we must demonstrate that we have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into our clinical and

organisational governance arrangements.

Sections 3.2.1 to 3.2.4 below describe the key requirements of the Chief Executive, Trust Board, the designated Director and the Complaints Manager in respect of the Trust's complaint management and accountability arrangements.

Annexes 11 to 16 provide greater detail regarding roles and responsibilities for the management and handling of complaints.

3.2.1 Chief Executive:

As Accountable Officer, the Chief Executive has overall accountability for ensuring compliance with statutory and legal requirements and with relevant complaint guidance.

The Chief Executive will:

i. ensure the Trust has clear accountability structures in place for the effective and efficient management of complaints;

ii. ensure complaints handling is included within the Trust's performance management framework and corporate objectives;

iii. ensure that complaints are integrated into the Trust's clinical and organisational governance and risk management arrangements;

iv. ensure a framework is in place whereby learning from complaints and compliments is incorporated into the Trust's clinical and organisational governance arrangements and that lessons from complaints and compliments are taken on board, shared and followed up appropriately in order to improve services and performance;

v. designate a Director to ensure compliance with the relevant Complaints Directions[6] and to ensure that action is taken in light of the outcome of any investigation; and

vi. ensure the appointment of a Complaints Manager with the appropriate authority, standing and support to co-ordinate the local complaints arrangements and manage the process.

3.2.2 Trust Board:

The Trust Board has a monitoring and assurance role to ensure compliance with the Trust's statutory obligations as described in the relevant complaints legislation.

The Board will:

i. ensure that the organisation arrangements contained within the Concerns, Complaints and Compliments Policy and Procedure are implemented;

[6] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

ii. monitor and review the overall reporting performance and receive regular reports;

iii. ensure complaints management is integrated within the Trust's Performance and Assurance Framework.

3.2.3 Designated Director with responsibility for Complaints:

The Director of xxx (or their deputy) is the lead Director on behalf of the Trust Board and Senior Management Executive Team for the management of complaints and responsiveness locally and will:

i. take responsibility for the local complaints procedure, ensuring compliance with the regulations and suitable organisational arrangements for the management of complaints;

ii. ensure identification of key issues and actions regarding the management of complaints through the Complaints Review Group for progression via the Learning Outcomes Review Group and onward reporting to the Assurance Committee;

iii. develop and maintain systems to ensure effective monitoring and dissemination of learning from complaints and compliments across the organisation;

iv. put systems in place to ensure robust and accurate reporting of complaints to external agencies as required e.g. Department of Health (DoH), Regulation, Quality and Improvement Authority (RQIA) and the Health & Social Care Board (HSCB);

v. ensure that action is taken in light of the outcome of any investigation;

vi. ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

3.2.4 Role of the Complaints Manager:

The Complaints Manager will support the Assistant Director of xx in executing those duties relating to the management of complaints. The key responsibilities of the role are to:

i. Acknowledge complaints within 2 working days of receipt;

ii. Contact complainants to confirm and agree areas for investigation and expected outcomes;

iii. Ensure that the preferred mode of contacting the complainant is agreed and ensure that the complainant is kept informed about progress with his/her response;

iv. Detail the specific points in the complaint that require to be answered;

v. Ensure all complaints involving a sudden unexpected death, serious harm or potential safeguarding issues are immediately escalated to the relevant Director, Medical Director and Professional Lead for consideration of independent investigation and to facilitate communication with the complainant;

vi. Notify the relevant Assistant Director and Investigation Manager within 2 working days of receipt of complaint;

vii. Liaise with the relevant Assistant Directors where a complaint relates to the actions of more than one Directorate to identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint;

viii. Agree grading of complaints in conjunction with the relevant Assistant Director and Investigation Manager;

ix. Obtain consent where required in the case of third party complaints or enquiries;

x. Record all relevant information about each complaint on DATIXweb and set up the agreed response timescales, track complaints and send reminders to Investigation Managers to facilitate the meeting of deadlines, including informing the Investigation Manager 10 working days before the final response deadline, and escalating delayed responses in accordance with the Complaints Escalation Process (Annex 17 refers);

xi. Ensure that the relevant Director, Medical Director and Professional Lead are notified where a health professional has been identified in a complaint;

xii. Ensure the contents of draft complaint responses have been discussed and agreed with contributing staff;

xiii. Quality assure the draft response letter to ensure that all points have been fully addressed by the Directorate, to include the

accuracy of dates, names/titles and address of complainant etc., before forwarding to the Chief Executive (or their deputy) for signature;

xiv. Provide service user feedback, related analyses and reports to services and committees within the Trust's governance and accountability framework;

xv. Thematically review complaints for learning locally and across the Trust;

xvi. Provide information as requested to external sources including RQIA, DoH, HSCB and the Ombudsman;

xvii. Provide guidance and support to relevant managers, supervisors and staff to enable them to carry out their duties and responsibilities relating to complaint prevention and management;

xviii. Provide training in relation to complaints awareness, investigation and management.

xix. Ensure DATIXweb is fully developed, rolled out and implemented across the Trust to make best use of its functionality and enhance the management of complaints and compliments;

In addition to the above key responsibilities listed above, the HSC Complaints Procedure requires the Complaints Manager to:

a) be readily accessible to both the public and members of staff;

b) deal with complaints referred by staff;

c) be easily identifiable to service users;

d) be available to complainants who do not wish to raise their concerns with those directly involved in their care;

e) provide advice and support to vulnerable adults;

f) consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;

g) provide support to staff to respond to complaints;

h) be aware of and advise on the role of the Medical Defence Organisations (MDOs)[7] to assist staff requiring professional indemnity[8];

i) have access to all relevant records (including personal medical records);

[7] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).

[8] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

j) take account of all evidence available relating to the complaint e.g. witness to a particular event;

k) identify training needs associated with the complaints procedure and ensure those needs are met;

l) ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;

m) compile a summary of complaints received, actions taken and lessons learnt;

n) maintain and appropriately store records;

o) Assist the Director in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement;

p) Assist the Director in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

The Complaints Manager in required to involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant will be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager will assess what further action might best resolve the complaint and at each stage keep the complainant informed.

3.3 Training:

The Trust will ensure that all staff are trained and empowered to deal with complaints as they occur, appropriate to their needs. The training programme will include information about the needs of service users, including mental health, disability and equality awareness training.

Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. Staff have responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function effectively in their role and the Trust has a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

A programme of complaints awareness, investigation and management training will be ongoing throughout the Trust to ensure that the Concerns, Complaints and Compliments Policy and Procedure are followed and that staff encourage service users to provide feedback about their treatment and care experiences.

Complaints awareness training is part of the mandatory induction programme for all new NIAS employees.

Relevant staff and managers will be provided with training to ensure the effective use of the DATIXweb system for the management of complaints and compliments.

3.4 Informal resolution:

In many cases complaints are made orally and staff are able to resolve the complaint 'on the spot' to the complainant's satisfaction. This is known as informal resolution. As such, all frontline staff must be trained and supported to respond sensitively to concerns and complaints raised and be able to distinguish those issues that would be better referred elsewhere.

The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to a complaint are addressed.

If circumstances allow, staff should attempt to resolve a complaint in the first instance, to the satisfaction of the service user. Staff are encouraged to advise the Complaints Manager of any complaint they have informally resolved for recording purposes. An electronic Informal Resolution form is to be developed and made available on DATIXweb for ease of access and reporting purposes.

Should an 'on the spot' complaint be made that cannot be resolved informally, the complainant should be asked to formalise their complaint in writing. If they are unable to do so, then any member of staff, the Complaints Manager or the Patient Client Council can provide assistance. It is helpful to establish from the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction that may lead to subsequent complaints.

3.5 Formal (local) resolution:

Formal, or local, resolution is the satisfactory resolution of a complaint to the complainant's satisfaction through the application of this Procedure.

3.6 Actions on receipt of a complaint:

All complaints should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered.

The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. The Complaints Manager should discuss individual cases with complainants at an early stage and an important aspect of the discussion

will be about the time it may take to complete the investigation, especially if it is likely to exceed the **20 working day target** for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint.

Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the Trust's complaints procedure by other means. Frontline staff will often find the information they gain from complaints useful in improving service quality. This is particularly so for complaints that have been resolved 'on the spot' and have not progressed through the formal complaints procedure.

3.7 Acknowledgement of complaint:

The Complaints Manager will acknowledge a complaint in writing within **2 working days of receipt**. The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the Trust. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person's health or well-being.

There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

The acknowledgement letter will be conciliatory, and indicate that a full response will be provided within **20 working days**.

The acknowledgement letter will:

- confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with the Complaints Manager or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

The Complaints Manager will provide the complainant with further information about the complaints process, for example a Complaints Information Leaflet and information about the disclosure of patient information.

Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative

work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure.

Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the Trust should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be **updated every 20 working days** on the progress of their complaint by the most appropriate means.

The Complaints Manager must ensure that all contact with the complainant is recorded.

3.8 Joint HSC Complaints:

The Complaints Manager is required to notify the other organisations involved where a complaint relates to the actions of more than one HSC organisation. The complainant's consent must be obtained before sharing the details of the complaint with other HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own areas of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

3.9 Investigation:

The Trust will investigate the complaint in a manner appropriate to the nature of the issues raised, aim to complete the investigation as efficiently and effectively as possible and ensure that the complaint response is provided with the agreed timescales.

The purpose of investigation is not only 'resolution' but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;
- detect misconduct or poor practice; and
- improve services and performance.

The Trust will ensure that investigations are conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening

learning and improving. Investigation Officers should seek advice from the Complaints Manager or the Investigation Manager, wherever necessary, about the conduct or findings of the investigation.

The Investigation Officer should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of the complaint should be advised of the process and what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

3.10 Assessment of the complaint:

Not all complaints need to be investigated to the same degree or at the same level. The Complaints Manager will assess the grading of each complaint in conjunction with the relevant Assistant Director and Investigation Manager, in accordance with the Risk Matrix as set out in the Trust's Risk Management Policy and Procedure. Complaints that warrant investigation as a Serious Adverse Incident (SAI) will be referred immediately to the Risk Manager for action. Only those aspects of the complaint not falling within the SAI investigation will continue via the complaints procedure.

3.11 Investigation and resolution:

The Investigation Officer is required to establish the facts relating to the complaint and assess the quality of the evidence. Annexes 8, 9 and 10 provide further detail in relation to the investigation process.

The subject matter and complexity of the investigation may warrant the services of others to assist in the resolution of a complaint, such as a Senior Manager, Independent Expert, Lay Person or Conciliation. Annex 5 refers. It is not intended that the Trust use all the options outlined above as not all these will be appropriate in the resolution of a complaint. Rather the Trust will consider which option, if any, would assist in providing the desired outcome.

3.12 Completion of the investigation:

The Investigation Officer is required to prepare a draft report and a draft response letter to the complainant once they have reached their conclusion. The purpose is to record and explain the conclusions reached after the investigation of the complaint.

Where the complaint involves clinical/professional issues, the draft response must be shared with the relevant clinicians/professionals to ensure the factual accuracy and to ensure clinicians/professionals agree with and support the draft response.

All correspondence and evidence relating to the investigation should be

retained. The Complaints Manager is required to ensure that a complete record is kept of the handling and consideration of each complaint.

3.13 Responding to a complaint:

A response must be sent to the complainant within **20 working days of receipt** of the complaint or, where that is not possible, the complainant must be advised of the delay.

Where appropriate, the Trust must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or their deputy). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness.

Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

Annex 8 provides practical advice regarding meeting a complainant.

Where complaints have been raised electronically the Trust may reply electronically whilst ensuring we adhere to IT policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures.

The Chief Executive may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task. In such circumstances, the arrangements for clinical and organisational governance must ensure that the Chief Executive maintains an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place. The Trust should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, event or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any

aspect of the letter;

- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

3.14 Concluding formal (local) resolution:

The Trust should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants may contact the Trust within one month of the response if they are dissatisfied with the response or require further clarity[9]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

This completes the Trust's Complaints Procedure in accordance with the HSC Complaints Procedure. There is a statutory duty on the Trust to signpost to the Ombudsman upon completion of the complaints procedure. Annex 5 refers.

4.0 LEARNING FROM COMPLAINTS

4.1 Monitoring and Learning:

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally.

The Trust must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to

[9] Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

improve services and performance.

Complaints are viewed as a significant source of learning and are an integral aspect of our patient/client safety and quality of service ethos. Complaints will help the Trust to continue to improve the quality of our services and safeguard high standards of care and treatment. The Trust must manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services.

The Trust has designated groups in place with operational responsibility for the oversight and monitoring of the complaints process within the Trust Assurance Framework, including the Complaints Review Group, the Learning Outcomes Review Group and the Assurance Committee, a standing Committee of Trust Board.

The Complaints Review Group meet quarterly to review the number of ongoing complaints, the number and outcome of Ombudsman cases the number of re-visited complaints, identify trends, discuss cases of specific concern and identify shared learning for onward progression to the Learning Outcomes Review Group.

Any identified areas of non-compliance or gaps in assurance arising from the monitoring of this procedure will result in recommendations and proposals for change to address areas of non-compliance and/or to embed learning.

4.2 Recording and Reporting:

All complaints and compliments will be recorded on DATIXweb. The system will be used to generate reports.

The Complaints Manager has responsibility for ensuring DATIXweb is fully developed, rolled out and implemented across the Trust to make best use of its functionality and enhance the management of complaints and compliments. He/she will ensure relevant staff and managers are provided with the training necessary to ensure the effective use of the system.

Monthly Reports will be generated for sharing with relevant Directors, Assistant Directors and Investigation Managers.

Quarterly Reports will be generated for Trust Board, the Complaints Review Group and the Learning Outcomes Review Group.

The report will:

- outline the number and types of complaints received;
- the investigation undertaken;
- action as a result; and
- summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints;
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement; and
- monitor performance via analysis of Key Performance Indicators.

The report will include an analysis of compliments received in order to learn from good practice.

Quarterly Statistical Returns will be made to the DoH in accordance with the requirements of the HSC Complaints Procedure.

An Annual Concerns, Complaints and Compliments Report will be generated and reported through the Trust Assurance Framework structures and published on the Trust website as required by statutory regulation. The report, which details the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints will be made available to the HSCB, PCC, RQIA, the Ombudsman and the DoH.

4.3 Review:

This policy and its supporting procedure will be reviewed annually. Feedback from stakeholders will be taken into consideration, along with a review of systems/processes and ongoing analysis of the actual management of complaints via the assurance structure. Audit findings will be taken into consideration and any new legislation, best practice or guidance will be taken into account.

4.4 Consultation:

The following individuals and groups of staff were consulted with during the development of this procedure:

- Administration & Complaints Manager
- Risk Manager
- Corporate Manager
- HR Manager
- Investigation Officers
- Investigation Managers
- Assistant Directors/Tier 3 Managers
- Trade Union Representatives
- Senior Management Executive Team
- Trust Board

5.0	**SIGNATORIES**

Linda Rafferty	
Linda Rafferty - Lead Author	**Date**
Michael Bloomfield, Chief Executive	**Date**

Annex 1

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Leads in FPS settings);

2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;

3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;

4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;

5. Each HS organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;

6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;

7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and

8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;

2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;

3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and

4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;

2. Complaints from a third party must, where possible, have the written consent of the individual concerned;

3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;

4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;

5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and

6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;

2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;

3. HSC organisations will promote the use of independent advice and advocacy services;

4. HSC organisations will facilitate, where appropriate, the use of conciliation;

5. HSC organisations will adopt a consistent approach in the application of DoH guidance on responding to unreasonable or abusive complainants;

6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and

7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria:

1. Investigations are conducted in line with agreed governance arrangements;

2. Investigations are robust and proportionate and the findings are supported by the evidence;

3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;

4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;

5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;

6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;

7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and

8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements.

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;

2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;

3. HSC organisations must consider alternative methods of responding to complaints;

4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;

5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);

6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint, and

7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;

2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;

3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;

4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;

5. HSC organisations must review the arrangements for complaints handling and responsiveness; and

6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;

2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;

3. Learning will take place at different levels within the HSC (individual, team and organisational);

4. HSC organisations will ensue that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;

5. HSC organisations will incorporate learning arising from any review of findings of an investigation;

6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and

7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

Annex 2

What the Procedure does not cover

This procedure has been developed in accordance with the requirements of the DoH Guidance in Relation to the Health and Social Care Complaints Procedure 01 April 2019. The following is an extract from the guidance in relation to **What the HSC Complaints Procedure does not cover**:

Complaints about private care and treatment or service; which includes private dental care[10] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HS organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by the HSC Board
- requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR)
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[11]

Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints Manager for onward transmission to the appropriate department. Where a complaint

[10] The Dental Complaints Services deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/

[11] Public Interest Disclosure (Northern Ireland) Order 1998

is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances – HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure – disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body. The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

The Chief Executive (or designated senior person[12]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body – a similar approach to that outlined above should be adopted in a case referred to a professional regulatory body. The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation nay need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the HSC Board – complaints about the HSC Board's commissioning decisions regarding purchasing of services may be made by, on or on behalf of any individual personally affected by a commissioning decision taken by the HSC Board. The HSC Complaints Procedure may not deal with complaints about the merits of a decision where the HSC Board has acted properly and within

[12] A designated Senior Person should be a Director

its legal responsibilities. Where general concerns about commissioning issues are raised with the HSC Board a full explanation of the HSC Board's policy should be provided. These issues should not, however, be dealt with under the HSC Complaints Procedure.

Requests for Information/Access to Records – although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[13] and requests for access to health or social care records under the General Data Protection Regulation (GDPR)[14].

Independent Inquiries and Criminal Investigations – where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints Procedure.

Children Order Representations and Complaints Procedure – arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 15 of the guidance. The HSC Board and HC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[15].

Adult Safeguarding – where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[16]) and the associated '*Protocol for Joint Investigation of Adult Safeguarding Cases*' (August 2016[17]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[18]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly.

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[13] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents

[14] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

[15] Children (NI) Order 1995: https://www.legislation.gov.uk/nisi/1995/755/contents

[16] Adult Safeguarding Operational Procedures: http://www.hscboard.hscn.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Adult-Safeguarding-Operational-Procedures.pdf

[17] Protocol for Joint Investigation of Adult Safeguarding Cases: https://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Protocol-for-joint-investigation-of-adult-safeguarding-cases.pdf

[18] Information about and contact details for HSC Trusts can be accessed at the following link: https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse=exploitation-or-neglect

However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures – any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

Coroners Cases – with the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroners investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroners investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action – even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

If the complainant has either instigated formal legal action or advised that he or she intends to do so the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI) – complaints may indicate the need for a Serious Adverse Incident (SAI) investigation. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI investigation is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI investigation. However, only those aspects of the

complaint not falling within the scope of the SAI investigation will continue via the HSC Complaints Procedure.

The overall consideration must be to ensure that when the investigation is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Annex 3(A)

CONSENT FOR THIRD PARTY TO ACT ON BEHALF OF PATIENT/SERVICE USER

Agreement for Personal Patient/Client Information to be released for use in the Northern Ireland Ambulance Service HSC Complaints Procedure

I, (Insert Name)	
Of (Insert Address)	
	Postcode:
Date of Birth (DOB)	/ /
Patient's Signature	
Date	

OR

I, (Insert Name)	
Of (Insert Address)	
	Postcode:
am complaining on behalf of (Insert Patient's Name)	
Of (Insert Patient's Address)	
	Postcode:
Patient's DOB:	/ /
My relationship to the patient is (insert relationship eg wife, son, mother etc). The patient can/cannot sign this form (delete as appropriate).	
Signature of Patient (if applicable)	
Date	

Signature of Complainant: _____ Date: _____

All HSC staff have a duty of confidence to ensure that any personal information held on members of the public (which includes medical records and personal "non-health" information such as patient's or client's name and address or details of his or her financial or domestic circumstances) is not used for a different purpose or passed to anyone else without the consent of the provider of the information or someone formally appointed to act on their behalf.

Completed form to be returned to: Complaints Manager, Northern Ireland Ambulance Service, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

Annex 3(B)

CONSENT FOR ACCESS TO MEDICAL RECORDS

DATA PROTECTION ACT 1998
GENERAL DATA PROTECTION REGULATIONS 2018
FREEDOM OF INFORMATION ACT 2000
ACCESS TO HEALTH RECORDS (NI) ORDER 1993

AGREEMENT FOR PERSONAL & SENSITIVE INFORMATION TO BE SOURCED FOR USE IN THE NORTHERN IRELAND AMBULANCE SERVICE HSC INVESTIGATIONS UNDER COMPLAINT, DISCIPLINARY, HARRASSMENT AND GRIEVANCE PROCEEDINGS

The Data Protection Act 1998, General Data Protection Regulations 2018, Freedom of Information Act 2000 and Access to Health Records (NI) Order 1993 apply to personal information processing in relation to complaint, disciplinary, harassment and grievance proceedings.

When a patient or a patient's representative raises an issue with the Northern Ireland Ambulance Service (NIAS), further information may need to be sourced to fully investigate the issue raised. This will include access to medical records completed following the incident and held in the patient's Hospital file which contain levels of personal and sensitive information in relation to the patient's condition following an incident attended to by NIAS personnel and under investigation. This information will either be directly viewed by an Officer of NIAS or formally provided by other relevant Hospital personnel in line with legislative requirements.

This information may also be required to be shared with other individuals directly involved in the investigation or proceedings to fully address the issues raised. This may include a disciplinary panel or Trade Union representative representing a staff member, if appropriate.

The purpose of this consent form is to record your approval or non-approval of accessing further information held in your Hospital file. This record will then be maintained on file.

I do/ do not **(stroke out as appropriate)** consent to the accessing of relevant Hospital records.

Name (please print): _____

Signature: _____

Date: _____

Please note that if consent is not provided, this may lead to the issue not being fully investigated or address.

Incident Information

Date of Incident	
Address of Incident	
Nature of Incident	
Any further comments:	

All HSC staff have a duty of confidence to ensure that any personal information held on members of the public (which includes medical records and personal 'non-health' information such as patient's or client's name and address or details of his or her financial or domestic circumstances) is not used for a different purpose or passed to anyone else without the consent of the provider of the information or someone formally appointed to act on their behalf.

Completed form to be returned to: Complaints Manager, Northern Ireland Ambulance Service, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

Annex 3(C)

CONSENT TO RELEASE STATEMENTS UNDER TRUST PROCEEDINGS

DATA PROTECTION ACT 1998
GENERAL DATA PROTECTION REGULATIONS 2018
FREEDOM OF INFORMATION ACT 2000

AGREEMENT FOR PERSONAL & SENSITIVE INFORMATION TO BE SOURCED FOR USE IN THE NORTHERN IRELAND AMBULANCE SERVICE HSC INVESTIGATIONS UNDER COMPLAINT, DISCIPLINARY, HARRASSMENT AND GRIEVANCE PROCEEDINGS

The Data Protection Act 1998, General Data Protection Regulations 2018 and the Freedom of Information Act 2000 applies to personal information processing in relation to disciplinary, harassment and grievance proceedings.

Any information that you provide, for example a witness statement during a complaint, disciplinary, harassment and grievance proceeding can if appropriate be accessed by parties involved in the proceedings including individual employees, alleged harasser or complainant subject to the necessary consent of this being received. In the absence of consent, a restricted copy of the file created can be released to the relevant requestor and processed in line with legislative requirements.

The purpose of this consent form is to record your approval or non-approval of releasing any information you provide during this investigation to requestors. This record will then be maintained on file.

I consent to the release of personal information that I provided during this investigation.

Name (please print): _____

Signature: _____

Date:_____

Completed form to be returned to: Complaints Manager, Northern Ireland Ambulance Service, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

Annex 4

RECORD KEEPING

A complaint file has the same status as any other record created by a healthcare organisation and is therefore a confidential record.

The Trust will ensure that the management and storage of complaint files is consistent with the relevant guidance including the Data Protection Act, the General Data Protection Regulations and Good Management Good Records[19].

A record of a complaint should include:

- the name of the complainant and, if applicable, the name of the patient/service user that the complainant is acting for;
- address and contact details – to include preferred method of communication
- the date of birth of the patient/service user (to confirm identity)
- a completed consent form if appropriate (the consent form type will depend on who is making the complaint);
- details of the incident (date, time, location etc);
- staff members connected with the complaint, if relevant; *staff members connected with the complaint are sourced and electronically linked to the Datix file. These will also be discoverable on the paper file;
- where possible, what remedy is being sought e.g. an apology or an explanation or changes to services
- all correspondence between the Trust and the complainant
- all documentation related to the complaint*

The following key principles apply to the management of records for all complaints and enquiries:

- concerns, complaints and compliments will be recorded on DATIXweb;
- DATIXweb will be fully developed, rolled out and implemented across the Trust to make best use of its functionality in order to enhance the management of complaints and compliments;
- all correspondence regarding the complaint will be marked 'confidential'.
- formal records of complaints will be stored securely and disposed of by the Complaints Department in accordance with the Trust's Retention & Disposal Policy and Schedule or to meet the requirements of any formal Inquiry that may be established;
- information and reports produced to identify trends and inform future good practice from lessons learned will safeguard the confidentiality of service users and staff;
- confidential information sent outside the Trust must have the appropriate level of security applied e.g. encryption, password protection etc.

**The Investigation Officer is required to provide the Complaints Manager with all documentation relating the investigation within 2 weeks of the complaint being closed.*

[19] Good Management Good Records https://www.health-ni.gov.uk/topics/good-management-good-records

Annex 5

EXTERNAL SUPPORT/CONTACTS

ADVOCACY AND CONCILIATION

Some people who might wish to complain do not do so because they do not know how to, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people gain access to information they need, to understand the options available to them, and to make their wishes and views known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the Patient Client Council. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. A conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the Trust and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Trust;
- where there are misunderstandings with relatives or carers during the treatment of the patient.

All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 6 refers) then conciliation would NOT be an appropriate option.

Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties.

Conciliation may be requested by the complainant or the Trust.

Using conciliation does not affect the right of a complainant to pursue their complaint further through the Trust if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

The Trust is responsible for formally appointing an appropriate conciliation service and other arrangements, including remuneration.

PATIENT AND CLIENT COUNCIL

The Patient and Client Council (PCC) is an independent no-departmental body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public
- promoting involvement of the public
- providing assistance to individuals making or intending to make a complaint
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services

If a person feels unable to deal with a complaint alone, the staff of the PCC an offer a wide range of assistance and support. This assistance may take the form of:

- Information on the Complaints Procedure and advice on how to take a complaint forward
- Discussing the complaint and drafting letters
- Making telephone calls
- Helping prepare for a meeting and accompanying the complainant
- Preparing a complaint to the Ombudsman
- Referral to other agencies, for example, specialist advocacy services
- Help on accessing medical / social services records

All advice, information and assistance with complaints are provided free of charge and are confidential. Further information can be obtained from:

Patient and Client Council
The Patient Client Council Headquarters
1st Floor, Lesley House
25-27 Wellington Place
Belfast
BT1 6GQ
Tel: **Freephone (0800) 917 0222**
Email: complaints.pcc@hscni.net
Website: www.patientclientcouncil.hscni.net

REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard an quality of health and social are services provided by independent and statutory bodies in Northern Ireland.

The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DoH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

The RQIA has a duty to encourage improvement in the delivery of services and o keep the DoH informed on matters concerning the provision, availability and quality of services.

The RQIA may be contacted at:

9th Floor, Riverside Tower
Lanyon Place
Belfast
BT1 3BT
Tel: **(028) 90 517500**
Fax: **(028) 90 517501**
Email: info@rqia.org.uk
Website: www.rqia.org.uk

INDEPENDENT EXPERTS

The use of an Independent Expert in the resolution of a complaint may be requested by the complainant or by the Trust. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;

- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation; and
- to give an independent perspective on clinical issues.

Agreement and consent

The Trust must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the Trust will make the necessary arrangements. The Trust may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding our treatment and care practice.

Where it has been agreed that an Independent Expert will be involved the Tust should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

The Independent Expert's findings/report will be forwarded to the Trust. A full report of the findings should be made available to the complainant.

The letter of response to the complainant is the responsibility of the Trust.

The Trust is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Expert should be recruited from another Local Commissioning Group are to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland). The HSCB will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and Family Practitioner Services (FPS) including the implementation of any recommendations in FPS.

LAY PERSONS

Lay persons may be beneficial in providing an independent perspective of non-clinical/technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the Investigation Officer during the investigation process where the complainant is considered unreasonable (Annex 6 refers).

Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships; and
- access arrangements (appointment systems).

It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

Lay persons should be appropriately trained in relation to the Trust's Concerns, Complaints and Compliment Procedure and have the necessary independence an communication skills.

Agreement and consent

The Trust must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the Trust will make the necessary arrangements.

Where it has been agreed that a lay person will be involved the Trust should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means:
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

The lay person's findings/report will be forwarded to the Trust. The full report will be made available to the complainant.

The letter of response to the complainant is the responsibility of the Trust.

Appointment of lay persons

The Trust is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements including training, performance management and remuneration.

The HSCB will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

THE NI PUBLIC SERVICES OMBUDSMAN

The Ombudsman[20] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or

[20] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation

were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

(1) This section applies where a listed authority's complaints handling procedure is exhausted.
(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating -
   a) That the complaints handling procedure is exhausted, and
   b) That the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.
(3) A notice under subsection (2) must –
   a) Inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and
   b) Provide details of how to contact the Ombudsman.

The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN
Freepost: FREEPOST NIPSO
Telephone: (028) 9023 3821
Freephone: (0800) 34 24 24
Email: nipso@nipso.org.uk

Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at: www.nipso.org.uk

Annex 6

REGIONAL GUIDANCE - UNREASONABLE OR ABUSIVE COMPLAINANTS

HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual

The following *Unacceptable Actions Policy*[21] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Action Policy

People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the HSC organisation or unreasonable behaviour towards HSC staff to be unacceptable. It is these action that HSC organisations aim to manage under this policy.

Aggressive or abusive behaviour

HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any

[21] Unacceptable Actions Policy base on best practice guidelines issued by the Scottish Public Services Ombudsman – updated 18 January 2017

evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also considers that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC positon in relation to attacks on the workforce. Staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

Examples of action grouped under this heading include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; and
- repeatedly changing the substance of a complaint or raising unrelated concerns.

An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the Trust or inundates us with copies of information that has been sent already or that is irrelevant to the complaint.

The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint or with other people's complaints.

Unreasonable use of the complaints process

Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once if subsequent incidents occur.

However, this contact becomes unreasonable when the effect of the repeated complaints is to harass or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances

that it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

When the HSC organisation is looking at a complaint it will need to ask the individual who has complained to work with them. This can include agreeing with the Trust the complaint it will look at; providing it with further information evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

Sometimes, an individual repeatedly refuses to co-operate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

The threat or use of physical violence verbal abuse or harassment towards HSC staff is likely to result in a termination of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

HSC staff will end telephone calls if they consider the caller aggressive abusive or offensive. The staff member taking the call has the right to make this decision tell the caller that their behaviour is unacceptable and end the all if the behaviour persists. In extreme situation the HSC organisation will tell the complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

When a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;

- return any documents to the complainant or in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decision about unreasonable behaviour

HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensure that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their action were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They must advise the complainant in writing that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

The HSC organisation records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above, may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complaints with restricted contact arrangements on a regular basis.

Annex 7

GOOD PRACTICE PRINCIPLES FOR DEALING WITH COMPLAINTS

These are good practice principles for anyone handling a complaint, either a verbal complaint or written complaint but are particularly for front line staff. A lot are common sense and common courtesy – how we would all like to be treated.

- Treat everyone with respect & dignity. You are representing the organisation.
- Identify yourself – it is polite to always introduce self.
- Listening carefully – find out the real nature of the problem – person may be anxious/upset & find difficulty expressing their issues. Take the extra couple of moments – it will pay off.
- Helpful, sensitive, courteous – complainants want to be taken seriously; offer to help; show you want to help; stay calm and empathetic; DON'T argue back! Try to defuse the situation.
- Confidentiality – discuss protection of patient / client confidentiality; ensure patient/client agreeable to discussions about them – consent / authorisation.
- An apology can often resolve matter quickly. It's ok to say sorry!
- Take ownership – attempt to find a solution but DON'T "jump in" with solutions until you are sure you have heard and understood their complaint – people often initially only want someone to listen to them – get something "off their chest". Check details. Ask what they would like to happen. Agree actions. Emphasise resolution is best as quickly as possible and as near to the point of contact as possible. Don't make promises you can't keep. Don't blame others or policies.
- Ask for help from someone else, e.g. line manager, supervisor, colleague etc, if in doubt; you are unsure how to handle; "out of your depth" or indeed to provide you with support.
- If a complaint raises a specific urgent concern or risk, ensure the patient/client's immediate needs are met before looking at the other aspects of the complaint.
- Do you know who the designated person is for managing complaints within your organisation? And how to contact them?
- If staff have dealt with a verbal complaint, discuss how they are expected to document and report this within individual organisation – if there is a form, provide with copy for reference. If a complainant is still unhappy, advise of the formal process and provide a complaints leaflet.

Annex 8

OVERVIEW OF THE INVESTIGATION PROCESS

1. The purpose of the complaint investigation process is to establish the facts, to identify areas for improvement and to gain resolution for the complainant.

2. All Complaints will be subject to an appropriate investigation in accordance with the Trust's Concerns, Complaints and Compliments Policy and Procedure.

3. The Complaints Manager will be responsible for allocating each complaint to the relevant Investigation Manager and Assistant Director/Tier 3 Manager (Tier 3 where no tier 4 exists) upon receipt of the complaint.

4. The Investigation Manager and Assistant Director will assess and agree the grading of the complaint in conjunction with the Complaints Manager.

5. The Assistant Director will ensure any complaint identified as high risk is assessed, reported to the relevant Director and/or Professional Lead and appropriately managed and investigated using Root Cause Analysis methodology. Consideration should be given to undertaking independent investigations into high risk complaints that do not meet Serious Adverse Incident (SAI) criteria.

6. If deemed appropriate, independent experts or lay people may be appointed to undertake or assist with an investigation with the consent of the complainant.

7. The Assistant Director and Investigation Manager will appoint an appropriate Investigation Officer to conduct the complaint investigation. The level of investigation must be proportionate to the grading of the complaint.

8. The Investigation Officer will conduct the complaint investigation in accordance with Complaints Investigation training, related policy and procedure and defined timescales. The Complaints Manager's role is to continuously monitor progress and escalate any delays or difficulties in accordance with the Complaints Escalation Process (Annex 17 refers).

9. The Investigation Officer will ensure that the investigation is thorough, robust, proportionate and supported by evidence. The Investigation Officer must identify what happened (establish the facts), why it happened and what can be done to prevent a recurrence. At all times, the Investigation Officer must ensure impartiality in an investigation. An investigation must not be adversarial and must uphold the principles of fairness and consistency.

10. The Complaints Manager and Investigating Manager will provide advice to the Investigation Officer as and when required.

11. The Investigation Officer must immediately highlight any issues or concerns that may arise during the investigation regarding patient/client safety to the relevant manager for action.

12. The Investigation Officer will make contact with the complainant at the earliest opportunity following receipt of the complaint to assist in achieving successful resolution.

13. The Investigation Officer must ensure they understand the full details of the complaint and what the complainant wants as an outcome before commencing the investigation, e.g. the complainant may want an apology or to be reassured that action has been taken to ensure there will be no recurrence of the issue that led to the complaint, or they may wish for a change in the provision of our services, compensation etc.

14. Staff who are involved in a complaint will be notified by the Investigation Officer at the earliest possible opportunity. Staff should be advised of support mechanisms that exist for them both during and after the investigation, i.e. line management support and the availability of the Trust's 24 hour confidential counselling service accessed via Carecall (Telephone 0808 8000 002). If staff feel they are not receiving the support they need from their line manager, and this may not always be possible if the line manager is the manager conducting the investigation, then they may seek help and support from the next level of management.

15. Where staff are directly involved in the complaint, statements will be taken at the time of the investigation as an accurate account of events. Individuals may be interviewed by:

    i. the Investigation Officer
    ii. line manager / senior manager with the appropriate level of seniority
    iii. an independent person with appropriate level of seniority
    iv. a relevant medical, clinical, nursing or professional person with the appropriate level of understanding and seniority
    v. Complaints Manager where appropriate
    vi. Governance Manager where appropriate

16. In certain circumstances it may be preferable for two persons to interview an individual. Consideration must be taken to ensure that the interviews are carried out in a non-blame manner and that the interview is fair, proportionate to the complaint and independent.

17. The person conducting the interview should always review any relevant documentation that may have a bearing on the complaint.

18. Where it is not possible for an interview to take place the individual named in the complaint will be asked to respond in writing. This response together with the relevant patient/client notes must always be peer reviewed by an appropriate person with the appropriate level of skills and understanding of

the speciality. This peer review must be clearly documented and sent as part of the investigation to the Investigation Officer.

19. There is no automatic right for staff to have representation during the complaints investigation. Staff have a responsibility to assist the Trust in dealing with and responding to complaints within set timeframes.

20. On the occasion where an individual person is named more than twice within a period of one year the Director and Assistant Director of the Directorate will be informed.

21. Where professional issues are identified in a complaint the appropriate Director and Professional Lead will be notified and sent a copy of the complaint and, when available, a copy of the draft response for information.

22. Where an investigation highlights that further support/training is needed for the staff involved in the complaint, the relevant Manager will make the necessary arrangements, appropriate for the individual complaint. This should be clearly documented in the Investigation Report Action Plan.

23. Where an investigation highlights potential misconduct on the part of the employee or a breach of legislation or policy issue, the investigation into the complaint will cease and these matters referred to the Disciplinary Procedure in accordance with Annex 2.

24. All managers have a responsibility for complaints investigated within their operational/functional area to ensure compliance with timeframes throughout the complaints process.

25. An audit trail must be established for each investigation. To achieve this, the Investigation Officer must complete the Complaints Investigation Report (Annex 18) and Action Plan (Annex 19).

26. The Investigation Officer is responsible for ensuring timeframes are met for completion of the investigation to ensure a response is provided to the complainant within set timescales.

27. Some complaints will take longer than other to resolve because of differences in complexity, seriousness and the scale of the investigative work required. It is important that the Complaints Manager is informed of any delays to ensure the complainant is kept updated.

28. A Complaints Escalation Process has been developed to ensure timescales for completion of investigations, to include the completion of an investigation report and response letter, are carefully managed. Annex 17 refers.

29. Relevant staff must be kept informed of the investigation and have the opportunity to review and comment on the draft response.

30. On completion of the investigation, the Investigation Officer should prepare a draft response. The response should explain how the investigation was carried out and how the conclusions were reached. This draft response must be shared with the relevant staff to ensure factual accuracy and agreement.

31. The draft response, report and action plan should be quality assured by the Assistant Director and Investigation Manager prior to being submitted to the Complaints Manager within **14 working days** of receipt of the complaint.

32. The Complaints Manager will ensure all issues are addressed in the draft response, taking account of information obtained from reports received and will provide a layman's interpretation to otherwise complex reports and letters of response.

33. The Complaints Manager is responsible for forwarding the draft letter of response to the relevant Director for their review and/or comment in preparation for sign off by the Chief Executive (or their deputy) and for issuing the final response to the complainant within the **20 working day** timeframe. Information on the role of the Ombudsman will be enclosed in the letter.

34. It may be appropriate, depending on the complexity of the complaint, that a meeting is offered to the service user or whoever is acting on their behalf to discuss the outcome of the investigation.

35. All investigation correspondence should be uploaded onto DATIXweb upon completion of the investigation process, and the complaint closed.

36. On occasion, a complainant may highlight issues that have not been addressed; this is known as a 're-visited' complaint. This should be investigated as soon as possible and the investigation should follow the process as for the original complaint. If the complainant raises new issues, the Complaints Manager will formally determine whether the complaint should be deemed as a new complaint and update DATIXweb accordingly.

37. While every effort must be made to ensure that a response has covered all the issues raised by the complainant in an open, honest and fair manner it may not be possible to resolve a complaint where the complainant's expectations of the outcome are unrealistic. In these circumstances the relevant Director, in collaboration with the Complaints Manager, should consider referring the complaint to the Ombudsman

MEETING A COMPLAINANT

If a meeting is arranged with a complainant at any point in the complaint management process, the Investigation Officer in collaboration with the Complaints Manager will ensure that:

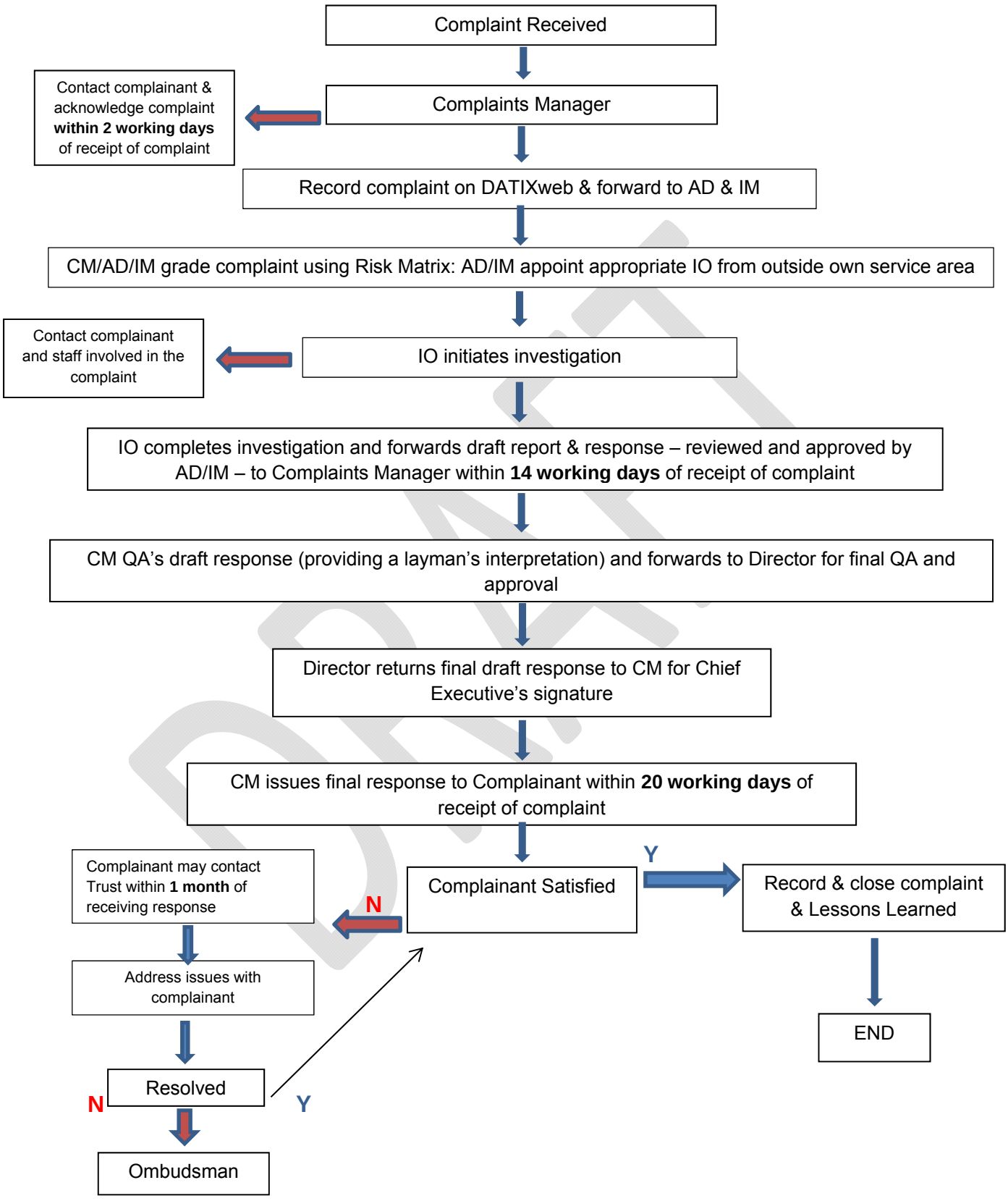
- the reasons for the meeting are discussed with the complainant a minimum of 5 working days ahead of any arrangements for a meeting being made, to

ensure the complainant understands the purpose and is agreeable to attending

- encouraging the complainant to bring a relative or friend to the meeting
- an appropriate time and venue for the meeting is arranged
- an agreed agenda is sent to the complainant and attendees a minimum of 5 working days prior to the meeting
- the relevant Trust staff are present at the meeting
- where appropriate, the Complaints Manager will attend the meeting
- a record is kept of the meeting. A copy of the meeting notes should be sent to the Complaints Manager for issue to the complainant (if requested) no later than 10 working days from the date of the meeting

Annex 9

INVESTIGATION PROCESS – KEY STEPS FLOWCHART



CM = Complaint Manager AD = Assistant Director IM = Investigation Manager IO = Investigation Officer

Annex 10

TIME LIMITS AND PERFORMANCE TARGETS

Complaint should be made within 6 months of the event which caused the problem, or within 6 months of realising the person had something to complain about, provided that this is within 12 months of the event

↓

Complaints Manager will:

- log complaint onto DATIXweb
- issue a written acknowledgement to complainant within 2 working days
- identify all points of complaint which require investigation and response
- issue all relevant correspondence to the relevant Investigation Manager and Assistant Director for investigation and provision of draft response by appointed Investigation Officer

↓

Investigation Officer to provide draft response letter – reviewed and approved by Assistant Director and Investigation Manager – to Complaints Manager within **14 working days** of receipt of complaint

↓

Complaints Manager quality assures (QA) the approved draft response to ensure all points of the complaint are adequately addressed and presented in layman's terms

↓

Complaints Manager forwards QA'd draft response and associated files to the relevant Director's office for final QA and approval

↓

Director reviews final draft response. If required, Director sends to Investigation Officer (copied to Complaints Manager) for any amendments. Investigating Officer returns amended response to Director (copied to Complaints Manager) for final approval

↓

Director forwards final response to Complaints Manager for final sign off by Chief Executive (or their deputy) within **20 working days** of receipt of complaint and issue to the complainant. Complaints Manager will ensure a signed copy of the final response is issued to all relevant staff for their information; all aspects of the complaints process is recorded on DATIXweb; and a signed copy of the final response is filed in the complaint file.

↓

Learning from the complaint to be recorded on the Investigation Report Action Plan. Assistant Director in collaboration with the Investigation Manager ensures progression of any required actions arising from learning, including appropriate sharing of learning in accordance with the Trust's governance arrangements

↓

Investigation Officer will forward all records relating to the investigation and management of the complaint to the Complaints Manager within **2 weeks** of the complaint being closed.

Annex 11

Role of Designated Assistant Director of xx

The designated Assistant Director will support the (designated) Director in meeting their responsibility for complaints management.

Annex 12

Directors Role

Directors are responsible for ensuring that the standards and processes referred to in this policy are followed within their respective Directorates, thus ensuring that the Trust does not suffer reputational damage due to maladministration of complaints.

Directors will:

i. disseminate and promote the Concerns, Complaints and Compliments Policy and Procedure within their areas of responsibility and ensure their implementation by providing support and advice to managers and staff;

ii. ensure complaints are investigated timely and thoroughly in accordance with existing policy and procedure, including approving extensions to timescales as appropriate upon request from Investigation Managers;

iii. review and amend draft complaint responses in preparation for sign off by the Chief Executive (or their deputy);

iv. ensure that learning from complaints is shared in accordance with the Learning from Serious Adverse Incidents, Complaints, Claims and Litigation Policy through appropriate management structures;

v. ensure that complaints are monitored and reviewed within respective Directorates;

vi. implement action plans as required to ensure any recommendations made as a result of investigations are implemented and monitored, and provide assurance to the Complaints Review Group, the Learning Outcomes Review Group and subsequently to the Assurance Committee;

vii. take account of relevant complaints when reviewing local Risk Register and ensure that this is linked appropriately to the Corporate Risk Register;

viii. ensure staff have access to appropriate training on complaint management and, where appropriate, investigation of complaints.

Annex 13

Assistant Directors/Tier 3 Managers Role

Assistant Directors are responsible for ensuring that all complaints are managed efficiently and effectively within their areas of responsibility and all complaint responses are provided in a timely way.

Assistant Directors/Tier 3 Managers will:

i. assess and agree the grading of the complaint in conjunction with the Investigation Manager and Complaints Manager;

ii. ensure any complaint identified as high risk is assessed, reported to the relevant Director and appropriately managed and investigated using Root Cause Analysis methodology. Consideration should be given to undertaking independent investigations into high risk complaints that do not meet the Serious Adverse Incident (SAI) criteria;

iii. deal with any queries Investigation Managers might have, including the need to contact or meet with the service user who raised the complaint or concern;

iv. maintain oversight of and implement effective performance management systems to ensure the quality and timeliness of responses provided by their areas of responsibility, reviewing complaints management data on an ongoing basis and prioritising actions to address issues identified regarding outstanding responses and any trends of excessive response times;

v. where a complaint relates to the actions of more than one Directorate the relevant Assistant Directors will liaise with the Complaints Manager to identify and agree who will take the lead in investigating the complaint and co-ordinating the response for the complaint;

vi. agree the draft response with the Investigation Manager (ensuring that all aspects of the complaint are addressed, and that the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling are reflected in the response) and forward to the Complaints Manager within identified timescales;

vii. where appropriate, ensure action plans arising out of investigations (including Ombudsman's recommendations) are agreed, progressed, monitored and evaluated;

viii. ensure that the Directorate fosters an ethos of learning in order to minimise future occurrences of issues identified through complaints;

ix. ensure any serious allegations regarding staff performance and behaviour that may arise through the Complaints Procedure is appropriately followed up.

Investigation Managers/Tier 4 Managers

Investigation Managers are responsible and accountable to their Director to ensure that complaints are thoroughly investigated and responded to within the given timescales.

Investigation Managers/Tier 4 Managers will:

i. assess and agree the grading of the complaint in conjunction with the relevant Assistant Director and Complaints Manager and identify the most appropriate Investigation Officer (IO) to carry out the investigation;

ii. source the IO from a different service area to that in which they work in order to enhance impartiality, e.g. source an appropriate IO from a different Division for a complaint that relates to Belfast Division;

iii. ensure the IO has the appropriate knowledge, training and level of seniority to undertake the complaint investigation;

iv. advise the IO of the grading of the complaint and provide advice and guidance on the most appropriate way to investigate the complaint;

v. ensure the IO is supported throughout the investigation process and has adequate protected time to carry out the investigation following due process, write the investigation report and draft the response to the complaint within identified timescales;

vi. ensure that complaints investigations are conducted thoroughly in a manner that is supportive to those involved and takes place in a blame free atmosphere;

vii. provide support to staff during an investigation and ensure that staff named in the complaint are made aware of the content of both the complaint and the response;

viii. ensure that their teams review and approve draft responses in a timely manner;

ix. quality assure draft response letters to ensure all issues raised by the complainant are fully addressed;

x. ensure that complaint reports and draft responses are provided within agreed timescales, promptly escalating obstacles that may cause delays to the relevant Assistant Directors;

xi. notify the Complaints Manager at the earliest opportunity of any delays, including the reason for the delay;

xii. ensure appropriate action is taken when a health professional is identified in a concern or complaint. Where more than one concern or complaint is raised about an individual, ensure there is appropriate escalation to the relevant professional lead;

xiii. ensure that comprehensive records are maintained throughout all complaint investigation and management processes;

xiv. upon closure of each complaint ensure that the Complaints Department receives all relevant correspondence relating to the complaint (e.g. statements from staff,

investigation notes, interview records etc.) to facilitate retrieval in a timely manner should the complaint be reviewed at a further stage for example by the Ombudsman or the Trust legal department;

xv. liaise regularly with the Complaints Manager as required;

xvi. ensure that agreed action plans arising out of investigations are completed and any recommendations implemented across appropriate teams/departments.

Annex 15

Investigation Officers

The Investigation Officer (IO) will:

i. conduct the complaint investigation in accordance with Complaints Investigation training, related policy and procedure and defined timescales;

ii. ensure the investigation is thorough, robust, proportionate and supported by evidence; the IO must identify what happened (establish the facts), why it happened and what can be done to prevent a recurrence. At all times, IO's must ensure impartiality in an investigation. They need to be unbiased and objective, and keep an open mind. An investigation must not be adversarial and must uphold the principles of fairness and consistency;

iii. seek advice and support from the Investigation Manager and/or Complaints Manager as and when required;

iv. immediately highlight any issues or concerns that may arise during the investigation regarding patient/client safety to the relevant manager for action;

v. make contact with the complainant as soon as possible following receipt of the complaint to assist in achieving successful resolution;

vi. ensure they understand the full details of the complaint and what the complainant wants as an outcome before starting the investigation e.g. the complainant may want an apology or to be reassured that action has been taken to ensure there will be no recurrence of the issue that led to the complaint, or they may wish for a change in the provision of our services, compensation etc;

vii. provide support to the complainant or advise how they may access support e.g. Complaints Manager, Patient/Client Council, Independent Advocacy;

viii. notify staff involved in the complaint as soon as possible;

ix. provide support to staff involved in the complaint i.e. Complaints Manager; line management support or if they feel they are not receiving the support they need (and this may not always be possible if the first line manager is the manager carrying out the investigation) then they may seek help and support from the next level of management; the availability of the Trust's 24 hour confidential counselling service accessed via Care Call (Telephone No: 0808 8000 002);

x. advise staff that there is no automatic right to have representation during the complaints investigation. Staff have a responsibility to assist the Trust in dealing with and responding to complaints within identified timescales;

xi. establish an audit trail by keeping robust records of notes of meetings and statements, if applicable, and by completing a Complaints Investigation Report (Annex 18) and Action Plan (Annex 19).

xii. ensure they record when further support and/or training is recommended for an individual or group of staff involved in the complaint in the Complaints Report Action Plan; the relevant manager will be responsible for making the necessary arrangements for further support or training, appropriate to the complaint;

All Staff

The management of concerns, complaints and compliments is the responsibility of all staff providing services within and on behalf of the Trust regardless of level, role or location. It is essential that everyone takes relevant responsibility for managing complaints and compliments in order to improve the service users' experience and to support continuous improvement.

A complaint can be made orally or in writing to any member of Trust staff (any complaints received in writing must be passed to the Complaints Manager). The most satisfactory outcome from complaints often comes when the issues identified are dealt with fully and effectively in the first instance if possible. This is known as informal resolution. As such the Trust expects all staff to attempt to resolve issues on the front line speedily and to the complainant's satisfaction, with the assistance of a more senior member of staff when necessary.

The first responsibility of the recipient of a complaint is to ensure that the patient's immediate healthcare needs are being met. This may require urgent action before any matters relating to the complaint are tackled.

Complainants should be listened to and treated courteously with dignity and respect.

Reassurance should be given to the complainant that their concern is being taken seriously, that it will be dealt with confidentially and will not in any way adversely affect their or their relative's treatment.

Staff will:

i. work to put things right and help resolve issues or concerns raised by complainants in an open, compassionate, constructive, non-judgemental and timely manner;

ii. refer the matter as soon as possible to their line manager if unable to deal with complaints raised directly with them or seek advice from the Complaints Manager (or their deputy) on how to proceed;

iii. keep their line manager updated on complaints and enquiries they are currently dealing with, and complaint outcomes (including resultant service improvements);

iv. provide patients, patient relatives, carers, visitors and other service users with appropriate information regarding how to give feedback on concerns, complaints and compliments;

v. co-operate fully with the investigation of complaints within the service/team particularly by returning statements, reports and other information to Investigation Officers in a timely and appropriate manner;

vi. enable the process of organisational learning following a complaint;

vii. release staff for relevant complaints awareness/ customer satisfaction training, if appropriate;

viii. maintain good record keeping (including updating DATIXweb with relevant information as required;

Annex 17

COMPLAINTS ESCALATION PROCESS

Every effort should be made to ensure complaints are responded to within 20 working days from receipt of complaint. Efficient processes for the prioritisation and management of complaints must be established in all Directorates, with every effort being made by staff to promptly identify potential obstacles to the provision of responses within **20 working days** and to take action (escalating to more senior staff as necessary) to ensure the prompt handling of complaint investigation and response writing.

It is recognised, however that there may be instances when, for example the complaint is complex and/or involves more than one Directorate, that it becomes apparent **20 working days** will not afford adequate time to fully investigate the concerns raised. It is vitally important to identify likely delays at the earliest opportunity and to immediately notify the Complaints Manager to allow prompt communication with the complainant.

1. The Complaints Manager should send a reminder to the relevant Investigation Manager 10 working days following receipt of the complaint;

2. If a response is not received and no information provided within **12 working days** from receipt of complaint, the relevant Assistant Director/Tier 3 Manager will be informed.

3. If no response or information is provided within **15 working days** from receipt of complaint, the relevant Director will be informed.

4. Complaints which have not been responded to within the **20 working day** timeframe will be escalated as follows:

- Complaints outstanding **after 20 working days**
  A reminder will be sent to the Investigation Manager, Assistant Director/Tier 3 Manager and Director highlighting that the complaint is now outside the 20 working day timeframe.

- Complaints outstanding after **30 working days**
  A further notice will be sent to the Assistant Director/Tier 3 Manager and Director advising that the complaint is now well outside of the timeframe and urgently requires action. The designated Director for the management of the Complaints Procedure will be made aware of the delay.

- Complaints outstanding after **40 working days**
  An escalation notice will be sent to the Chief Executive

Annex 18

Northern Ireland Ambulance Service
Health and Social Care Trust

REGIONAL INVESTIGATION OVERVIEW REPORT

If more than one service involved, service managers to liaise and agree lead Investigation Officer

Complainant Name (person making complaint)	<<DATIX>>	**Complainant's Contact Details** (e.g. phone, email)	<<DATIX>>
Service User Name (if different from above)	<<DATIX>>	**Service User's Details** (Address, DOB, Record No.)	<<DATIX>>
Draft Response due (to Complaints from Directorate)	«COM_DRECEIVED»	**Service User Consent Received?**	<<DATIX>>
Complaints Office Initial Grading	Potential Risk to Trust: <<DATIX>> Impact to Service User: <<DATIX>>	**Service Area's Initial Triage** (issues to consider before proceeding with formal complaints process)	**1. Confirm Grading:** _____ **2. Can this be resolved informally by immediate contact with complainant?** ☐YES ☐NO _____ **3. Who will Investigation Officer/s be?** _____ _____ **4. Does it meet criteria for SAI?** ☐YES ☐NO
Any delay in draft response? (from Directorate to Complaints)	☐YES ☐NO **If yes, give reason:** **(inform Complaints Department asap of delay & reason)**		

Key Issues of Complaint for Investigation (list below or reference other document where you have these as applicable)
Where appropriate, you should contact complainant (phone / meet) to clarify issues / nature of complaint / their expectations / outcome they would like, before commencing investigation – *getting your investigation right first time*

	Complainant's expectations for outcome?

Investigation Methodology **Details of how you carried out your investigation (list not exhaustive) (tick box as applicable)**
Attach all documentation to support your investigation, e.g. service user records (inc. electronic), staff rotas, policy/procedure/guidance, reports, interviews, record of phone calls, emails, timeline, etc – *you need to evidence a thorough, robust & proportionate investigation*

☐ Records reviewed (inc. electronic records)? Details:
☐ Reports received? Details:
☐ Trust policy/procedure/protocol/standard etc? Details:
☐ Regional or National policy/procedure/guidelines/guidance etc? Details:
☐ Staff/witnesses interviewed? Details:
☐ Complainant/other external witnesses interviewed? Details:
☐ Chronology or timeline of events? Details:
☐ Independent advice internal? Details:
☐ Independent expert advice external? Details:
☐ Use of Lay Person? Details:
☐ Root Cause Analysis? Details:
☐ Other? Details:

Investigation Details / Analysis / Findings – Review each key issue identified above (detail below or reference other document where you have recorded these, as applicable) (see tools on iconnect)
Example: What happened? What should have happened? If something went wrong, what? Why, when & how did it happen? Facts v disputed events? What is the root cause? Any contributory factors? Mitigating circumstances? Any good practice?

Conclusion/s

Remedy for Complainant / Put Things Right
See Ombudsman's 'Principles for Remedy' i.e. if possible, returning the person to the position they would have been in if the poor service had not occurred, e.g. apology, reviewing/changing a decision, remedial action, reimbursement for costs incurred, etc.

Action Plan to Prevent Recurrence / Lessons Learnt (SMART Objectives)
NB: If no action has been identified, please indicate this below

	Issue Identified	Action Taken / Planned	Person Responsible	Completion Date	
				Target	Completed
1					
2					
3					
4					

Sharing the Learning

What has been learned?

How will you share the Learning?	☐ **Directorate(s)** (specify)		☐ **Trustwide**	
	☐ **Other** (specify)		☐ **Regional**	

Providing Outcome of Investigation to Complainant – How will you provide the outcome of your investigation?

Meeting? – ☐YES ☐NO
(arrangements can be made via the Complaints Department; a minute/note of the meeting will be required)

Written Response? – ☐YES ☐NO
(to draft a Trust response to the complainant, please ensure you address all their issues, and send the draft via email to the Complaints Department >email address< – see checklist for draft response at Appendix 1)

Checklist	☑ ☒ N/A	Comments
1. At the outset, did you contact the complainant to establish the nature of their complaint and what their expectations are for outcome?		
2. Have you identified all issues of complaint?		
3. Have you separated facts from disputed events?		
4. Have you interviewed any staff / witnesses involved?		
5. Have you reviewed all relevant records/documentation?		
6. Was a visit to the relevant site / facility / clinical area required?		
7. Have you liaised with any other service areas involved to ensure one coordinated investigation and response?		
8. If the complaint relates to clinical / professional issues, have you included review by clinician / professional with appropriate seniority?		
9. Have you obtained all evidence to support your findings?		
10. Have you attached all investigative documentation?		
11. Has your draft response received all relevant Directorate approval (e.g. Assistant Director; Associate / Clinical Director, etc)		
12. Have you shared the outcome with any staff complained about?		

Investigation Officer Completing this Complaints Investigation Report

Name: _____ **Designation:** _____
Date: _____

Send this form and attachments to Complaints Office for retention on central complaints file

Appendix 1 – Checklist for Preparing Draft Response to Complaint

*Quality assurance checklist for Investigation Officer – the response letter will be from the Chief Executive or Nominated Director

	Criteria	☑ ☒ N/A	Comments
1	You fully understand what the complainant is unhappy about before you start to prepare draft response		
2	Polite opening to the letter – thank them for raising their complaint		
3	If the response is outside the target timeframe for reply, include an apology and the reason for the delay		
4	Include condolences if there has been a bereavement		
5	It is a good idea to start with a short summary of the complaint issues in your own words		
6	Ensure each issue raised is fully addressed – clear explanation of investigation findings into each issue		
7	Response is clear, concise and does not include unnecessary information		
8	Acknowledge and accept responsibility for any failures, and give an apology at the outset, a clear explanation and what actions will be taken to prevent a recurrence		
9	If you cannot find anything that has gone wrong, ensure a customer friendly response which acknowledges their point of view or concern		
10	Express regret for any misunderstandings		
11	Use of straightforward, simple language – avoid jargon, abbreviations or medical / technical terms – where it is used, explain the meaning		
12	Use appropriate language – personalised, sincere, non-defensive, empathetic, courteous and sensitive. Tone of letter matches the nature of the complaint.		
13	Double check accuracy of <u>all</u> facts		
14	Ensure you advise the complainant of any changes / improvements that have taken place (or planned) as a result of their complaint		
15	Offer of remedy, where appropriate (e.g. further appointment; reimbursement of costs incurred)		
16	Offer of meeting to discuss the outcome of your complaint investigation, if appropriate		
17	Does the response reflect the Trust Values?		

18	If you did not work in the department, would you understand it?		
19	Would you be happy for your loved one to receive this response?		
20	Remember who the letter is from (i.e. CE or Director) – will they be satisfied to sign it?		

Annex 19

ACTION PLAN

ACTIONS REQUIRED: (Actions identified as a result of the complaint investigation. If no action is required, please state why)	**WHO WILL ARRANGE THE ACTION?**	**TIMESCALE FOR COMPLETION OF THE ACTION**
LEARNING (Describe the learning that has been gained from the complaint investigation)	**HOW AND TO WHOM WILL THE LEARNING BE SHARED?**	**URGENCY**

Details of person completing this form:		
Name	*Position*	*Date*

Annex 20

DEFINITIONS OF KEY TERMS

Chief Executive	The Chief Executive of the HSC organisation.
Complaint	An expression of dissatisfaction that requires a response. Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.
Complainant	An existing or former patient, client, family, representative or carer (or whoever has raised the complaint).
Complaints Manager	The person nominated by an HSC organisation to handle complaints.
Compliment	An expression of praise, commendation or admiration.
Concern	Usually where an individual remarks, expresses an opinion or makes an observation about a patient's treatment/care that can be defined as a matter of interest, importance or anxiety.
DoH	Department of Health in Northern Ireland[22]
HSC Board	Health and Social Care Board
HSC organisation	An organisation which commissions or provides health and social care services; includes the HSC Board, HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers.
Informal resolution	Where the complainant's issues are identified and dealt with fully and efficiently in the first instance to the complainant's satisfaction.
Formal (local) resolution	The satisfactory resolution of a complaint by the Trust, working closely with the service user.
PCC	Patient and Client Council.

[22] Formerly the Department for Health, Social Services and Public Safety (DHSSPS)

RQIA	The Regulation, Quality and Improvement Authority is an independent, non-departmental public body, charged with overall responsibility for regulating inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.
Senior Person	Means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust.
Service user	Means a patient, client resident, carer, visitor or any other person accessing HSC services.

TB/01/08/2019/06

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

Thursday 1 August 2019

Title:	Update on the Good Attendance Programme
Purpose:	For noting (Public)
Content:	Update against deliverables.
Recommendation:	
Previous Forum:	Trust Board 4th April 2019
Prepared by:	Director of HR & CS
Presented by:	Director of HR & CS

The Good Attendance Programme was commenced on 25 March 2019 with a stakeholder workshop and the first Programme Team meeting. The programme structure was agreed and the related deliverables provided to Project Managers. At the Programme Board meeting on 16/4/19 the recruitment of a project administrator was approved. The post was filled on 9/7/19 and the related Programme and Project meetings are in the process of being scheduled. Recruitment campaigns for a Good Attendance HR Manager and a Good Attendance Operational Manager are in progress and these roles will be critical in delivering on the Programme. The Project Initiation Document (PID) is being developed and will be presented to Programme Board at August meeting for agreement. This will specify the deliverables, related prioritisation, timeframe, risks and constraints. It is intended to report progress against the PID to Assurance Committee as well as to the Programme Board.

Programme Structure:

Senior Responsible Officer (SRO)	Programme Manager (PM)	Programme Board	Programme Team:	Project 1: Review of attendance Policy and related Procedure	Project 2: Operational Directorate Priorities & Improvements	Project 3: Occupational Health Improvements	
Director of Human Resources and Corporate Services	Assistant Director of Human Resources and Corporate Services	Senior Management Team (AACE Specialists when required)	Director of Human Resources and Corporate Services (SRO) Director of Operations Assistant Director of Human Resources and Corporate Services (PM) Assistant Director Operations ASAM South Division Assistant Director Organisational Development and Equality (AACE Specialists when required)	Project Manager: Assistant Director of Human Resources and Corporate Services (AACE Specialists when required)	Project Manager: Assistant Director of Operations (AACE Specialists when required)	Project Manager: Ambulance Service Area Manager, South Division (AACE Specialists when required)	Project Manager: Assistant Director of Organisational Development and Equality (AACE Specialists when required)
	Weekly highlight meetings are scheduled with SRO on progress and risks to delivery.	Programme Board meetings were held on 16/4/19; 11/6/19 and 16/7/19. Monthly meetings are now being scheduled.	Project Team meeting held on 25/3/19 and meetings are now being scheduled.				

PROJECT 1	DELIVERABLES	PROGRESS AT JULY 2019	RAG (completion dates not yet agreed)
	Review Attendance Management Policy / Procedure.	Workshop planned for 7/8/19 to review policy and procedure with key stakeholders, facilitated by AACE.	
	Review associated policies / procedures to support implementation of the revised Attendance Management Policy / Procedure.	Review of the following policies and/ or procedures: • Probationary period • Medical Redeployment and redeployment under DDA (Revised Management Framework agreed by SMT and implemented) • Lighter duties • Annual leave – (revised policy currently out with Trade Unions for consultation).	
	Develop of Management Resource to support implementation of revised Policy / Procedure. To include training, development of a Managers Toolkit.	Management Toolkit currently being drafted with associated actions delayed pending the appointment for the Good Attendance Managers and competing priorities for the Project Team.	
	Re-launch revised Policy / Procedures.	N/A	
	Explore HR best practice and roll out across the Trust.	• Format of monthly meetings between HR / Operational Management refreshed to bring renewed focus • Weekly collaborative meetings with Senior Operational/HR Managers have been established to consider Operational (Divisional and Control) complex cases. • Monthly meetings have been agreed with Occupational Health, HR specialists and Operational managers to case review complex cases. • Good Attendance Managers to commence benchmarking on appointment • HR Business Partnering at Divisional and Control level is being explored with related bench marking and business case in development.	
	Develop and deliver a communications plan.	To be reflected in draft PID for agreement at August Programme Board meeting	
	Review governance arrangements for reporting of absence and related corporate reports	Delayed pending the appointment for the Good Attendance Managers and competing priorities for the Project Team.	

PROJECT 2	DELIVERABLES	PROGRESS AT JULY 2019	RAG (completion dates not yet agreed)
	Review and establish Senior Managers performance management systems for Attendance Management to ensure that each tier of management holds to account its direct reports for attendance management and includes monitoring of (timely) escalation through Policy/Procedure.	Work in progress to review Key Performance Indicators (KPI) and establish an operational performance management framework. Trust Board Operations performance report to be revised to reflect new KPIs once agreed.	
	Review the provision and source of timely information reports to identify and deliver on areas of improvement.	Programme Board approved proposal to use GRS as source of timely information reports for Operational management to use in delivering on attendance improvement.	Complete
	Explore local best practice and roll out across Directorate.	The quality improvement pilot for return to work interviews has been approved for roll out across Operational Divisions.	
	Review the role of RMC and utilisation of GRS in relation to managing attendance to include staff reporting of sickness and contact arrangements, R2W interview, recording of attendance management activity and develop appropriate systems/processes/protocols.	Programme Board approved proposal to use GRS for Operational attendance management.	
	Review Operational Directorate staff absence reporting methodology to reflect best practice.		
	Review of Operational Directorate processes for management of sickness certificates and recording of absence.		
	Ensure local recording of Attendance Management activity		
	Review of R2W practices to include establishing a system to ensure timely undertaking of interviews, review of template documentation for completion and a system that ensures related forms are signed and dated.	Links to KPIs above	
	Joint review of Operational Directorate Annual Leave Procedure.		
	Develop and deliver a communications plan linked to this work stream.	To be reflected in PID and agreed at Programme Board meeting in August.	

PROJECT 3	DELIVERABLES	PROGRESS AT JULY 2019	RAG (completion dates not yet agreed)
	Specify what is required from an Occupational Health Service for NIAS	Occupational Health Workshop planned for September 2019 with key stakeholders	
	Review specification against existing Occupational Health Services and identify gaps	As above	
	Scope provision for enhanced or new local Occupational Health Services	• Prioritisation mechanisms being explored to prioritise current OH resources • Current provider has been asked to consider employing a full time OH nurse for NIAS. Related Service Level Agreement under development and discussions in progress in this regard with current provider. • Further work has commenced in identifying alternative OH providers to address specification gaps once identified.	
	Develop an outline business case for investment in Occupational Health Services to meet identified requirements and gaps	Specification and gap analysis required in advance of outline business case. Pending workshop in September 19.	
	Develop and deliver a communications plan linked to this work stream.	To be reflected in PID and agreed at Programme Board meeting in August.	
PROJECT 4	DELIVERABLES	PROGRESS AT JULY 2019	RAG
	Invest in the Joint Partnership Health & Well Being priorities, as identified in the partnership survey and agree a related annual work plan to deliver on these.	Regular joint meetings of Partnership teams and steering Group. Action Plans agreed and on track for delivery	Complete
	Embed peer support	Work in progress to enhance current resources with 2 full time secondments agreed from august 19. An additional Cohort was trained in July and a further Cohort is planned for October 19. Project evaluation planned by November 19. Business case to be prepared by January 20 for mainstreaming peer support.	On track
	Consider formal post-incident support availability for staff across the Trust, including associated “stand down” arrangements.	Formal support and stand-down procedures will be finalised once the new Peer Support secondees are operational.	On track
	Review arrangements to support mental health and well-being and make recommendations for improvements	Included in the H&WB annual work plan and on track for delivery	On track
	Develop and deliver a communications plan linked to this work stream.	Action Plans already in place for elements of this work, Project specific communication plan will be presented to Programme Board for agreement in September 19	On track

TB/01/08/2019/07

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING 1 AUGUST 2019

PRESENTATION OF PAPER

Title:	Claims Management Policy & Procedure
Purpose:	To provide a framework for the effective management of professional/clinical negligence; employers' and occupiers' liability; and other general litigation claims within the Trust. To ensure compliance with DoH guidance, specifically Circulars HSC (SQSD) 5/10, i.e. 'Handling Clinical and Social Care Negligence and Personal Injury Claims' and Circular HSC (F) 52/2016 , i.e. "Revised HSC & NIFRS Delegated Limits and Requirements for Departmental/DoF Approval".
Content:	Outlines the roles and responsibilities of senior officers of the Trust who contribute to and manage the claims management process. Details associated arrangements/procedures for the Trust's management of such claims.
Recommendation:	For Approval
Previous Forum:	SEMT
Date of SEMT Approval:	17 July 2019
Prepared and Presented by:	Roisin O'Hara Director of Human Resources & Corporate Services

Northern Ireland Ambulance Service
Health and Social Care Trust

This is an official Northern Ireland Ambulance Service Trust policy and should not be edited in any way	
Title: CLINICAL NEGLIGENCE & EMPLOYER AND PUBLIC LIABILITY CLAIMS **Part 1: CLAIMS MANAGEMENT POLICY;** **Part 2: CLAIMS MANAGEMENT PROCEDURE;** **Part 3: Appendices**	
Reference Number:	
Target audience: All Staff	
Replaces (if appropriate): N/A	
Type of Document: Trust Wide	
Details of Consultation & Engagement: NIAS Senior Management and Trust Board Directorate of Legal Services	
Approved by SEMT:	**Date: 16/7/19**
Approved by Trust Board:	**Date: pending August 2019 meeting**
Issued by	**Date:**
Review:	**Date:**

CLINICAL NEGLIGENCE & PERSONAL INJURY CLAIMS (EMPLOYER AND PUBLIC LIABILITY CLAIMS)

POLICY & PROCEDURE FOR LITIGATION CLAIMS MANAGEMENT

CONTENTS

Part 3: APPENDICES

PART 1: CLAIMS MANAGEMENT POLICY

Claims Management Policy

Introduction

The effective management of professional/clinical negligence, employers' and occupiers' liability and other general litigation provides essential information for the identification and management of risk within the Trust.

This policy, including associated procedures, details the Trust's arrangements for the management of such claims, as primarily directed by Circular HSC (SQSD) 5/10 as issued by the Department of Health,(DOH), (Northern Ireland) as either arising from incidents which occurred within the Trust facilities or at another location e.g. patients home or a hospital.

Excluded from this policy are arrangements in respect of Employment Law claims. Claims where causation is an insurable matter against which risk the Trust has purchased commercial insurance for example, third party motor insurance, are also excluded.

Target Audience

This policy is particularly directed to Directors, Assistant Directors and other Senior Managers having responsibilities for the provision of services and the management of staff.

All Managers must ensure that staff are made aware of this policy and of their responsibility to familiarise themselves with, and to comply with its contents.

1.0 Policy Aims

The aim of this policy is to achieve the following objectives:

1.1 To detail the roles and responsibilities of senior officers of the Trust who contribute to and manage the claims management process, and what the operational arrangements in relation to that process are.

1.2 To ensure compliance with guidance contained in Circulars HSC (SQSD) 5/10, i.e. 'Handling Clinical and Social Care Negligence and Personal Injury Claims' and Circular HSC (F) 52/2016 , i.e. "Revised HSC & NIFRS Delegated Limits and Requirements for Departmental/DoF Approval", with relevant rules and protocols issued by the Courts in Northern Ireland including those in respect of 'Alternative Dispute Resolution' and for the 'Resolution of Clinical Disputes', and also with applicable Departmental guidance in respect of confidentiality and the management of records.

1.3 To implement an approach which ensures that all claims:

1.3.1 are dealt with promptly and efficiently within an organisational culture of openness which encourages all parties to resolve disputes, reduce delays and costs, and which ultimately reduces the requirements for litigation.

1.3.2 where litigation has been instigated that, without good reason, indefensible claims are not defended or settlement is delayed, and are dealt with in accordance with the Pre-Action Protocols for the Handling of Clinical Negligence and general litigation claims, ensuring that claims against the Trust are dealt with expeditiously and fairly and that the Trust either provides a robust defence or effects early settlement of claims as appropriate.

1.4 Application of the risk management systems and processes detailed in the Trust's Risk Management Strategy to the management of claims including ensuring that all claims are thoroughly investigated, learning identified and improvements made so as to reduce the risk of further similar adverse events again occurring in the future.

2. Definitions and Scope of the Policy

This policy applies to all staff and has particular relevance to those staff involved in the provision of reports, information statements or other documents for any claim.

2.1 *Personal Injury Claim*

''Any claim in respect of injury to any person including bodily injury, psychiatric injury or death for which an HSC body is legally liable and which does not fall within the definition of clinical and social care negligence.''

2.2 *Clinical and social care negligence*

''A breach of duty of care by members of the health care and social care professions employed by HSC organisations or by others consequent on decisions or judgements made by members of those professions acting in the course of their employment, and which are admitted as negligent by the employer or determined as such through the legal process.''

2.3 *Employer's Liability Claim*

Where an employee of the Trust alleges a breach in the Trust's duty of care as an employer which has resulted in their injury, or other damage or loss.

2.4 *Public/Occupier's Liability Claim*

Where a service user, relative, employee or other member of the public alleges that they have suffered injury, damage or loss due to the negligence of the Trust as a Landlord/occupier.

2.5 *Plaintiff/ Claimant*

Any person, or an agent acting on behalf of any person, who alleges that they have been adversely affected by the Trust, its services, or the acts or omissions of its staff who initiates legal proceedings against the Trust with the objective of securing compensation or other legal remedy.

2.6 *Medico-Legal Claim*

A legal claim where the Trust is not a Defendant but may have an interest by way, for example, of seeking recovery to it of payments made during periods of sick leave or the recovery of costs of care from a third party Defendant.

3. Roles and Responsibilities

3.1 *Assurance Committee of Trust Board*

The Assurance Committee, on behalf of Trust Board to which it reports, is responsible for seeking assurance that a robust system of risk management, including in respect of claims management, as represented by the Trust's Accountability Framework, is in operation.

3.2 *Audit Committee*

The Audit Committee has a specific role in ensuring that payments in respect of Claims are in accordance with:

a) the Trusts Scheme of Reservation and Delegation; and
b) the HSC Guidance on Delegated Limits, HSC (F) 52/2016; and
c) annual accounting guidance issued by the DoH and DoF.

3.3 *Learning Outcomes* Review *Group*

The Learning Outcomes Review Group (LORG) has a role in assuring the Assurance Committee, and ultimately the Trust Board, that effective learning has taken place as a result of events which lead to claims against the Trust as well as other incidents, complaints and compliments.

3.4 *Claims Advisory Group*

A Claims Advisory Group (CAG) should be formed to oversee claims management. It should consist of the Responsible Director, Claims Officer, Representative from Financial Accounts and the relevant solicitor from the Directorate of Legal Services.

The Claims Advisory Group (CAG) will meet on a bi-annual basis to review the management of claims and will be responsible for the following areas:

I. review professional and clinical negligence claims and employer's and occupier's liability claims against the Trust;

II. facilitate provision of guidance and advice from and discussion with the Directorate of Legal Services (DLS);

III. review the progression of claims, consider what might be the Trust's liability position and to consider and agree further action;

IV. update and provide International Accounting Standard 37 (IAS37) details including estimates on the value and probability of settling obligations;

V. undertake an annual review of all of the Trust's legal claims with a view to:
   - avoiding record duplication;
   - considering closure of cases static for 3 or more years;
   - evaluating and re-evaluating expected compensation, associated costs and date of settlement.

3.5 ***Chief Executive***

The Chief Executive is the Accounting Officer of the Trust and has, within this role, ultimate responsibility for ensuring that all claims are managed effectively and efficiently.

3.6 ***The Responsible Director***

The Responsible Director is the Trust's Board member with responsibility for Employer's and Occupier's Liability personal injury claims who reports to the Board on a regular basis

The Responsible Director is the Trust's Designated Officer who has strategic and operational responsibility for the management of claims against the Trust and carries designated delegated financial and related authorities, e.g. in relation to the engagement of Counsel and other expert advice and for settlement of claims in defined circumstances.

The Responsible Director will be responsible for the interaction between the Trust and the Directorate of Legal Services at the Business Services Organisation, the Trust's Legal Advisers, in relation to claims to which this policy applies.

The Responsible Director is also responsible for facilitating, both during the management of a claim and at its conclusion, the identification of root and contributory causes giving rise to the event which caused it to arise, their recording and dissemination across the Trust in the form of trend and other reporting so as to promote learning and improvement.

The Responsible Director will ensure the provision of periodic reports to Trust Board and/or its delegated committees.

3.7 Medical Director

The Medical Director is the Trust Director accountable to the Chief Executive with responsibility for clinical and social care negligence issues and the operation of corporate risk management arrangements within the Trust.

3.8 Directors, Assistant Directors, Line Managers and staff

The Trust's Risk Management Strategy details the responsibilities of staff at all levels of the organisation for risk management including incident recording and reporting and for the population of Directorate (local) and Corporate Risk Registers with risks identified, including those arising following occurrence of incidents and the instigation of claims. Incidents anticipated as having the potential to give rise to litigation will be subject to that level of investigation as

determined by application of the Risk Rating System as detailed in the Trust's Strategy, including earliest possible notice to the Trust's Risk Manager and the securing of all relevant documentation, equipment etc. pending receipt of further direction.

Within that investigation and as might be identified during the management of any claim which subsequently arises, Directors will ensure that the emphasis is placed on the identification of learning and the development, dissemination and implementation of improvement measures so as to reduce the risk of similar incidents again occurring.

Upon being made aware that legal proceedings have been initiated staff will ensure that responses to requests for reports and for other documentation and information will be fully responded to within the timescales identified in the Claims Management Procedure as required to facilitate the Trust's compliance with relevant court protocols and to enable a defence of the claim to be pursued.

3.9 ***Claims Manager***

The Claims Manager is responsible for the day-to-day management and administration of all legal claims, including Medical/Clinical Negligence, Public and Employers Liability Claims against the Trust.

3.10 ***Directorate of Legal Services (DLS)***

Professional legal advice will be provided to the Trust in the following circumstances:

I. Where a formal complaint is being pursued under the Trust's Complaint's Procedure which includes a demand for compensation;

II. When a Letter of Claim or other notice of legal proceedings is received.

3.11 DLS will also provide advice and assessment on the following as required:

I. Alternative methods of dispute resolution;

II. Engagement of Counsel;

III. Liability and causation;

IV. Strength of defence and the balance of probabilities as to successful rebuttal;

V. Quantum of damages including projections of low, likely and high;

VI. Likely defence costs;

VII. Requirement for, and the identification of 'Expert' witnesses;

VIII. Whether a 'without prejudice' settlement should be sought;

IX. Likelihood of settlement.

4.0 Medico-Legal Claims/ Recovery of Costs

4.1 Requests for information from Solicitors in relation to Medico-Legal Claims where the Trust is not a Defendant will be processed by the relevant department, i.e. Information Governance.

4.2 The Claims Manager must be made aware of any such request on behalf of a current or former service user where intimated or indicated that the information is required for use in a claim for damages against a third party in order that recovery of the Trust's costs might be pursued.

4.3 Similarly where, in the provision of health or social care services, it becomes known that a compensation claim is being pursued on behalf of the service user arising from an accident or other event giving rise to the need for that provision, the Claims Manager must be informed.

5.0 Confidentiality

5.1 The Trust will comply with all Data Protection Regulations in relation to the processing of data in respect of claims.

5.2 Details in respect of claimants, and information gathered during the investigation and management of claims will be treated with strict confidentiality by all parties who might require access to it.

5.3 Staff involved in the management of claims are required to ensure that there is no discussion of a claim other than with other persons employed or engaged by the Trust in its management.

5.4 All documentation in relation to claims held by the Trust will be maintained in a strictly confidential manner with access to it being limited to those persons directly involved in the management of claims.

6.0 Commitment to staff

6.1 It is recognised that there are occasions when staff may feel under particular pressures when claims are made against the treatment, care, services or management they have provided in good faith.

6.2 The Trust will ensure that staff are provided with adequate support during the management of claims both for their own wellbeing as well as in terms of explanation of and participation in the legal process.

6.3 Accordingly, and as well as being kept as updated as possible as to how claims are progressing, staff will also be encouraged to utilise such support mechanisms as might be provided by:

- Line Management

- Occupational Health Services
- Inspire Services
- Trade Union Representatives
- Specialist and legal advice as appropriate.

6.4 The Trust expects all staff to provide their full cooperation to the investigation and management of claims, including the prompt provision of all relevant information and documentation.

7.0 Apologies and Explanations

7.1 In the event that a complaint is being investigated and a letter of claim relating to the same issue is received from a solicitor acting on behalf of the complainant, the complaints process cannot proceed and the matter will be dealt with as a claim against the Trust.

7.2 The Trust encourages staff to offer apologies, sympathy and/or explanations as soon as an adverse outcome is discovered and which expressions of regret would not normally constitute an admission of liability, either in part or full. If appropriate an offer of early corrective treatment and/or rehabilitation should be made.

7.3 Should an individual clinician or other professional wish to adopt a form of apology or explanation in a manner other than described in the Trust's policies and which might expose them to a claim as an individual, they should firstly seek the advice of their medical defence organisation and/or professional body in the event that their actions exceed that level of indemnity normally available to any member of Trust staff in the performance of their duties.

7.4 When appropriate and in discussion with DLS and the Responsible Director, the Trust will consider alternative means of dispute resolution in line with the Court Service Pre-Action Protocols.

8.0 Novel, Contentious or Repercussive Claims

8.1 The Trust will always seek to avoid settling claims of doubtful merit, however low value, purely on a 'nuisance value' basis. The decision on whether any claim is to be contested or settled always being based on an assessment of likely success and the economics of defending, particularly where the Plaintiff is legally aided making it impossible to recover costs.

8.2 The approval of the DoH will be sought on any proposed settlement of a claim of a novel, contentious or repercussive nature, i.e. involving some new and/or unusual feature so as to avoid creating an unwelcome precedent for Health and Social Care in Northern Ireland.

9.0 Delegated Authority Limits

In line with HSC (F) 52-2016 the following delegated officers and limits have been set for authorising the combined total of defence costs, third party solicitors and/or compensation settlements.

Category of Compensation	Delegated Officer/s	Delegated Limits
CLINICAL NEGLIGENCE **(with legal advice)**	DoH Chief Executive ***and*** Medical Director Medical Director ***and*** Director of Finance Medical Director ***and*** Responsible Director	Above £2,000,000 Up to £1,000,000 Up to £500,000 Up to £250,000
PUBLIC AND EMPLOYERS LIABILITY **(with legal advice)**	DoH Responsible Director Nominated deputy for Responsible Director	Above £100,000 Up to £25,000 Up to £15,000
CLINICAL NEGLIGENCE, PUBLIC AND EMPLOYERS LIABILITY **(without legal advice)**	DoH Trust Officers	Up to £10,000 NIL

9.1 **Public and Employer's Liability Claims**

Claims which are liable to settle in excess of the amounts set out in the table above, ***must be notified*** in advance to Finance Policy and Accountability Unit (FPAU), DoH, using the ***Request for Approval of Settlement above Delegated Limits*** found in **APPENDIX 3**.

The Chief Executive, or in his/her absence a delegated Director, will authorise all out of court settlements.

9.3 **Clinical and Professional Negligence Claims**

All "Out of Court" settlements must be authorised within the delegated limits set out in the Trust's Scheme of Reservation and Delegation. The Chief Executive must be advised of all "Out of Court" settlement requests.

The authority to settle should be communicated in writing to DLS as early as possible in an appropriate form, e.g. e-mail, if verbal approval is given in the first instance.

9.4 Clinical negligence claims which are liable to settle in excess of the Trust's delegated limit amount must be notified ***in advance*** to Finance Policy and Accountability Unit (FPAU), DoH, using the ***Request for Approval of Settlement above Delegated Limits*** form found in **APPENDIX 3**.

9.5 Prior approval is required from DoH for authority to settle up to a specified amount above this limit. This can only be granted based upon the written advice of Senior Counsel representing the Trust stating the best estimate of the settlement amount. Should a settlement fail to be reached within the approved amount, further approval must be granted prior to any final settlement.

9.6 In line with Departmental delegations, FPAU will seek the approval of the Department of Finance (DoF) on behalf of HSC bodies in respect of all potential settlements in excess of £1m. DoF requests that all applications for approval to settle above this amount are submitted at least three working days before the case is due to be heard. This allows sufficient time for proper consideration of the case with all relevant papers.

9.7 Further advice on the procedures for Approval of Clinical Negligence Settlements above Delegated Limits can be found at Annex C of HSC Circular HSC (SQSD) 5/10 *Handling Clinical and Social Care Negligence and Personal Injury Claims*.

9.8 On occasions when the Trust's Legal Advisers may require an urgent response to a request for authority to settle cases, for example during 'at the court door' negotiations on the morning of a hearing prior to the case going into court, the Trust will ensure that an officer holding, or having been given, the anticipated level of authority is readily available. This authority must be communicated to DLS in writing as soon as is practical.

10.0 Reporting and Accountability Arrangements

10.1 To facilitate sharing of learning, quality improvements and discharge of accountability, the Responsible Director will ensure the following information in relation to claims is provided on a quarterly basis for the Senior Management Team; the Claims Advisory Group, the Learning Outcomes Review Group; the Assurance Committee; the Trust Board:

i. type, number and aggregate value of claims

ii. claims received and settled since previous report

iii. details of claims or classes of claims considered significant

iv. Analyses of root and contributory causes.

10.2 In particular, the Learning Outcomes Review Group should receive sufficient information to allow full understanding of the events which have led to litigation

and to recommend actions that should be taken to reduce risk of recurrence. They should also ensure that an action plan is implemented and monitored in respect of changes.

10.3 The Assurance Committee should seek assurances from the Senior Management Team and from the Chair of the Learning Outcomes Review Group which allow them to offer assurance to the Audit Committee and Trust Board for its Governance Statements.

11.0 Related Trust Policies and Procedures/DoH Circulars

11.1 The following policies and procedures have relevance to this policy and can be accessed on or through the Trust's intranet site and include:-

- Standing Orders and Scheme of Reservation & Delegation
- Standing Financial Instructions
- Untoward Incident Reporting Procedure
- Policy on Records Management
- Risk Management Strategy
- NIAS Complaints Procedure

11.2 Further information is also available in HSC (SQSD) 5/10 – 'Handling Clinical and Social Care Negligence and Personal Injury Claims'. Via DoH website.

12.0 Recording of Claims

12.1 The organisation maintains a database of comprehensive, up-to-date information on all claims to support claims management;

13.0 Equality, Human Rights and DDA

13.1 This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories and no significant differential impacts were identified, therefore, an Equality Impact Assessment is not required.

14.0 Alternative formats

14.1 This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

15.0 Sources of Advice in relation to this document

15.1 The Responsible Director or Claims Manager should be contacted with regard to any queries on the content of this policy.

16.0 Review

16.1 This policy will be formally reviewed every two years but will be amended as necessary to maintain compliance with changes in judicial or related rules and procedures.

PART 2: PROCEDURE FOR THE MANAGEMENT OF LITIGATION CLAIMS

PROCEDURE FOR THE MANAGEMENT OF LITIGATION CLAIMS

PURPOSE: This Procedure details the roles and responsibilities of staff and departments involved in administrative arrangements for the management of clinical, professional and general , i.e. Employer's and Occupier's, liability claims, made against the Northern Ireland Ambulance Service Health and Social Care Trust.

SECTION 1: NOTIFICATION OF CLAIMS	**Timescale**	**Responsible Officer/Dept.**
Claims may be made to the Trust by the following means: • receipt of a Letter of Claim from the Plaintiff's Solicitor • receipt of an Ordinary Civil Bill (County Court) or a High Court Writ • inclusion in a letter of complaint.		
Action to be taken on receipt of a claim/formal notice of legal proceedings		
a) Confirm that the claim is against the Trust; b) Open new Medical Clinical Negligence (CN), Professional Negligence (PN), Employers Liability (EL) or Occupiers Liability (OL) Claims file as applicable; c) Create new record on Trust's Claims Management database ***d)*** Send acknowledgement of receipt letter to Plaintiff's Solicitors and confirming that matter has been passed to Trust's legal advisers (**APPENDIX 1**)(***appropriate to category of claim)*** e) Send copy of Letter of Claim or other formal notice and of Trust's	**Within 2 working days of receipt** " " " "	**Claims Management (CMgt)** " " " "

acknowledgement letter to Director of Legal Services ***(APPENDIX 2)***(***appropriate to category of claim)*** f) Inform Director responsible for employee or service area concerned	 “	 “
SECTION 2. DOCUMENTATION COLLATION		
In order to progress a claim efficiently obtain the following documentation, as applicable, in the proactive investigation and progression of the claim and as determined by nature of claim, i.e. Clinical and Professional or Employer’s/Occupier’s Liability :		
Action to be taken to collect appropriate information and documents	**Timescale**	**Responsible Officer/Dept.**
The following information should be collected in respect of each case (taking account of the case type i.e. CN/EL/OL/General).		
• Incident Report Form • Personal File • Confirmation from Occupational Health Services that employee is known to them • Absence Printout • Details of Earnings	**Within 10 working days of receipt of claim** “ “ “	**Claims Team** **HR Dept** **Occupational Health** **HR Manager**

• Details of previous and/or similar incidents • Witness Statements • Training records • Maintenance/service records • Contractual documentation • Duty rotas • Investigation reports • Inspection and cleaning schedule	“ “ “ “ “ “ “ “	**Payroll (BSO)** **Line Manager** **Claims Team** **Training Dept.** **Fleet Manager** **HR Manager** **Line Manager** **Line Manager** **Line Manager**
Once copies obtained these should be sent to the Directorate of Legal Services	**Within 10 working days of receipt of claim**	**Claims Team**
In the case of Employers or Occupiers Liability Claims: • Report from the Line Manager responsible for the Plaintiff where the Plaintiff is an employee, or for the service area, where a service user is involved. **In the case of Clinical/Professional Negligence :**	**Within 4 weeks**	**Line Manager**

• Report from the clinicians and/or health and social care professionals involved in the service user's care or treatment. (This 'involvement report' describing the management of the service user and specifically addressing the allegations of negligence when known). • Relevant notes and records for service user (discovery of copies being required to Plaintiff's Solicitors within 40 days) **Note:** **Where the claim is being managed in accordance with the Pre-Action Protocols collation of documentation must be completed within 8 weeks of receipt of Letter of Claim**.	**Within 4 weeks** **Within 4 weeks**	**Line Manager** **Line Manager**
SECTION 3 : MONITORING OF PROGRESS		
In order that all claims are dealt with effectively, any learning is shared promptly and that risks are addressed appropriately, it is essential that all documentation and relevant information is collated without delays.		
Action to be taken	**Timescale**	**Responsible Officer/Dept.**
Liaise with the relevant Line Manager during the progression of the claim and in particular on receipt of the Statement of Claim, of Replies to Notice for Further and Better Particulars, of reports from Independent Experts and Counsel's Advices.	**Ongoing based on a B/F system**	**Claims Team**
SECTION 4: DIRECTORATE OF LEGAL SERVICES ROLE		

The Directorate of Legal Services which is a part of the BSO is to provide legal advice and support for all legal claims. This is professional advice based on the circumstances of the cases presented to them and any accompanying evidence and information. In order to maximise the benefit of this service the Trust will need to have an effective ongoing process of monitoring of progress and provision of timely information and documentation.		
Action to be taken on progressing cases	**Timescale**	**Responsible Officer/Dept.**
DLS Role: a) Ensure contact is maintained with the Trust on a regular basis regarding progression of the claim and as significant developments occur. b) At the appropriate times advise the Trust regarding: • further information and/or documentation required • liability and quantum • an assessment of the strength of any defence • damages quantum and probability (IAS 37 figures) • anticipated defence costs • whether a 'without prejudice' settlement should be attempted	**Ongoing** **Ongoing**	**DLS Solicitor** **DLS Solicitor**

• defence strategy • engagement of Medical, Engineering or other Experts • engagement of Junior and/or Senior Counsel • requirement to convene consultations with witnesses • date of Court hearing **Trust Role:** c) Obtain approval from the DoH where settlement for a clinical negligence claim is expected to be in excess of £1,000,000 **(APPENDIX 3)**. d) Report to the Learning Outcomes Review Group	**When notified by DLS** **Quarterly**	**Financial Accounts** **Responsible Director (RD)**
SECTION 5: RISK ASSESSMENT		
Grading of claims The initial level of risk grading will be subject to ongoing review and revision until the claim is closed and taking into account issues such as progress made in implementing improvement measures identified following incident investigation and development of an Action Plan so as to reduce the potential for recurrence of the situation giving rise to the claim.		

Action to be taken:	**Timescale**	**Responsible Officer/Dept.**
Actual and Potential Risk Claims will be graded according to the Risk Rating System, including Matrix, detailed in the Trust's Risk Management Strategy **(APPENDIX 9)** and taking account of: a) Actual level of severity – taking account of harm caused and financial implications for the Trust; b) Potential future risk for the Trust and likelihood of the claim succeeding. In the event where a claim is graded as either 'Major' or 'Catastrophic' the relevant Director will be informed and consideration given to having it included in the Corporate Risk Register. Obtain approval from the DoH where settlement for a clinical negligence claim is expected to be in excess of £1,000,000 ***(*APPENDIX 3*)***.	**On receipt of claim** **On receipt of claim**	**Risk Manager** **Risk Manager**
Investigation of claims		
Action to be taken:	**Timescale**	**Responsible Officer/Dept.**
Claims arising from previously investigated incidents:		

It would be anticipated that many claims would originate from either an adverse incident and/or a complaint and would have previously been subject to the level of investigation detailed in the Trust's Untoward Incident Reporting Procedure. ***The records from that investigation should be included in the documentation collated in preparation of the defence of the claim.***	**On receipt of claim**	**Risk Manager**
Claims not previously investigated: A claim which has not previously been the subject of investigation at Directorate level will be investigated as part of the process for preparing its defence or, if graded as either 'Major' or 'Catastrophic' by the service Directorate concerned.	**On receipt of claim**	**Risk Manager**
SECTION 6: REVIEW OF EMPLOYER'S AND OCCUPIER'S LIABILITY CLAIMS Obtain approval from the DoH where settlement for an Employer's and Occupier's Liability Claim is expected to be in excess of £1,000,000 ***(*****APPENDIX 3*****)*** **It is essential that the Trust is aware at all times of the status of ongoing claims to ensure they are managed efficiently and effectively and that the Trust is aware of any factors affecting the outcome e.g. changes to potential settlement value of compensation**		
Action to be taken:	**Timescale**	**Responsible Officer/Dept.**
Meet on a quarterly basis with the appointed DLS Solicitor to review and update the position on	**Quarterly**	**Responsible**

all active cases and discuss their future management including further action required. Obtain approval from the DoH where settlement for an Employer's and Occupier's Liability Claim is expected to be in excess of £1,000,000 ***(*****APPENDIX 3*****)***. a) Any risk management issues will also be highlighted at these reviews. b) The outcome of this meeting will be provided to the Senior Management Team	 **Quarterly**	**Director and Claims Manger** **Responsible Director**
Section 7 : Settlement of claims		
Claims may be settled in 2 ways: a) By a pre-hearing negotiation (either before or after proceedings have been issued) ; **OR** b) If they have been subject to court hearing and the claim has either been upheld and damages awarded or rejected in the Trust's favour.		
Action to be taken:	**Timescale**	**Responsible Officer/Dept.**
When authority has been requested by DLS to settle a claim: • Complete a Settlement Approval Form **(APPENDIX 4)** • Advise the Financial Accounts immediately they become aware of any proposed	 **Immediately** **Immediately**	 **Claims Team** **Claims Team**

settlements over the value of £1,000,000		
• Ensure that a Form of Discharge has been received where a compensation payment is being made directly to the claimant	**Immediately**	**Claims team**
• the settlement approval form will be forwarded, along with the most recent copy of Counsel's Advices, to relevant staff in accordance with the Delegated Authority Limits;	**Within time agreed with DLS**	**Claims team**
• Confirm authority to DLS on receipt of appropriately signed (i.e. in accordance with Delegated Authority Limits) settlement approval form;	**ASAP**	**Claims Team & Delegated Officer**
• Where a schedule of periodic payments has been agreed by way of settlement:		
➢ ensure that Financial Accounts are provided with a copy of the final Periodic Payment Order (PPO)	**Ongoing**	**Claims Team**
➢ B/F the file for an adequate time period prior to the due date of the next scheduled payment :	**Ongoing**	**Claims Team**
▪ contact the Plaintiff's solicitor / case manager to ensure that the Plaintiff is not deceased and has not had any periods of inpatient / residential care which may have had an impact in the provision of the care package detailed within the order	**Immediately**	**Claims Team**
▪ on receipt of the above confirmation, contact Financial Accounts to obtain the value of the scheduled payment	**Immediately**	**Claims Team**
On being advised by DLS that a claim is settled the **:**		

• Inform all relevant staff that the case is settled, the reason for settlement and thanking them for their support and assistance • Schedule the claim for consideration at Learning and Outcomes Review Group and Claims Advisory Group • Record the settlement details on DATIX, i.e. date of settlement and means of settlement	**Immediately** **Next Meeting of L&ORG/ CAG** **Immediately**	**Claims Team** **Claims Team** **Claims Team**
SECTION 8 : CLOSURE OF CLAIMS		
A Claims File will remain open and active until confirmed by DLS that the claim has been: o Statute Barred o Withdrawn o Discontinued o Settled by pre-hearing negotiation o Subject to Court hearing and that the claim has either been upheld and damages awarded or rejected in the Trust's favour.		
Action to be taken:	**Timescale**	**Responsible Officer/Dept.**

On being advised by DLS that a file is to be closed ensure the following:		
a) Complete an 'Authorisation of Closure Form' **(APPENDIX 5)**	**Immediately**	**Claims Team**
b) Place an Authorisation of Closure Form and Recommendation of Closure Letter from DLS in the Claim File	**Immediately**	**Claims Team**
c) Confirm with DLS that all payments have been made;	**Immediately**	**Claims Team**
d) Confirm with DLS that the CRU have been informed of the claim outcome and receive CRU certification;	**Immediately**	**Claims Team**
e) Inform the relevant Director and Manager that the case is closed, the reason for closure and acknowledging their support and assistance	**Immediately**	**Claims Team**
f) Notify Financial Accounts that the case is closed;	**Immediately**	**Claims Team**
g) Inform the Record the closure details on DATIX, i.e. date of closure/settlement and reason for closure	**Immediately**	**Claims Team**
h) Relocate the Claim File to storage for retention in accordance with the Trust's Records Management – Retention & Disposal Schedule and with legal advice being sought prior to destruction.	**Immediately**	**Claims Team**
SECTION 9: RE-OPENING A 'CLOSED' CLAIM FILE		
A 'Closed' Claim File will only be reopened on receipt of ***written advice*** from DLS		

Action to be taken:	**Timescale**	**Responsible Officer/Dept.**
a) Ensure formal request is received from DLS; b) Update DATIX to record the details of the claim and the reason for its re-opening **c)** ensure that an 'Authorisation to 'Re-open Litigation Claim Form' **(APPENDIX 6)** is completed; **d)** The Claim File will be retrieved from storage and into which all correspondence regarding re-opening of the claim will be placed;	**Immediately** **Immediately** **Immediately** **Within 10 working days**	**Claims Team** **Claims Team** **Claims Team** **Claims Team**
SECTION 10 : FINANCIAL MANAGEMENT		
There must be effective internal and external controls operated over any payments made for litigation settlements to prevent errors or fraud occurring. All payment requests must be supported by authorised documentation and fully checked before funds are released.		
Action to be taken: Directorate of Legal Services	**Timescale**	**Responsible Officer/Dept.**

DLS will ensure that, before forwarding to the Trust: a) all bills received for costs, Fee Notes etc. are on original, headed stationery and with VAT registration number shown where applicable b) payments requested comply with the approved scale rates c) payment requests are accurate d) obtain a Forms of Discharge from recipients following payments being made and forward to the Trust.	 **On Receipt** **On Receipt** **On Receipt** **On Receipt**	 **DLS** **DLS** **DLS** **DLS**
Action to be taken: The Trust Administration and Complaints Department	**Timescale**	**Responsible Officer/Dept.**
On receipt of a written request for payment from DLS : a) check that the payment is relevant to the claim being referred to, that all relevant original documentation is attached and that the payment is not a duplicate request b) check that the report, consultation or other service for which payment is being requested has been received c) check that where the requested payment is in respect of damages that it is accompanied by documentation from either the Court or the Plaintiff's Solicitors confirming the value of that payment d) check the accuracy of the payment being requested	 **Immediately** **Immediately** **Immediately** **Immediately**	 **Claims Team** **Claims Team** **Claims Team** **Claims Team**

e) complete a 'Litigation Claim Payment Request Form' (**APPENDIX 7**) for approval, subject to value of payment involved, in accordance with agreed levels of authority and forward, with relevant supporting documentation, to Financial Accounts who will arrange for payments to be forwarded to DLS within three weeks so as to avoid imposition of additional interest charges on the Trust	**Immediately**	**Claims Team**
f) record each payment on DATIX	**Immediately**	**Claims Team**
g) check that Forms of Discharge are received for payments made.	**Immediately**	**Claims Team**
Action to be taken : NIAS Financial Accounts	**Timescale**	**Responsible Officer/Dept.**
On receipt of a request for payment:		
a) Check that the request has been authorised in accordance with the Scheme of Reservation & Delegation of the Trust;	**Immediately**	**Finance Officer**
b) If the payment is in excess of the Trust authority levels then ensure there is a written confirmation of authorisation from the DoH;	**Immediately**	**Finance Officer**
c) check to ensure that all necessary documentation is attached, i.e. approval letters, together with invoice with VAT number recorded;	**Immediately**	**Finance Officer**
d) confirm the value is in line with the authorised amount	**Immediately**	**Finance Officer**
e) confirm that the payment amount requested has not been previously made	**Immediately**	**Finance Officer**
f) arrange for processing of payment in accordance with DLS directions and, where payment is being made to a third party, a receipt is requested.	**Immediately**	**Finance Officer**

SECTION 11: REPORTING TO DoH		
The Trust is required to advise the DoH of ongoing litigation information.	**Timescale**	**Responsible Officer/Dept.**
The following documentation must be completed and returned to the DoH:		
9.1.1 'Clinical/Social Care Negligence (Annual Return') - (**APPENDIX 8**)	**Annually**	Finance Officer
9.1.2 'Clinical/Social Care Negligence (Quarterly Return)' in accordance with timetable issued by HIB (**APPENDIX 8**)	**Quarterly**	Finance Officer

PART 3: APPENDICES

(

APPENDIX 1

Northern Ireland Ambulance Service
Health and Social Care Trust

(Medical/Professional Negligence - Acknowledgement Letter to Solicitor -Template)

(Plaintiff's Solicitors address)

Date **Our Ref:** **Your Ref:**

Dear Sir / Madam

RE:

I refer to your letter of (date), issued on behalf of the above named, concerning treatment in (facility) on (dates) .

The letter has been referred to the Trust's Legal Advisers and any further correspondence should be sent to them at the following address:

Chief Legal Adviser
Directorate of Legal Services
Medical Negligence Section
HSC Business Services Organisation
2 Franklin Street
BELFAST
BT2 8DQ

Yours faithfully

_____
Litigation Management Department

Enc.

C. Responsible Director

APPENDIX 1

Northern Ireland Ambulance Service
Health and Social Care Trust

(Employers/Occupiers Liability - Acknowledgement Letter to Solicitor - Template)

(Plaintiffs Solicitors address)

Date **Our Ref:** **Your Ref:**

Dear Sir / Madam

Re: Your Client -

I acknowledge receipt of your letter dated (date) regarding an incident allegedly suffered by your client, the above named, on or about (date) at (location)

Your letter is being forwarded to the Trust's legal advisers to whom further correspondence should be addressed at:

Chief Legal Adviser
Directorate of Legal Services
HSC Business Services Organisation
2 Franklin Street
BELFAST
BT2 8DQ

Yours faithfully

Litigation Management
Department
Enc.

C. Responsible Director

APPENDIX 2

Northern Ireland Ambulance Service
Health and Social Care Trust

(Medical/Professional Negligence - Acknowledgement Letter to DLS -Template)

Chief Legal Adviser
Directorate of Legal Services
Medical Negligence Section
HSC Business Services Organisation
2 Franklin Street
BELFAST
BT2 8DQ

Date **Our Ref:** **Your Ref:**

Dear Sir

RE:

I enclose, for your attention, copy correspondence from (Name of Plaintiff's Solicitor), Solicitors on behalf of the above named. I have acknowledged the letter and asked that they refer all further correspondence to your office.

I will obtain the relevant medical records or other records as appropriate and await your further instructions.

Yours faithfully

_____
Litigation Management Department
Enc.

C. Responsible Director

APPENDIX 2

Northern Ireland Ambulance Service
Health and Social Care Trust

(Employers/Occupiers Liability - Acknowledgement Letter to DLS - Template)

Chief Legal Adviser
Directorate of Legal services
HSC Business Services Organisation
2 Franklin Street
BELFAST
BT2 8DQ

Date **Our Ref:** **Your Ref:**

Dear Sir

RE:

Attached for your attention is a letter dated (date) from (Name of Plaintiff's Solicitor) Solicitors, on behalf of the person referred to above.

Receipt of this letter and its forwarding to you have been acknowledged.

Further information regarding the circumstances of the incident giving rise to this claim, are currently being collated and will be forwarded to you in due course in order that your advice regarding future management of this claim might be provided.

Yours faithfully

_____
Litigation Management Department
Enc.
C. Relevant Director

APPENDIX 3

REQUEST FOR APPROVAL OF SETTLEMENT ABOVE DELEGATED LIMITS

Name of HSC Body/Bodies	
Contact name within HSC Body	
Contact telephone number	
Case reference number	
Plaintiff name	
Date of incident	
Summary of incident	
Estimated settlement date	
Estimated settlement figure	
Is the case novel, contentious or repercussive?	
Is structuring feasible/acceptable to the plaintiff?	

I, _____, confirm that this case has been handled in accordance with claims handling guidance set out in circular HSC (SQSD) 5/10

Authorised by:

_____

Position within Organisation _____

Date: _____

This form must be submitted to FPAU for prior authority to negotiate clinical negligence claims above **£1,000,000.**

Finance Policy and Accountability Unit
Room D3
Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
fpau@dhsspsni.gov.uk

APPENDIX 4

Settlement Approval Form

Our Ref: **Business Services Organisation Ref**:

Plaintiff:	
Home Address:	
Date of Birth:	
Date of Claim:	
Date Opened:	
Date of Incident:	
Details of Incident:	
Present Position:	
Reserves:	Minimum - £ @ ..% Medium - £ @ % Maximum - £ @ %
Proposed Settlement:	
Recommendation by **Litigation Management** to settle for the following reasons:	

Risk Manager **Date**

Responsible Director **Date**

Executive Medical Director **Date**

Chief Executive **Date**

APPENDIX 5

Northern Ireland Ambulance Service
Health and Social Care Trust

AUTHORISATION FOR CLOSURE OF A PROFESSIONAL NEGLIGENCE/EMPLOYERS LIABILITY/OCCUPIERS LIABILITY CLAIM

I, _____, **Claims Manager** on receipt of written advice from the Trust's Legal Advisers – Business Services Organisation **(attached to this form)** authorise the closure of the following claim as at _____.

The claim will remain closed until either the claim is reopened under advice from Business Services Organisation or a review is carried out of closed files.

Name	
Trust Ref. No.	
BSO Ref No.	
Date Opened	
Reason for Closure	

Signature:

_____

_____
Dated

This case file will only be re-opened on the express instructions of the Trust's Legal Advisers – Business Services Organisation – and subject to the recommendations of the Claims Manager and approval of the Chief Executive.

APPENDIX 6

Northern Ireland Ambulance Service
Health and Social Care Trust

AUTHORISATION FOR RE-OPENING OF A PROFESSIONAL NEGLIGENCE/EMPLOYERS LIABILITY/OCCUPIERS LIABILITY CLAIM

I, _____, Claims Manager on receipt of written advice (attached to this form) from the Trust's Legal Advisers – Business Services Organisation authorise the re-opening of the following claim as at

Name	
Trust Ref. No.	
BSO Ref No.	
Date Closed	
Reason Closed	
Reason for reopening	
Date of reopening	

Signature: Dates:

_____ _____

APPENDIX 7

LITIGATION CLAIM PAYMENT REQUEST FORM

1. Name of Payee: _____
2. Trust reference number: _____
3. Legal Advisers reference number _____
4. Amount due for Payment: _____
5. Requested by: _____
   Litigation Management Department
6. Date of Request: _____
7. Authorised by: _____
   Director
8. Date Authorised: _____
9. Approved by Finance: _____
   Senior Finance Officer
10. Date Approved: _____

A COPY OF THIS AUTHORISATION MUST BE HELD ON THE LITIGATION FILE AND A COPY RETAINED IN FINANCE WITH THE FORMAL DOCUMENTED REQUEST FROM DLS

CLINICAL / SOCIAL CARE NEGLIGENCE

CN1

Provider Name:	
Contact Name:	
Telephone Number:	
Year Ending	31 March 2010

Provider Comments:

Guidance available on next worksheet, or alternatively by selecting each column header.

	Patients Reference Number i.e. PS/026A-003	Type of Claim	Date of Incident (DD/MM/YYYY)	Date of Claim (DD/MM/YYYY)	Estimated Year of Settlement (YYYY)	Settled Date (DD/MM/YYYY)	Closed Date (DD/MM/YYYY)	Case Specialty	Nature of Incident
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									

	...e of ...YY)	Persons Date of Death (DD/MM/YYYY)	Complaint
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
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21			
22			
23			
24			
25			
26			
27			
28			

CLINICAL / SOCIAL CARE NEGLIGENCE (QUARTERLY REPORT)

CN1a

Provider Name:	
Contact Name:	
Telephone Number:	
Quarter Ending	

Provider Comments:

Guidance available on next worksheet, or alternatively by selecting each column header.

Claims / Cases	Number
Cases Open on last day of quarter	
New Cases Opened during quarter	
Cases Closed during Quarter	

Financial Payments During Quarter	Amount (£)
Damages	
Defence Costs	
Plantiff Costs	
Total Amount Paid During Quarter	

APPENDIX 9

RISK RATING SYSTEM

Instructions for use:

1. *Identify the risk*
2. *Using Table 1 identify the Potential Impact/Consequences should the risk occur and select number from scale*
3. *Using Table 2 identify the Measure of Likelihood or immediacy of the risk occurring and select descriptor from scale*
4. *Impact/Consequences Score X Frequency/Likelihood Score = Risk Rating as described in Risk Rating Matrix (Very Low, Low, Moderate or High)*

Table 1 – Potential Impact (Consequence of the risk should it be realized.)

	People (Any person affected) Patient/ Staff member/member of the Public	**Resources** (Premises, Equipment, Service provision) Business Continuity	**Environment** (Air, Land, Water)	**Reputation** (Adverse Publicity, Complaints, Litigation)
Insignificant	No injuries no obvious harm,	No service disruption, low financial loss (<1K)	Nuisance releases	Minimal risk to Trust. Informal complaint potential for litigation.
Minor	First aid treatment, number of people affected 1-2 non-permanent harm (<1 month for recovery)	Impact to service immediately containable, medium financial loss (1K-10K)	On site release contained by Trust	Minimal risk to Trust, directorate investigation into complaint potential for litigation.
Moderate	Medical treatment required, semi-permanent harm (<1 year for recovery)	Impact on service contained with assistance, high financial loss (10K-50K)	Onsite release requiring external assistance	Damage to public relations. Trust investigation including into a complaint potential for litigation

	People (Any person affected) Patient/ Staff member/member of the Public	Resources (Premises, Equipment, Service provision) Business Continuity	Environment (Air, Land, Water)	Reputation (Adverse Publicity, Complaints, Litigation)
Major	Extensive injuries, permanent harm, sharps injury with patient with known or suspected infection e.g. Hep C	Loss of ability to provide services, major financial loss (50k-500K)	Release affecting minimal off-site area requiring external assistance	Local adverse publicity, External investigation or independent review into a complaint. Potential for litigation
Catastrophic	Unexpected death or multiple patients seriously affected	Collapse of service, huge financial loss (>500K), (NB 500k= 1% of expenditure)	Toxic release affecting off site with detrimental effect	National adverse publicity, DHSSPS Executive investigation following an incident or complaint. Potential for litigation

Table 2 - Measure of Likelihood

To determine the likelihood of a risk occurring use historically data, for example, how often has a risk occurred in the in the previous year and what was the outcome.

Descriptor	Definition
Almost certain	~90-100% chance of occurrence or reoccurrence, will occur or does occur regularly
Likely	~60-90% chance of occurrence or reoccurrence, will occur or likely to occur imminently
Possible	~30-60% chance of occurrence or reoccurrence, may occur occasionally
Unlikely	~10-30% chance of occurrence or reoccurrence, do not expect it to happen but it is conceivable
Rare	~0-10% chance of occurrence or reoccurrence, could only happen in exceptional circumstance

Table 3 - Risk Rating Matrix (Likelihood X Consequence = Risk Rating)

Risk Severity Rating Matrix (Consider HSCB chart, as listed below.) This chart changes the level of risk to the

Likelihood of Recurrence	Most likely consequences				
	Insig-nificant	Minor	Moderate	Major	Cata-strophic
Almost Certain	5	10	15	20	25
Likely	4	8	12	16	20

Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

Table 4 - *Risk Severity Rating Definitions*

This rating identifies the residual risk to the Trust following the completion of all actions to mitigate or minimise the risk to the Trust.

Severity of Risk	Descriptors	*Action*
High	Identified risks, which fall into the red area, are deemed to present a high risk to the Trust and require immediate action to reduce the risk to an acceptable level.	Reports must be immediately forwarded to the relevant Director who will consider the risk and take action to treat and mitigate the risk. The Risk Manager will entry the relevant details on Datix and provide reports for consideration by the Assurance Committee and Trust Board and addition to the risk register
Moderate	Identified risks, which fall into the orange area are deemed to present a moderate risk to the Trust and require action with 6 months to reduce the risk to an acceptable level.	Reports must be immediately forwarded to the relevant Director who will consider the risk and take action to treat and mitigate the risk. The Risk Manager will entry the relevant details on Datix and provide reports for consideration by the Assurance Committee and Trust Board and addition to the risk register
Low	Identified risks which fall into the yellow area are deemed to present a low risk to the trust and require action within 12 months to reduce the risk to an acceptable level.	This would normally be undertaken locally within the Directorates/ Programmes/Service Areas, monitored locally by the relevant manager and recorded using the risk log that will be recorded on the relevant risk register.
Very Low	Identified risks which fall into the green area are deemed to be acceptable and require no	Risk must be monitored regularly

	immediate action	

TB/01/08/2019/08

Return to Agenda

Re: IPC Training & Education Strategy

Introduction

Following unannounced inspections in November 18, the RQIA identified that further work was required by the Trust to develop a robust training and competency- based assessment framework programme in respect of IPC policy and procedures. The latest *Improvement Notice* issued by RQIA in Dec 18 (with a compliance date of June 19), specifies the related improvements below as being required to achieve minimum compliance;

The NIAS Trust Board, Chief Executive and Executive Team must ensure in relation to clinical practice:

- **An Infection Prevention and Control Training Strategy is developed and implemented across the Trust. The Strategy must encompass organisational roles and responsibilities, assurance framework and accountability, compliance monitoring, training, education and communication.**
- **The content of Trust IPC training programme should be tailored to meet the needs of staff at all levels across the Trust, including Non-Executive Directors of the Trust.**
- **Sufficient designated staff need to be made available, to deliver training, carry out competency assessment of practice and support front-line staff.**
- **Outcomes from staff training and competency assessment should be aligned and used to inform staff members' performance appraisal.**
- **Key Performance Indicators related to IPC training and competency assessment must be routinely reported through the Trust assurance framework.**

The attached strategy, which has been developed in partnership with the regional training team describes the Trusts aspirations to deliver on the improvements required to meet ***minimum*** compliance.

Recommendation

Trust Board are asked to approve the IPC Training and Education Strategy

Northern Ireland Ambulance Service
Health and Social Care Trust

Infection Prevention & Control Education & Training Strategy

July 2019

Title:	**Infection Prevention & Control Training & Education Strategy**		
Author(s):	Dr Nigel Ruddell, Medical Director (Director of Infection Prevention & Control) Frank Orr – Assistant Director Education, Learning and Development Seamus McAllister – Clinical Training Manager Lynne Charlton – PHA Secondee		
Ownership:	Medical Director Director of Human Resources and Corporate Services Director of Operations		
Date of SEMT Approval	TBC	**Date of Trust Board Approval**	TBC
Target Audience:	All NIAS Trust Employees		
Operational Date:	TBC	**Review Date:**	3 Yearly
Version No:	0.1	**Supercedes:**	N/A
Key Words	Statutory, Mandatory, Training, Policy		
Other Relevant Policies	NIAS IPC Policy & Procedures (2018)		

Date	Version	Author(s)	Comments
014/07/2019	0.1	AD ELD CTM MD PHA Secondee	Initial Draft
23/07/2019	0.2	AD ELD CTM MD PHA Secondee	Amendments to reflect comments from Clinical Support Staff

Contents

1.0 Introduction

The Northern Ireland Ambulance Service (NIAS) recognises that there are significant risks to patients, staff and visitors as a consequence of Healthcare Associated Infection (HAI). These risks necessitate a specific Infection Prevention and Control (IPC) Education & Training Strategy to ensure that education on infection prevention and control is provided and accessible to all healthcare teams and individuals to enable them to minimise infection risks that exist in care settings. Patients have the right to be cared for by competent staff. Training is therefore an essential component for staff to achieve their personal development goals and for the teams within NIAS to achieve their objectives.

The environment in which patients are cared for and in which staff work in should have sufficient and effective cleaning. Consequently staff involved in ensuring environmental cleanliness must also be supported to attend suitable training & education programmes to enable them to provide a safe and clean environment.

Infection prevention and control is everyone's business, the IPC Education & Training Strategy will be relevant to all staff employed by NIAS. NIAS will provide access to an education & training programme that includes multiple and integrated approaches to training to ensure access to infection prevention and control education & training commensurate with staff roles.

2.0 Objective

The overall objective of this Strategy is to ensure that:

The *Northern Ireland Ambulance Service has a workforce with the necessary knowledge and skills in infection prevention and control to ensure they can practise safely, preventing and minimising the risks of HAI to their patients, the general public, their colleagues and themselves.*

The (IPC) Education & Training Strategy will:

- Define organisational roles and responsibilities related to IPC Education & Training.
- Meet specified national educational objectives
- Meet the IPC education and training needs of all staff across the Trust including the Non-Executive Directors
- Support systems and procedures to identify and promote individual education and training needs of all staff in NIAS, including personal development reviews.
- Include the monitoring and quality of education delivered.
- Include exploration of delivery modes and involve external agencies for delivery and collaboration.
- Support the provision of resources available to allow staff to understand their HAI responsibilities.
- Assist managers to develop the IPC knowledge of staff under their supervision**.**
- Support the organisation to demonstrate a continuous quality improvement approach and learning culture to ensure the knowledge and competency of staff.

3.0 Roles and Responsibilities

Trust Board
The Board have a collective responsibility to ensure that infection prevention and control is a core part of clinical governance and patient safety programmes. They are also responsible for ensuring that they promote compliance with infection prevention and control policies in order to ensure low levels of health care associated infections and are aware of legal responsibilities to identify, assess and control risk of infection

Chief Executive
The Chief Executive is ultimately responsible for infection control measures including the provision of education and training, a responsibility which is discharged through the Medical Director.

Director of Infection Prevention and Control
The role of Director of Infection Prevention and Control (DIPC) is assigned to the Medical Director. The DIPC will ensure delivery of the organisational IPC Training & Education Strategy and will report to the Board through the Assurance Committee on its progress via the IPC annual report and IPC education and training Key Performance Indicators (KPIs).

Director of Human Resources and Corporate Services
The Director of Human Resources is responsible for providing assurance with compliance with the Statutory and Mandatory Training Policy. They also maintain contracts with external education providers and will ensure that the Statutory & Mandatory Training Policy is updated as required in accordance with guidance from the trust IPC Lead and IPC Group.

Risk Manager
The Risk Manager is responsible for working with Directors to identify and manage the risks associated with the implementation and delivery of the IPC Education & Training Strategy and to monitor compliance with related internal and external assurance frameworks in conjunction with the Medical Director and Director of Operations.

Clinical Training Manager
The Clinical Training Manager is responsible for ensuring that training (clinical and non-clinical), education, and competency assessment in infection prevention and control appropriate to staff job role is provided. They will ensure that IPC is included as appropriate in training development plans, learning outcome plans and is robustly recorded through an effective and accessible training records system.

Training Officers and Clinical Support Officers

Training Officers and Clinical Support Officers are responsible for cascaded delivery of education and training relating to infection prevention and control. Through their clinical observation role will carry out competency based assessments, identifying both good practices as well as providing support when the need for improvement has been identified. They will offer advice or escalating developmental needs through the relevant line manager and training team as required. They will also be responsible for formally sharing outcomes from staff training and competency assessments with line managers to inform staff members' personal development reviews. They should also ensure maintenance of their own level of knowledge and skills in IPC.

Infection Prevention and Control Lead

The Infection Prevention Control Lead is responsible for developing and updating the trust's IPC training needs analysis to ensure it reflects the latest IPC guidance. They will put systems in place to monitor the quality of IPC education & training ensuring that this is continually reviewed as part of the overall strategy. They will lead on the development and delivery of dedicated IPC training and education sessions and support others with the delivery of IPC related training as appropriate. They will support Clinical Support Officers and Training Officers in carrying out competency based assessments related to IPC practices.

Line Managers

All managers must ensure that IPC education & training needs of their staff and themselves are identified, supported and evaluated through personal development reviews and personal development plans. Line managers should facilitate time for completion of training and maintain up-to-date records of all staff training in IPC.

Trust Staff will:

- Demonstrate a commitment to preventing and minimising HAI and ensure that they complete, as a minimum, all IPC training as per the IPC Training & Education Strategy.
- Be supported to carry out an annual personal development plan to facilitate identification of specific objectives to ensure continuous personal development in IPC.
- Maintain competence, skills and knowledge in IPC through attendance at education events and/or completion of training.
- Demonstrate an acceptable level of competence in the workplace by the application of infection prevention and control standards and engage in supportive arrangements for improvement or reassessment as appropriate.
- Act as a role model to others in the maintenance of a safe environment.

4.0 Training Needs

Mandatory IPC Training

As per UK Core Skills Training Framework **-** Statutory/Mandatory Subject Guide (2018) all staff will be required to complete mandatory IPC training.

To ensure that knowledge and skills are up to date all staff groups involved in direct patient care or services will be expected to:

- complete the Level 2 IPC e learning module annually and achieve 80% to pass the assessment.
- attend a face to face practical IPC session every other year for relevant updates.

All other staff **not** involved in direct patient care or services will be expected to:

- complete the Level 1 IPC e learning module every three years and achieve 100% to pass the assessment.

Corporate Induction Training

Infection Prevention & Control Training will be provided during Corporate Induction to all members of staff when joining the organisation. The content will include awareness of NIAS IPC Policy & Procedures, Chain of Infection, Hand Hygiene and Standard Precautions.

Vehicle Cleaning Operative Training

In addition to completion of Level 1 IPC e-learning all vehicle cleaning operatives will receive standardised IPC related training specific to vehicle cleaning upon joining the organisation.

Non-Executive Director IPC Training

A bespoke IPC training programme will be delivered to Non-Executive Directors following appointment to the Board and on a three yearly refresher basis thereafter. The training will tailored to address the roles and responsibilities of Non Executives Directors in relation to Infection Prevention & Control.

Associate Ambulance Practitioner (AAP) IPC Training

Associate Ambulance Practitioner (AAP) IPC training is delivered in line with a national curriculum through pre reading preparation followed by face to face training.

There are three components to the IPC training:

- Promote Infection Prevention and Control measures in the Emergency and Urgent Care Setting
- Causes and Spread of Infection in the Emergency and Urgent Care Setting
- Cleaning, Decontamination and Waste Management in the Emergency and Urgent Care Setting

Foundation Degree in Science (FdSc) in Paramedic Practice

The FdSc is delivered in line with an approved curriculum and as such includes relevant IPC learning outcomes within modules. Competencies related to minimizing cross-infection, implementation of infection control procedures along with aseptic non touch technique form are included within the programme.

Post Proficiency (PP) IPC Training

In addition to annual Level 2 IPC e learning, a dedicated face to face IPC session will be included every two years in post proficiency training for all staff involved in the delivery of direct patient care or services. This session will be tailored to meet the needs of the service and staff, provide updates, and will offer an opportunity for practical demonstration, competency assessment, shared learning and improvement. The content will be guided by the trust IPC Lead.

IPC Link/Champion Training

Individuals identified as IPC Link Personnel/Champions will receive IPC Update training twice yearly, the training will be developed and delivered by the trust IPC Lead.

5.0 Competency Assessment of Practice

Competency assessment of hand hygiene and aseptic non touch technique (antt) will be carried out using standardised assessment tools.

Hand Hygiene
Competency assessment of hand hygiene will be carried out by:

- **Clinical Support Officers and Training Officers** through their clinical observation role where they will identify both good practices as well as providing support when the need for improvement has been identified, offering advice or escalating developmental needs through the relevant line manager and training team as required. They will also be responsible for formally recording and sharing outcomes from individual competency assessments with line managers to inform staff members' personal development reviews.

- **The Infection Prevention Control Lead/Practitioner** who will support the programme of hand hygiene competency assessments when accompanying staff on clinical ride alongs and when observing practices within Emergency Departments (EDs) and Ambulance Stations. They will also be responsible for identifying both good practices as well as providing support when the need for improvement has been identified, offering advice or escalating developmental needs through the relevant line manager and training team as required and will formally record and share outcomes from individual competency assessments with line managers to inform staff members' personal development reviews (see app x).

- **IPC Link Personnel/Champions** who will carry out monthly random hand hygiene audits whilst on a dedicated IPC shift at station level. The overall compliance outcome of the hand hygiene audits will be shared with the IPC lead and staff locally and will inform improvement plans at station level.

Aseptic Non Touch Technique (antt)

Aseptic Non-Touch Technique (ANTT) competency assessment of practice for all staff who undertake clinical practices will be carried out every two years.

A staff member who fails an assessment should be supported with further training and a subsequent reassessment within 2 weeks. ANTT assessors must have an up-to date ANTT skills check within the previous year, this will be carried out by the IPC Lead/practitioner.

Competency assessment of antt practice will be carried out by:

- **Clinical Support Officers and Training Officers** through their clinical observation role both in the clinical environment and in the classroom environment during training, where they will identify both good practices as well as providing support when the need for improvement has been identified, offering advice or escalating developmental needs through the relevant line manager and training team as required. They will also be responsible for formally recording and sharing outcomes from individual competency assessments with line managers to inform staff members' personal development reviews.

- **The Infection Prevention Control Lead/Practitioner** who will support the programme of antt competency assessments when accompanying staff on clinical ride alongs and when observing practices within Emergency Departments (EDs) and Ambulance Stations. They will also be responsible for identifying both good practices as well as providing support when the need for improvement has been identified, offering advice or escalating developmental needs through the relevant line manager and training team as required and will formally record and share outcomes from individual competency assessments with line

6.0 Monitoring & Compliance

Corporate Induction Training
Attendance at corporate induction will be recorded on HRPTS.

IPC e learning
On successful completion of IPC e learning a certificate of completion will be issued to the staff member and a record of completion will be recorded electronically on the eLearning platform. A quarterly report will be provided to the IPC Lead, Clinical Training Manager, Area Managers & Station Officers as well as the IPC group to inform reporting of IPC education and training related KPIs and improvement plans as necessary.

Post Proficiency Training
A record of attendance at post proficiency training (incorporating a face to face IPC session) will be recorded on HRPTs and will be made available to IPC Lead, Clinical Training Manager, Area Managers & Station Officers as well as the IPC group to inform reporting of IPC education and training related KPIs.

Competency Assessments of Practice
Individual competency assessments carried out by Clinical Support Officers, Training Officers and the IPC lead/practitioner will be recorded on the electronic audit on line system. A copy of the assessment will be formally shared with the relevant line manager to inform personal development reviews and plans.

A quarterly report will be provided from the audit online system by the IPC Lead and provided to the Clinical Training Manager, Area Managers & Station Officers as well as the IPC group to inform reporting of IPC education and training related KPIs and improvement plans as necessary.

7.0 Key Performance Indicators

IPC e learning
Staff involved in the delivery of direct patient care or services
Compliance Standard
A minimum of 90% compliance with successful completion of Level 2 e learning module annually, with ongoing improvement to reach and maintain 100%

Staff not involved in the delivery of direct patient care or services
Compliance Standard
A minimum of 90% compliance with successful completion of Level 1 e learning module every three years, with ongoing improvement to reach and maintain 100%.

Post Proficiency IPC
Staff involved in the delivery of direct patient care or services
Compliance Standard
A minimum of 90% compliance with staff attendance at post proficiency IPC session every two years, with ongoing improvement to reach and maintain 100%.

Hand Hygiene
Compliance Standard
A minimum 90% Hand Hygiene compliance, with ongoing improvement to reach and maintain 100%.

Aseptic Non Touch Technique
Compliance Standard
A minimum of 90% compliance with two yearly competency based assessment of Aseptic Non-Touch Technique (ANTT) for all staff who undertake clinical practices, with ongoing improvement to reach and maintain 100%.

100% compliance with yearly ANTT skills check for all ANTT assessors

100% compliance with reassessment for staff who fail ANTT assessment within two weeks.

8.0 Assurance Framework

IPC KPIs will be monitored by the IPC lead who will report to the Infection Prevention and Control Group which reports to the Trust Board through the Assurance Committee

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Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee
Tuesday 21 May 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 S McCue	Director of Finance & ICT
	Ms R O'Hara	Director of HR & Corporate Services
	Mr B McNeill	Programme Director, CRM Implementation
	Mr R Sowney	Interim Director of Operations
	Mrs K Keating	Risk Manager
	Ms L Gardner	Asst Director, Education, Learning & Development
	Mr F Orr	Employee Relations Manager
	Mr J Dennison	Non-Executive Director (Observer)
	Mrs J McSwiggan	Minute-taker

1.0 Welcome and Apologies

T Haslett welcomed J Dennison to the meeting as an observer, and R Sowney as Interim Director of Operations.

No apologies had been received.

K Keating is deputising for Dr Nigel Ruddell, Medical Director.

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 12 March and 4 April 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:

- With regards development of the Near Miss Register, this is a work in progress with completion anticipated before the next Assurance Committee meeting.

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

A verbal update on the action plans arising from this Internal Audit report was provided.

The Learning from Serious Adverse Incidents Procedure was noted as evidence of the Trust's robust approach to managing SAIs. The Chair agreed that the meeting Agenda be amended to include reference that this was noted.

Correspondence between the Chief Executive and the Department of Health was noted, in particular the response from the Deputy Chief Medical Officer acknowledging the actions being undertaken by NIAS in response to the audit report, and his request for an update on the action plans in September 2019.

The Committee noted the plans to deploy dedicated and additional resources to address the outstanding complaints and SAIs. It was noted that NIAS has commissioned AACE to review the corporate support functions across the Trust and their report is anticipated by end June.

The Committee discussed the value of including the action plans within the meeting papers, and the broader issue of presenting information in the most effective way, giving the Committee an opportunity to probe the key issues and risks. It was agreed that there is no criticism of the work being undertaken, but that it could be better presented to highlight the key issues and provide assurance to Committee members. It was felt that the salient points are currently being obscured by the volume of information included within the papers.

6.0 IPC Progress Update

L Charlton, IPC Lead, highlighted the key issues in a presentation to the Committee, including updates on KPIs and the sluice replacement programme.

The Committee acknowledged the successful recruitment of an IPC Lead Nurse. It was noted that this position is separate to L Charlton's secondment to NIAS.

Action: J McSwiggan to circulate copy of presentation to members and attendees.

7.0 Standing Agenda Items

With regards Directorate Assurance Frameworks and Directorate Risk Registers, concern was expressed that because these are reviewed on rotation, it is possible that key issues and risks are not being identified, escalated and brought to the Committee's attention in a timely manner. It was agreed that an overhaul of the Trust's Committee structure and how this information is presented to the Committee is required in order to

highlight key risks in a clearer, more effective way. The role of the new Board Secretary in developing this new structure was highlighted. Recruitment for this post is underway.

Action: K Keating to review Terms of Reference for the three anticipated Committee areas of audit, assurance and resources.

7.1 Assurance Framework (Medical Directorate)

The key issues within the Medical Directorate Assurance Framework were highlighted.

7.2 Corporate Risk Register

A new risk around violence and aggression has been added. One risk relating to overreliance on staff goodwill has been removed. The Committee also noted the work being undertaken around cybersecurity risks.

Action: K Keating to update Lead Director for violence and aggression risk from Director of HR to Operations Director.

7.3 Local Risk Register Review (Medical Directorate)

One risk was highlighted for information: Risk 252 – resources around risk and governance.

7.4 Serious Adverse Incidents

The Committee was pleased to note that five of the ten open incidents have been closed within the past fortnight: Incidents N1001, N1570, N4543, N5894, N7914.

7.5 Incident Data

The Committee commended this valuable summary.

7.6 Coroner's Reports & Letters

Correspondence from the Coroner's Service relating to an incident involving exposure to carbon monoxide was noted, and the Committee was advised that carbon monoxide monitors have now been purchased for issue across the Service in conjunction with associated training and standard operating procedures.

7.7 Medical Device Alerts

Fifteen alerts had been received and reviewed during the reporting period. Fourteen were not relevant to NIAS. One alert relating to the ingestion of cleaning chemicals is being actioned by the Health & Safety Officer.

7.8 NICE Guidelines and Departmental Advisory Notices

New Departmental Guidance surrounding death has been received.

Action: Dr Ruddell to review and issue guidance to staff around the verification of life extinct.

7.9 Pharmacy & Medicines Management

Noted.

7.10 Implementation of IHRD

The significance of this inquiry was emphasised and the Committee noted the extensive assurances that will be required from all Trusts by the Department of Health arising from the inquiry recommendations.

7.11 Whistle-Blowing Register

An update on the two pending cases was provided to the Committee and it is anticipated that these will both be brought to a conclusion by end June. Clarification was provided on the review process for staff suspensions.

8.0 Reports from Groups and Committees

As already discussed under items 5.0 and 7.0, consideration must be given to whether these reports are the best format for identifying risks and providing assurance to the Committee moving forwards.

The Committee discussed the dichotomy between a quorum providing robustness and rigour to a meeting, and hampering Trust business when it is not met. While a quorum is statutory for some Trust Committees, it was agreed that the status of other groups and sub-committees needs to be reviewed. The process for reconvening a non-quorate meeting also requires review.

8.1 Health & Safety Committee

This Group had not met during the reporting period, but a report was subsequently circulated to the Committee and noted.

8.2 Fire Compliance Group

Noted. The Committee asked that the Terms of Reference of the Fire Compliance Group be circulated after the meeting to provide clarity around its quorum and membership.

Action: K Keating to circulate.

In response to concerns expressed at the Trust Board workshop on 7 May, B McNeill provided assurance to the Committee that all risks around fire and health & safety are acceptable. The Committee acknowledged the extensive work that has taken place since Trust Board in order to provide this assurance.

- ***Fire Risk Assessments and Fire Safety Audits***

  It was noted that while the fire risk assessments had been carried out by an external contractor prior to the Trust Board meeting, the reports had not yet been made available to NIAS. They have subsequently been obtained from the contractor and it was noted that 86.5% of NIAS facilities are ranked as tolerable risk, and the remaining 13.5% as moderate risk. Only the NIAS HQ building had required immediate action to mitigate its risk to moderate.

  It was noted that an updated version of the Fire Safety Inspections table is available.

  Action: B McNeill to issue updated table.

  B McNeill clarified that fire assessments are required under law and are carried out on a three year cycle. The fire audits provide evidence that the assessments are relevant and up-to-date.

- ***Fire Action Plan***

  This provides a summary of the schedule of work planned for NIAS stations.

There is significant work to be undertaken and this will be prioritised.

In the absence of a key, the Committee noted that red indicates completion of action. The abbreviation AB was clarified as “Admin Building” and the Committee noted that both Admin Building and EAC within HQ are compliant in fixed wire testing. It was noted that a fire drill work schedule is being developed.

- ***Health & Safety Audit***
  With regards the Health & Safety Audit, it was noted that no audit scores of zero were allocated, and any issues scored 1 were addressed immediately. The average site score is 2.9 against an acceptable baseline score of 3.7, indicating the significant work that is still required. There is a scheme of work in place to address H&S issues as they emerge, and this will be prioritised.

  Action: B McNeill to consider how best to reflect progress and provide assurance to the Committee.

  It is anticipated that Site Safety Audit Reports for stations can be completed in the future on Docworks, similar to the completion of IPC audit reports.

The urgent need for additional resources within the Estates Department to prioritise the work relating to fire and H&S issues was again highlighted to the Committee.

The Committee thanked B McNeill for the clarity and assurance provided in his presentation. It was agreed that had this detail been available on 7 May, the ensuing concern could have been avoided. It was noted that these reports supersede the unrepresentative table “State of the Estate” which was provided to Trust Board on 7 May and which must no longer be used or replicated.

Action: M Bloomfield to formally update Board members.

Action: B McNeill to prepare a briefing note on these areas for Trust Board at their next meeting on 13 June.

Action: Committee Chair to consider the most appropriate mechanism for providing ongoing assurance to the Committee in these areas.

Action: J McSwiggan to circulate copy of presentation to members and attendees.

8.3 **Facilities & Support Group**
This group has not met during the reporting period.

8.4 **Information Governance Steering Group**
This group has not met during the reporting period.

8.5 **Medical Equipment Group**
Noted.

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

8.7 Emergency Preparedness & Business Continuity Group
Noted.

8.8 Learning Outcomes Review Group
This group has not met during the reporting period.

8.9 Joint PSNI/NIAS Clinical Care Working Group
This group has not met during the reporting period.

8.10 Community Resuscitation Strategy Implementation Group
Noted.

8.11 Frequent Callers Group
Noted.

9.0 Additional Items

9.1 Controls Assurance Standards
The summary report on the new arrangements was noted. The Committee agreed that this new framework should be seen as an opportunity to develop NIAS-specific standards that will provide robust assurance across the Trust. It was agreed that Non-Executive Directors should be involved in developing these new standards.

9.2 RQIA

9.2.1 Audits & Inspections re: Restraint & Seclusion
It was noted that NIAS has still not received a report on this regional review.

9.2.2 Review of Serious Adverse Incidents
This RQIA review continues, with NIAS having submitted four cases for review.

9.3 Revised Corporate Risk Management Policy & Strategy
It was noted that this is a scheduled review. Appendix 2 within the Strategy is under review; it was agreed this be referred to as an Interim Strategy in the meantime.

The Policy & Interim Strategy will be presented to Trust Board for approval on 13 June.

9.4 Revised Policy & Procedures for the Management of Medicines
This is a scheduled review. It was noted that Clinical Training is still noted as falling within the HR Directorate, and this should be updated to the Medical Directorate.

Subject to this change, the Policy & Procedures will be presented to Trust Board for approval on 13 June.

9.5 **Clinical Education Update**
Noted.

9.6 **HSC Core Standards for Emergency Planning 2018/19**
Noted.

9.7 **Emergency Planning Annual Report**
Noted. The Committee asked that its congratulations be passed on to the Assistant Director of Emergency Planning, B Newton, on his receipt of a PSNI Recognition Certificate.

10.0 Any Other Business

The Chief Executive made the Committee aware of current media reports around health and wellbeing of staff and weekend pressures.

Date of Next Meeting

Tuesday 15 October 2019, 11am, Board Room, NIAS HQ.

Signed: _____ **Date:** 7 June 2019
(Trevor Haslett, Chairman)

TB/01/08/2019/10

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NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Medical Director
1 August 2019
(April-June 2019)

Medical Directorate Performance Report for Trust Board

Emergency Planning & Business Continuity	
	The 24/7 HART response became fully operational on 1 June 2019, based at the facility in the Lissue Industrial Estate in Lisburn. A Departmental visit has already taken place but a further invitation has been extended to the Chief Medical Officer. Following the introduction of the policy for business continuity, a regime for testing of plans has been developed and is available via the NIAS SharePoint system. The situation with regard to a potential EU Exit remains unclear but a potential no-deal leaving date of 31 October 2019 exists. Work is continuing on both sides of the border to ensure that current cross-jurisdiction arrangements for health will continue regardless and NIAS has already participated in the trial of the reporting system for EU Exit-related issues to the PHA and Department of Health.
Risk Management	
Corporate Risk Register	The Trust's Corporate Risk Register is presented monthly to SEMT, and to the Assurance Committee as a standing agenda item. The format of this presentation has been updated in order to highlight new, deleted or altered risks. Following recommendations from Internal Audit, the Corporate Risk Register is now included quarterly with Trust Board papers and will form part of the Chief Executive's business. The Local Risk Registers of each Directorate are presented to the Trust's Assurance Committee on a rolling basis to ensure that all are considered during the year.
Incident Reporting Procedures	Work is ongoing to address the issues highlighted by the Internal Audit report into the handling of incidents and SAIs. An associate from the Leadership Centre has been tasked with leading on outstanding SAI investigations alongside the part-time contribution of a NIAS Station Officer whose work has previously demonstrated a significant improvement in reporting. Job descriptions for employment of investigation officers are progressing through AfC banding and scope remains for the use of agency staff in the short term. The pressure on Control and frontline operational staff continues to make it difficult to progress some of the practical elements of investigation and family engagement.

Outcomes from Reports, Alerts, etc.	Regular reports on adverse incidents including SAIs involving NIAS are provided to the Assurance Committee. In addition, 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 which is aimed at disseminating relevant learning from incidents across the entire Service.
Clinical Care	
Infection Prevention & Control	A business case has now been submitted to the Department seeking support for all of the factors necessary for sustained improvement including long-term provision of dedicated vehicle cleaners, updates to estate in order to meet compliance with IPC standards, and hardware and software required to facilitate the real-time audit process. A decision from the Commissioners is awaited, but work is continuing on the upgrading of estate facilities e.g. sluices. NIAS has also submitted an IPC Training Strategy as part of the work to address the remaining improvement notice from RQIA which expired at the end of June. The associated action plan indicates that there is still work to be done in this respect, although much of this will be progressed once the new IPC Lead is in place. This post has now been appointed and we are awaiting confirmation of the date of commencement. Local audit is being facilitated by the DocWorks system and there has been clear guidance issued instructing staff to continue to highlight areas of work that are not yet complete so that the impetus is maintained.
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 and Newtownabbey, Armagh, Banbridge & Craigavon, Derry City & Strabane, are being followed up. Plans to follow up with Belfast, Causeway Coast & Glens, Mid & East Antrim, Fermanagh & Omagh. The GoodSAM App was launched on 28 June by the CMO. 200 general registrations is the baseline snapshot prior to going live. The first stage is NIAS Staff, SHSCT staff & Community First Responders. **AEDs**

	Number of AEDs now registered on the NIAS interactive map: 1489, an increase of almost 500 AEDs since October 2017. **Community First Responders** 3 New CFR Schemes have received training – Newtownhamilton (Go Live TBC), Braid Valley (Ballymena, Broughshane, Kells) – Go Live 15.07.2019, North West (Limavady, Eglington) Go Live TBC.
Regional Electronic Ambulance Communications Hubs (REACH) Project (previously ePRF)	"Kick off " meeting took place with Ortivus UK on 15 and 16 April. Met with the project team, clinical team and IT team including BSO to begin to scope project and ensure everyone understands the requirements. Ortivus have raised some points in the contract which they have asked to be reviewed, in particular the project milestones and related payments. NIAS (with advice from PaLS) has considered the proposals. There is no change to the contract which is based on the standard crown commercial contract. An additional milestone has been added which allows for an upfront payment to allow for resources for supplier development from the outset of the software. PaLS are content that the schedules can be updated. There are 6 milestones in the contract which are based on key deliverables and outputs for payment. To date the contract has not been signed. This is anticipated prior to the next REACH programme board on 3 July. Progress is underway with BSO to establish data links with the regional data centres where the system will be hosted.
Appropriate Care Pathways	The Appropriate Care Pathways continue to be used by staff routinely with approx. 150 patients per day being offered an alternative to transport to the ED. An additional pathway has been drafted with Northern Ireland Fire and Rescue Service which will enable NIAS staff to refer any patient who is at risk of harm from fire to NIFRS for a home fire safety check. The CEC continue to offer a range of short courses to promote the use of pathways. During the reporting period, two wound care courses were offered which were attended by 20 members of staff. Members of the medical directorate have presented at all new staff inductions to promote the use of ACPs. Inductions attended have included: • New EMDs • New EAC control officers 140 additional licences for the NIAS / JRCALC app have been purchased and released to

	Ambulance Care Attendant's. Other key events which occurred in April - June were: **Project A / Ambulance Q** The Transformation and Improvement Programme lead and Clinical Service Improvement Lead attended the regional Project A / Ambulance Q event in Edinburgh which was facilitated by NHS Horizons and had Helen Bevan as a keynote speaker. NIAS also hosted the NEAS QI team to explored current improvement topics and opportunities for shared projects and training. **Adverse Childhood Events (ACEs)** NIAS attended the ACEs launch event at the Titanic centre and The CSD, frequent caller team and Peer support team received ACEs training on 31st May. **Nursing and Residential Triage Tool (NaRT)** The Nursing and Residential Triage tool has now been implemented in 4 care homes across the BHSCT / SEHSCT areas. This tool aims to reduce ED admissions via ambulance from patients within care homes. This initiative is being led by NIAS but supported by PHA / RQIA. A number of training sessions were attended by both the SEHSCT Enhanced Care at Home team and representatives of PHA. This pilot aligns with the regional Care Home Transformation Project which NIAS is also contributing to. **National Paramedic Conference** NIAS supported 6 members of staff to attend the National Paramedic Conference in Newcastle. Staff from various departments attended including Operations and HR. **Urgent and Emergency Care Review** A small panel presented to the Urgent and Emergency Care Review committee on the role of ACPs; CSD; NaRT and the management of frequent callers. NIAS now regularly attend the Review Task and Finish Group. A number of NIAS staff are due to attend the Review summit on 25th June. **Clinical Support Desk** A further CSD recruitment has been completed with 7 paramedics successfully completing the process. Training is anticipated to commence Aug 2019.

The CSD have also been leading on a number of modernisation initiatives including:

Direct contract by PSNI – This pilot involves PSNI officers contacting NIAS directly via 999 rather than via the PSNI control centre. This approach means that information passed is more accurate and provides CSD with a phone number on which they can call the PSNI officer back on to provide remote triage. Following the success of the pilot, PSNI now plan to extend into Belfast districts.

A number of meetings have taken place with the PSNI regarding demand management. One of the outcomes of these meetings will see an additional CSD desk operate from PSNI HQ on 11th and 12th July.

Primary Care Response – This response see CSD paramedics respond to GP calls from 1500-2100. These calls which would originally have been 999 emergency calls are managed as HCP urgent calls.

Presentations
The Transformation and Modernisation team have made a number of presentations regarding their current work streams during the reporting period to a number of forums including:

- Frequent caller presentation at NIAS leadership conference
- Sepsis update at Regional Sepsis workshop facilitated by Patient Safety Forum
- Urgent and Emergency Care Review presentation to Trust Board
- Presentation of current NIAS improvement initiatives to NHSCT ICP

Meetings
Key meetings attended during the reporting period included:

- Attendance at national Frequent Caller Network meeting
- Attendance at PSNI demand management meeting
- Attendance at Making Life Better Conference
- Attendance at Mencap training
- Attendance at opening of Daisy Hill Direct Assessment Unit.
- Attendance at ED turnaround workshop facilitated by Patient Safety Forum
- Attendance at Review of mental health interagency guidance facilitated by PHA.
- Attendance at BHSCT ICP meeting
- Attendance at BHSCT Locality Area Network meeting

Helicopter Emergency Medical Service (HEMS)	The consultants providing medical cover for HEMS continue to do so in addition to their full hospital work commitments. This alone can place cover at risk due to competing pressures within the hospital system and more recently, changes within the HSC pension scheme have resulted in many consultants across the system dropping additional duties. This carries a high risk of dropped cover for the HEMS service which would effectively take it offline. To date this has been narrowly avoided due to the efforts of the Clinical Lead and the flexibility of the remainder of the team. The Department has asked that any such drop in cover be notified by an early alert. The helipad on top of the Critical Care Building at the Royal Victoria Hospital site has recently passed the final CAA inspection but a subsequent inspection by NIFRS raised further issues. These are currently being addressed by the Belfast Trust but will require reinspection by NIFRS when complete. The availability of the pad has the potential to reduce transfer times by around 22 minutes as well as improving the availability of the medical team due to a quicker turnaround.
Personal Public Involvement / Patient Client Experience	
Patient and Client Experience Standards (PCES)	The Patient Experience function continues to include focus on: • collection of patient stories and work with the PHA and service users on the evaluation of the stories in order to ensure learning from 10,000 More Voices leads to improve services; • engagement with the Comms Team on options for a NIAS 10,000 More Voices awareness and promotional campaign; • continued promotion of 10,000 More Voices and gathering of more stories from patients and staff, reviewing progress and learning from results with service users; • promotion of the pilot of the Appropriate Care Pathways survey; • review of the 10,000 More Voices methodology to deliver more effective outcomes in the context of also delivering on PPI duties; and • learning from results – ensuring that learning is shared with senior management and lessons learnt are used in training and service delivery. The Trust met with PHA in relation to the promotion of 10,000 More Voices and to agree a new process for gathering more stories from patients and staff, review progress and learn from results with service users. Further work is underway to use 10,000 More Voices as a learning and engagement tool across the Trust. The Trust also continued to engage with colleagues regionally in relation to the development of the Real Time/Online User Feedback project. In this regard, the Trust – including the Chair, Chief Executive and Director of HR & CS - met with senior officials from the Department of Health and

	PHA, and a representative of a local citizens hub, to consider further opportunities for embedding the broad agenda of people partnerships, from patient experience feedback, through PPI activity, through existing engagement/consultation work, through to mainstreaming an effective approach to co-production. Staff attitude, behaviour and communication are continuing themes emerging from complaints and we continue to work to address these issues through internal processes including training. We will also prioritise staff attitude and will raise awareness of and communicate the patient experience standards across all staff groups through learning and development programmes including induction training.
Personal and Public Involvement (PPI)	The Trust's Personal and Public Involvement (PPI) Strategy outlines its commitment to involving key stakeholders such as service users, carers and their representatives in the development of services. Work is continuing on reviewing NIAS's PPI strategy and structure, in the wider context of Trust restructuring. During this reporting period, the Trust met with PHA and regional colleagues through the Regional PPI Forum. As outlined above, the relationship between PPI and Patient Experience work is now being developed in the wider context of Departmental and regional work to bring these work-stream closer on an outcomes-based approach. The Trust has continued engagement and consultation on a range of transformation policies in development, alongside a specific focus on the PPI standards, taking into account the DoH's recently published guidance on co-production and co-design. Work has continued during this reporting period on developing a significant public and staff engagement programme, particularly in relation to next steps on the new Clinical Response Model.
Clinical Education and Training	
	Various education and training courses continued throughout the quarter April – June 2019. The first cohort of 47 students on the NIAS/UU Foundation Degree in Science in Paramedic Practice (FdSc) moved into the second semester of their studies, including periods in practice placements in both ambulance and hospital placements across all Trust areas. The course runs until October 2019. Successful completion provides eligibility to apply to HCPC to register as a Paramedic.

	Two Associate Ambulance Practitioner (AAP) courses, with a combined total of 44 students, continued simultaneously. One course was held in the 'RADAR' Centre in Belfast and the other on the UU Campus at Magee. Both courses completed with an end of course awards event held on 20th May, after which the 44 successful students moved to Operations into Emergency Medical Technician (EMT) roles. During the quarter, another two AAP courses commenced, one on 20th May with 14 students in Belfast and another on 17th June with 23 students on the Magee campus. All of these AAP programmes are part of a significant commitment to train sufficient numbers of staff for workforce stabilisation and to enable backfill of positions of EMTs who have going on to Paramedic courses. Following a retirement in April, a new Clinical Training Officer (CTO) was appointed to the team in May and an additional 3 new CTOs were appointed in June. Due to existing temporary vacancies associated with temporary secondments, these new Training Officers only help maintain the status quo and do not add any capacity to the team. Subsequently, a further recruitment for CTOs was initiated in June. The students on the Paramedic and AAP programmes undertake practice placements as part of the courses. These student placements are facilitated by mentorship provided by local staff and the Clinical Support Officer (CSO) tier acting as Lead Practice Educators. This has added to the work streams undertaken by CSOs and therefore impacts on some of their other core work. Delivery of the Continuing Education programme (Post Proficiency – PP) remained on hold with courses deferred until later in the year. This helps to maintain capacity for training associated with the Paramedic programme, whilst minimising the release of frontline operational staff. This is due to resourcing and operational pressures including limitations on release of staff for training at a time when all the other courses are also ongoing. RACTC and the transformation team continue to collaborate with the HSC Clinical Education Centre who are delivering a programme of voluntary, short courses open to both EMTs and paramedics alike. Preparatory work was underway in collaboration with Ulster University, who will be delivering a level 6, credit bearing module in Patient Assessment and Clinical Decision Making. This Module is scheduled to be rolled out to existing Paramedics from September.

EMERGENCY PLANNING REPORT FOR APRIL-JUNE 2019

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

Potential Major Incident

On 2 April 2019 @ 0246hrs NIAS received a 999 call to Queens Parade, Belfast for a report of a fire. Tasked to the scene 4 A&E crews, 3 Officers, the Mobile Control Vehicle & Emergency Equipment Vehicle. The incident was stood down by NIFRS at 0256hrs before any NIAS vehicles arrived on scene. Two hospitals were alerted to the potential but quickly stood down.

Major Incidents

On 3 April 2019 @ 0217hrs NIAS received a 999 call for reports of a fire in a block of apartments on Great Victoria Street, Belfast. Tasked to the scene 7 A&E crews, 1 ICV crew, 1 HART, 2 Doctors, 3 Officers (3 Officers went to hospitals), the Mobile Control Vehicle & Emergency Equipment Vehicle. A small number of patients were transported to hospital and 30 persons were moved to a community centre for the night.

Airport Alerts

On 3 April 2019 there was a ground incident with no casualties - only one Officer tasked after consultation with airport.

On 18 June 2019 @ 0844hrs NIAS received an airport alert to the George Best Belfast City Airport for reports of an aircraft making an emergency landing with hydraulic issues. Tasked to the scene 5 A&E crews, 2 Rapid Response Vehicles, 6 Officers, 1 HART and the Mobile Control Vehicle & Emergency Equipment Vehicle. The plane landed safely prior to an Officer arriving on scene. The Officer on scene held one A&E crew to ensure that all passengers disembarked safely then stood the incident down at 0920hrs.

HAZMAT / Hazardous Area Response Team (HART) deployments

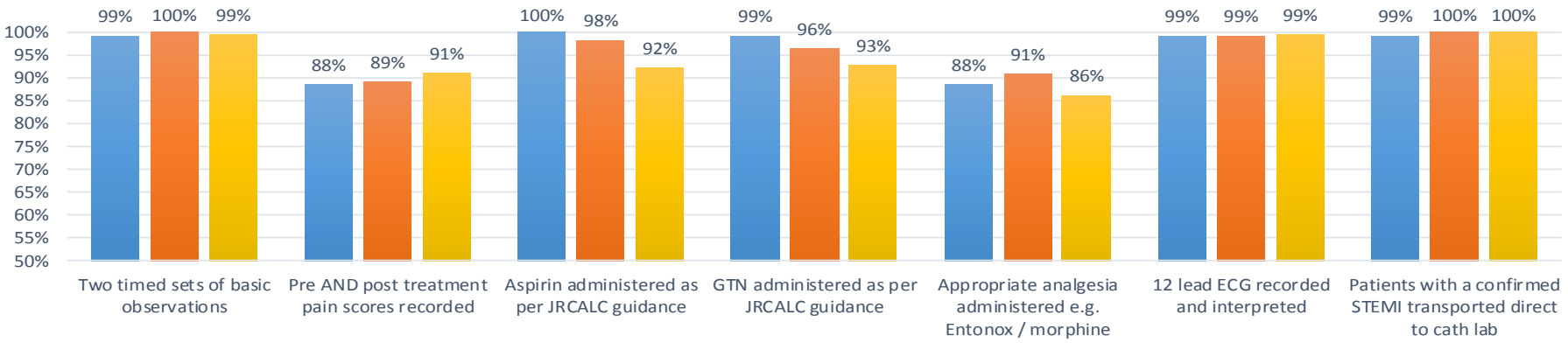
156 = Deployments with Breathing Apparatus skills/ HAZMAT deployments
45 = Restricted space
37 = In-land Water Operations
1 = Incident at height
2 = Special Services Operations
19 = HAZMAT

William Newton
Assistant Director of Emergency Planning

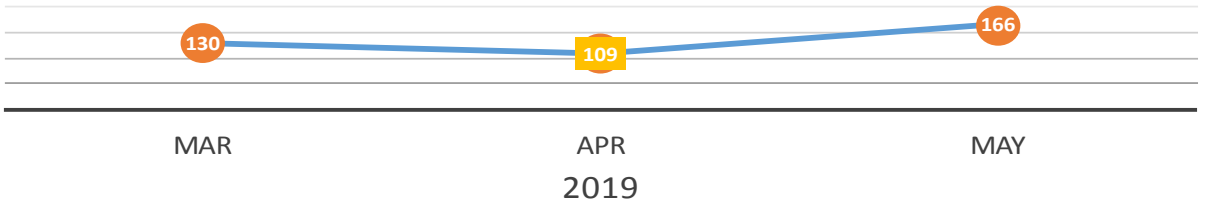
Northern Ireland Ambulance Service
Health and Social Care Trust

ACUTE CORONARY SYNDROME

QUALITY IMPROVEMENT COMPLIANCE



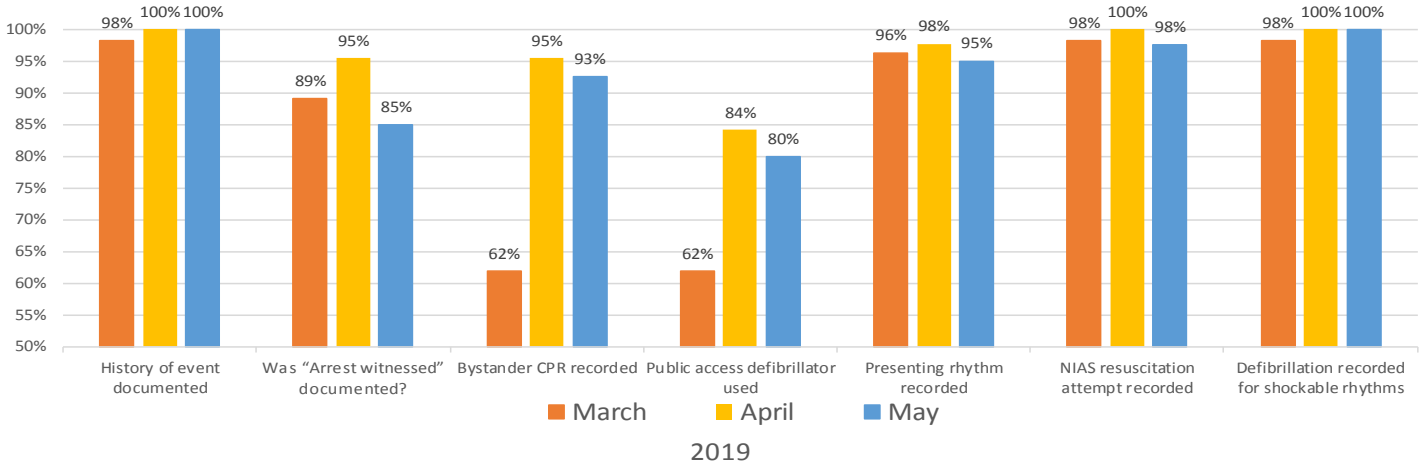
Total PRFs Audited

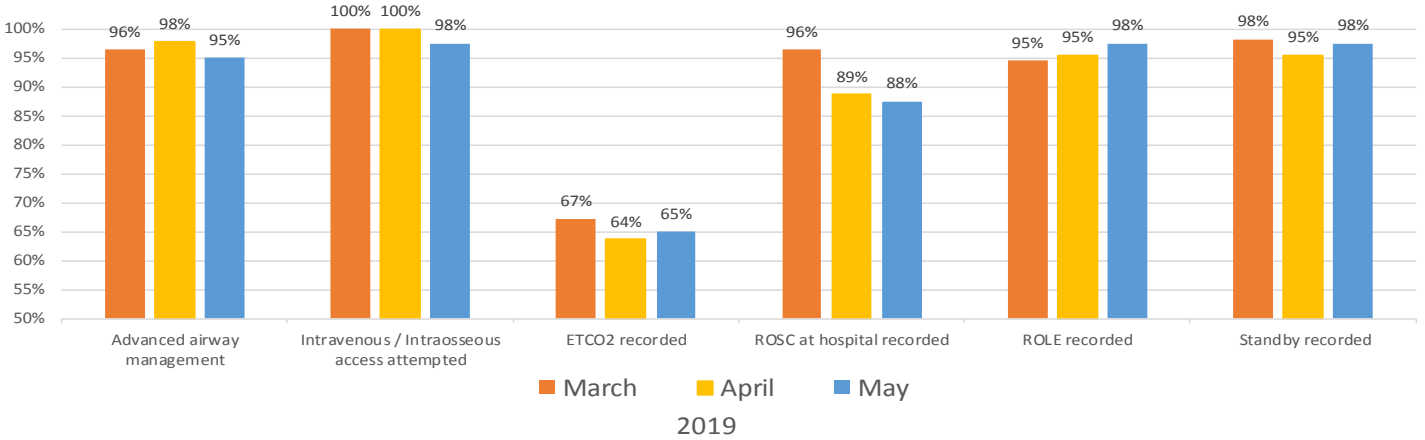


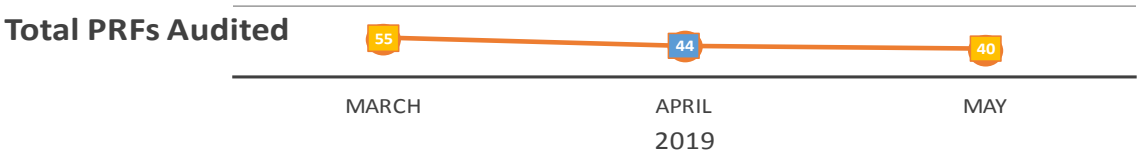
Northern Ireland Ambulance Service
Health and Social Care Trust

CARDIAC ARREST

QUALITY IMPROVEMENT COMPLIANCE



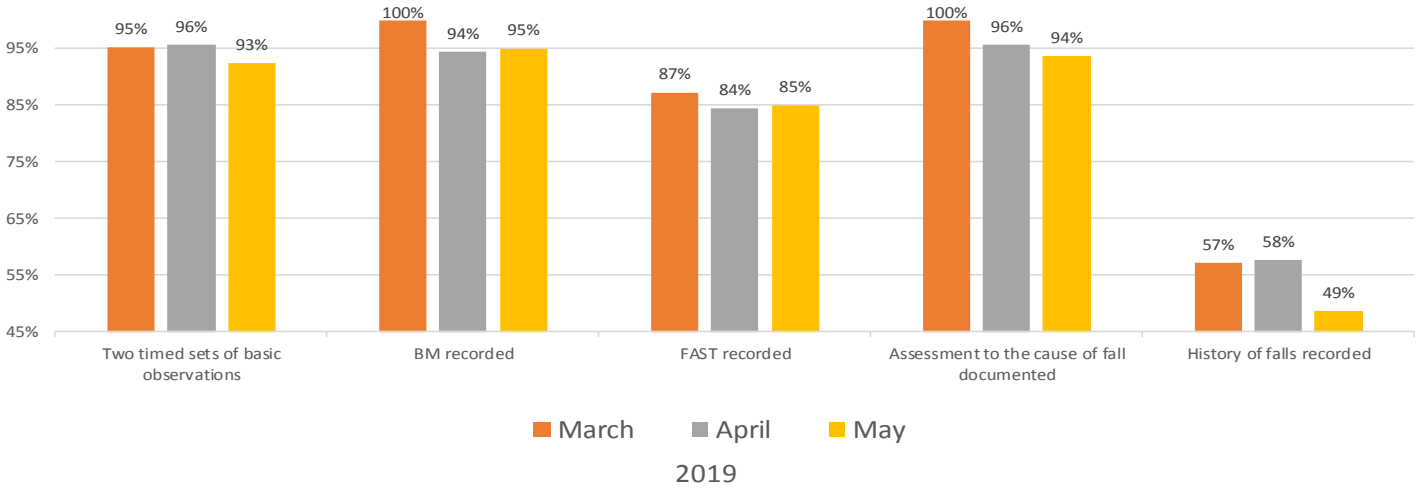


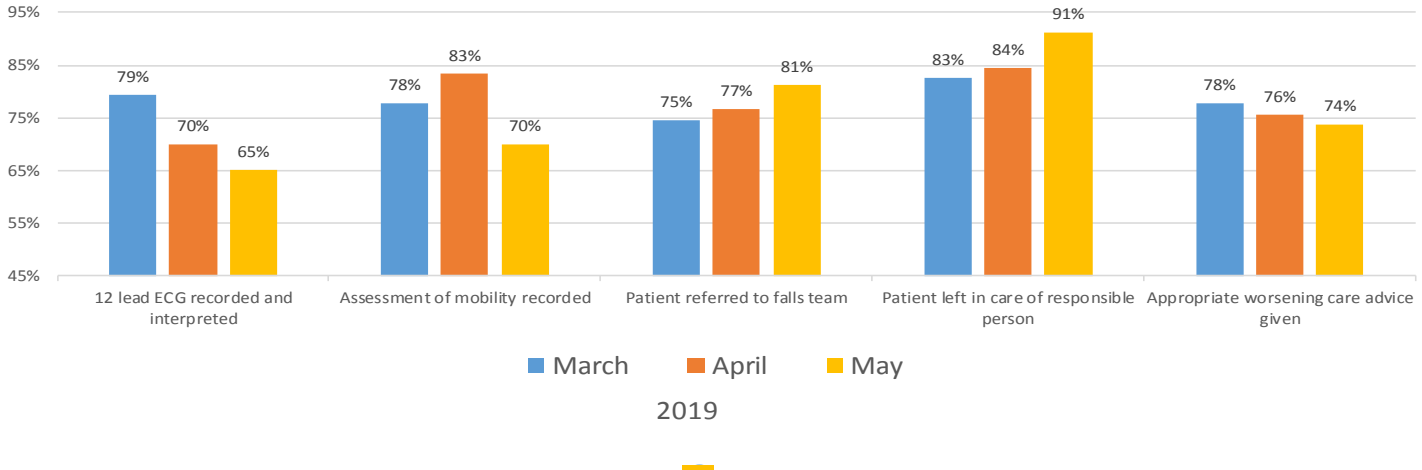


Northern Ireland Ambulance Service
Health and Social Care Trust

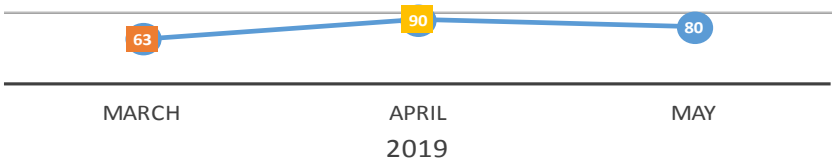
FALLS

QUALITY IMPROVEMENT COMPLIANCE





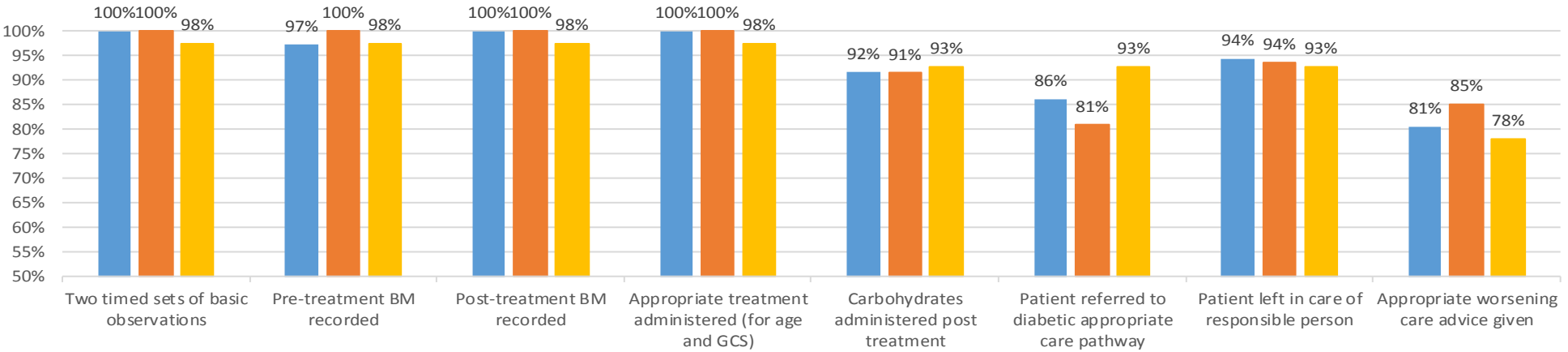
Total PRFs Audited

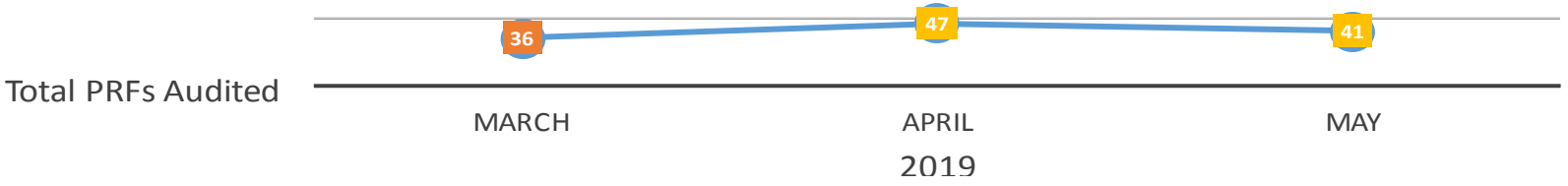


Northern Ireland Ambulance Service
Health and Social Care Trust

HYPOGLYCAEMIA

QUALITY IMPROVEMENT COMPLIANCE

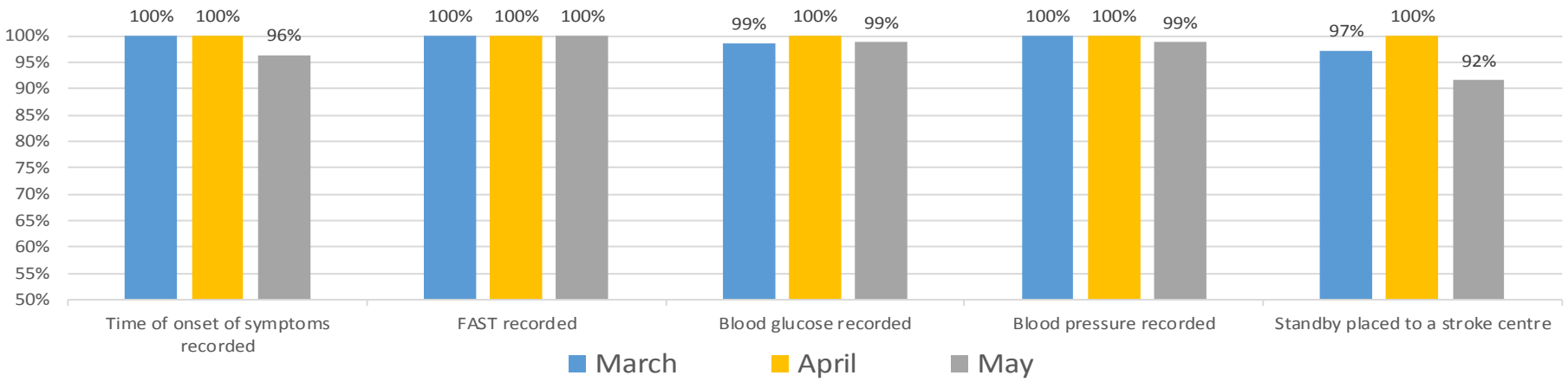


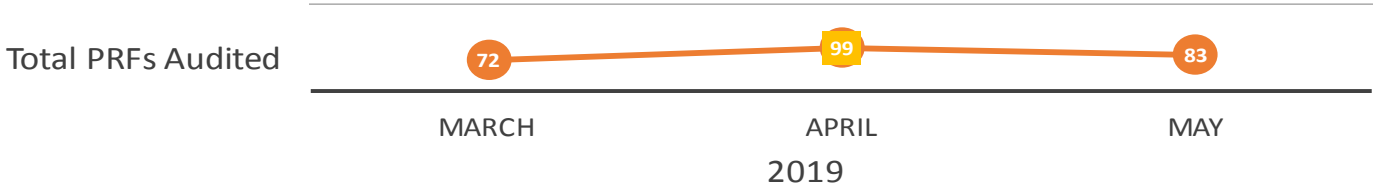


Northern Ireland Ambulance Service
Health and Social Care Trust

STROKE

QUALITY IMPROVEMENT COMPLIANCE





TB/01/08/2019/11

Return to Agenda

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

HUMAN RESOURCES AND CORPORATE SERVICES DIRECTORATE

Director of Human Resources and Corporate Services

(As at 31 May 2019)

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

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

WORKFORCE INFORMATION

Monthly Corporate Workforce Information is published monthly in arrears; consequently the table below reflects the NIAS workforce position as at **31 May 2019**. This information is taken from HRPTS.

MAY 2019	TRUST TOTAL	CX / BOARD	FINANCE / ICT	HRCS	MEDICAL	OPERATIONS
FUNDED (WTE) RECURRENT / (TEMPORARY FUNDING)	1379.28 (50.00)	9.00 (0.00)	34.63 (8.00)	27.15 (10.00)	77.00 (15.00)	1231.50 (17.00)
STAFF IN FUNDED POSTS (WTE) PERM STAFF / (TEMP STAFF)	1263.79 (14.76)	1.00 (3.00)	23.38 (2.00)	21.85 (1.00)	71.87 (2.00)	1145.69 (6.76)
OVERALL VACANCY LEVELS (WTE)	**-150.73**	**-5.00**	**-17.25**	**-14.30**	**-18.13**	**-96.05**

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

On the basis of the information above @ **31 May 2019**, the Trust has an overall vacancy level of **150.73** WTE posts.

*Non-Executives employed on a Fixed Term Contract.

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

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

WORKFORCE INFORMATION

The following table provides a breakdown of frontline vacancies as at **31 May 2019**.

Post	Funded Est (WTE)	Staff-in-Post (WTE)	Vacancy (WTE)	Bank Staff
Station Supervisor	31.00	14.80	-16.20	0
Paramedic + Trainee Para	320.40	341.13	20.73	39
RRV Paramedic	85.20	58.20	-27.00	0
EMT + Trainee EMT	301.40	266.10	-35.3	7
ACA (inc. PCS Sup.) + Trainee ACA	269.50	255.67	-13.83	3

Section 1: Human Resources & Corporate Services

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

CORPORATE ABSENCE REPORT (@ 31 MAY 2019)

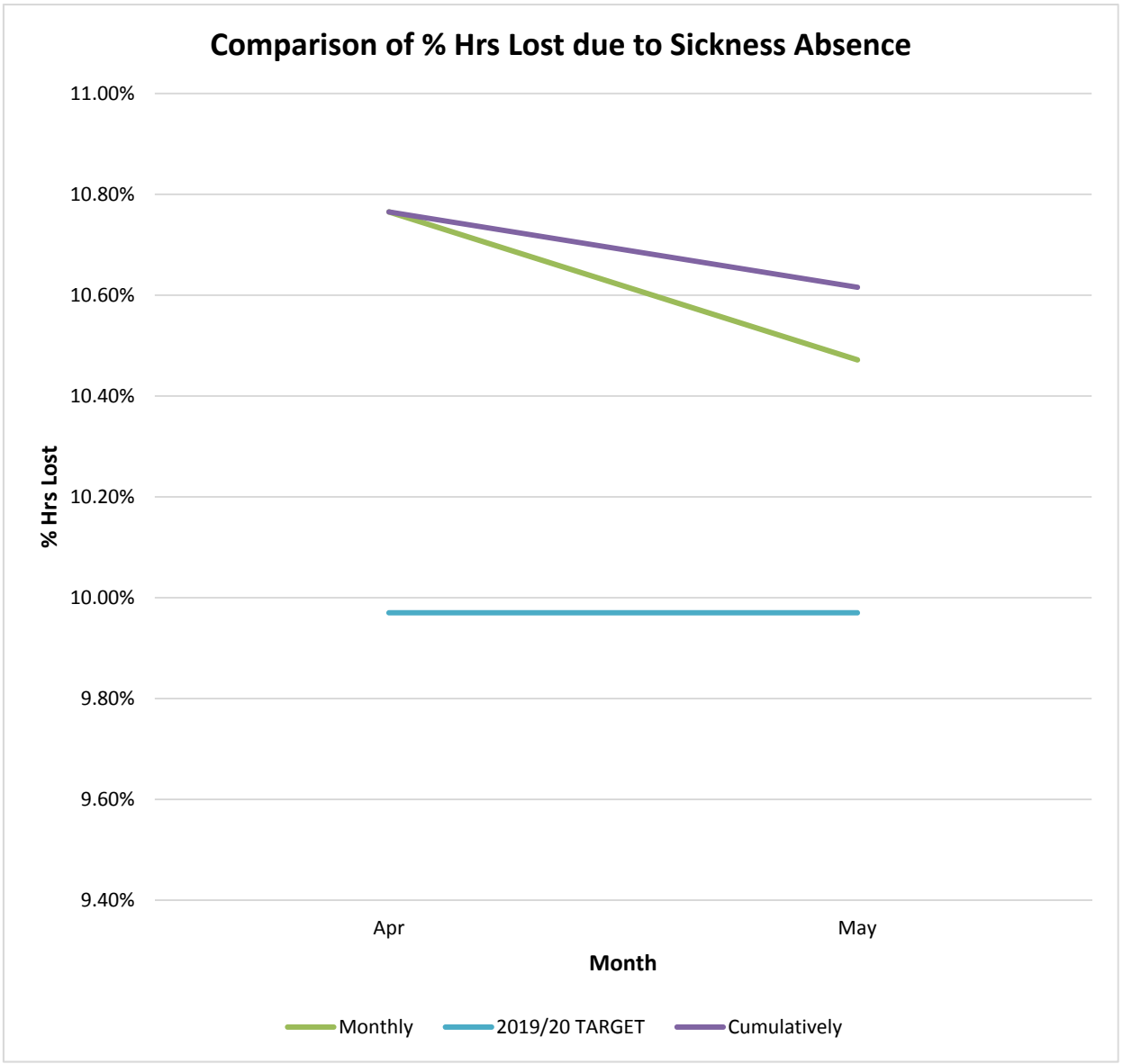
The Trust's sickness absence target for the current Reporting Year (2019/20) has not yet been advised by the Department of Health. Working on last year's Department of Health target to deliver 5% improvement on the previous year's absence levels NIAS target for 2019/20 would be 10.9%. This target is however subject to review.

2019/20 Monthly Sickness Absence including Comparators to Previous Reporting Year (2017/18)												
MONTH	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
NIAS ABSENCE TARGET (2018/19)	**REDUCE SICKNESS ABSENCE RATES BY 5% ON 2017/18 PERFORMANCE TO 9.97%**											
NIAS cumulative % hrs lost (18/19)	**9.73%**	**9.88%**	**10.92%**	**11.33%**	**11.36%**	**11.52%**	**11.44%**	**11.25%**	**11.35%**	**11.39%**	**11.41%**	**11.48%**
NIAS monthly % hrs lost (18/19)	**9.73%**	**10.02%**	**13.09%**	**12.57%**	**11.50%**	**12.32%**	**11.05%**	**9.98%**	**12.09%**	**11.78%**	**11.57%**	**12.21%**
NIAS cumulative % hrs lost (18/19)	**10.77**	**10.62%**										
NIAS monthly % hrs lost (18/19)	**10.77**	**10.47%**										
Monthly % hrs lost (S/T)	2.15	2.00%										
Monthly % hrs lost (L/T)	8.62	8.48%										
Av. days lost (7.5 hrs) per Employee per Mth	2.29	2.34										
Av.NIAS cumulative costs (£'000)	£424	£411										
NIAS CUMULATIVE % HRS LOST:	**(2018/19) 11.48%**				**(2019/20 @ 31 May 2019) 10.62%**					**NOT ON TARGET**		

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

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

- AACE associates have now completed their Review of Attendance Management within NIAS. The findings and recommendations of their Report have been accepted and a Good Attendance Programme structure has been developed to implement the recommendations;
- Recruitment is ongoing for an HR Lead for Attendance Management. An appointment to this post is anticipated for Quarter 2, 2019/20;
- BSO Internal Audit have completed their audit of compliance with the current Attendance Management Policy/Procedure and an action plan to take forward their recommendations has been finalised;
- Collaborative working is ongoing within regional HSC on Attendance Management workstreams;
- Workstreams under the Health & Well-Being Programme ongoing including: Unison Partnership Project; Peer Support Project; Health & Wellbeing workshops for staff.



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

Mental Health	23.94%
Other Reasons	22.67%
Back problems + Injury / Fracture + Other Musculosketal problems	22.38%
Accident / Untoward Incidents at work	9.96%
Gastrointestinal problems	7.05%
Asthma, Chest, Resp.	1.37%
Heart, Cardiac & Circulatory Problems	6.68%
ENT	1.43%
Pregnancy Related	1.23%

ABSENCE REASONS RECORDED WITHIN "OTHER REASONS" CATEGORY (APR 19 – MAY 19) INCLUDE:

General Debility	14.62%
Hospital Investigation	1.77%
Post Surgery Debility	6.28%

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

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

Section 1: Human Resources & Corporate Services

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

England Ambulance Services	**April 2019**	**May 2019**	**June 2019**	**July 2019**	**Aug 2019**	**Sept 2019**	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb 2020**	**Mar 2020**
	Not available at time of print	Not available at time of print										
East Midlands Ambulance Service NHS Trust												
East of England Ambulance Service NHS Trust												
Yorkshire Ambulance Service NHS Trust												
South Central Ambulance Service NHS Foundation Trust												
London Ambulance Service NHS Trust												
S/East Coast Ambulance Service NHS Foundation Trust												
North East Ambulance Service NHS Foundation Trust												
North West Ambulance Service NHS Trust												
West Midlands Ambulance Service NHS Foundation Trust												
South Western Ambulance Service NHS Foundation Trust												
By Staff Group - Ambulance												
By Organisation Type - Ambulance												
	2017/18	**2018/19**	**2019/20**									
Scottish Ambulance Service	7.67%	5.39%										
	Apr-Jun 17	**Jul-Sep 17**	**Oct-Dec 17**	**2017**	**Jan-Mar 18**	**Apr-Jun 18**	**Jul-Sep 18**	**Oct-Dec 18**	**Jan-Mar 19**	**Apr-Jun 19**		
Welsh Ambulance Service	6.30%	6.90%	7.40%	6.80%	8.10%	7.50%	7.60%	7.90%	Not available	Not available		
Information Source:												
1. NHS Digital (www.digital.nhs.uk)												
2. ISD Scotland (www.isdscotland.org)												
3. Stats Wales (www.statswales.gov.wales)												

TRUST BOARD GOOD ATTENDANCE PROGRAMME UPDATE

The Good Attendance Programme was commenced on 25 March 2019 with a stakeholder workshop and the first Programme Team meeting. The programme structure was agreed and the related deliverables provided to Project Managers. At the Programme Board meeting on 16/4/19 the recruitment of a project administrator was approved. The post was filled on 9/7/19 and the related Programme and Project meetings are in the process of being scheduled. Recruitment campaigns for a Good Attendance HR Manager and a Good Attendance Operational Manager are in progress and these roles will be critical in delivering on the Programme. The Project Initiation Document (PID) is being developed and will be presented to Programme Board at August meeting for agreement. This will specify the deliverables, related prioritisation, timeframe, risks and constraints. It is intended to report progress against the PID to Assurance Committee as well as to the Programme Board.

Programme Structure:

Senior Responsible Officer (SRO)	Programme Manager (PM)	Programme Board	Programme Team:	Project 1: Review of attendance Policy and related Procedure	Project 2: Operational Directorate Priorities & Improvements	Project 3: Occupational Health Improvements	
Director of Human Resources and Corporate Services	Assistant Director of Human Resources and Corporate Services	Senior Management Team (AACE Specialists when required)	DHR&CS (SRO) DOps ADHR&CS (PM) ADOps ASAM (South) AD OD & Equality (AACE Specialists when required)	Project Manager: Assistant Director of Human Resources and Corporate Services (AACE Specialists when required)	Project Manager: Assistant Director of Operations (AACE Specialists when required)	Project Manager: Ambulance Service Area Manager, South Division (AACE Specialists when required)	Project Manager: Assistant Director of Organisational Development and Equality (AACE Specialists when required)
	Weekly highlight meetings are scheduled with SRO on progress and risks to delivery.	Programme Board meetings were held on 16/4/19; 11/6/19 and 16/7/19. Monthly meetings are now being scheduled.	Project Team meeting held on 25/3/19 and meetings are now being scheduled.				

PROJECT 1	DELIVERABLES	PROGRESS AT JULY 2019	RAG (completion dates not yet agreed)
	Review Attendance Management Policy / Procedure.	Workshop planned for 7/8/19 to review policy and procedure with key stakeholders.	
	Review associated policies / procedures to support implementation of the revised Attendance Management Policy / Procedure.	Review of the following policies and/ or procedures: • Probationary period • Medical Redeployment and redeployment under DDA (Revised Management Framework agreed by SMT and implemented) • Lighter duties • Annual leave – (revised policy currently out with Trade Unions for consultation).	
	Develop of Management Resource to support implementation of revised Policy / Procedure. To include training, development of a Managers Toolkit.	Toolkit in draft. Further actions delayed pending the appointment for the Good Attendance Managers and competing priorities for the Project Team.	
	Re-launch revised Policy / Procedures.	N/A	
	Explore HR best practice and roll out across the Trust.	Weekly meetings with Operational Managers have been established to consider Divisional and Control related (complex) cases. Monthly meetings have been agreed with Occupational Health, HR specialists and Operational managers to case review complex cases. Monthly HR/Ops collaborative meetings continuing with renewed focus on attendance including review of monthly absence information. Good Attendance Managers to commence bench marking on appointment HR Business Partnering at Divisional and Control level is being explored with related bench marking and business case in development.	
	Develop and deliver a communications plan.	To be reflected in draft PID for agreement at August Programme Board meeting	
	Review governance arrangements for reporting of absence and related corporate reports	Benchmarking of corporate reporting ongoing. Further actions delayed pending the appointment for the Good Attendance Managers and competing priorities for the Project Team.	
PROJECT 2	DELIVERABLES	PROGRESS AT JULY 2019	RAG (completion dates not yet agreed)
	Review and establish Senior Managers performance management systems for Attendance Management to ensure that each tier of management holds to account its direct reports for attendance management and includes monitoring of (timely)	Work in progress to review Key Performance Indicators (KPI) and establish an operational performance management framework. Trust Board Operations performance report to be revised to reflect new KPIs once agreed.	

	escalation through Policy/Procedure.		
	Review the provision and source of timely information reports to identify and deliver on areas of improvement.	Programme Board approved proposal to use GRS as source of timely information reports for Operational management to use in delivering on attendance improvement.	Complete
	Explore local best practice and roll out across Directorate.	The quality improvement pilot for return to work interviews has been approved for roll out across Operational Divisions.	
	Review the role of RMC and utilisation of GRS in relation to managing attendance to include staff reporting of sickness and contact arrangements, R2W interview, recording of attendance management activity and develop appropriate systems/processes/protocols.	Programme Board approved proposal to use GRS for Operational attendance management.	
	Review Operational Directorate staff absence reporting methodology to reflect best practice.		
	Review of Operational Directorate processes for management of sickness certificates and recording of absence.		
	Ensure local recording of Attendance Management activity		
	Review of R2W practices to include establishing a system to ensure timely undertaking of interviews, review of template documentation for completion and a system that ensures related forms are signed and dated.	Links to KPIs above	
	Joint review of Operational Directorate Annual Leave Procedure.		
	Develop and deliver a communications plan linked to this work stream.	To be reflected in PID and agreed at Programme Board meeting in August.	
PROJECT 3	DELIVERABLES	PROGRESS AT JULY 2019	RAG (completion dates not yet agreed)
	Specify what is required from an Occupational Health Service for NIAS	Occupational Health Workshop planned for September 2019 with key stakeholders	
	Review specification against existing Occupational Health Services and identify gaps	As above	
	Scope provision for enhanced or new local Occupational Health Services	Current provider has been asked to consider employing a full time OH nurse for NIAS. Related Service Level Agreement under development and discussions in progress in this regard with current provider. Further work has commenced in identifying alternative OH providers to	

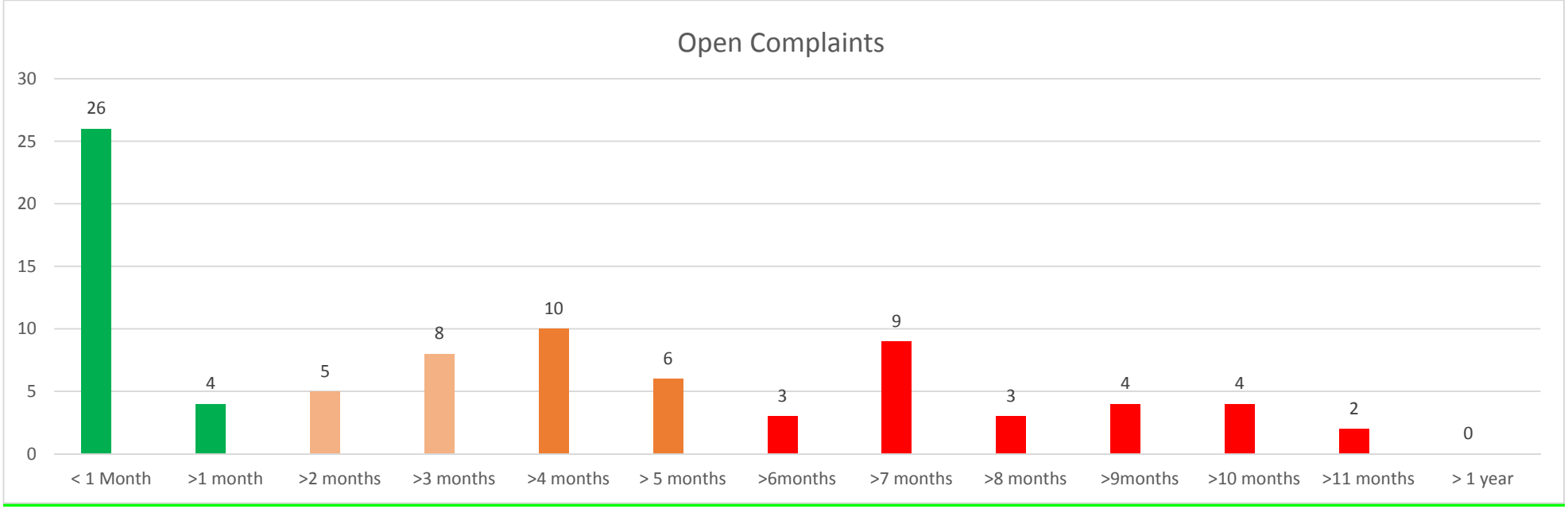
		address specification gaps once identified.	
	Develop an outline business case for investment in Occupational Health Services to meet identified requirements and gaps	Specification and gap analysis required in advance of outline business case. Pending workshop in September 19.	
	Develop and deliver a communications plan linked to this work stream.	To be reflected in PID and agreed at Programme Board meeting in August.	
PROJECT 4	DELIVERABLES	PROGRESS AT JULY 2019	RAG
	Invest in the Joint Partnership Health & Well Being priorities, as identified in the partnership survey and agree a related annual work plan to deliver on these.	Regular joint meetings of Partnership teams and steering Group. Action Plans agreed and on track for delivery	Complete
	Embed peer support	Work in progress to enhance current resources with 2 full time secondments agreed from august 19. An additional Cohort was trained in July and a further Cohort is planned for October 19. Project evaluation planned by November 19. Business case to be prepared by January 20 for mainstreaming peer support.	On track
	Consider formal post-incident support availability for staff across the Trust, including associated “stand down” arrangements.	Formal support and stand-down procedures will be finalised once the new Peer Support secondees are operational.	On track
	Review arrangements to support mental health and well-being and make recommendations for improvements	Included in the H&WB annual work plan and on track for delivery	On track
	Develop and deliver a communications plan linked to this work stream.	Action Plans already in place for elements of this work, Project specific communication plan will be presented to Programme Board for agreement in September 19	On track

Northern Ireland Ambulance Service – Trust Board, Complaints and Compliments Report

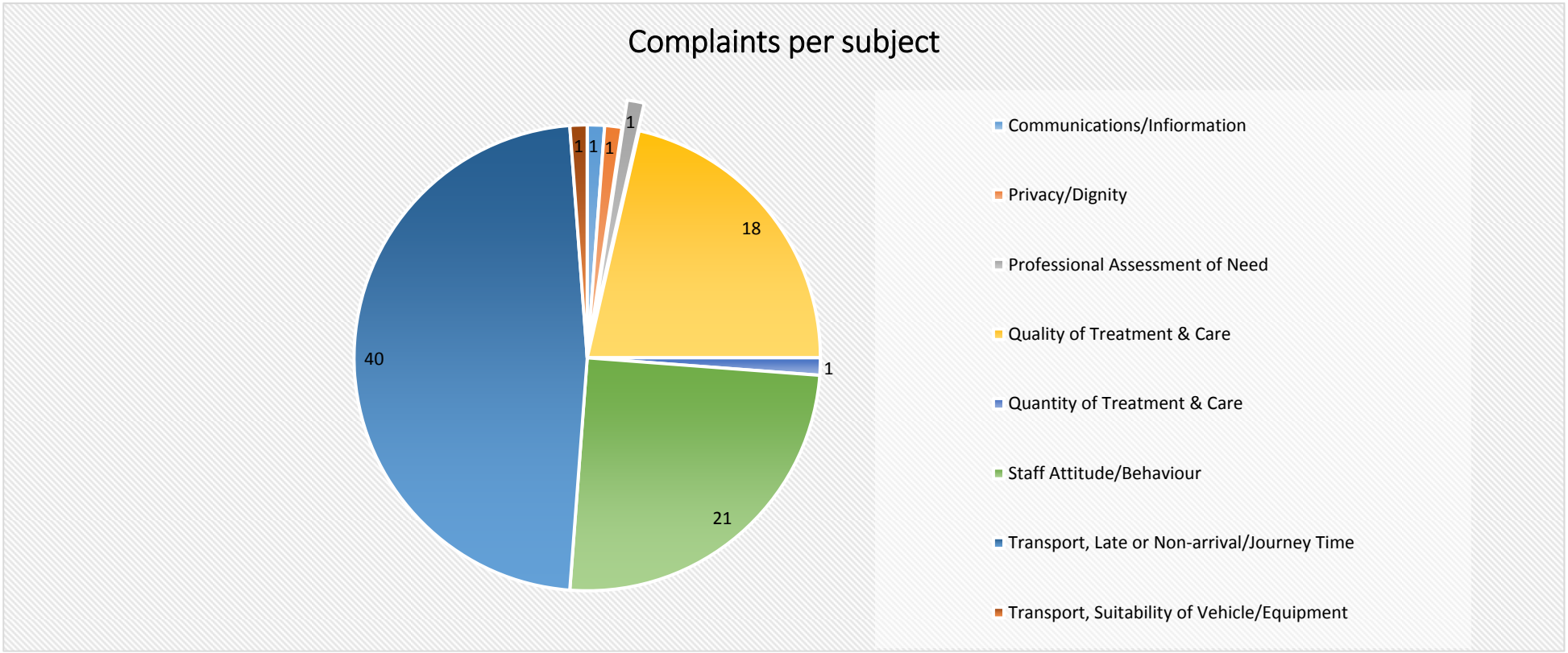
Figures correct as of 30 June 2019:

Number of open complaints	**84**				
Number of complaints received to date *(from 1 April 2019)*	35	**Number received for same period during 2018-19**	27	**% Difference**	+25.8%

	< 1 Month	>1 month	>2 months	>3 months	>4 months	> 5 months	>6months	>7 months	>8 months	>9months	>10 months	>11 months	> 1 year	Total
Ambulance Control	4	2	2	2	2	4		2	1	1	1	1		22
Non-Emergency Ambulance Control	1			1	1		1	1			2			7
East City	7	1		2	1	2		2		1	1			17
Northern	1	1	1		3			3		1		1		11
Southern	4				1			1						6
Western	5		1	1	1		1			1				10
East Country	3		1	2	1		1		2					10
Other *(Headquarters)*	1													1
	26	**4**	**5**	**8**	**10**	**6**	**3**	**9**	**3**	**4**	**4**	**2**	**0**	
	< 1 Month	>1 month	>2 months	>3 months	>4 months	> 5 months	>6months	>7 months	>8 months	>9months	>10 months	>11 months	> 1 year	**84**



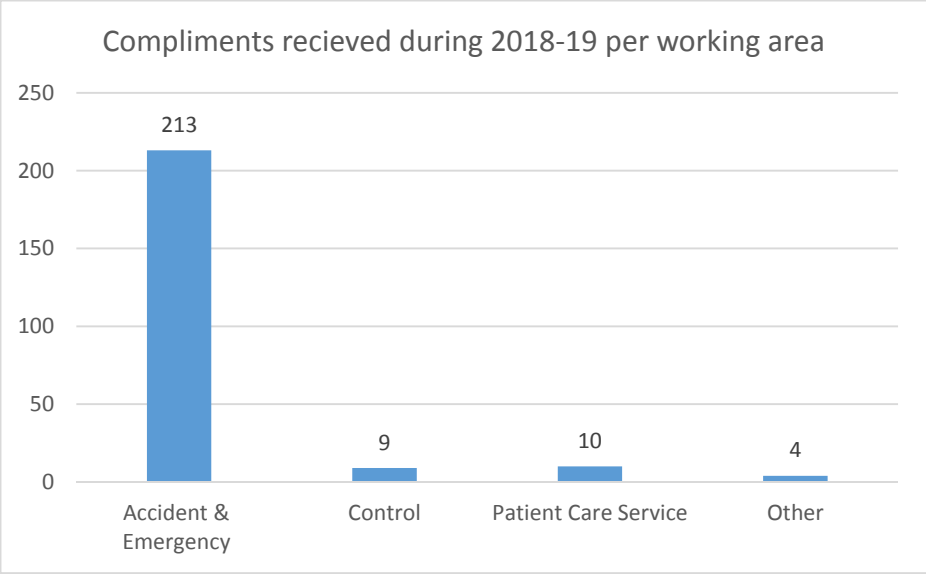
A.Watterson – Complaints Manager

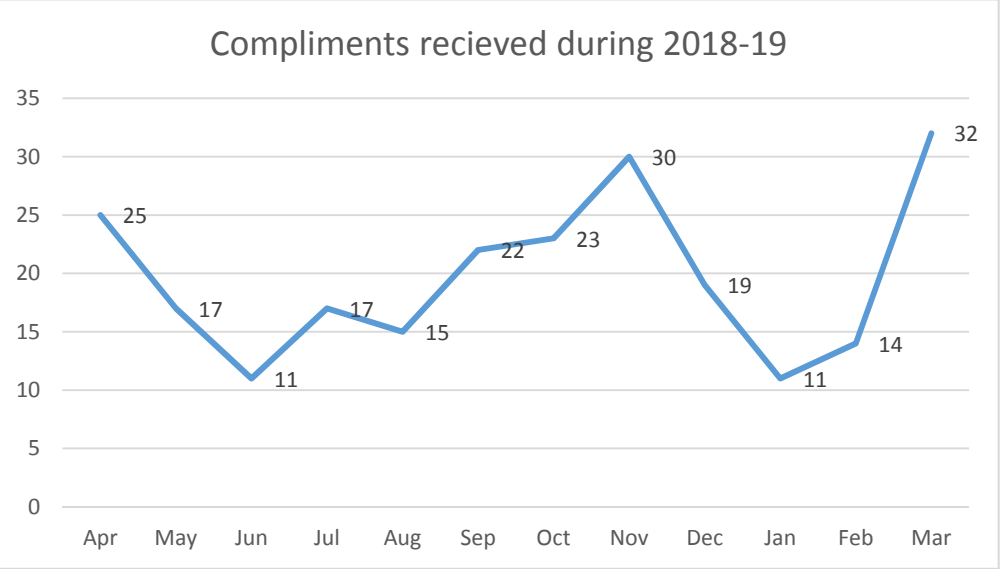


Subject	n=
Communications/Information	1
Privacy/Dignity	1
Professional Assessment of Need	1
Quality of Treatment & Care	18
Quantity of Treatment & Care	1
Staff Attitude/Behaviour	21
Transport, Late or Non-arrival/Journey Time	40
Transport, Suitability of Vehicle/Equipment	1
Grand Total	84

A.Watterson – Complaints Manager

COMPLIMENTS RECEIVED 2018-19															
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2018-19**		**2017-18**
RECEIVED	25	17	11	17	15	22	23	30	19	11	14	32	**236**		**298**
SERVICE AREA OF COMPLIMENTS RECEIVED															
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2018-19**	**%**	**2017-18**	
Accident & Emergency	24	14	10	15	14	21	22	25	17	11	12	28	**213**	*90.3%*	**274**	*92%*
Control	1	0	1	2	1	0	0	4	0	0	0	0	**9**	*3.8%*	**14**	*5%*
Patient Care Service	0	3	0	0	0	0	1	1	0	0	2	3	**10**	*4.2%*	**6**	*2%*
Other	0	0	0	0	0	1	0	0	2	0	0	1	**4**	*1.7%*	**4**	*1%*
TOTAL	**25**	**17**	**11**	**17**	**15**	**22**	**23**	**30**	**19**	**11**	**14**	**32**	**236**		**298**	





A.Watterson – Complaints Manager

TB/01/08/2019/12

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NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT

August 2019 (Month 4)

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently reporting a breakeven position for the three months ending 30 June 2019 (Month 3), subject to key risks and assumptions. 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 June 2019 (Month 3)

Financial Breakeven Assessment (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Costs		10,042	15,225									
Other Expenditure		2,410	3,696									
Expenditure Total		12,452	18,921									
Income		147	220									
Net Expenditure		12,305	18,701									
Net Resource Outturn		12,305	18,701									
Revenue Resource Limit (RRL)		12,305	18,701									
Surplus/(Deficit) against RRL		0	0	0	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. The Trust has received an opening baseline Revenue Resource Limit (RRL) allocation of £68.3m. Further indicative allocations have been advised of the order of £7.7m and specific Transformation allocations of £3.8m. There are currently a further £6.6m of assumed allocations in the draft financial plan. The Trust is also required to identify 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 £7.982m. This allocation allows the Trust to continue with planned cyclical fleet replacement. Within this allocation, £3.981m has been earmarked for specific ICT schemes and also contingency control room arrangements.

The Department of Health require detailed reporting of capital expenditure including monthly reporting and forecasting of levels and profiles of spend. The Trust continues to engage with the Department of Health in relation to capital expenditure forecasts. Forecast levels and profiles of expenditure can vary for a number of reasons, not least as a result of tender exercises and also supplier capacity and project risks and lead times. The capital requirements for all projects are continually reviewed and any changes in the forecast profile and level of expenditure will be reflected in further adjustments to the CRL allocation.

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. Performance for June is provisional only and currently under review.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Total bills paid	2,324	2,686	2,466										7,476
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,124	2,510	2,254										6,888
% bills paid on time	91.4%	93.4%	91.4%										92.1%
Total bills paid within 10 working days (14 calendar days)	1,509	1,909	1,976										5,394
% bills paid on time	64.9%	71.1%	80.1%										72.2%

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. At the time of writing, performance against these KPI's at June 2019 (Month 3) were not available. Performance to the end of May 2019 (Month 2) is as follows:

Key Performance Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Average Processing Time Per Requisition Days (Target 5 Days)	3.37	3.21										
Percentage of Products Supplied on First Request % (Target 95%)	99.10%	99.90%										
Number of Lines Issued (Stock and Non Stock Line)	1,456	1,285										
Value of Spend £k (Stock and Non Stock)	675	218										

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.

Apr – May Telephony Issues

4th April 2019 - Telephony was unavailable for 4 hours while patches were applied to the telephony system by manufacturers Avaya. This was a planned interruption to service and contingency worked well with minimal disruption to service.

Information Technology Systems - Developments

Any system developments are reported in this section.

The new Mobile Data system is now in rollout stage and operational in a number of vehicles. Work is on-going to complete the installation to all A&E fleet and then to commence the rollout to Non-emergency fleet. There will be a period of duel working with the legacy system until the new implementation is complete.

The procurement process for an Electronic Patient Record system is now complete with a preferred supplier identified and contract signed. Implementation of the system will commence in this financial year.

Cyber Security: A HSC Cyber Security Programme Board has been set up to define Cyber Security assessment standards for HSC organisations and to undertake or commission assessment of achievements against those standards. The Board will also make recommendations on priority actions and required investment to address gaps and further proactive cyber security measures and be in position to provide a transparent statement on the status of Cyber Security and preparedness for the HSC. Funding has been identified By HSCB for each HSC Trust to procure and implement network device scanning and network vulnerability scanning software. A number of Cyber Security awareness sessions for Trust Senior Executives and Board Members have been scheduled from July to October 2019.

ICT Help Desk Performance

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

	April			May		
Target to Respond to 95%	No of Calls	Within time	Actual	No of Calls	Within time	Actual
Immediate	17	17	100%	8	8	100%
Urgent	46	45	98%	41	41	100%
High	11	11	100%	8	8	100%
Medium	579	567	98%	667	647	97%
Low	1007	1007	100%	922	922	100%
Total	1660			1646		

ICT Planned Maintenance April 2019 – system upgrades Critical Systems

	Availability	**Maximum down time**	**Actual**	**Exceeded Maximum Down Time**
C3 A&E	740	4 Hours	0.5	No
C3 PCS	740	4 Hours	0	No
Pro-QA	740	4 Hours	0	No
ICCS A&E	740	4 Hours	0	No
ICCS PCS	740	4 Hours	0	No
DTR	740	4 Hours	0	No
Voice Recorder	740	4 Hours	0.25	No
Defib	740	4 Hours	0.10	No
Mobile Data	740	4 Hours	0	No

These are business critical systems which manage front line resources and need to be available on a 24/7 365 basis.
It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.

ICT Planned Maintenance April 2019 – system upgrades Corporate Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	These are business support systems which need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
E-mail	206	4 Hours	0	No	
File Server	206	4 Hours	0.45	No	
Virtual Server	208	2 Hours	0	No	
BlackBerry	206	4 Hours	0.10	No	
Promis	206	4 Hours	0.25	No	

ICT Planned Maintenance May 2019 – system upgrades Critical Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	These are business critical systems which manage front line resources and need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
C3 A&E	740	4 Hours	0.15	No	
C3 PCS	740	4 Hours	0.15	No	
Pro-QA	740	4 Hours	0	No	
ICCS A&E	740	4 Hours	0	No	
ICCS PCS	740	4 Hours	0	No	
DTR	740	4 Hours	0	No	
Voice Recorder	740	4 Hours	0.15	No	
Defib	740	4 Hours	0	No	
Mobile Data	740	4 Hours	0	No	

ICT Planned Maintenance May 2019 – system upgrades Corporate Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	These are business support systems which need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
E-mail	216	4 Hours	0	No	
File Server	216	4 Hours	0.10	No	
Virtual Server	218	2 Hours	0	No	
BlackBerry	216	4 Hours	0.10	No	
Promis	216	4 Hours	0.15	No	

***Information Governance/Informatics* – Developments: 01/04/2019 to 31/05/2019**

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

- ***Control Assurance – Information Management: Self-Assessment completed for 2018/19.***
- ***Supporting Medical Directorate and Transformation Collaborative with Quality Improvement Templates and data analysis. These continue to be developed and monitored. Includes Falls, Hypoglycaemia, Acute Coronary Syndrome, Cardiac Arrest (refer to Medical Directorate section of report for reporting)***
- ***ACP monitoring aspects reviewed. ACP pathways continued to be monitored and reviewed. Ad hoc datasets have been provided to support further initiatives as required ie quality improvement***
- ***Information Analysts have attended HSC Informatics Professionalism Conference to support professional accreditation to Association of Professional Healthcare Analysts (AphA). Access to training and learning materials to support BI developments including movement to PowerBI and potential live reporting***
- ***Business Intelligence datasets extracted from multi technical systems to support ORH Review including raw datasets of performance activity, Global Rostering Activity, fleet etc***
- ***Ad hoc data requests to support FOIs and acute service modernisation included stabbings, non-emergency datasets, overdose activity/private and voluntary transfers etc***
- ***Supporting work and data streams in Frequent Caller Monitoring and Information Markers including policy/procedures and analytics***
- ***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 Frequent Caller Activity – weekly reports***
- ***Interactive tool being updated regularly to support HEMs Activity – monthly report***
- ***Interactive tool being updated to support Clinical Support Desk Monitoring – weekly report***

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 May 2019	April 2018 to May 2018	% Increase / (Decrease)
1 Freedom of Information Requests Received	43	32	+34%
1a Freedom of Information Questions Received	185	100	+85%
2 General Data Protection Regulations, Subject Access Requests Received	13	9	+44%
3 Police Service of Northern Ireland Requests Received	92	73	+26%
4 Solicitor Enquiries Requests Received	127	93	+37%
Total (1a) not included in Count	**275**	**207**	**+33%**

1 FREEDOM FOR INFORMATION ACT (2000) – REQUESTS FOR INFORMATION – 01/04/2019 to 31/05/2019

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 Mar-20	Total Mar-19
Number of Requests Received	15	31											**46**	19
Number of Questions Received	37	75											**112**	67
Completed Requests processed within 20 days or less	7	24											**31**	11
Completed Requests exceeding 20 days	7	2											**9**	6
REQUESTS Still Being Processed (within 20)	0	0											**0**	
REQUESTS Still being processed (outside 20)	1	5											**6**	
Stood Down	0	0											**0**	
Number of Records Fully Disclosed	20	51											**71**	
Vexatious Requests	0	0											**0**	
Number of Records for which records not held	10	7											**17**	
Requests where exemptions wholly/partially applied	2	0											**2**	
Questions stood down	0	0											**0**	
QUESTIONS Still Being Processed (within 20)	0	0											**0**	
QUESTIONS Still Being Processed (outside 20)	4	17											**21**	
Referrals for Independent Review	0	0											**0**	
Appeals to the Information Commissioner	0	0											**0**	
Requestor Type														
Member of Public	5	18											**23**	
Local Government	0	0											**0**	
Staff Member	3	4											**7**	
Media	2	4											**6**	
Student	0	4											**4**	
Commercial Company	2	1											**3**	
Solicitor	1	0											**1**	
WhatDoTheyKnow.com	2	1											**3**	
NHS	0	0											**0**	
Trade Union	0	0											**0**	

%age completed within 20 working days	
Apr '19 - Mar '20	67.39%
Apr '18 - Mar '19	57.89%

Data will be subject to amendments.

2. DATA PROTECTION ACT 1998/GENERAL DATA PROTECTION REGULATIONS – 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 31/05/2019

General Data Protection Regulations/Data Protection Act 2018 – Subject Access	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 19 – May 20	April 18 – May 20
Number of Requests Received	7	6											13	9
Completed Requests processed within 30 days or less	5	2											7	9
Completed Requests exceeding 30 days	2	3											5	0
Requests still being processed in line with 30 days	0	0											0	0
Outstanding Requests exceeding 30 days	0	1											1	
Request received and action taken but identity not confirmed or requestor stood down the request	3	0											3	3
COMPLIANCE RATE – 53.8%														
Patient	2	1												
NIAS Staff Member	1	1												
External Agency ie Solicitor acting on behalf of patient/staff	2	3												
Relative of Patient	2	1												

- 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

3 POLICE SERVICE OF NORTHERN IRELAND REQUESTS – Police Acts, Common Law 01/04/2019 to 31/05/2019

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 – May 19**	**Apr 18-May 18**
Number of Requests Received (based on receipt of correspondence date)	51	41											92	73

4 SOLICITOR ENQUIRIES 01/04/2019 to 31/05/2019

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 – May 19**	**Apr 18-May 18**
Number of Requests Received (based on receipt of correspondence date)	65	62											127	93

5 DEPARTMENT OF HEALTH – REQUESTS FOR INFORMATION

Processing for the Period 01/04/2019 TO 31/05/2019

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

As no Government is currently in operation within Northern Ireland, requests have been limited since March 2017

6 PRF V PATIENT NUMBERS COMPARISON

19/20 - PRF v PATIENT NUMBERS COMPARISON

Summary		Patient Journeys where a patient has transported to a hospital			Number of PRF's completed for the treatment of a patient.		
Month	Emergency Response(s) which arrived on scene	Emergency	Routine	Total	Completed PRFs (Formic)	Difference between Emergency Responses and completed PRF's	Difference Patient Journeys and completed PRF's
April 2019	15994	12814	254	13068	15007	-987	+1,939
May 2019	16228	12934	307	13241	13323	-2,905	+82
June 2019				0		+0	+0
July 2019				0		+0	+0
August 2019				0		+0	+0
September 2019				0		+0	+0
October 2019				0		+0	+0
November 2019				0		+0	+0
December 2019				0		+0	+0
January 2020				0		+0	+0
February 2020				0		+0	+0
March 2020				0		+0	+0
Total	32222	25748	561	26309	28330	-3,892	+2,021

Emergency Response(s) which arrived on scene only counts as 1 record irrespective of the number of resources that arrive on scene.
There will always be more Emergency responses than patient journeys as patients do not always respond.

All patient contact should result in a PRF being completed, and consequently the number of completed PRF's should always be higher that the Emergency Response(s) which arrived on scene figure.

Please note figures for 2019/2020 are provisional and will rise as data processing is ongoing.

TB/01/08/2019/13

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TRUST BOARD REPORT

OPERATIONAL DIRECTORATE

Reporting to May 2019

Emergency Ambulance Control (EAC) Report

EAC Call Taking Statistics

Emergency Ambulance Control has three designations of call covered by Automatic Call Distribution (ACD): Emergency, Routine and Urgent / HCP.

Emergency Call (999) Activity

The number of "999" calls being answered is continuing to rise and total number of calls are shown in the table below:

Month	Year 2014-15	Year 2015-16	Year 2016-17	Year 2017-18	Year 2018-19	Year 2019-20
Apr	14988	16079	16321	17403	17598	20882
May	15433	16795	17437	18365	19864	21421
Jun	15911	16321	17030	17173	19263	21412
Year Total	**194804**	**200272**	**210027**	**226670**	**234717**	**63715**

Source: Avaya ACD system. 'Application Performace report'

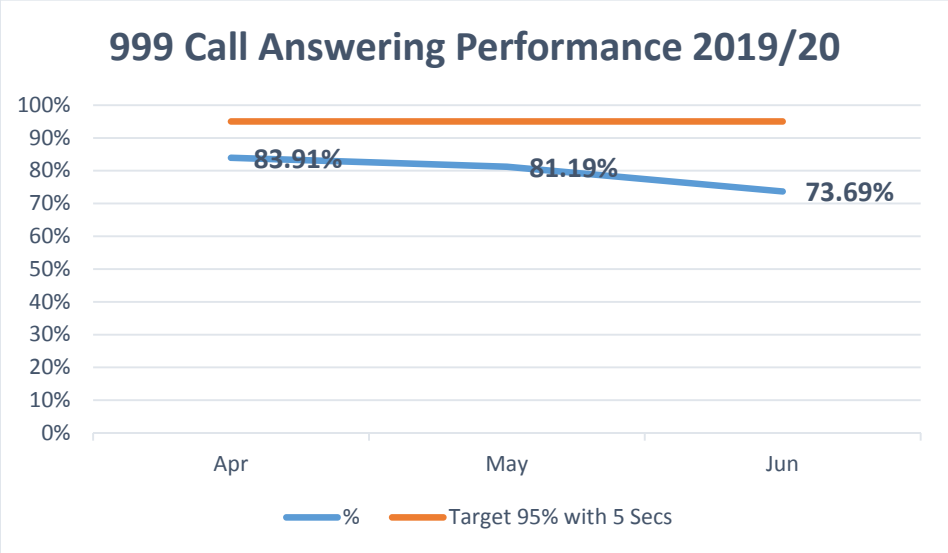
As well as taking calls from the general public NIAS also takes calls from hospitals, GP surgeries and other health care professionals. The average daily calls (all calls including 999, Routine & HCP) to EAC has increase 5.1% to an average of 1263 calls.

Key Performance Indicator - 999 Call Answer Times

EAC aims to answer telephone calls as quickly as possible and has a target of 95% of all Emergency calls answered in 5 seconds.

The table below shows the performance on call answering by month from April 2019 and an increase in the average percentage time to answer Emergency calls.

CALL ANSWERING PERFORMANCE CHART 2019/20



Source: Avaya ACD system. 'Application Performace report'

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

Increase in call demand

- 14.5% increase in Emergency calls (as per draft ORH Report July 2019)

Reduction of frontline operational response capacity leading to an increase of duplicate 999 calls.

- Reduction in operations crews leading to increase in duplicate calls, increases call volume/increase in call pick up times within EAC and also impacting on the >2 mins delays of 999 calls holding with BT operator.

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 e.g. New Years Eve
- External telephony system failures in other Ambulance Services ie Buddy site (Scotland) e.g. when Scotland loses its telephony for some reason, NIAS takes Scotlands phone calls and passes the details back via the electronic command and control system.

Key Actions from April – May 2019

- Control Reconfiguration Working Group continues to meet to progress the Control Improvement Plan.
- Pre Triage Sieve including Pre Triage Questions and Nature of Call introduced on 1 April 2019 as part of our call taking script to help quickly identify potentially immediately life threatening calls at the start of the call taking process.
- 6 New EMDs successfully completed training course
- Internal EMD conversation course commenced for 2 EAC staff to convert to EMD by June 2019.
- New recruitment process for EMDs commenced with a view to hold an EMD training course for 8 new staff in September 2019 with training to be completed by December 2019.
- The recruitment of 6 EMD Supervisors has now commenced with the posts being released for applications W/C 22nd July 2019 with projected in post by 1st Oct 19. This will give greater oversight of the function allowing real time performance monitoring.
- A review of the EAC rotas is taking place at this time to ensure we have the right skills on duty at the right time to meet the service demand.

EMD (999 Call Takers) Award Scheme

Emergency Ambulance Control operates an EMD award scheme in place awarding certificates and badges 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”.

During the months of April 2019 and May 2019 23 awards were distributed to the Emergency Medical Dispatchers in EAC. These certificates were awarded for compliance to MPDS

protocol, customer service and in the month of May we helped provide instructions to deliver 2 baby boys and 2 baby girls before a crew arrived on scene.

Award Example

The most recent call that lead to an award for a call-taker was from a young couple at home who were having their second baby. Labour progressed quickly from the start of the call. The Father was understandably panicked as he tried to care for his young daughter who was crying while following instructions from the EMD to help deliver the baby and support his partner. The EMD provided constant reassurance and was clear and concise in their instructions, repeating them when necessary due to the intensity of the scene.

The ongoing audit as part of our Quality Assurance of 999 call-taking up to May 2019 shows that EAC continues meet the IAED Accredited Centre of Excellence standards thus providing clinical assurance that 999 calls are being prioritised appropriately.

RESPONSE TIME PERFORMANCE REPORT YEAR END REPORT

For April 2019 to May 2019

Summary of Trends:

1. Cumulative NI Cat A performance from April 2019 – May 2019 was 32.6% (8.3% decrease for same period last year 40.9%)
2. Average response time across Northern Ireland for Cat A responses in May 2019 was 15 minutes 44 seconds, an increase of 2 minutes 46 seconds (12 minutes 58 seconds).
3. Total cumulative Emergency Call demand for April 2019 to May 2019 (including Cat HCP activity) has increased by 2% = 726 calls for the same period last year.
4. Trends for ambulance turnaround times greater than the standard (i.e. 30 mins) continue to heavily impact on NIAS response and availability. It is noted that in the May 2019 there was an increase in the number of lost hours at Altnagelvin Hospital and Craigavon Area hospital and a decrease in lost hours at all other hospitals.

DISCLAIMER

Please note that due to system issues the data provided below may be subject to change at a later stage. Please use in a cautionary manner at this time.

Key Performance Indicator: Resources are deployed in line with the Category/Code and measured through Key Performance Indicators

When the call taking process is completed calls are categorised for deployment as per table:

Call type	Category / code	Key Performance Indicators
999 Potentially immediately life threatening	A (Purple/ Red)	< 8 minutes
999 Serious but not life threatening	B (Amber)	< 21 minutes
999 Neither life threatening or serious	C (Green)	< 60 minutes
Healthcare Professional Calls (HPC)(GPs who 'book' and ambulance after seeing a patient and deciding they need to be admitted to hospital within a set time frame)	HCP Calls	1 hour 2 hours 3 hours 4 hours
Routine	Routine	As agreed with caller and call taker

KEY PERFORMANCE INDICATORS (KPIs) for the Year 2017/18
From April 2016, 72.5% of Cat A (potentially immediately life threatening) calls to be responded to within 8 minutes, 67.5% in each Local Commissioning Group area (LCG) with 95% of Cat A have a conveying resource <21 min
95% of Category B Response <21 mins
95% Category C Non- Health Care Professional <60mins
Health Care Professional (formally GP Urgent) within agreed target of either 1, 2, 3, 4, hours

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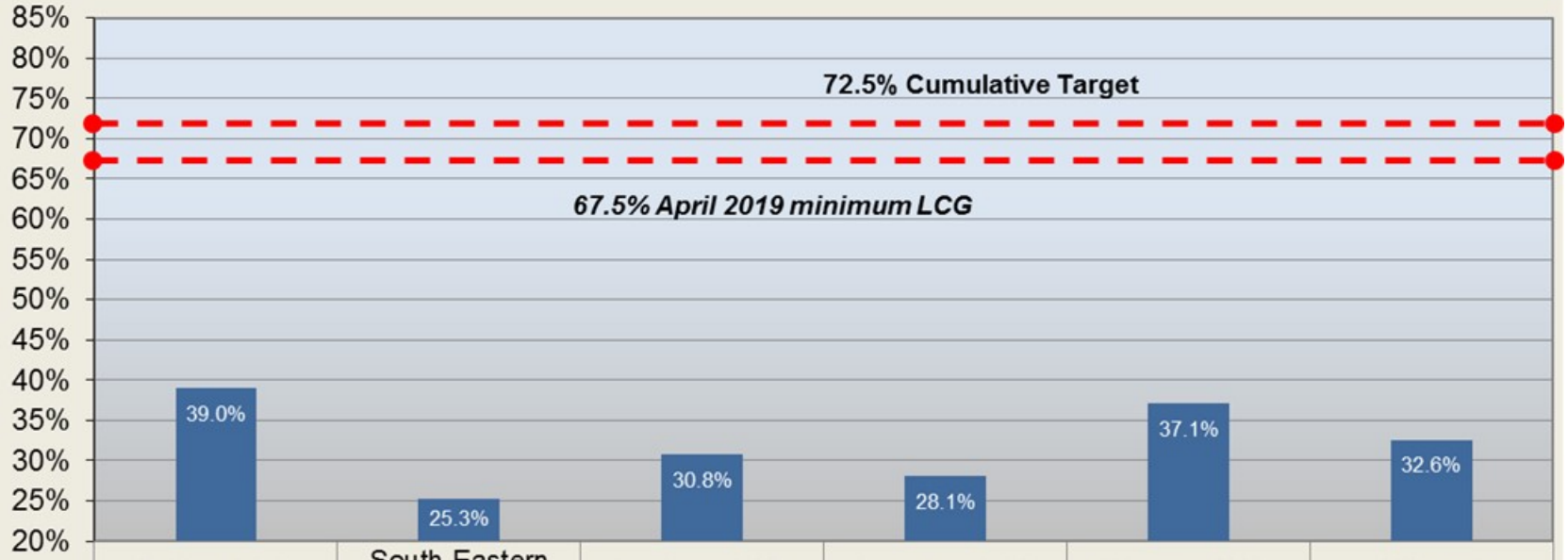
% Cat A Calls Responded to Within 8 Minutes Cumulative from April 2019 to end May 2019

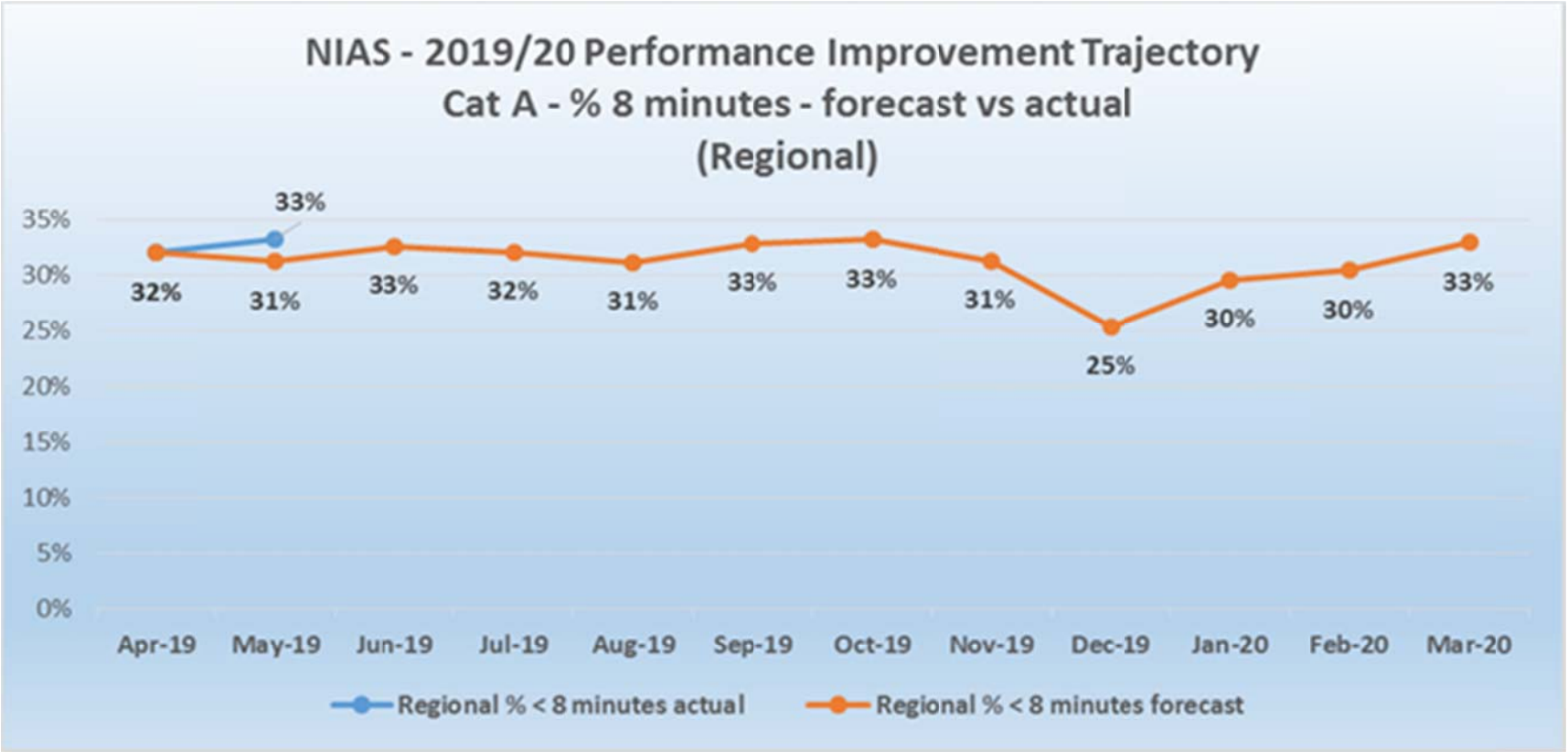


	Belfast LCG	South Eastern LCG	Northern LCG	Southern LCG	Western LCG	NI Total
% Cat A Within 8 Min	39.0%	25.3%	30.8%	28.1%	37.1%	32.6%
Cat A within 8 min	1,007	453	673	474	645	3,252
Total No. of Cat A	2,580	1,791	2,188	1,688	1,737	9,984

From April 2019, 72.5% of Category A (life threatening) calls are to be responded to within eight minutes, 67.5% in each LCG area.
*Disclaimer may be subject to change at a later date.

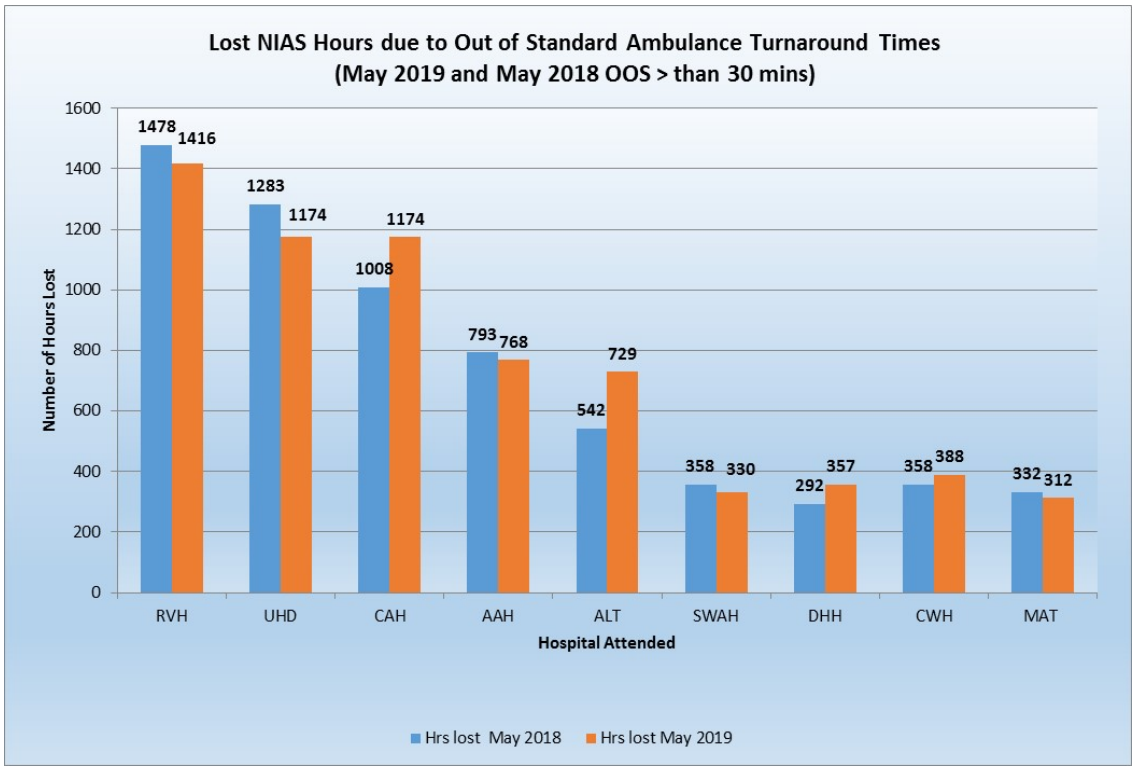
DISCLAIMER: Please note that due to system issues the data provided below may be subject to change at a later stage. Please use in a cautionary manner at this time

Cat A Performance – Performance Improvement Trajectory



Ambulance Turnaround at Emergency Departments within 30minutes – May 2019

In May 2019 over 6600 hours were lost at ED by ambulances waiting more than 30minutes to be clear for the next call. Effectively this is equivalent to the loss of 277 24hr ambulances in the month that were no longer available to respond to emergency calls because they were waiting at ED.



Operational Production

Operational production is the percentage of planned cover that is actually provided. This is net of all abstractions from the shifts (sickness, training, vacancies, secondments etc) and shifts covered by relief, bank and overtime working. Typically Ambulance services operate around 97% production. NIAS figures for May and June for the component parts of the service are shown below:

A&E

A&E Delivered Hours		May 2019	June 2019
North	Delivered	87.0%	88.1%
South	Delivered	81.6%	94.8%
Belfast	Delivered	77.5%	83.3%
South East	Delivered	82.0%	85.4%
West	Delivered	88.8%	93.1%
TOTAL	Delivered	**83.6%**	**88.0%**

PCS Delivered Hours		May 2019	June 2019
North	Delivered	96.3%	91.1%
South	Delivered	92.3%	88.2%
Belfast	Delivered	92.7%	78.3%
South East	Delivered	83.5%	79.1%
West	Delivered	98.0%	91.1%
TOTAL	Delivered	**93.2%**	**86.0%**

RRV Delivered Hours		May 2019	June 2019
North	Delivered	57.5%	69.1%
South	Delivered	58.8%	64.1%
Belfast	Delivered	49.3%	52.3%
South East	Delivered	55.2%	54.7%
West	Delivered	82.0%	82.1%
TOTAL	Delivered	**59.4%**	**63.3%**

There are several initiatives ongoing to mitigate the effect of the reduced ambulance cover. There is a recruitment and training programme to fill current vacancies and address the skill mix within the service and to bring the service to current base level. Additionally there is a good attendance programme to reduce sickness absence. Both of these programmes are relatively long term and will not yield immediate results.

In addition there are several other operational actions that have been instigated for the summer period and beyond:

- The overtime system has been relaxed to make it easier for staff to register for overtime at times that suits them.
- An additional PCS shift per division has been planned for the afternoon and night at weekends to support A&E activity.
- There are daily operational Huddles to address issues as they arise.
- Over July holiday period staff were provided with welfare over 11th, 12th & 13th July 2019
- A Rest Period Pilot is running in Newcastle and Newtownards to improve the compliance with giving the meal break at a reasonable time.

All of these initiatives will be monitored throughout the Summer and adjusted as necessary. Nonetheless July and August will remain challenging.

Quality improvement

Members of NIAS were recently awarded their certificates for completion of SQE quality improvement programme. The group consisted of operational clinical staff, supervisors, managers and admin staff.

SQE Names	Directorate	Mentors	Project Aim
Claire Fitsimmons	Operations	Marianne J	To increase the use of NEWS scores in pre-hospital care amongst frontline staff. Could increase uptake of this tool improve recognition of possible deterioration and red flag sepsis?
David Marshall	Operations	John W	Reverting unscheduled emergency cardiac transfers back to scheduled non-emergency transfers - A review of the planning and scheduling of inter-facility cardiac transfers between Antrim Area Hospital and the Royal Victoria Hospital.
Jacqueline O'Hara	Operations	Phil L	Every member of staff returning from a period of sick to have received a RTW on their first shift. In Dungannon station 36 staff.
Laura Hill	Medical	Katrina K	To improve management of incidents and incident investigation feedback to staff following incident reporting.
Marie Breen	Operations	David McC	I believe that there is a role to play for the paramedic in diagnosing Urinary Tract Infection (UTI) pre-hospital by use of a urine analysis dipstick. Which is a simple, quick, cost-effective procedure with results immediately available to aid clinical decision making
Michael Allen	Operations	Joanna S	I propose a project centred around the process of writing and delivering witness statements within the scope of Ambulance practice.
Stephanie Leckey	Medical	John W	Improve the CFR's response to OHCA and other pre-agreed specific medical emergencies.
Wayne Meehan	Operations	Phil L	To End Pyjamas (PJ) Paralysis: We as a service can initiate this by mobilising our patients where possible when we bring them into hospital.

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