Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

Meeting to be held on Thursday 12 April 2018, 2:00pm at Craigavon Civic Centre, 66 Lakeview Road, Craigavon, BT64 1AL

TB/12/04/2018/01

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of Trust Board
Thursday 1 February 2018, 2.00pm in the Boardroom, Northern Ireland Ambulance Service Headquarters, Knockbracken Healthcare Park, Belfast BT8 8BH

Present:

Mr P Archer	Chairman
Mr W Abraham	Non-Executive Director
Mr T Haslett	Non-Executive Director
Mr A Cardwell	Non-Executive Director
Mr S Devlin	Chief Executive
Mrs S McCue	Director of Finance & ICT
Ms M Lemon	Interim Director of HR & Corporate Services
Dr N Ruddell	Interim Medical Director
Mr B McNeill	Director of Operations

In Attendance:

Ms H Coard	Senior Secretary
Miss K Magee	Senior Secretary

1.0 Apologies:

The following apologies were noted:

Dr J Livingstone Non-Executive Director

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

The Board was confirmed as quorate.

3.0 Minutes of the previous meeting of Trust Board held on 7 December 2017

Trust Board members requested that the relationship of The Chair being a Trustee of St John's Ambulance is noted at each meeting.
Due to competing pressures, some late changes have been made to the last Trust Board minutes so a new set of minutes were distributed. Following an explanation of the changes, Mr T Haslett proposed the minutes and seconded by Mr W Abraham.

4.0 Matters Arising:

The Chair sought clarification if the HEMs Management Desk had been moved to NIAS Control Room. Dr N Ruddell confirmed that at present the desk was within NIAS Control and running as a pilot and it would be hoped to be imbedded further following the pilot.

5.0 Chairman's Business

5.1 Chairman's Update

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

- Visit to Purdysburn Station today outlining some problems with the upkeep of an old building which could present difficulties if looked into by RQIA
- Has had a lot of activity with HR in the recruitment of a new Chief Executive, shortlisting took place for this post on 30th January 2018
- Attended the Assurance Committee as an observer on 19th January 2018
- Attended a seminar on HSC involvement with Brexit on 25th January 2018
- Regular meetings have taken place between the Chairman and the Chief Executive

6.0 Chief Executive's Business

6.1 Chief Executive's Update

Mr S Devlin outlined his activities and meetings attended since the last Trust Board, highlighting the following:

- It was acknowledged the extreme pressures of the winter months and the engagements of each of the Trusts throughout scrutiny in the press.
- Radio broadcast regarding the recent attacks on paramedics
- Attended Accountability Meeting with the Department of Health which focused on Infection Prevention Control
- Attended Trust's Chiefs meeting regarding HSC Reform

Mr T Haslett stated he had seen and heard Mr S Devlin on Television and Radio and commended him on his interviews.

7.0 Performance Report as at 1 February 2018:

7.1 Operations Directorate:

Mr B McNeill, Director of Operations provided an update to Trust Board, highlighting the following:

- Mr B McNeill gave a presentation regarding the Winter Pressures faced by NIAS, he commended the Control Team in dealing with these over the last few months and also thanked the Scottish Ambulance Service Control in Glasgow who NIAS buddy with. A capacity chart showed how difficult it was to manage over the

Christmas period with significant growth in demand between December 2017 and January 2018.

- Discussion around the flows of the main Emergency Departments during the winter period and patients being sent to hospitals outside of their catchment area as capacity in places run out with NIAS being caught in the middle. Mr W Abraham asked if it was the role of NIAS to manage these flows and Mr B McNeill explained the only other option would be to end up queuing in an over capacitated Emergency Dept.
- Mrs S McCue asked whether capacity in the hospitals was on a par with last year. Mr S Devlin stated there were issues with hospital discharge packages hence a build-up. The Chair remarked that the Ulster Hospital figures are extremely high and a general discussion took place around these figures. NIAS work closely with all Trust in regards to space in Emergency Depts.
- Mr B McNeill explained he had spent time in the Control Room and tensions were high and moral with staff was low.
- A Discussion took place around winter pressure funds. Mrs S McCue explained this funding was non recurrent so NIAS could not depend on this until it was confirmed and advised not to recruit if funding is non recurrent. Mr S Devlin said the Board set aside £7-9 million of winter monies that this should be made recurrent so NIAS could invest in planned resources.
- Mr B McNeill suggested NIAS would need collaborative funding and plans for all Trusts, Mr S Devlin suggested that more staff could be employed in the Ulster as there is a ward with 20 beds empty however they need recurrent funds to do this.
- Mr T Haslett asked if there was any way NIAS could recognise staff efforts during this winter period, Mr S Devlin explained it had been discussed perhaps an extra day's annual leave may be given to staff. Ms M Lemon acknowledged that Mr B McNeill had written a letter to all staff thanking them.
- Mr B McNeill presented the comparison chart from December 2017.
- The Chair and Trust Board commended Mr B McNeill's hard work and dedication over winter pressures including the Christmas period and asked that this thanks be passed onto his team.

7.2 Finance & ICT Directorate:

Mrs S McCue, Director of Finance provided an update to Trust Board, highlighting the following:

- Mrs S McCue presented the Finance Report – NIAS are coming into the final quarter and are forcasting a break even position for the end of the month.
- NIAS have a Capital Spend Budget of £8.27m and have reviewed the programme of spend of £6.48m and have handed money back to the Department of Finance. Mr T Haslett asked if this was surrendered back to the Department can NIAS still avail of it next year. Mrs S McCue stated it had to be returned or it would be a loss to NIAS, however we would hope to get it added to our allocation for next year.
- Finance and Operations are working on spend on vehicles and on MDT equipment which is going through a Tender Process at present.
- Cyber Security - Internal Audit are assessing at present how prepared we are for Cyber Attacks.
- Freedom of Information (FOI) requests – the number of Freedom of Information requests has decreased, however the number of FOI questions has increased and is putting pressure on the department. FOI response times are within 20 days for only 62% of the time. Mr A Cardwell asked if the Commissioner has ever raised

concerns, Mrs S McCue stated she has met with the Commissioner and they are aware of the issues and have been supportive of this.

7.3 Human Resources Directorate:

Ms M Lemon, Acting Director of HR&CS provided an update to Trust Board, highlighting the following:

- HR and Operations are working together to develop a recruitment plan.
- Sickness Absence – an overview of sickness was provided and ongoing work is in place to address the high levels. Workshops with trade unions have been arranged and NIAS are investing in the health and wellbeing of staff. A peer support service has also been developed for staff after dealing with difficult events.
- Flu Vaccine – NIAS have nearly reached their target of getting 40% of frontline staff vaccinated, a number paramedics have been trained in giving the vaccine.
- Recruitment – Mr T Haslett raised that vacancies should be filled to replace high levels of overtime to help with the stress and low morale of staff. Mr B McNeill acknowledged this point and said Operations and HR would be holding a workshop and intended to fill baseline posts.
- Education, Learning and Development – NIAS have awarded a contract to Ulster University in delivering a foundation degree. The Chair requested a paper on this be brought to the next meeting.
- Media and Communication – 12 media interviews were conducted during this period in regards to assaults on crew, festive pressures and response delays. Mr A Cardwell enquired how seriously these assaults are taken by the Courts. Ms M Lemon said that the individual staff member must submit the case as it is not down to NIAS as an organisation, however NIAS would support the staff member throughout the process. Mr S Devlin updated Trust Board, NIAS do not currently have on record the number of people sentenced for these assaults.

7.4 Medical Directorate:

Dr N Ruddell, Interim Medical Director provided an update to Trust Board, highlighting the following:

- Capital Funding equipment has been confirmed
- Incident Reporting is putting pressure on staff
- Infection Prevention & Control - follow up inspections and reports are awaited, however staff do state conditions have improved. Dr N Ruddell commended staff on completing IPC training by the end of January 2018. This has proven to have a positive impact on staff. The Chair queried how often this training took place, Dr N Ruddell conformed staff must update this training every three years.
- Defibrillator training had been postponed due to the urgency of IPC training however this has now begun, and there are over 10,000 registered community defibrillators.
- REACH Project - received support for capital from DoH for electronic Patient Report Form. The procurement process has commenced and NIAS hope to have a tender in place by June 2018.
- All GPs in Northern Ireland have been written to, detailing the process for Alternative Care Pathways and the role of the Clinical Support Desk. The Chair commended this and Dr N Ruddell acknowledged the hard work of the Clinical Support Desk.

- Helicopter Emergency Medical Service (HEMS) – continues to be a success, the Chair suggested that the HEMS blog is a good way of keeping updated on its progress. HEMS workshop is planned for 01/03/ 2018 at Maze Long Kesh site. Mr T Haslett enquired if the funding was successful again this year for HEMS. Dr N Ruddell confirmed that the initial funding came from LIBOR funds and Mrs S McCue would be providing a report on this. The HEMS Management Board have given assurance the funds would be available.

7.5 Risk Register

The Chair welcomed questions on the Risk Register, however nothing was raised. All agreed this will be discussed at next Assurance Committee meeting.

8.0 Items for Approval

8.1 Briefing Note Charitable Funds

Mrs S McCue presented a Brief Note on NIAS Charitable funds which are below £10,000. Discussions took place around the Allister Barr funds and the Chair asked why the money could not all just be moved into General Funds, Mrs S McCue explained these are made up of donations and people can be specific to which station or project they would like to donate to. Mrs S McCue requested that the £162 Omagh fund is added into general funds as there have been no significant donations made to this fund in 2017/18 and this balance would still be available to the Omagh station from the General fund. Mr W Abraham proposed this proposal and Mr T Haslett seconded.

9.0 Items for Information/Noting

9.1 Mid-Year Assurance Statement

Mrs S McCue stated the final version had been forwarded to the Department.

9.2 Audit Committee Minutes 15/06/2017

9.3 Audit Committee Minutes 12/10/2017

9.4 Assurance Committee Minutes 02/11/2017

10.0 Forum for Questions

None

11.0 Any Other Business

Mrs S McCue updated Trust Board that the Trust Seal for Lisnaskea Community Enterprises Facility was signed for in December 2017 for a two year period with a possible one year extension thereafter.

The Chair acknowledged that this would more than likely be the Chief Executive Mr S Devlin's last Trust Board meeting before moving onto his new post as Chief Executive of SHSCT. He commended Mr S Devlin for his hard work over the past 15 months in NIAS.

12.0 Summary & Forward Agenda

The Chair reminded Trust Board the workshop for HEMS is on 1st March 2018.at Maze Long Kesh.

Date, Time and Venue of Next Meeting

The next scheduled Trust Board meeting will be held on **Thursday 12 April 2018 @2pm in Southern Division. Location to be confirmed.**

Signed: _____ **Dated:** _____
(Chairman)

TB/12/04/2018/02

TRUST BOARD REPORT

OPERATIONAL DIRECTORATE

Reporting to 28 FEBRUARY 2018

PERFORMANCE ANALYSIS AND REPORT

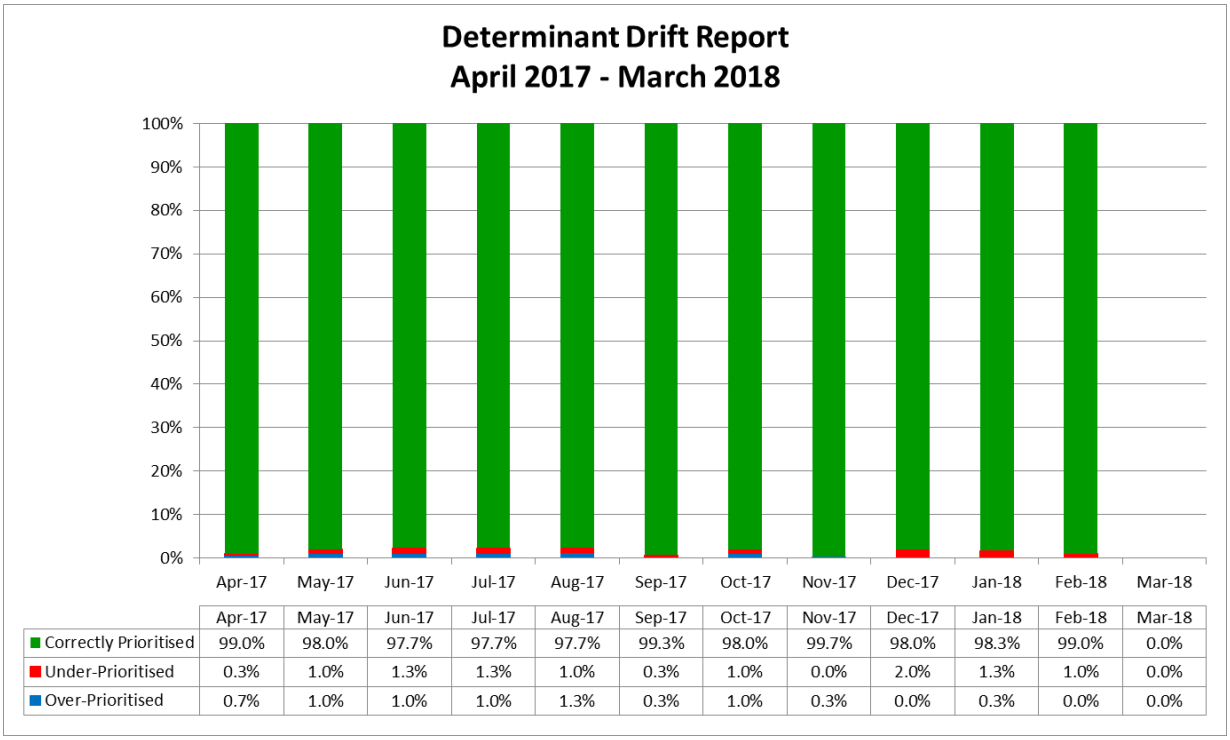
Emergency and Non-Emergency Control Centres

Key performance indicator: No more than 5% of calls audited should be either 'under' or 'over' prioritised.

NIAS is committed to reviewing a percentage of 999 calls in line with annual call volume. For 2017-18 this equates to approximately 2.58% of 999 calls or approximately 70 calls per week.

Calls are measured across seven areas including customer service and final coding to ensure the highest standards of patient care are provided.

The monthly determinant drift report below indicates whether the audited calls have been 'over' or 'under' prioritised. NIAS has consistently been well within this target.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Correctly Prioritised	99.0%	98.0%	97.7%	97.7%	97.7%	99.3%	98.0%	99.7%	98.0%	98.3%	99.0%	0.0%
Under-Prioritised	0.3%	1.0%	1.3%	1.3%	1.0%	0.3%	1.0%	0.0%	2.0%	1.3%	1.0%	0.0%
Over-Prioritised	0.7%	1.0%	1.0%	1.0%	1.3%	0.3%	1.0%	0.3%	0.0%	0.3%	0.0%	0.0%

EMD Award Scheme

NIAS has 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 "Compliant" or "High Compliance".

The table below shows the level and number of awards attained by EMDs for the reporting period as well as the year 2017-18 to date. A number of calls are also under assessment for possible awards.

Type	Level	Jan & Feb 2018	Year to Date (Apr 17 – Mar 18)
999 High Compliance	Bronze	1	13
	Silver	3	7
	Gold	2	17
Exemplary Customer Service	Bronze	0	3
	Silver	0	8
	Gold	2	12
Baby Born		1	6
Cardiac Life Saver		0	0
Non-Cardiac Life Saver		1	1

EAC Call Taking Statistics

Emergency Ambulance Control has three designations of calls: Emergency, Routine and Urgent / HCP.

Emergency Call Activity

In December we were faced with a significant increase in "999" call volume in comparison to the previous year and we answered a total of 24,020. This equated to an increase of 3680 calls or 18.09% in comparision to the same period on 2016. This trend continued in Jan 2018 which also saw a 15.96% increase from the previous year.

Month	Year 2014-15	Year 2015-16	Year 2016-17	Year 2017-18
Apr	14988	16079	16321	17403
May	15433	16795	17437	18365
Jun	15911	16321	17030	17173
Jul	16633	16266	17773	18352
Aug	16244	16814	17728	18486
Sep	16244	15802	16803	17994
Oct	15803	16701	18282	18208
Nov	15860	16083	16979	18236
Dec	18088	18494	20340	24020
Jan	16590	16989	17630	20444
Feb	16138	16188	16181	17756
Mar	16872	17740	17523	
Total	**194804**	**200272**	**210027**	**206437**

As well as taking calls from the general public NIAS also takes calls from hospitals, GP surgeries and other health care professionals. These types of call are classified as Health Care professional (HCP) calls and have a small dedicated team who deal with processing these calls.

NIAS also are in constant contact with the other Emergency Services. In the period Apr 2017 until Feb 2018 The Northern Ireland Ambulance have responded to 64 requests from the Coast Guard, 1263 requests from the Fire Service and 15147 request from the PSNI.

This December over the festive period (18/12/17- 03/01/18) we answered a total of 313 calls with the peak number (104) answered on 1st JAN).

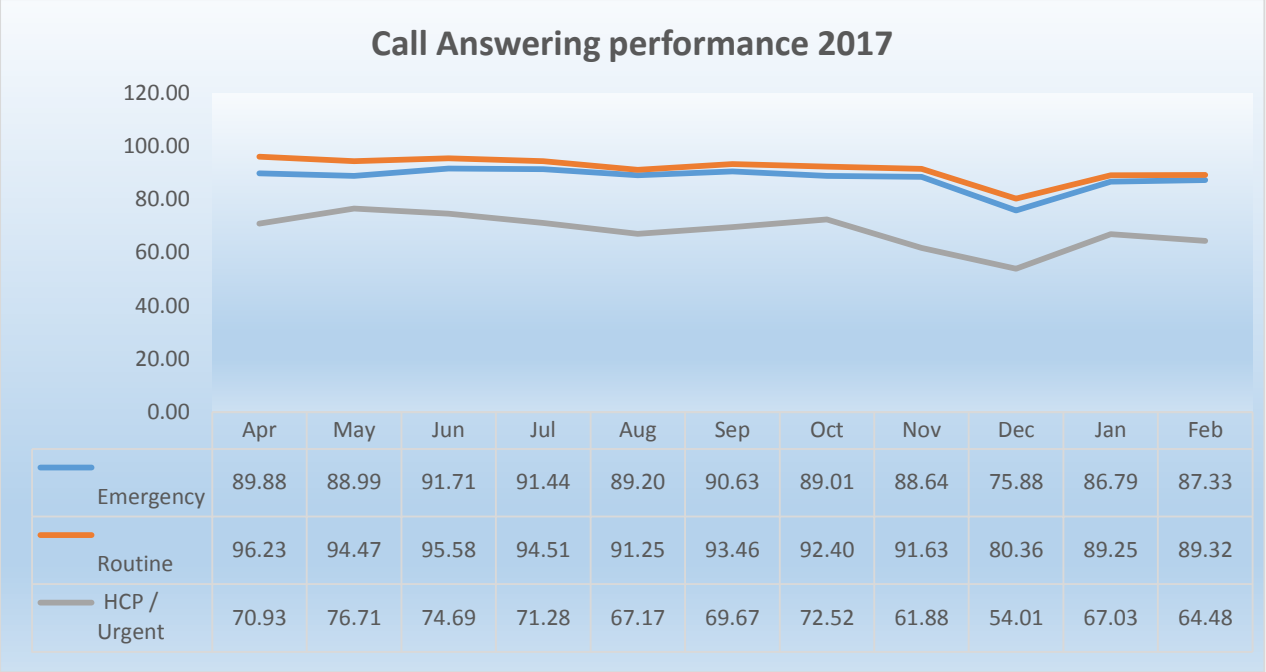
999 Call Answer Times

Key Performance Indicator

NIAS aims to answer telephone calls as quickly as possible and the target is 95% of all Emergency calls answered in two minutes. NIAS operates a "buddy" arrangement with the Sciottish Ambulance Service as an element of its contingency plans. This is where both services support each other in taking calls during periods

of extreme demand or for other reasons; for example, technical problems, disruption of service etc.

The table below shows the performance on call answering by month from April to February 2018 and an increase in the average percentage time to answer Emergency calls.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Emergency	89.88	88.99	91.71	91.44	89.20	90.63	89.01	88.64	75.88	86.79	87.33
Routine	96.23	94.47	95.58	94.51	91.25	93.46	92.40	91.63	80.36	89.25	89.32
HCP / Urgent	70.93	76.71	74.69	71.28	67.17	69.67	72.52	61.88	54.01	67.03	64.48

- Call answering shows a higher achieved target for Routine calls due to all staff having the skill sets to handle them.

- The target of 95% 999 call taking is yet to be achieved – new recruitment in EMD levels would be expected to improve this performance level however overall increases in call volumes has impacted this figure particularly in December.

- EMDs are required by the IAED to remain on the line for certain health critical situations. They remain on the line until one of NIAS operational resources is in attendance at the scene. High volumes of incidents and reduced levels of cover can impact on availability of call takers resulting in delays. The average delay is 5 seconds for the average 4% of calls not meeting the 2 second standard.

RESPONSE TIME PERFORMANCE REPORT

For April 2017 to February 2018

Summary of Trends:

1. **Cumulative NI Cat A performance from April - February 2018 = 46.0% (4.9% decrease for same period last year 50.9%)**
2. **Average response time across Northern Ireland for Cat A response in February 2018 was 14 minutes 46 seconds.**
3. **Cumulative Cat A Responses from April to February 2018 has increased by 2.6 % = 1356 responses for the same period last year.**
4. **Total cumulative Emergency Call demand for April to February 2018 (including Cat HCP activity) has increased by 3.7% = 7182 calls for the same period last year.**
5. **Trends for ambulance turnaround times greater than the standard (i.e. 30 mins) continue to heavily impact on NIAS response and availability. Long delays evident over the Christmas and New Year period at all sites.**

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

Performance Against Each KPI by Local Commissioning Group – Summary per month April 2017 to December 2017

KPI - From April 2017 to March 2018 – Cat A CUMULATIVE Position for April 17 to December 17												
LCG	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 17**	**Feb 18**	**Mar 17**	**2017/18**
Belfast	61.5%	63.7%	66.2%	66.1	65.3	64.7%	63.9%	63.3%	60.3%	58.5%	57.8%		
South Eastern	43.3%	42.3%	44.7%	44.6	43.8	43.6%	43.7%	43.6%	41.0%	39.5%	38.8%		
Northern	41.0%	42.2%	42.9%	42.9	42.7	42.6%	42.5%	42.3%	40.5%	40.1%	39.5%		
Southern	44.5%	45.7%	45.5%	44.0	43.1	43.0%	42.5%	42.0%	40.5%	39.8%	39.0%		
Western	54.3%	55.4%	55.6%	54.7	53.5	53.5%	53.3%	53.6%	52.7%	52.3%	51.8%		
Northern Ireland	49.4%	50.5%	51.7%	51.2	50.5	50.3%	50.0%	49.7%	47.5%	46.6%	46.0%		

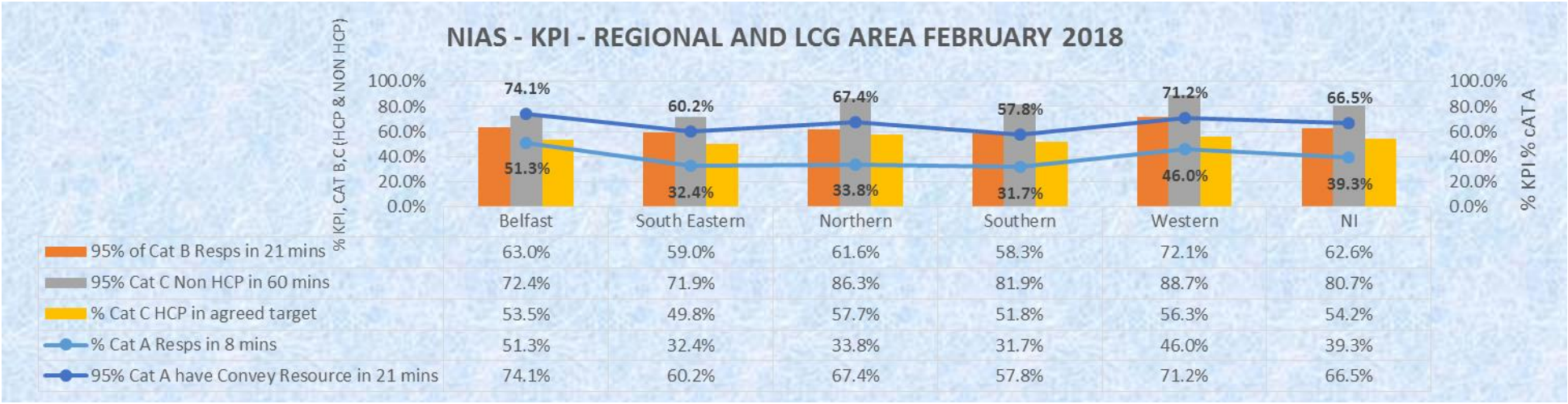
KPI - From April 2017, 72.5% of Cat A (potentially immediately life threatening) calls to be responded to within 8 minutes, 67.5% in each Local Commissioning Group area (LCG) – MONTHLY												
LCG	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 17**	**Feb 18**	**Mar 17**	**2017/18**
Belfast	61.5%	65.7%	71.2%	66.0	62.1	62.0%	59.3%	58.7%	41.2%	44.6%	51.3%		
South Eastern	43.3%	41.2%	49.8%	44.3	40.7	42.7%	43.9%	43.1%	24.8%	28.7%	32.4%		
Northern	41.0%	43.2%	44.4%	42.7	42.2	41.6%	41.8%	41.2%	29.5%	36.6%	33.8%		
Southern	44.5%	46.9%	45.1%	39.4	39.5	42.2%	40.3%	38.2%	31.2%	34.6%	31.7%		
Western	54.3%	56.5%	56.0%	52.0	48.6	53.5%	51.9%	55.8%	47.2%	49.3%	46.0%		
Northern Ireland	49.4%	51.6%	54.2%	49.7	47.6	50.3%	48.1%	47.7%	34.6%	38.8%	39.3%		

KPI - 95% of Cat A have a conveying resource <21min – MONTHLY												
LCG	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 17**	**Feb 18**	**Mar 17**	**2017/18**
Belfast	77.0%	74.0%	77.9%	75.0	78.8	74.9%	74.4%	71.7%	67.8%	70.8%	74.1%		
South Eastern	67.3%	69.3%	71.2%	73.5	66.4	66.5%	68.6%	73.4%	61.2%	66.6%	67.4%		
Northern	73.9%	72.1%	72.1%	74.9	73.4	72.3%	73.7%	62.3%	52.5%	55.9%	60.2%		
Southern	69.5%	68.7%	70.7%	66.9	64.9	65.8%	68.1%	65.5%	60.9%	62.2%	57.8%		
Western	78.0%	78.5%	76.6%	85.0	73.3	73.9%	75.0%	80.3%	68.8%	73.9%	71.2%		
Northern Ireland	73.4%	72.6%	73.9%	74.9	72.0	71.1%	72.2%	70.5%	62.4%	66.1%	66.5%		

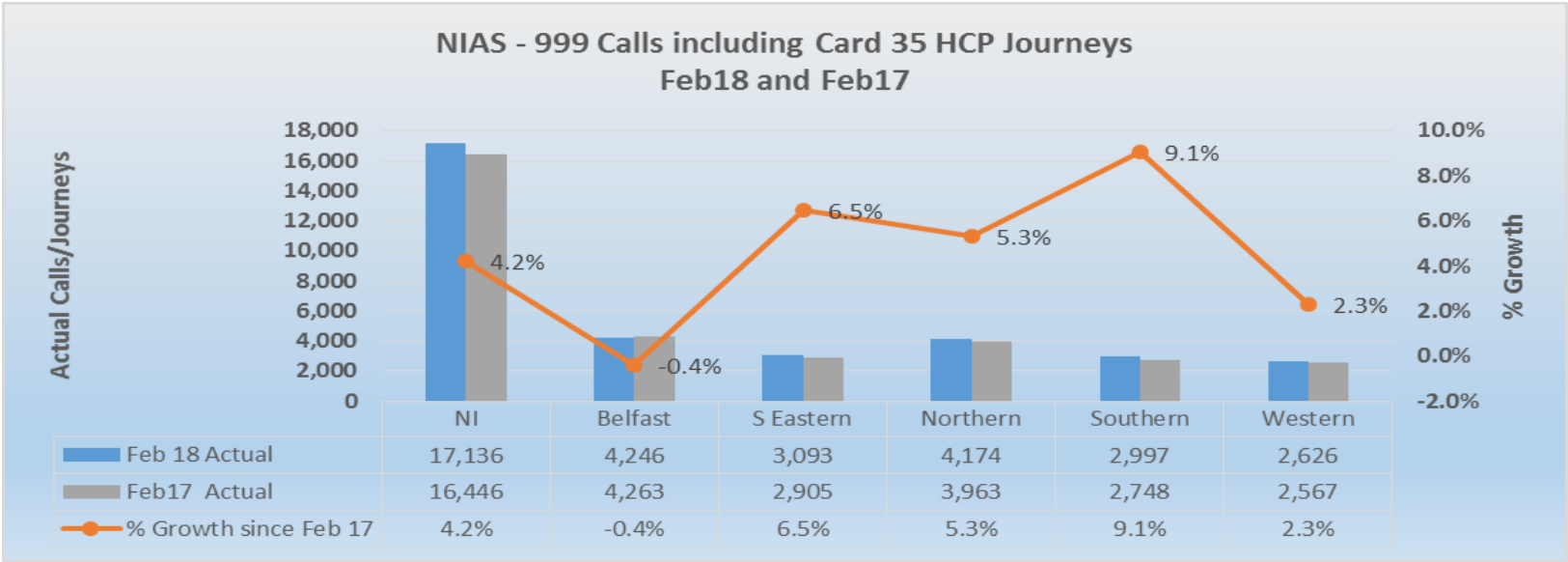
KPI - 95% of Category B Response <21 mins - MONTHLY													
LCG	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 17**	**Feb 18**	**Mar 17**	**2017/18**
Belfast	79.0%	81.5%	85.1%	82.0	77.8	78.2%	80.4%	76.4%	54.0%	63.9%	63.0%		
South Eastern	73.3%	72.7%	79.5%	71.8	70.1	68.7%	75.9%	68.1%	51.5%	52.8%	59.0%		
Northern	74.7%	74.9%	79.5%	74.8	73.1	75.5%	73.4%	74.0%	54.6%	67.1%	61.6%		
Southern	76.9%	77.3%	79.5%	73.3	67.3	71.4%	71.6%	70.9%	57.1%	59.4%	58.3%		
Western	81.8%	83.3%	83.4%	76.1	78.1	78.7%	77.4%	82.2%	68.2%	71.8%	72.1%		
Northern Ireland	77.0%	78.0%	81.5%	75.9	73.6	74.7%	75.9%	74.3%	56.6%	63.3%	62.6%		

KPI - 95% Category C Non- Health Care Professional <60mins - MONTHLY													
LCG	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 17**	**Feb 18**	**Mar 17**	**2017/18**
Belfast	82.4%	83.5%	89.7%	87.3	81.8	83.4%	89.3%	79.2%	65.4%	73.6%	72.4%		
South Eastern	84.8%	86.5%	91.2%	83.1	84.3	82.9%	89.2%	80.1%	59.4%	65.8%	71.9%		
Northern	91.6%	87.9%	91.2%	88.7	92.0	87.5%	92.4%	90.9%	76.6%	86.6%	86.3%		
Southern	89.7%	88.8%	90.0%	87.0	87.2	89.9%	90.9%	91.3%	84.0%	78.9%	81.9%		
Western	92.2%	94.4%	92.0%	93.5	90.9	88.8%	92.5%	92.1%	83.8%	85.9%	88.7%		
Northern Ireland	87.9%	87.8%	90.7%	87.8	86.8	86.3%	90.8%	86.4%	74.2%	78.3%	80.7%		

KPI - Category Health Care Professional (formally GP Urgent) within agreed target of either 1, 2, 3, 4, hours (measured against first response at scene													
LCG	**Apr 17**	**May 17**	**June 17**	**July 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 17**	**Feb 18**	**Mar 17**	**2017/18**
Belfast	70.8%	64.1%	69.8%	72.6	63.2	61.2%	57.4%	50.8%	43.0%	45.9%	53.5%		
South Eastern	68.8%	66.3%	65.3%	70.9	61.9	61.5%	60.3%	48.0%	36.8%	44.5%	49.8%		
Northern	66.2%	65.7%	62.0%	62.0	55.6	58.2%	62.2%	63.1%	46.0%	56.4%	57.7%		
Southern	67.5%	64.3%	62.2%	59.8	59.0	54.9%	60.7%	52.5%	55.1%	48.1%	51.8%		
Western	64.7%	68.0%	70.6%	63.7	59.3	63.3%	61.7%	63.2%	52.6%	54.3%	56.3%		
Northern Ireland	67.9%	65.5%	65.9%	66.4	59.9	59.8%	60.3%	55.4%	45.8%	50.2%	54.2%		



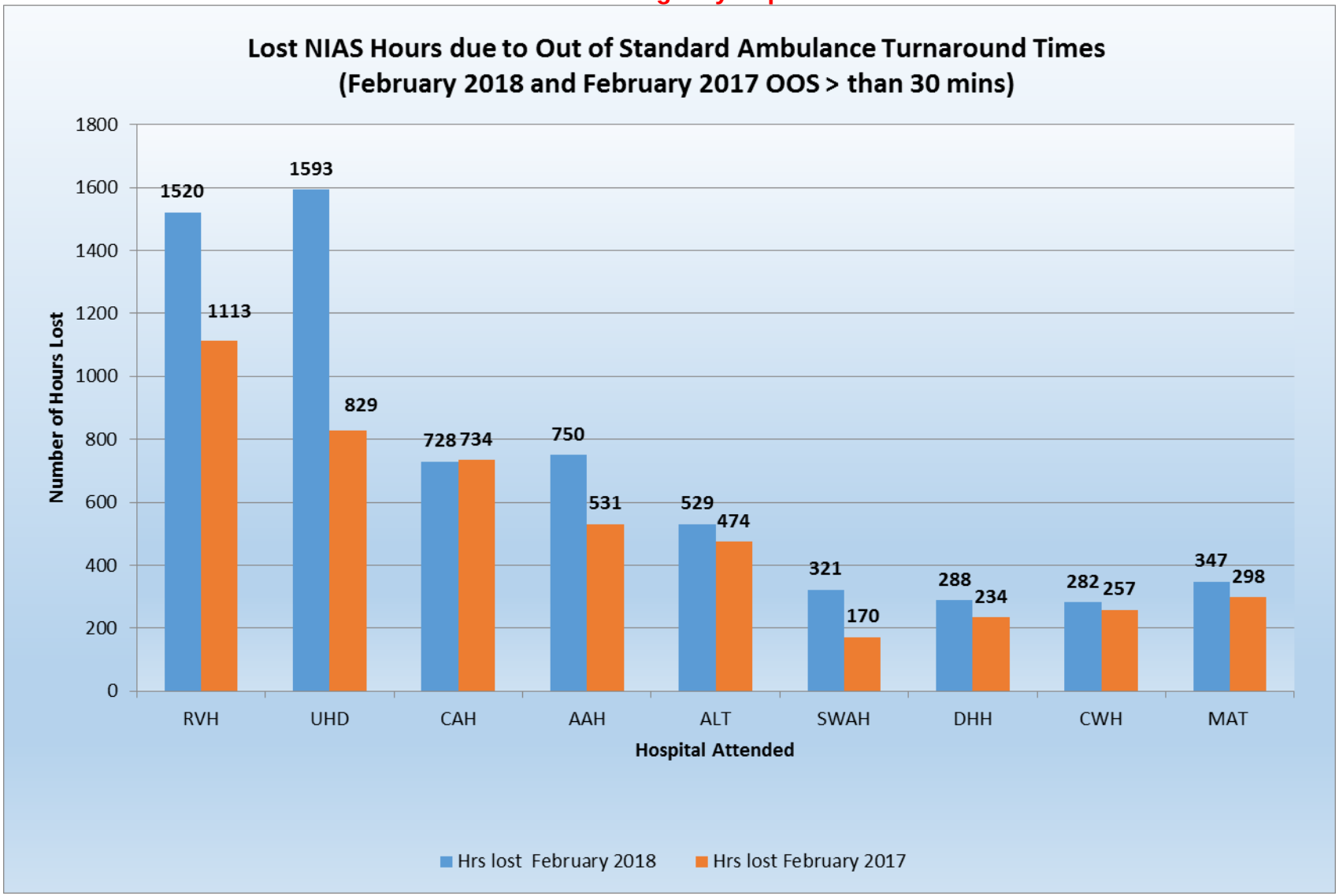
DEMAND COMPARISON FEBRUARY 2018 v FEBRUARY 2017 FOR 999 CALLS AND CARD 35 HCP ACTIVITY



DEMAND COMPARISON BY MONTH FOR 2017/18 v 2016/17 FOR 999 CALLS AND CARD 35 HCP ACTIVITY

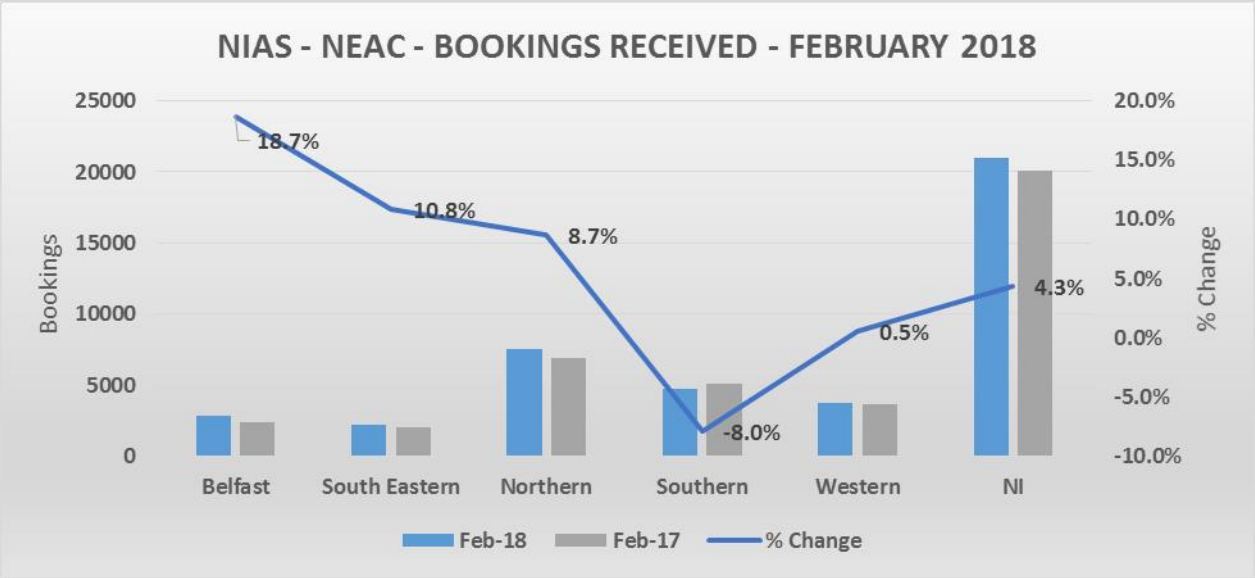
MONTH	Belfast LCG		South Eastern LCG		Northern LCG		Southern LCG		Western LCG		Northern Ireland	
	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17
Apr 17 (Actual)	4,312	4,486	3,130	2,961	4,164	3,960	2,897	2,823	2,721	2,589	17,224	16,819
% Change 16v17	-3.9%		5.7%		5.2%		2.6%		5.1%		2.4%	
May 17 (Actual)	4,820	4,648	3,235	4,414	4,414	4,137	3,081	3,004	2,894	2,701	18,444	17,554
% Change 16v17	3.7%		5.6%		6.7%		2.6%		7.1%		5.1%	
Jun 17 (Actual)	4,495	4,429	3,066	3,135	4,293	4,021	2,961	2,897	2,660	2,558	17,475	17,040
% Change 16v17	1.5%		-2.2%		6.8%		2.2%		4.0%		2.6%	
Jul 17 (Actual)	4,502	4,506	3,149	3,246	4,387	4,220	2,976	2,863	2,853	2,737	17,867	17,572
% Change 16v17	-0.1%		-3.0%		4.0%		3.9%		4.2%		1.7%	
Aug 17 (Actual)	4,625	4,484	3,229	3,225	4,201	4,099	2,936	2,899	2,768	2,796	17,759	17,503
% Change 16v17	3.1%		0.1%		2.5%		1.3%		-1.0%		1.5%	
Sept 17 (Actual)	4,658	4,435	3,264	2,924	4,101	4,105	2,943	2,926	2,702	2,508	17,668	16,898
% Change 16v17	5.0%		11.6%		-0.1%		0.6%		7.7%		4.6%	
Oct 17 (Actual)	4,668	4,651	3,259	3,261	4,438	4,501	3,136	3,182	2,802	2,767	18,303	18,362
% Change 16v17	0.4%		-0.1%		-1.4%		-1.4%		1.3%		-0.3%	
Nov 17 (Actual)	4,651	4,446	3,370	3,155	4,229	4,266	3,039	2,998	2,714	2,648	18,003	17,513
% Change 16v17	4.6%		6.8%		-0.9%		1.4%		2.5%		2.8%	
Dec 17 (Actual)	5,402	5,015	3,842	3,518	5,236	4,805	3,568	3,448	3,255	3,058	21,303	19,844
% Change 16v17	7.7%		9.2%		9.0%		3.5%		6.4%		7.4%	
Jan 18 (Actual)	4,918	4,561	3,638	3,346	4,806	4,513	3,393	3,070	3,113	2,827	19,868	18,317
% Change 17v18	7.8%		8.7%		6.5%		10.5%		10.1%		8.5%	
Feb 18 (Actual)	4,246	4,263	3,093	2,905	4,174	3,963	2,997	2,748	2,626	2,567	17,136	16,446
% Change 17v18	-0.4%		6.5%		5.3%		9.1%		2.3%		4.2%	
Mar 18 (Actual)												
% Change 17v18												

Key Performance Indicator: Ambulance Turnaround at Emergency Departments within 30 minutes – DEC 17 V DEC 16



Key Performance Indicator: Provide non-urgent transport of patients across Northern Ireland through its Patient Care Service (PCS) to locally agreed specifications

	NEAC BOOKINGS AND JOURNEYS - FEBRUARY 2018						
Bookings	LCG AREA	Belfast	South Eastern	Northern	Southern	Western	NI
	Feb-18	2817	2189	7539	4710	3707	**20962**
	Feb-17	2374	1975	6938	5117	3688	**20092**
	% Change	18.7%	10.8%	8.7%	-8.0%	0.5%	**4.3%**
Completed Journeys	LCG AREA	Belfast	South Eastern	Northern	Southern	Western	NI
	Feb-18	2017	1550	5645	3636	2737	**15585**
	Feb-17	1828	1564	5676	3933	2886	**15887**
	% Change	10.3%	-0.9%	-0.5%	-7.6%	-5.2%	**-1.9%**
Completed Journeys	Journey Type	Outpatient	Discharge	Transfer	Admission	Second Crew	Home Assessment	Total
	Feb-18	11736	2693	971	169	10	6	**15585**
	Feb-17	12482	2266	930	186	11	12	**15887**



CATEGORY A PERFORMANCE: AVERAGES AND OUTLIERS

Feb 18

REGIONAL CATEGORY A PERFORMANCE: TOTAL NUMBER OF RESPONSES

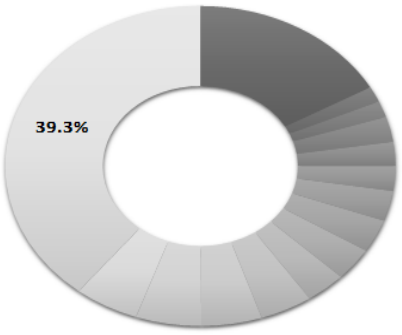
NORTHERN IRELAND REGIONAL TOTAL

TOTAL NUMBER OF CATEGORY A RESPONSES	Number of Category A responses required to exceed Regional target (72.5%)
4666	3383
AVERAGE RESPONSE TIME [MM:SS]	**1550 responses below target**
14:46	

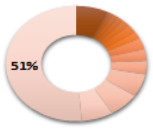
BELFAST HSCT	SOUTH EASTERN HSCT	NORTHERN HSCT	SOUTHERN HSCT	WESTERN HSCT
Total number of Cat A responses: 1145	Total number of Cat A responses: 893	Total number of Cat A responses: 1071	Total number of Cat A responses: 849	Total number of Cat A responses: 708
Number required to exceed LCG target (67.5%): 773	*Number required to exceed LCG target (67.5%)*: 603	*Number required to exceed LCG target (67.5%)*: 723	*Number required to exceed LCG target (67.5%)*: 574	*Number required to exceed LCG target (67.5%)*: 478
Number of category A responses at scene within 8 mins: 587 / 51.3%	Number of category A responses at scene within 8 mins: 289 / 32.4%	Number of category A responses at scene within 8 mins: 362 / 33.8%	Number of category A responses at scene within 8 mins: 269 / 31.7%	Number of category A responses at scene within 8 mins: 326 / 46.0%
186 responses below target	314 responses below target	361 responses below target	305 responses below target	152 responses below target
Average response time [mm:ss]: 12:05	Average response time [mm:ss]: 17:24	Average response time [mm:ss]: 15:27	Average response time [mm:ss]: 16:35	Average response time [mm:ss]: 12:35

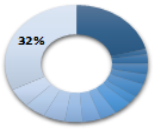
REGIONAL CATEGORY A PERFORMANCE SUMMARY

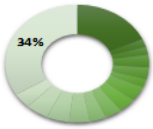
Northern Ireland Ambulance Service Health and Social Care Trust

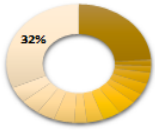


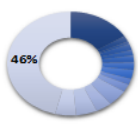
Category A Performance		%	Cumulative %
Within 8 minutes	1833	39.3%	39.3%
Within 8 - 9 minutes	250	5.4%	44.6%
Within 9 - 10 minutes	254	5.4%	50.1%
Within 10 - 11 minutes	234	5.0%	55.1%
Within 11 - 12 minutes	204	4.4%	59.5%
Within 12 - 13 minutes	156	3.3%	62.8%
Within 13 - 14 minutes	155	3.3%	66.1%
Within 14 - 15 minutes	155	3.3%	69.5%
Within 15 - 16 minutes	142	3.0%	72.5%
Within 16 - 17 minutes	116	2.5%	75.0%
Within 17 - 18 minutes	114	2.4%	77.4%
Within 18 - 19 minutes	119	2.6%	80.0%
Within 19 - 20 minutes	76	1.6%	81.6%
Within 20 - 21 minutes	73	1.6%	83.2%
Over 21 minutes	785	16.8%	100.0%
Total	4666		











BELFAST HSCT

Response Time	N	%	Total
< 8 m	587	51.3%	51.3%
8 - 9 m	83	7.2%	58.5%
9 - 10 m	81	7.1%	65.6%
10 - 11 m	73	6.4%	72.0%
11 - 12 m	43	3.8%	75.7%
12 - 13 m	38	3.3%	79.0%
13 - 14 m	36	3.1%	82.2%
14 - 15 m	23	2.0%	84.2%
15 - 16 m	26	2.3%	86.5%
16 - 17 m	21	1.8%	88.3%
17 - 18 m	16	1.4%	89.7%
18 - 19 m	15	1.3%	91.0%
19 - 20 m	9	0.8%	91.8%
20 - 21 m	8	0.7%	92.5%
21 + m	86	7.5%	100.0%
Total	1145		

SOUTH EASTERN HSCT

Response Time	N	%	Total
< 8 m	289	32.4%	32.4%
8 - 9 m	47	5.3%	37.6%
9 - 10 m	43	4.8%	42.4%
10 - 11 m	44	4.9%	47.4%
11 - 12 m	36	4.0%	51.4%
12 - 13 m	37	4.1%	55.5%
13 - 14 m	33	3.7%	59.2%
14 - 15 m	36	4.0%	63.3%
15 - 16 m	20	2.2%	65.5%
16 - 17 m	33	3.7%	69.2%
17 - 18 m	25	2.8%	72.0%
18 - 19 m	27	3.0%	75.0%
19 - 20 m	23	2.6%	77.6%
20 - 21 m	13	1.5%	79.1%
21 + m	187	20.9%	100.0%
Total	893		

NORTHERN HSCT

Response Time	N	%	Total
< 8 m	362	33.8%	33.8%
8 - 9 m	45	4.2%	38.0%
9 - 10 m	55	5.1%	43.1%
10 - 11 m	54	5.0%	48.2%
11 - 12 m	50	4.7%	52.8%
12 - 13 m	40	3.7%	56.6%
13 - 14 m	41	3.8%	60.4%
14 - 15 m	42	3.9%	64.3%
15 - 16 m	44	4.1%	68.4%
16 - 17 m	24	2.2%	70.7%
17 - 18 m	35	3.3%	73.9%
18 - 19 m	37	3.5%	77.4%
19 - 20 m	23	2.1%	79.6%
20 - 21 m	24	2.2%	81.8%
21 + m	195	18.2%	100.0%
Total	1071		

SOUTHERN HSCT

Response Time	N	%	Total
< 8 m	269	31.7%	31.7%
8 - 9 m	37	4.4%	36.0%
9 - 10 m	37	4.4%	40.4%
10 - 11 m	34	4.0%	44.4%
11 - 12 m	39	4.6%	49.0%
12 - 13 m	24	2.8%	51.8%
13 - 14 m	32	3.8%	55.6%
14 - 15 m	34	4.0%	59.6%
15 - 16 m	35	4.1%	63.7%
16 - 17 m	23	2.7%	66.4%
17 - 18 m	26	3.1%	69.5%
18 - 19 m	26	3.1%	72.6%
19 - 20 m	15	1.8%	74.3%
20 - 21 m	15	1.8%	76.1%
21 + m	203	23.9%	100.0%
Total	849		

WESTERN HSCT

Response Time	N	%	Total
< 8 m	326	46.0%	46.0%
8 - 9 m	38	5.4%	51.4%
9 - 10 m	38	5.4%	56.8%
10 - 11 m	29	4.1%	60.9%
11 - 12 m	36	5.1%	66.0%
12 - 13 m	17	2.4%	68.4%
13 - 14 m	13	1.8%	70.2%
14 - 15 m	20	2.8%	73.0%
15 - 16 m	17	2.4%	75.4%
16 - 17 m	15	2.1%	77.5%
17 - 18 m	12	1.7%	79.2%
18 - 19 m	14	2.0%	81.2%
19 - 20 m	6	0.8%	82.1%
20 - 21 m	13	1.8%	83.9%
21 + m	114	16.1%	100.0%
Total	708		

Fleet & Estate

Fleet Section:

Objective 1: To provide a professionally managed, safe and reliable ambulance Fleet which supports the operational model for service delivery.

Key Performance Indicator: Replace 20% of fleet annually.

- A&E & PCS vehicle builds for 2017/18 Completed and awaiting commissioning
- Cars & Specialist vehicle builds nearing completion.

Key Performance Indicator: Age of fleet should be less than 5 years old.

The percentage of A&E & PCS ambulances less than 5 years old has reduced however once the 23 new A&E Ambulances and 22 new PCS ambulances are commissioned this will increase again.

Percentage of Fleet Less than 5 Year Old

Fleet Profile 2017/18	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
(**%** less than 5 yrs old)	**2017**										**2018**		
Emergency Ambulances	97.4	98.3	98.3	98.3	98.3	98.3	98.3	98.3	98.3	98.3	80	80	
Non-Emergency Ambulance	81.1	82.9	85.6	85.6	85.6	86.5	86.5	86.5	88.3	85.6	77.5	79.2	
Rapid Response Vehicles	71.4	71.4	76.2	79.1	81.4	81.4	81.4	81.4	86.0	88.4	88.3	88.3	
Support Vehicles	44.0	44.0	44.0	43.1	43.1	43.1	43.1	47.1	52.9	52.9	58.8	58.8	

NIAS ESTATES:

Summary of Commercial Lease renewals and status:

SITE	SOC to AEMB	OBC	LPS - VFM	ALTERNATIVES FOUND by LPS	AEMB APPROVAL	LEASE SIGNED AND SEALED BY NIAS	LEASE SIGNED AND SEALED BY CLIENT	LEASE RETURNED TO NIAS
Newcastle	YES	YES	YES	NO	YES	YES	YES	YES
Kennedy Way	YES	YES	YES	NO	YES	MARCH 18	MARCH 18	APRIL 18
Derriaghy	YES	YES	NO	YES	NO	NO	NO	NO
Lisnaskea	YES	YES	YES	NO	YES	MARCH 18	APRIL 18	APRIL 18
Irvinestown	YES	YES	YES	NO	YES	MARCH 18	APRIL 18	APRIL 18
Carrickfergus	MARCH 18	YES	YES	NO	APRIL 18	MAY 18	MAY 18	MAY 18

KEY:

SOC = Strategic Outline Case
OBC = Outline Business Case
LPS = Land and Property Services
AEMB= Assets & Estates Management Branch
VFM = Value for Money Statement Received

Derriaghy – LPS in negotiations with Landlord to accept reduced rental proposal. Deadline imposed of 21st March.
If no agreement, then Directorate of Legal Services will issue 3 month notice to quit and NIAS will prepare to move to alternative property found by LPS.

Once NIAS submits the SOC for Carrickfergus, NIAS will have achieved compliance with DOH AEMB policy regarding lease renewals

Omagh Dromore Road - NIAS will vacate Omagh Dromore Road in middle of March 2018. Notice has been served to Landlord. NIAS has a number of remedial works to perform before handing back to landlord at the end of March 2018

Facilities Maintenance Contract – NIAS commenced a review in February 2018 of works conducted under the auspices of the FM Contract to ,not only, improve value for money but also to help stablish a service standard for the management of reactive repairs, planned repairs and minor works.

Clinical Sluice Programme

NIAS need to upgrade the Sluice Facilities in the majority of its Ambulance Stations to meet the requirements of RQIA. Essentially, each station needs to have separate Clinical Sluice and Domestic Sluice facilities. Currently, most stations contain one shared sluice facility, and this doesn't meet the standards required by RQIA. The table below summarises projected costs and programme in 2018.19 to complete sluice works:

SITE	TOTAL PER SITE (£)	Quarter 1 (£)	Quarter 2 (£)	Quarter 3 (£)	Quarter 4 (£)
Altnagelvin	0	0			
Antrim	28,644		28,644		
Ardoyne	9,044				9,044
Armagh	28,644	28,644			
Ballycastle	28,644	28,644			
Ballymoney	28,644			28,644	
Ballynahinch	9,044				9,044
Banbridge	28,644	28,644			
Bridge End	9,044				9,044
Carrickfergus	28,644		28,644		
Castlederg	28,644		28,644		
Coleraine	28,644		28,644		
Cookstown	28,644		28,644		
Craigavon	28,644	28,644			
Derriaghy	28,644			28,644	
Downpatrick	28,644				28,644
Dungannon	9,044	9,044			
Kilkeel	9,044		9,044		
Knockbracken	28,644			28,644	
Larne	9,044		9,044		
Limavady	9,044				9,044
Lisburn	28,644		28,644		
Magherafelt	28,644	28,644			
Newcastle	9,044			9,044	
Newry	9,044	9,044			
Newtownards	28,644				28,644
Omagh	28,644			28,644	
Strabane	28,644			28,644	
Whiteabbey	28,644		28,644		
TOTAL	**625,632**	**161,308**	**218,596**	**152,264**	**93,464**

TB/12/04/2018/03

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT

February 2018 (Month 11)

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently reporting a small surplus of £8k for the eleven months ending 28 February 2018 (Month 11), 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 February 2018 (Month 11)

Financial Breakeven Assessment (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	47715	Mar
Staff Costs		8,681	12,880	16,933	21,186	25,349	29,781	33,952	38,392	42,447	47,175	
Other Expenditure		2,071	3,004	4,284	5,831	7,787	8,918	10,311	11,483	13,609	15,176	
Expenditure Total		10,752	15,884	21,217	27,017	33,136	38,699	44,263	49,875	56,056	62,351	0
Income		73	99	136	292	394	511	660	700	839	922	
Net Expenditure		10,679	15,785	21,081	26,725	32,742	38,188	43,603	49,175	55,216	61,429	0
Net Resource Outturn		10,679	15,785	21,081	26,725	32,742	38,188	43,603	49,175	55,216	61,429	0
Revenue Resource Limit (RRL)		10,680	15,786	21,085	26,729	32,747	38,193	43,608	49,174	55,222	61,437	
Surplus/(Deficit) against RRL		1	1	4	4	5	5	5	(1)	6	8	0

NIAS Trust Board Budget Report at February 2018

(£ 000s)	FYB	YTD Budget	YTD Actual	*Variance*
Chief Executive's Office				
Payroll	*158*	*145*	*139*	*6*
Non-Payroll	*43*	*39*	*40*	*(1)*
Chief Executive's Office Total	**200**	**184**	**179**	***5***
Director of Finance				
Payroll	1,609	1,492	1,468	*24*
Non-Payroll	748	702	701	*1*
Director of Finance Total	**2,357**	**2,194**	**2,168**	***26***
Director of HR				
Payroll	3,950	3,606	3,537	*69*
Non-Payroll	746	698	697	*1*
Director of HR Total	**4,696**	**4,304**	**4,234**	***71***
Dir of Ops (incl Divisions & RCC)				
Payroll	46,337	42,499	42,239	*260*
Non-Payroll	10,848	10,075	10,419	*(343)*
Dir of Ops (incl Divisions & RCC) Total	**57,185**	**52,574**	**52,658**	***(83)***
Medical Director				
Payroll	1,518	1,390	1,399	*(9)*
Non-Payroll	1,733	1,713	1,713	*(1)*
Medical Director Total	**3,251**	**3,103**	**3,112**	***(10)***
NIAS Total Payroll	**53,572**	**49,132**	**48,781**	***351***
NIAS Total Non-Payroll	**14,117**	**13,228**	**13,570**	***(342)***
NIAS Total	**67,689**	**62,359**	**62,351**	***8***

Underlying this overall financial forecast is a complex budgetary position. There are a range of vacancies creating underspends against the pay budget. The level of underspend is reduced by overtime costs to provide operational cover. There are also significant levels of sickness absence that can create a financial pressure beyond budgeted levels. Expenditure on Voluntary and Private Ambulance Services and also the Voluntary Car Service to offset these vacancies and maintain cover and performance is creating a corresponding pressure on the non-pay budget. NIAS is also coordinating some Voluntary and Private Ambulance Service activity on behalf of other HSC Trusts. The cost of this is being recharged to the respective HSC Trust.

Plans to stabilise the workforce and reduce the level of vacancies are well progressed and a full programme of recruitment and training is ongoing. Attendance management continues to be managed in line with the Trust's Health and Wellbeing Attendance Management Action Plan. Detailed monitoring of the budget and financial performance continues in conjunction with operational managers and the Senior Executive Management Team.

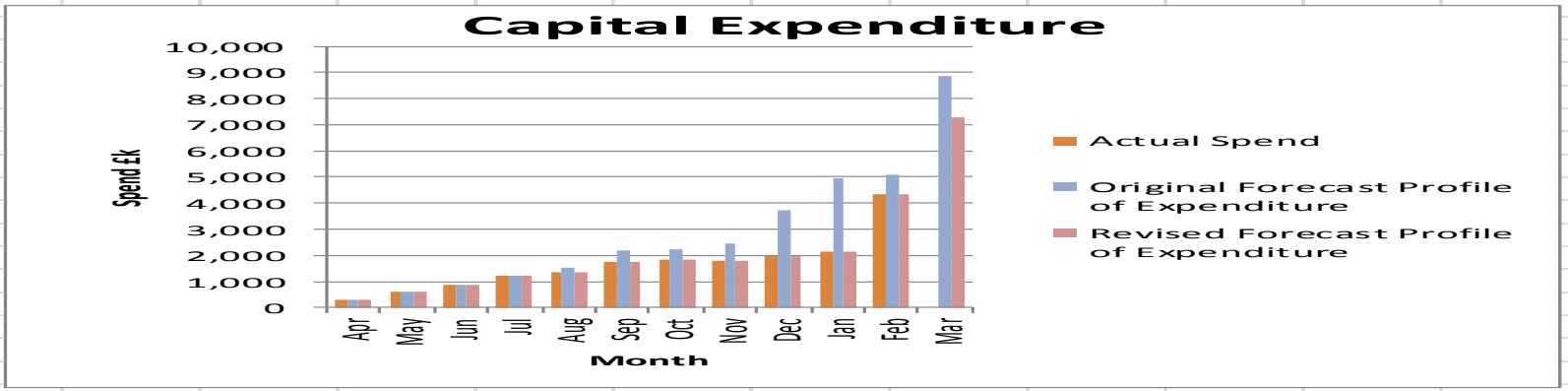
The Trust continues to work with HSCB and other stakeholders to highlight emerging cost pressures and service changes with a view to achieving objectives and maintaining financial balance.

Budgets have been increased to reflect the increased employer national insurance costs from 2016/17. Further adjustments will be made during the year to reflect supported developments and the implementation of savings plans. Proposals to address a savings requirement of £1.0m in 2017/18 have been included in the Trusts plans.

Capital Spend

The Trust has received a revised Capital Resource Limit (CRL) allocation of £7.29m (previously £6.48m). The adjustments to the CRL allocation reflect a number of additions for ICT schemes and an Emergency Planning scheme. 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.

Cumulative Capital Spend (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Fleet	0	0	0	0	0	0	0	0	0	120	2,217	
Estate	304	604	836	1,088	1,233	1,575	1,675	1,604	1,677	1,675	1,661	
Medical Equipment	0	0	0	0	0	0	0	0	0	0	0	
ICT Schemes	0	0	2	4	4	4	11	11	11	52	61	
General Capital	0	0	27	116	133	148	148	161	284	305	412	
Actual Spend	304	604	865	1,208	1,370	1,727	1,834	1,776	1,972	2,152	4,351	0
Original Forecast Profile of Expenditure	304	604	864	1,225	1,521	2,175	2,233	2,430	3,733	4,966	5,083	8,870
Revised Forecast Profile of Expenditure	304	604	865	1,208	1,370	1,727	1,834	1,776	1,972	2,152	4,351	7,294



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. The Trust is also engaging with BSO to review the calculation of prompt payment performance statistics.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Total bills paid	1,315	1,617	1,591	1,324	1,592	1,309	1,488	1,639	1,222	2,098	1,593		16,788
Total bills paid within 30 calendar days of receipt of undisputed invoice	1,288	1,519	1,483	1,269	1,524	1,253	1,337	1,446	1,132	1,906	1,515		15,672
% bills paid on time	97.9%	93.9%	93.2%	95.8%	95.7%	95.7%	89.9%	88.2%	92.6%	90.8%	95.1%		93.4%
Total bills paid within 10 working days (14 calendar days)	898	944	1,158	931	1,032	851	1,045	1,099	891	1,370	928		11,147
% bills paid on time	68.3%	58.4%	72.8%	70.3%	64.8%	65.0%	70.2%	67.1%	72.9%	65.3%	58.3%		66.4%

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.

10 January 2018 and 5 February 2018 Telephony Fault NEAC.

On 10 January and on 5 February NEAC experienced Telephony outages where they were unable to make or receive calls for approximately two hours on each occasion. The faults were logged with BT and on investigation were categorised as Session Initiated Protocol (SIP) network related. On each occasion the fault rectified itself before BT could diagnose the exact cause of the outage. Logs of the incident have been captured by BT for analysis and there have been no further incidents reported. Contingency mobile phones were used during the outages with minimum disruption to service.

Information Technology Systems - Developments

Any system developments are reported in this section.

A project to replace the Mobile Data System which transmits data from the command and Control system to the Ambulance has now completed the tender evaluation stage and the preferred supplier identified. Award of contract is imminent and NIAS will work with the preferred supplier over the coming months to procure and implement the system.

A Business Case to implement an Electronic Patient report form system (EPRF) has been formally approved to proceed to procurement stage. This project will involve, through the project team, representatives across all directorates and a fuller appreciation of the costs involved will be provided through the procurement process. A number of workshops with stakeholders is ongoing to develop a user specification and all related procurement and contract documentation.

Cyber Security: NIAS were recently audited on the management of one specific area of cyber security – Secure Configuration. There were nine priority 2 and one priority 3 findings in the audit and NIAS has developed an action plan to address these findings. Whilst Incident Management was not part of the scope of the NIAS IT Audit, Internal Audit noted that the current HSCNI governance and leadership over cyber security needs reviewed, in terms of clarity over responsibility for Incident Management and issued a priority 1 finding to all HSCNI Trusts and BSO. On-going engagement with HSC colleagues is helping to develop a regional plan and specific NIAS actions are being managed through the IGSG.

ICT Help Desk Performance

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

	Jan			Feb		
Target to Respond to 95%	No of Calls	Within time	Actual	No of Calls	Within time	Actual
Immediate	11	11	100%	5	5	100%
Urgent	48	47	98%	49	49	100%
High	12	12	100%	3	2	67%
Medium	519	507	98%	558	551	99%
Low	808	808	100%	885	885	100%
Total	1398			1500		

ICT Planned Maintenance January 2018 – system upgrades Critical Systems

	Availability	**Maximum down time**	**Actual**	**Exceeded Maximum Down Time**
C3 A&E	740	4 Hours	1	No
C3 PCS	740	4 Hours	1	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

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.

Voice Recorder	740	4 Hours	0	No	
Mobile Data	740	4 Hours	0	No	

ICT Planned Maintenance January 2018 – 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	226	4 Hours	0	No	
File Server	226	4 Hours	0.25	No	
Virtual Server	228	2 Hours	0	No	
BlackBerry	226	4 Hours	0.10	No	
Promis	226	4 Hours	0.10	No	

ICT Planned Maintenance February 2018 – 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	668	4 Hours	0	No	
C3 PCS	668	4 Hours	0	No	
Pro-QA	668	4 Hours	0	No	
ICCS A&E	668	4 Hours	0	No	
ICCS PCS	668	4 Hours	0	No	
DTR	668	4 Hours	0	No	
Voice Recorder	668	4 Hours	0.10	No	
Mobile Data	668	4 Hours	0	No	

ICT Planned Maintenance February 2018 – system upgrades Corporate Systems

There was no planned maintenance on Corporate Systems for this period

***Information Governance/Informatics* – Developments: 01/01/2018 to 28/02/2018**

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

- ***Control Assurance – Information Management: 76% Substantive Achieved through Self-Assessment for 2016/17. Action Plan for outstanding items being developed. This work continues to be a priority of the Trust. Along with outstanding Priority 1 Audit Recommendations relating to Information Governance aspects relating to Information Asset Register and Data Flow Exercise. Work in this area has been ongoing and templates for an Information Asset Register and Data Flow template have been created and information gathering is underway***
- ***General Data Protection Regulations (to replace Data Protection Act 1998 in May 2018) – Development of Action Plan, Privacy Notices Aspects, appointment of Data Protection Officer all being considered***
- ***Processing in all areas of the Information Department has noted to have increased across Freedom of Information, Solicitor and Police Enquiries during 2017/18 to date and has placed additional pressures on the Department.***
- ***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 mental health***
- ***Informatics and business intelligence to support Transformation and Information Collaborative workflows continue to be worked on including ambulance turnaround reports, Prison attendances etc***
- ***Supporting work and data streams in Frequent Caller Monitoring and Information Markers including policy/procedures and analytics***
- ***Ad hoc datasets relating to winter pressure datasets from Christmas and New Year including diverts, lost hours, hospital turnaround times, performance; HEMs datasets to support Board meetings; datasets to support freedom of information requests; mapping datasets to visually represent activity to support Ballymena Business Case; identification of new station locations; Patient Care Service – Contract Monitoring.***
- ***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***
- ***Cardiac and ROSC datasets currently being worked to support Community Resuscitation Strategy***

- 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, DATA PROTECTION (SUBJECT ACCESS), PSNI REQUESTS AND SOLCITOR ENQUIRIES PROCESSING LEVELS

Summary April 2017 – February 2018 requests compared with same period in 2016-17:

	April 17 – Feb 18	April 16 – Feb 17	% Increase / (Decrease)
1 Freedom of Information Requests Received	145	142	+2.1%
1a Freedom of Information Questions Received	562	503	+11.7%
2 Data Protection Act 1998 Section 7, Subject Access Requests Received	29	33	-12.1%
3 Police Service of Northern Ireland Requests Received	439	384	+14.3%
4 Solicitor Enquiries Requests Received	567	559	1.4%
	1180	**1118**	**5.5% in processing**

Total (1a) not included in Count			

1 FREEDOM FOR INFORMATION ACT (2000) – REQUESTS FOR INFORMATION – 01/04/2017 TO 28/02/2018

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 Data Protection Act (see following).

2017-18 Data

Freedom of information	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Feb-18	Total Feb-17
Number of Requests Received	14	12	17	11	15	13	10	20	7	14	14		**147**	145
Number of Questions Received	70	34	81	35	54	48	29	66	47	60	38		**562**	503
Completed Requests processed within 20 days or less	11	7	14	9	12	5	7	9	2	5	7		**88**	108
Completed Requests exceeding 20 days	2	4	3	2	2	3	3	5	1	4	2		**31**	30
REQUESTS Still Being Processed (within 20)	0	0	0	0	0	0	0	0	0	0	3		**3**	
REQUESTS Still being processed (outside 20)	1	1	0	0	1	4	0	6	4	5	2		**24**	
Stood Down	0	0	0	0	0	1	0	0	0	0	0		**1**	
Number of Records Fully Disclosed	55	27	54	30	20	20	28	34	17	34	26		**345**	
Vexatious Requests	0	0	0	0	0	0	0	0	0	0	0		**0**	
Number of Records for which records not held	6	0	27	5	0	7	0	2	0	10	0		**57**	
Requests where exemptions wholly/partially applied	2	0	0	0	10	5	1	1	0	0	0		**19**	
Questions stood down	0	0	0	0	0	3	0	0	0	0	0		**3**	
QUESTIONS Still Being Processed (within 20)	0	0	0	0	22	0	0	0	0	0	8		**30**	
QUESTIONS Still Being Processed (outside 20)	7	7	0	0	2	13	0	29	31	16	4		**109**	
Referrals for Independent Review	0	0	0	0	0	0	0	0	0	0	0		**0**	
Appeals to the Information Commissioner	0	0	0	0	0	0	0	0	0	0	0		**0**	
Requestor Type														
Member of Public	6	8	8	3	7	1	5	4	2	4	2		**50**	
Local Government	0	1	0	0	0	0	0	0	0	0	1		**2**	
Staff Member	2	1	4	1	0	2	1	5	0	0	0		**16**	
Media	1	0	1	3	1	7	1	7	1	3	0		**25**	
Student	0	0	0	0	1	0	0	1	0	0	2		**4**	
Commercial Company	3	0	0	1	2	1	1	0	4	5	3		**20**	
Solicitor	0	0	0	0	0	0	0	0	0	0	0		**0**	
WhatDoTheyKnow.com	2	2	1	3	3	2	1	3	0	2	6		**25**	
NHS	0	0	3	0	1	0	1	0	0	0	0		**5**	
Trade Union	0	0	0	0	0	0	0	0	0	0	0		**0**	

%age completed within 20 working days	
Apr '17 - Feb '18	59.86%
Apr '16 - Feb '17	74.48%

Data may be subject to amendments.

2 DATA PROTECTION ACT 1998 – SECTION 7: SUBJECT ACCESS MONITORING

The 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 01/04/2017 to 28/02/2018

Data Protection Act 1998 – Section 7, Subject Access	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 17 – Feb 18	April 16 – Feb 17
Number of Requests Received	1	8	4	1	3	1	1	4	1	2	3		29	33
Completed Requests processed within 40 days or less	1	8	4	1	2	1	0	2	0	2	3		24	24
Completed Requests exceeding 40 days	0	0	0	0	1	0	0	2	1	0	0		4	6
Requests still being processed in line with 40 days	0	0	0	0	0	0	0	0	0	0	0		0	0
Identity Not Confirmed/Fee Not Received and therefore could not be further processed	0	0	0	0	0	0	1	0	0	0	0		1	3
Patient	1	1	1	1	3	0	0	2	0	1	3		13	16
NIAS Staff Member	0	5	0	0	0	0	0	1	1	1	0		8	13
External Agency	0	2	3	0	0	1	1	0	1	0	0		8	2
Relative of Patient	0	0	0	0	0	0	0	0	0	0	0		0	2

- **From 01/04/2017 to 31/12/2017: 83% of Subject Access Requests processed within 40 calendar days**
  (this is based on this requests that were fully processed i.e. identity and fee received)

- There are a number of DPA requests from 2016/17 that remain outstanding relating to staff requests for disciplinary files, HR records etc - these are currently being prioritized

3 <u>POLICE SERVICE OF NORTHERN IRELAND REQUESTS – Police Acts, Common Law 01/04/2017 to 28/02/2018</u>

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 17 – Feb 18**	**Apr 16- Feb 17**
Number of Requests Received (based on receipt of correspondence date)	29	35	42	27	42	32	42	48	41	56	45		439	384

4 SOLICITOR ENQUIRIES 01/04/2017 to 28/02/2018

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

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr 17 – Feb 18**	**Apr 16 – Feb 17**
Number of Requests Received (based on receipt of correspondence date)	52	61	68	49	49	49	66	54	36	33	50		567	559

5 DEPARTMENT OF HEALTH – REQUESTS FOR INFORMATION

Processing for the Period 01/04/2017 to 28/032/2017

DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr 17 – Feb 18
Assembly Questions (Oral)	0	0	0	0	0	0	0	0	0	0	0		0
Assembly Questions (Written)	0	0	0	0	0	0	0	0	0	0	0		0
CORs/SCORs Received	2	0	2	0	1	0	0	0	1	3	1		6
TOFs Received	1	0	0	0	0	0	0	0	0	0	0		2
INVs Received	0	0	0	0	0	0	0	0	0	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

17/18 - 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 2017	16028	12899	353	13252	15978	-50	+2,726
May 2017	17157	13789	366	14155	17327	+170	+3,172
June 2017	16293	12957	406	13363	16500	+207	+3,137
July 2017	16661	13204	342	13546	16550	-111	+3,004
August 2017	16475	13077	334	13411	16157	-318	+2,746
September 2017	16457	13031	358	13389	15965	-492	+2,576
October 2017	16756	13322	389	13711	16468	-288	+2,757
November 2017	16615	13112	372	13484	15538	-1,077	+2,054
December 2017	18523	14578	236	14814	15822	-2,701	+1,008
January 2018	17871	13954	260	14214	13703	-4,168	-511
February 2018	15537	12300	222	12522	8263	-7,274	-4,259
March 2018				0		+0	+0
Total	184373	146223	3638	149861	168271	-16,102	+18,410

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 2017/2018 are provisional and will rise as data processing is ongoing.

TB/12/04/2018/04

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

HUMAN RESOURCES AND CORPORATE SERVICES DIRECTORATE

Director of Human Resources and Corporate Services

2018 / 04 / 12

(As at 28 February 2018)

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

HRCS KPI: **Shaping & Developing Future Workforce (Workforce Information, Recruitment, Job Evaluation)**

JOB EVALUATION - PARAMEDICS, RRV PARAMEDICS AND EMTS

Further to the report to Trust Board in December 2015, NIAS has received Partnership correspondence from the Regional Quality Assurance (RQA) team advising that the RQA team had reached a conclusion "that the current banding levels ie: 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. Production of the Job Evaluation Report is currently in abeyance pending investigation of Trade Unions' challenge of the job evaluation process.

WORKFORCE INFORMATION

Monthly Corporate Workforce Information is published monthly in arrears, consequently the table below reflects the NIAS workforce position as at 28 February 2018. This information is taken from HRPTS.

FEBRUARY 2018	TRUST TOTAL	CX / BOARD	FINANCE / ICT	HRCS	MEDICAL	OPERATIONS
FUNDED (WTE) RECURRENT / (TEMPORARY FUNDING)	1,318.28 (27.00)	7.00 (0.00)	31.63 (1.00)	68.15 (11.00)	16.00 (9.00)	1,195.50 (6.00)
STAFF IN FUNDED POSTS (WTE) PERM STAFF / (TEMP STAFF)	1,187.34 (16.53)	1.00 (5.00)	20.58 (1.00)	62.49 (3.37)	20.80 (1.00)	1,082.47 (6.16)
OVERALL VACANCY LEVELS (WTE)	**-141.41**	**-1.00**	**-11.05**	**-13.29**	**-3.20**	**-112.87**

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 @ 28 February 2018, the Trust has an overall vacancy level of **141.41** WTE posts.

Section 1: Human Resources & Corporate Services

HRCS KPI: Shaping & Developing Future Workforce (Workforce Information, Recruitment, Job Evaluation)

RECRUITMENT ACTIVITY

The following table provides a breakdown of frontline vacancies as at 28 February 2018 and provides related details on current recruitment activity, in line with operational directives.

Post	Funded Est (WTE)	Staff-in-Post (WTE)	Vacancy (WTE)	Bank Staff	Recruitment Activity	Current Trainees (WTE)	Date Next Training Cohort Due to Commence	Further Planned Training Cohorts
Station Supervisor	31.00	20.72	-10.28	0	No recruitment activity planned, due to industrial relations issues, relating to the Station Supervisor model.	N/A	N/A	N/A
Paramedic	320.40	308.44	-11.96	29	Waiting List of Paramedic Applicants was exhausted during this period. Opened ended Qualified HCPC Paramedic recruitment advertised on 28/2/18.	N/A	N/A	N/A
RRV Paramedic	85.20	72.20	-13.00	0	No recruitment planned.	N/A	N/A	N/A
EMT + Trainee EMT	301.40	264.83	-36.57	6	No recruitment exercises took place during this period. Pre-employment checks for 28 remaining candidates on recruitment waiting list ongoing in preparation for Cohort 3.	23 (Cohort 2). Clinical placements commenced during Sept-17, with full qualification anticipated by Apr-18.	N/A	N/A
ACA (inc. PCS Sup.) + Trainee ACA	263.50	246.89	-16.61	2	Waiting List of 47 Applicants in place until May-18.	N/A	N/A	N/A

Currently the Operations and HR Directorates are working together to develop recruitment and training plans to address the vacancy levels.

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

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

CORPORATE ABSENCE REPORT (@ 28 FEBRUARY 2018)

The HSC Trusts' sickness absence targets for the current Reporting Year were confirmed by the DHSSPSNI on 2 October 2017, namely **for those HSC Trusts with current performance sitting above 5.5%, the target will be a 5% improvement on the 2016/17 performance**. NIAS's cumulative % hours lost in 2016/17 was 10.47% (based on end-of-year re-run, as Regionally agreed), therefore NIAS's sickness absence target for 2017/18 is **9.95%.**

The table below provides a summary of the Trust's sickness absence for the period 1 April 2017 to 28 February 2018. Since the last Trust Board, monthly absence has increased to 11.38% in February, therefore cumulatively, the Trust's absence is not on target, at **10.57%** cumulatively.

2017/18 Monthly Sickness Absence including Comparators to Previous Reporting Year (2016/17)

MONTH	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NIAS ABSENCE TARGET (2017/18)	REDUCE SICKNESS ABSENCE RATES BY 5% ON 2016/17 PERFORMANCE TO 9.95%											
NIAS cumulative % hrs lost (16/17)	9.78%	*9.70%**	*9.91%**	9.54%	9.68%	9.80%	9.91%	10.06%	10.40%	10.56%	10.49%	10.34%
NIAS monthly % hrs lost (16/17)	9.78%	9.64%	10.30%	8.39%	10.21%	10.41%	10.55%	11.09%	13.11%	13.12%	9.36%	8.69%
NIAS cumulative % hrs lost (17/18)	8.18%	7.98%	8.11%	8.40%	9.00%	9.36%	9.60%	9.67%	10.14%	10.50%	10.57%	
NIAS monthly % hrs lost (17/18)	8.18%	7.82%	8.36%	9.30%	11.24%	11.25%	11.05%	10.13%	14.05%	13.55%	11.38%	
Monthly % hrs lost (S/T)	2.27%	2.03%	2.30%	1.85%	2.00%	2.08%	3.15%	3.07%	4.25%	4.29%	4.26%	
Monthly % hrs lost (L/T)	5.90%	5.79%	6.06%	7.45%	9.24%	9.15%	7.90%	7.06%	9.80%	9.26%	7.12%	
Av. days lost (7.5 hrs) per Employee per Mth	1.59	1.75	1.79	1.90	2.52	2.29	2.42	2.17	2.88	3.03	2.22	
NIAS cumulative costs (£'000)	£272	£531	£824	£1,151	£1,557	£1,960	£2,343	£2,701	£3,135	£3,624	£4,044	

* May-16 & Jun-16 cumulative absence figs adjusted due to late notifications received after production of reports.

NIAS CUMULATIVE % HRS LOST:	(2016/17) 10.47%	(2017/18 @ 28 February 2018) 10.57%	NOT ON TARGET

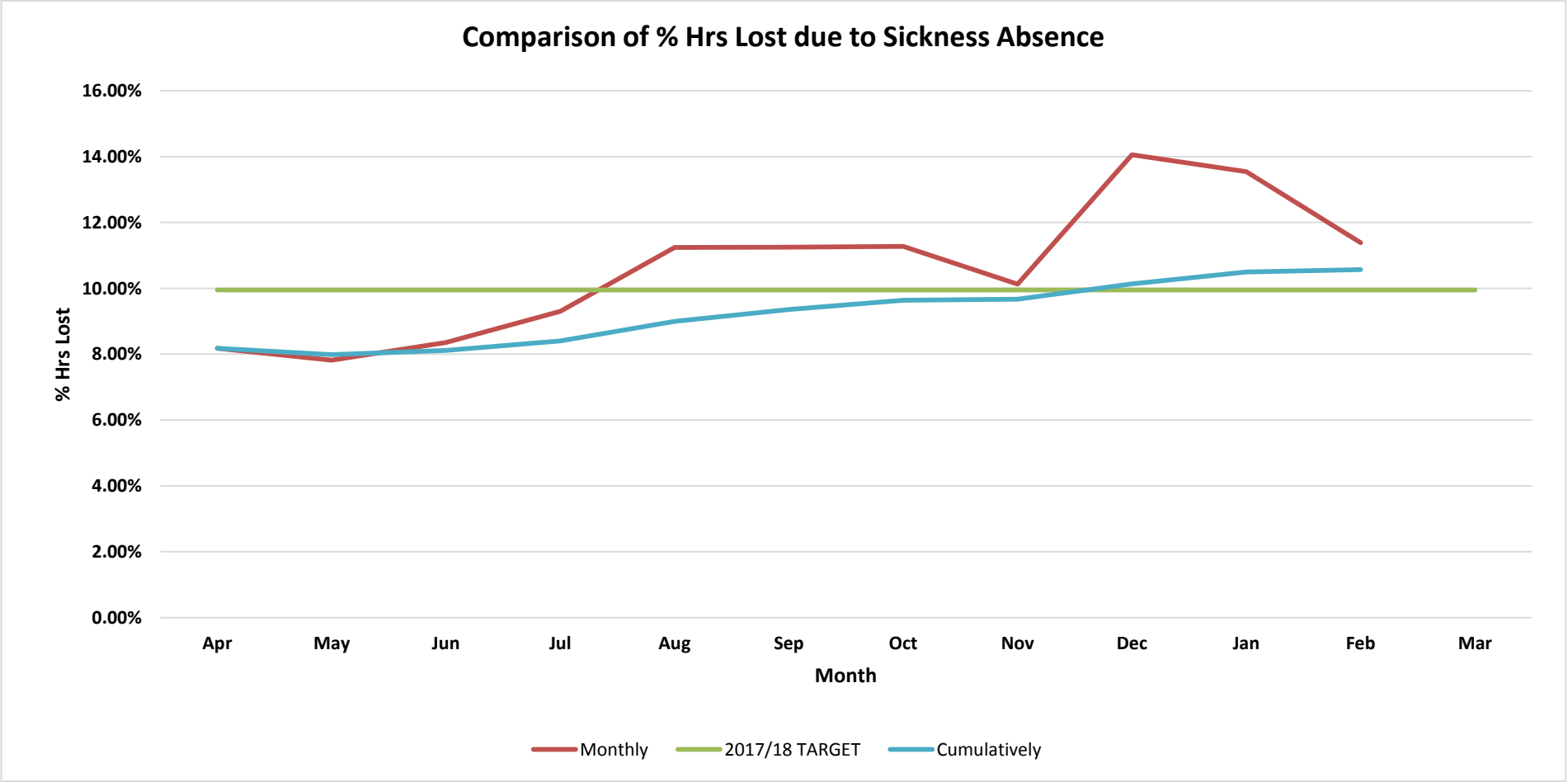
calculation automatically divides working days over a standard 5-day week (Monday – Friday, based on a 7.5 hr day).

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

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

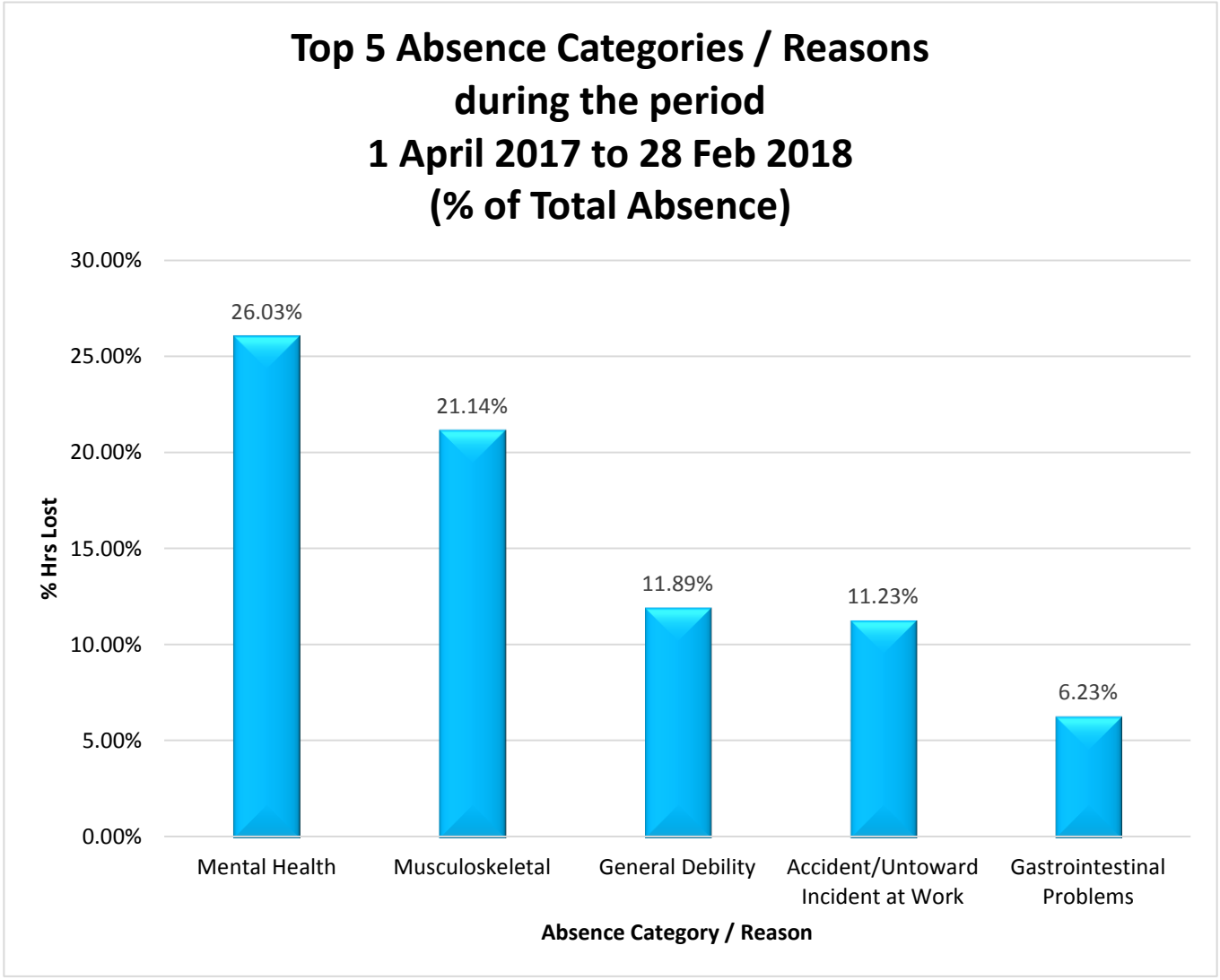
- Two Health and Wellbeing workstreams have been developed under TIC;
- Trade Union Partnership Survey with Unison now complete. Results are being analysed, Partnership Working Group meeting regularly;
- Peer Support Pilot Project: staff engagement, benchmarking and project planning ongoing, peer support volunteer training (around 30 volunteers) taking place during end March / early April;
- Engagements for learning and information sharing with Partners (eg PSNI) ongoing;
- Wider NIAS stress awareness and resilience workshops planned for roll-out during April and May across all areas;
- Attendance Management Policy and Procedure agreed and training ongoing;
- "Attendance Management" Management Toolkit under development;
- East Division Attendance Management pilot;
- Ongoing additional intervention by Inspire in relation to mental health issues within the EAC environment;;
- Access of all staff to a fast-track Physiotherapy service;
- Promotion of flu vaccine uptake and introduction of peer vaccinations to increase accessibility of the vaccination to support delivery of NIAS target of 40% of frontline staff. Current uptake of frontline staff via peer support vaccinations is 20.1%, with an overall total of 32.7%. This compares to an 11% uptake reported in 2016/17.

COMPARISON OF NIAS % CUMULATIVE / MONTHLY ABSENCE: The following chart shows the comparison of cumulative % hours lost due to sickness absence from April 2017 - February 2018, compared to monthly % hours lost during the same period during 2017/18.



Section 1: Human Resources & Corporate Services

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



"OTHER" CATEGORIES / REASONS WITH MORE THAN 1% ABSENCES INCLUDE:

Post Surgical Debility	6.05%
Asthma, Chest, Resp.	3.94%
Influenza	3.04%
Hospital Investigations	1.83%
Heart/cardiac/circulatory	1.79%
Tumours and Cancers	1.52%
ENT	1.29%
Headache/Migraine	1.23%

OTHER CATEGORIES WITH LESS THAN 1% ABSENCES INCLUDE:-

Chronic Fatigue Syndrome; Dental/Oral Problems; Endocrine/Glandular Problems; Eye Problems; Genitourinary & Gynaecological Conditions; Infectious Diseases; Pregnancy Related; Skin Conditions; 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)

Disciplinary Cases:

Position as at 28 February 2018	TRUST TOTAL	Patient Care	Wilful Damage	Criminal Conduct	Fraud	Failure to comply with Trust Policy / Procedure
Total Ongoing Cases	**12**	**3**	**0**	**1**	**0**	**8**
HCPC Referrals*	4	2	0	2	0	0
Suspensions	3	2	0	0	0	1
New Cases**	**3**	**1**	**0**	**1**	**0**	**1**

*It should be noted that HCPC Referrals include matters which have been referred to HCPC, but are no longer being investigated by the Trust.

** New Cases (opened since 1 January 2018).

Grievance Cases:

Position as at 28 February 2018	TRUST TOTAL	Transfer	Application of T&C	Recruitment	Job Evaluation	Equal Opps	Employee Relations Processes	Promotion	Pay
Total Ongoing Cases	**17**	**2**	**8**	**4**	**0**	**0**	**3**	**0**	**0**
Informal Stage	0	0	0	0	0	0	0	0	0
Formal Stage 1	12	1	4	4	0	0	3	0	0
Formal Stage 2 (Appeal)	5	1	4	0	0	0	0	0	0
New Cases	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**

Working Well Together / Harassment Cases:

Position as at 28 February 2018	TRUST TOTAL
Total Ongoing Cases	**6**
Informal Resolution / withdrawn	2
Formal Stage 1	4
Formal Stage 2 (Appeal)	0
New Cases	**0**

Employee Relations/Industrial Relations:

Trade Union Side continue to work in partnership with NIAS management to facilitate the ongoing Job Evaluation processes, including the evaluation of both new and existing posts. The Trust's established industrial relations mechanisms continue to function, with meetings of JCNC and its Sub Groups taking place on a regular basis.

Flu Vaccination Programme 2017/18

The implementation of a Peer Vaccination model during the 2017/18 Flu Vaccine period has been very successful, with a large increase in uptake among frontline staff in particular.

As of 3 March 2018, **214** staff were vaccinated through the NIAS Peer Vaccination programme, which represents **20.1%** of frontline staff with patient contact. In addition to this, **134** staff were vaccinated by Occupational Health as at 3 March 2018, which is equivalent to **12.7%** of frontline staff with patient contact. In total, **348** frontline staff with patient contact **(32.7%)** received the flu vaccine, compared to an 11% uptake reported in 2016/17.

In addition to this, 54 non-frontline staff had received the flu vaccine as at 18 December 2017, although this figure was not reported to the PHA.

Case File Closures:

The table shows the number of Employee Relations cases (i.e. Grievance, Disciplinary and Harassment/Working Well Together) which have been closed within a rolling 12 month period, by month.

Position as at 28 February 2018	March 2017	April 2017	May 2017	June 2017	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018
Grievance	0	0	2	2	0	1	3	5	1	0	0	1
Disciplinary	0	0	1	2	2	0	1	1	0	0	0	0
Harassment	0	0	0	0	0	0	0	1	0	0	0	1
Total	**0**	**0**	**3**	**4**	**2**	**1**	**4**	**7**	**1**	**0**	**0**	**2**

Section 1: Human Resources & Corporate Services

HRCS KPI: Compliments, Complaints & Claims

The following tables show the number of complaints / compliments received from April 2017 and the associated timescales for processing of same.

Total complaints received to date:	129	For same period last year:	143	% Difference	9.8%

HANDLING TIMES OF COMPLAINTS FOR 2017-18

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	%	2016-17	
Complaints Received	12	13	7	11	13	15	14	12	7	14	11		**129**		**161**	*100%*
Total A&E & PCS Activity	***27912***	***31167***	***30010***	***29171***	***29767***	***29267***	***29980***	***29493***	***29398***	***30540***	***27,292***		***323997***			
% Complaints/Activity	***0.04%***	***0.04%***	***0.02%***	***0.04%***	***0.04%***	***0.05%***	***0.05%***	***0.04%***	***0.02%***	***0.05%***	***0.04%***		***0.04%***			
Acknowledged within 2 working days	12	13	7	11	13	15	14	12	7	14	11		**129**	*100%*	**160**	*99.4%*
Acknowledged after 2 working days	0	0	0	0	0	0	0	0	0	0	0		**0**	*0%*	**1**	*0.6%*
Response within 20 working days	2	5	4	3	4	4	3	3	0	1	0		**29**	*22%*	**44**	*27.3%*
Response after 20 working days	6	5	2	4	0	1	0	2	0	5	3		**28**	*22%*	**112**	*69.6%*
Complaints Investigations ongoing	4	3	1	4	9	10	11	7	7	8	8		**72**	*56%*	**5**	*3.1%*
Cases referred to NI Ombudsman (cases ongoing)	0	0	1	0	0	0	1	1	0	0	0		**3**		2	

NATURE OF COMPLAINTS RECEIVED 2017-18

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017-18	%	2016-17	
Staff Attitude	10	7	3	6	5	4	6	2	2	3	2		50	*39%*	**73**	*45%*
Ambulance Late/No Arrival	1	3	3	3	5	7	5	8	2	5	1		43	*33%*	**65**	*40%*
Quality of Treatment & Care	0	1	0	0	1	1	2	1	3	6	7		22	*17%*	**12**	*7%*
Suitability of Equip/Vehicle	0	0	1	0	1	0	0	0	0	0	0		2	*2%*	**5**	*3%*
Other	1	2	0	2	1	3	1	1	0	0	1		12	*9%*	**6**	*4%*
Patient Property	0	0	0	0	0	0	0	0	0	0	0		0	*0%*	**0**	*0%*
TOTAL	**12**	**13**	**7**	**11**	**13**	**15**	**14**	**12**	**7**	**14**	**11**	**0**	**129**		**161**	

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

HRCS KPI: **Supporting Trust Priorities**

SERVICE AREA OF COMPLAINTS 2017-18																
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**	***%***	**2016-17**	
Accident & Emergency	7	7	2	6	8	6	10	6	7	10	10		79	*61%*	90	*56%*
Patient Care Service	2	1	1	2	1	3	2	1	0	1	0		14	*11%*	10	*6%*
Control & Communications	2	4	4	2	4	5	2	5	0	3	1		32	*25%*	57	*35%*
Other	1	1	0	1	0	1	0	0	0	0	0		4	*3%*	4	*2%*
Voluntary Car Service	0	0	0	0	0	0	0	0	0	0	0		0	*0%*	0	*0%*
TOTAL	**12**	**13**	**7**	**11**	**13**	**15**	**14**	**12**	**7**	**14**	**11**	**0**	**129**	*100%*	**161**	*100%*

COMPLIMENTS RECEIVED 2017-18															
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2017-18**		**2016-17**
RECEIVED	16	36	15	18	23	13	30	30	28	37	25		**271**		**207**
SERVICE AREA OF COMPLIMENTS RECEIVED															
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2016-17**	***%***	**2016-17**	
Accident & Emergency	13	35	14	15	22	11	27	30	28	34	20		**249**	*91.9%*	**190**	*92%*
Control	1	1	1	1	1	1	1	0	0	2	3		**12**	*4.4%*	**3**	*1%*
Patient Care Service	0	0	0	1	0	1	2	0	0	1	1		**6**	*2.2%*	**7**	*3%*
Voluntary Car Service	0	0	0	0	0	0	0	0	0	0	0		**0**	*0.0%*	**0**	*0%*
Other	2	0	0	1	0	0	0	0	0	0	1		**4**	*1.5%*	**7**	*3%*
TOTAL	**16**	**36**	**15**	**18**	**23**	**13**	**30**	**30**	**28**	**37**	**25**	**0**	**271**		**207**	

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Trust Priorities

CLOSED COMPLAINTS: JANUARY / FEBRUARY 2018

Type	Ref	Opened	Closed	Subject	Description	Outcome	Action taken (Investigation)
FORMAL	COMP/1337	27/11/2017	20/02/2018	Transport, Late or Non-arrival / Journey Time	Complaint regarding the poor response time to a 999 call, in which the patient died at scene.	Complaint upheld and letter of apology and explanation issued. At the time of the 999 call, despite the call being triaged as 'RED' there were no emergency ambulances available in this region as they were engaged on other 999 calls.	No further actions identified.
FORMAL	COMP/1341	14/12/2017	26/02/2018	Quality of Treatment & Care	Crew did not support patient's head whilst she was being transferred to ambulance in a carry chair. Patient also sustained nasty wound to leg that the family suspect occurred whilst the patient was in the ambulance.	The investigating officer has spoken to the paramedic and can find no evidence to substantiate the allegations that have been made around the patient's leg injury. Paramedic refutes allegation that the patient's head was unsupported.	Letter of explanation and invitation to meet with NIAS Officer, issued to the family. No further actions identified at present.
FORMAL	COMP/1302	19/09/2017	03/01/2018	Privacy / Dignity	Complainant's husband was involved in serious RTC and believes that a NIAS staff member unlawfully disclosed personal information regarding the collision/patient to another family member who had no right to this information. Potential DPA breach.	Complaint investigation could not find any evidence to uphold the allegation made. NIAS staff member in question has assured the investigation that she did not make breach any patient confidential information.	No further action identified. Letter of explanation issued to the complainant.
FORMAL	COMP/1353	15/01/2018	18/01/2018	Staff Attitude / Behaviour	Complaint around the poor attitude of a paramedic. Complainant states that she was 'treated like dirt'.	Complaint upheld and apology issued. Station Officer contacted complainant to discuss her concerns. The NIAS Station Officer suggested that he counsels the crew member around his poor communication and body language. The complainant was happy with this and is satisfied the complaint has been appropriately addressed and resolved.	No further action identified.
FORMAL	COMP/1277	17/07/2017	09/02/2018	Staff Attitude / Behaviour	Complainant called an ambulance for her friend. Control called back after an hour and a half, operator was "very ignorant and passive aggressive" and said they cannot send out an ambulance for her friend without her friend's permission.	The investigation has shown that the EAC call taker handled the call in a professional and appropriate manner. Letter of explanation issued.	No further actions necessary.

Type	Ref	Opened	Closed	Subject	Description	Outcome	Action taken (Investigation)
FORMAL	COMP/1305	25/09/2017	26/01/2018	Staff Attitude / Behaviour	Complainant is unhappy as the paramedic questioned the decisions made by a doctor.	Complaint upheld. Due to the seriousness of the allegations made, the local Station Officer has decided to move this complaint for investigation under the Trust's disciplinary process.	Letter of apology and explanation issued. The alleged behaviour and potential consequences to be discussed with the NIAS Medical Director and/or NIAS Clinical Lead as this is a Doctor/Paramedic
FORMAL	COMP/1339	04/12/2017	26/02/2018	Transport, Late or Non-arrival / Journey Time	Elderly lady had to wait on the floor for over 4 hours for an ambulance after falling and fracturing her hip.	Complaint upheld. Apology and explanation issued. The high incoming call volume was much greater than the supply of resources within the NIAS Eastern Area for the duration of this shift. The shortfall of two accident and emergency crews and delays at the receiving hospitals only compounded this problem.	No further actions identified.
FORMAL	COMP/1343	20/12/2017	27/02/2018	Quality of Treatment & Care	When the ambulance crew arrived, the complainant states they appeared to be 'very laid back'. She states they began questioning her on how they would transfer her onto the stretcher. The complainant feels that the crew did not act with enough urgency and feels the crew 'dithered' at the scene.	Complaint partially upheld. Crew were not appropriately trained to use the patient's hoist. Investigating Officer can find no evidence to uphold the allegation around not acting with any urgency.	Letter of apology and explanation on the use of hoists issued to the complainant.
FORMAL	COMP/1273	10/07/2017	18/01/2018	Transport, Late or Non-arrival / Journey Time	Complaint regarding delay of an ambulance to a cardiac arrest patient who sadly passed away. It took the first NIAS resource (NIAS RRV) 29 minutes to arrive on scene with the patient. Complainant would like an explanation/investigation around the call.	Complaint upheld. NIAS Area Manager and Chief Executive met with the complainant to discuss the incident. Issues around ambulance cover and capacity and cover were discussed and considered.	Letter of apology and explanation issued in relation to the delay in response.
FORMAL	COMP/1357	19/01/2018	26/02/2018	Quality of Treatment & Care	Complainant has raised concerns around the route taken by a non-emergency ambulance whilst transferring his mother from hospital. He further states she was cold during the journey and that the crew 'jolted' her head when getting out of the ambulance.	Complaint upheld and apology issued. The local Station Officer contacted the complainant and resolved the matter locally. The complainant is satisfied with the response and is happy the complaint has been dealt with.	No further action taken.
FORMAL	COMP/1335	22/11/2017	20/02/2018	Transport, Late or Non-arrival / Journey Time	Complainant unhappy with the waiting time for an ambulance for her mother. Feels there was a lack of support from the call taker about what she was stating and the clinical risk her mother was in.	Complaint upheld, letter of apology and explanation issued. The investigation has identified that there were no available ambulances at the time of the call due to the high demand at the time of the call.	No further actions identified.

Type	Ref	Opened	Closed	Subject	Description	Outcome	Action taken (Investigation)
FORMAL	COMP/1319	23/10/2017	16/02/2018	Staff Attitude / Behaviour	Two female crew members could not carry patient downstairs. Comments allegedly made about size of patient. Complainant wants to know why another crew were not called when needed.	Complaint upheld. Letter of apology issued. The crew accept that the comments made were not entirely appropriate. The crew have stated that they did not call for a 2nd crew as the family offered assistance to lift the patient.	Crew to complete a call reflection with their Clinical Support Officer.
FORMAL	COMP/1342	14/12/2017	26/02/2018	Staff Attitude / Behaviour	The Trust has received a complaint from NHSCT regarding staff attitude and behaviour. The Staff Nursing team have reported that they were robustly challenged on the need for the patients to be transferred to an acute setting even though they advised the NIAS crew that this was the outcome of GP medical advice.	Complaint upheld. Due to the seriousness of the allegations made, the local Station Officer has decided to move this complaint for investigation under the Trust's disciplinary process.	No further action required under Complaints Procedure.
FORMAL	COMP/1340	06/12/2017	08/02/2018	Staff Attitude / Behaviour	NIAS attendant was allegedly rude, insulting and unprofessional to a patient. Questioned his need for ambulance and requested that he walked to ambulance despite patient being too weak.	Complaint partially upheld. Apology and explanation letter issued. The paramedic accepts that his questioning of the patient/family may have been misinterpreted and has reflected on his management of the call. Paramedic states patient agreed to walk to ambulance.	Paramedic is to carry out call reflection. Reminded in writing by line manager around levels of professionalism.
FORMAL	COMP/1360	31/01/2018	20/02/2018	Transport, Late or Non-arrival / Journey Time	Complaint placed by HCP on behalf of patient. An ambulance arrived late to bring patient to appointment, transport arrived 20 minutes late. Crew were allegedly abrupt to patient and patient also passed comments that the crew drove too fast.	Patient withheld consent and wishes to withdraw complaint proceedings. Complaint closed.	No further action required.
FORMAL	COMP/1257	10/05/2017	16/01/2018	Staff Attitude / Behaviour	Patient took fit whilst on bus. When NIAS crew arrived, it has been stated that their attitude was very poor. They abruptly told the patient's partner to 'stay where she was' and questioned the patient repeatedly even though he had lost his speech as result of the fit episode.	Complaint partially upheld. The crew refute the allegations made. However, the crew accept that 'learning difficulties' should not have been stated on the patient's PRF.	Letter of apology and explanation issued to the complainant.

Type	Ref	Opened	Closed	Subject	Description	Outcome	Action taken (Investigation)
FORMAL	COMP/1320	25/10/2017	26/02/2018	Transport, Late or Non-arrival / Journey Time	Complainant called for an ambulance for her mother. Made back and forth phone calls with EAC for about 40 mins and was then told to bring her mother to A&E herself.	The investigation has demonstrated that a relative of the patient agreed a course of action for the patient to make their way to A&E. At no time was an ambulance refused. Letter issued explaining these events.	No further actions required.
FORMAL	COMP/1361	01/02/2018	28/02/2018	Staff Attitude / Behaviour	Patient unhappy with attitude and behaviour of the paramedic who attended to her. Crew allegedly made inappropriate comments.	Despite reminder letters, we have not received consent to progress the investigation of the complaint. Complaint closed and complainant advised.	No further actions required.
FORMAL	COMP/1329	08/11/2017	25/01/2018	Transport, Late or Non-arrival / Journey Time	Husband of patient had been waiting for a non-emergency ambulance to transport his wife back to her care home following a stay in hospital since 00.30hrs - It was 11.13am when complainant rang and ambulance had still not arrived.	Complaint upheld. The investigation has shown that resources were limited at the time of the call and first available ambulance was sent. Meeting held with the complainant.	Apology and full explanation given. A meeting was held with the complainant. The Assistant Director of Command and Control, along with the Non-Emergency Control Manager discussed the complaint with complainant and the reasons for the long delay in response. NIAS were able to demonstrate to the complainant, the high demand on the Ambulance Service and what NIAS are doing to address this increase. A productive and helpful meeting took place.
FORMAL	COMP/1355	19/01/2018	09/02/2018	Staff Attitude / Behaviour	Complainant states that paramedic's attitude 'stank' and his caring nature was 'somewhat lacking'.	Complaint upheld. Paramedic accepts that his communication could have been better on this occasion and has been reminded around same by the Station Officer.	Letter of apology and explanation issued.
FORMAL	COMP/1314	09/10/2017	16/01/2018	Staff Attitude / Behaviour	Patient states that paramedic had very poor attitude. States that he was intimidating, condescending and made patient feel as though she was telling lies about her condition. Also kept getting patient's name wrong and was noted to be laughing with colleagues on arrival at hospital. Complainant was very distressed around how she was treated.	Complaint partially upheld. Letter of apology and explanation issued for the incident.	Station Officer to issue a letter to the Paramedic as a reminder to act in a professional manner at all times.

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

HRCS KPI: **Supporting Trust Priorities**

Claims 2017-18

The tables below demonstrate the types of claims received / settled.

	C/O	A	M	J	J	A	S	O	N	D	J	F	M	Total
Employers Liability	**33**													
Claims Received		1	1	1	2	1	3	0	4	0	1	0		**14**
Claims Settled		0	0	1	2	0	0	0	0	0	0	0		**3**
Cases Ongoing														**33**
Public Liability	**4**													
Claims Received		0	0	0	0	0	0	1	2	0	0	0		**3**
Claims Settled		0	0	0	0	0	0	1	0	0	0	0		**1**
Cases Ongoing														**4**
Clinical Negligence	**10**													
Claims Received		0	1	0	0	0	0	0	0	0	0	0		**1**
Claims Settled		0	0	0	0	0	0	0	0	0	0	0		**0**
Cases Ongoing														**10**

Lessons Learned:

No 'lessons learned' reports were submitted during the January / February 2018 period.

Commentary:

The Trust aims to ensure that all claims:

- 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.
- Where litigation has been instigated that, without good reason, indefensible claims are not defended or settlement is delayed.
- 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.

Categories of Claims Received 2017-18

Categories	*Slips / Trips / Falls*	*Quality of Treatment / Delay*	*Needle Stick Injury*	*Equip / Vehicle Faults*	*RTA's*	*Other*
Employers Liability	*6*				*4*	*4*
Public Liability	*1*			*1*	*1*	
Clinical Negligence		*1*				

Claims Summary

Employers Liability Claim: (Received during January 2018)

1. *Staff member sustained injury to wrist, arm and back as a result of incident which occurred in the back of a moving NIAS ambulance.*

Section 1:	Human Resources & Corporate Services
HRCS KPI:	Supporting Trust Priorities

Concerns raised under Public Interest Disclosure (NI) 1998 (WHISTLE BLOWING) 2017-18

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017-18
0	0	0	0	0	0	1	0	0	0	0		**1**

Section 2: Education, Learning & Development

HRCS KPI: Support Trust Priorities; Modernisation & Reform; Shaping & Developing Future Workforce; Education, Learning & Development

Regional Ambulance Training Centre (RATC) Education, Learning and Development

The RATC following the successful recent external quality assurance visit, look forward to hosting a formal external quality assurance visit for the Associate Ambulance Practitioner Programme. Building on our recent satisfactory report form the external assessor in regard to our driving programme.

ELD Highlight report:

- The annual Post Qualification 'Continuing Education' programme for Clinical staff is underway (a working title which supersedes the traditional 'Post Proficiency' or 'PP' terminology). The new title reflects the novel way in which the course will be formatted. Even though the course will always be a means to assist and ensure that our clinicians remain contemporary in their practice, it has been recognised that historically the assessment element may have hampered the learning experience for many. For example, it is intended that the annual re-validation of Intermediate and Advanced Life Support will be incorporated into the training on new defibrillators, in a scenario-based manner and thus remove a perceived barrier to learning which should in-turn enhance the retention of the contemporary thinking. The CE/PP will be delivered in separate training days over quarters 3 and 4.
- The second cohort of student EMTs (*Associate Ambulance Practitioner 2)* have emerged into practice placement and are actively bridging the theory-practice gap with the support of the Divisional Training Teams.
- RATC's interim External Quality Assurance visit from FutureQuals has taken place. The visit was delayed on request by FutureQuals and negates two visits within a short space of time. The visit pertains to the first AAP cohort and is a condition of running a regulated programme of education and training. RATC built upon the very positive initial visit report and cemented the AAP programme as fit-for-purpose whatever the scrutiny. It was successful, with the visiting EQA citing that the programme documentation was of a 'high to very high standard and internal
- Further days of the CE/PP will incorporate various skills and information which will include enhanced Respiratory Assessment; with an additional focus on upskilling our EMTs to provide additional interventions and drug therapies. RATC are very keen to support our EMT colleagues through this potential transition and the format of the CE will fully utilise the existing paramedic/EMT relationship to help impart and support the skills upgrade in a measured way.
- Cohort 3 of the Patient Assessment and Clinical Reasoning module (PACR) has completed, with Paramedic Station Supervisors and Station Officers availing of the opportunity this time. The clinical leadership role of this group is vital to develop and will further facilitate the mainstreaming of the Trust's Quality Improvement vision.
- A recruitment process has commenced with the aim of attracting qualified Paramedics to join the NIAS. This process is ongoing.
- The RATC continues to deliver education and training despite a very challenging environment. This has included a backdrop of some staff vacancies in the team, a number of which are temporary due to long term secondments to other departments, such as HEMS, as well as staff who have moved to new permanent posts or left.

  Another draw on the RATC team has been the need to allow 3 of the CTOs to commence work on a course development group for the Foundation Degree in Paramedic Science, which is being developed in partnership with the Ulster University. To help address these situations, recruitment processes have been ongoing and on 1st November 6 staff took up permanent posts as Clinical Support Officers. A trawl for permanent and temporary Clinical Training Officers has been completed with offers being made for permanent and temporary posts.
- On a broader ELD front, work is progressing to action the priorities,

quality assurance robust". Praise was also given to individual members of the RATC team for the work. Subsequently, RATC has achieved 'Direct Claim Status' for certification; this reflects well on the quality and quantity of work that the clinical/driving tutors have put into the AAP and Level 2 / Level 3 driving awards. • RATC and the transformation team continue to collaborate with the HSC Clinical Education Centre and have secured a programme of courses open to both EMTs and paramedics alike. Following on from the universally welcomed 'Advanced ECG Interpretation' course; RATC and TMPT are now in a position to offer a diary of similar educational courses which will extend into Feb 2019 and beyond. The courses will include such topics as: Delirium; Safeguarding Adults and Children; Heart and Lung Sounds; Record Keeping; Epilepsy Awareness; Bereavement, Grief and Loss; and Falls prevention.	which arose from our last BSO internal audit. A HRPTS Course Catalogue is now set up and available, roles have been allocated to the various training administrators and training will be rolled out in the coming weeks. This will enable the move to capturing all NIAS training records on HRPTS. There have been some competing priorities within HR that have delayed the training although this is still planned to take place as soon as possible. • Mandatory training and associated eLearning programmes have been developed to increase accessibility for frontline staff; staff will have access to iPad devices at their next CE/PP days to allow remote access to this mandatory training element. The eLearning site has been updated and all staff with HRPTS accounts have been sent their new logins. There has been a good uptake with the programmes so far and compliance reports will be shared with SEMT in April. • We have purchased Mi-Fi devices, which will allow frontline staff to access Mandatory eLearning via an iPad device when not in a Wi-Fi enabled area. The first training session for this will commence on Tuesday 27th March. • The Station Supervisor Development Programme has commenced with two Cohorts being facilitated in Belfast and Ballymena. In total there are 17 Supervisors on the course which is accredited to ILM 3 and will award them on successful completion 5 QCF points.

Section 3:	Equality & Human Rights/Personal and Public Involvement/ Patient Experience/Media and Communication
HRCS KPI:	Supporting Trust Priorities; Transformation and Modernisation; Equality and Human Rights; Partnership & Employee Engagement

Section 75

- Section 75 implementation requirements are set out in the Trust's Equality Scheme and delivery is monitored by the Trust's Equality and PPI Steering Group.
- The Trust works mainstream section 75 considerations into policy development through engagement and screening processes.
- NIAS contributes to the HSC regional Equality and Human Rights agenda through participation in the DHSSPS Equality and Human Rights Steering Group.
- Contribute to regional work to develop revised Equality Scheme and Action Plan 2018-23. Collaborative working with other HSC Trusts to review Equality Schemes and engage with the Equality Commission for Northern Ireland in relation to delivery of statutory duties within Health and Social Care.

Key Work Streams underway include

- Re-establishment of Trust Equality Forum to ensure engagement with Trade Union representatives and staff in relation to equality issues.
- Establishment of a NIAS Women's Forum and LGBT Forum.
- Lead on achievement of Rainbow Project's Diversity Champion status across HSC Trusts.
- Development and introduction of a Good Relations Strategy for NIAS.
- Development of an Equality Toolkit and Training Module.
- Contribution to the development of a regional Discovering Diversity e-learning module.

Human Rights

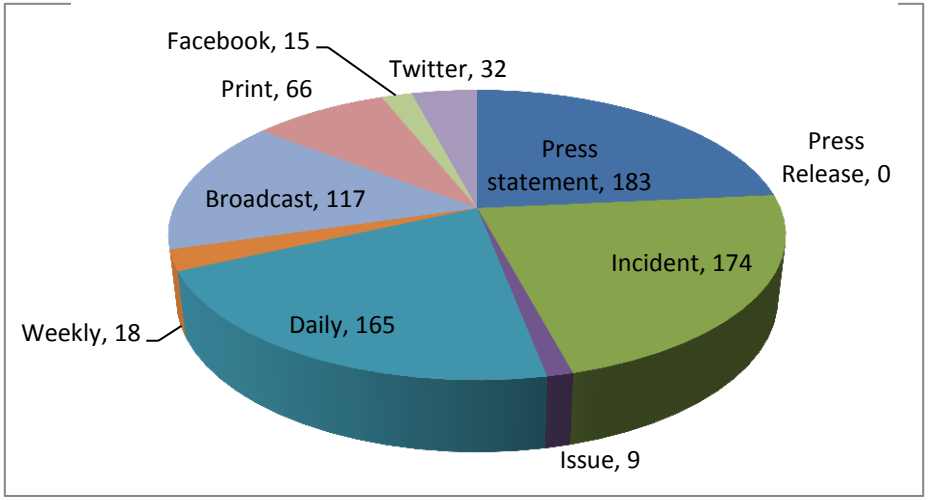
- Human Rights consideration to Trust policy is incorporated within Equality and Human Rights Screening documentation.
- The Trust has been engaging with the Northern Ireland Human Rights Commission in respect of Trust policy plans and the potential human rights considerations of these.
- Work is underway to develop an Equality and Human Rights toolkit for policy leads to mainstream statutory obligations into the policy development, consultation and implementation processes.

Supporting Trust policy

- The Equality, PPI and Patient Experience team support the Trust in respect of statutory obligations associated with strategic policy development. This includes Equality, Human Rights, PPI, and Patient Experience considerations.
- Key in this regard has been the mainstreaming of statutory requirements within the Trust's Transformation and Modernisation agenda. This has involved engagement with Section 75 representative groups impacted by proposals, including AGENI, Diabetes UK and Epilepsy Action.

Section 3:	Equality & Human Rights/Personal and Public Involvement/ Patient Experience/Media and Communication
HRCS KPI:	Supporting Trust Priorities; Transformation and Modernisation; Equality and Human Rights; Partnership & Employee Engagement

Press and Media Activity. Jan – Feb 2018



Key Themes in Press Coverage

- During Jan and Feb 2018, NIAS issued 183 Press Statements in response to enquiries from the media.
- 4 media interviews were conducted during the period on issues including seasonal pressures, fatal Toome incident and response delays.
- The number of media outlets reached in this period totalled 183.
- Press statements tend to be issued in response to particular incidents which, in this period, SAI's relating to included fatal Toome incident and death of elderly patient in Carryduff assaults on crews and turnaround times.
- Our Social Media platforms continue to support mainstream media activity

Community Education

Number of Community Education Visits	69

- The Trust has continued to attend schools and community groups.
- Key messages have included the impact of hoax calls, innappropriate use of the service and violence against staff.
- Work is ongoing to further develop the public awareness campaign in respect of the changing face of the service linked to the Trust's modernisation agenda.

General Media and Communication Work Streams

- Ongoing engagement with regional and national communications groups has continued. Nationally this has involved work in line with priorities agreed by the Association of Ambulance Chief Executives (AACE) and regionally is linked to departmental objectives. The Trust's Media and Communications Manager continues to participate in the National Ambulance Communications Group (sub-group of AACE group) and its work streams.
- The Trust's Equality and Patient Experience and Communication functions support delivery of the Transformation and Modernisation agenda through leadership of a programme of Engagement and Communications. This included systems of communication and engagement with staff, service users, the public and other key stakeholders to inform development of the work streams within this framework.

Section 4: Transformation and Improvement Collaborative

HRCS KPI: Modernisation and Reform

The Transformation Improvement Collaborative continues to meet and monitor the range of Modernisation and Improvement Projects ongoing during 17/18.

Clinical Developments

There are a wide range of clinical developments underway and the introduction of new pieces of medical equipment in this project led by the Clinical Service Improvement Lead. These include the following:

- Continued roll out of NIAS Clinical App (Android & iOS)
- Trail of Penthrox
- Trail of new thermometers
- Point of care lactate testing
- Development of post resuscitation care standard operating procedure

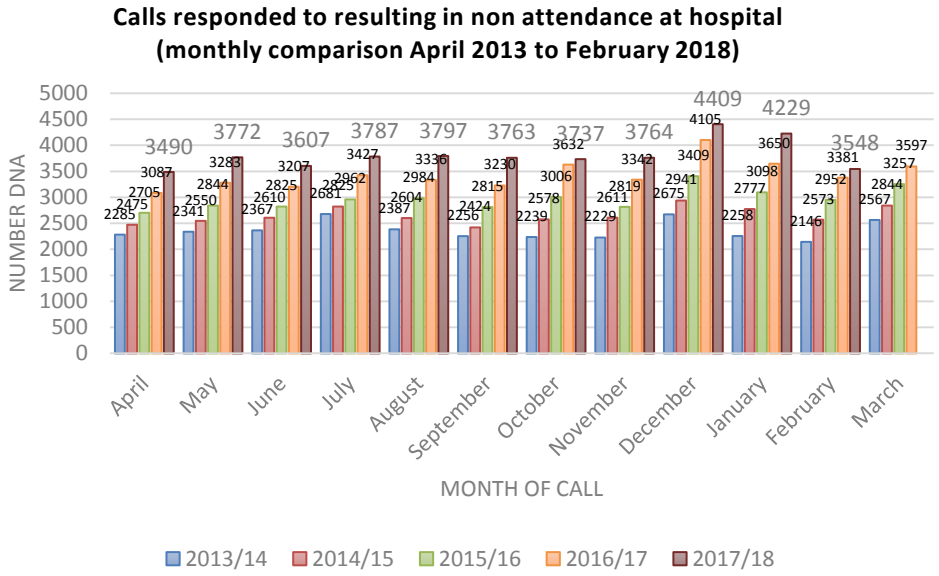
To support these developments, a range of short courses have been offered to staff. These courses were developed in conjunction with the Clinical Education Centre.

Frequent Callers Project Update

The Top 10 callers to NIAS accounted for approximately 1,000 calls per year. The Frequent Caller Project aims to reduce the demand of these Frequent or Vulnerable service users by working on a multi-disciplinary basis with other statutory agencies and the community and voluntary sector. Since the project commenced of the Top 10 Callers, six have been successfully managed and are no longer dialling 999. The other four people are being actively managed with a reduction in their call volume.

The project continues to grow and we are now aware of 98 Frequent or Vulnerable service users. Managing the call volume of these callers not only assists the patient but improves staff morale and releases resources to attend genuine emergencies while helping ensure the needs of these individuals are met in a more appropriate manner.

NIAS has also signed up to participate in the regional roll out of Support Hubs, a project headed up by Policing and Community Safety Partnerships and DOJ, where the most vulnerable members of the community who often have complex care needs and rely heavily on the 999 system are actively managed by a local multidisciplinary team of experts to improve their quality of life and reduce reliance on the emergency services.



Summary of Referral to Alternative Destinations (other than EDs)

	Cumulative Position	*Monthly Position*
	Alternative Destinations during first eight months of 17/18 (i.e. attended hospital, non ED).	**Alternative Destinations FEBRUARY 2018**
BCH Direct (Paramedic Referrals only)	564	35
Cath Labs (Accepted by Cath Lab)	371	25
Type 3 Hospitals & Minor Injury Units	185	12
Antrim Area Medical Assessment Unit (Paramedic Referrals only)	243	28
Alcohol Recovery Centre	73	0
Total	**1,436**	**100**

April 2017 – February 2018 (Cumulative)		*February 2018*
Diabetes Treat and Leave / Refer	633	74
Falls Referral	1,855	172
Southern Trust Acute Care at Home Team	49	0
SET Enhanced Care at Home Team	20	2
Belfast Trust Acute Care at Home Team	85	2
Palliative Care	34	3
Epilepsy	198	11
Respiratory	61	4
Community Nursing	109	5
GP Referral	2,266	204
Total	**5,310**	**477**

Summary of ACP data (April – February 2018)

The data shows that the use Appropriate Care Pathways have been embedded and usage continues to grow but that there is still work to improve uptake on the use of the Pathways. This is reflected in the increase of Non-Conveyance to ED from 22.8% (n=37,680) to the same period last year (17/18) to 24.6% (n=41,903). These figures should be considered in the context that overall call volume increased during the same period by 3%.

The Paramedic Clinical Support Desk (CSD) went operational on 2 October 2017. Call audits of the CSD calls have also been undertaken and the calls audited are in compliance with the standards of the triage system used – Manchester Triage System.

OVERVEW

- 5627 calls processed through CSD
- Average 38 calls per day handled by CSD
- 3554* A&E Ambulance hours saved (*Average call cycle c.2hrs)

Total 999 Calls Passed to CSD	**5634**	
CSD Outcome	n	%
A&E Ambulance Required	**2,957**	52%
No A&E Ambulance Required	**2,677**	48%
Breakdown of "No A&E Ambulance Required" outcomes:		
Self Care (No Resource Required)	***1,531***	*28%*
Calls assessed as ICV Suitable	***1,146***	*20%*

A recruitment exercise has commenced for a Clinical Hub Manager and an additional five CSD Paramedics to increase the governance and capacity of the CSD.

TB/12/04/2018/05

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Interim Medical Director
12 April 2018
(January-February 2018)

Medical Directorate Performance Report for Trust Board

Emergency Planning & Business Continuity	
	Please refer to attached Emergency Planning Reports for January-February 2018. The Trust's Emergency Planning Team continues to participate in major incident planning and multi-agency exercises. Following approval of the MTFA business case, capital funding has been agreed to cover purchase of vehicles and equipment necessary to progress this project. There is also agreement on the ongoing funding stream required for recruitment and training of staff in order to provide the 24/7 MTFA response at the level specified by the Department of Health. This cover will not be to the same extent as that provided in other areas of the UK as this model was rejected by the Department following submission of a business case designed to meet the original specification of having an identical response model. In line with the NIAS Business Continuity Strategy and Policy, and a Priority 1 finding from Internal Audit, the Business Continuity lead is continuing a series of meetings with representatives from all Departments of NIAS in order to review and develop individual Business Continuity Plans, and exercising of these will be undertaken in due course. The EP&BC lead has been progressing continuity plans with NIAS Directorates, although those from the Operations Directorate remain outstanding. Current on-call arrangements were subject to review by the NIAS Workforce Planning Group and a series of recommendations agreed. The implementation of these recommendations was initially deferred due to a number of significant events such as G8, World Police & Fire Games etc. This was further impacted by the outcome and recommendations of the review of industrial action and an independent review to inform the development of a policy on the use of marked vehicles in 2017/18.
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. A series of Directorate-specific Risk Register workshops, facilitated by the Risk Manager, took place earlier in the year. Following recommendations from Internal Audit, the Corporate Risk Register is now included with Trust Board papers and appears as an Appendix to this report.

	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. In accordance with the 2017/18 annual audit plan, BSO Internal Audit carried out an audit of Risk Management within Northern Ireland Ambulance Service (NIAS) during June 2017. The final report has been received and no Priority 1 issues identified. Further review of risk management is anticipated in Q4 2017/18 as part of the ongoing assurance process.
Incident Reporting Procedures	Incident reporting has now moved to a primarily electronic platform with the widespread implementation of DatixWeb. This also allows for closer integration with other Trusts for incidents that involve more than one agency. The work is supported by a full-time Datix Administrator working within the Medical Directorate. The O'Hara Report into hyponatraemia-related deaths in Northern Ireland has produced a large number of recommendations, many of which relate to incident reporting and investigation. These will have many implications for Trusts and the Department is leading multiple workstreams related to this. NIAS has already submitted a response to the Department looking at recommendations 10 to 30 as detailed in the report. NIAS Directors are all scheduled to undergo update training in SAI process on 16 April. NIAS continues to participate in the learning outcomes review from SAIs regionally with a composite report of Untoward and Serious Adverse Incidents being reported at each meeting of the Assurance Committee.
Outcomes from Reports, Alerts, etc.	Regular reports on complaints, compliments, adverse incidents including SAIs involving NIAS, Coroner's reports, medication and device alerts continue to be provided to the Assurance Committee as standing agenda items. NIAS also continues to review relevant NICE guidelines and regional learning and quality letters and reports for relevance to an ambulance service.

Clinical Care	
Infection Prevention & Control	The work of the Infection Prevention and Control Group is presently a standing item on the Assurance Committee Agenda where it has detailed the extensive work relating to the improvement notices served by the RQIA following inspections at Belfast and Broadway Stations. A more recent round of inspections raised concerns regarding Craigavon Station prompting a wider review of a total of 21 stations across Northern Ireland. Both Belfast and the Western Divisions had satisfactory outcomes with some examples of particularly good practice being recognised. The South Eastern Division had a mixed report but significant deficiencies in both the Northern and Southern Division where practice and governance arrangements have not yet been embedded. RQIA has recommended the introduction of a special measure which specifically calls for the provision of an IPC Governance Lead by the Department of Health to assist NIAS to embed governance arrangements regionally. This topic has now attracted significant media attention. The review of the IPC Policy & Procedures has been completed with the final document being presented for approval at this meeting of Trust Board.
Regional Community Resuscitation Strategy	All of the Community Resuscitation Team are now in place, the Community Resuscitation Officers commenced post on 1 January 2018. They are currently baselining data in each of their geographical areas and they have completed their induction period. **Schools** – A scoping exercise is being carried out to determine number of schools who teach CPR in each Trust and Council area and update teacher training has already commenced. Meetings are progressing with Education Authority NI to discuss collaboration and partnership working to meeting the outcomes of both organisations **CFRs** – The first meeting of CFR co-ordinators has taken place to enable networking and also share best practice. All CFR Schemes were represented and the meeting was welcomed by all and there is a plan to meet Bi-annually. The CROs are working with the CFR Schemes in their geographical area to develop improved monitoring and collaboration with the CFR volunteers through quarterly meetings and ongoing support. **AEDs** – The AED registration template and information on AEDs is now live on the NIAS website and there is ongoing work to follow up on those registered prior to the development of the new template in order to gain their consent to share AED location data. **Community** – All 11 Council areas have been contacted and all of them apart from Belfast City Council have been in contact and meetings have taken place to progress Community

	Resuscitation within Health and Wellbeing of the Community Plans. Representation has been given from Department for Communities on the CR Strategy Implementation Group. **Data** – Currently the NIAS Audit department are collating data for out of hospital Cardiac Arrest Survival. It is hoped that this will be available in April 2018 for the year 2017. This will provide us with data which will enable an Out of Hospital Cardiac Arrest (OHCA) Registry to be developed and benchmarking to commence. There has been positive engagement from HSE Ambulance Service OHCA lead so it is hoped this partnership would enable All Ireland data for OHCA as well as linking to UK data.
Regional Electronic Ambulance Communications Hubs (REACH) Project (previously ePRF)	The business case for introduction of an electronic Patient Report Form (ePRF) received the support for capital from the Department of Health and Department of Finance in June 2017. A Project Board led by the Chief Executive has been established and work has now commenced to initiate procurement options and the full tender process. A procurement strategy has been agreed which will follow a restricted Official Journal of the European Union (OJEU) process. The Procurement and Logistics Service (PaLS) have indicated a lack of resources which continues to cause delays in getting the procurement underway. They have offered an option to use their Procurement Services framework to "buy in" a resource. NIAS has agreed with PaLS to extend the current arrangements (under the Technology Partnership Agreement [TPA]) to retain procurement expertise and guidance as this provides continuity to the project. Feedback on the specification of requirements has been sought both internally within NIAS and externally from Business Services Organisation (BSO) IT Services, ehealth and representatives from EDs both clinical and technical. There is confidence that the requirements are comprehensive and meet the needs of a NIAS system for electronic patient records. A further timetable has been issues to be agreed with PaLS. Requirements have been sent to the legal team in order to draw up contracts. PaLS have advised that they want all of this in place "as best practice" before NIAS enters into stage one of the restricted process.
Alternative Care Pathways	NIAS has shown that the use of appropriate care pathways was able to limit winter pressures on Emergency Departments to some degree but this does have the potential to impact on response performance for our Trust. Safety performance is monitored by the regular auditing of patient report forms and this data is presented at Assurance Committee on a rolling basis. Despite the change in provider NIAS is still able to signpost patients to the Lifeline service and it is hoped that we can introduce a pathway for direct referral to crisis response teams. A pilot is planned involving "street triage" where a prehospital team involving NIAS staff and a community psychiatric nurse

	can provide early assessment of patients. Work on policies including information markers and frequent callers continues, but these are not yet ready for submission to Trust Board. A temporary post has been created for an officer to focus on frequent callers and is currently managing around seventy patients by engaging with the patients directly and their relevant healthcare providers. This has seen a significant reduction in the number of calls from some patients. The success of the Clinical Support Desk has been recognised and funding has been agreed to extend both the hours and volume of cover for this project.
Helicopter Emergency Medical Service (HEMS)	A review of the decision to site the Airdesk Paramedic in Emergency Ambulance Control (EAC) has already shown benefit and this pilot has been extended. Early results indicate a more rapid deployment of the HEMS team and a wider range of calls attended. NIAS is working with the charity partner Air Ambulance Northern Ireland (AANI) to produce their first annual report and already has regular management meetings with them to discuss progress. This covers areas of operational, financial and more recently clinical performance. Due to a close working relationship with London HEMS, the NIAS paramedics and HEMS doctors have been progressing through update training based in London. The helipad at the Royal Victoria Hospital site is nearing completion and should become operational in the first half of 2018. This will significantly reduce the transfer time of patients who will have to undergo secondary road transfer from alternative sites at the Musgrave Park Hospital or Belfast City Airport in the interim. When flight operations are affected by weather or daylight restrictions, the team responds by road using a vehicle which has been provided with the call sign Delta 7. This is in keeping with all of the Delta call signs which represent a prehospital care doctor response, and historically was the personal call sign of Dr John Hinds, who campaigned for the introduction of the HEMS service. All UK air ambulance helicopters have call signs commencing “Helimed” in order to receive priority from air traffic control, and therefore the Delta call sign could not be assigned to the aircraft. The combined clinical advisory groups for HEMS and the Regional Trauma Network continue to meet. The full implementation of the Regional Trauma Network is not a prerequisite for the introduction of the HEMS service, but it is hoped that it will commence in Q1 2018/19. The hospital Trusts have expressed concern regarding capacity for and repatriation of trauma patients,

	although regular review of HEMS missions has indicated a responsible approach to the choice of destination hospital for patients which should help to avoid overwhelming any individual site.
Personal Public Involvement / Patient Client Experience	
Patient and Client Experience Standards (PCES)	The Trust's Patient Experience Workplan for 2017/18 includes: continued 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 Voices leads to improve services; • engagement with the Comms Team on options for a NIAS 10,000 Voices awareness and promotional campaign; • continued promotion of 10,000 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; • re-launch 10,000 Voices staff survey; and • learning from results – ensuring that learning is shared with senior management and lessons learnt are used in training and service delivery. The Trust continued to promote 10,000 More Voices and gather more stories from patients and staff, review progress and learn from results with service users. Over 300 patient stories related to the Ambulance Service have been collected covering all aspects of the service, including emergency 999 response, Patient Care Service and ambulance control. The results from feedback have been very positive and reflect a high degree of satisfaction in terms of compliance with the patient experience standards. The vast majority of patients (90%) described their experience as either positive or strongly positive. The following activities were completed to promote 10,000 More Voices during the reporting period: • NIAS Facilitator and Communications Officer attended regional meeting to develop a Communication Plan for 10,000 More Voices – 12 January 2018. • Generic and ACP surveys promoted at NIAS stands at Bloomfield and Abbey Shopping Centres on 15 and 16 February. Further shopping centre visits across the region are planned for March and April during which 10,000 Voices will be promoted. • Shared learning form stories with NIAS Training staff to look at areas for learning and improvement (part of a review on how the patient's voice can be reflected in training). Further work is underway to use 10,000 Voices as a learning and engagement tool for the Transformation and Modernisation Programme around Transforming Your Care and Appropriate

	Care Pathways. A pilot of a separate survey on Appropriate Care Pathways has been developed and is being implemented. Learning related to a minority of individual experiences which did not meet our required standards related to delays in ambulance arrival and staff attitude. These reflect themes included in complaints and work has been undertaken in relevant training programmes to address issues around attitude and behaviour. 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 the Corporate Induction Resource Pack and training programmes.
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. During this reporting period, work continued on reviewing NIAS's PPI strategy and structure in collaboration with the PHA, and meetings in that regard remain ongoing. NIAS met again with PHA PPI leads to seek further guidance and support in terms of review of structures and systems. A paper is now being drafted for submission with recommendations to SEMT. Discussions are planned for the next Equality and PPI Steering Group meeting in March 2018. Effort has continued during this reporting period on developing a significant public and staff engagement programme for 2018. This will see engagement and consultation on a range of transformation policies in development, alongside a specific focus on the PPI standards, whilst taking into account the evolving DoH guidance on co-production and co-design.

EMERGENCY PLANNING REPORT January-February 2018

KPI No		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2	**No of Potential Major Incidents**	**1**	**1**	**1**	**1**	**1**			**2**	**1**			
	No of Declared Major Incidents		**1**			**1**							
	No of Airport alerts												
	Belfast International Airport					**1**			**1**		**1**	**1**	
	Belfast City Airport		**1**					**1**					
	City of Derry Airport												
	St Angelo Airport												
	Newtownards Airfield												
	Other airfields												
	Business Continuity	**3**	**5**	**3**	**1**	**5**	**3**	**1**	**8**	**10**	**9**	**2**	
	Hazardous Material Incidents (HART calls)				**6**	**4**							
	HART pre-planned deployments	**1**	**2**		**2**	**1**	**6**	**2**					
4	**Training sessions**	**1**	**3**	**3**		**3**	**3**	**3**	**4**	**3**	**2**	**3**	
	Emergency Planning	**2**	**3**	**2**	**1**	**2**	**1**	**1**	**5**	**1**	**4**	**3**	
	HART	**7**	**11**	**6**	**1**	**1**	**2**	**7**	**8**	**5**	**3**	**5**	
	Business Continuity	**1**							**1**				
5	**Exercises**												
	Live	**1**		**2**		**1**			**1**				
	Tabletop	**1**		**2**		**1**				**2**	**1**	**2**	
	Observer		**2**						**1**				
6	**Updates or Amendments to MIP**												
	Events		**3**	**1**	**3**	**4**	**2**	**2**					
	HART Calls / Deployments	**68**	**93**	**79**	**101**	**90**	**87**	**79**	**85**	**81**	**85**	**63**	
	GOLD Operational							**1**					

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

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

Airport Alerts
On 14 January 2018 at 12.36 NIAS received an alert to the Belfast International Airport for an aircraft making an emergency landing with a fault with “the flaps”. Tasked to the scene 4 A&E crews, 3 Intermediate Care Vehicle crews, 2 Rapid Response Vehicles, 2 HART vehicles, 6 Officers and the Mobile Control Vehicle & Emergency Equipment Vehicle. The plane landed safely and the incident was stood down.

On 25 February 2018 at 19.59 NIAS received an alert to the Belfast International Airport for an aircraft making an emergency landing having reported an engine failure. Tasked to the scene 4 A&E crews, 2 Rapid Response Vehicles, 4 Officers, and the Emergency Equipment Vehicle and the Mobile Control Vehicle. The plane landed and the stand down came in at 20.09 before any NIAS resources had arrived at the Rendezvous Point.

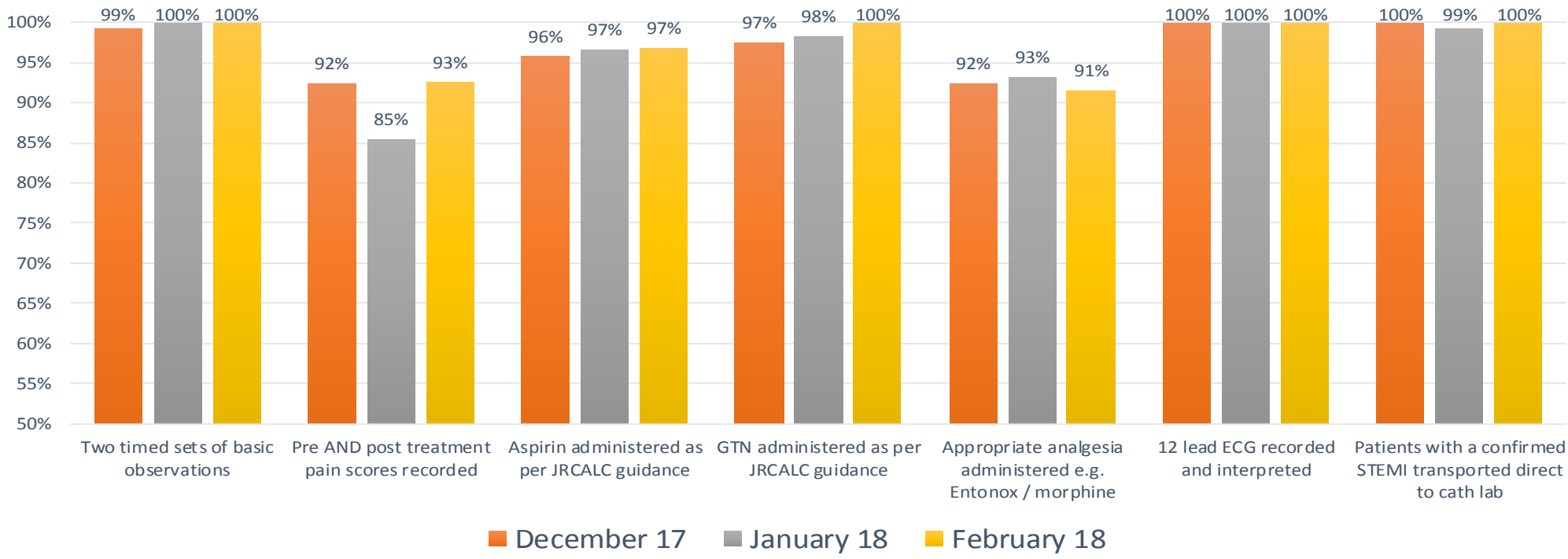
HAZMAT / Hazardous Area Response Team (HART) deployments
108= Deployments with Breathing Apparatus skills / HAZMAT deployments
0 = Incident at height
23 = Restricted space
0 = Rope tech
0 = Quick don
0 = Mountain rescue
0 = MTFA
14 = In-land Water Operation
3 = HAZMAT

_____
William Newton

Northern Ireland Ambulance Service
Health and Social Care Trust

ACUTE CORONARY SYNDROME

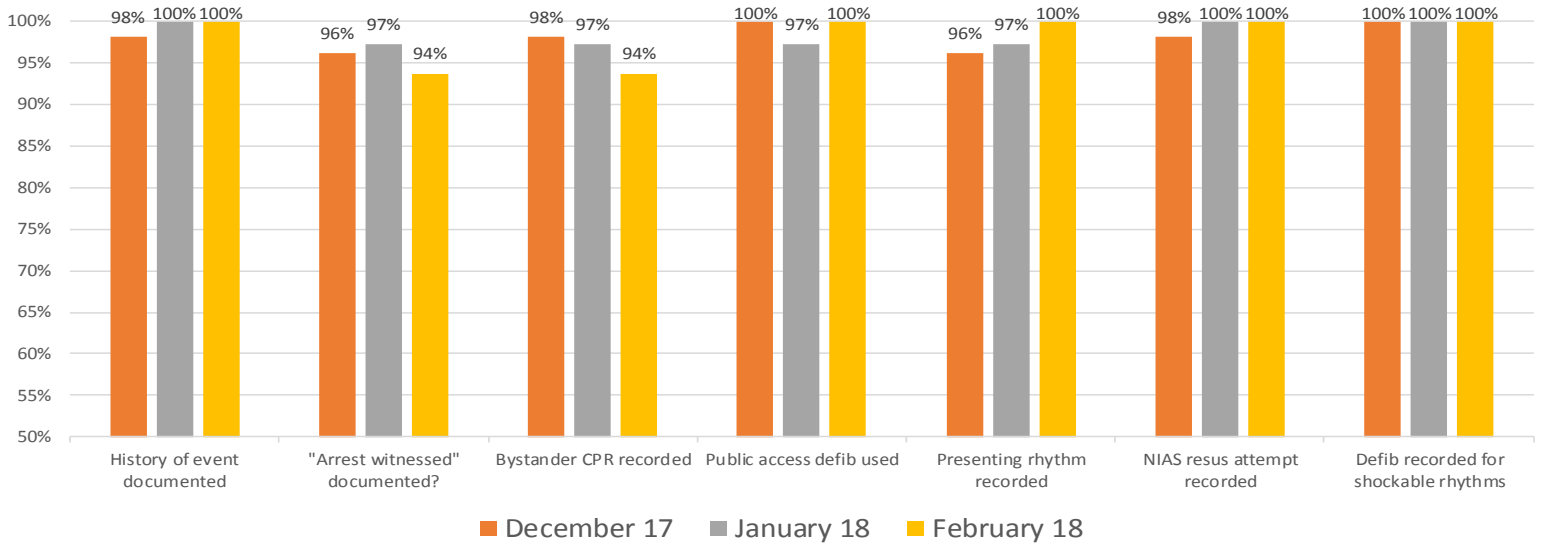
QUALITY IMPROVEMENT COMPLIANCE

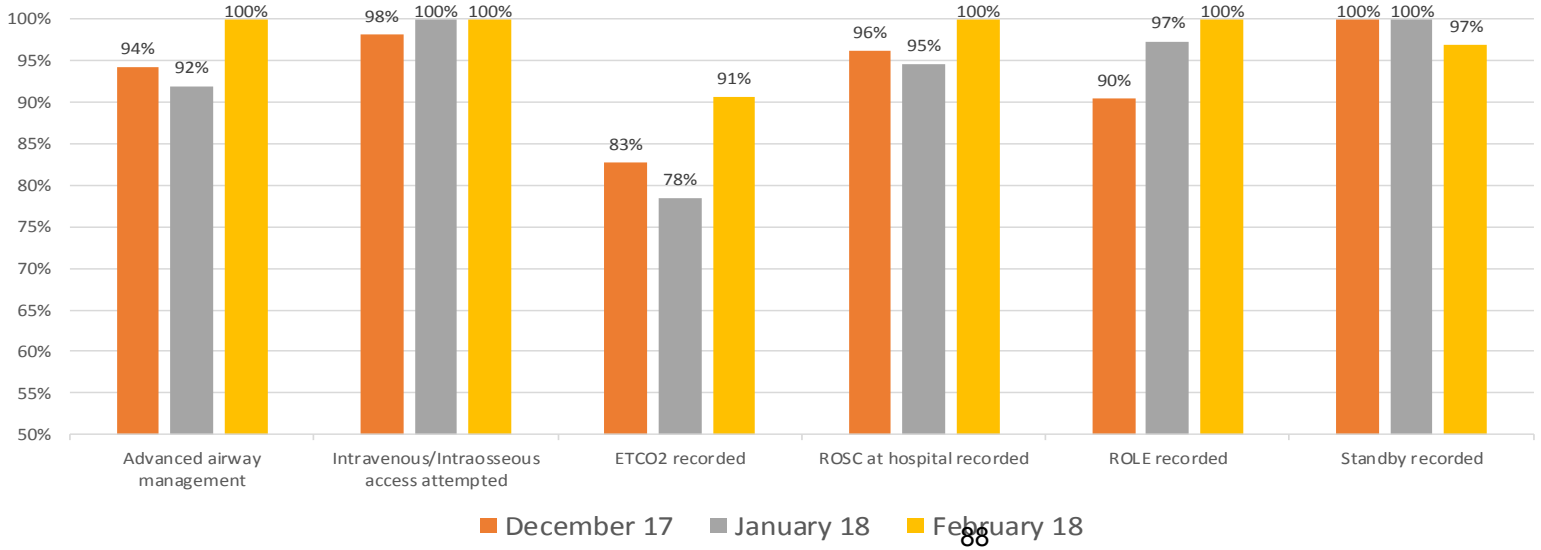


Northern Ireland Ambulance Service
Health and Social Care Trust

CARDIAC ARREST

QUALITY IMPROVEMENT COMPLIANCE

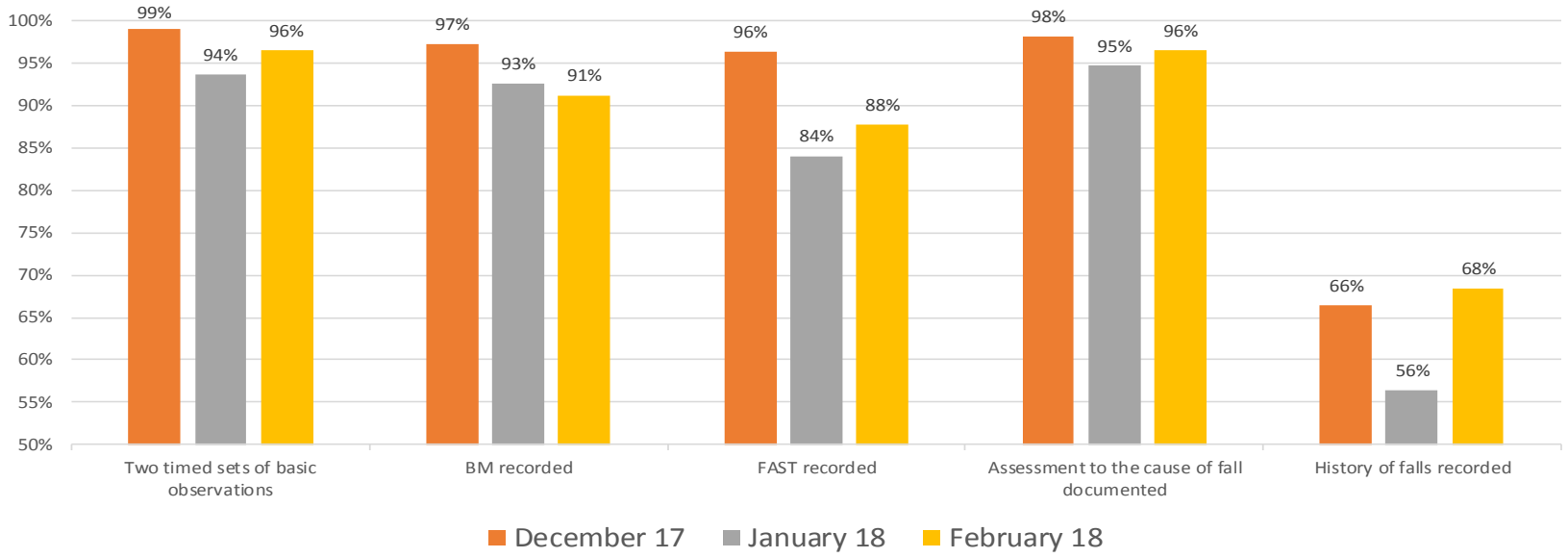


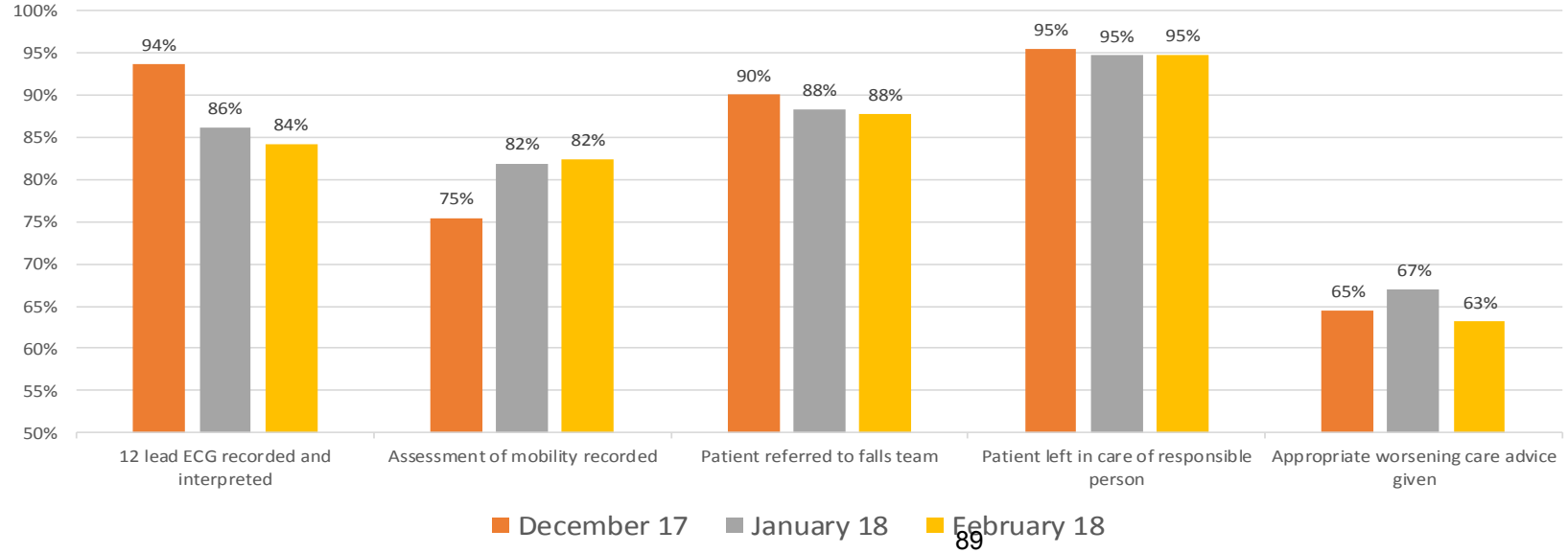


Northern Ireland Ambulance Service
Health and Social Care Trust

FALLS

QUALITY IMPROVEMENT COMPLIANCE

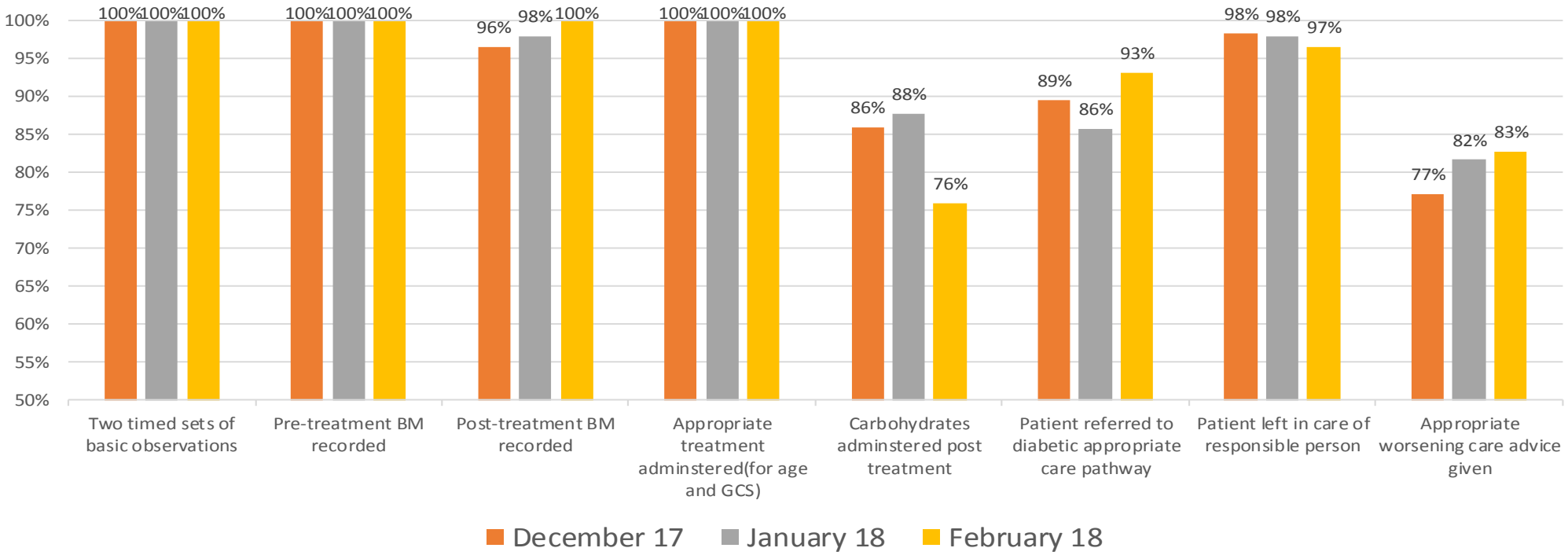




Northern Ireland Ambulance Service
Health and Social Care Trust

HYPOGLYCAEMIA

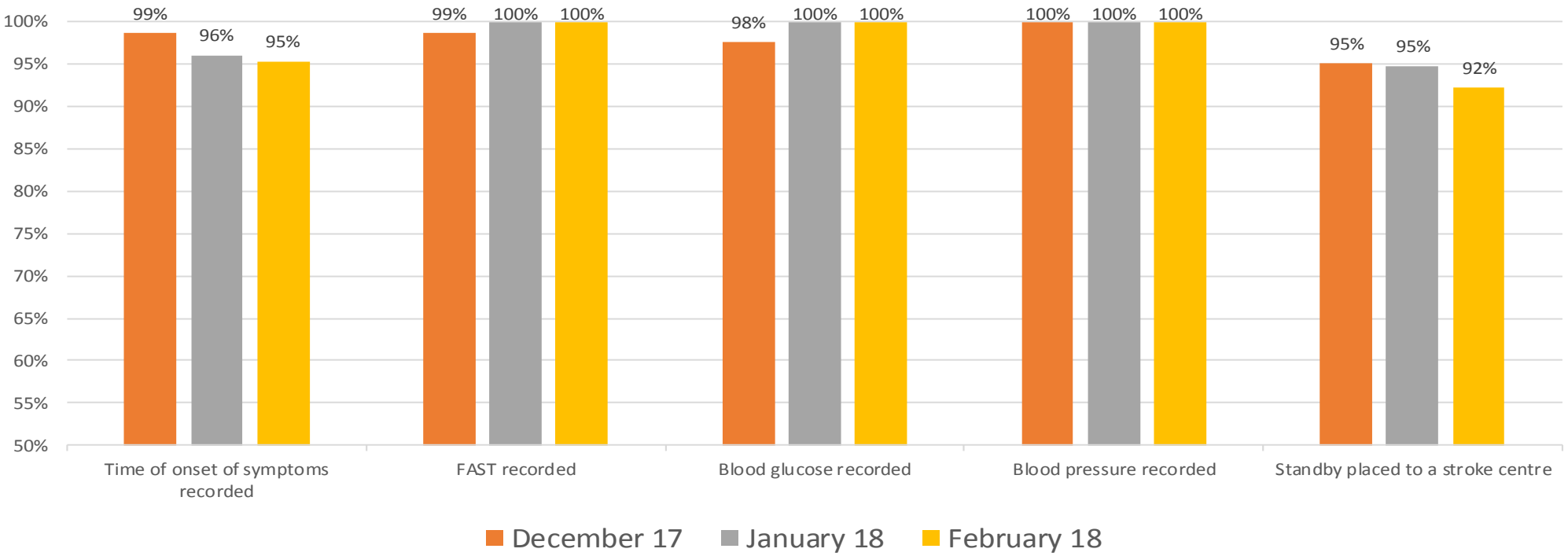
QUALITY IMPROVEMENT COMPLIANCE



Northern Ireland Ambulance Service
Health and Social Care Trust

STROKE

QUALITY IMPROVEMENT COMPLIANCE



TB/12/04/2018/06

ID	Principal Aim,Objective,Value	Description (Policies)	Risk level (initial)	Risk level (current)	Risk level (Target)	Lead Director	Initial Action Taken to Control/ Mitigate Risk	Opened	Review Date	Action Plan to Address /Mitigate Risk
318	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	There is a risk to the Trust of safe care to the public as a consequence of the impact of pressures within the HSC system due to winter pressures. NIAS are experiencing longer response times across all categories but significantly Category A response. This is due to increased turnaround times, assisting Trusts with equalising ambulance arrivals, resulting in crews being out of area, frequent requests for 999 diverts etc.	HIGH	HIGH	MEDIUM	DIROPS	NIAS has developed a Winter Plan. The plan focuses on increasing patient transport capacity and co-ordination to improve the flow within the system. □ NIAS liaises with the HCSB and Acute Trusts on daily conferences to assess and manage risk to services including ambulance. □ NIAS has introduced additional measures to support staff, e.g. respite for crews experiences long turnaround times. □ Ambulance receivers in place at Ulster Hospital Dundonald (UHD) and Craigavon Area Hospital (CAH). □ Additional Voluntary Ambulance Services (VAS) and Private Ambulance Services (PAS) to protect emergency response capacity□ Use of scripts in Emergency Ambulance Control (EAC)	15/01/2018	27/02/2018	Continue to implement agreed winter plan.□ Continue to work proactively with HSC and Acute Trusts.□ Continue to support staff.□ Continue to monitor risk on a daily basis.□ Regional Group to be established to look at Turnaround times. To be led by HSCB/PHA Safety Forum/Clinical Director (February 2018).
300	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	If adequate business continuity arrangements are not in place for Emergency Ambulance Control (EAC), there is a risk that calls may not be answered and patient care will be compromised. □ □ In the event of a systems failure in EAC the current options of decanting to either East Control Knockbracken or Non-Emergency Ambulance Control (NEAC), Altnagelvin could only be sustained for a short period, i.e. less than one week. The Trust needs to consider a more resilient contingency arrangement, i.e. a remote site with associated technology infrastructure.	HIGH	HIGH	MEDIUM	DIROPS	There are a number of contingencies in place in the event of a failure: □ If EAC is no longer functioning but systems are available, staff can operate from the onsite recovering room at RMC. If onsite recovery not available Control staff have to operate from Altnagelvin.□ C3 failure - move to paper based system. Radio/telephony failure - move to land lines/mobile telecommunications/Zetron/hand portable radios. ICCS failure - desk based phone contingency. □ BT failure - calls can be diverted to our 'Buddy' service the Scottish Ambulance Service (SAS).□ Discussion with IT with regards to improvement of mobile signal (August 2017).□ Review of fire risk assessment carried out, a number of recommendations have been made including fixed wiring test. Fixed wire testing took place 18th October 2017. □ Risk escalated to Corporate Risk Register at SEMT 24.10.17.□ Business Impact Analysis template has been produced and distributed to all Directorates (November 2017).	26/10/2016	27/02/2018	Complete review of arrangements for Business Continuity in Emergency Ambulance Control and Non-Emergency Ambulance Control required (Q3 16/17). Slippage due to EAC pressures - (Q1 18/19). □ Discussion required with IT with regards to contingencies for server failure (Q3 17/18) e.g. consideration of moving hardware to HSC data centres/data warehouse etc. Slippage due to EAC pressures - (Q1 18/19). □ Inspect water pipes above emergency ambulance control; determine if further action is required to reduce risk of further leak/rupture; which includes a possible realignment of pipework (Q3 17/18). Slippage due to EAC pressures - (Q1 18/19).□ Fixed wire debrief to be arranged (Q4 17/18).□ Strategic options paper required to consider estate requirements and CAD/ICS contracts, along with numbers, capacity and location (2017/18).
252	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	There is risk to the Trust that resources allocated to the strategic management of risk and governance are not sufficient. This includes areas such as patient safety, Quality 2020, PHA Initiatives, health and safety (including RIDDOR reporting, risk assessment, policy development etc.), medical devices, infection prevention and control, HCIs, medicines management, Serious Adverse Incident process, involvement reports to other Trusts, interface incidents, child protection/vulnerable adult/safeguarding reporting, address flags/warnings, frequent callers, oversight of risk registers/action plans, administration of the Datix Risk Management System, Oversight of RQIA Reports, Francis Report, Oversight of Trust wide Controls Assurance Process, action plans and continual improvement, general administration etc. The area is not presently sufficiently resourced to support the Trust in ensuring compliance across all related statutory requirements and Ministerial priority work streams in these areas.□ □ There is a risk that the administrative burden associated with these areas will detract from the management of risk within NIAS. □ □ There are not enough resources to take forward a number of outstanding reviews, IPC and H&S projects. Unlike other Trusts in respect of these initiatives, NIAS has not received dedicated funding. □ □ Due to the lack of resources, the Medical Director and Assistant Medical Director are constantly being diverted to operational/minor issues, reducing their ability to focus on core functions.	MEDIUM	HIGH	LOW	MEDDIR	At the introduction of its Risk Management processes the Trust created a role which was dedicated to discharging its duties in respect of risk management and statutory compliance with regard to risk management and specific health and safety regulations. □ Resource issue raised at SEMT (August 2014), initial draft document prepared Jan 2015. MD developed and submitted option appraisal Jan 2015. Recruitment document and option appraisal drafted for discussion between MD and CEO in April 2015.□ Temporary Risk Manager (RM) appointed with affect from 19th January 2016.□ Escalated to Corporate Risk Register 26.07.16.□ Temporary Incident Administrator in post from 28th November 2016, funded until March 17.□ Safeguarding Pathway introduced November 2016.□ Approval to recruit Risk Manager passed to HR January 2017. TUs agreed to re-engage with Job Evaluation process (February 2017). □ Upgrade to DATIX Version 14.0 complete (Risk Manager - August 2017). □ Datix Administrator appointed (October 2017).□ Planned Governance Review Complete; a number of recommendations have been made (MEDDir/CEO Q3 2017/18).	04/08/2014	27/02/2018	Permanent full time resource required for Risk/Governance Lead. Job Description and Approval to Recruit passed to HR (January 2017); awaiting evaluation (Led by MedDir, input from HR). □ Complete review of Incident Management processes required (to include new policy, procedure, investigation protocol, guidance for statements, SAIs, RIDDOR, inter-trust incidents, controlled drugs incidents process etc.). Risk Manager (Q3 17/18). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ DATIXWeb Incident reporting training and instruction manuals required for line management for management of incidents (Risk Manager - July 2017). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ Modernisation of Datix, full implementation of DATIXWeb incidents and DATIXWeb Risks (Risk Manager - August 2017). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ Plan to appoint IPC specialist (MEDDir Q3 2017/18). Re-evaluation required, expected completion February 2018.□ Plan to appoint Clinical Lead (MEDDir Q3 2017/18). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ Complete review of warnings/flags process (to include new policy, procedure). (MEDDir Q3 2017/18). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ Complete review of safeguarding process (to include new policy, procedure). (MEDDir Q3 2017/18). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ Complete review of frequent callers process (to include new policy, procedure). (Operations Q4 2017/18). This has slipped due to competing priorities. Expected completion (Q1 18/19).□ H&S Advisor Job description evaluated (October 2017). Recruitment ongoing Q3 17/18.
262	Build and maintain a high performing, appropriately skilled and educated workforce, suitability equipped and fit for purpose	There is a risk to the Trust in relation to the building condition incorporating physical structure, mechanical and electrical systems, space utilisation, statutory standards, and functional suitability.	MEDIUM	HIGH	LOW	DIROPS	Annual Review by Divisional Management Teams / Heads of Departments.□ Monthly Checks. □ Annual Reviews by Asst. D Op's and Risk Manager.□ Minor Works Consultancy Framework (MWCF) appointed (2017). □ Property Asset Management Report return made to the DOH (PAM PLAN) Quarter 3 2017. □ State of the Estate Report completed and returned as per DOH request 8th June 2017. □ All facilities assessed using RQIA Assessment toolkit (August 2017). □ NIAS has taken all actions required to address estate issued raised in the July and September inspection reports for Broadway and Bangor Stations (Q3 17/18). □ Estates Officer focusing on RQIA improvement works appointed January 2018. □ Acting Head of Estates appointed February 2018.	31/12/2014	27/02/2018	Annual review of estate appraisal to prioritise work by Divisions / Heads of Departments delayed due to competing pressures. One division still outstanding (Belfast). Works to be prioritised and approved for completion by 31 March 2018 (Led by Head of Estates). □ Newly appointed Estates Officer has prioritised five stations for sluice upgrades by 31st March 2018 (Led by Head of Estates). Also see local risk 9, Estate Strategy.□ Estate Strategy being reviewed to identify and support capital investment priorities. Led by Head of Estates (Q4 17/18).
286	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	There is a risk to the Trust in the provision of safe care to the public. Increasing demand for ambulance response and transportation continues to outstrip capacity and compromise the delivery of safe, high quality care. Demand has been increasing by 5% annually (increase of 26% since 2012).	MEDIUM	HIGH	MEDIUM	DIROPS	NIAS uses internationally accredited Clinical Prioritisation System (AMPDS) to differentiate calls on basis of urgency and assign resources to the most urgent calls as a priority.□ NIAS uses Computer Assisted Dispatch (CAD) and Tactical Deployment Plan to align available resources with anticipated demand to deploy resources to location where they are most likely to be required to respond promptly to most urgent calls.□ NIAS financial planning prioritises provision of front-line resources.□ Performance Improvement Plan 2017/18 developed and being implemented. Demographic funding for poorest performing LCG agreed with HSCB.□ Financial resource and activity/performance are issues discussed at Trust Board and with HSCB. □ NIAS Modernisation programme established, this introduces measures to manage demand which result in an alternative outcome which is more appropriate for the patient and better for NIAS/HSC.□ Proposed clinical response model developed and approved by Trust Board (September 2016)□ Demand / Capacity review commenced April 2017; report July 2017.	16/05/2016	27/02/2018	New clinical response model and associated revised response targets to be consulted on post Capacity Review. Expected completion Q4 17/18.□ Meeting with HSCB to take place 08.03.18.

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240	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	There is a risk to the Trust that increased levels of sickness absence could lead to an inability to deliver the required service, and contribute to the inability to achieve financial balance. There are also associated reputational issues.	MEDIUM	HIGH	LOW	DIROPS	RMC processes for rostered leave since 2014.□ Absence levels reviewed and targets identified for Directorates and Areas 2017/18.□ Introduced 10% casual leave process to support long notice requests. Implemented across all NIAS frontline operational staff (A&E and PCS) since Jan 2016.□ Health and Wellbeing Group established (2016).□ Weekly reports of expected dropped shifts shared by RMC with Senior Managers.□ Staff encouraged to proactively manage own health and wellbeing.□ Flu vaccination offered to all staff annually, along with other health promotion initiatives.□ Processes in place to redeploy available resources across the region.□ Use of Private Ambulance Services and Voluntary Ambulance Services as necessary.□ The revised Trust Attendance Management Procedure was implemented 31 July 2017, associated training delivered September 2017. □ ASAMs actively implementing Absence Management Policy; individual case management involving Occupational Health as necessary, led by ASAMs.□□ Use of overtime as necessary.□ Use of bank staff as necessary.□ Development and implementation of Absence Management Service Improvement Plan as part of the Operational Performance Improvement Plan (Q1 17/18).Development and implementation of Operations procedures to support implementation of NIAS Absence Management Policy. Transformation Team to support programme of projects to facilitate reduction in sickness absence levels (Q2 17/18).□□ Development and implementation of Operations procedures to support implementation of NIAS Absence Management Policy. Transformation Team to support programme of projects to facilitate reduction in sickness absence levels (Q2 17/18).	21/12/2012	27/02/2018	The focus of improving attendance is now two collaborative projects "good attendance" and "improved productivity resource management" being managed under the Trust's Transformation and Improvement Collaborative Projects. Expected completion Q4 17/18. □ Service improvement of RMC/GRS/associated support services to ensure Operational Managers are able to optimise resources (Q4 17/18). □ Ops/HR identifying options for electronic monitoring and reporting of monthly absence management figure (Q4 17/18). □ Occupational Health Workshop planned (Q4 2017/18). □ A number of Health and Wellbeing Workshops are ongoing in relation to Pilot of a Peer Support Model for the Trust. Health and Wellbeing Partnership Project launched by NIAS and Unison in December 2017 and surveys are in the process of being issued to staff through agreed methodology (Q1 18/19).
4	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	There is a risk to the Trust from the failure to review, update and test the internal business continuity plans.	MEDIUM	HIGH	MEDIUM	MEDDIR	Four 'critical' activities were identified in 2011, Call Taking, Information Processing, Ambulance Despatch and Clinical Care. Existing plans reviewed to ensure that the areas which directly influence these 'critical' activities have been tested, activated and reviewed or debriefed: including: REMDC, Operational Divisions, and specific ICT Infrastructures. □ Business Continuity Strategy and Policy reviewed and updated October 13 and submitted to Assurance Committee December 13 and Trust Board January 14. Overarching Business Continuity submitted to Assurance Committee Sep/Oct 2014. □ EP/BCP planning was added to induction for all new staff (May 2015). □ Risk de-escalated from Corporate Risk Register local Medical Directorate risk register following Trust Board Workshop July 2014. □ An Emergency Preparedness and Business Continuity Planning Group was established June 2012 to oversee the process. Business Continuity incidents and plan activations are reviewed as standing agenda items. Internal Audit recommendations in relation to BCP are regularly reviewed and actions agreed. Terms of Reference and Schedule of Meetings submitted to the Assurance Committee on a quarterly basis.□ Training for Directorate functional leads in BPC completed in November 2015. Business Impact Analysis Training carried out February 2016.□ Escalated To Corporate Risk Register May 16.□ Emergency Planning Lead seconded on a full time basis, review of Strategy/Policy/Plan commenced Led by Emergency Planning Officer (Q1/Q2 17/18).□ BCP Strategy, Policy and overarching plan sent out for consultation to the Emergency Preparedness & Business Continuity Group Meeting members, Area Managers and Staff Side representatives (May 17); then presented to EP Group (June 2017). BIA template reviewed and reduced to a six page document, tabled at EP Group (June 2017). □ BCP Strategy and Policy ratified by Trust Board in August 17. Documents also placed on SharePoint for reference for Staff. EAC exercise completed and report available. Business Impact Analysis started with IT. □ Business Continuity Exercise (Fixed Wire Testing) completed on 18 Oct 17.□ Complete review of arrangements for Business Continuity in Emergency Ambulance Control and Non-Emergency Ambulance Control required (Q3 16/17). Risk 300 opened in order to address this as a separate issue (raised 26.10.17).□ Business Continuity Certificate has been obtained by Business Continuity Lead (November 17).□ Business Continuity schedule has been developed as well as a calendar to capture all activations of the Business Continuity Plan (17/18 and ongoing/annually).□ Business Continuity Strategic Plan agreed at EPBC Group (February 2018).	30/12/2010	27/02/2018	Directorate functional leads to complete BIA & BCPs; supported by the Emergency Planning Unit Q2 17/18. This has slipped due to competing priorities, expected completion Q4 17/18. □ Planning a test exercise with IT against a cyber security attack, to be completed by March 18.
311	Review and develop operational systems and processes to support the service delivery model and provide necessary assurances of appropriateness, accessibility, timeliness and effectiveness.	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. □ □ This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services (e.g. the ability to dispatch and monitor emergency ambulances, appointments, admissions to hospital, ED attendances) or data contained within. This may result in the need for HSC to cancel appointments and treatments, or divert emergency/essential clinical or other services. □ □ The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions and ambulance response, suboptimal clinical outcomes and potentially bring liabilities for the Service.□ □ It could also lead to unauthorized access to any of our systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.	HIGH	HIGH	LOW	FINDIR	Technical Infrastructure i.e. HSC security hardware (e.g. firewalls), NIAS security hardware, HSC security software (threat detection, antivirus, email & web filtering), NIAS security software (threat detection, antivirus, email & web filtering), Server / Client Patching, 3rd party Secure Remote Access, Data & System Backups.□ □ Policy, Process, i.e. Regional and Local ICT/Information Security Policies (2016), Data Protection Policy (March 2016), Change Control Processes (template developed), User Account Management processes (IT Policy 2016), Disaster Recovery Plans (last reviewed 2016), Emergency Planning & Service/Business Continuity Plans (last reviewed 2016). Corporate Risk Management Framework, Processes & Monitoring (last updated Oct 16), Regional & Local Incident Management & Reporting Policies & Procedures (under review).□ □ User Behaviours - influenced through Induction Policy, Mandatory Training Policies, HR Disciplinary Policy, Contract of Employment, 3rd party Contracts / Data Access Agreements, IG Training (ongoing).□ □ Senior HSC IT Management concurred with Internal Audit's assessment that the National Cyber Security Centre (NCSC) 10 Steps to Cyber Security was appropriate guidance for HSCNI organisations to use as benchmark for their Cyber Security Control environments (Q1 17/18).□ □ ICT Security Monitoring is a standing agenda item on IGSG which reports to the Assurance Committee. Additional reporting structures for Trust Board are being considered (Q1 17/18).□ Completed roll out of regionally funded antivirus Sophus and Intercept X. NIAS now using the same antivirus software as other HSC Trusts (completed Q3 17/18).	09/08/2017	27/02/2018	Internal Audit has substantively assessed three of NCSC 10 Steps to Cyber Security in respect of Incident Management, Malware Prevention and Secure Configuration (December 2017). Internal Audit Assignment report with an assurance classification for each organisation will be provided (Q4 17/18).□ A regional business case to fund improved cyber security for HSC is currently in development Q4 17/18. □ A series of Business Impact assessments in relation to Business Continuity is ongoing. NIAS Emergency Planning Department (Q3 17/18). Delayed, expected completed Q1 18/19. □ A SIRO Cyber Security Programme Workshop is to be arranged to baseline the key perceived cyber security threats that exist across all HSC organisations. This workshop will examine and collate existing controls, accountability, processes and general preparedness for Networks and Information Systems Directive and General Data Protection Regulation (GDPR) with a view to formulating a regional approach that adopts the information security compliance framework detailed in ISO 27001 (Q3 17/18). Delayed, expected completed Q1 18/19.□ Explore "faux" cyber security exercises to test user behaviours, service continuity / disaster recovery plans (AD ICT, Q4 17/18).

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312	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	There is a risk to the Trust that it will fail to meet its statutory duty to achieve financial balance. □ □ The Trust has consistently returned a break-even financial position and has a sound understanding of cost / income with controls in place to manage spend. There are however a number of factors which can contribute to the risk that the Trust will fail to achieve financial balance namely:□ □ 1. Increases to Savings Target given significant emerging pressures across Northern Ireland public sector. The Trust has been advised at this date (July 2017) of a savings requirement of £1m in 2017/18.□ □ 2. Overspending against core budget.□ □ 3. Cost Pressures and Service changes not fully recognised and funded by Commissioners. Income levels for prior year developments, new service developments and other unavoidable pressures have been highlighted to HSCB /DoH colleagues and the Trust is assuming that these costs will be met in full. □ □ 4. 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.□ □ Given the challenging financial position for the public sector in Northern Ireland NIAS will continue to actively engage with Commissioners and DoH to track emerging financial pressures and their impact on NIAS. Any changes in these assumptions will result in further contingency measures which are likely to impact directly on the delivery of front line services.	HIGH	HIGH	LOW	FINDIR	Controls are in place to mitigate each of these factors as follows: □ A. Applying internal budgetary control processes led by Director of Finance reporting monthly to Chief Executive as Accounting Officer. This will continue to be underpinned by detailed budget reports produced by finance to support budget holders. Directors are held accountable to Chief Executive. Financial position is a standing item on SEMT agenda for DoF to provide update and test assumptions.□ B. Submission and engagement with DoH/HSCB re any emerging financial implications for HSC in the context of Northern Ireland public sector budgets to be reflected in NIAS Trust Delivery Plan. Ongoing monitoring, review and engagement with stakeholders.□ C. Ongoing monitoring, review and engagement with stakeholders will continue throughout to highlight emerging cost pressures and service changes.□ D. Ongoing monitoring, review and engagement with stakeholders will continue throughout recognising that there remain uncertainties in particular in respect of the outcome of Agenda for Change (both in terms of timing and magnitude).□ E. Development and implementation of a Trust Delivery Plan, including savings proposals, by NIAS for 2017/18 in conjunction with Trust Board. Engagement with staff and patient representatives and fulfillment of any statutory consultation requirements.□ □ Ongoing application of controls A to E above.□ □ At July 2017, the Trust awaits guidance from HSCB over the format and content of the Trust Delivery Plan for 2017/18. The Trust continues with the regular completion and submission of Trust Monitoring Returns and other financial returns. The Trust continues with the budgetary reporting cycle to Budget Holders, SEMT and Trust Board.□ □ Guidance on the Trust Delivery Plan structure and timeline for 2017/18 was received in September and a draft submitted to HSCB in November 2017.□ □ In December 2017, the Trust received notification that the HSCB are generally satisfied with the content of the Trust Delivery Plan. This approval noted the forecast balanced position in 2017/18 was largely due to in year non recurrent savings and referenced ongoing discussion with HSCB in regard to achieving a balanced financial position in subsequent financial years.□ □ Formal approval for the Trust Delivery Plan for 2017/18 was received on 12th February 2018.	28/07/2017	27/02/2018	Ongoing application of controls A to E (controls in place) throughout 2017/18.□ The Trust is engaging with HSCB/DoH in a comprehensive exercise to forecast expenditure levels in the current and subsequent financial years.
316	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective	Due to demand for services it may not be possible for NIAS to stand vehicles down for cleaning. This may result in the failure to comply with Infection Prevention and Control Policy and Procedures which could present a risk to patient safety. □ □ NIAS is currently unable to meet RQIA timeframes in three divisions due to the complexities of the logistics and service delivery.	HIGH	HIGH	LOW	DIROPS	Infection Prevention Control Policy & Procedures in place.□ NIAS will continue to provide protected time to facilitate cleaning and make ready after patient handover as required to meet standards under the Trusts Infection Prevention Control Policy & Procedures 2015.□ Due to winter pressures, increase in demand and long turnaround times at EDs, the weekly vehicle cleaning rota has been stood down for Q4 17/18. A new vehicle cleaning model using non-uniform personnel has been developed and implemented regionally Q4 17/18.	13/10/2017	27/02/2018	NIAS has now appointed a dedicated team to design and implement a new vehicle cleaning model, subject to funding and management capacity. A number of options are being explored including the use of contractors under the Trust's facilities contract and development of an in house model using non clinical staff. Commissioner support will be required going forward. Led by Operations Director, expected completion date Q2 18/19.□ Review/streamlining of procedures for monitoring cleaning underway (ASAMs Q4 17/18).□ Area Managers progressing plans to introduce dedicated cleaning teams by Q4 17/18.
283	To Achieve the best outcomes for patients whilst Ensuring High Quality Corporate Governace, Risk Management and probity	If Human Resources does not have adequate resources to support the Trusts key priorities, there will be delays in the delivery organisational objectives. There is also a risk to the timely delivery of departmental objectives and an inability to meet statutory requirements. There is the potential to lead to further delays in meeting statutory requirements.□ □ □ □ Ongoing organisational pressures resulting in significantly increased workload for HR staff (relating to Workforce Stabilisation Programme which commended in June 2014); new/additional unfunded HR workstreams (relating to Job Evaluation and mainstreaming of residual BSTP workstreams) and lack of stability within the HR Department over the last number of years (due to secondments to BSTP project and long term sickness absence of key members of staff).	HIGH	HIGH	LOW	DIRHR	(1) Ongoing prioritisation of statutory duties;□ □ (2) Operation of Escalation Procedures together with robust performance management arrangements;□ □ (3) Employment of temporary agency staff for short fixed term periods, with budgetary constraints;□ □ (4) Prioritisation of engagement in regional and local workstreams;□ □ (5) Support mechanisms for HR staff including line management support, Carecall 24 hour confidential counselling service and Occupational Health;□ □ (6) Work on HR role clarity and development of managers toolkit for HR processes has commenced;□ □ (7) Recruitment activity has transitioned to RSSSC;□ □ (8) Relevant statutory duties up-to-date and processes in place to review.	29/04/2016	27/02/2018	HSC Leadership Centre review in relation to HR structure and capacity to has been undertaken and further work on proposed structure has been completed by DHRCS. Implementation will be incorporated into corporate restructuring plans. Workstreams related to statutory requirements continue to be prioritised. Statutory reporting to ECNI is now on target (Q1 18/19)..
309	To Achieve the best outcomes for patients whilst Ensuring High Quality Corporate Governace, Risk Management and probity	The Trust is currently not able to meet RQIA standards in relation to infection, prevention and control across the entire region; this may present a risk to patient safety, staff safety and potentially organisational reputation.	HIGH	HIGH	LOW	MEDDIR	IPC covered in PP training (2009/10).□ IPC contained in annual workbook (2012/13).□ Hand hygiene audits carried out (2014). □ IPC Policy and Procedures in place and signed for by all staff (2015). □ Infection Prevention & Control Group established and meeting quarterly; items escalated to Assurance Committee as necessary (ongoing). Vehicle cleaning is considered as a 'standing item'.□ Incident reporting procedures in place (under review).□ IPC training included in Futurequals EMT syllabus (16/17 & 17/18).□ Vehicle cleaning reporting system developed with EAC recording on a database (ongoing). □ Presentation on 'Make ready' system to IPC and MEG (November 2016).□ RQIA highlighted difficulties in maintaining vehicle cleaning regimes due to operational pressures (05.07.17).□ Corporate IPC Action Plan developed (July 2017).□ ASAM IPC Risk Management Workshop (August 17).□ Regional IPC refresher programe ongoing (commenced 17.10.17).□ Implementation of regional IPC Audit Tools (July 17 forward).□ IPC Group meeting monthly from October 2017.□ IPC KPIs for 2017/18 set (September 2017). □ IPC KPIs updated following feedback from RQIA (November 2017). □ Note also Vehicle Cleaning Risk 316 opened due to increasing pressures and a change in Lead Director (October 2017).□ IPC Lead Job Description evaluated (October 17).□ Estates Officer appointed (January 18). □ Agency vehicle cleaning staff pilot ongoing (January 2018).□ Head of Estates appointed (February 18).	24/07/2017	27/02/2018	Review of IPC Policy, Procedures & SOPs (MEDDir & Risk Manager Q3 17/18). Delayed - anticipated Q4 17/18.□ Appointment of IPC Lead (MEDDir Q3 17/18). Delayed due to requirement to change and re-evaluate JD, anticipated Q4 17/18. □ Ongoing review of systems and procedures for facilities, equipment and vehicle cleaning (Ops Dir 2018/19).□ External consultant engaged to deliver 7 one day IPC sessions for line management and Training (MEDDir Q3 17/18). Mop up sessions to be delivered February and March 18.□ Job description for Vehicle Cleansing Operative under development, anticipated evaluation February 2018.

TB/12/04/2018/07

Northern Ireland Ambulance Service
Health and Social Care Trust

Infection Prevention and Control

Policy and Procedures

Document version:	v4.1
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Date of Issue:	
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CONTENTS

OBTAINING URGENT INFECTION CONTROL ADVICE

Expert infection control and prevention advice is available to staff 24hrs, 7-days a week. Requests for advice must be made via Ambulance Control, who will contact the appropriate service. Non-urgent enquiries should be directed to the Risk Manager in the first instance.

In-Hours:

The Control Officer/Duty Manager should initially attempt to contact the following people by telephone

- NIAS Risk Manager, or in case of Category 4 Disease, the Emergency Planning Officer
- Clinical Lead or Medical Director, who may in turn refer to specialist advice provided by the microbiology team in the South Eastern Trust
- Northern Ireland Public Health Agency (12-22 Linenhall Street, Belfast. Telephone 0300 5550114 for duty room.
- The UK Health Protection Agency, now part of Public Health England, are also available to provide specialist advice on infectious diseases (020 8200 4400)

Out-of-Hours:

Out-of-hours advice is available by contacting

- Senior Officer on Call via NIAS EAC, who may in turn contact the Medical Director.
- Northern Ireland Public Health Agency (Consultant on Call available by pager through NIAS EAC)
- The UK Health Protection Agency, now part of Public Health England, are also available to provide specialist advice on infectious diseases (020 8200 4400)

STRATEGY

STRATEGIC STATEMENT

There is a national drive for improved infection control within the NHS, with the Department of Health promoting evidence based guidelines and frameworks for assessment. Greater emphasis is being placed on encouraging better use of infection control to prevent infections, rather than relying on antibiotics when infections occur. Healthcare acquired infections cause serious problems for the Health Service. Infections can complicate illnesses, cause distress to patients and family, and in some cases may even lead to patient death. It is estimated that healthcare acquired infections kill around 5,000 people a year and contribute to 15,000 more. Around 100,000 people acquire a healthcare associated infection each year, with 30% of these being preventable.

POLICY STATEMENT

The Northern Ireland Ambulance Service is committed to creating robust systems of infection control, based on a comprehensive Infection Prevention and Control Policy which is reviewed annually, as required.

Continual infection control audit allows areas of good practice to be promoted, whilst systematically identifying areas where improvements are necessary.

An infection control plan will be developed for each financial year to set a programme of work for that year.

The infection control work will be underpinned by robust and comprehensive infection prevention and control processes and procedures.

An annual infection control update is presented to the trust Board to report on progress made and to provide assurance of continued compliance with the Policy and Procedures in this document.

SUSTAINING PROGRESS

Infection control measures have been highlighted by several incidents of disease outbreak affecting HSC trusts in recent years as well as the Swine Flu pandemic of 2009. NIAS is committed to working with our partner trusts in order to strive for best practice in infection prevention and control, and has engaged with the Regulation and Quality Improvement Authority in the areas of audit of specific topics relating to current practice as well as developing a comprehensive audit tool which recognises the significant challenges faced by staff working in the pre-hospital field. This document should be regarded as a core reference providing information for staff and covers all areas of infection prevention and control, but it is recognised that new developments will change or add to the details within, and staff should at all times ensure they are familiar with the latest updates and standard operating procedures issued by the Medical Directorate and NIAS Training Department.

Significant progress had been made to date, with the evolution of an Infection Prevention and Control Group meeting on a bi-monthly basis, all clinical staff being advised regarding the national “Clean Your Hands” hand hygiene campaign, the issue of vehicle and personal alcohol handrub dispensers, greater use of single-patient equipment, new guidelines on and equipment for cannulation, and infection control training continuing to be an integral part of the annual recertification program. The newest ambulance vehicles in the NIAS fleet have been designed to minimise the accumulation of infectious agents, and to facilitate effective cleaning. As a Health and Social Care Trust, NIAS is also committed to playing its part in the Priorities for Action identified by the Minister for Health in reducing the rate of infection by multi-resistant infectious organisms including MRSA, MSSA, clostridium difficile and pseudomonas.

This document represents a comprehensive review of infection control on the part of the Northern Ireland Ambulance Service, and reflects the commitment of the Trust’s Board, senior management and clinicians to the infection prevention and control, and to creating a safer environment for our staff and patients.

_____	_____
Shane Devlin	Nigel Ruddell
Chief Executive	Interim Medical Director

January 2018

POLICY

INTRODUCTION

The trust's Guidance and Procedures for Infection Prevention and Control Policy/Strategy set out the strategic and policy approach to the prevention and control of infection, and describes the organisational infrastructure in place including key accountabilities.

The document has been developed by the Medical Directorate and the Infection Prevention and Control Group, based on the requirements set out in national guidance, the Hygiene Code, and the core Standards for Better Health. It is approved by the Assurance Committee, ratified by the Trust Board, and is reviewed on a bi-annual basis.

The Infection Prevention and Control document is made available to the public through the trust's internet site to ensure they are made aware of the trust's arrangements for Infection Control.

PURPOSE

Procedures and guidance on infection prevention and control have been developed and reviewed and are incorporated within the policy document to assist all clinical staff in ensuring they follow best practice in order to achieve the aim of a reduction in the incidence of healthcare acquired infections.

SCOPE

This document has been designed to clearly identify the line of accountability for infection prevention and control from the Chief Executive to all staff. The document sets the standards expected and the monitoring and educational requirements necessary for their achievement. In conjunction with supporting policies, the document provides a source of procedural advice and guidance for clinical staff. Separate action plans exist for the infection control work programme and to ensure compliance with the Hygiene Code and Standards for Better Health.

In order to provide staff with comprehensive and easily accessible information on all aspects of infection prevention and control, this document refers to the various policies, procedures and guidelines which can be obtained from the NIAS intranet via Sharepoint.

RESPONSIBILITIES

The Trust Board

Board members are collectively responsible for providing leadership and direction on health and safety matters. Members will have a full understanding of the risks, systems in place for managing the risks and appreciation of the causes of any failures. The Board are responsible for monitoring the effectiveness of infection control measures through the annual infection audit and report.

Chief Executive

The Chief Executive has a key role in ensuring that systems are in place and being adhered to, to manage any significant risks facing the organisation and ensure compliance with the Health Act. The Chief Executive is ultimately responsible for infection control measures, a responsibility which is discharged through the Medical Director. The Chief Executive is responsible for ensuring compliance with the Trusts policy which includes standard (universal) infection control precautions, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients, disinfection and the reporting of HCAIs to the Health Protection Agency.

Medical Director

The role of Director of Infection Prevention and Control is assigned to the Medical Director, who has been nominated by the Board to have executive responsibility for infection control within the trust. The Medical Director has responsibility for overseeing the Infection Prevention and Control Group, Infection Prevention and Control Policy and Action Plan, and is an integral member of the Assurance Committee, reporting to the Trust Board. The Trust Board is responsible for monitoring and managing the risks associated with infection control, in accordance with the trust's risk management strategy to ensure compliance with the Health Act. They have the authority to challenge inappropriate clinical hygiene practice. Day to day responsibility has been devolved to the IPC Lead.

Assistant Medical Director / Clinical Lead

The Clinical Lead is responsible for the day to day management of infection control, maintaining the Infection Prevention and Control Policy, and implementing good practice within the trust in conjunction with the Operations Directorate. The Clinical Lead is responsible for working with Directors to identify and manage the risks associated with infection prevention and control and to monitor compliance with internal and external assurance frameworks in conjunction with the Medical Director and Director of Operations.

Risk Manager

The Risk Manager is responsible for the day to day review of issues arising in relation to infection control, working alongside the IPC lead to implement good practice across the trust. The Risk Manager is responsible for working with Directors to identify and manage the risks associated with infection prevention and control and to monitor compliance with internal and external assurance frameworks in conjunction with the Medical Director and Director of Operations. They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures.

Infection Prevention and Control Lead

The IPC Lead is responsible for the development and review of the trust's Infection Prevention & Control Policy & Procedures, day to day management of infection control, and implementing good practice within the trust in conjunction with the Operations Directorate. The IPC Lead will work with the Operations Directorate in a system of regular audit of IPC practice and training throughout the trust, including inspection of trust facilities to report on progress and identify areas for improvement, highlighting areas of risk to the Risk Manager and the appropriate director and reporting all findings to the IPC group. The IPC Lead must maintain current knowledge in IPC matters through professional liaison, and advise on updates to trust practice as required. The IPC lead will review interface or untoward incidents relating to infection prevention and control, and liaise with other agencies as required.

Clinical Training Manager

The Clinical Training Manager is responsible for ensuring that all staff (clinical and non-clinical), including contractors receive education, information and training in infection prevention and control appropriate to their job role. They are responsible for ensuring that all staff have a working knowledge of Infection Prevention and Control Guidance and Procedures detailed within trust documents.

The Clinical Training Manager is responsible for developing and updating the trust's training needs analysis to ensure it reflects the latest guidance with regards to standard (universal) precautions, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients and disinfection. Infection prevention and control must be included as appropriate in training development plans, learning outcome plans and be robustly recorded through an effective and accessible training records system.

Assistant Director of Operations (Estates & Fleet)

The Assistant Director of Operations (Estates) is responsible for liaising with the Director of Operations, Medical Director, and Clinical Lead to ensure that all environmental policies and estate management are compliant with infection prevention and control best practice. They are responsible for ensuring that all premises are suitable for purpose and maintained in good physical repair and condition to support good infection prevention and control practice. The

Assistant Director of Operations (Estates) is responsible for ensuring that all non-trust owned and/or maintained premises comply with trust standards.

Fleet Manager

The Fleet Manager is responsible for ensuring that all ambulance vehicles and equipment have received an infection prevention and control evaluation prior to purchase.

Divisional Officers

In addition to the responsibilities listed for management staff, Divisional Officers and Station Officers / Supervisors are responsible for infection prevention and control in all activities within their area of responsibility.

They are responsible for ensuring the effective implementation and monitoring of infection prevention and control, including undertaking infection prevention and control audits as stipulated by the Medical Director. They are responsible for ensuring that ambulance vehicles, stations and equipment are cleaned appropriately and achieve the trust's high standard of cleanliness through a visible presence, monthly station reviews and support of their Station Officers and Supervisors. Divisional Officers are designated as the responsible manager for the routine decontamination of equipment within their area.

Station Officers

All line managers are required to oversee and supervise the implementation of infection control policies within their area of responsibility and to actively participate in the management of infection control related incidents and risks. Management staff are responsible for including infection prevention and control within the managerial job descriptions and appraisals of all staff under their line management. Station Supervisors are responsible for ensuring the cleaning and decontamination of vehicles and equipment according the policy and for challenging any inappropriate practice.

Director of Human Resources and Corporate Services

The Director of Human Resources maintains contracts with external Occupational Health departments to ensure the effective screening of new staff and expert support and services for staff in accordance with the trust's occupational health policy.

Training Officers and Clinical Support Officers

Training Officers and Clinical Support Officers are responsible for cascaded delivery of issues relating to infection prevention and control, and through their clinical observation role may identify and challenge any poor practice encountered, offering remedial advice or escalating issues through the training team as required. They may also undertake specific audits in relation to infection prevention and control practice.

Trust Staff

Responsibility for infection prevention and control is devolved to *all* staff and clinicians within the Trust. All staff have a responsibility to attend infection control training and to ensure that infection control policies are effectively implemented in their area of work; which must meet the trust's high standard of cleanliness at all times. All staff are responsible for ensuring the continued compliance of the trust with the Health Act 2006 including following trust policy and guidance on standard (universal) infection control precautions, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients and disinfection.

Out of Hours

In the event of an infection control issue occurring out-of-hours, the matter should be reported to the Duty Officer and, if necessary, the Senior Officer-on-Call. The Senior Officer will access further support from the Medical Directorate, NI Public Health Agency and Health Protection Agency as required.

Organisational Framework

Infection control performance is monitored and led by the Infection Prevention and Control Group which reports to the Trust Board through the Assurance Committee. The group provides feedback and advice to other working groups as requested. The group advises the Clinical Training Manager of any identified training needs to ensure that learning from experience is incorporated into practice.

The Medical Equipment Group, Accident and Emergency Working Group, Patient Care Service Working Group and Uniform Working Group are responsible for ensuring that infection prevention and control is fully considered during the selection of consumables and medical and other equipment.

Adverse incidents relating to infection control must be reported using the Untoward Incident Reporting procedure detailed in the Untoward Incident Reporting Policy. Incidents relating to infection control will be reviewed at the Infection Prevention and Control Group. CBRN/E-related incidents infection incidents are dealt with separately in the Major Incident Plan.

RISK ASSESSMENT

Risk assessments must be carried out in accordance with the trust's risk management strategy and associated documentation. Risks in respect of healthcare associated infection and serious communicable diseases may be identified on an ongoing basis via incident reporting procedures, complaints, claims, infection control audits and risk assessments. These processes are monitored to ensure that any risks are identified and acted upon in a timely manner. Incidents and change in risk ratings are reported to the Infection Prevention and Control Group, for revision of the trust's Infection Prevention and Control Risk Assessment. All staff receive training in risk management and risk assessment during their induction.

Staff undertake dynamic risk assessments as part of their working practice and the trust will undertake an organisational risk assessment as part of the rolling risk assessment program. The organisational risk assessment will identify any specific roles within the organisation that are at higher risk, and a specific risk assessment will be carried out for these. The organisational risk assessment will assess how likely it is that blood borne viruses or other communicable diseases (e.g. respiratory or gastrointestinal infectious diseases) could cause ill health and decide if existing precautions are adequate.

The assessment will consider the following:

- Frequency and scale of contact with blood or other body fluids.
- Number of different persons' blood/body fluids with which contact is made.
- Existing information on injuries/ill health reported in the workplace.
- Impact on the organisation of multiple 'casualties' within staff resources in the event of an outbreak.
- Quality of control measures.

Healthcare-associated infection risk assessments will be owned by the Clinical Governance Committee who will monitor the action plans. The Risk Manager and Clinical Lead will co-ordinate the risk assessments and monitor progress with reviews. Staff will be made aware of any specific risks via clinical updates or formal memoranda.

EDUCATION AND TRAINING

All new employees are required to fulfil the pre-employment health checks detailed in Appendix 4 (Occupational Health). Before commencing operational duties, all members of clinical staff must complete appropriate infection control induction training. Induction training programmes for new staff incorporate the principles and practice of infection prevention and control, awareness of policy and guidance documents, hand hygiene, safe handling and disposal of sharps, management of linen and waste, decontamination of equipment, management of inoculation incidents, feedback of audit results, examples of good practice and action needed to correct deficiencies.

Infection control training covering all areas identified above is incorporated in the annual recertification program, as detailed in the trust's training schedule. Compliance with training will be monitored as part of the annual personal development review (PDR) process. All members of staff have a personal training record, which is monitored using the training database. The frequency of training for all members of staff including non-clinical will be in accordance with the Trusts training needs analysis.

Station Officers and Supervisors are responsible for monitoring compliance with the Infection Prevention and Control Policy on a daily basis and challenging inappropriate practice. The results of infection control audits, external assessments and incidents reported to the Infection Prevention and Control Group will be used to ensure that the training programme provides effective, focused training. Specific root-cause analysis training is delivered to officers and managers as required.

MONITORING COMPLIANCE

The Chief Executive and the Board are responsible for monitoring the effectiveness of the Infection Prevention and Control strategy and policy. The Board will receive infection prevention and control reports from the Medical Director via the Assurance Committee.

The annual Infection Prevention and Control Report will be the trust's infection control assurance framework and will:-

- Detail progress against the annual infection prevention and control action plan with the use of Key Performance Indicators where applicable.
- Request ratification of the following year's annual infection prevention and control action plan.
- Demonstrate the effectiveness of the policy through the presentation of audit findings from station reviews, identifying improvements in infection control standards.
- Assure continued compliance with the latest infection prevention and control guidance, including compliance with standard (universal) precautions, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients, decontamination of equipment, waste management, management of linen, Regional Infection Control Manual, disinfection and the reporting HCAIs to the Health Protection Agency.
- Assure compliance with Control Assurance Standards / RQIA
- Provide information from the Clinical Training Manager to reflect that the standards of training for non-clinical and clinical staff identified within the training needs analysis are being met.
- Provide a summary of reported incidents reviewed by the Infection Prevention and Control Group and resultant changes to practice.
- Demonstrate the reduction of infection control risks and their subsequent review on the Risk Register.
- Provide a report from the Risk Manager regarding the number of inoculation incidents reported, confirmation that the immediate management of the injury recorded was appropriate and that support services were provided as appropriate.
- Provide assurance from the Stores Manager that all external laundry contractors continue to comply with appropriate guidance for used and infected linen.
- Detail findings of any internal audits conducted.
- Provide a summary of work undertaken by the key individuals responsible for infection prevention and control, demonstrating that they are fulfilling their identified duties.
- Confirm that information about the trust's processes and arrangements for preventing and controlling health care acquired infections have been and continue to be available to patients and the public through publication of the Policy and Procedures for Infection Prevention and Control document on the trust's internet site.

The Assurance Committee will receive reports from the Medical Director or Clinical Lead on a quarterly basis. The report will detail any deviations from the policy, identify any improvement notices issued, provide an update on effectiveness and identify any appropriate issues. The committee may also gain assurance from the Risk Manager through the presentation of information regarding submitted incident reports.

Monthly audit returns are received via ambulance control with respect to vehicle cleaning. This audit assesses compliance with Vehicle Cleaning Procedures throughout the trust, ensures that all aspects of the policy are implemented, and standards are maintained. Control staff must complete the on-line recording form as and when vehicles are cleaned, with the results being fed via the Risk Manager to the Medical and Operational Directorates for information and appropriate action.

The relevant Area Manager will be informed if the reporting is not being completed to ensure that prompt action can be taken to achieve a full review.

INVESTIGATIONS

It is fundamental to the trust's risk management system that all clinical and non-clinical adverse incidents, hazards and near misses are identified, recorded, analysed with the lessons learnt implemented and controls put in place to avoid their future re-occurrence. All incidents regarding infection prevention and control, including reported outbreaks of healthcare acquired infections, must be reported and investigated according to the Untoward Incident Reporting Policy. The Infection Prevention and Control Group reviews all related incidents and root cause analysis may be undertaken. In the case of suspected outbreaks, the trust will co-operate fully with the DHSSPSNI, Regional Health Board, PHA and other acute trusts during any investigation.

The Serious Adverse Incident policy must be followed for any incident that:

- Causes a patient, staff, or member of the public serious harm, or unexpected death.
- Are likely to cause significant public concern.
- Might seriously impact upon service delivery.
- May attract regional media attention or risk litigation.
- Reflects a serious breach of standards or quality of service

IMPROVEMENT ORDERS

The trust strives to ensure that all estates and vehicles are maintained to a high standard of cleanliness, compliant with the relevant Control Assurance Standards. Should any area of the estate or vehicle(s) be found to fall below the standards specified within the policy or other associated documentation (e.g. cleaning schedules), an incident report must be submitted.

Routine concern not immediately affecting the health and/or safety of patients or staff.

In the first instance the concern should be discussed with the responsible line manager, with a clear deadline agreed for completing the actions. Should resolution not occur within the agreed period, the incident must be reported to the Medical Director who will liaise with the appropriate Director to ensure rapid completion of any outstanding actions. Examples of routine concerns include non-performance of cleaning staff or estates issues which comprise the achievement of infection prevention and control standards.

Urgent concern potentially affecting the health and/or safety of patients or staff.

Where a concern is raised regarding the standards of infection control which poses a potential threat to the health and/or safety of patients or staff, the trust must respond quickly to address the breech in standards. Following any immediate action required to reduce the risk of the breech, the following senior staff are authorised to issue a memo detailing an Improvement Order:

- Chief Executive
- Medical Director
- Director of Operations
- Director of Human Resources
- Director of Finance
- Clinical Lead
- Assistant Director of Operations
- Risk Manager
- Area Managers

The Improvement Order will be issued to the appropriate line manager for urgent action within a timeframe deemed appropriate by the issuing Director/Manager. The Improvement Order may authorise the removal of any vehicle from service or the closure of premises. Any failure to achieve compliance will be escalated to the Chief Executive. All improvement notices will be reported to the Clinical Governance Committee within the standard Infection Control report.

DOCUMENT DEVELOPMENT AND REVIEW

The Infection Prevention and Control Policy (incorporating the Infection Control Strategy) has been developed in consultation with the Infection Prevention and Control Group, local trusts and Public Health Agency. The trust is also a member of the National Ambulance Infection Prevention and Control Group. The policy and procedures will be reviewed every two years , or as required in response to external guidance and recommendations, by the Infection Prevention & Control Lead in conjunction with the Medical Director. The policy and procedures will be presented to the Assurance Committee, prior to being ratified by the Board.

ASSOCIATED DOCUMENTATION

A comprehensive range of associated documents are available via Sharepoint on the NIAS Intranet relating to:

- Appropriate IPC & H&S Appearance / Clothing / Equipment (ACE)
- Universal Precautions & Hand Washing Policy
- NIAS Infection Control Training Manual
- Risk Management Strategy
- Medicines Management Strategy
- Incident Reporting Policy
- Personal Protective Equipment Policy.
- Standard Vehicle Equipment Policy
- Premises Cleaning Schedules
- Equipment Selection and Procurement Checklist

External publications include:

- Basic Training Manual
- Paramedic Training Manual
- JRCALC Clinical Guidelines
- The Segregation, Primary Packaging, Secondary Packaging and Storage of Clinical Waste, DHSSPSNI
- Ambulance Guidelines: Reducing Infection Through Effective Practice in the Pre-hospital Environment
- Saving Lives High Impact Intervention: Intravenous Cannulation
- NICE Guidelines
- SABS Clean Hands Save Lives
- Health Protection Agency Guidance on Infection Control

EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

This Policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

This Policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

This document can be made available on request in alternative formats, e.g. Braille, disc, audio cassette and in other languages to meet the needs of those who are not fluent in English.

INFECTION PREVENTION AND CONTROL PROCEDURES

These Infection Prevention and Control Procedures have been revised to ensure that local procedures are in line with the recommendations of the Ambulance Service Network and the Department of Health. The guidelines have been developed to aide staff to minimise the risks of transmission associated with infectious diseases. This process is dynamic, particularly in the various situations faced daily by ambulance staff. Safe practice can be achieved by ensuring staff:

- Are supported by management to deliver recommendations within these guidelines
- Have received infection control training
- Understand and can apply the principles of risk assessment to minimise the risks of transmission of infectious diseases

Safe infection control practice requires:

- A knowledge of micro-organisms
- The diseases they cause
- An understanding of how they spread between humans

These guidelines acknowledge that provision of a limited list of diseases may well inhibit the ability of staff to properly risk assess situations and utilise appropriate personal protection. For this reason, in addition to Appendix 1, guidance for individual infectious diseases should be obtained via the Health Protection Agency: www.hpa.org.uk

The infectious disease section, whilst not exhaustive, is regularly updated by national experts and should provide a framework for risk assessment, based upon establishing:

- What the organism/disease is
- How is it spread?
- How can staff protect themselves from transmission?

Standard principles should be applied for all patients. These have been developed and provide protection for patients and healthcare workers. The use of standard principles is supported by the National Institute for Clinical Excellence. The full NICE guidelines can be accessed via: www.nice.org.uk

External expertise can be accessed through the Health Protection Agency, NICE, National Patient Safety Agency and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

The trust is committed to tackling the risks involved and reducing the impact of healthcare associated infections on patients, staff and the organisation. Infection Prevention and Control should be integral to the role of all operational ambulance staff and should reflect their commitment to the provision of a safe environment for patients and staff.

All staff engaged in clinical practice on behalf of the trust must be aware of and familiar with the following procedures for their own protection and that of their patients, and to support the trust's efforts towards reducing the incidence of healthcare acquired infection. The trust must continue to focus on the six commitments of Cleaner Care:

- Carrying alcohol handrub whenever in uniform.
- Cleaning hands with alcohol handrub or soap and water between every patient.
- Mopping the vehicle using appropriate cleaning materials during each shift.
- Cleaning the patient trolley and any equipment used after each patient.
- Following the new infection prevention and control policy and updates to ensure that we deal with cleaning, waste disposal and laundry according to the latest national guidelines.
- Ensuring that our patients receive care in an environment that we would be proud for our relatives to experience.

CLEANING AND DECONTAMINATION

The maintenance of high standards of cleanliness on all surfaces and equipment is a crucial factor in the prevention and control of infection. Whilst all dust, dirt and moisture can harbour infection, the key risks are associated with contamination arising from contact with blood and body fluids, mucous membranes or damaged skin. In all cases the surface or equipment must be thoroughly cleaned and disinfected in order to destroy any pathogenic microorganisms. Specific guidance on cleaning ambulance buildings, vehicles and equipment is detailed in Appendix 5.

The Northern Ireland Ambulance Service has selected suitable cleaning and disinfectant products and staff which are available by order from NIAS stores; staff must not use alternative cleaning products as these may not have undergone the same quality and effectiveness assessment. The approved products are detailed in the following table.

Cleaning Products

Only NIAS-approved cleaning products must be used, including disinfectant agents, vehicle cleaning agents, mops, brushes, wipes, hand sanitizers etc. Orders for these can be placed via the eProc system and a running stock maintained at station level.

The products should be also stored on each vehicle as follows, and must be checked during the vehicle daily inspection (VDI).

Product	A&E Ambulance	PTS Ambulance	Rapid Response Vehicle
Actichlor Plus Tablets	No	No	No
Kleenkut detergent bactericidal liquid	No	No	No
Surface Wipes	Yes	Yes	Yes
Single Use Spill Pack	Yes	Yes	Yes

CLEANING MATERIALS COLOUR CODING

The trust has fully adopted the recommendations of the NPSA Safer Practice Notice 15: Colour Coding Hospital Cleaning Materials and Equipment in order to improve the safety of cleaning, ensure consistency and provide clarity for staff.

All cleaning materials and equipment both re-usable and disposable such as mop heads, mop handles, buckets, clothes and gloves must be colour coded. The trust has acquired mop heads which must be disposed of as appropriate to ensure cleaning standards. Posters displaying the colour scheme detailed below should be in placed at all locations where cleaning is carried out within the trust.

Cleaning is a process which physically removes contamination, but does not necessarily destroy micro-organisms. Disinfection is a process used to reduce the number of viable microorganisms and can apply to hand washing, skin preparation and equipment. During routine cleaning, all surfaces must be both cleaned and disinfected.

CLEANING PROCEDURE:

All staff must use appropriate PPE when undertaking cleaning tasks. Use PPE as appropriate.

The standard NIAS cleaning agent for clinical areas is Actichlor Plus, provided in the form of Chlorine releasing disinfectant tablets with detergent. It is used in different ways depending on the likely agent and situation faced as detailed below:

- Dissolve Actichlor Plus tablets according to the dilution instructions below.
- Cold water is required. Do not use hot water.
- If using a dilution bottle, leave the lid off until the tablets have dissolved.
- **Disinfection of the environment** – do not apply the solution directly to vomit, urine or faeces as chlorine gas may be emitted. Clear away gross contamination before cleaning the area.
- **Blood spills** – place paper towels (or similar) over the blood spill and carefully pour the solution over the towels. Leave for two minutes and dispose as clinical waste. Clean and disinfect an area larger than the spill with your solution.
- Report any concerns immediately.
- Practice good personal hygiene, i.e. wash after cleaning, before eating, drinking etc. Use soap, moisturisers, wipes, sanitisers etc. as per procedures and training.

ACTICHLOR INSTRUCTIONS

Actichlor Plus 1.7g Tablets	Required concentration	Tablets added to 1 litre	Contact Time
Disinfection of the environment	1 000 ppm	1	5 minutes
Sporicidal – C.difficile	1 000 ppm	1	10 minutes
Disinfection of Wet/Dry Blood Spills	10 000 ppm	10	2 minutes

WARNINGS AND PRECAUTIONS							
							
Don't take internally. Avoid eye contact i.e. wear eye protection when handling tablets or there is a spray or splash risk. Avoid direct skin contact. Gloves and apron must be worn. Coveralls for deep cleaning.	Don't use directly on urine, vomit or faeces. Don't mix with other chemicals or acids or ammonia.	Avoid prolonged contact with stainless steel or clothing.	Dispose of used materials such as PPE, alcohol wipes, detergent wipes, cloths, paper towels and used mop heads as clinical waste.	Always replace lid after use and store in a secure dry place / CoSHH cabinet. Store in suitable, labelled containers.	Always keep out of the reach of children.	Always make up a fresh solution at the correct dilution (don't keep solutions for more than 24 hours). Dispose of remaining solution into appropriate drains with running water e.g. sluice.	Irritating to respiratory system. Don't breathe dust / fume / gas / mist etc. Always ensure good ventilation when using. RPE not required.

Staff should refer to Sharepoint for the latest Standard Operating Procedure and guidance relating to the use of Actichlor Plus

MANAGEMENT OF BLOOD & BODY FLUID SPILLAGESODY FLUID SPILLAGE MANAGEMENT

Effective management of blood and body fluid spillage is a crucial factor in controlling the spread of infection. Exposure to any such fluid constitutes a risk to all staff and others within the immediate environment. These risks can be minimised by dealing promptly with the spillage by appropriate cleaning and disinfection.

In general, staff must always use appropriate PPE when managing body fluids, and waste material should be discarded via the clinical waste stream

Staff should refer to Sharepoint for the latest version of the NAIS SOP on "Management of - Blood and Body Fluid Spillages" for up-to-date guidance.

STERILISATION

Sterilisation is a process used to render the object free from viable microorganisms, including spores and viruses, but not prions. All clinical instruments and equipment used to surgically penetrate skin, tissue or mucosa - MUST be sterile. Within NIAS, sterile equipment is purchased in the form of pre-sterilised single use items. These avoid the need for re-sterilisation and are a practical and safe method. They must be stored using a stock rotation system in accordance with manufacturer's recommendations.

Sterilised equipment must be kept in its packaging until the moment of use. Excessive handling should be avoided before application. If the outer wrapping is damaged, do not use, as it will not be sterile.

All sterile items used by the trust are single use; no items are to be re-sterilised.

VEHICLE CLEANING

IN the context of an ambulance service, the rear of an accident and emergency ambulance equates closely to the clinical treatment area in the hospital setting, and careful cleaning and maintenance of the area is therefore vital in reducing the infection risk to patients and staff alike.

Staff should refer to Sharepoint for the latest version of the NIAS Standard Operating Procedures on Ambulance Cleaning, which provides detail on regular cleaning including that necessary after every patient, regular scheduled (deep) cleaning and emergency cleaning when a vehicle is specifically contaminated and requires to be stood down for decontamination.

Operational staff are expected to undertake such cleaning as is required to maintain the state of their vehicle during an operational shift, including managing minor spills of body fluids on mattresses etc. with emergency cleaning reserved only for cases of serious contamination or when specifically required following transfer of a patient whose specific infection state requires it.

MANAGEMENT OF LINEN

Germs in most soiled and fouled linen are unlikely to cause infection in healthy workers provided that care is taken. To further minimise the risk:

- Maintain Standard/Universal Precautions
- Wear an apron and gloves when dealing with contaminated laundry
- Remove any protective clothing and wash hands before returning to other duties
- Cover cuts and abrasions with waterproof dressings

Disposable Linen

Single patient use linen is provided on the Emergency Equipment and decontamination vehicles for use in a major incident or other hazardous situation. Once used all items are placed into the yellow clinical waste bag.

Non-Disposable Linen

For laundry purposes linen must be segregated into one of the following groups:

- General used linen, bed linen, towels etc.
- Fouled linen contaminated with blood or other body fluids
- Staff Uniform, contaminated

Bags should not be filled in excess of two-thirds of their capacity. Particular care should be exercised when handling laundry in case clinical waste or sharps have been accidentally concealed within. Once linen has been placed in a bag for laundry service collection, it must not be handled again.

Water soluble bags should be used for contaminated linen, and linen bags should be colour coded to ensure correct segregation of linen.

The trust utilises external laundry contractors (including hospital facilities) to process and supply linen. All operations both within and outside of the trust must comply with Health Service Guidance HSG (95)18, Hospital Laundry Arrangements for Used and Infected Linen.

Staff Uniforms

Uniformed staff should read refer to the NIAS Standard Operating Procedure for Appropriate IPC & H&S Appearance / Clothing / Equipment (ACE) which is available on the Sharepoint via the Trust Intranet.

MANAGEMENT OF CLINICAL WASTE

The following should be read in context with the NIAS Standard Operating Procedure for Clinical Waste Management (Including Sharps) which is available via Sharepoint on the Trust Intranet.

Segregation of Waste

Segregation of waste at the point of production into suitable colour-coded packaging is vital to good waste management and ensuring compliance with current regulations. The colour-coded segregation system outlined in this chapter identifies and segregates waste on the basis of waste classification and suitability of treatment/disposal options. Health and safety, carriage and waste regulations require that waste is handled, transported and disposed of in a safe and effective manner.

Trust premises must provide the required waste streams appropriate to the function of the building, where waste can be segregated at source. All clinical areas must have facilities to

segregate waste into the streams detailed. Although the majority of the ambulance fleet does not currently have provisions to segregate waste, all new vehicles are supplied with separate domestic and orange waste bins. Waste must be segregated where facilities exist.

Domestic waste is waste similar in nature and composition to waste generated at home. Domestic waste must not contain any infectious materials, sharps or medicinal products. Domestic waste must be placed in black bags for disposal. Gloves that have no visible contamination can be disposed of as household waste into the black-bag waste stream. Gloves contaminated with blood and/or body fluids must be disposed as clinical waste.

When handling clinical waste all staff must use personal protective equipment, (PPE) the minimum being gloves. Aprons must be considered if leakage is anticipated. All items of disposable PPE become clinical waste once used.

Staff are expected to make every effort to ensure that any waste arising from their activities, clinical and non-clinical is disposed of properly. In particular, contaminated equipment including sharps must not be left in a public place or private dwelling.

Pharmaceutical Waste

Drugs that have been opened and not used or, only part used, must be disposed of in an approved sharps container. Unused drugs must be return to central stores for disposal through a hospital pharmacy in accordance with the trust's Medicines Management Policy and Procedures.

PROCEDURE FOR CARE OF THE DECEASED

Attention must be paid to infection prevention & control procedures in the event of a patient dying in transit, or in the case of a crew needing to confirm death or move a deceased patient. The Resuscitation Policy should be followed to ascertain the circumstances in which resuscitation should/should not be carried out.

Handling and Transport:

- The body must not be handled unnecessarily.
- Deceased patients beings transported by the Trust must be placed in a heavy-duty disposable plastic body bag.
- Protective clothing must be worn at all times – including disposable gloves, and a disposable plastic apron if contamination of uniform is likely.
- If there is any risk of infection, hospital staff must be warned.
- Upon completion of the incident, the vehicle and all appropriate equipment must be decontaminated according to procedures.
- All materials used must be disposed of in a Clinical Waste bag, which must be sealed, labelled and sent for incineration.

CLASSIFICATION OF INFECTIOUS DISEASES

Infectious diseases are classified into three categories according to the infection control precautions required. The previous classification of Category 1 and 2 are now combined and referred to as cases requiring standard (universal) precautions. An increased level of protection may be required for Category 3 diseases, and above this lie Category 4 diseases which require very specific arrangements and precautions which are detailed below. Further information can be obtained from the Health Protection Agency: www.hpa.org.uk

STANDARD (UNIVERSAL) PRECAUTIONS

No special precautions are required when transporting patients with these diseases, but standard (universal) infection control precautions must be applied as normal practice, unless advised otherwise by the hospital Consultant. A brief description of infectious diseases requiring standard (universal) precautions can be found in Appendix 6, together with their mode of transmission between humans and any particular issues that staff should pay attention to during transportation.

CATEGORY 4:

The transportation of a patient with a known Category 4 infectious disease requires special precautions and procedures which are detailed in section 17.5 of the IHCD Ambulance Service Basic Training Manual and on the HPA web site. In the UK, most patients who could have a Category 4 disease are likely to present to Emergency Departments either directly or via their GP. The patient will present with a pyrexia (fever) of unknown origin (PUO) shortly after having returned from abroad but these early symptoms could indicate any number of far less serious conditions and a positive diagnosis can only be made following extensive tests. See Appendix 6 for further details.

It is likely that ED staff will already have had contact with such patients before their illness is formally diagnosed. The Advisory Committee on Dangerous Pathogens (ACDP) have issued guidance that most pre-diagnosis Category 4 patients can be safely managed by following the Standard Infection Control Precautions and the safe disposal of clinical waste. Any resuscitation regime must include the use of either a bag & mask, or resuscitation pack. Under no circumstances should any form of direct oral resuscitation be carried out.

However, should a Category 4 disease be subsequently diagnosed, the attending ambulance crew will be required to undergo surveillance for a period of 21 days from the last possible date of exposure to infection.

There need be no restriction on work or movement within the UK, surveillance will simply be the daily monitoring of body temperature and the reporting of any suspicious symptoms. During surveillance those suffering any rise of temperature above 37.5°C will be kept under surveillance at home and, if fever persists for more than 24 hours, advice sought from a consultant in infectious or tropical diseases. Category three diseases are detailed in Appendix 6.

Patients with a confirmed diagnosis of a Category 4 disease may require transport to a specialist infectious diseases unit. Locally this is provided at the Infections Diseases ward of the Royal Victoria Hospital, Belfast. Occasionally onwards transport to a specialist unit on the UK mainland is required and special arrangements will be put in place for this. Medical advice may determine that the patient should be transported in an isolator. In the event of this arising in the UK, crews involved will receive special training and instruction at the time by officers and members of the hospital staff.

PROCEDURE FOR INFESTATIONS

Ambulance personnel may occasionally come into contact with patients who are infested with parasites. These parasites live on or in the skin. There are three types of ectoparasite which crews are likely to encounter:

- Scabies
- Lice (Head / Body / Clothing and Pubic)
- Fleas

Protective Measures

Standard precautions should be taken if there is any suspicion of infestation, especially hand washing and the use of PPE such as gloves and apron. If re-useable items are used all items of linen should be bagged and laundered appropriately.

In general, no specific cleaning of the vehicle is necessary other than close attention to the area immediately occupied by the patient. The trolley, adjacent walls and floor should be washed with general purpose detergent and hot water, or wiped with multi-surface wipes. In cases where there is visible infestation with fleas, crews may wish to request a return to base to change clothing. Any member of staff who suspects they may have become infested should contact the Occupational Health Department or visit their GP for further advice.

Scabies
Sarcoptes scabiei is a human mite which penetrates the outer layer of the skin. The body's immune system reacts to the mite's droppings and saliva resulting in an immune reaction which causes intense itching. Incubation period is up to 8 weeks after contact with an infected person. It may take up to 2 weeks before symptoms present. Lesions occur mainly on the hands, finger webs, wrists, inside of arms, abdomen / waist, groin and under buttocks. Scabies is spread from person to person by prolonged (5-10 minutes) direct skin-to-skin contact. It can also be acquired during sexual contact. Mites do not survive away from their host as it is too cold for them outside the skin. Scabies presents a low risk for contraction to ambulance crews providing standard precautions are observed, especially hand hygiene.

Lice
Lice are wingless insects, which are found worldwide as ectoparasites of mammals. They feed by sucking blood from their host.

Headlice - the female louse lives for 2 —4 weeks and can lay 5— 8 eggs per day. The eggs are enclosed in tiny sacs, which are attached to the base of the hair and hatch after 7 days. The

empty egg cases are called 'nits'. The louse takes 10 days to become mature and in turn then able to lay eggs. These lice are only found on the head. Transmission is via head to head contact (approx 1 minute). They cannot jump, fly or swim. Headlice found on clothing or furniture are either dead or dying.

Clothing / Body Lice - These lice live in the seams of clothing rather than on the skin of the host. They will live for 13—30 days if they are able to feed. If unable to feed they will die of starvation in 5 days. Infestations usually affect people with poor personal hygiene, who do not regularly change their clothing.

Pubic Lice / Crab Lice - This louse will infest all coarse body hair. Living on pubic hair, axillary hair, beard, eyebrows and eyelashes. The eggs take 6 —8 days to incubate and the life cycle from egg to egg is about 3 weeks.

Fleas

Human fleas are rarely encountered. Animal fleas are host specific, requiring a specific host animal e.g. cat or dog, to breed and complete their life cycle. However animal fleas will feed from any warm-blooded animal. In the UK, fleas are generally not responsible for the transmission of disease. Cat and dog fleas account for 95% of flea problems in the UK. Although they will not remain on a human, the fleas have the ability to jump on to a person and bite before jumping off again.

PROCEDURE FOR ROUTINE TRANSFER OF INFECTED PATIENTS

The trust frequently transfers patients between two hospital facilities, and to or from care homes. In order to prevent the spread of infectious diseases between facilities, hospitals are responsible for following locally agreed policies and procedures. In general the transfer of an infectious patient/client, especially those with diarrhoea or vomiting, should be avoided unless for essential medical or psychological intervention. Under the Health Act, NHS bodies have a duty to ensure they provide suitable and sufficient information on a patient's infection status whenever they arrange for a patient to be moved from the care of one organisation to another, so that any risks to the patient and others from infection may be minimised.

The infection status of patients is defined as either no risk, suspected risk or confirmed risk. A confirmed risk patient/client has been confirmed as being colonised or infected with Methicillin–resistant staphylococcus Aureus (MRSA), Glycopeptide-resistant enterococci (GRE), Extended Spectrum Beta Lactamase (ESBL), Pulmonary Tuberculosis (TB) and enteric infections (diarrhoea and/or vomiting) including Clostridium Difficile.

A suspected risk patient/client is one who is awaiting laboratory test results to identify infections/organisms or has been in recent contact or close proximity to an infected patient.

Transferring facilities are responsible for:

- Liaising with their Infection Control Teams to ensure that the risks of cross infection are assessed and minimised prior to planning suspected or confirmed infectious patients' discharge or inter-healthcare transfer.

- Informing the Infection Control Team at the receiving facility of any infectious conditions (during working hours) before the transfer is carried out
- Notifying Ambulance Control of any suspected or confirmed risk at the time of requesting transport, including the presence of diarrhea and/or vomiting.
- Ensuring that any wounds are covered with an appropriate occlusive dressing.
- Providing the attending ambulance clinicians with a full verbal handover

NIAS is responsible for:

- Ensuring Control staff inform the attending ambulance clinicians of the patient's infection control status (where this is known).
- Following infection and control guidance to minimise the spread of infection.
- Informing the receiving staff of any confirmed or suspected risk patient during the clinical handover.
- Safely conveying patient notes and the Transfer Form (where provided).

In many cases the patient's infection status will not be known; staff must follow standard universal precautions for all patients.

BIOLOGICAL WARFARE AGENTS

These agents include Anthrax, Plague, Smallpox and some of the viral haemorrhagic fevers. Generally these organisms do not survive easily in the general atmosphere and the risk is therefore minimal. None of the diseases present an immediate risk to life and therefore there is time to seek expert medical advice from ED and subsequently from public health consultants. Staff in the service's HART and emergency planning teams have been trained to use specialised PPE and decontamination procedures. Only these staff should deal with incidents in which such agents are thoughts to be involved. All other staff should remain at a safe distance and await support from trained staff. Control should be immediately informed, and will initiate the appropriate procedure.

In the event that staff are inadvertently contaminated they should report this to the ambulance incident officer who will arrange appropriate after care and support. Special "pods" are strategically placed throughout the country and are available to assist ambulance services deal with incidents of this nature. Incidents of this nature are normally dealt with by implementation of the major incident plans and all staff should ensure that they are familiar with their contents

MAJOR OUTBREAKS AND THE HEALTH PROTECTION AGENCY

The Regional Health Protection Agency provides specialist support to prevent and reduce the impact of infectious diseases, chemical and radiation hazards, and major emergencies. The HPA is bases in Belfast and are involved in a range of activities, including:

- Local disease surveillance.
- Laboratory services.
- Alert systems.
- Investigation and management of health protection incidents and outbreaks.
- Delivery and monitoring of national action plans for infectious diseases at local level.

In the case of a major outbreak, the HPA will coordinate the response and investigation. Rapid microbiological and epidemiological investigations are essential for effective immediate control and to ensure lessons are learnt for longer term prevention. The HPA DHSSPSI are responsible for holding and updating national outbreak plans, as well as many disease-specific major incident plans, working with microbiology and clinical colleagues, Local and Regional Services and, for emergencies, with the Centre for Emergency Preparedness and Response.

In the case of a major outbreak, the Control Duty Manager is responsible for informing and liaising with the HPA, appropriate Duty Officer and Duty Director. The trust will follow directions from the HPA as the lead body and Strategic Health Authority during the management of the situation. Contact details can be found at the front of this document and at www.hpa.org.uk

SUPPLIERS AND CONTRACTORS' PROCEDURE

Conditions of Contract

The Trust has contracted out the majority of services for the provision of linen and clinical waste disposal. All contracts with NHS providers and external suppliers are subject to the NHS Conditions of Contract for the Supply of Laundry Services and the NHS Conditions of Contract for the Supply of Services. All clinical waste is handled in accordance with the Controlled Waste Regulations 1991 and the Control of Pollution Act 1989.

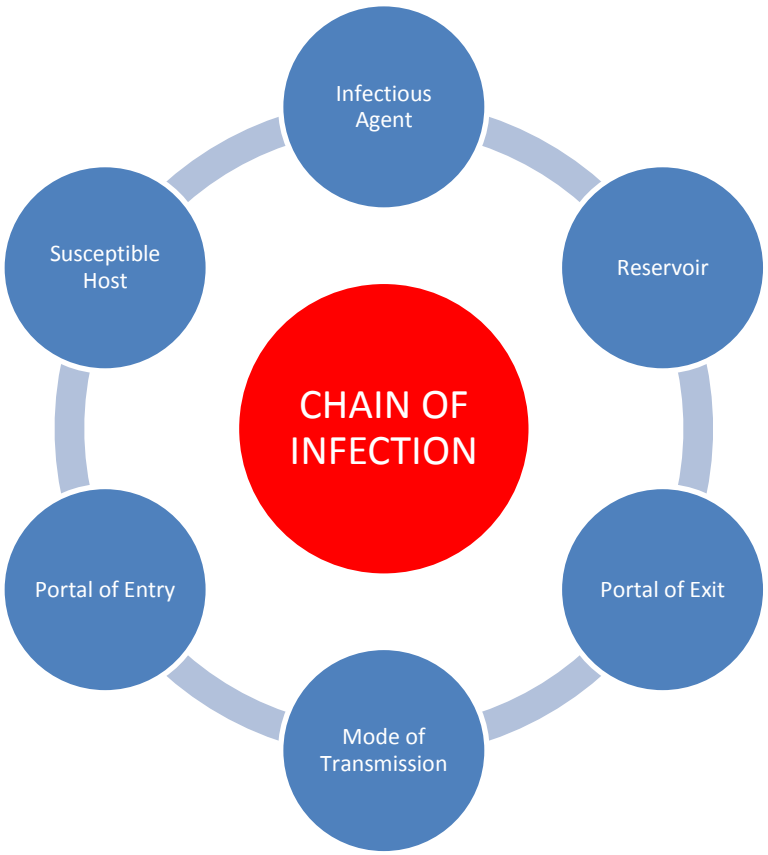
APPENDIX 1 – MICROBIOLOGY & THE SPREAD OF INFECTION

PATHOGENIC MICROORGANISMS

The term micro-organism, or microbe, is used to describe any organism which is too small to be seen with the naked eye. Many microbes normally live inside or on the surface of other organisms. Such organisms living on the human body are called commensals and are generally harmless. Micro-organisms capable of causing infection and disease are known as pathogenic. Pathogenic organisms or the toxins they produce, destroy body tissues. The pathogenic process causes signs and symptoms of infection e.g. pain, swelling, fever.

THE CHAIN OF INFECTION

In order to control or prevent infection it is essential to understand that transmission of a pathogen resulting in colonization or infection requires the following six vital links, known as the chain of infection.



Each link must be present for infection or colonisation to proceed, and breaking any of the links can prevent the infection.

Infectious Agent

The causative agent for infection is any micro-organism capable of producing disease. Sometimes micro-organisms that are a normal part of a patient's own body flora can cause infection in the immuno-compromised host. These infections are called endogenous infections, whilst infections acquired from external sources are referred to as exogenous. Micro-organisms responsible for infectious diseases include:

Bacteria are minute organisms about one-thousandth to five thousandth of a millimetre across. They are susceptible to a greater or lesser extent to antibiotics.

Viruses are much smaller than bacteria and although they may survive outside the body for a time they can only grow inside the cells of the body. Viruses are not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

Pathogenic fungi can be either moulds or yeasts. For example, a mould which causes infections in humans is Trichophyton rubrum which is one cause of ringworm and which can also infect nails. A common yeast infection is thrush caused by an organism called Cadida albicans.

Protozoa are microscopic organisms, but larger than bacteria. Free living and non-pathogenic protozoa include amoebae and paramecium. Examples of medical importance include: Giardia lamblia, which causes enteritis (symptoms of diarrhoea).

Worms are not always microscopic in size but, pathogenic worms do cause infection and some can spread from person to person. Examples include: threadworm and tapeworm.

Prions are infectious protein particles. Examples: new-variant Creutzfeldt-Jakob Disease.

Reservoir

The second link in the chain of infection is the reservoir; the environment or object in or on which a micro-organism can survive and in some cases multiply. Inanimate objects, human beings, and animals can all serve as reservoirs, providing the essential requirements for a micro-organism to survive at specific stages in its life cycle.

Infectious reservoirs abound in health care settings, and may include patients, staff, medical equipment, food, water, and body fluids.

A human reservoir may be either a case or a carrier. A case is a patient with an acute clinical infection while a carrier is a person who is colonized with a specific pathogenic micro-organism but shows no signs or symptoms of infection. Carriers, especially when asymptomatic, may present a risk of transmission to susceptible patients in health care facilities, because their illnesses go unrecognized and they and those around them are unlikely to take appropriate precautions against infection.

Portal of Exit

The portal of exit is the path by which an infectious agent leaves its reservoir. Usually this portal is the site where the micro-organism grows. Common portals of exit associated with human reservoirs include the respiratory, genitourinary, and gastrointestinal tracts, skin, mucous membranes and the placenta

Mode of transmission

The microorganism can be acquired by inhalation (through respiratory tract), ingestion (through gastrointestinal tract), inoculation (through accidental sharp injury or bites), contact (during sexual intercourse) and transplacental transmission (microbes may cross placenta from the mother to foetus). It is important to remember that some microorganisms use more than one transmission route to get from the reservoir to a new host. Of the six links in the chain of infection, the mode of transmission is the easiest link to break and is key to control of cross-infection.

Contact is the most common mode of transmission of infection in the health care settings. Contact transmission may be subdivided into direct contact, indirect contact, and contact with droplets that enter the environment.

Direct contact refers to person-to-person spread of microorganisms through actual physical contact. Microorganisms with a direct mode of transmission can be transferred during such patient care and with the insertion of invasive devices if the hands or gloves are contaminated. Diseases that spread by direct contact include scabies.

Indirect contact occurs when a susceptible person comes in contact with a contaminated object. In health care settings, virtually any item could be contaminated with certain microorganisms.

Droplet transmission results from contact with contaminated respiratory secretions. A person with a droplet-spread infection coughs, sneezes, or talks, releasing infected secretions that spread through the air to the oral or nasal mucous membranes of a person nearby. Microbes in droplet nuclei (mucus droplets) can travel up to 1m. Droplet transmission differs from airborne transmission in that the droplets don’t remain suspended in the air, but settle on surfaces. Examples of diseases spread by droplets include influenza and whooping cough.

Airborne transmission occurs when fine microbial particles or dust particles containing pathogens remain suspended in the air for a prolonged period, and are then spread widely by air currents and inhaled. The tiny particles remain suspended in the air for several hours and may cause infection when a susceptible person inhales them. Examples of diseases spread by airborne transmission include pulmonary tuberculosis, varicella and measles.

Portal of Entry

The portal of entry is the path by which an infectious agent invades a susceptible host. Usually, this path is the same as the portal of exit. The portal of entry for tuberculosis and diphtheria is through the respiratory tract, hepatitis B and Human Immunodeficiency Virus enter through

the bloodstream or body fluids and Salmonella enters through the gastrointestinal tract. In addition, invasive devices such as IV lines and catheters creates an additional portal of entry into a patient's body, increasing the risk of developing an infection.

Susceptible Host / Person at Risk

The final link in the chain of infection is the susceptible host. The human body has many defence mechanisms for resisting the entry and multiplication of pathogens. When these mechanisms function normally, infection does not occur. However, in immunocompromised patients where the body defences are weakened, infectious agents are more likely to invade the body and cause an infectious disease. The very young are at higher risk for infection because the immune system does not fully develop until about age 6 months. Elderly patients are also at an increased risk, as the aging process is associated with declining immune system function as well as with chronic diseases that weaken host defences.

Defence Mechanisms

The human body has two lines of defence against infection:

External and mechanical barriers such as the skin, other body organs, and secretions serve as the body's first line of defence.

If a micro-organism gets past the first line of defence by entering the body through a break in the skin, white blood cells and the inflammatory response come into play.

APPENDIX 2 – PERSONAL PROTECTION MEASURES

STANDARD PRECAUTIONS

Ambulance staff who come into contact with blood or body fluids may be exposed to occupation risk from blood borne viruses e.g. HIV, Hepatitis B (HBV), Hepatitis C (HCV) or other pathogens. The most likely means of transmission of these viruses to ambulance personnel is by direct percutaneous inoculation of infected blood by a sharps injury, or by blood splashing onto broken skin, eyes or mucous membrane. Body fluids which may contain pathogenic micro organisms are:

- Faeces
- Urine
- Vomit
- Sputum

In addition, the following may also contain the organisms of HIV, HBV and HCV:

- Blood
- Bloodstained body fluids
- Semen
- Vaginal secretions
- Body tissues
- Cerebrospinal fluid, amniotic fluid, pericardial fluid etc.
- Unfixed human tissues and organs
- Exudate or other tissue fluid from burns or skin lesions

It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed AT ALL TIMES. These routine procedures are called Standard Principles or Universal Precautions. All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them. By close adherence to universal precautions, ambulance personnel will reduce the risk of contamination to themselves and others from infected body fluids.

Standard (Universal) Precautions include:

- Hand washing and skin care — the skin is a protective barrier, microorganisms can be washed off. Breaks in the skin, cuts and abrasions can provide an entry/exit point for infective microbes and should be covered with waterproof dressings.
- Protective clothing — reduce the risk of substances contaminating you by placing a barrier between the substance and yourself i.e. clothing, visors, masks
- Safe handling and disposal of sharps
- Spillage management
- Waste management
- Linen management
- Maintaining a safe and hygienic environment — decontamination & cleaning procedures

PERSONAL PROTECTIVE EQUIPMENT (PPE)

The choice of protective clothing selected depends on the anticipated risk of exposure to body fluid during the particular activity. Many clinical activities involve no direct contact with body fluid and do not require the use of protective clothing, for example, taking a pulse, blood pressure or temperature. Staff are responsible for confirming that they and their vehicle are appropriately equipped with the requisite PPE prior to going on duty.

Staff must use their judgement in determining the likely requirements in each case.

What to Wear When

No exposure to blood or body fluids anticipated	→	No protective clothing
Exposure to blood or body fluids anticipated but low risk of splashing	→	Wear gloves and apron
Exposure to blood or body fluids anticipated and high risk of splashing	→	Wear gloves, plastic apron and eye / mouth / nose protection

Gloves

General purpose gloves should be worn for any cleaning procedure. These should be latex-free. After use they should be washed with detergent and water and dried. When dealing with blood/body fluids, or after infected cases, these gloves should be disposed of in the clinical waste.

Disposable Gloves

Gloves should be seamless, well fitting, powder-free and low in allergenicity, i.e. powder free latex or nitrile gloves.

Gloves should **not** be worn while travelling to a call but should be fitted just prior to contact with the patient if contact with blood or body fluids is anticipated.

Gloves must be worn whenever contact with body fluids, mucous membranes or non-intact skin is anticipated, when dealing with contaminated equipment or with a patient with an infection or suspected infection. However emergency treatment should not be withheld in the absence of gloves but in these circumstances hands should be thoroughly washed as soon as possible

Choice of size in the selection of gloves should be made on comfort — not too tight as to become restrictive, but also not too loose as to compromise grip and dexterity

If there is the potential for gloves to become punctured during use, e.g. at an RTC staff should consider wearing two pairs of gloves as an additional precaution

Gloves are not worn as an alternative to hand washing. They should be changed after each procedure and hands must be cleaned following their removal.

Gloves should not be washed because this may affect their integrity.

Used gloves should be disposed of in the clinical waste

Any member of staff developing skin irritations on their hands should seek referral to the Occupational Health department

Disposable Aprons

Water-repellent protection should be worn when there is a possibility that contamination of the clothing with body fluids may occur or when cleaning the ambulance and equipment. Disposable aprons should be used for one procedure only and then discarded in the clinical waste. Staff must always ensure they have at least one complete spare uniform available for occasions when uniform contamination has occurred.

Coveralls are not required routinely. However these are provided for use when the risk of contamination or soiling of the uniform is considered beyond the scope of a disposable apron such as when dealing with infections caused by more hazardous organisms or chemical spills.

Goggles / Visors / Eye Protection

These are worn when a particular procedure is likely to cause splashing of body fluids, particularly blood or tissue, into the eyes or face (e.g. during intubation). In the case of SARS or Avian Influenza completely sealed 'chemical protection' goggles may be issued for use. Following use, eye protection should be washed in hot soapy water, dried and stored ready for re-use.

Face Masks

Masks are generally ineffective against airborne infection; however they may offer protection against splashing of the mouth and face. Use of face masks is recommended during procedures when there is likely to be splash of blood or tissue into the mouth, or if the patient is prone to episodes of coughing or sneezing, or during intubation of patients who are suspected to have meningococcal disease, and in cases of suspected TB. Where patients have an uncontrolled productive cough (cannot cough into a tissue), consideration should be given to encouraging the patient to also wear a face mask.

High efficiency masks complying with FFP3 standard are recommended in some specific circumstances e.g. when caring for patients suspected to be suffering from Severe Acute Respiratory Syndrome (SARS), and may be recommended at other times e.g during an influenza pandemic when aerosol generating procedures are being carried out in close proximity to staff. Face masks should fit correctly with no gaps at the sides and the user should be formally assessed for correct fitting prior to first use of such a mask. They must not be

touched and should be discarded when wet. They should not be pulled up and down, but renewed after each episode of use. They are for single use only and should be disposed of in the clinical waste.

Pocket resuscitation masks eliminate the need for mouth-to-mouth contact during resuscitation, when other equipment if not available. Their use will minimise the risk of exposure to infection. These masks are reusable but the one-way valve is single patient use only. The valve should be disposed of as clinical waste. After use, the mask should be cleaned and disinfected and a new one-way valve installed.

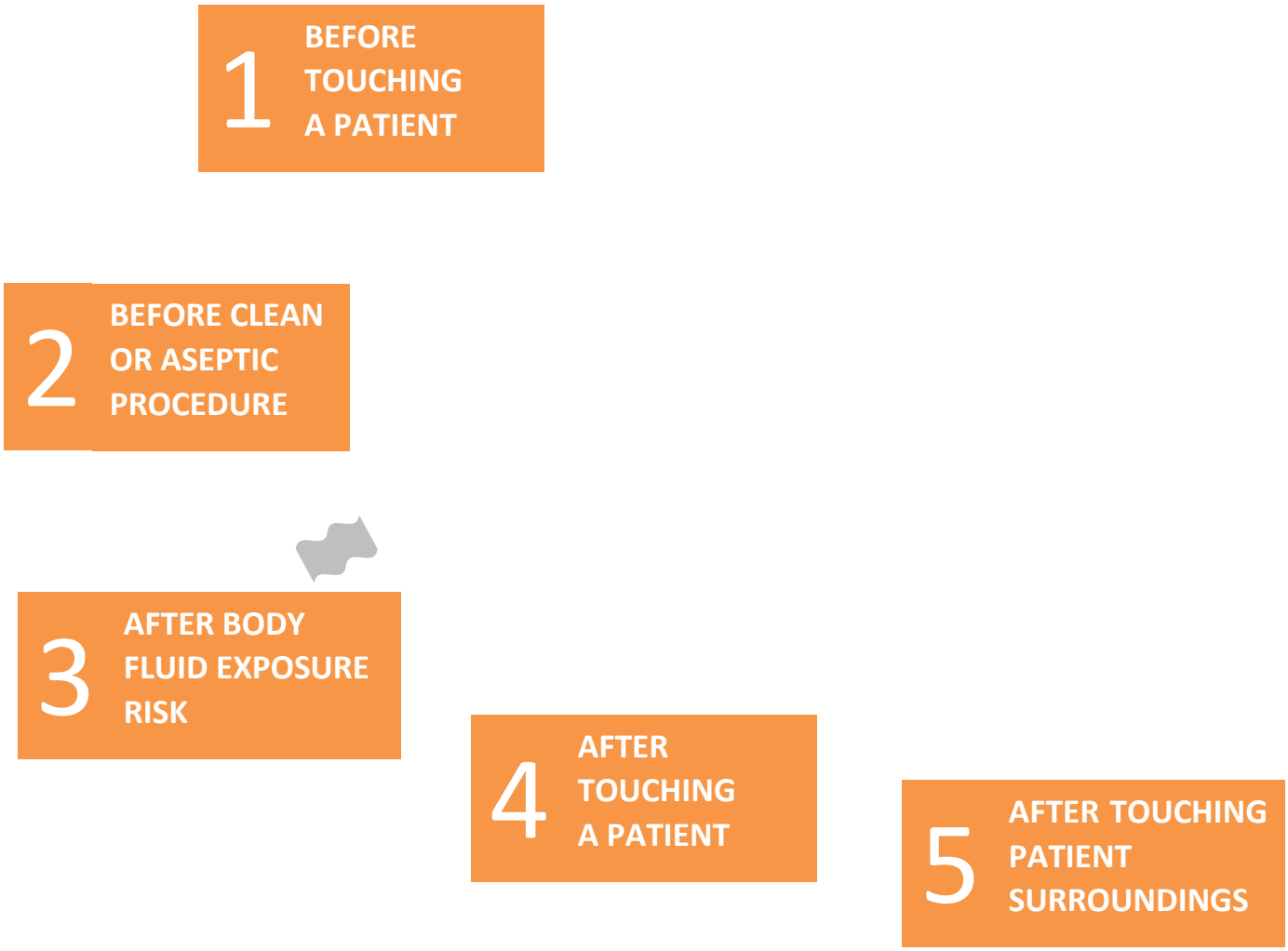
HAND HYGIENE AND SKIN CARE

This section should be read in conjunction with the NIAS Hand Washing Policy

Hand Washing and Skin Care

There are two populations of micro-organisms found on the skin. The resident bacteria live in the deeper skin layers; they are not readily transferred and are usually not harmful. Transient micro-organisms do not normally live on the skin but are both readily acquired and transferred by touch. In clinical settings hands can cause cross infection by transferring these transient micro-organisms between patients but are easily removed by simple hand decontamination procedures. The wearing of gloves is not an alternative to hand hygiene.

Hand hygiene is the single, most effective method of preventing cross- infection. Hands must be washed with consideration to the WHO Five Moments of Hand Hygiene.



Hands must be washed before:

- Patient contact.
- Undertaking a care procedure.
- An aseptic task.
- Taking a break / going home.
- Putting on protective clothing.
- Eating, drinking, handling food.

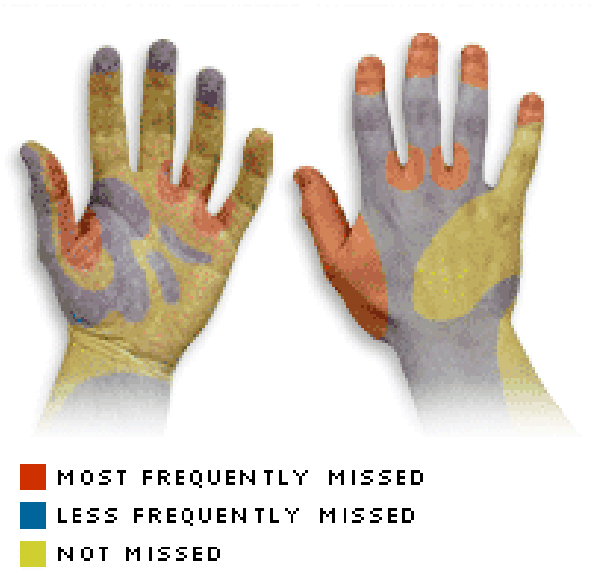
And after:

- Contact with patient surroundings.
- Direct contact with a patient.
- Handling contaminated items such as dressings, bedpans, urinals, urine drainage bags.
- Body fluid exposure risk.
- Cleaning equipment / environment.
- Handling dirty linen or waste.
- Hands become visibly soiled.
- Removal of gloves and/or aprons.
- Going to the toilet, blowing nose or covering a sneeze.

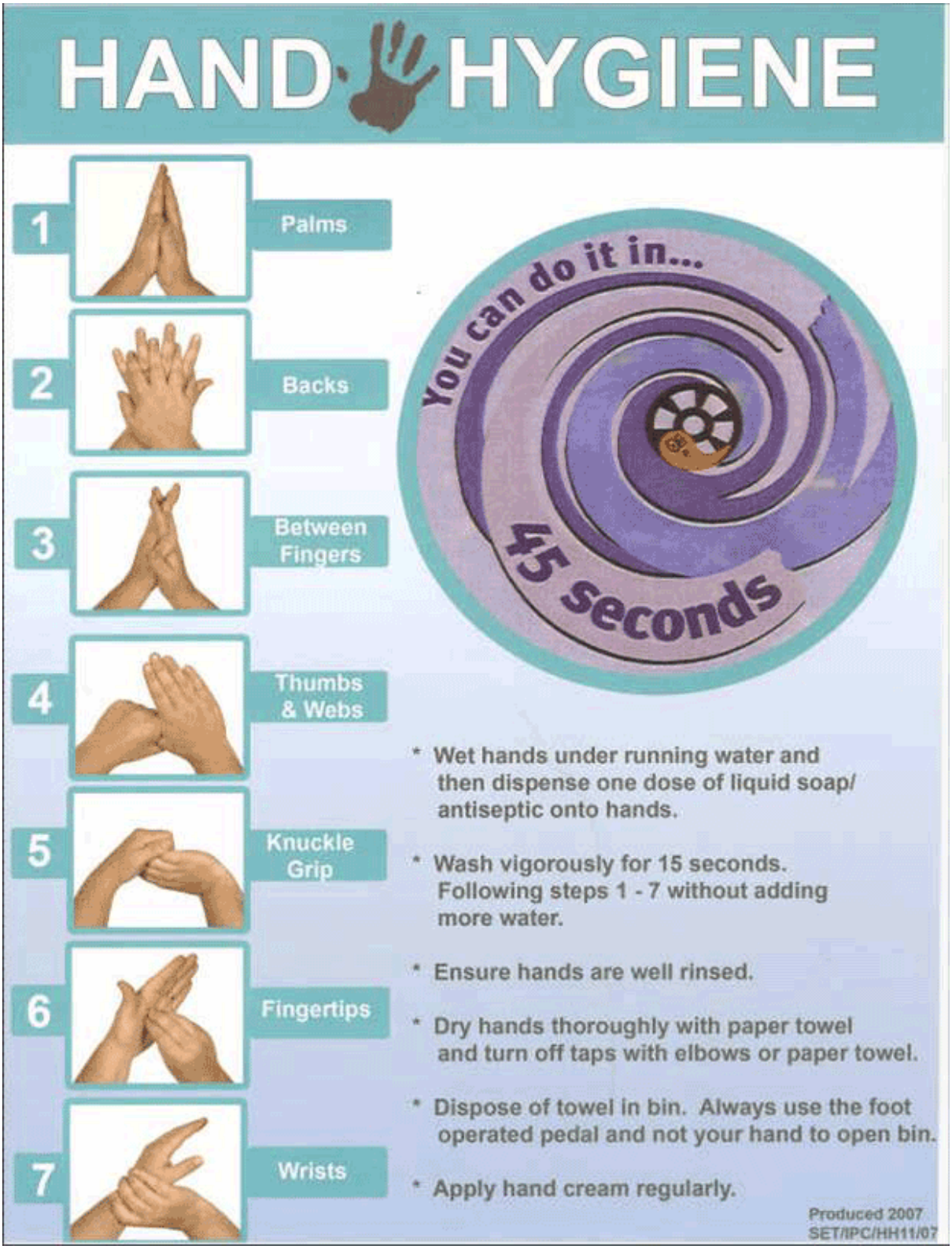
Hand Washing Technique

Technique is more important than the solution used. Remove jewellery (rings).

When hands are washed in a hasty manner certain areas tend to be missed. The diagram shows the areas of skin that are commonly missed during poor hand washing.



Effective hand washing technique involves 3 stages: preparation, washing and rinsing, and drying. Preparation requires wetting hands with water and then applying liquid soap. This should be followed by vigorous rubbing of hands for 10-15 seconds paying particular attention to tips of fingers, thumbs and between the fingers. Hands should be thoroughly rinsed and properly dried using paper towels. The following seven steps are used to ensure that all areas of the hands are properly cleaned.



Hand Washing Facilities

Hand washing facilities are available in all toilets and washroom areas of ambulance facilities. These should not have a plug and should be fitted with liquid soap dispensers. Nailbrushes should be avoided unless they are single-use / disposable. Disposable paper towels or blow-dryers are available for drying.

Most clinical areas of hospitals have hand washing facilities available and these should be utilised whenever necessary. Hand washbasins are not available on ambulance vehicles. When staff are unable to access hand washing facilities it may be necessary to use other methods to decontaminate the hands. Clinell wipes canbe used to clean and disinfect handsin the absence of handwashing facilities, and should be used after every patient contact, after using sanitary facilities, and before/after eating.

Alcohol hand rub can be used effectively, although should not be used as an alternative if a hand basin is available. However, alcohol gel will not penetrate through soil such as blood or dirt, so hands should ideally be cleaned before gel is applied. If hands are not soiled, gel can be used alone. When using a gel, apply 5-10mI to visibly clean hands and rub using the hand washing technique, until the alcohol has evaporated and hands are dry. Only 3-4 applications of alcohol gel should be used before hands will need to be washed as they will become ‘tacky’. It is also important to note that alcohol gel is not particularly effective against the organism Clostridum Difficile which is more readily removed by thorough washing and drying of the hands.

Skin Care

A healthy, intact skin provides an effective barrier against infection. It is important to keep the skin in good condition by using the correct hand washing method, drying hands thoroughly and regular use of hand cream.

All cuts and abrasions should be covered with an impermeable waterproof dressing prior to and during any period of duty. The dressing’s integrity must be checked regularly while on duty and replaced if necessary. Any member of staff with extensive skin lesions must seek advice from the Occupational Health department e.g. eczema. Avoid unnecessarily subjecting skin to laceration in social / domestic activities e.g. DIY or gardening — cover arms and use gardening gloves.

Moisturiser creams should be used regularly following hand washing. The moisturiser helps to prevent dry skin, which in turn will reduce the risk of lesions developing. Hand cream should preferably not be shared, but used direct from dispensers or tubes for single person use only.

APPENDIX 3 – PROCEDURE FOR ASEPTIC TECHNIQUE

ASEPTIC TECHNIQUE

Asepsis is defined as the absence of pathogenic organisms. Aseptic technique is used to describe clinical procedures that have been developed to prevent the contamination of wounds and other susceptible body sites by using sterile equipment and fluids during invasive medical procedures and by avoiding contamination of the equipment by adopting a non-touch technique.

- Aseptic technique keeps procedures as free from organisms as possible. The principles of aseptic technique are:
- Keeping the exposure of susceptible sites to a minimum.
- Ensuring appropriate hand decontamination prior to the procedure.
- Using gloves (sterile or non-sterile, depending on the nature of the susceptible site).
- Ensuring that all fluids and materials used are sterile.
- Checking that all packs used are sterile and show no evidence of damage.
- Ensuring that contaminated and non-sterile items are not placed in the sterile field.
- Not reusing single-use items.
- Reducing staff and/or bystander activity (wherever possible) in the immediate vicinity of the area in which the procedure is to be performed.

The principles of aseptic 'no-touch' technique play a vital role in preventing the transmission of infection in any environment. It is the responsibility of each staff member to understand these principles and to incorporate them into everyday practice. If aseptic technique cannot be applied, for example because of the nature of the emergency, receiving hospital staff must be informed at patient handover in addition to clear documentation on the patient report form

INTRAVENOUS CANNULATION

Due to the increased risk of infection with pre-hospital cannulation, patients should only be cannulated where clinically necessary. Unjustified prophylactic cannulation, and cannulation purely on the basis that it has become expected by the hospital must not occur. As a general guide, cannulation would be considered appropriate where a drug or fluid is likely to or needs to be administered en-route to hospital or immediately on arrival at A&E, or where the patient's condition is unstable and likely to deteriorate.

The choice of cannula gauge must reflect the size of the vein and the maximum flow rate required. Most drugs can be administered through a 22g blue or 20g pink cannula; an 18g green cannula is not generally required for routine drug administration. Inserting a cannula which is too large for the size of the vein increases endothelial damage, leading to an

increased risk of phlebitis. Venous return cannot take place because the vein itself is actually occluded by the cannula (interfering with the haemodilution effect). Using the smallest suitable gauge that will deliver the required flow rate not only reduces the risk of phlebitis, but increases the uptake of the drug into the circulation.

Intravenous cannulation must be carried out aseptically whenever the patient's clinical condition allows a routine insertion, such as when a stable patient requires the administration of morphine. Evidence on peripheral intravenous cannula care recommends:

- Apply the tourniquet (single use disposable is recommend).
- Palpate the vein.
- Decontaminate your hands.
- Clean the site for venepuncture using 2% chlorhexidine gluconate in 70% isopropyl alcohol wipes - do not re-palpate the vein.
- Leave skin to dry for 30 seconds.
- Choose a cannula, open the pack and place the cannula aseptically in a sterile field. If this is not possible, another clinician should open the cannula packaging and present the cannula so that it can be grasped by the cannulating clinician without touching the outer surface of the packaging.
- Decontaminate your hands and don gloves.
- Insert the cannula according to IHCD guidelines, ensuring that the insertion site is not touched. If insertion attempt is not successful, the same cannula must not be used again.
- Use a sterile, semi-permeable, transparent dressing to secure the cannula.
- Record the date and time of insertion on cannula dressing.
- Dispose of any items used in the appropriate waste receptacles.
- Decontaminate hands.
- Record the date and time of insertion on the PRF and on the label of the cannula dressing.
- Always ensure that the giving set and any syringes are handled aseptically.

If any of the above steps cannot be performed due to the patient being in a time-critical condition, the receiving hospital staff must also be made aware, so that the cannula can be replaced aseptically as soon as it is possible, normally within 24 hours. The cannula should be recorded on the PRF as being "Emergency Inserted".

MANAGEMENT OF SHARPS

Sharps include needles, scalpels, stitch cutters, glass ampoules, sharp instruments, razors, and broken crockery and glass, i.e. any article that can cut or puncture the skin by having a fine edge or point. Sharps must be handled and disposed of safely to reduce the risk of exposure to blood borne viruses. Always take extreme care when using and disposing of sharps. Avoid using sharps whenever possible. All clinical procedures involving the use of sharps must only be practised by staff who have received the appropriate training and as a result are duly authorised to perform such tasks. Training should include the safe handling and disposal procedures for the sharps involved.

- Clinical sharps should be single use only and must be stored at all times in their designated containers on the vehicle or in response bags.
- Procedures involving sharps should only be attempted in the vehicle when it is stationery and extreme care must be exercised when treating restless or aggressive patients. The needle should only be removed from its sheath once the patient has been prepared.
- It is the personal responsibility of the individual using the sharp to dispose of it safely in a properly assembled sharps container provided. (BS 7320:1990 / UN 3291 standards)
- Disposable gloves should be worn when handling sharps.
- Sharps must not be passed directly from hand to hand and handling should be kept to a minimum.
- Needles and cannulae should not be re-sheathed.
- Discard sharps directly into a sharps container immediately after use and at the point of use. NEVER leave clinical sharps lying around.
- Sharps should be discarded using a single handed technique. Do not hold the sharps container in the other hand. Do not ask someone else to hold it.
- Needles must not be bent or broken prior to use or disposal. Needle and syringes must not be disassembled.
- Sharps containers should be placed on a level, stable surface. They should not be placed on the floor or above shoulder height. Wall mounted boxes should be used in vehicles.
- When commissioning a new sharps container, a start date and proposed disposal date (three months after commissioning) should be entered on the label at first usage. The container should be disposed of either when 2/3 full or at the disposal date, whichever is sooner.
- Training centre sharps containers do not contain blood products, they may therefore be disposed of when they become 2/3 full, regardless of the date.
- Sharps containers should not be filled more than 2/3 full. They should be fully closed and labelled with the vehicle callsign or station name. ‘NIAS’ should be clearly written on the label to identify the origin of the container as the Northern Ireland Ambulance Service.
- The aperture to the sharps container must be closed, but not locked, when carrying or if left unsupervised, to prevent spillage or tampering.
- Under no circumstances should a sharps container be emptied of its contents or attempts be made to retrieve items from it.
- Sharps containers should be disposed of safely in accordance with local procedures.
- Used sharps containers that become damaged should be placed into a larger secure container with the outer compartment appropriately labelled. They must not be placed into a clinical waste bag.
- Incidents where adequate and appropriate measures have not been taken to dispose of sharps, thereby puffing others at risk of injury, should be regarded as untoward incidents and reported using the untoward incident reporting system (UIR1).

APPENDIX 4 – OCCUPATIONAL HEALTH

OCCUPATIONAL HEALTH

All new employees will be required to attend a health check, which will include a review of the person immunisation status. Prior to the interview, applicants will be sent a copy of the Health Information Letter together with the Immunisation Confirmation Form for completion.

STANDARD HEALTH CHECKS

Tuberculosis (TB) - BCG vaccination offers substantial but not complete protection against TB. All operational staff should be made aware of this and of the need to seek medical advice should they develop symptoms compatible with TB. Individuals with previous contact with TB, including living in a country with high TB prevalence, are at increased risk.

Hepatitis B Immunisation - it is recommended that all staff who have direct contact with patients' blood, blood stained body fluids or patients' tissues, are offered immunisation against hepatitis B and have their response to immunisation checked. Consideration should also be given for other members of staff to receive this immunisation, based on risk assessment e.g. fleet maintenance staff.

The vaccination programme consists of a series of three injections, with the second and third doses administered after intervals of one and five months respectively, following which it is vital that staff attend Occupational Health for a follow up blood test. This is to ensure that adequate levels of antibodies have been achieved. After completion of the initial vaccination programme, a boost injection will then be required at 5 yearly intervals. Guidance on immunisation for hepatitis B, which includes information about dosage/protocols and supplies, is contained in the UK Health Departments publication Immunisation Against Infectious Disease 1996.

Non-responders — a small number of individuals may not be able to gain immunity through the vaccination programme. Where results indicate a hepatitis B surface antibody immunity level of less than l0miu/ml, despite multiple vaccinations, such individuals are likely to be deemed as 'non-responders'. Staff whose duties include performing exposure prone procedures and either, refuse vaccination or are non-responders will be required to have a six-monthly HBsAg blood test performed.

OTHER CHECKS

All operational staff, in association with their Occupational Health Department, should ensure that their immunisations status is up-to-date in relation to:

- Poliomyelitis
- Rubella (German Measles)
- Tetanus

Individuals born before 1958 may not have been adequately immunised against Polio. As the vaccine, which is live, is excreted in the faeces, all those coming into contact with infants who have recently been vaccinated need to ensure their own immunity status. Pregnant staff who do not know if they are immune and believe they may have been in contact with a case of rubella, parvovirus or varicella should see their GP without delay and inform the Occupational Health Department

ADDITIONAL CHECKS FOR SERIOUS COMMUNICABLE DISEASES

Hepatitis C - Ambulance technicians and paramedics will be offered a hepatitis C antibody test (and, if positive, a hepatitis C RNA test) during their health check with the Occupational Health Department, prior to employment within the trust.

- The major risk factors for hepatitis C infection are:
- Receipt of unscreened blood or untreated plasma products
- The sharing of injecting equipment whilst misusing drugs
- Having been occupationally exposed to the blood of patients known to be infected, or deemed to be at high risk of infection, with hepatitis C by sharps or other injuries
- Involvement as a health care worker or patient in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of hepatitis C infection

HIV - Ambulance technicians and paramedics will be offered a HIV antibody test during their health check with the Occupational Health Department, prior to employment within the trust.

The most likely ways in which an individual may have been exposed to HIV:

- Engaged in unprotected sexual intercourse between men
- Shared injecting equipment whilst misusing drugs
- Had unprotected heterosexual intercourse in, or with a person who has been exposed in, a country where transmission of HIV through sexual intercourse between men and women is common
- Involvement in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate, or with populations with a high prevalence of HIV infection
- Had a significant occupational exposure to HIV infected material in any circumstances
- Engaged in unprotected sexual intercourse with someone in any of the above categories

Immunisation is not available against all infections, neither is it guaranteed to be 100% effective. Immunisation should therefore not be regarded as an alternative to practising high standards of infection prevention and control.

STAFF SICKNESS AND REPORTING

It is important for staff to remember that infection can be passed in either direction, i.e. patients to staff or staff to patient and relatives. Staff who suspect they have acquired an

infectious illness should seek advice and treatment from their family doctor. Staff who work in direct contact with patients should follow their local sickness reporting procedures if they develop any of the following diseases, and should contact Occupational Health for advice on when they may report for duty.

- Skin infection on exposed areas or infestation
- Severe respiratory infection (e.g. pneumonia, TB, NOT self limiting viral infections or the common cold)
- Diarrhoea (liquid stool) and vomiting (staff should be 48 hr symptom free before return to work)
- Jaundice
- Hepatitis
- Infectious diseases, such as chicken pox, measles, mumps, rubella or scarlet fever
- Staff should refer to the Notification of Absence policy and Management of Sickness Absence Policy, which are available on station, or through the intranet for further guidance.

ACCIDENTAL EXPOSURE TO BLOOD / BODY FLUIDS

These guidelines are to be followed in the event of a sharp injury or contamination incident. These may be defined as:

- Inoculation of blood by a needle or other sharp
- Contamination of broken skin with blood
- Blood splashes to mucous membrane e.g. eyes or mouth
- Swallowing a person's blood e.g. after mouth-to-mouth resuscitation
- Contamination where clothes have been soaked by blood
- Body exudates or secretions through a wound or sore
- Human bites or scratches

The risk of transmission of infection from a needlestick injury is low. When a sharp injury or contamination incident occurs:

<u>Immediately</u>

1. Encourage bleeding from the wound by gently squeezing (do not suck the wound)
2. Wash the wound in soap and warm running water (do not scrub) or with a disposable
3. Cover the wound with a dressing.
4. Irrigate eye or mouth splashes with plenty of water or saline.
5. Dispose of any sharps involved safely.
6. Report the incident immediately to a CSO/Paramedic Supervisor or Station Officer and complete an incident report.
7. If the source of the injury is known document the details of person(s) involved.
8. All incidents must be reported to Control immediately, who will inform the Manager (or Duty Officer out-of-hours).

<u>As soon as possible (but within an hour)</u>

9. Inform your CSO/ Station Supervisor / Officer.

10. The receiving / nearest A&E department must be informed and blood samples will be taken from the member of staff and patient (providing they give consent).
11. Contact the Occupational Health Department for advice and follow-up on post-exposure prophylaxis, including booster injections. Out of normal hours this advice is available from the local Accident & Emergency Department.
12. CSO / Station Supervisor should ensure that the injured person receives appropriate immediate assistance from Occupational Health or A&E department, and that the relevant details are recorded on an incident report form.

Control Measures

Any staff working in a healthcare facility that handles sharps or clinical waste should receive a full course of Hepatitis B vaccine and have their antibody level checked. New staff or any existing staff who know they are not already protected should contact the Occupational Health Department to arrange a vaccination without delay. Staff who perform exposure prone procedures (see below) need to be aware of their obligations to declare if they know they have been at risk of exposure to a blood borne virus infection (Hepatitis B, C or HIV).

Exposure prone procedures are those where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips and sharp bone / teeth inside a patient's open cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.

Post-Exposure Prophylaxis (PEP)

Following an exposure incident, staff should be assessed, either by the Occupational Health Department or in an emergency department.

Testing the Source Patient

In some instances it will not be possible to identify the source patient. However, if the source is identifiable and available for testing, the Occupational Health Department or hospital emergency department may, with consent of the patient, obtain a blood specimen and send this to the microbiology laboratory to test for Hepatitis B and possibly Hepatitis C and HIV testing if clinical circumstances indicate this is warranted. The patient does however have the right to refuse. Testing can be done on an urgent basis, in consultation with the laboratory. Counselling should be offered to the source patient as well as the member of staff involved.

In the event that the source patient cannot be tested, management of the member of staff should be based on a risk assessment. Clinical information about the incident and/or the source patient should be reviewed. If the source patient is considered to be 'high risk' then the healthcare worker may be managed as if exposed to a source known to be positive. (Such exposures would normally be limited to sharps injuries contaminated with fresh blood from a known high risk population such as IV drug users).

Hepatitis B Virus

Staff should be aware of their own Hepatitis B immunity status. Prophylaxis is available through the Occupational Health Department or an emergency department.

Hepatitis C Virus

There is no post exposure prophylaxis for Hepatitis C.

Human Immunodeficiency Virus (HIV)

The risk of acquiring HIV from single percutaneous exposure is small and on average is estimated to be 0.3%. The risk of acquiring HIV through mucous membranes exposure is less than 0.1%. A triple drug therapy is available for post exposure prophylaxis.

When to consider Post-Exposure Prophylaxis

PEP should only be considered when there has been exposure to blood or other high risk body fluids *known to be* or *strongly suspected* to *be* infected with HIV. (These fluids include amniotic fluid, vaginal secretions, semen, human breast milk, CSF, peritoneal fluid, pericardial fluid, pleural fluid, synovial fluid and saliva in association with dentistry, unfixed organs and tissues).

'Strongly suspected' includes individuals with clinical symptoms highly suggestive of HIV disease or individuals from countries where HIV is highly prevalent who may not yet have had a blood test.

'Strongly suspected' does not include an injury from an unknown source e.g. an inappropriately discarded needle in the healthcare setting or in a public place, nor an individual with a single life-style factor e.g. IV drug abuser. PEP should not be considered following contact through any route with low risk materials e.g. urine, vomit, saliva, faeces, unless they are visibly blood stained.

If PEP is indicated it should be started as soon as possible after the incident, ideally within one hour of the exposure incident. (The Department of Health recommends it may be worth considering PEP even if 1-2 weeks have elapsed since the incident). The individual should attend the nearest emergency department without delay. Ongoing advice, e.g. regarding return to work, can be obtained from the Occupational Health Department or the individuals GP.

N.B. All injuries involving 'exposures' to HIV and Hepatitis B must be reported to the Health & Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Regulations 1995. This reporting will be the responsibility of the Risk Manager.

Staff Support

The notified Station Supervisor / Officer is responsible for providing support to the member of staff in the first instance, ensuring that appropriate services are accessed and information is provided. The member of staffs Station Officer should continue to provide local support in conjunction with the Divisional Officer

During the next working day, the relevant Area Manager will assume responsibility for ensuring that the member of staff is fully supported, and that the full range of support services available are identified. Services may include occupational health and the Trusts staff support telephone line. When involved, the Duty Officer must inform the relevant Area Manager during the next working day.

APPENDIX 5 – SPECIFIC CLEANING PROCEDURES

GENERAL GUIDANCE

Cleaning materials should be colour-coded in line with national guidance. In order to reduce the risk of cross-contamination, mops and buckets etc should not be used across different areas.

AMBULANCE STATIONS / OTHER TRUST BUILDINGS

The environment plays a relatively minor role in transmitting infection, but dust, dirt and liquid residues will increase the risk. They should be kept to a minimum by regular cleaning and by good design features in equipment, fittings and fixtures.

Premises must be cleaned according to trust cleaning schedules. All premises must display an agreed schedule based on the generic schedules available for premises with and without external cleaning staff. In the case of premises not directly cleaned by the trust, the relevant Area Manager will agree a cleaning schedule with the service provider. All deep cleans must be conducted according to the specification within the deep clean schedule.

Achievement of cleaning schedules must be monitored by station supervisors and reported through the monthly returns. Any concerns regarding the standard of cleaning by external contractors or directly employed cleaning staff must be report to and subsequently managed by the Area Manager.

Cleaning staff employed directly or sub-contracted by the trust must follow the NHS Healthcare Cleaning Manual, which must be read in conjunction with the NPSA Safer Practice Notice and the Trust Infection Prevention and Control policy.

In addition to the agreed premises cleaning schedule, the following points will assist in the maintenance of an appropriate environment:

- Work surfaces and floors should be smooth-finished, intact, durable, washable and should not allow pooling of liquids or be impervious to liquids.
- Keep mops and buckets clean, dry and store inverted
- Provide single use, non-shredding cloth or paper roll for cleaning
- Keep equipment and materials used *for* general cleaning separate from those used for cleaning up body fluids
- Use general purpose detergent for all environmental cleaning (following the manufacturers' instructions) unless disinfection is required
- When replacing paper hand towels, these must be put into the holder, and not placed on top. Paper towel and liquid soap dispensers of the cartridge type must be cleaned regularly.
- Vacuum cleaner bags must be changed as necessary and the brush cleaned of hair and fluff before storage.
- Crockery and cutlery should be washed immediately after use in hot water and general-purpose detergent. Wherever possible, dry with disposable paper towels.
- It is usually sufficient to clean floors by removing dust with a properly maintained filtered vacuum cleaner. They can then be cleaned by washing with hot water and general purpose detergent, using mops or suitable scrubbing machine.
- Food preparation surfaces should be cleaned regularly with hot water and general-purpose detergent. These areas should be kept in good repair to facilitate cleaning. Ovens and microwaves must be cleaned after use.
- Hands must be washed thoroughly following any cleaning session. Communal nailbrushes must not be used.
- Refrigerators should be defrosted and cleaned regularly. Should a spillage occur or food become stale, the whole interior of the fridge should be cleaned with hot water and general purpose detergent and dried thoroughly.
- Anti-slip shower mats must be washed with hot water and general-purpose detergent after use. (Cork type shower mats are not to be used).
- Shower rooms and hand basins should be cleaned daily with a cream cleanser, using a piece of disposable cloth which can be disposed of into a black waste sack. A full clean should be undertaken weekly
- Toilets should be cleaned daily with a toilet brush, more often if soiled, using a toilet de-scaling liquid. A full clean should be undertaken weekly. Toilet brushes should be cleaned after use in hot water and general-purpose detergent and stored dry in brush holder.
- Waste bins must be cleaned at least weekly inside and outside with hot water and general purpose detergent. Sack holders should also be cleaned regularly as above.

CLEANING OF AMBULANCE VEHICLES AND EQUIPMENT

It is well recognized that high standards of hygiene within the ambulance will help to prevent the spread of infection. All crew members have an individual responsibility to keep the ambulance clean and thus reduce the risk of cross infection to themselves, their colleagues and their patients. This can best be achieved by all crew members participating in frequent and routine cleaning activities. No emergency or urgent call should ever be delayed as a result of a vehicle being washed or cleaned. Crews must use their judgment in determining the most appropriate time to attend to vehicle and equipment cleaning in order to avoid any disruption to the vehicles deployment. (Staff may also be allocated a specific time to clean their vehicles.)

The Vehicle Exterior

The exterior surfaces of all ambulance service vehicles should be maintained in a consistently clean and hygienic condition. Pressure cleaners on stations should be utilised as necessary. The use of PPE is recommended to avoid inadvertent soiling of uniforms while cleaning a vehicle, and eye protection should be considered when using high pressure washers. Hand protection is important and rubber household gloves or latex/nitrile gloves should be worn when using vehicle cleaning chemicals.

If pressures of operational requirements prevent a thorough cleaning of the vehicle exterior, attention should be prioritised to the relevant safety and legal requirements i.e. windscreen, windows, lights, indicators, reflectors, mirrors and number plates. In addition cleaning should pay particular attention to any areas where dirt is likely to be transferred to the crew's hands e.g. door handles. The usual detergent based cleaning agents are satisfactory for general exterior vehicle cleaning. However, if the exterior has become contaminated with blood or body fluids, the detergent clean should be followed by disinfection to eradicate the potential source of infection. PPE (disposable gloves and apron) should be worn in this case and these items must be disposed of into the yellow clinical waste bag.

Vehicle cleaning, including the interior / clinical areas, must be performed in line with the NIAS Standard Operating Procedures for A&E Ambulance Cleaning and A&E Ambulance Full Vehicle / Equipment Decontamination (Formally Known as a 'Deep Clean'. These SOPs are available via Sharepoint on the NIAS Intranet.

DECONTAMINATION OF EQUIPMENT

The aim of decontaminating equipment is to prevent potentially harmful pathogenic organisms reaching a susceptible host in sufficient numbers to cause infection. Certain items of equipment are classified as 'single-use only'.

Single Use means that the manufacturer:

- Intends the item to be used once then thrown away
- Considers the item unsuitable for use on more than one occasion
- Has insufficient evidence to confirm that re-use would be safe

Single patient use means that the item can be reused if re-processed using an appropriate method and is used on the same patient only. The duration of use is dependent on undertaking a risk assessment of individual factors.

The MHRA (MDA) (2000) guidance suggests that re-processing and re-using such items may pose hazards for patients and staff if the re-processing method has not been validated. Therefore re-use of single use products is not advisable unless the outcomes have been taken into account. The Consumer Protection Act 1987 will hold a person liable if a single use item is re-used against the manufacturer's recommendations.

Re-useable equipment, including vehicles, should be appropriately decontaminated between each patient using a risk assessment model.

RISK ASSESSMENT FOR DECONTAMINATION OF EQUIPMENT

Risk	Application of Item	Minimum Standard
Low	In contact with healthy skin, or not directly in contact with patient. E.g. trolley bed handles, side rails.	Clean
Intermediate	In contact with intact mucous membranes or contaminated with virulent or readily transmissible organisms (body fluids).	Single-use
High	In contact with a break in the skin/mucous membrane, or introduction into sterile body areas. E.g. cannulae	Single-use

SPECIFIC EQUIPMENT CLEANING AND DISPOSAL

The following table gives guidance on equipment which is reusable and therefore requires cleaning as per the cleaning schedule. If equipment is grossly contaminated then it should be disposed of as clinical waste.

Equipment	**Recommended Care**
Blood Glucose Monitor	Clean between each use. Refer to manufacturer's instructions. Test strips are single use – disposable and should be placed in sharps box after use
Body Bags (Disposable)	*Single patient use only*
Buckets	Empty, wash and dry thoroughly after each use. Store inverted
Carry Chair If contaminated with blood / body fluids	Check fabric and straps intact. When visibly soiled clean using hot water and detergent, rinse and dry thoroughly, or clean with detergent wipe. Clean with detergent then disinfect using chlorine releasing agent (e.g. Milton), dry thoroughly
Defibrillator / ECG Daily Straps / Wires After each patient	 Wipe with alcohol / chlorhexidine wipes . Wipe over with damp cloth, detergent and hot water Decontaminate with disinfectant hand wipe. Dry thoroughly with absorbent towels.

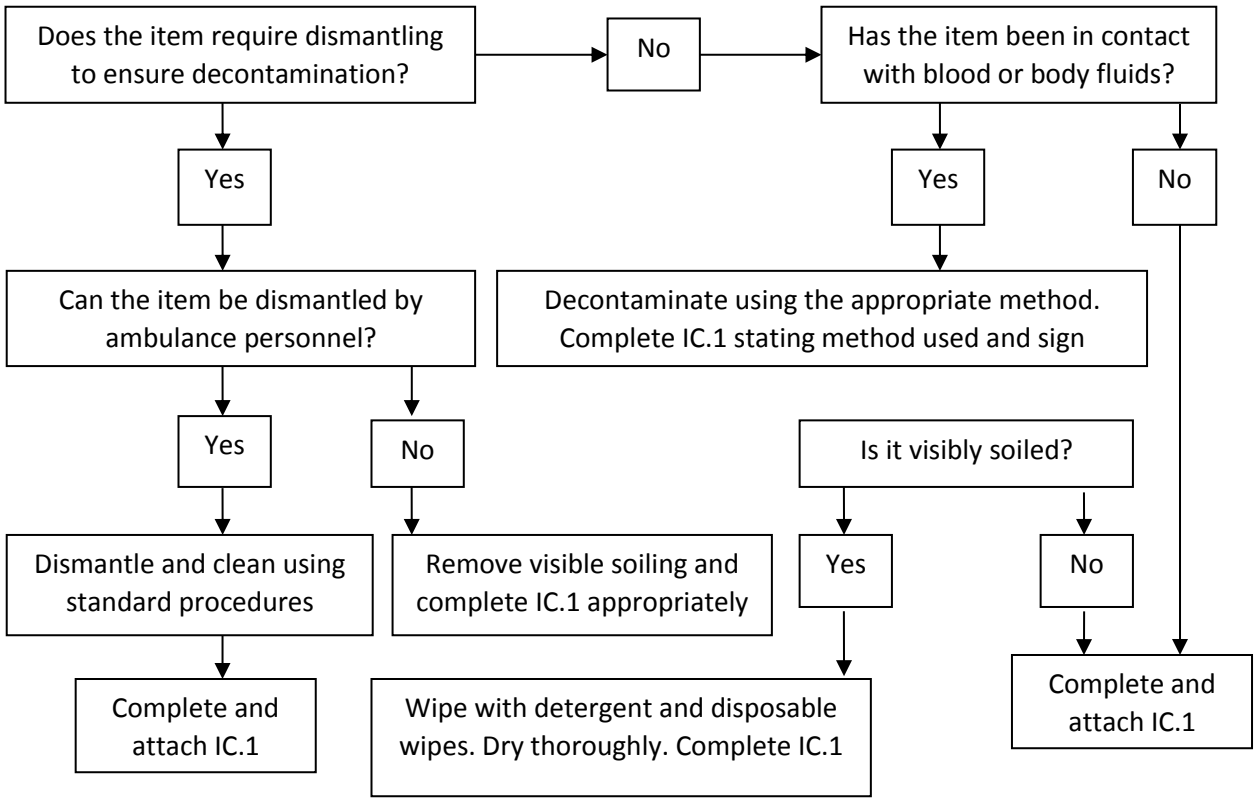
If contaminated with blood *I* body fluids	Wipe with a damp cloth, detergent and water (ensuring none enters the equipment), and then disinfect with an alcohol / chlorhexidine wipe.
Entonox apparatus After each use	Face masks and in-line filters are single use The main apparatus should be cleaned by applying detergent and leaving for 2 - 3 minutes. Dry thoroughly with absorbent towels. Dispose of all materials in Clinical Waste bag.
Hand held Radio	Clean using detergent wipe.
Lancet holder (for BM Testing)	Wipe with alcohol / chlorhexidine wipes after each use
Linen	Place in appropriate colour coded bag for laundry or disposal
Peak Flow Meter	Wipe with 70% alcohol / chlorhexidine wipe. *One-way-valve or filter patient mouthpiece is single use - disposable*
Pillows	Should be encased in an intact waterproof cover. Clean with detergent and hot water — dry. If integrity of cover is breached — dispose of pillow as clinical waste and replace
Resuscitator (MicroVent)	Disinfected according to manufacturer's instructions. Patient masks are single use.
Safety Helmet If contaminated with blood / body fluids	Check visor, strap and casing intact. Clean using detergent wipe. Use disinfectant then an alcohol / chlorhexidine wipe
Sphygmomanometer Cuffs (Re-usable)- after each patient use If contaminated with blood / body fluids	If soiled, apply detergent and leave for 2 —3 minutes. Dry thoroughly with absorbent towels Ensure material is intact and equipment is functional. Apply detergent and leave for 2 - 3 minutes. Dry thoroughly with absorbent towels. Clean with detergent, then use chlorine releasing agent and dry thoroughly. Cuffs that cannot be cleaned should be discarded and replaced.
Stethoscopes After each patient use	Wipe earpieces and bell with disinfectant wipes. Earpieces must be changed when damaged.
Stretcher Mattresses	Check that cover is intact. At start and finish of each shift and when visibly soiled, clean with detergent and hot water and leave for 2 - 3 minutes. Dry thoroughly with absorbent towels.
Suction Catheter Tubing **Suction Unit Bottle (disposable) or Bag Liner** **Suction Unit (Hand Held)**	*Single patient use only.* Dispose of in Clinical Waste bag. *Single patient use only.* Dispose of in Clinical Waste bag. Dispose of aspirate bottle ONLY in Clinical Waste bag.
Thermometers	Electronic Thermometer body: *wipe with disinfectant wipe* Probe cover for electronic thermometer: *single use* Tempadot thermometers: *single use*

CLEANING OF VEHICLES PRIOR TO INSPECTION, SERVICE OR REPAIR

Equipment (including vehicles) requiring repair or servicing must be cleaned of all organic material, by the professional user or other appropriately trained staff, before it is sent away. A decontamination certificate must be attached to the equipment on dispatch, which states the method of decontamination used, or the reason why it was not possible. Vehicles should instead be accompanied a copy of the Vehicle Maintenance and Defect Reporting Book sheet confirming that the vehicle is in a suitable condition in line with the NIAS Infection Prevention & Control Policy.

All reusable medical devices must be decontaminated in accordance with manufacturer's instructions as well as legislative and best practice requirements (see flowchart). It is also important to ensure that vehicles going for maintenance or repair are sent to workshops, including external contractors, in a state which is safe for non-clinical staff to work in. All clinical waste should be removed and the sharps box should either be removed or placed in the closed position. The interior and equipment should be checked for sharps and contamination, and cleaned if necessary. If cleaning and checking of the vehicle has not been possible workshops should be notified of the risk and advised of any precautions to take.

FLOWCHART FOR DECONTAMINATION PRIOR TO SERVICE OR REPAIR



FORM IC.1

Northern Ireland Ambulance Service

Certificate of Equipment Decontamination

(Prior to Inspection, Service or Repair)

Make: ……...

Model: ……...

Description: ……...

……

Serial No: ……..

In the case of a vehicle, insert callsign and registration mark

Tick one of the following boxes as appropriate

This item has not been exposed internally or externally to body fluids or other hazardous material.

This item has previously been exposed to body fluids or other hazardous material but has been decontaminated following the Infection Prevention and Control Policy

Please state decontamination procedure used (if applicable):

……

……

……

……

Full Name: ……...

Position: ……...

Signature: ……... Date: ……

VEHICLE MAINTENANCE & DEFECT REPORTING BOOK CERTIFICATE

15151

Top Copy – To be completed and presented to Contractor on Collection of vehicle

Date _____ Vehicle Type A&E/PCS/RRV/Support

Vehicle Reg No _____ Vehicle Mileage _____

Work Requested Defect repair/ Servicing /MOT /Accident

Please Supply Details of work requested

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

This vehicle is in a suitable condition to be released for repair in line with the NIAS Infection Prevention & Control Policy V2.3 ☐

All drugs have been removed ☐

Equipment removed ☐

Work Requested By _____ Print _____

Contractor Contacted _____ Date _____ Time _____

Additional information

_____

_____

_____

_____

If the vehicle is not suitable for release contact Station Supervisor/ Station officer

Name of Supervisor/Station Officer Contacted _____ Date _____

Contractor Please Note

ENSURE A VALID ORDER HAS BEEN RECEIVED. REPAIRS OVER OR LIKELY TO EXCEED £500 WILL REQUIRE AN ESTIMATE FIRST.

APPENDIX 6 – PROCEDURES FOR INFECTIOUS DISEASES

Infectious diseases are classified into two categories according to the infection control precautions required. The previous classification of Category 1 and 2 are now combined and referred to as cases requiring standard (universal) precautions. Further information can be obtained from the Health Protection Agency (www.hpa.org.uk)

DISEASES REQUIRING STANDARD (UNIVERSAL) PRECAUTIONS

Disease	Mode of Transmission	Particular Issues
Chickenpox (Varicella)		
Viral infection causing skin rash, spots and blisters. Childhood illness which provides natural immunity.	Airborne droplets. Direct contact with rash.	None likely to be effective
Cholera		
Bacterial infection of the intestines causing diarrhoea, vomiting and severe dehydration, often fatal.	Direct contact with faeces and vomit.	Wear gloves and aprons I fnecessary.
Clostridium Difficile		
Bacterial infection sometimes present in the bowel of healthy people, but may flourish following treatment with antibiotics for other infections. Can cause mild diarrhoea to severe illness with ulceration and perforation of the bowel and peritonitis. Can be fatal	Direct contact with faeces and contaminated clothing / bedding which may contain spores that can survive for a significant length of time outside of the body.	Wear disposable gloves and apron. Disinfect vehicle after use. Treat soiled linen as clinical waste.
CPE (Carapenemase-producing enterobacteriaceae)		
Bacteria which can exist harmlessly in the human gut but can cause system infection including urinary tract or septicaemia. Some	While the organism itself is not especially infectious, it is very difficult to eradicate or treat, and precautions must therefore be taken to reduce the risk of infection.	The receiving ward or unit should be notified ahead of arrival that a patient is a carrier of CPE or is suspected of having a CPE infection, and they may

strains are highly resistant to almost all antibiotics	This relies mainly on standard precautions i.e. careful hand hygiene coupled with the use of a disposable apron	specify a specific route of access or destination for the patient. The infection status should also be advised to any receiving nursing or medical staff. After the call, the mattress, trolley and interior of an ambulance used to transport a patient with CPE should be thoroughly cleaned with the normal disinfectant solutions available at NIAS stations
Diptheria		
Bacterial infection of the throat causing a membrane like exudate of clotted serum, white cells, bacteria and dead surface tissue cells to form which obstruct the upper air passages and often require a tracheotomy.	Airborne droplets although the bacteria can only live for a short time once outside of the body.	Staff can be vaccinated by the Occupational Health Department.
Dysentry		
Bacterial inflammation of the bowel causing abdominal pain, fever and frequent passage of stools containing blood and mucus.	Direct contact with faeces and vomit.	Wear gloves and aprons if necessary.
Encephalitis		
A viral inflammation of the brain causing fever, vomiting, seizures, mental confusion, coma and death.	Direct contact with faeces and vomit.	Disinfect vehicle after use.
Enteric Fever		
Bacterial infection of the bowel causing headache, fever, loss of appetite, abdominal discomfort and constipation.	Direct contact with faeces and vomit.	Wear gloves and aprons if necessary.

In severe cases, delirium, diarrhoea, skin rashes and enlargement of the liver or spleen may occur.		
Erysipelas		
Bacterial infection of the skin which often blisters and may weep.	Direct contact with skin lesions.	Wear gloves when handling lesions.
Glandular Fever (Infectious Mononucleosis)		
Viral infection causing weakness, headache, sore throat and enlargement of the lymph nodes and spleen.	Direct contact with saliva.	Do not use mouth to mouth resuscitation, use a bag and mask.
Gastroenteritis		
Bacterial or viral inflammation of the intestine and stomach lining causing fever, abdominal pain, diarrhoea and vomiting.	Direct contact with faeces and vomit.	Wear gloves and aprons if necessary.
Hepatitis A		
Viral inflammation of the liver giving rise to fever, loss of appetite and jaundice	Contact with contaminated faeces / water	Wear gloves and apron if necessary Staff can be vaccinated by the Occupational Health Department.
Hepatitis B and Hepatitis C		
Viral inflammation of the liver (which can be fatal). 10% of those that do recover become carriers and may develop cirrhosis or cancer of the liver. Four out of five carriers have a very low infectivity, the remainder, and those suffering acute Hepatitis at	Exchange of blood and blood stained body fluids. The prime risk of infection for ambulance staff is by accidental self inoculation, or the entry of infectious material through broken skin, or the mucous	Staff can be vaccinated against Hepatitis B (not Hepatitis C) by the Occupational Health Department.

the time, are highly infectious.	membranes of the eye, nose or mouth. Simple contact between blood and intact skin does not constitute a risk.	
Herpes Simplex		
Viral infection causing skin lesions around the mouth, genitalia, and other mucous membranes	Direct contact with lesions	Wear gloves if necessary.
HIV / AIDS		
A person infected with HIV may go on to develop AIDS (Acquired Immunodeficiency Syndrome) over the following weeks, months or years. An AIDS diagnosis is given when the immune system has been damaged by HIV causing a number of specific infections and/or cancers which may be fatal.	Exchange of blood and body fluids but not saliva or tears. The prime risk of infection for ambulance staff is by accidental self inoculation, or the entry of infectious material through broken skin, or the mucous membranes of the eye, nose or mouth. Simple contact between blood and intact skin does not constitute a risk.	
Impetigo		
Bacterial infection of the skin causing blisters or crusting sores on the skin, most commonly in children.	Direct contact with skin lesions.	Wear gloves when handling lesions.
Infestations e.g. fleas, lice		
Parasitic infestation of the skin causing intense irritation.	Direct contact.	Wear disposable gloves and apron. Disinfect vehicle after use.
Influenza		

Viral infection causing fever, tatigue, loss of appetite, headache, generalised muscle and joint pains. Some strains have the potential to cause more serious illness, particularly in the elderly or compromised	Airborne droplets.	Wear disposable gloves and mask. In pandemic situations further measures such as aprons, filter masks and eye protection should be considered with reference to specific procedures published at the time Normal vehicle cleaning with disinfection of the area the patient was in and any equipment used.
Leptospirosis		
Bacterial infection which can cause influenza like symptoms and may lead to jaundice, heart failure or meningitis.	Passed to humans by rat urine. None between humans.	
Leprosy		
Bacterial infection of the skin and nerves causing tissue destruction.	Long term, intimate, direct contact.	
Malaria		
Parasitic infection which causes shaking, headache and red blood cell destruction.	Passed to humans via mosquito bites or blood transfusion. None between humans.	
Measles		
Viral infection causing skin rash, mouth spots, fever, cough, and conjunctivitis. A childhood infection living lifelong natural immunity.	Airborne droplets. Direct contact with saliva.	Do not use mouth to mouth resuscitation, use a bag and mask. Vaccinations are available from GP's for the rare adult that escaped childhood infection / vaccination.
Meningitis and Septicaemia		

Meningitis is a viral or bacterial inflammation of the lining of the brain. Symptoms may include fever, vomiting, headache, stiff neck, aching limbs and joints, a dislike of bright light, drowsiness and a rash. Bacterial meningitis is rare but can cause permanent deafness or brain damage and can be fatal. Viral meningitis is more common but the effects are mild and most people make a full recovery. Some bacteria that cause Meningitis may also cause Septicaemia (blood poisoning) as well. This can develop quickly and is evident from a rash which can be anything from tiny red spots to large blotchy bruises. Both bacterial Meningitis and Septicaemia require urgent antibiotic treatment. The bacteria which causes meningitis is carried in the nose and throat of 10- 15% of the general population without any harmful effect at all, it is very rare that they overcome the body's defences and cause meningitis.	Airborne droplets. Spread during coughing, sneezing and kissing but the germs cannot live outside of the body for more than a few seconds and are not easily passed from one person to another. The prime risk to ambulance staff is by conducting unprotected mouth to mouth resuscitation. There is no risk from merely being in the ambulance with a patient.	There is no risk from merely being in the ambulance with a patient. Do not use mouth to mouth resuscitation, use a bag and mask If direct contact has occurred then the Public Health Agency may offer prophylactic antibiotic treatment.

Methicillin Resistant Staphylococcus Aureus (MRSA)		
Staphylococcus Aureus (SA) is a common bacteria found on 30% of the population as part of their normal skin flora. Most strains of SA have acquired resistance to some antibiotics and MRSA has acquired resistance to the most commonly used antibiotics. In normal healthy people MRSA does not pose a threat to health. Infections are rare but if one does occur the infection is trivial and affects the skin, resulting in infected cuts or boils which are easily treated. In people that are unwell (and therefore already have a reduced resistance to infection) open wounds or invasive procedures such as cannulation, airway intubation or surgery, cause breaks in the skin which can allow MRSA bacteria to enter deep into the body and cause more severe infections which can be difficult to treat.	Direct contact. MRSA does not represent a specific hazard to ambulance personnel or their relatives but is a cross infection risk to other patients. The main mode of transmission to other patients is via handling by healthcare workers and this is usually caused by not disposing of gloves or cleansing hands between handling open wounds on different patients.	Wear gloves when handling open wounds and dispose of them after each patient use. The most important prevention strategy is hand hygiene. There is no need for MRSA patients to be transported separately from other patients.
Mumps		
Viral infection causing malaise and fever, and swelling of the salivary glands.	Airborne droplets. Direct contact with saliva.	Vaccinations are available from GP's for the rare adult that escaped childhood infection / vaccination.

A childhood infection giving lifelong natural immunity. In adult men, can cause painful inflammation of the testicles but sterility is very rare.		
Ophthalmia Neonatorum		
Bacterial infection of the eye. Occurs in new born babies as a result of infection acquired during birth.	Direct contact with exudate.	Wear gloves when handling eye.
Poliomyelitis		
Viral infection causing fever, sore throat, headache, and vomiting. In severe cases stiffness of the neck and back, muscle ache, twitching and paralysis may occur.	Direct contact with faeces and vomit.	Wear gloves and aprons if necessary. Disinfect vehicle after use. Staff can be vaccinated by the Occupational Health Department.
Ringworm		
Fungal infection causing re ringed patches on skin	Direct contact	Wear gloves as required
Salmonella		
Bacterial infection causing fever, abdominal pain, nausea, vomiting and diarrhoea	Ingestion of infected foodstuffs, faecal-oral spread	Wear gloves and apron as required. Normal cleaning of vehicle,
Scabies		

Parasitic skin infestation causing intense itching.	Intimate direct contact.	There is no risk from being in the vehicle with an infected patient. Stretcher linen should be removed after journey and placed in a red laundry bag.
Shingles		
Viral infection caused by the reactivation of an earlier infection with Chickenpox. Symptoms include inflammation of the nerve ganglia near the spinal cord, localised pain and skin rash on the trunk. Severe cases cause a rash around the eye and vision impairment. Contact with shingles may cause Chickenpox in individuals without natural immunity.	Airborne droplets. Direct contact with rash.	Precautions are unlikely to be effective.
Tetanus		
Bacterial infection of the nervous system causing muscle contractions.	Penetrating skin wounds only.	Staff can be vaccinated by the Occupational Health Department.
Tuberculosis		
Bacterial infection usually affecting the lungs but can also affect the bowel, lymph nodes, skin, bones or other vital organs. Symptoms include fever, fatigue, weight loss, night sweats, coughing and blood streaked sputum.	Airborne droplets.	Immunity can be checked by the Occupational Health Department and vaccination offered if required.
Typhus		

Parasitic infection causing headache, back and limb pain, shivering, cough, constipation, skin rash, delirium, prostration, weakness of the heart action, stupor, coma or death.	Direct contact with saliva, faeces or vomit.	Do not use mouth to mouth resuscitation, use a bag and mask.
Whooping Cough (Pertussis)		
Bacterial infection of early childhood causing an exhausting cough. Adults are not normally infected.	Airborne droplets.	Bacteria can only live for a very short time once outside of the body.

DISEASES REQUIRING CATEGORY 4 MEASURES:

Disease	Mode of Transmission	Particular Issues
Anthrax		
Bacterial infection which may present as a boil. Can attack the lungs resulting in respiratory distress, cyanosis, shock and coma	Direct contact with animal hair, hides or waste Contact with anthrax spores which are particularly resilient and may survive for years in the environment	Clean by disinfection. All contaminated materials including blankets are clinical waste
Plague		
Bacterial infection which may present with swollen glands, haemorrhagic rash, cough, heaemoptysis or meningitis	Direct contact and airborne droplets and other body fluids. Indirect contact via contaminated surfaces, or vector borne via animals and parasites	
Rabies		
Viral inflammation of the brain causing fever, headache, neck stiffness, anxiety and disorientation. This progresses to a fear of swallowing, choking, panic, hallucinations, coma and death.	Bites from infected animals or direct human contact with rash, saliva, urine and cerebro-spinal fluid	
SARS (Severe Acute Respiratory Syndrome		
Viral infection causing high fever, headache, generalised pains and respiratory symptoms	Airborne droplets and direct contact if infectious particles are brought into contact with eyes, nose or mouth e.g. by unwashed hands	Wear gloves, filter mask, eye protection and apron. Hand hygiene is of primary importance.
Smallpox		
Severe viral infection causing fever, headache, muscle ache and a blistering rash, often fatal.	Airborne Droplets	
Viral Haemorrhagic Fevers		
Initial symptoms include fever, malaise, headache and muscle and joint pains. Nausea, vomiting and diarrhoea may also occur.	Airborne droplets possibly if patient is suffering pulmonary infection.	Wear gloves, filter mask, eye protection and apron. Hand hygiene is of primary importance. Further specific guidance will be issued in

Ebola and Marburg often cause a measles-like rash after 4-7 days. Obvious bleeding is a later or terminal event. Pyrexia may last as long as 16 days with temperatures up to 41°C; severe cases result in coma and death.	Accidental inoculation or contamination of broken skin or mucous membranes by infected blood or body fluids and the risk may extend for many weeks after a patient has recovered from their own infection.	the event of notification of these diseases.

GUIDELINES FOR DEALING WITH CATEGORY THREE AND FOUR DISEASES

These guidelines should be read in conjunction with those set out in the Ambulance Service Basic Training (ASBT) Manual on Category 4 infectious diseases. They should be followed or the conveyance of patients suffering from or suspected to be suffering from highly infectious diseases to the Infectious Diseases ward of the Royal Victoria Hospital or in extreme circumstances for transfer to a specialist unit on the UK mainland.

REMDC staff should be aware that special precautions are needed with these types of cases as there is a risk of the spread of infection by contact with infected blood, vomit, excreta and possibly air droplets.

Infection Control Vehicles

Northern Ireland Ambulance Service have a number of specially adaptations to reduce the risk of infection spread. If transporting a patient with a known Category 3 or 4 disease, EAC must allocate one of the Infection Control Vehicles to the duty.

Transportation of Isolator Patients

Requests for the transportation of a patient to the Infectious Diseases Unit will come from the Royal Victoria Hospital or the Department of Public Health / Consultant for Communicable Disease Control. The Physician-in-charge of the Infectious Disease Unit at the Royal Victoria Hospital will inform Ambulance Control of the level of containment appropriate for the journey required. In all such cases one of the dedicated Infection Control A&E Vehicles must be allocated to the call, but where containment requires the use of a Transit Isolator, this will be provided by the Royal Victoria Hospital. The Northern Ireland Ambulance Service does not have a transit isolator.

Action by Control

When a request for transportation is received in-hours, the Duty Control Manager/Officer must inform the

- Emergency Planning Department
- Medical Director
- Director of Operations

Outside of working hours the

- Officer on Call
- Senior Officer on Call
- HART Advisor on Call

The Duty Control Manager/Officer should be aware that a crew of three is necessary. The third member of the crew will drive the vehicle, but they will not take part in patient handling. The Duty Control Manager/Officer should inform the Police of the impending movement and seek advice on the most suitable routes.

Control must log the times when the crew:-

- Leave the station
- Arrive at the pick-up point
- Leave the scene and their expected time of arrival
- Complete the case (i.e. arrive back at their home station)

The Duty Control Manager/Officer must arrange an escort vehicle – this will normally be the HART Advisor on call or the Officer on call. The escort must not come into contact with the patient or crew after contact has been made with the patient but simply follows the ambulance to cope with any unforeseen events.

Action by Ambulance Crew

On being notified of an exotic disease case staff should proceed to the agreed ambulance station. The third crew member is required to drive the ambulance and must not take any part whatsoever in patient handling procedures. The vehicle must be prepared in accordance with Section 17.5 of the ASBT manual.

If for any reason a non-specialist Infection Control Vehicle is being used, the bulkhead door and all windows (if applicable) in the patient compartment must be closed. Tape must be applied around both sides of the bulkhead door to prevent air movement into the cab, and around the edges of all cupboards within the patient compartment to prevent contamination of the units. In a dedicated infection control vehicle, a tape strip is placed across the edge of all cupboards etc. to mark them as sealed. After completion of the transport, any compartments which have had their tape removed will require full disinfection.

Personal Protection

If staff have not received specific appropriate training on the transport of infectious cases then they must be supervised by an appropriately trained officer. Staff must remove all clothing (except underwear) and put on a disposable suit. Contact lenses should not be worn unless essential. If contact lenses are worn during a transfer, they should be removed for

disinfection immediately on completion of the transfer and replaced either with spectacles or with clean contact lenses. Watches, rings, etc should be removed and put in a place of safety in the escorting vehicle together with spare uniform/clothing, etc.

The infectious diseases unit will advise as to the level of specialist PPE required but the default position is that all staff must wear disposable overalls, disposable overshoes, gloves, FFP3 mask and visors before entering the place from which the patient is to be collected. Whilst it is not necessary for the driver to wear overshoes, eye protection or a mask, they must be available in the cab.

Journey Arrangements

The route selected should be adhered to, with any necessary diversions reported to Ambulance Control by the escorting vehicle. The escorting vehicle is responsible for keeping Ambulance Control updated on throughout the process.

If it becomes necessary to stop the vehicle e.g. in the event of a breakdown, remain with the vehicle. The escort vehicle driver will notify EAC and may attempt repairs. If repairs are not successful, the escort vehicle will arrange for the vehicle to be towed to its destination or will seek alternative assistance.

On arrival at the destination unit, the ambulance will be directed to the appropriate area to unload the patient

Disinfection of Vehicle

After the admission of the patient the crew will remove all disposable items and bedding for incineration as directed by the receiving unit. The ambulance will be taken to the decontamination area. Any ambulance equipment used en-route should be placed into a sealed clinical waste bag which will in turn be double-bagged. Unless directed otherwise the vehicle crew will then carry out a thorough disinfection of the interior of the vehicle and its equipment by washing down with a 10,000ppm hypochlorite solution. Disinfection by fogging must not be used.

Personal Decontamination

Personal decontamination will be undertaken on the directions of the Infectious Diseases Unit and will include disposal of items of clothing and shower and changing facilities.

Medical Surveillance

Medical surveillance will depend upon the instructions given by the consultant in charge of the infectious diseases unit and the Consultant for Communicable Disease Control.

STAFF CONTACT TRACING

Should a patient treated by the trust subsequently be found to have an infectious disease or illness, it may be necessary for the ambulance clinician or staff to be traced. Form IC.2 should be completed on receipt of a call from an Infection Control Department, Duty Microbiologist, Occupational Health Department or other responsible person.

Form IC.2

CONTROL ROOM TRACING FORM Form IC.2

Date call received in ambulance control: _____/_____/_____ Time: _____:_____
Call received from (name and position): _____ Contact no. _____
Patient's Name: _____
Patient conveyed from: _____
Patient conveyed to: _____
Date of journey: _____/_____/_____ NIAS C3 call reference: _____
Advice from caller: _____
_____
_____
_____
_____
Contact no. for further advice: _____
First Vehicle Call Sign: _____
Crew member #1: _____ Contact no. _____
Crew member #2: _____ Contact no. _____
Information passed to crew: _____
_____
_____
_____

Second Vehicle Call Sign: _____
Crew member #3: _____ Contact no. _____
Crew member #4: _____ Contact no. _____
Information passed to crew: _____
_____
_____
_____

Date & time information passed to Crew or Senior Officer (detail): _____

Signed (Duty Control Manager): _____
Name (Print): _____

TB/12/04/2018/08

Northern Ireland Ambulance Service
Health and Social Care Trust

Your Right to Raise a Concern (Whistleblowing) Policy

Title:	Your Right to Raise a Concern (Whistleblowing) Policy		
Author(s):	Lorraine Gardner Assistant Director of HR and Corporate Services		
Ownership:	HR and Corporate Services Directorate		
Date of SEMT Appoval	March 2018	**Date of Trust Board Approval:**	April 2018
Operational Date:	April 2018	**Review Date:**	April 2019
Version No:	WB/HRCS(03)	**Supersedes:**	All previous versions
Key Words:	Your Right to Raise a Concern (Whistleblowing) Policy		
Other Relevant Policies/Documents:	Public Interest Disclosure Order 1998 Employment Act (NI) 2016 (Commencement Number One) Order (NI) 2017 Fraud Policy		
Version			
(01)			
(02)			
(03) 2016-2018	A regional HSC review of whistleblowing arrangements was undertaken in response to RQIA recommendations following their Review of Whistleblowing arrangements within the HSC. A Model HSC Framework and Policy was developed from these recommendations and was subject to a HSC wide consultation process. This Policy is in keeping with the HSC Framework and Policy and legislative changes.		

NIAS Circulation List:

This Policy was circulated to the following groups for consultation: -

- Trade Unions
- Senior Executive Management Team

Following approval, this policy document was circulated to the following staff and groups of staff:

- All Trust staff
- Trust Internet/Intranet Site

1. INTRODUCTION

All of us at one time or another may have concerns about what is happening at work. The Northern Ireland Ambulance Service HSC Trust (herein referred to as NIAS) wants you to feel able to raise your concerns about any issue troubling you at any time. It expects its managers to listen to those concerns, take them seriously and take action to resolve the concern, either through providing information which gives assurance or taking action to resolve the concern. However, when the concern feels serious because it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues, or NIAS itself, it can be difficult to know what to do.

NIAS recognises that many issues are raised by staff and addressed immediately by line managers – this is very much encouraged. This policy and procedure is aimed at those issues and concerns which are **not resolved, require help to get resolved, or are about serious underlying concerns.**

Whistleblowing refers to staff reporting suspected wrongdoing at work - for example, concerns about patient safety, health and safety at work, environmental damage or a criminal offence such as fraud.

You may be worried about raising such issues and may think it best to keep it to yourself, perhaps feeling it is none of your business or that it is only a suspicion. You may also feel that raising the matter would be disloyal to colleagues, to managers or to the organisation. It may also be the case that you have said something but found that you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it-** rather than waiting for proof, raise the matter when it is still a concern. If something is troubling you which you think we should know about or look into, please let us know. NIAS has implemented these whistleblowing arrangements for you to raise any concern where the interests of others or the organisation itself are at risk.

2. AIMS AND OBJECTIVES

NIAS HSC Trust is committed to running the organisation in the best way possible. The aim of this policy is to promote a culture of openness, transparency and dialogue which at the same time:

- Reassures staff that it is safe and acceptable to speak up
- Upholds patient confidentiality
- Contributes towards improving services provided by NIAS
- Assists in the prevention of fraud and mismanagement
- Demonstrates to all staff and the public that The Trust is ensuring its affairs are carried out ethically, honestly and to high standards
- Provides an effective and confidential process by which staff can raise genuine concerns so that patients, clients and the public can be safeguarded.

Trust roles and responsibilities in the implementation of this policy are set out at **Appendix A.**

3. SCOPE

The Trust recognises that existing policies and procedures which deal with conduct and behaviour at work (Disciplinary, Grievance, Working Well Together, Harassment and Bullying, the Complaints Procedure and the Accident/Incident Reporting Procedure) may not always be appropriate to extremely sensitive issues which may need to be handled in a different way.

This policy provides a procedure for all staff of The Trust, including permanent, temporary and bank staff, staff in training working within The Trust, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk. **If in doubt - raise it!**

Examples may include:

- Malpractice or ill treatment of a patient or client by a member of staff
- Where a potential criminal offence has been committed, is being committed or is likely to be committed
- Suspected fraud
- Breach of Standing Financial Instructions
- Disregard for legislation, particularly in relation to Health and Safety at Work;
- The environment has been, or is likely to be, damaged
- A miscarriage of justice has occurred, is occurring, or is likely to occur
- Showing undue favour over a contractual matter or to a job applicant
- Research misconduct
- Information on any of the above has been, is being, or is likely to be concealed.

This list is not intended to be exhaustive or restrictive

If you feel that something is of concern, and that it is something which you think the Trust should know about or look into, you should use this procedure. If, however, you wish to make a complaint about your employment or how you have been treated, you should follow NIAS local Grievance Procedure or Policy for making a complaint about Bullying and/or Harassment which can be obtained from your manager.

This policy complements professional and ethical rules, guidelines and codes of conduct and freedom of speech. It is not intended to replace professional codes and mechanisms which allow questions about professional competence to be raised (however such issues can be raised under this process if no other more appropriate avenue is apparent).

4. SUSPECTED FRAUD

If your concern is about possible fraud or bribery the Trust has a number of avenues available to report your concern. These are included in more detail in the Trust's Fraud Policy, Fraud Response Plan and Bribery Policy and are summarised below.

Suspicions of fraud or bribery should initially be raised with the appropriate line manager, but where you do not feel this is not appropriate the following officers may be contacted:

- NIAS Director of Finance Tel: 028 90 400751
- NIAS Fraud Liaison Officer Tel: 028 90 400766
- Head of Internal Audit Tel: 0300 5550115

Employees can also contact the regional HSC fraud reporting hotline on **0800 096 33 96** or report their suspicions online to www.repporthealthfraud.hscni.net These avenues are managed by Counter Fraud and Probity Services (CFPS) on behalf of the HSC and reports can be made on a confidential basis.

The Trust's Fraud Response Plan will be instigated immediately on receipt of any reports of a suspicion of fraud or bribery.

The prevention, detection and reporting of fraud and bribery and other forms of corruption are the responsibility of all those working for the Trust or under its control. The Trust expects all staff and third parties to perform their duties impartially, honestly, and with the highest integrity.

5. NIAS HSC TRUST COMMITMENT TO YOU

5.1 Your safety

The Trust, the Chief Executive, managers and the trade unions/professional organisations are committed to this policy. If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any detriment (such as a reprisal or victimisation). The Trust will not tolerate the harassment or victimisation of anyone who raises a genuine concern.

NIAS expects you to raise concerns about malpractices. If any action is taken that deters anyone from raising a genuine concern or victimises them, this will be viewed as a disciplinary matter.

It does not matter if you are mistaken or if there is an innocent explanation for your concerns, you will be protected under the law. However, it is not uncommon for some staff to maliciously raise a matter they know to be untrue. In cases where staff maliciously raise a matter they know to be untrue, protection under the law cannot be guaranteed and NIAS reserves the right to take disciplinary action if appropriate.

5.2 Confidentiality

With these assurances, NIAS hopes that you will raise concerns openly. However, we recognise that there may be circumstances under which you would prefer to speak to someone in confidence first. If this is the case, you should say so at the outset to a member of staff in the Human Resources & Corporate Services Directorate.

The Trust is committed to maintaining confidentiality for everyone involved in a concern. This includes the person raising the concern and the person(s) whom the concern is about. Confidentiality will be maintained throughout the process and after the issue has been resolved.

If you ask for your identity not to be disclosed, we will not do so without your consent unless required by law. You should however understand that there may be times when we will be unable to resolve a concern without revealing your identity, for example, where personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

5.3 Anonymity

Remember that if you do not disclose your identity, it will be much more difficult for us to look into the matter. It will also not be possible to protect your position or give you feedback. So, while we will consider anonymous reports in the exact same manner as those which are not anonymised, these arrangements are not best suited to deal with concerns raised anonymously. If you are unsure about raising a concern you can get independent advice from Public Concern at Work (see contact details under Independent Advice).

6. RAISING A CONCERN

If you are unsure about raising a concern, you can get independent advice at any stage from your trade union/professional organisation, or from one of the organisations listed in Section 7. You should also remember that you do not need to have firm evidence before raising a concern. However, you should explain as fully as possible the information or circumstances that gave rise to the concern.

6.1 Who should I raise a concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it with your line manager. But where you do not think it is appropriate to do this, you can use any of the options set out below.

If raising it with your line manager does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

- a designated advisor/ advocate
- a member of the HR Team

If you still remain concerned after this, you can contact:

- the Director of Human Resources & Corporate Services, who has responsibility for whistleblowing

All of these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies (see Section 7 below).

If exceptionally, the concern is about the Chief Executive, then it should be made (in the first instance) to the Chair, who will decide on how the investigation will proceed.

6.2 Independent advice

If you are unsure whether to use this policy, or if you require confidential advice at any stage, you may contact your Trade Union/professional organisation.

Advice is also available through the independent charity Public Concern at Work (PCaW) on 020 7404 6609.

6.3 How should I raise my concern?

You can raise your concerns with any of the people listed above, in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concerns.

7. RAISING A CONCERN EXTERNALLY

The Trust hopes this policy reassures you of its commitment to have concerns raised under it taken seriously and fully investigated, and to protect an individual who brings such concerns to light.

Whilst there may be occasions where individuals will wish to report their concerns to external agencies or the PSNI, The Trust would hope that the robust implementation of this policy will reassure staff that they can raise such concerns internally in the first instance.

However, The Trust recognises that there may be circumstances where you can raise a concern with an outside body including those listed below:

- Department of Health
- A prescribed person, such as:
  - General Chiropractic Council, General Dental Council, General Medical Council, General Osteopathic Council, Health & Care Professional Council, Northern Ireland Social Care Council, Nursing and Midwifery Council, Pharmaceutical Society Northern Ireland General Optical Council
  - The Regulation and Quality Improvement Authority
  - The Health and Safety Executive

- Serious Fraud Office
- Her Majesty's Revenue and Customs
- Comptroller and Auditor General
- Information Commissioner
- Northern Ireland Commissioner for Children and Young People
- Northern Ireland Human Rights Commission

Disclosure to these organisations/persons will be protected, provided that you honestly and reasonably believe the information and associated allegations are substantially true.

We would prefer you to raise a matter with the external agencies listed above than not at all. Public Concern at Work (or your Trade Union) will be able to advise you on such an option and on the circumstances in which you may be able to contact an outside body safely.

8. THE MEDIA

You may consider going to the media in respect of your concerns if you feel that NIAS has not properly addressed them. You should however carefully consider any information you choose to put into the public domain to ensure that patient/client confidentiality is maintained at all times. NIAS reserves the right to take disciplinary action if patient/client confidentiality is breached.

Communications with the media are coordinated by the Communications Department on behalf of the Trust. Staff approached by the media should direct the media to this department in the first instance.

9. CONCLUSION

While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly, impartially and properly. By using these whistleblowing arrangements you will help us to achieve this.

Please note, this document has been developed to meet best practice and comply with the Public Interest Disclosure (NI) Order 1998 (the Order) which provides employment protection for whistleblowing.

The Order gives significant statutory protection to staff who disclose information reasonably in the public interest. To be protected under the law an employee must act with an honest and reasonable belief that a malpractice has occurred, is occurring or is likely to occur. Disclosures may be made to certain prescribed persons or bodies external to The Trust listed in the Order. The Order does not normally protect employees making rash disclosures for example to the media, when the subject could have been raised internally.

10. APPENDICES

Appendix A – Roles and Responsibilities

Appendix B – Procedure
Appendix C – Advice for Managers

11. EQUALITY, HUMAN RIGHTS & DDA

This policy has been drawn up and reviewed in 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.

The policy has been **screened out** without mitigation or an alternative policy proposed to be adopted.

12. PERSONAL & PUBLIC INVOLVEMENT (PPI)/CONSULTATION PROCESS

Consultation on this Policy has taken place with NIAS Trade Union colleagues via NIAS HR Joint Consultative Group (HR JCG). The NIAS HR JCG is a sub group of its Joint Consultative & Negotiating Committee (JCNC).

13. ALTERNATIVE FORMATS

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other languages to meet the needs of those who are not fluent in English.

14. SOURCES OF ADVICE IN RELATION TO THIS DOCUMENT

The Policy Author and/or responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

15. POLICY SIGN OFF

Lead Policy Author:	**Date**
LORRAINE GARDNER	**20 MARCH 2018**
Acting Director of HR:	**Date**
MICHELLE LEMON	**20 MARCH 2018**

APPENDIX A

ROLES AND RESPONSIBILITIES

The Trust

- To listen to our staff, learn lessons and strive to improve patient care
- To ensure that this policy enables genuine issues that are raised to be dealt with effectively
- To promote a culture of openness and honesty and ensure that issues are dealt with responsibly and taken seriously
- To ensure that employees who raise any issues are not penalised for doing so unless other circumstances come to light which require this - e.g. where a member of staff knowingly raises an issue regarding another member of staff which they know to be untrue
- To share learning, as appropriate, via the Trust's Learning Outcomes Committee

The Non Executive director (NED)

- To have responsibility for oversight of the culture of raising concerns within the organisation.

Senior Manager

- To take responsibility for ensuring the implementation of the whistleblowing arrangements.

Managers

- To take any concerns reported to them seriously and consider them fully and fairly.
- To recognise that raising a concern can be a difficult experience for some staff and to treat the matter in a sensitive manner if required.
- To seek advice from other professionals within the Trust where appropriate.
- To invoke the formal procedure and ensure the Human Resources & Corporate Services Directorate is informed, if the issue is appropriate.
- To ensure feedback/ learning at individual, team and organisational level on concerns and how they were resolved.

Whistleblowing adviser/ advocate

- To ensure that any safety issue about which a concern has been raised is dealt with properly and promptly and escalated appropriately through all management levels
- To intervene if there are any indications that the person who raised a concern is suffering any recriminations
- To work with managers and HR to address the culture in an organisation and tackle the obstacles to raising concerns

This list is not intended to be exhaustive or restrictive

All Members of Staff

- To recognise that it is your duty to draw to The Trust attention any matter of concern
- To adhere to the procedures set out in this policy
- To maintain the duty of confidentiality to patients and the Trust and consequently, where any disclosure of confidential information is to be justified, you should first, where appropriate, seek specialist advice for example from a representative of a regulating organisation such as the Health Care Professions Council (HCPC).

Role of Trade Unions and other Organisations

All staff have the right to consult and seek guidance and support from their Professional Organisations, Trade Union or from statutory bodies such as the Health and Care Professions Council and General Medical Council.

APPENDIX B

PROCEDURE FOR RAISING A CONCERN

Step One (Informal)
If you have a genuine concern about what you believe might be malpractice and have an honest and reasonable suspicion that the malpractice has occurred, is occurring, or is likely to occur, then the matter should be raised in the first instance with your Line Manager. This may be done verbally or in writing.

You are entitled to representation from Trade Union/ fellow worker or companion to assist you in raising your concern.

Step Two (Informal)
If you feel unable to raise the matter with your Line Manager, for whatever reason, please raise the matter with a designated adviser/ advocate.

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concerns
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the Trust of the need to give you timely feedback on how your concern is being dealt with
- ensure that you have access to personal support since raising your concern may be stressful.

If you want the matter dealt with in confidence, please say so at the outset so that appropriate arrangements can be made.

Step Three (Formal)
If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

Director of Human Resources & Corporate Services
Tel: 028 90 400741

Step Four (Formal)
You can raise your concerns formally with the external bodies listed at paragraph 7:

What will we do?

We are committed to listening to our staff, learning lessons and improving patient care. On receipt, the concern will be recorded and, where possible, you will receive an acknowledgement within three working days.

A central register will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback. While your identity may be included within the allegation or report, the register will not include any information which may identify you, nor should it include any information which may identify an individual or individuals against whom an allegation is made.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your Line Manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the Trust, or outside of NIAS) and properly trained – and we will reach a conclusion within a reasonable timescale (of which we will notify you).

Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process: for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

We will advise you, where possible, and those identified as the subject of a concern, of the process, what will be investigated and what will not, those who will be involved, the roles they will play and the anticipated timescales.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

Where an Agency worker raises a concern then it is the responsibility of The Trust to take forward the investigation in conjunction with the Agency if appropriate.

For the purposes of recording, if the concern is already, or has previously been, the subject of an investigation under another procedure e.g. grievance procedure it will not be appropriate to categorise it under The Trust Whistleblowing Policy.

Communicating with you

We welcome your concerns and will treat you with respect at all times. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will endeavour to provide a response within 12 weeks of the concern being received. We will provide an update on progress by week 6 and again by week 10 of the investigation. We will share the outcome of the investigation report with you (while respecting the confidentiality of others).

How we will learn from your concerns

The focus of the investigation will be on improving our services. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. The final outcome and 'lessons learned' will be documented and approved as final by the responsible Director. In addition the relevant Executive Director will independently assess the findings and recommendations for assurance that the matter has been robustly considered and appropriately addressed.

Board oversight

The Trust Board and the Department of Health will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The Board supports staff raising concerns and want you to feel free to speak up. The Chair has nominated a Non-Executive director with responsibility for the oversight of the Trust's culture of raising concerns.

Review & Reporting

We will review the effectiveness of this policy and local processes at least annually, with the outcome published and changes made as appropriate. We will provide regular reports to senior management and to our Assurance Committee on our Whistleblowing caseload and an annual return to the Department of Health setting out the actions and outcomes.

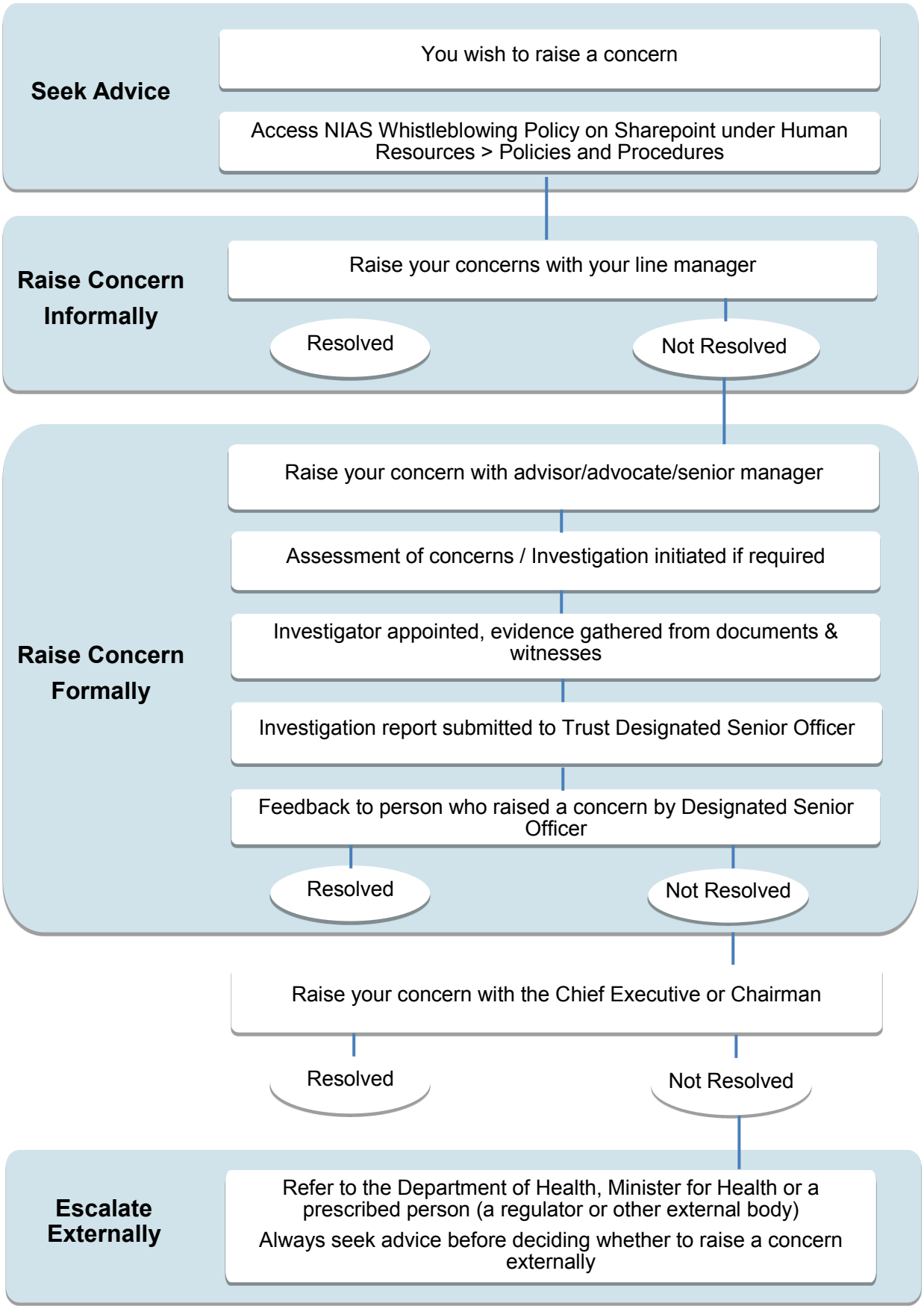
APPENDIX C

ADVICE FOR MANAGERS RESPONDING TO A CONCERN

1. Thank the staff member for raising the concern, even if they may appear to be mistaken
2. Respect and heed legitimate staff concerns about their own position or career
3. Manage expectations and respect promises of confidentiality
4. Discuss reasonable timeframes for feedback with the member of staff
5. Remember there are different perspectives to every story
6. Determine whether there are grounds for concern and investigate if necessary as soon as possible. Where appropriate alert those identified as the subject of the concern. If the concern is potentially very serious or wide-reaching, consider who should handle the investigation and know when to ask for help. If asked, managers should put their response in writing
7. Managers should ensure that the investigator is not connected to the concern raised and determine if there is any actual, potential or perceived conflict of interest which exists prior to disclosing full details of the concern. Should a conflict of interest arise during the investigation the investigator must alert the manager. (Note: Any such conflict must be considered, and acted on, by the manager)
8. Managers should bear in mind that they may have to explain how they have handled the concern
9. Feed back to the whistleblower and those identified as the subject of a concern (where appropriate) any outcome and/or proposed remedial action, but be careful if this could infringe upon any rights or duties which may be owed to other parties
10. Consider reporting to the Board and/or an appropriate regulator the outcome of any genuine concern where malpractice or a serious safety risk was identified and addressed
11. Record-keeping - it is prudent to keep a record of any serious concern raised with those designated under the policy, and these records should be anonymous where necessary.

ANNEX B: FLOWCHART

Raising Concerns and Whistleblowing Process



TB/12/04/2018/09

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee
Wednesday 14 March 2018 11am
Board Room, NIAS, Knockbracken Healthcare Park, Belfast

PRESENT	Mr T Haslett	Non-Executive Director (Chair)
	Mr W Abraham	Non-Executive Director
IN ATTENDANC E	Dr N Ruddell	Interim Medical Director
	Mr B McNeill	Director of Operations
	Ms M Lemon	Director of HR & Corporate Services (Acting)
	Mr P Archer	Trust Chairman
	Mrs J McSwiggan	Note-taker

1.0 Welcome and Apologies

An apology was noted from Dr J Livingstone. The Committee noted that Dr Livingstone has tendered his resignation as a Non-Executive Director from October 2018. Dr Livingstone's valuable contribution as Chair of the Committee was acknowledged.

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 19 January 2018

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

4.0 Matters Arising

With regards item 6.1 in the previous Minutes (Trust Board Governance Structures), it was noted that a briefing paper had been produced by the Chief Executive and it had been agreed at the Trust Board meeting on 1 February that all Non-Executive Directors would now become members of Assurance Committee due to the ongoing shortage of available Non-Executive Directors. This had not been conveyed to the Assurance Committee administrator so Alan Cardwell had not been invited to attend this meeting.

Other matters arising are covered within the Agenda.

5.0 Chairman's Business

The Chair had no business to report.

6.0 IPC Progress Update

The Committee acknowledged the extensive ongoing work being undertaken and the improvement in levels of compliance to date, particularly in relation to patient safety.

However it was noted that following the most recent round of IPC inspections by RQIA, the Permanent Secretary of the Department of Health had written to the Trust's Chief Executive and Chairman to advise that RQIA have recommended a special measure be introduced to ensure improvement:

- The Department of Health will identify and appoint a senior practitioner on secondment to the Trust, initially for three months, to drive the programme of improvement forward.
- The Department of Health will require the Trust to submit a detailed and comprehensive quality improvement plan setting out how areas of concern will be addressed.
- Progress against this improvement plan will be reported at six-weekly accountability meetings between the Chief Executive, Chairman and Department, with the first meeting to take place in April 2018.

The Committee welcomed the appointment of the senior practitioner and it was acknowledged that their expertise in the implementation of IPC systems would be a valuable resource.

The Committee also welcomed the opportunity to present a quality improvement plan to the Department. It was agreed that it would be important to understand the parameters / terms of reference of this plan. The plan will be developed by the Director of Operations and the Medical Director, with oversight by the senior practitioner. It was suggested that the plan should start with the patient, and the first level should cover vehicles, vehicle equipment, hygiene, waste and sharps. The second level of focus should cover the estates issue. Overarching this will be the assurance process. The Committee agreed that the priority is to develop level one of the plan in anticipation of the arrival of the senior practitioner in the coming weeks.

Action: Chief Executive, Medical Director and Director of Operations to develop high level plan for presentation to the Department of Health at the first accountability in April.

It was noted that the remit of the IPC Group has been extended, with all Area Managers now invited to attend to allow for a much more in-depth review and assessment of the audit reports submitted from Divisions/stations, identifying issues across the Trust, determining what is preventing progress in these areas, and providing assurance that the reports correspond with the reality on stations, in conjunction with the leadership walkarounds. The main issues identified by operational staff remain vehicle cleaning and the condition of estate.

The Committee welcomed the development of a tool for Clinical Support Officers to observe practice in relation to IPC as well as clinical practice.

6.1 Reviewed IPC Policy & Procedures

The Committee noted the revised IPC Policy & Procedures and that these will now be presented to Trust Board for approval. In addition to being available electronically to all staff, hard copies will be issued and signed for by all staff to meet RQIA requirements.

It was noted that in addition to the Policy & Procedures underpinning IPC knowledge, practical reference tools have now been developed as Standard Operating Procedures (SOPs) which will be available to all staff.

Action: Dr Ruddell to provide list of SOPs to the Committee.

The Committee was assured that prior to the current RQIA inspections, the Trust had already highlighted the IPC challenges it faced and had actively invited RQIA to develop an ambulance-specific audit tool and to undertake an inspection of current practice.

The Committee welcomed the opportunity to improve the Trust's IPC governance infrastructure, and acknowledged that this knowledge could then be extended to other areas of the Trust.

The Committee acknowledged the huge amount of additional work for the Operations and Medical Directorates, in particular the Risk Manager, and would advocate additional support.

Action: Acting Committee Chair to approach the Trust Chairman to request the provision of additional support.

7.0 Review of Terms of Reference

As previously discussed, all Non-Executive Directors except the Trust Chairman will now be members of the Assurance Committee. Item 2.1 to be amended accordingly.

It was agreed that the Trust Chairman may not be a member of the Assurance Committee (as per item 2.3 of the current Terms of Reference) as this would interfere with the governance structure and reporting line from Assurance Committee to Board (as per item 7.1), but will continue to be invited to attend by the Committee Chair (item 3.2).

8.0 Standing Agenda Items

8.1 Assurance Framework at 31 January 2018

The Committee acknowledged that this remains a work in progress, and updates to the framework were noted.

It was noted that a regional group has been established to review winter pressures, led by the Health & Social Care Board.

The point of handover at hospital by NIAS was clarified in the context of significant delays in turnaround time and the system-wide issues of patient flow within Emergency Departments.

8.2 **Corporate Risk Register at 31 January 2018**

The Committee noted that the Trust still plans to appoint an IPC lead but that this has been delayed through the banding of that role being assessed at a much lower grade than anticipated and which would not attract the appropriate level of applicant.

The Committee asked that a separate risk be escalated in relation to turnaround time and the impact this has on the delivery of services.

Action: Dr Ruddell to escalate this.

8.3 **Local Risk Register Review (Finance) at 31 January 2018**

Noted.

8.4 **Serious Adverse Incidents at 31 January 2018**

The number of incidents recorded in this period clearly illustrates the demand and capacity issues faced by the Trust, particularly over the winter period. However the Committee agreed that infection prevention and control is not negotiable regardless of demand and capacity issues, and is central to patient care. It was noted that RQIA's terms of reference do not include consideration of context, and their focus is solely on the ability to meet IPC standards.

Clarification on the criteria for identifying, notifying and investigating a serious adverse incident was provided.

8.5 **Clinical Incidents at 31 January 2018**

The Committee noted that crews have been encouraged to submit Untoward Incident Reports relating to difficulties in having vehicles stood down for vehicle cleaning, and this, along with winter pressures, is reflected in the increased number of incidents in this reporting period.

8.6 **Untoward Incidents at 31 January 2018**

The Committee noted that an increase in incidents within the reporting period, with the main themes being missed meal breaks, late finishes and requests for vehicles to be stood down.

It was noted that delays with turnaround at Emergency Departments are causing serious concern around health and safety of staff, and a workshop with operational managers and Trade Unions is being organised to address this.

Action: The Chair to convey the Committee's concerns in this area to Trust Board.

8.7 **Coroner's Reports and Letters**

None in this reporting period.

8.8 Medical Device Alerts

It was noted that these all alerts are reviewed and the vast majority are not relevant to NIAS.

Two estates alerts had been reviewed in conjunction with the estates team and any necessary action taken.

One alert relating to nitrous oxide waste gases is currently under review.

8.9 NICE Guidelines and Departmental Advisory Notices

Noted.

8.10 Pharmacy & Medicines Management Update

Noted.

9.0 Standing Agenda Items

9.1 Presentation on Learning Outcomes Review Group

Due to time constraints this item was deferred to the next meeting in May.

9.2 Health & Safety Committee – Notes of Meeting 19 October 2017

It was noted that the Chief Executive has requested that all these Groups operate as governance sub-committees and as such should report on key requirements, Key Performance Indicators and performance against these to Assurance Committee, as opposed to simply presenting Notes and Minutes of these Groups. A template is currently under development.

With regards a carbon monoxide incident previously reported to the Committee, it was noted that this is now within the remit of the Medical Equipment Group, although it was initially raised at the Health & Safety Committee.

The Committee noted that funding has been secured to provide temporary health & safety support to the Risk Manager.

9.3 Health & Safety Committee – Meeting 14 December 2017

Meeting was not quorate.

9.4 Health & Safety Committee – Notes / Mgt Summary of Meeting 18 January 2018

Noted.

9.5 Fire Compliance Group

No meetings within reporting period.

9.6 Medical Equipment Group – Notes of Meeting 31 October 2017

Noted.

9.7 Medical Equipment Group – Notes of Meeting 4 January 2018

Noted.

9.8 Infection Prevention & Control Group – Notes of Meeting 27 October 2017
Noted.

9.9 Infection Prevention & Control Group – Notes of Meeting 16 November 2017
Noted.

9.10 Infection Prevention & Control Group – Notes of Meeting 12 December 2017
Noted.

9.11 Infection Prevention & Control Group – Notes of Meeting 10 January 2018
Noted.

9.12 Emergency Preparedness & Business Continuity Group – Notes of Meeting 13 October 2017
The Committee requested more succinct Notes from this Group in future.

9.13 Information Governance Steering Group – Notes of Meeting 5 January 2018
Noted.

9.14 Learning Outcomes Review Group – Notes of Meeting 27 November 2017
Noted.

10.0 Additional Items

10.1 Controls Assurance Standards
The Committee noted that following the withdrawal of the current standards, NIAS will self-assess using a similar format.

10.2 RQIA IPC Audits & Inspections re: Restraint & Seclusion – update
The RQIA report is still awaited.

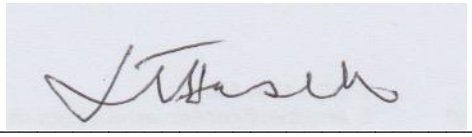
10.3 HSCB SAI Summary Report (April-Sept 2017)
Noted.

11.0 Any Other Business

No other business.

Date of Next Meeting

The next meeting takes place on **Thursday 10 May 2018**. The Committee agreed that this meeting will start at **10am** rather than 11am.

Signed:  **Date:** 29 March 2018

(Trevor Haslett, Chairman)

TB/12/04/2018/10

TERMS OF REFERENCE

ASSURANCE COMMITTEE

1.0 CONSTITUTION

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

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

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

2.0 MEMBERSHIP OF THE COMMITTEE

2.1 All Trust Non-Executive Directors are to be included as members of this Committee with the exception of the Trust Board Chairman.

2.2 A Non-Executive Member of the Committee will be appointed Chair of the Committee by the Board.

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

2.4 In the absence of the Chair another Non-Executive Member may be appointed to that role by agreement of the Non-Executive Directors.

2.5 One member of the Committee shall be the Chair of the Audit Committee.

2.6 Where practicable, one member of the Committee should have a clinical background.

2.7 A quorum shall be two members including the Chair.

3.0 ATTENDANCE AT MEETINGS

3.1 The Medical Director, Director of Operations, Director of Finance & ICT and Director of Human Resources & Corporate Services shall normally attend meetings.

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

3.3 The Medical Director shall attend to the minutes of the meeting and provide appropriate support to the Chairman and Committee members.

4.0 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year.

5.0 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS 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.

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

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

5.4 The Committee is authorised by the Board to obtain outside legal, clinical or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6.0 DUTIES

6.1 The duties of the Committee can be categorised as follows:

6.2 Governance, Risk Management and Internal Control

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

6.3 In particular the Committee will:

6.3.1 Provide assurance that adequate systems and processes are in place to support the achievement of the organisation's objectives and strategically manage clinical and non-clinical risks.

6.3.2 Provide assurance that adequate systems and processes are in place for the delivery of high quality patient care that is safe, effective and patient focused through the review and monitoring of:

- clinical activities;
- professional self-regulation;
- development and implementation of national standards of care and practice;
- clinical audit activity;
- professional and clinical performance standards;
- continuing professional development for all staff;
- adverse incidents and complaints with a clinical component;
- infection prevention and control arrangements;
- clinical research and development activity;
- Personal and Public Involvement (PPI) arrangements and activities;
- corporate social responsibility.
- emergency planning and business continuity;
- information governance;
- compliance with the relevant DHSSPS Controls Assurance Standards and associated action plans.

6.3.3 Review the Trust's Assurance Framework and the Trust's Risk Register and to make recommendations to Trust Board for action as required to ensure high quality patient care.[1]

6.3.4 Report and review the outcome of Serious Adverse Incidents (SAI) including Serious Clinical Adverse Incidents in line with DHSSPS guidance and to ensure that appropriate remedial action has been taken including measures to prevent recurrence.[2]

6.3.5 Receive reports from other Committees and Working Groups in relation to areas of risk and governance.

6.3.6 Provide Trust Board with regular reports on the management of risk and quality of patient care and an annual report on clinical governance.

6.4 In carrying out its work, the Committee will utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions. It will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

[1] Safety First – A framework for sustainable Improvement in the HPSS (March 2006)
[2] Procedure for reporting and follow up of SAI (April 2010)

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

6.6 Other Assurance Functions

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

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

6.8 Governance Statement

The Committee shall review the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

7.0 REPORTING

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

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

8.0 OTHER MATTERS

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

DATE OF ISSUE: **March 2018**

DATE OF REVIEW: **March 2019**

TB/12/04/2018/11

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a meeting of the Audit Committee held on Friday 19th January at 10.00am in the Boardroom, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT:	Mr W Abraham	Non-Executive Director (Chair)
	Mr A Cardwell	Non-Executive Director
IN ATTENDANCE:	Mrs S McCue	Director of Finance & ICT
	Mr P Nicholson	Assistant Director of Finance
	Mr A Phillips	Assistant Director of Finance
	Mr S Knox	NI Audit Office
	Mrs C McKeown	BSO Internal Audit
	Mr B Clerkin	External Audit (ASM)
	Miss K Magee	Senior Secretary
APOLOGIES:	Mr J Livingstone	Non-Executive Director

Welcome and Introduction to the Meeting

Mrs McCue welcomed Mr Phillips in his new temporary role as Assistant Director of Finance, Accounting & Financial Services. Mr Abraham (Chair) welcomed Mr Phillips. Mrs McCue also highlighted the work which Paul Nicholson had carried out in support of the Audit Committee to date.

Mr Abraham welcomed everyone and thanked all members for their attendance. Mr Abraham also thanked Mr Cardwell for stepping in to make the meeting quorate due to the illness of Mr Livingstone.

1.0 Apologies

Apologies were noted from J Livingstone.

2.0 Declaration of Potential Conflict of Interest & Confirmation of Quorum

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

3.0 Minutes of Previous Meeting of the Audit Committee held on 12th October 2017 (for approval)

Mrs McCue advised that the timeliness of the minutes would improve with the additional staff resources.

Mr Cardwell asked that wording be changed in section 3. Mrs McCue advised that the minutes in error did not include mention of the closed meeting and it was decided that the meeting should be noted in the minutes to record that the meeting occurred and that there were no action points arising from it. Mr Abraham advised he would sign off the minutes with these changes.

4.0 Matters Arising

4.1 Mid-Year Assurance Statement – *submitted to the DOH on 13th October 2017 and reported to Trust Board on 7th December 2017*

Mrs McCue stated that there had been an error in the preparation of the December Trust Board Papers and that the version included in those papers was not the final version submitted to the Department of Health. Mrs McCue advised that the correct version would be included in the next Trust Board Papers in February 2018.

5.0 Chairman's Business

Mr Abraham discussed the current shortage of Non-Executive Directors and that meetings could very easily not be quorate if one of the two NON-Executives was unavailable. Mr Abraham raised the issue of how Non-Executives could be appointed in the absence of a Minister of Health and that an interim solution was required. Mr Cardwell noted this was a wider issue than just NIAS. Mrs McKeown suggested to consider bringing other Non-Executive Directors from other committees and to flag the issues to the Department of Health regarding potential consequences. Mrs McCue suggested and Mr Abraham agreed that he would advise the Chairman noting the concerns raised. Mr Clerkin advised that, should there not be a quorate committee, the Trust Board itself would assume the role of the Audit Committee.

6.0 Internal Audit

6.1 Progress Report

Mrs McKeown presented the progress report detailing key performance indicators and acknowledged that the audit plan is being implemented in line with the agreed timeframe however final turnaround times (to include management responses) were not up to date. Mrs McKeown presented 2 final reports as follows:

Helicopter Emergency Medical Service 2017-18

Mrs McKeown advised that she was providing a Satisfactory level of assurance. Mrs McKeown said the service was still being defined as it only went live in July 2017 and was audited in October 2017. There were no major concerns, however, there were 3 key findings in relation to: governance arrangements and assurances; policy and procedures for medicines management; and the security of a window in the drugs room. Management had accepted all audit recommendations and there were no priority 1 findings.

Mr Cardwell queried the delay in receipt of LIBOR funds to NIAS as it was due in July 2017 and not received until October 2017. Mr Nicholson explained that the flow of funding was a complicated process and that the lack of Assembly had an impact and advised that is possible that a delay will happen again in April 2018. Mr Nicholson advised that when the money is allocated to NIAS it is passed on without delay. He highlighted that it had been paid over within 3 days of receipt in NIAS and that the issue did not affect Air Ambulance NI.

Governance and Assurance Structures and Reporting 2017-18

Mrs McKeown advised that she was providing an overall Satisfactory level of assurance, but was providing a Limited level of assurance specifically in relation to governance and oversight of clinical education and clinical audit. There was one significant priority 1 finding relating to the fact that clinical education, clinical audit and quality improvement do not sit within the reporting structure of the Trust's Committee structure. Mr Abraham asked for clarification of this issue.

Mrs McKeown advised that the Medical Director does not have professional responsibility for the above areas. Mrs McCue advised that a review of the structures within NIAS is being undertaken and that it is proposed that the Medical Director will be taking responsibility for the area of clinical training, although this has not been approved as yet. There was a discussion regarding the Assurance Committee audit finding on the level of information provided to the committee. Mrs McKeown advised that management had accepted all audit recommendations.

Mr Cardwell noted that the headings on pages 11 to 14 of the report were not correct.

7.0 External Audit

7.1 Audit of 2017-18 Financial Statements – Audit Strategy

Mr Clerkin presented the Audit Strategy for 2017-18 advising it had been presented in a new format and Mr Abraham commended the clarity of the new format. Mr Clerkin highlighted the key risks and actions for the Audit Committee in the document. The one significant audit risk relates to Agenda for Change and Mr Clerkin said this item had been noted for a number of years with little movement and would review the issue during the audit. Other risk factors in the document were discussed but Mr Clerkin noted that these were not classed as significant risks. These risks included the change in Accounting Officer, HEMS, and RQIA and the audit would review how these issues are reflected in the Governance Statement.

Mr Clerkin also discussed the audit timetable, materiality levels, the audit team and fees, and the value for money work of the NIAO. Mr Clerkin welcomed any questions in relation to the report.

8.0 For Approval

Nothing for approval.

9.0 Any Other Business

Mr Nicholson provided a fraud update and advised that there has been one new fraud case and a brief discussion took place around the nature of the case.

10.0 Date, Time and Venue of Next Meetings

Friday 16th March 2018, 2.00pm NIAS Headquarters Boardroom *(to be confirmed).*

Chair of the Audit Committee

16th March 2018

TB/12/04/2018/12

Northern Ireland Ambulance Service
Health and Social Care Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

Audit Committee Terms of Reference

Submitted for approval to Audit Committee 16 March 2018

Submitted for approval to Trust Board 12 April 2018

CONTENTS

1. CONSTITUTION

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

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

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

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

2. MEMBERSHIP OF THE COMMITTEE

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

2.2 None of these members should be the Chair or a member of the Remuneration Committee.

2.3 A quorum shall be two members.

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

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

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

2.7 One member of the Committee should have a financial background.

3. ATTENDANCE

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

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

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

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

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

4. FREQUENCY OF MEETINGS

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

5. AUTHORITY

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

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

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

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

6. DUTIES

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

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

6.2 In particular the Committee will review:

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

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

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

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

Internal Audit

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

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

External Audit

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

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

Other Assurance Functions

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

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

Financial Reporting

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

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

Value for Money

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

7. REPORTING

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

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

8. OTHER MATTERS

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

TB/12/04/2018/13

Health and Social Care Board

Directorate of Commissioning

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 02895 363231
Web Site : www.hscboard.hscni.net

Our Ref: MM/LETTERS/TrustNIAS

Date: 12 February 2018

Mr Brian McNeill
Director of Operations
NI Ambulance Trust
Knockbracken Healthcare Park
Saintfield Road
BELFAST
BT8 8SG.

Dear Brian

TRUST DELIVERY PLAN 2017/18 – DECISION OF APPROVAL

Following engagement between Trust and HSCB officers, satisfactory assurances have been received on the outstanding issues relating to: Ministerial targets; commissioner priorities; income assumptions; and savings proposals as outlined in Valerie Watt's letter of 17 December 2017.

Please be advised that the Trust Delivery Plan for 2017/18 has been approved.

Yours sincerely,

Dr Miriam McCarthy
Director of Commissioning

Cc: HSCB SMT
Paul Cavanagh
Lindsay Stead
Roger Kennedy
Jonathan Houston

TB/12/04/2018/14

Northern Ireland Ambulance Service
Health and Social Care Trust

Equality Action Plan 2018-23

The Northern Ireland Ambulance Service HSC Trust (NIAS) works in partnership with HSC organisations to implement statutory duties in respect of Section 75 of the Northern Ireland Act 1998, as reflected in the HSC Equality Action Plan.

Although also a Trust, NIAS is a smaller organisation with approximately 1,200 staff and with the specific purpose of provision of ambulance services. The Trust will contribute to implementation of the regional HSC Plans and **in addition** the following will be key priorities for the NIAS. The framework and progress for delivering equality outcomes within NIAS is reported in the annual Section 75 progress report and triennial Article 55 monitoring report to the Equality Commission for Northern Ireland.

For further information, contact: Michelle Lemon, Asst. Director (Equality, PPI and Patient Experience)
Michelle.Lemon@nias.hscni.net

Section 1 – Simplifying our Section 75 processes - Feedback from consultees has indicated that implementation of our Equality Schemes tends to be process-driven. We recognise the value of having a legislative framework that promotes equality of opportunity and good relations however we want to ensure that the focus is on outcomes for people within the nine Section 75 equality categories and making a positive difference for them.

NIAS Actions	Measures	Timescale
We will deliver a new Equality and Human Rights screening toolkit for managers and staff We will deliver a training module to support the toolkit's implementation	• Dedicated shelf-resource to advise managers and staff of their obligations and options • Dedicated practical training module to inform and advise staff • Staff and managers clearer about relevance and application of equality and human rights • Service users and carers have better awareness of expectations on staff and managers	Years 1/2
We will review screening reports to ensure they are clear and focus on outcomes	• Reviewed screening reports are clearer, more easily understood and take account of best practice guidance	Years 1/2

Section 2 – Promoting equality in our services

While consultees were positive about all the work that has been done to date to promote equality of opportunity they provided many suggestions on how to improve equality of access to health and social care services. We know that the people who use our services come from many different cultures, communities, and backgrounds and being responsive to the diverse range of needs is a responsibility we take very seriously. The following actions have been developed in response to what we have heard and are aimed at providing welcoming, person-centred and accessible services for everyone.

NIAS Actions	Measures	Timescale
We will focus on addressing the needs of those with disabilities in terms of our service	• Audit and improve the provision of facilities for service users with hearing loss difficulties, for example renewed deaf awareness training for staff, promotion of information about how to access our services and make a complaint for deaf service users	Year 1
	• Launch and implementation of Transportation of Assistance Dogs Policy and Procedure	Year 1
We will continue to deliver equality measures for LGBT service users, including promoting PRIDE	• Continued practical involvement in PRIDE events across Northern Ireland • Develop the community education dimension at PRIDE events, including official NIAS involvement	Year 1-5

Section 3 –Supporting our staff

We recognise that our staff are our most valuable resource and that they deserve to be treated with dignity and respect and can expect to experience equality of opportunity and good relations in the workplace. Similarly every member of Trust staff shares a responsibility to promote equality of opportunity and good relations with their co-workers, service users and carers. The following actions will help to promote equality of opportunity for our staff and support them to understand their responsibilities in valuing differences and advancing equality of opportunity to ensure an inclusive and welcoming environment.

NIAS Actions	Measures	Timescale
We will reinvigorate the NIAS Equality Forum, involving staff and unions to promote the equality agenda through structures, projects and issues	• Regular meetings on a quarterly basis, building on work during 2017/18 • Identify issues and themes that relate to equality and human rights • Provide advice and initiative to NIAS equality and human rights work-plans • Establish the NIAS Women's Forum	Year 1
We will ensure the rollout of the regional e-learning programme on equality and diversity	• Better awareness among NIAS staff of context, obligations and application of equality and diversity • Continued implementation of regional partnerships in developing resources	Year 1

NIAS Actions	Measures	Timescale
We will continue to promote PRIDE across NIAS and deliver equality measures for LGBT staff	• Continued practical involvement in PRIDE events across Northern Ireland • A more welcoming environment for LGBT staff through corporate communications, social media and visibility across the organisation • Continue to explore formal agreement around 'Diversity Champions' status • Ensure implementation of new Regional Gender Identity and Expression Policy • Establish a NIAS LGBT Forum	Years 1-5
We will focus on addressing the needs of those with disabilities, both staff and service users	• Establish a Disabled Employee Network through the Trust's Equality Forum	Year 2

TB/12/04/2018/15

Northern Ireland Ambulance Service
Health and Social Care Trust

Disability Action Plan 2018-23

The Northern Ireland Ambulance Service HSC Trust (NIAS) works in partnership with HSC organisations to implement statutory duties in respect of Section 75 of the Northern Ireland Act 1998, as reflected in the HSC Equality Action Plan.

Although also a Trust, NIAS is a smaller organisation with approximately 1,200 staff and with the specific purpose of provision of ambulance services. The Trust will contribute to implementation of the regional HSC Plans and **in addition** the following will be key priorities for the NIAS.

For further information, contact: Michelle Lemon, Asst. Director (Equality, PPI and Patient Experience)
Michelle.Lemon@nias.hscni.net

1. What is in our Disability Action Plan for 2017 - 2022

The following tables outline our actions for the next five years. This Plan is designed to be flexible and responsive to changing circumstances and needs. Our Plan will be reviewed on an on-going basis and when the Equality Commission publishes their statement on key inequalities in health. We will report annually via our S75 Annual Progress Report to the ECNI which is submitted at the end of August each year and available on all of our websites or by contacting the Equality Units.

Section 1 – Promoting positive actions and increased participation through training, awareness and resources

Disabled people have told us that promoting well-informed social attitudes to disability is central to securing the right to equality for all disabled people. We are committed to providing training and resources to support our staff in the implementation of our disability duties.

What we will do	How will we measure what we have done	When
• We will launch and disseminate NIAS policy and procedure for Transportation of Assistance Dogs Policy and Procedure	• Provide advice and induction awareness about the implementation of NIAS assistance dogs policy and procedure • Continue to oversee and monitor implementation	Year 1

Section 2 – Supporting full participation of disabled people by improving accessibility

We have done much work over the years in enhancing the accessibility of health and social care services but disabled people continue to tell us that barriers to full accessibility remain. We are committed to working with disabled people on the initiatives listed below to improve accessibility for and participation of disabled people when accessing our buildings, information and services.

What we will do	How will we measure what we have done	When
We will develop deaf awareness training for staff, and enhance involvement of deaf community in service development	• Training sessions to inform and advise staff • Staff and managers clearer about issues affecting the deaf community • Staff and managers aware of various options for communicating with deaf community • Engagement with sector re: service/policy issues and through PPI work re: service transformation	Year 1-2

Section 3 – Supporting full participation of and positive attitudes towards disabled people in our workforce

We know that there continues to be gaps between the proportion of disabled people employed in health and social care compared with non-disabled people. We are committed to ensuring that disabled people are afforded equality of opportunity in respect of entering and continuing employment in health and social care. We will work in partnership with disabled people to make sure our employment policies and practices and working environments are as inclusive and accessible as possible.

What we will do	How will we measure what we have done	When
We will establish a network of disabled employees	• Broaden the effectiveness of the staff Equality Forum by developing disabled employees network • Lift the profile of disability issues on the agenda of the Equality Forum • Develop awareness of key issues facing staff with disabilities • Consider options to further address any such issues by involving staff with disabilities and their representatives in review of the Trust's management of disability and reasonable adjustment procedures	Year 2

Northern Ireland Ambulance Service Health and Social Care Trust

www.nias.hscni.net